NHS
Dorset
Clinical Commissioning Group

Dorset Dementia Services Review

FULL BUSINESS CASE

Supporting people in Dorset to lead healthier lives

DOCUMENT VERSION CONTROL SHEET	
Heading	Dementia Review Full Business Case
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1.2	10.10.19	Sara Bonfanti amends
1.3	14.10.19	Sarah Hall amends
1.3	14.10.19	Micki Attridge amends
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1.3	14.10.19	Steve Jones amends
1.3	14.10.19	Sally Sandcraft amends
1.3	14.10.19	Carlvin Josephs amends
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1.5	16.10.19	Mark Harris amends
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4.1	9.9.20	Rachel Small/Jane Austin- Implementation Plan update

EXECUTIVE SUMMARY

Introduction

The vision of the Dementia Services Review is to ensure people living with dementia and their families/carers will achieve similar outcomes, regardless of where they live in Dorset and to be enabled to live well with dementia, no matter what the stage of their illness or where they receive care.

The CCG and partners have been through a rigorous process of needs and data analysis, engagement and view seeking and have coproduced a new model for dementia which is presented within the Strategic Outline Case.

The Strategic Outline Case (SOC) and subsequent Full Business Case (FBC) followed the Five Case Business Model approved by the Treasury Department. This document outlines in detail the strategic context and the economic and commercial landscape. The financial implications are fully described and the management case highlights the project process followed and the proposal for implementing the new dementia care pathway.

Key elements

The Dementia Services Review was enacted following concerns about the existing pathways of care, increasing demand for services, rising costs, an ageing population and national policy.

The review project was co-designed with a wide variety of stakeholders from the outset and stage two and three co-produced with a wide range of people including people living with dementia, their family carers, Dorset HealthCare NHS Foundation Trust, the three Local Authorities, Alzheimer's Society, other voluntary sector providers, acute hospital providers, care home sector and local councillors.

A Strategic Outline Case (SOC) approved in March 2019 made the case for change and proposed a revised diagnostic model, additional community based resources including new 'Dementia Co-ordinators' and the formal commissioning of services into the West which have previously only been commissioned in the East of the county. In particular, to expand the Intermediate Care Service for Dementia (to be rebranded 'Intensive Care Service for Dementia), offer a crisis helpline and In-Reach Services. Also proposed was a revised model of care with the day hospitals integrated with the Intensive support service as a means of reducing admissions.

The SOC outlined the benefits and potential outcomes from this revised model of care. It includes a shortlisted selection of viable options which meet the agreed critical success factors and includes a recommendation for a preferred way forward which was then taken forward through a consultation process.

Option B: preferred way forward

This Full Business Case (FBC) has been developed following the consultation on the preferred option. The consultation findings have influenced the final proposal with some amendments to the proposed services detailed in this document.

The financial case gives detail on the required investment with a staged implementation process.

The cost benefits from earlier interventions and greater support within the community preventing crisis indicate significant savings. This would be particularly from reduced inpatient admissions across both acute and dementia specialist beds. Furthermore, a reduction in Mental Health Act detentions would reduce Section 117 funding which has been significantly rising over recent years. It is estimated that the direct cost benefit will be £2,201,820 per year, although not all elements will be cash releasing. In addition, the evidence summarised above indicates that there will be a substantial return on investment, that would be realised across the life of the patients.

The required investment with a phased implementation plan for Year 1 is £823,021. This is made up of set up costs of £64,512 and recurrent pay and non- pay of £758,509. Year 2 and thereafter (excluding uplifts) will require £1,108,554 recurrent.

Anticipated benefits and outcomes

- People will experience a smoother and quicker diagnostic process and receive post diagnostic support from diagnosis to end of life
- People will be supported to live well with dementia and experience less crisis
- More choice for people living with dementia through an increased range of community options including more support for carers
- More efficient and cost effective services
- Greater compliance with NICE Standards
- Reduced inpatient admissions
- Cost benefits estimated at £2,201,820 per year
- Substantial return on investment realised across the life of patients with dementia

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INTRODUCTION

1.1 The purpose of this Full Business Case document is to set out the detail for securing resources, procuring and implementing the new service model for dementia services following a public consultation as part of the Dorset Dementia Services Review.

1.2 This document builds on the 'Strategic Outline Case' which set out the case for change and project process whereby various proposals were developed through a co-production approach. A preferred option was identified with a range of stakeholders and this was subjected to NHS England Assurance processes and then a public consultation. The purpose of the 'Full Business Case' is to identify the market opportunity which offers best value for money and sets out the procurement strategy and approach alongside demonstrating that the management arrangements are in place for successful delivery.

1.3 The Strategic Outline Case and Full Business Case have been prepared using HM Treasury's recommended 'Five Case Model' for business case development[1] and adapted proportionately to the nature of this scheme. The documents explore the proposal from five perspectives:

- The **strategic case** explores the case for change, whether the proposed change and investment is necessary and whether it fits with the overall local and national strategies. It also sets out the vision for the new pathway and its key core functions;

- The **economic case** identifies and appraises a wide range of realistic and achievable options. It asks whether each proposed approach offers the best value for money and meet the critical success factors agreed;

- The **financial case** considers the financial implications of the proposed investment and distils from the analysis within the Economic Case. It offers detailed modelling and costing for the proposed model that was consulted upon and the subsequent investment required;

- The **commercial case** tests the likely attractiveness of the proposal and demonstrates that the service can be delivered in the area and by the best provider for the job;

- The **management case** highlights implementation issues and demonstrates that Dorset CCG and partners are capable of delivering the proposed service care pathway.

1 www.gov.uk/government/uploads/system/uploads/attachment_data/file/469317/green_book_guidance_public_sector_business_cases_2015_update.pdf

1.4 Dementia is a growing challenge nationally. As the population ages and people live for longer, it has become one of the most important health and care issues facing the world. In the whole of the UK, the number of people with dementia is estimated at 850,000. There is a considerable economic cost associated with the disease estimated at £23 billion a year[2], predicted to triple by 2040 and has higher costs than cancer, heart disease and stroke.

1.5 The term 'dementia' is used to describe a collection of symptoms including memory loss, problems with reasoning and communication, and a reduction in a person's ability to carry out daily activities such as washing, dressing and cooking. The most common types of dementia are: Alzheimer's disease, vascular dementia, mixed dementia and dementia with Lewy bodies.

1.6 Dementia is a progressive condition which will vary from person to person. For some individuals they may develop behavioural and psychological symptoms such as depression, psychosis and behaviours that are challenging to others. Dementia mainly affects older people, and after the age of 65, the likelihood of developing dementia roughly doubles every five years. However, for some dementia can develop earlier, presenting different issues for the person affected, their carer and their family.

1.7 There are around 540,000 unpaid carers of people with dementia in England. It is estimated that one in three people will care for a person with dementia in their lifetime. From those carers currently working, estimations suggest 66,000 people have already cut their working hours to care for a family member, whilst 50,000 people have left work altogether.[3]

[2] NHS Rightcare 2017

[3] NHS Rightcare 2017

Project initiation in Dorset

1.8 A review of specialist dementia services across Dorset commenced in earnest from 2017 following being prioritised and included in the Clinical Commissioning Programme 5 Year plan. This was re-reinforced by increasing demand for services, rising costs, an ageing population, national policy and significant challenges to recruit and retain registered staff for specialist in-patient units leading to the closure of beds in Blandford and Weymouth on the grounds of safety.

1.9 At commencement the three Local Authorities requested to incorporate social care services within scope in order to ensure a whole system approach and to consider the whole of the health and social care dementia pathway. Unfortunately, despite the best efforts of all partners, as the review progressed it became apparent that local authority service developments would not align to the project timeframes. Consequently, on 1st February 2018, the Dementia Services Review Project Board agreed to revise the scope to focus on the commissioning of health elements of the pathway whilst continuing to work together where possible in the context of social care service developments. However, at a Joint Commissioning Board on 14th October 2019 it was agreed to reconvene the 'Dementia Joint Commissioning Officers' meeting to explore opportunities for joint commissioning arrangements within dementia provision.

Services in scope

1.10 The range of dementia services included and interdependencies are shown below.

Figure 1. Services within scope of Dementia Services Review

Provider	Services in scope
Dorset HealthCare NHS Foundation Trust	Memory Assessment Service
	Dementia In-reach Service
	Intermediate Care Service for Dementia (ICSD) East
	16 commissioned In-patient beds Chalbury Unit (closed in 2016)
	12 commissioned In-patient beds Betty Highwood (closed in 2013)
	Older persons Community Mental Health Teams
	Haymoor Day Hospital, Alderney
	Melcombe Day Unit, Weymouth
	40 operational specialist dementia In-patient beds Alderney Hospital, Poole
Alzheimer's Society	Memory Support and Advisory Service

Figure 2. Interdependent services to Dementia Services Review

Provider	Interdependent services
Dorset HealthCare	Psychiatric Liaison Services
Poole Borough	Care UK: Specialist dementia care at home (domiciliary) Respite provision Dementia Care homes and Dementia Respite Care
Bournemouth Borough Council (BBC)	Early Help and Prevention services commissioned by BBC to support people living with dementia in the community Dementia Care Homes and Dementia Respite Care
Dorset County Council	Dementia Care Homes and Dementia Respite Care Domiciliary Care
Acute and Community Hospitals	Hospital links to community services (inpatient provision outside scope)
Various	Information provision Out of Hours crisis services Care home providers providing dementia care Domiciliary providers Dementia workforce – recruitment, retention and training

Co-production methodology

1.11 Throughout the Dementia Services Review, the Project Board's methodology has been to apply best practice in its decision-making processes and to embed 'co-production'. Co-production is a value driven approach in which decision makers e.g. professionals and citizens are involved in a relationship in which power is shared wherever possible and where there is recognition that everyone involved has a contribution to make.

Stakeholders

1.12 The co-production approach has encouraged anyone with an interest with dementia to participate and become involved. Stakeholders include:

- People living with dementia;
- Family members, friends, informal carers and carer groups;
- Health and social care staff from Home Care, Care Homes, Voluntary and Private sector organisations, NHS, Local Authorities, Ambulance Trusts, bordering CCG's and staff;
- Other public sector organisations: Police, Fire brigade etc;
- NHS England and Strategic Clinical Networks;
- Universities;
- Local Councillors.

1.13 Project updates have been shared with local Health and Wellbeing Boards, Dorset Joint Commissioning Board and each of the three Health Overview and Scrutiny Committees. Local councillors have been invited to view seeking events to support their communities at the outset of the project and to engage within the Design and modelling process. Senior Local Authority officers are core members of the Project Board ensuring that decisions and progress has been actively shared in their organisations.

Core statutory duties

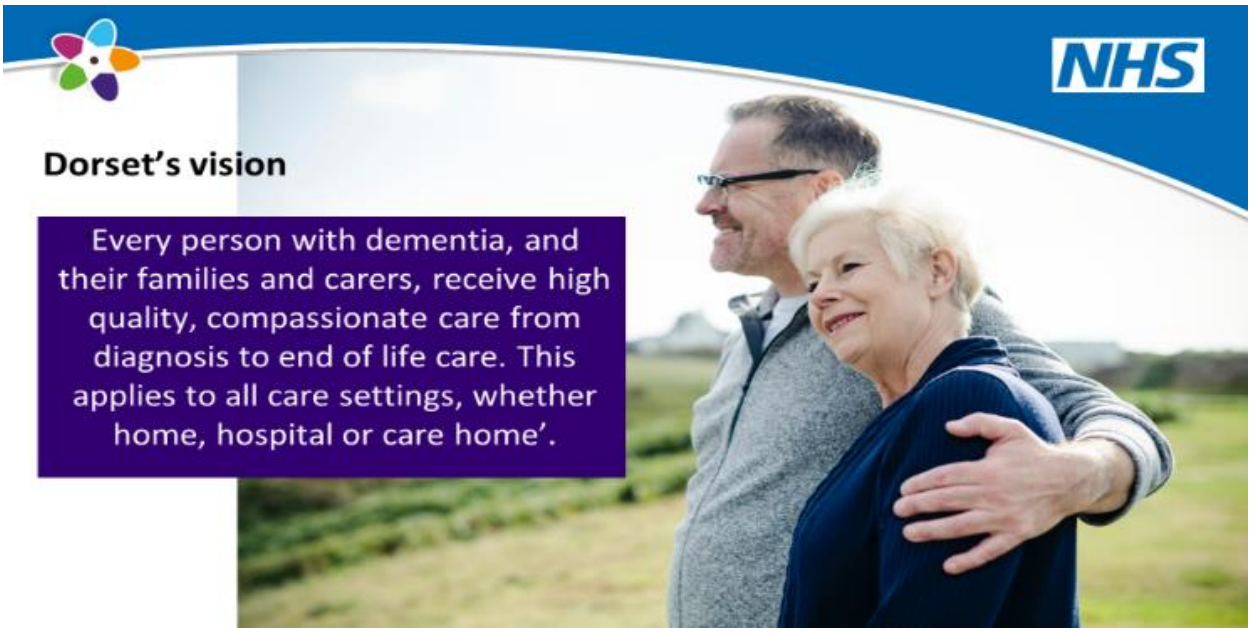
1.14 All engagement and communication throughout this review has ensured the legal requirements to involve local people about the way the NHS and Social Care is operating and about any proposed changes are followed. The duties particularly focus on:

- Involving patients and the public;
- Involving the Local Authority Overview and Scrutiny Committee.

1.15 To comply with the Equality Act 2010[4] and the NHS Act 2006 s.14T and reducing inequalities between patients with respect to accessibility, and outcomes. An 'Equality Impact Assessment' and 'Privacy Impact Assessment' as part of this review have both been completed and approved through the CCG Information Governance Board.

Vision and Objectives

1.16 The vision by Dorset Dementia Partnership in '*Living Well with Dementia Strategy*' [5]:



[4] https://www.gov.uk/guidance/equality-act-2010-guidance

[5] http://www.dorsetccg.nhs.uk/Downloads/aboutus/CCP/Mental%20Health/Dorset%20Dementia%20Partnership%20-%20Dementia%20Strategy%202016-18.pdf

Project Outcomes

1.17 The agreed outcomes are for each person diagnosed with dementia across Dorset to be able to agree with the following statements[6]:

- I have personal choice and control over the decisions that affect me;
- I know that services are designed around me, my needs and my carer's needs;
- I have support that helps me live my life;
- I have the knowledge to get what I need;
- I live in an enabling and supportive environment where I feel valued and understood;
- I have a sense of belonging & of being a valued part of family, community and civic life;
- I am confident my end of life wishes will be respected. I can expect a good death.

Project Objectives

1.18 The objectives have been to utilise a 'co-production' approach to:

- design and deliver consistent and high quality, compassionate care and support to meet the needs of people living with dementia and their carers from diagnosis to end of life within the existing financial resource;
- ensure equity of outcomes for people living with dementia and their carers across Dorset localities;
- consider implications and any additional resource requirements of increasing the number of people being diagnosed with dementia, and starting treatment, within six weeks from referral;
- support the ambition of a diagnosis rate of two thirds of prevalent population;
- improve the quality of post diagnosis treatment and support.

Spending Objectives

1.19 The initial agreement was to work within existing resources to take forward a re-procurement of services following the contract end of Memory Support and Advisory Service to re-utilise these recurrent funds. Also to identify remaining funds from previous closures of two inpatient units and reinvest these into new or existing dementia services. Finally, to ensure all services are cost efficient and offer best value for money. The operational budget for 2019-20 is in Figure 3 below.

Figure 3. Current dementia services operational budget (2019/20)

Service	Operational Budget £	WTE
Memory Support and Advisory Service	596,510	18.00
VOLUNTARY SECTOR TOTAL	**596,510**	**18.00**
Memory Assessment Service	1,009,635	23.47
Memory Assessment Service Medics	201,391	1.60
Memory Assessment Drugs and Scans (notional)	89,419	-
Day Hospitals	314,887	10.63
ICSD (Intensive Support Service)	2,232,876	58.56
Dementia Specialist Inpatients	4,379,256	125.65
ORGANIC SERVICES TOTAL	**8,227,464**	**219.91**
Older People CMHT (54% of total service)	2,149,858	50.49
OP Psychology (54% of service)	138,417	2.40
OP Psych (notional) Neuropsychology	29,365	0.51
OP Inreach (Functional and Organic)	182,203	4.00
Modern Matron (Functional and Organic)	56,625	1.0
INTEGRATED SERVICES TOTAL	**2,556,469**	**58.40**
GRAND TOTAL	**11,380,442**	**296.31**

1.20 At the original inception of the project there was an expectation that funds from the temporarily closed units would be available for reinvestment. However, as time as passed these funds have been utilised and reinvested into various community services including establishing the 'Intermediate Care Service for Dementia' for people living in the West of the county. The remaining sum to be re-invested totals £47k. To note:

- Integrated service budgets have been split out on an estimated 54% split for organic needs. These are total operational expenditure budgets (pay, non-pay & income);
- Inpatients includes Herm, St Brelades and remaining budget from Chalbury (£47k) after creating Intermediate Care Service for Dementia (ICSD) West;
- ICSD includes Social Care budget in addition to the ICSD East and West Teams.

Critical success factors

1.21 Key success factors were agreed with the Project Board in order to evaluate emerging model options. See Figure 4 below.

Figure 4. Critical success factors

Factor to be considered	Issues to be included when considering this factor
Can the option really be implemented?	Will there be sufficient / appropriate workforce? Will it be attractive enough to retain the workforce? Will the necessary IT systems be in place? Will all other necessary systems be in place?
Does the option deliver services which are safe and sustainable?	Will there be sufficient staffing and systems to ensure the safety of staff and people who use services in all settings? How vulnerable will the services be to unexpected staff shortages?
Will the option be affordable?	Using high-level estimates, do we believe that the option can be delivered by reshaping existing resources? If there will be short-term transitional costs, do we believe there will be a way of funding them? Will the option be affordable in the long term?
Will this option deliver services which will be acceptable to people?	Will services be acceptable / attractive to people who use services and the families/carers? Will they be acceptable / attractive to all groups – for example, BME communities?
Is the option based on evidence of best practice?	Is there objective, accepted evidence of the effectiveness of the proposed service model?
Will this option result in a better experience for those who use the service?	Will it promote positive relationships between those who use the service and the clinicians who support them? Will it enable people to live the lives they wish to live?

Service Review Project Methodology

1.22 A Project Management approach was adopted and a Project Initiation Document approved. A Privacy Impact Assessment and Equality Impact Assessment were developed to ensure all Public Sector Equality duties and Information Governance are met. Furthermore, a Risk Log including mitigating actions was maintained.

1.23 **Stage one** of the project included a comprehensive health and social care needs analysis and the output was a Needs and Data Analysis report developed jointly with the three local authorities, Public Health Dorset and Dorset HealthCare NHS Trust.

1.24 A full copy of the report can be found at the following link: https://www.dorsetsvision.nhs.uk/wp-content/uploads/2018/05/Dementia-Health-Needs-and-Data-Analysis-for-Dorset-Version-2.6-final.pdf

View seeking and engagement stage

1.25 **Stage two** was a substantial public engagement and view-seeking exercise led by Dorset CCG in partnership with the Local Authorities, Dorset HealthCare University NHS Foundation Trust (thereafter noted Dorset HealthCare) and Alzheimer's Society. The output was a comprehensive, thematic analysis with the evaluation and report produced by Bournemouth University and published in March 2017. https://www.dorsetsvision.nhs.uk/wp-content/uploads/2018/05/Dementia-Services-Review-View-Seeking-Report-FINAL.pdf

1.26 The outcome of Stage two were views gathered from a wide range of stakeholders including those living with dementia, carers and staff from health, social care, voluntary sectors and others. There were 531 responses to the different view seeking methods. 275 responses to the online or postal surveys and one email response. There were 106 attendees to the 15 community events and 149 attended the 10 outreach events and meetings.

1.27 From a total of 2,107 comments were made by respondents: 498 comments mentioning aspects of services that work well; 843 comments related to what works less well and 766 related to ideas for improvements.

Design and Modelling Stage

1.28 **Stage three** of the project was the design and model options development stage. The development of the new service vision and the options to deliver this has been through a significant co-production exercise with a wide range of stakeholders and public. See below.

Figure 5. Summary of Design and Modelling Stage co-production

Type of group	Purpose	Attendance	Outputs
Innovation open group 16 May 2017	An open event was held for anyone interested in dementia services. National Clinical Lead as Keynote	101	Innovation and visioning Consider 'What is' and 'what might be'
Co-Production Design & Modelling Groups: Poole, Bournemouth Dorchester. May – Sept 2017	3 groups made up of a wide variety of stakeholders whom considered different areas along the whole care pathway. All met together for final group to summarise the model design	Total attendance = 333	Staged workshops across stages. 'What should be' 8 modelling summaries of whole pathway developed
Working Groups Sept 2017 – April 2018	• Modelling group • Diagnosis sub group • Acute sub group • Crisis and inpatient sub group • Data and intelligence sub group. • Local authorities DSR planning meetings	Overall approx. 70 members	Detailed model options developed across pathway. Acute hospital Action plan Data and costing of model options. Linking to local authority initiatives
Cross check event 11 April 18	Checking and validating the potential care models against critical success factors	67	Feedback and scoring on emerging model options
Final Options event 5th Sept 18	Applying an analysis to models and identifying preferred way forward	60	Evaluation of options. Identify preferred way forward
GP Survey (Feb 2018)	Online survey	14	Views on current services and how to improve
Community Mental Health Team survey (March 2018)	Online survey	21	Views on current services and how to improve
Team meeting visits March/April 2018	Discussions with CMHT OP and ICSD teams and Memory Advisors	Approx. 50	Checking emerging options and capturing ideas
Dementia Partnership	Update on the phases of the review and obtain feedback on related projects.	Varied Approx. 25 - 50	Regular updates
Other groups & engagement	• Equality and Diversity workshop • STP Patient Engagement Group • Poole Forum Learning Disability group • Alzheimer's society volunteer groups • Information task and finish group • Dorset HealthCare Operational Dementia Steering Group	20 16 25 30 + 25 10 10	Updates on review and how to be involved Gave solutions and ideas to support design & modelling phase Developed dementia directory Update on review including feedback from Cross check event

1.29 The design stage commenced with a large innovation event with Professor Alistair Burns, National Clinical Lead for Dementia in attendance and over 100 stakeholders. This was followed by three locality based groups identifying the different needs along all aspects of the dementia care pathway, utilising case study vignettes and other methodologies over a series of meetings to narrow down from a long list of options (see Annex).

1.30 Following this a series of service modelling sub groups were established to work further on the detail of each element of the pathway bringing in stakeholders with specific expertise on each element of the pathway.

1.31 It was recognised that the views of GPs were not fully captured within the stakeholder group work so a bespoke survey was developed and offered through 'survey monkey' and promoted across general practices. The views were evaluated and incorporated into the design developments. It was also felt that more specific information was needed to inform the review from staff working within the community mental health teams for older people. So another bespoke survey was developed through 'survey monkey' and views captured and evaluated (see Annex 14).

1.32 All stakeholders involved within the Design phase were invited back to a 'Cross check' event to consider all the evidence and the emerging model options with indicative costs attached. All participants in small groups scrutinised each option with a SWOT analysis and then individuals scored each option against the critical success factors and gave a measure of prioritisation.

1.33 Further refinement was then completed around modelling the different elements and costing in more detail aligning with the 5 Case Model and the options matrix. Finally, when all of the detail had been ascertained a Final Options event with stakeholders was held on the 5th Sept 2018 with further scrutiny against the Critical Success Factors. This enabled four potential options to be identified including a 'Preferred' option.

Figure 6 Process of converging from long list to preferred option

.

NHS England Major Service Change Tests

1.34 **Stage four** of the project was to ensure NHS Assurance was confirmed to proceed with the service reconfiguration. The Five tests within the Government Mandate for service reconfiguration include:

- strong public and patient engagement;
- consistency with current and prospective need for patient choice;
- a clear clinical evidence base;
- support for proposals from clinical commissioners;
- demonstrable financial deliverability, affordability and value for money applied to all proposals.

1.35 In March, 2017, NHS England announced a new test, to bring further assurances to service change proposals where significant bed closures are involved.

1.36 A Stage 1 Strategic Sense Check meeting with NHS England South West was held on 17th September 2018. The purpose of this meeting was to:

- establish the strategic direction of the service changes emerging through the Integrated Care System;
- to assess the level of significance of the service changes proposed, and;
- to determine what assurance processes are required going forward.

1.37 To support this meeting various project documentation including the 'Case for Change' and evidence was submitted by NHS Dorset CCG. It was agreed that the Dorset Dementia Review would need to pass through NHS England Stage 2 Assurance process.

1.38 On 24th October 2018 a letter from Amanda Fisk, Director of Assurance and Delivery, NHS England South West (South) confirmed that we had satisfied the 5 key tests of Service Change commensurate with a Stage 1 Strategic Sense Check.

1.39 Following this Wessex Clinical Senate Council were requested to review the plans and this review was carried out with the assistance of an External Review Team. A meeting was held on 14th March 2019 with NHS Dorset CCG and the External Review team where documents were submitted including the draft 'Strategic Outline Case' and a presentation given by NHS Dorset CCG followed by scrutiny questions by the panel. The report findings can be found at www.dorsetccg.nhs.uk/dementia.

1.40 Stage 2 Strategic Sense Check meeting on 29th April was held in Taunton with NHS England, representatives from Wessex Clinical Senate and NHS Dorset CCG. On 10th June 2019 Elizabeth O'Mahony, Regional Director South West, NHS Improvement and NHS England informed NHS Dorset CCG Accountable Officer, Tim Goodson that the Dorset Dementia Review scheme was fully assured against the four tests of service change and the NHS England Beds test.

1.41 Final CCG approval to move to public consultation through the Governing Body was given on 4 June 2019.

Consultation Stage

1.42 **Stage Five** was the consultation stage and the consultation was run from 17th June to 11th August 2019 for a period of 8 weeks.

1.43 The consultation material was co-produced with the project champions. It was agreed to use a mixed methodology for the consultation which included:

- online survey;
- Consultation material including a questionnaire insert and freepost envelope to return;
- Easy Read consultation document and survey and Easy Read online survey;
- Additional printed materials including consultation summary leaflets, pop-up banners and information and events posters;
- Regular press releases;
- Dedicated webpage providing up to date information and further detailed information;
- Short animation video and video blogs providing succinct information on proposals;
- Drop in Consultation events across Dorset during day and evenings to meet team and discuss proposals;
- Social media campaign providing information and promoting opportunities to get involved. This included paid for social media advertising.
- Promotion through other events and groups including BAME groups, faith groups, Dementia Friendly Communities, and other community groups;
- Wide distribution of material through a variety of routes including: Dementia Partnership members, local authorities, health and voluntary sectors, care homes, churches and businesses.

1.44 The planned drop in events and the attendance are in Figure 7 and 8 below. Each event was held with a similar format of offering refreshments then inviting people to watch the short animation followed by an opportunity to discuss the proposals with team members. Consultation material can be found at www.dorsetccg.nhs.uk/dementia.

Figure 7. Consultation drop in events

	Date	Time	venue	attendance
1	25 June 2019	1000-1300	Blandford Community Centre, Blandford	4
2	26 June 2019	1300-1600	Allendale Community Centre, Wimborne	16Leaflets given out in town
3	27 June 2019	0930-1330	Christchurch Library	5Leaflets given out in town
4	2 July 2019	1430-1900	Weymouth Fire Station	28
5	4 July 2019	0900-1230	Barrington Centre, Ferndown	19
6	9 July 2019	1500-1900	Dorchester Library	14
7	10 July	1500-1830	St Mary's Longfleet Church, Poole	4
8	15 July 2019	1500-1900	Kinson Community Centre, Bournemouth	8
9	16 July 2019	1400-1800	Gillingham Library	13
10	17 July 2019	1330-1700	Digby Hall, Sherborne	11
11	18 July 2019	1330-1630	Emmanuel Baptist Church, Swanage	16
12	7 August	1300-1600	Bridport WI Hall	8

Figure 8. Further Outreach as part of the Consultation

Dates 2019	Event	Attendance
19 June	Bournemouth Uni Living well with Dementia event	25
22 June	Dorset Assoc of Parish and Town Council, Dorchester	
23 June	Multi-cultural meet up, Swanage	
27 June	Milton and Blandford Deanery	
29 June	Gypsy, Roma and Traveller History event, Dorchester	100
10 July	Dorset CCG AGM and GP Membership event, Poole	125
10 July	South west Dorset Multi Cultural members meeting	20
12 July	African Caribbean lunch club, Boscombe	20
13 July	Bourne Free event, Bournemouth	200
14 July	Carers training group Kings Park Bournemouth	13
18 July	Equality and Diversity Forum, Bournemouth Town Hall	20
20 July	Wareham Carnival	50
22 July	Go Forum, Poole College	11
1 August	Polish 50+. Boscombe group	10

Consultation findings

1.45 The evaluation of the consultation was commissioned from the Market Research Group at Bournemouth University to give an independent evaluation. The full report findings can be found at www.dorsetccg.nhs.uk/dementia. This report was approved by the Dementia Services Review Project Board 17 September followed by endorsement by the Mental Health Programme Board on 26 September 2019.

1.46 Figure 9 highlights the number of responses as 503 and the breakdown of different stakeholders responding. Figure 10 and 11 shows the overall responses to the preferred model.

Figure 9 Responses

Online	277
Paper	136
Easy Read	85
E mail/letter	5
Total	**503**

Someone diagnosed with dementia	3%
A carer/former carer for someone living with dementia	44%
Someone working in health or social care	33%
Someone who is affiliated to a dementia organisation / volunteer	14%
Family/friend of someone that has/had dementia	7%
A concerned member of the public	7%
Other	5%

Figure 10. Main survey agreement

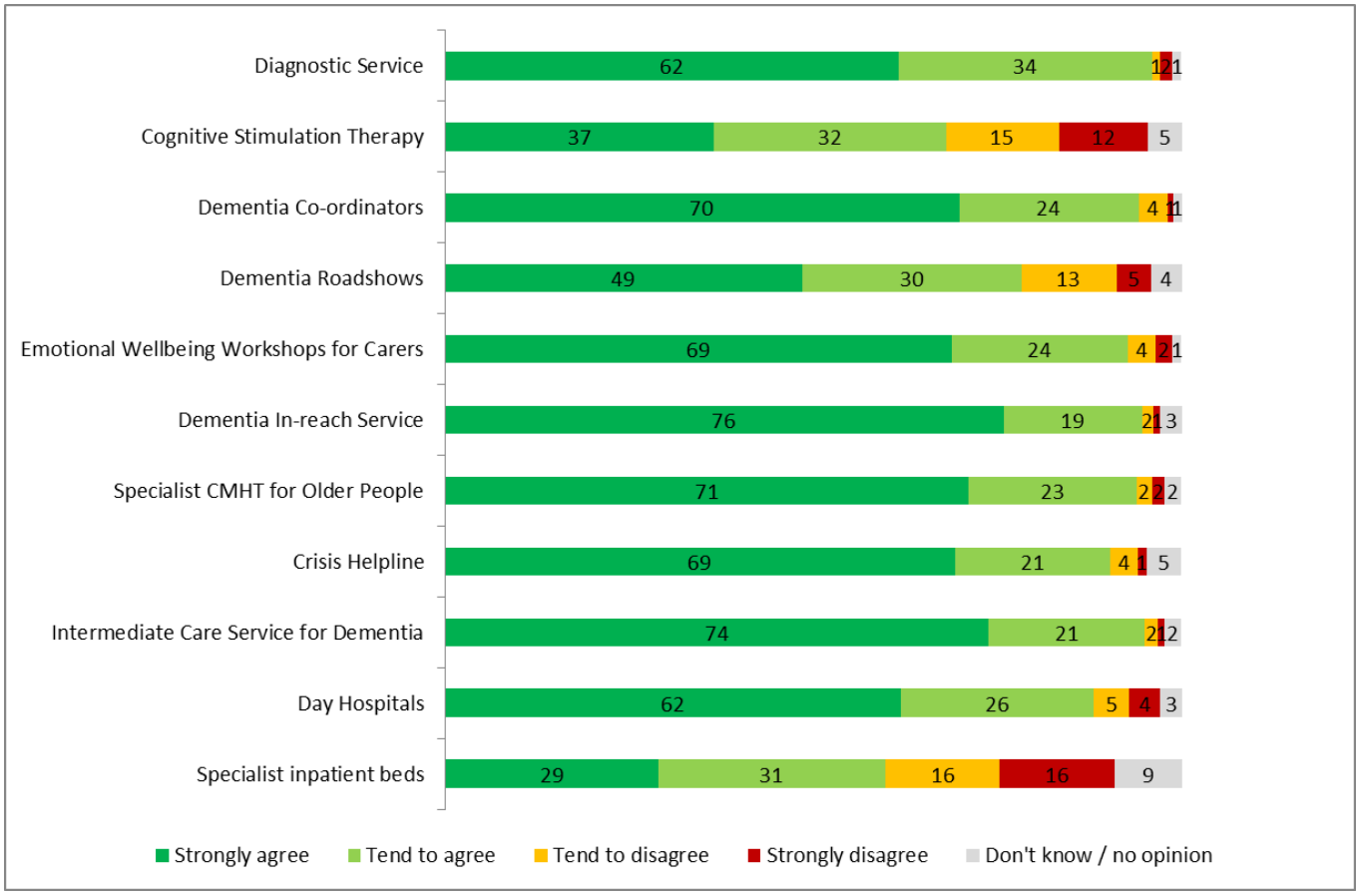
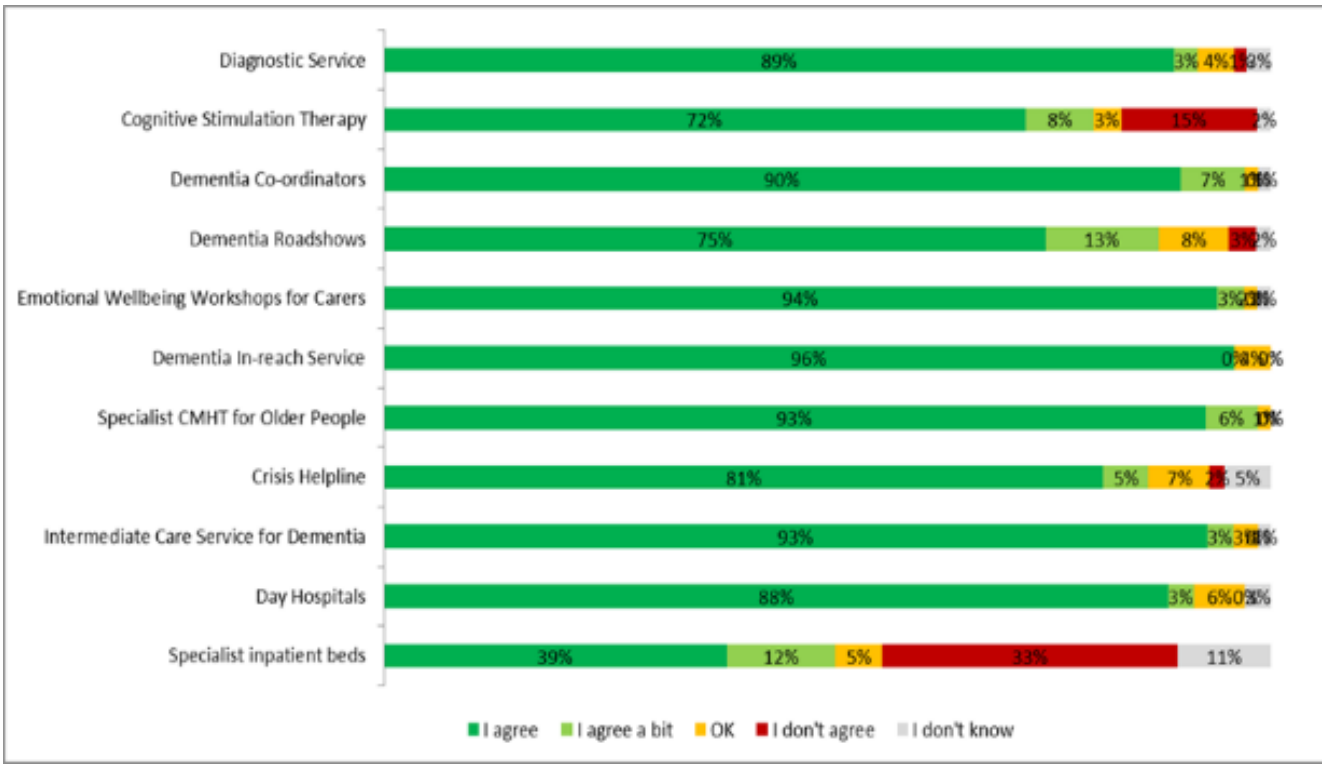


Figure 11. Easy Read Survey agreement



1.47 Updates on progress have been given regularly throughout the review. Most recently an update as given to Dorset Council Health Overview and Scrutiny Committee on 26 September 2019 and to BCP Health Overview and Scrutiny Committee on 18 November 2019. Full details on the consultation findings can be found in section 3.23 onwards.

Full Business Case development

1.48 **Stage six** was the development of the Full Business Case following the consultation taking into account the Consultation evaluation findings.

1.49 A revised Steering Group was established to support the detail necessary for the Full Business Case with sub group meetings held in-between meetings. The Full Business Case was then sent for approval initially by the Dementia Services Review Project Board followed by the Integrated Mental Health Programme Board. Final sign off is anticipated to be at the NHS Dorset CCG Governing Body Board on 13th November 2019.

2. STRATEGIC CASE

2.1 The strategic context is framed by the national NHS mandate[6] which outlines the objectives for the NHS as a whole:

- through better commissioning, improve local and national health outcomes, and reduce health inequalities;
- to help create the safest, highest quality health and care service;
- to balance the NHS budget and improve efficiency and productivity;
- to lead a step change in the NHS in preventing ill health and supporting people to live healthier lives;
- to maintain and improve performance against core standards;
- to improve out-of-hospital care and to support research, innovation and growth and to support the Government's implementation of EU Exit in regards to health and care.

Statutory drivers on dementia services

2.2 There have been a range of national documents since the 2009 'Living Well with Dementia: National Dementia Strategy'. Currently there is 'Prime Minister's Challenge on Dementia 2020'and the 'Implementation plan'[7] which includes:

- improving diagnosis, assessment and care for people living with dementia;
- ensuing that all people living with dementia have equal access to diagnosis;
- providing all NHS staff with training on dementia appropriate to their role;
- ensuring that every person diagnosed with dementia receives meaningful care.

2.3 Dementia remains a national priority with delivery of '*Challenge on Dementia 2020 Implementation plan*' by 2020[8]. NHS England 2018/19 mandates for dementia are:

- maintain a minimum of two thirds diagnosis rates for people with dementia;
- implement and embed the dementia pathway, set out in the Implementation Guide for dementia care, and improve the quality of post-diagnosis treatment and support.

2.4 The Care Act 2014 [9] created a new legislative framework for adult social care, and also gives carers a legal right to assessment and support. Furthermore, NICE guidance 'Dementia: assessment, management and support for people living with dementia and their carers' [NG97][10] was published in June 2018 replacing NICE guideline CG42 (November 2006) and 1.3 of NICE technology appraisal guidance 217.

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf
[7] https://www.gov.uk/government/publications/challenge-on-dementia-2020-implementation-plan
[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/507981/PM_Dementia-main_acc.pdf
[9] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
[10] https://www.nice.org.uk/guidance/ng97

Strategic Context

2.5 Nationally it is estimated that about 6 per cent of the population over 65 have dementia and that after the age of 65, the prevalence of dementia doubles every five years so that about 30 per cent of those aged over 95 years are affected.

2.6 Across the UK there is considerable economic cost linked to dementia, predicted to triple by 2040 with higher overall costs than cancer, heart disease and stroke[11]. The overall economic impact of dementia is estimated: £14.6 billion in direct costs of which £4.3 billion is spent on healthcare and £10.3 on social care, £11.6 billion in indirect costs associated with inputs from unpaid carers, and around £6.2 billion as the imputed cost of premature mortality[12]. People with dementia with higher numbers of comorbidities die earlier and have considerably higher health service usage in terms of primary care, hospital admissions and prescribing[13].

2.7 Public Health Dorset took forward some analysis of local data including utilising the Office of National Statistics (ONS) population forecasts for varying geographic classifications to gain a forecasted prevalence. This analysis highlighted what the national prevalence estimations of 13,102 vary significantly from the local figures of 10,362. Furthermore, this analysis found that people in Dorset on average live longer with dementia than the national average. For further information, see Annex 'Dementia diagnosis report'.

Figure 12. Comparison of key measurements of NHS England and Dorset Models. March 2018

		NHS England 2018	Dorset Model 2018	Dorset Model 2019
Estimated prevalence of people aged over 65		13,102	9,658	10,362
Numbers of people diagnosed with dementia on GP registers		8045	8161	8,219
Incidence rate per '000 person years 65+		19.78	12.47	
Average years with dementia		3.5	4.3	
Average years post diagnosis		2.1	3.5	
Time from onset to diagnosis		1.3	0.8	

2.8 In 2018 demand analysis suggested an estimated prevalence of 9,658 people over 65 years with dementia across Dorset and this was estimated to increase in 2019 to 10,362 in line with population growth. Local figures for March 2018 show 8,161 people over 65 years have been diagnosed with dementia which is 84.5% of the prevalent population. Nationally the 'Dementia diagnosis calculator' estimate a prevalence figure of 13,101 with 8,045 of people over 65 years diagnosed which gives an estimated 61.4%. Revisiting the figures in January 2019 showed an incidence of 8,219 which is approximately 2.3% increase and this is consistent with increased population growth of those aged 65 and over.

[11] NHS Rightcare 2017

[12] Dementia UK: second edition 2014 Kings College

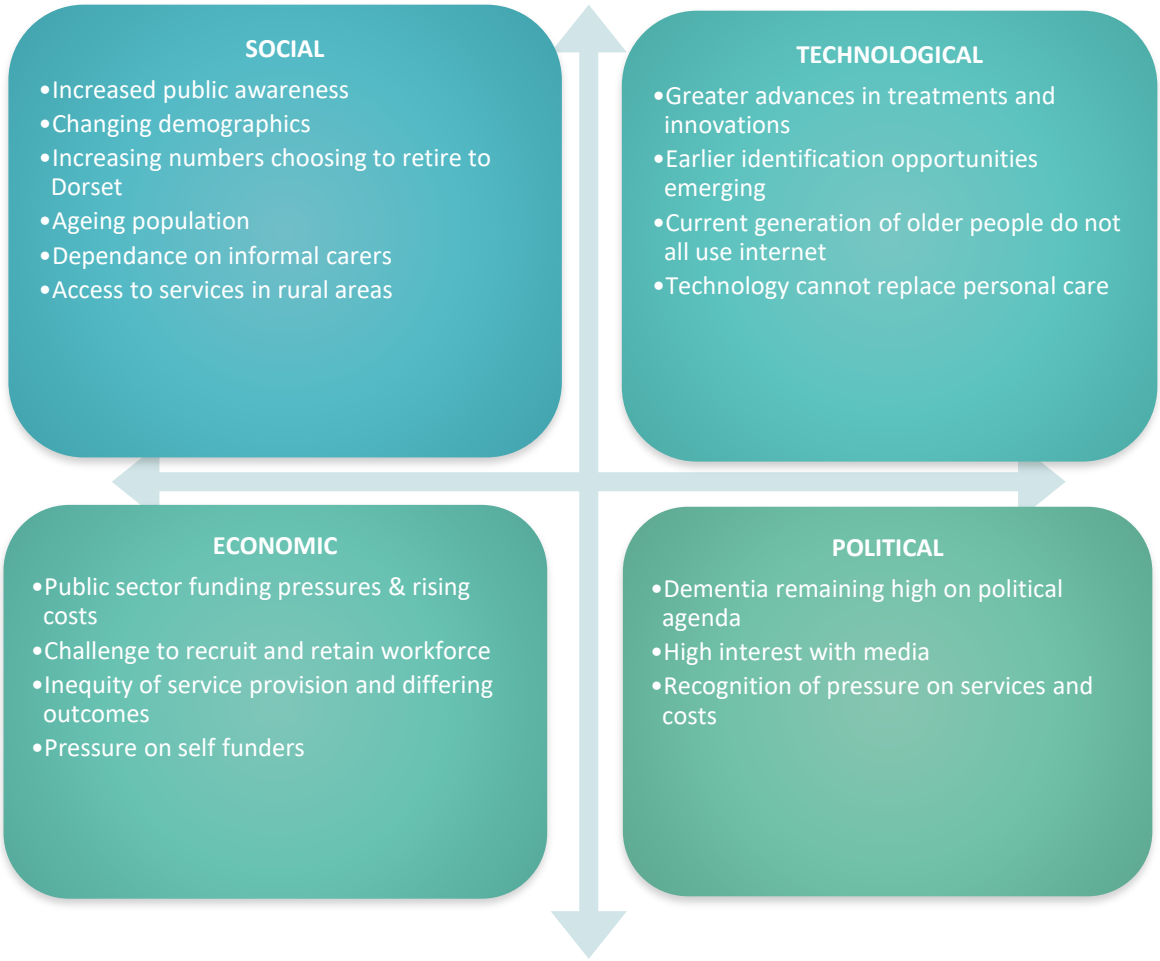
[13] https://otorhinolaryngologyblog.wordpress.com/2017/03/09/association-of-comorbidity-and-health-service-usage-among-patients-with-dementia-in-the-uk-a-population-based-study/

2.9 Dementia can start before the age of 65, nationally estimated to be around 2.2% of people with dementia in UK. This often presents different issues for the person affected, affecting their career and family. There are approximately 190 people under 65 diagnosed with dementia in Dorset equating to 1.9% of the prevalent population – lower than national estimation.

2.10 By the year 2025, the population of Dorset will have increased from 766,000 to 814,000. Whilst overall population growth is in line with the national average, growth in the number of people aged over 65 years will outpace average growth and therefore will put an increased demand on health and social care. Growth projections are outlined in Figures 11 and 12.

2.11 A strategic (STEP) analysis offers a useful summary of key issues for related to Dementia across Dorset (see Figure 13 below).

Figure 13. Strategic (STEP) analysis of key issues around dementia in Dorset



Dementia growth projections

2.12 Dementia prevalence based on local analysis for people aged over 65 years is estimated as 9,658 in 2018 rising to 11,319 by 2025. The greatest rate of growth is expected to be in the East, West and North Dorset localities. See Figure 14 and 15 below for detail.

Figure 14. Forecast of dementia prevalence across Dorset (based from ONS 2018)

Locality	2018	2019	2020	2021	2022	2023	2024	2025
Bournemouth North	532	541	551	560	574	588	602	616
Central Bournemouth	638	648	659	670	686	702	719	735
Christchurch	810	822	835	847	867	886	904	922
Dorset West	603	618	632	645	663	682	700	717
East Bournemouth	546	554	563	572	585	599	613	627
East Dorset	1,301	1,328	1,355	1,382	1,418	1,455	1,488	1,519
Mid Dorset	635	650	666	680	700	719	739	757
North Dorset	1,088	1,117	1,148	1,177	1,214	1,250	1,286	1,322
Poole Bay	949	966	984	1,001	1,027	1,053	1,079	1,103
Poole Central	616	628	640	652	669	686	701	717
Poole North	591	602	614	625	640	656	672	686
Purbeck	449	458	467	476	487	498	509	520
Weymouth & Portland	900	921	945	965	992	1,024	1,051	1,078
Total	**9,658**	**9,854**	**10,057**	**10,253**	**10,522**	**10,798**	**11,062**	**11,319**

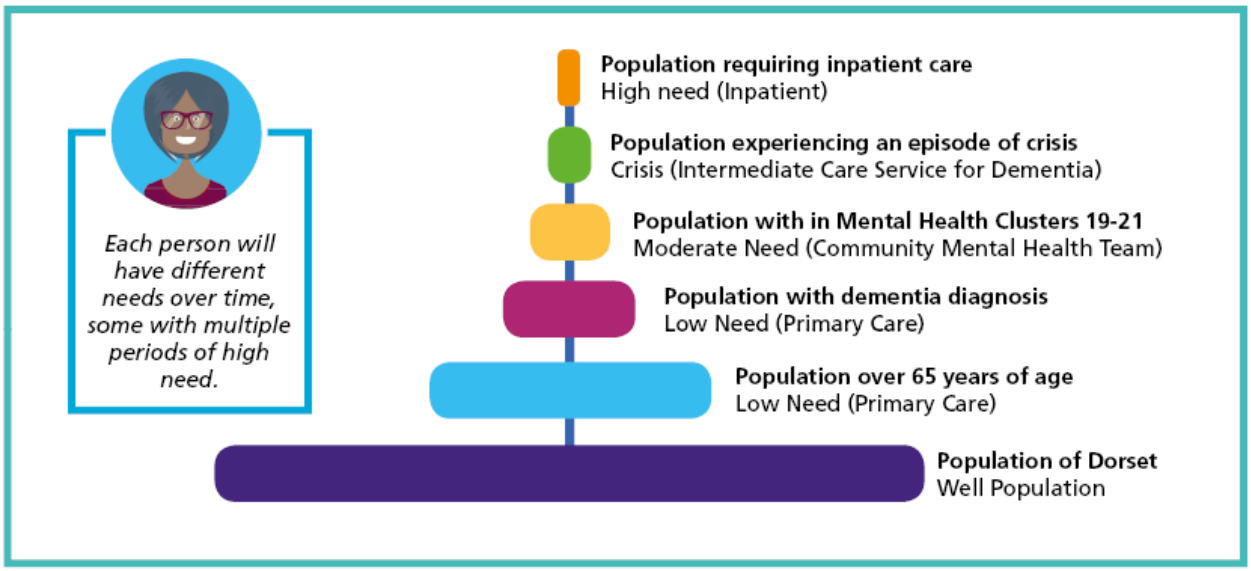
Figure 15. Forecast of dementia incidence across localities (based from ONS 2018)

Locality	2018	2019	2020	2021	2022	2023	2024	2025
Bournemouth North	140	142	144	147	150	154	158	162
Central Bournemouth	169	172	174	177	181	186	190	195
Christchurch	218	222	225	228	234	240	245	250
Dorset West	159	163	167	171	176	182	187	192
East Bournemouth	146	148	151	153	156	160	164	168
East Dorset	348	356	363	371	381	392	402	411
Mid Dorset	167	171	175	179	185	191	196	202
North Dorset	289	297	305	313	324	334	345	355
Poole Bay	256	261	266	270	278	285	292	299
Poole Central	162	165	168	171	176	181	185	190
Poole North	155	158	161	164	168	173	177	181
Purbeck	118	121	123	125	129	132	135	138
Weymouth & Portland	234	240	246	252	260	269	277	285
Total	2,562	2,614	2,670	2,722	2,798	2,878	2,954	3,028

Health and Social Care Needs analysis

2.13 Across Dorset there are a range of different needs across the population ranging from those with low needs within the community to needing high intensity and high costs services such as dementia specialist inpatient provision. Figure 16 below illustrates this.

Figure 16. The range of dementia needs across the population



2.14 A Health and Social Care Needs and Data analysis was developed during 2017 and a summary of key issues in Figure 17 below. The full report can be found at: https://www.dorsetsvision.nhs.uk/wp-content/uploads/2018/05/Dementia-Health-Needs-and-Data-Analysis-for-Dorset-Version-2.6-final.pdf

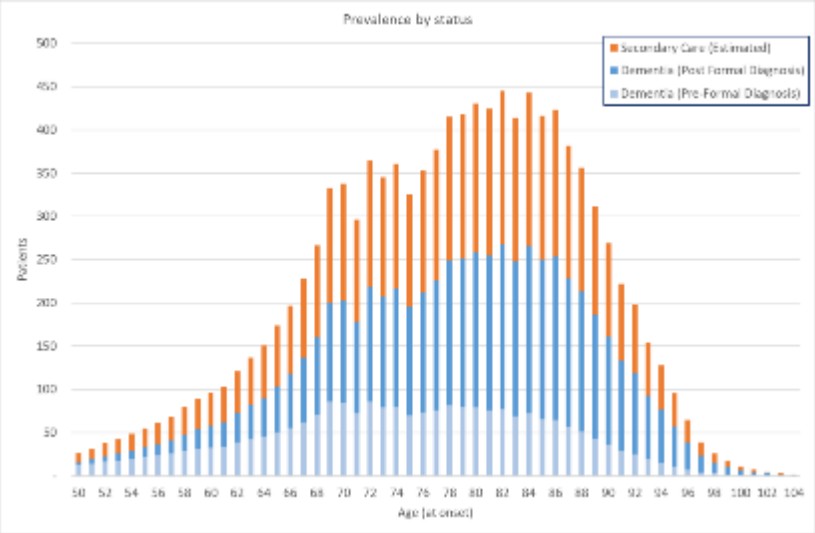
Figure 17. Data and Needs analysis summary

Key issues identified in the Needs and Data Analysis report
Dorset and Poole have a higher proportion of over 65s than the England average, with Bournemouth being similar to the England average. Dorset overall has a higher life expectancy at birth and at age 65 than England averages[14]
The over 65 populations across pan Dorset is forecast to increase from 24% of population to 30% by 2030. Rural localities are higher at 28% compared to urban /town areas 21%. North Dorset, East Dorset, Weymouth and Portland and Christchurch have the highest over 65 populations [12]
Dorset overall has only 0.7% of over 65 years from a black and minority ethnic background. This is significantly lower than the England average of 8%. The majority live within Bournemouth localities (1.3%). People from these backgrounds are noted to be at a greater risk of developing dementia.[15]
The national *Cognitive Functioning and Ageing Studies II* estimates 6.4% of over 65 population have dementia. This research study is used by NHS England to establish the national calculations applied to CCG's regarding achieving a diagnosis target.
Research estimates that dementia is an age related disease present in 0.9% of people aged 60 – 64 and increasing to 41.1% of those aged 95+. 61% are female and it is estimated nationally that 55% have a mild form of the disease, 32% moderate and 13% severe. The most common type of dementia is Alzheimer's Disease (62%), followed by Vascular Dementia (17%) and Mixed (10%)[16]
Risk factors for dementia include age, gender, vascular health, diabetes and education. People with developmental disabilities are at increased risk of dementia.
Men are more at risk of developing vascular dementia due to higher rates of poor vascular health. Dorset has higher rates of coronary heart disease, stroke and transient ischaemic attack than the England average[17]. However vascular dementia rates are lower in Dorset at 9% than nationally at 17% (this may be reflected by having a Centre of Excellence and high levels of interventions for these conditions).
Research suggests 61% of people with a dementia diagnosis have three or more other co-morbidities. Pneumonia, urinary tract infections and congestive cardiac failure accounting for two-thirds of preventable admissions into a general hospital for those with a dementia diagnosis.
People diagnosed under 65 years (early onset) and their families can incur issues with employment, family life, household resources and support, the duration of the disease and difficulties in diagnosis.
There was an average of 149 patients annually whom had one or more inpatient spell in a specialist dementia unit (based April 16 – March 18 data), which was 1.5% of prevalent population. The mean age of patients at admission in the same period was 78.7 years, (mean age not admitted 81.8 years).
Contrasting the dementia specialist inpatient admission age profile for dementia with the patients' Electronic Frailty Index[18] suggests a correlation between inpatient admissions and patients experiencing increasing difficulties with self-care, but still retaining physical strength to be a harm to themselves or others.
Mortality rate from Dementia is similar to the England average of 180.5 people per thousand populations. In 2015-16 around 1,144 people died of a dementia related cause.[19]

[14] Office for National Statistics (ONS) (2014) Subnational population projections based 2012 -2037
[15] http//www.dorsetforyou.gov.uk/media/pdf/t/a/Ethnicity1 1.pdf [accessed 10.2.2016]
[16] Dementia UK update. Kings College London and London School of Economics, Alzheimer's Society
[17] NHS Outcomes Framework 2014/15
[18] A national measure of frailty deficits recorded in primary care
[19] Public Health England Dementia Profile. http://fingertips.phe.org.uk/profile-group/mental-health/

2.15 Figure 18 below highlights the variation across pre diagnosis, post diagnosis and utilising secondary care services. The majority of patients with dementia are not in contact with secondary care mental health services.

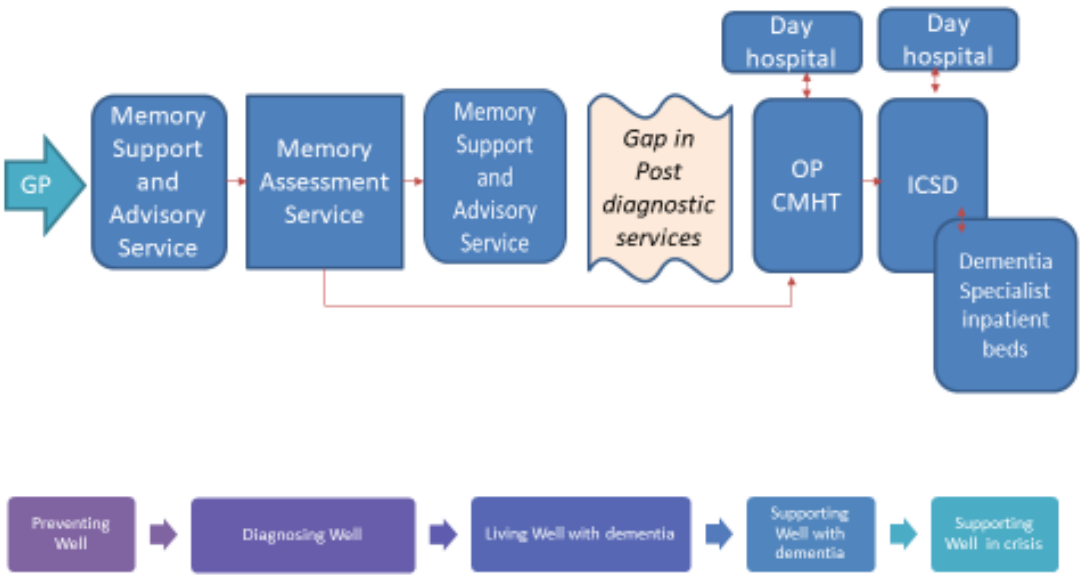
Figure 18. Patients with dementia, pre and post formal diagnosis & secondary care in Dorset



Existing services.

2.16 A schematic diagram shows the current services which are commissioned through NHS Dorset Clinical Commissioning Group and excludes those commissioned through the local authorities and non-commissioned services within the community. Detail is given below around each of these services and their current demand.

Figure 19. Schematic diagram of current NHS commissioned dementia services



Memory Services: Memory Support and Advisory Service

2.17 During 2014 the Memory Support and Advisory Service provided by Alzheimer's Society was commissioned between NHS Dorset CCG, Bournemouth Borough Council, Borough of Poole and Dorset County Council for three years. This service offers pre and post diagnostic support, advice and guidance through Memory Advisors.

2.18 From September 2017 NHS Dorset CCG maintained funding but the three local authorities were unable to continue funding which led to a reduction in staffing and a revised service model. Contract waivers were agreed until September 2020 to enable completion of the dementia services review.

2.19 Activity data for the Memory Support and Advisory Service includes pre diagnosis, post diagnosis and carers support. The majority of patients have one spell/contact. The number of unique patients accessing the service based on two year's data showed an average of 2,955 per annum. Post diagnostic support numbers have remained relatively stable and an average of 1,718 patients referred per annum.

Figure 20. Patients accessing Memory Support and Advisory Service prior to formal diagnosis. Average per year over 2016/17 and 2017/18.

Spells/ Contacts	Unique Patients Per Year	% Total		Total Spells/ Contacts	Spells per patient
1	2,697	91.3%		2,697	1.00
2	238	8.0%		475	2.00
3	20	0.7%		59	3.00
4	2	0.1%		6	4.00
Total	**2,955**	**100.0%**		**3,236**	**1.10**

Figure 21. Patients referred to Memory Support and Advisory Service for post diagnosis support. Based on data average 2016-17 and 2017-18

Spells/ Contacts	Unique Patients Per Year	% Total		Total Spells/ Contacts	Spells per patient
1	1,488	86.6%		1,488	1.00
2	190	11.1%		380	2.00
3	35	2.0%		105	3.00
4	5	0.3%		18	4.00
5	1	0.0%		3	5.00
Total	**1,718**	**100.0%**		**1,993**	**1.16**

Memory Assessment Service

2.20 Memory Assessment Service is provided by Dorset Healthcare NHS Trust and the service has aligned with the Memory Support and Advisory Service. Referrals to Memory Assessment Services based on four year's data shows an average of 2,342 referrals per annum. From these referrals over the last four years an average of 61.5% patients received a dementia

diagnosis and 11.6% received a 'Mild Cognitive Impairment diagnosis. During this time contacts have reduced from an average of 4.8 to 3 contacts per patient.

2.21 Over the last four years there has been an average of 1437 people diagnosed with dementia. During 2018-19 there was a slight increase with 1523 patients diagnosed with dementia with most increases in East Dorset, Dorset West and Poole Central localities.

2.22 Referrals diagnosed with 'Mild Cognitive Impairment' have been reducing over recent years from 17% in 2015-16 to 7.5% in 2018-19. 11% of these patients are referred again within a two-year period.

Figure 22. Memory Assessment Service referrals 2015-2019

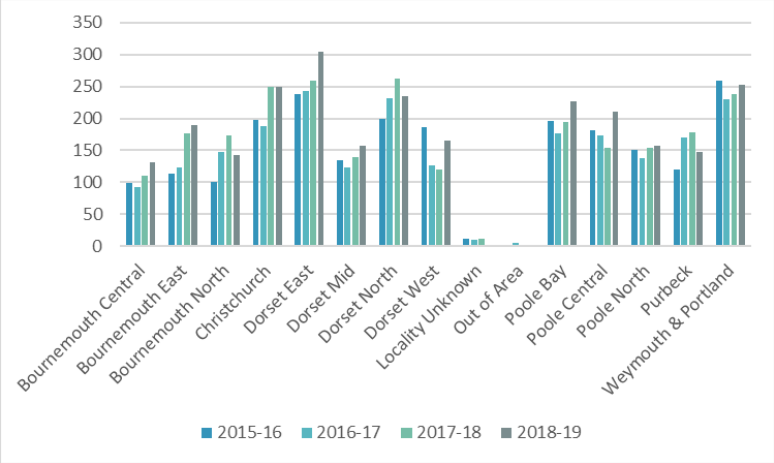


Figure 23. Summary of numbers diagnosed by Memory Assessment Service

Year	Referrals	Contacts	Numbers diagnosed 'Dementia'	% diagnosed dementia from overall referral total	Numbers diagnosed 'Mild Cognitive Impairment' (MCI)	% diagnosed MCI from overall referral total
2015/16	2191	10589	1418	64%	381	17%
2016/17	2180	10444	1408	65%	294	13%
2017/18	2425	9600	1397	58%	220	9%
2018/19	2572	8019	1523	59%	194	7.5%

Older People's Community Mental Health Teams (OP CMHT)

2.23 There are 14 Older People's Community Mental Health Teams across Dorset. The Bournemouth and Poole teams have integrated managers and the social work input is through each Local Authority. The teams cover both functional and organic mental illness

and offer a range of support and treatment. Total workforce covering both functional and organic illness is 106.96 WTE across health and social care.

2.24 Identifying the breakdown across functional and dementia client groups is challenging due to co-morbidities across many patients. Using needs-based care clusters which is utilised as a means to group patients into categories of similar characteristics[20] gives an estimation. Clusters 18-21 relate to dementia and ascertaining a snapshot in time splitting clusters suggests 54% (631 patients) of OP CMHT caseloads had dementia.

Figure 24. Referrals to Older Persons Community Mental Health Teams

Year	Total Referrals	Estimated Dementia (based 54% split)	Contacts (54% split)
2015-16	3506	1893	26,535
2016-17	3503	1891	24207
2017-18	3261	1760	21097
2018-19	3324	1795	18384

2.25 On this 54% basis the service received 1795 dementia related referrals during 2018-19 with a 5% reduction in referrals since 2015-16. Patients are in contact with the service on average for 222 days per referral. During 2018-19 (based on 54% split) with 18,384 total contacts this suggests an average of around 10 appointments per patient.

Day Hospitals

2.26 The two day hospitals operate with different models. Melcombe Day Hospital, based in Weymouth offers assessment, treatment and therapy for people with dementia and functional mental health conditions. Alongside assessment it offers mental stimulation and therapeutic treatment. It is open from Monday to Thursday and approximately 10 people attend each day and average length of attendance is 3 months. Referrals are received through CMHT care co-ordinators from Weymouth and Portland locality. The workforce is 1 RMN WTE Band 6, 2 WTE Nursing Assistants Band 2, 1 Nursing Assistant part time Band 2.

2.27 Haymoor Day Hospital, based in Poole is utilised by the Intermediate Care Service for Dementia to offer safe day provision and prevent hospital admission. Patients are observed to understand possible triggers to 'challenging behaviours' and regular reviews inform the CMHT coordinator and Intermediate Care Service for Dementia team. Average attendance is 8 patients daily and patients attend 2 or 3 times per week. Patients will either be discharged when they take up a social care day centre place, they need to move to a care home or are admitted to an acute hospital. The workforce is 1 RMN WTE Band 6, 1 RMN WTE Band 5, 2.8 WTE Band 3 support workers, 1 WTE Activity coordinator.

20 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499475/Annex_B4_Mental_health_clustering_booklet.pdf

Dementia In-Reach Service

2.28 There is an In-Reach service formally commissioned on the East side of Dorset. This service offers advice and support for care homes, day centres and community hospitals. It also provides hands on support and formal training. Currently the team are supporting around 106 care homes, 6 day centres and 5 community hospitals. The workforce is 3 RMN WTE Band 6. There is no formally commissioned service for North and West of Dorset however the West Intermediate Care Service for Dementia (ICSD) provide limited input into 6 community Hospitals and one off visits and training to 20 care homes and 1 day centre.

Intermediate Care Service for Dementia (ICSD)

2.29 During 2012 the Primary Care Trust Cluster in partnership with Dorset HealthCare University NHS Foundation Trust developed a new model of care for the East side of Dorset which was launched in 2013-14. The model aimed at enabling individuals to stay within their usual place of residence through providing more intensive support in the community. The workforce is 52.96 WTE.

2.30 Resources were moved from inpatient services to community services to achieve this model. The model was implemented in the East and have made a significant difference in supporting individuals, families and other services and reduced inpatient admissions. Intensive support to patients in their own homes is offered for up to six weeks to try to maintain them in their own home environments where possible. The service also provides the gatekeeping role to the specialist dementia inpatient beds. A pilot began in the West of the county in 2016.

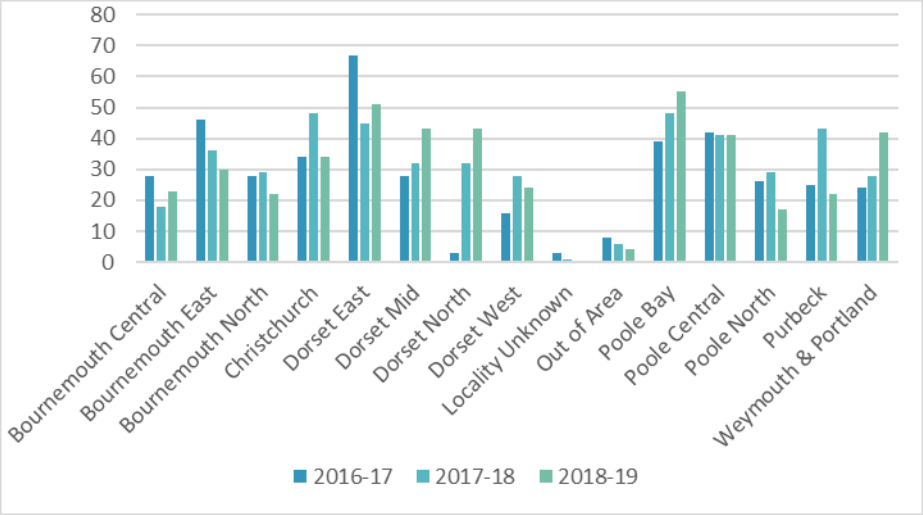
Figure 25. Intermediate Care Service for Dementia referrals 2016-2019

	Total referrals	Total contacts
2015-16	302	5805
2016-17	417	9674
2017-18	464	10532
2018-19	451	12549

2.31 Referrals across the service have grown as the service established and then further developed into the West of Dorset. Average referrals over the last two years have been 458 referrals with an average of 11,541 contacts indicating an average of 25 contacts per person.

2.32 From Figure 26 below it can be seen how the service has grown across the West localities with increase to demand in Weymouth and Portland, Mid and North Dorset during 2018-19.

Figure 26. Intermediate Care Service for Dementia referrals 2016-2019 across localities



Specialist dementia inpatient units

2.33 This review includes two temporarily closed specialist dementia inpatient units: a 12 bedded unit (Betty Highwood) based in Blandford Community Hospital (closed 2013) and 16 bedded unit (Chalbury) based in Weymouth Community Hospital (closed 2016) both of which had to be closed on safety grounds due to a lack of permanent qualified staff. Whilst not ideal, it is believed both of these units would be very difficult to reopen specifically due to the ongoing recruitment and retention issues of registered staff within dementia services which is a particular issue in the West of the county.

2.34 Currently there are 40 specialist dementia inpatient beds within Dorset HealthCare. These are based at Alderney Hospital, Poole and comprise of two wards: St Brelades and Herm. St Brelades has 17 inpatient beds and is a male assessment and treatment ward for older men with an organic mental health and associated complex behaviour. Herm has 18 female beds and 5 male beds however it is not really a mixed sex ward. The unit can accommodate males in urgent cases and the ward is split into male and female separate areas. The five male beds at Herm are not used for direct admissions from community only for men who are nearing discharge from St Brelades, and where a bed is urgently needed for a direct male admission. Male patient's beds are at the end of the ward split with doors and separate from the females. This area can be closed off and is staffed separately when required. Current workforce is 125.36 WTE.

2.35 Patients admitted to the wards are those whose severe needs cannot be met by either the Community Mental Health Team or the Intermediate Care Service for Dementia and often present with complex needs, high levels of acuity and often behaviours that can challenge. 97% are admitted under the Mental Health Act mainly due to the recent legal interpretation of the overlap between the Mental Health Act and Mental Capacity Act. The only exception (the 3%) is if a patient lacks capacity on a ward but is not receiving any treatment. For example, waiting for discharge.

Figure 27. Inpatient admissions to Dementia specialist beds in Dorset 2015-2019

	Herm	St Brelades	Chalbury	Total admissions	Occupancy rates
2015-16	57	64	31	152	75%
2016-17	88	78	3	169	84%
2017-18	76	56	-	132	82%
2018-19	73	52		125	82%

Summary of Service demand

Figure 28. Summary of referrals across Dementia Services from 2015 – 2018.

Demand profiling Referrals	2015-16	2016-17	2017-18	2018-19	% demand change from 15-16	Average over 4 years
Estimated prevalence (NHS Digital) (end of year)	13,638	12,987	13,033	13,354		
Total of people with Dementia diagnosis on GP registers aged 65+ (source NHS Digital)	8188 (62.2%)	8,010 (61.7%)	8007 (61.4%)	8345 (62.5%)		
Total diagnosed from MAS annually	1418	1408	1397	1523		
Memory Support and Advisory Service pre diagnosis referrals	2676	3253	3219	3738	+39%	3221
% conversion onto MAS	82%	67%	75%	69%		
Memory Assessment Services (MAS)	2191	2180	2425	2572	+17%	2342
MSAS post diagnosis	1966	2054	1933	1884	-4%	1959
OP CMHT referrals 54%	1893	1891	1760	1795	-5%	1826
ICSD	302	417	464	451	+49%	
Inpatient admissions & transfers	152	169	132	125	-18%	

Case for Change

Inequity of outcomes and access to services

2.36 Although there was a service review previously in the East of the county whereby reducing inpatient provision enabled resources to be released for the new community teams 'Intermediate Care Service for Dementia' and 'In-Reach' in 2012 this was not completed for the West. Therefore, although these services have developed they have not been formally commissioned.

2.37 Furthermore, particularly in the West and more rural areas of the county access to services is a significant issue. As noted in the new NICE guidance[21] services need to be accessible to as many people living with dementia as possible including those whom do not have a carer or whose carer cannot support them on their own, people with learning disabilities, sensory impairment or physical disabilities. Also encouraging those whom may be less likely to access health and social care services such as people from black, Asian and minority ethnic groups.

Ageing population

2.38 The number of people living in Dorset is growing and this is estimated to rise by around a further 50,000 people by 2020[22] and of these 70% will be aged over 70 years. With high numbers retiring to Dorset and people living longer the over 65 populations across Dorset is forecast to increase from 24% of population to 30% by 2030. Forecasting and preparing for such growth is essential.

Lack of integrated services

2.39 A clear message from the stakeholder view seeking was the sense of fragmentation, confusion and lack of joined up services. Suggestions for improvement were for integrated services, more collaboration and a clear single point of access.

Recruitment, retention and training of dementia workforce

2.40 Workforce is crucial to meet the demand for services and it is important staff are skilled and confident in delivering the right approach for people with dementia and therefore receive appropriate training. Sadly, within the view seeking it was felt that whilst many staff were very caring there were insufficient staff, lack of continuity, poor knowledge and ineffective staff training.

2.41 A significant challenge is the decline of a working age population impacting on being able to recruit enough staff. This is a problem particularly across the South West region and innovative solutions need to be collectively found.

[21] https://www.nice.org.uk/guidance/ng97/chapter/Recommendations#care-coordination
[22] https://www.dorsetsvision.nhs.uk/about/csr/

Information and Communication

2.42 The provision of information was criticised within the view seeking due to poor accessibility, information overload, appropriate advice and a lack of understanding of the systems in place. Communication issues among staff, carers and patients were also raised which included poor communication between staff in different departments, poor communication between staff and carers or patients and difficulties when contacting services in a crisis situation.

Needs of family carers

2.43 The contribution that carers bring to society is well recognised, and supporting the carer ensures that they can continue in their caring role. Carer support has been shown to improve outcomes and be cost effective. It is estimated that one in three people will care for a person with dementia in their lifetime. Half of them are employed and it is estimated that 66,000 people have already cut their working hours to make time for caring, while 50,000 people have left work altogether. [23] Carers of people with dementia often move into providing 50+ hours of care a week as the disease progresses.

2.44 It is recognised that peer support can provide practical and emotional support to carers, reducing social isolation and preventing crisis. There is evidence that providing carers with better information, training and coping strategies, including emotional and psychological support, improves their quality of life.

Dementia diagnosis national target

2.45 NHS Dorset CCG is required to meet a dementia diagnosis target of 66.7% against the prevalent population. The national dementia calculator utilised by NHS England stated in March 2019 Dorset CCG had an estimated prevalence of 13,354 for over 65 years and recorded diagnosis was 8,345 reaching a rate of 62.5%.

2.46 Numerous efforts and considerable resource investment has been given to improving the dementia diagnosis rate. Since 2015-16 referrals to the Memory Support and Advisory Service for pre-diagnosis support have increased by 39% with subsequent referrals into the Memory Assessment Service increasing by 17%. But numbers diagnosed with dementia have remained largely static at around 1437 annually based on data from 2015-2019. Analysis has identified that the numbers of patients being removed from GP Dementia registers due to death or moving out of area are very similar to the number of those newly diagnosed.

[23] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414344/pm-dementia2020.pdf

Urban and Rural differences

2.47 Variation in dementia diagnosis rates across Dorset have been observed for a number of years reflecting urban and rural differences. The more rural localities falling under Dorset County Council having a nationally estimated dementia diagnosis rate (Jan 2019) of 57.8% whereas the more urban Bournemouth Borough Council and Borough of Poole had recorded rates of 65.63% and 70.33% respectively. To note from 1 April 2019 there is a new configuration of local authorities with a newly formed Bournemouth, Christchurch, Poole Council (BCP Council) and re-configured Dorset County Council.

2.48 Total number of those on dementia registers aged 65 years were 8,240 as of 28 February 2019. This broke down to:

- Bournemouth 1,545
- Poole 2,076
- Dorset 4,619

2.49 GPs have highlighted in the West and rural areas of the county that patients can be reluctant to seek a formal diagnosis because of the fear that they will lose some of their freedoms (e.g. driving license) particularly where the lack of public transport is a significant barrier. This suggests that different approaches to support may be necessary in the more rural areas.

Memory Service issues

2.50 Despite both Memory services working closely together, unfortunately the current diagnostic pathway still has issues and needs to be improved. Respondents within view seeking felt the pathway was confusing, fragmented with long waits and patients feeling they are having repeated assessments.

2.51 Currently there is limited access to neuropsychological assessment for young onset, complex or abnormal presentations. The new NICE guidance[24] states the need for neuropsychological testing if it is unclear where the person has cognitive impairment, the cognitive impairment is caused by dementia or what the correct subtype diagnosis is.

[24] https://www.nice.org.uk/guidance/ng97/chapter/

Waiting times for diagnosis

2.52 A timely diagnosis should unlock the door to appropriate care and treatment and personalised care plans. The NHS England mandate[25] reflects the ambition that by 2020 we will 'increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral'. Average wait for a clinical diagnosis has over three years averaged 92 days (13 weeks). Long waits for scans, capacity of clinical specialists and administration delays add to the delays.

Variability of quality of GP Referrals

2.53 The waiting time issue above has also been compounded by a wide variability of the quality of GP referrals. Memory Service referrals require specific blood tests to be taken and patient history shared to exclude other physical health conditions and to ensure Memory clinicians have all relevant information. However nearly a third of all patients referred from GPs have had missing referral information which has required significant administration time to chase.

2.54 A survey was sent out across all practices in February 2018 asking for GP views on dementia services with a particular focus on the diagnostic pathway. A small sample of 14 responses were received with a mix of views around GPs completing screening prior to referring to memory services and there was a request for any screening to be short. Also GP respondents felt services were fragmented and there was a lot of frustration around phlebotomy and the need for blood tests for all patients and subsequent waits.

Lack of support for early onset dementia patients

2.55 Across Dorset there are currently just under 200 people under 65 years whom have been diagnosed with dementia. Whilst there are a few community groups established across Dorset there are no specific commissioned services for this cohort of patients. It is recognised that the needs of these people and their families can significantly differ to those of a much older person as some may be working, have families and dependants and will require skilled assessment, sensitive diagnosis and tailored specific support.

Dementia treatments and vascular dementia

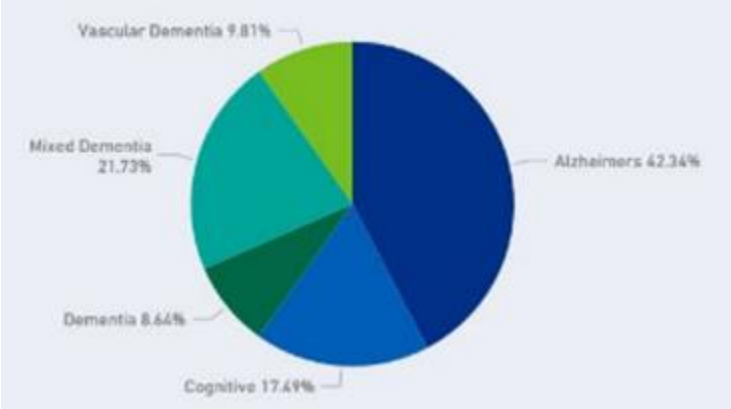
2.56 Nationally, vascular dementia is the second most common type of dementia estimated to affect around 17% of those diagnosed[26]. Vascular dementia has the same risk factors as cardiovascular disease and stroke, and so the same preventive measures and lifestyle factors are likely to reduce risk.[27] . Dorset however, perhaps indicated by the overall 'healthy population' and the fact there is a Centre of Excellence within Bournemouth Hospital is seeing a gradual decline of vascular dementia diagnosis with only 9.8% across all dementia types diagnosed which is much lower than the national average.

[25] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/507981/PM_Dementia-main_acc.pdf

[26] https://www.dementiauk.org/understanding-dementia/vascular-dementia/

[27] https://www.gov.uk/government/publications/health-matters-midlife-approaches-to-reduce-dementia-risk/health-matters-midlife-approaches-to-reduce-dementia-risk

Figure 29. Breakdown of dementia diagnosis types across Dorset (2018)



2.57 There is currently no cure for dementia. But there are medicines and other treatments that can help to temporarily reduce dementia symptoms particularly for Alzheimer's disease (Acetylcholinesterase inhibitors and Memantine) but there is no specific medication for vascular dementia. As there is no medication currently of benefit to this cohort of patients they are often discharged back to the GP with no offer of treatment. Therefore, having alternative treatment to offer such as cognitive stimulation therapy, reminiscence or cognitive rehabilitation could bring benefit to this patient group alongside other dementia patients.

Post diagnostic support to live well with dementia

2.58 The priority for many people with dementia is to stay independent and live at home for as long as they can. Whilst there are a wide range of community groups, memory cafes and various local initiatives across Dorset, ongoing support and joined up services for people living with dementia and their carers appear limited. Within the 'view seeking' stage there was a clear emphasis around a lack of post diagnostic support. Many felt having a supportive person available along the whole journey, with accessible and responsive services could have possibly prevented a crisis.

Acute and community hospital provision

2.59 Although not within the direct scope of this review views were collated around the three acute hospitals and the community hospitals across Dorset. (to note the Dementia Specialist Units are not classified as 'Community Hospitals' and were excluded from the Clinical Services Review). Views were mixed with positive comments with regards the creation of dementia friendly environments and improved care for patients living with dementia and support for their carer's. By contrast, there were some very negative experiences. Areas for improvement were noted particularly around prioritising people with dementia for discharge, simpler transition to a care home and increased staff training.

Day hospital provision

2.60 Views regarding the two day hospitals in Weymouth and Poole which offer different models both for relatively small numbers of patients have varied. The unit in Poole is aligned to the Intensive Support (ICSD) service with the aim of reducing admissions whereas the Weymouth service offers a service for both functional and organic clients offering mental stimulation and support. For those whose family member is utilising this service they are highly valued. However, within the co-production groups there was debate of how accessible these units are for the wider parts of the county, do they both offer value for money and in particular for Weymouth could these patient's needs be better met through social care day provision.

2.61 Recent research[28] has shown no strong evidence for day hospitals compared to other treatments. However, for those not receiving other care provision, day hospital patients showed a reduced odds of deterioration with 'Activities of Daily Living'. Research by Marshall et al[29] differentiates types of day hospitals into three areas of function across all client groups: 1. Acute psychiatric day hospital as alternative to admission; 2. Transitional day hospital for those recently discharged; 3. Rehabilitation, 4. Day treatment programmes as intensive alternative to outpatient care. These studies have suggested acute home based care is not cheaper particularly due to the number of professionals and costs of dislocating resources to a patient's residency. Marshall suggests if a day hospital is combined with an outreach service and short term crisis beds this could offer a powerful alternative.

2.62 Furthermore studies across psychiatric client groups cited by Lopes et al[30] (2012) have shown that this type of day care can achieve a substantial reduction in the numbers of people needing inpatient care where running a 30 place day hospital is roughly one third of those of a 30 bedded ward with a cost reduction of 22%.

Providing care closer to home - Step up and down inpatient provision

2.63 Step up and down provision has been suggested as a solution both to provide care closer to home within more local services, prevent admission to the Dementia specialist unit if possible and to enable a speedier discharge from inpatient settings (see Appendix 1).

Access to crisis support and specialist dementia beds

2.64 When people with dementia and particularly their family carers find themselves in a crisis situation there is currently no quick access into services other than through the GP or via Liaison Services within the Acute Hospital Emergency Department. Out of hours there is a duty service through social services however this is possibly not well known about.

[28] Brown et al (2015) Medical day hospital care for older people versus alternative forms of care Cochranelibrary-wiley.com/doi/10.1002/14651858.CD001730.pub3/full

[29] http://www.scielo.mec.pt/pdf/am/v26n5/v26n5a04.pdf

[30] Lopes R, Curral R (2012) Day Hospital in community psychiatry

2.65 There has been an overall decline by 18% in specialist dementia inpatient admissions since 2015-16 to 2018-19 including Chalbury and Alderney units. This reduction in the need for inpatient provision has been linked to the positive impact of the initiation of the Intermediate Care Service for Dementia (ICSD) commissioned in the East in 2013 which maintains people experiencing a crisis at home where possible. Following the temporary closure of Chalbury Unit in Weymouth, staff were redeployed to begin providing ISCD pilots in the west.

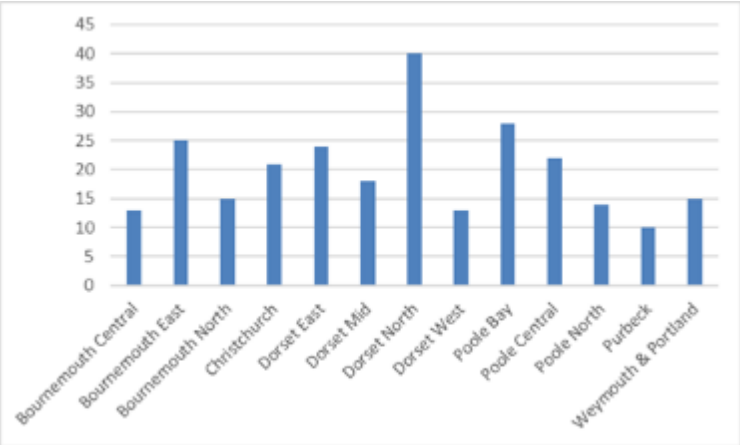
2.66 ISCSD is already a highly regarded, cost effective service and it is estimated that the service is now reducing inpatient admissions by around 400 per year

Figure 30. Number of admissions prevented by ICSD (Dorset CCG January 2019)

	2015-16	2016-17	2017-18	2018-19 (April – Aug)
ICSD East	291	357	325	207
ICSD West	-	57 (from Aug 16)	115	58
Total	**291**	**414**	**440**	**265 (5 months) (636 est FYE)**

2.67 Figure 31 below highlights that since 2015 63% of overall admissions have been from the East side of the county (Bournemouth, Poole, Christchurch and East Dorset localities). As noted above the highest number of admissions have been from Dorset North with 16%. The localities with the lowest admissions have been the Purbecks with 4% of total admissions (10 patients) and Dorset West at 5% (13 patients) and Bournemouth Central at 5% (13 patients).

Figure 31. Total admissions to specialist dementia inpatient beds by locality from 2015 - 2018



2.68 Bed occupancy across the dementia specialist beds averaged 75% during 2015-16, 84% for 2016-17 and 82% for 2017-18 (excluding home leave). Whilst the loss of Chalbury unit increased bed occupancy rate at Alderney in 2016 they have remained below the 85% suggested national rate for optimal bed usage. Highest occupancy was during August which is attributed to social care packages and holiday periods where visiting family members whom haven't seen their loved one for a while become very concerned. Occupancy is lowest during February. Average length of stay since 2015 – 18 has been higher for males than

females. Male average was 113 days and females 87 days. There has been a reduction in average length of stay from 2016 to 2018 by 8% for males and 3.6% for females.

2.69 There have been relatively few out of area placements for dementia specialist beds over the last three years with 6 during July – October 2017 and 1 in February 2018. Of these, 6 patients were male and 1 female and the primary reason for the placement was due to the unavailability of appropriate beds at that time. Noting the pressure was more around provision of male beds at that time. All out of area admissions were short term and repatriated back to Dorset within a few days. We are however exploring other possible options for males with more challenging behaviours with other local providers.

2.70 The majority of admissions to specialist dementia beds are from home residence (see Figure 32) which suggests earlier interventions in the home may prevent a crisis. Continuing to invest and develop the Intensive Support Service may further reduce avoidable admissions.

Figure 32. Admission source into Dementia inpatient beds 2015- 2018

Source	Count
Home Residence	176
Hospital	121
Care Home	74
Other	14
Total	**385**

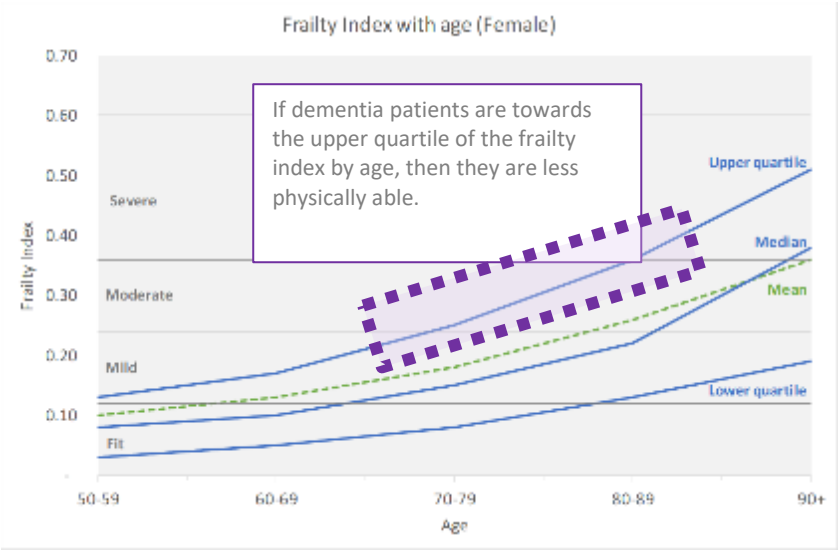
2.71 Benchmarking dementia specialist in-patient provision is complicated by differences in the way services are commissioned and configured with some areas providing continuing health care that is not provided by other statutory services. Other areas, including Somerset, utilize 'step up' and 'step down' beds in selected Care Homes. Even allowing for these variations, Dorset benchmarks high for specialist beds per prevalent population at 0.30% (Figure 26) compared to Norfolk, Somerset and Gloucestershire CCGs. This ratio is increased considerably further when the beds from the closed units (Chalbury and Betty Highwood) are included. See Annex 17 for full information.

Figure 33. Benchmarking Dementia Specialist Inpatient beds (March 2019)

CCG's demographically similar to Dorset (Rightcare)	Estimated prevalence (ages 65+) Source NHS Digital. Jan 19	Narrative	Percentage of inpatient beds per prevalent population
NHS West Norfolk	2,926	12 dementia assessment beds closed. staffing resource enabled the establishment of a Dementia Intensive Support Team (DIST) (12 May 2014)	0%
NHS Somerset	8,992	12 bed unit. Step up and down via care homes	0.13%
NHS Gloucestershire	8,738	14 specialist inpatient beds	0.16%
NHS Kernow	8,720	25 but utilize 15	0.17%
NHS Cambridgeshire and Peterborough	10,117	18 beds purpose built unit	0.18%
NHS Wiltshire	7,059	20 specialist beds	0.28%
NHS Northern, Eastern and Western Devon CCG	13,780	Approx 30 assessment beds across 2 units. Spot purchase 5-7 specialist beds at Cygnet, Taunton	0.28%
NHS Dorset	13,316/ (9658 local prevalence data)	40 beds operational on 2 wards	0.30% (0.41% based local prevalence)
NHS Coastal West Sussex	9,091	32 beds commissioned for 3 CCGs	0.35%
NHS Newcastle and Gateshead	5,278	20 beds with 8 occupied	0.37&
NHS North Cumbria	4,598	Two 15 bedded units for dementia assessment. Currently business case for 6 bedded 'enhanced care' for patients challenging needs being dev	0.65%

2.72 Whilst those with the most severe behavioral problems may require admission to specialist dementia beds; those who have predominantly frailty related problems with mild to moderate behavioral issues could have their needs met through social care or other frailty provision within the community hospitals rather than the dementia inpatient beds. Figure 34 below highlights this for female Dorset patients.

Figure 34. Frailty index with age for females



2.73 Delayed transfers of care from the specialist dementia inpatient unit vary from as low as 7 to 18 in any one month and the reasons can vary across each local authority. The most common reason for a delay was for individuals awaiting nursing care placement. Lower demand is for those awaiting a home package of care or residential placement. The majority are under the responsibility of Section 117 and social care commissioners. More recently with market changes (see Appendix 1 for social care developments) there is now more care home capacity.

2.74 Issues related to delays include:

- Affordable provision – the fees are too high;
- Choice and preferences;
- Family agreement;
- Provision for males with behaviors' that significantly challenge others.

Rising costs of Section 117 aftercare

2.75 For some people in England, the need for ongoing nursing and healthcare support is of such a level that they qualify for all their care needs to be met by the NHS, including those personal and social care needs which might otherwise be met by social services. This is NHS Continuing Healthcare and is arranged and funded by the NHS. Eligibility is based on a 'primary health need' and the overall day to day care needs required (and not based on a diagnosis).

2.76 The main exception to the above is where the individual is subject to Section 117 of the Mental Health Act 1983 and solely requires care and support for his/her mental health aftercare needs[31]. Section 117 applies after an individual has been the subject of a compulsory treatment order under the Mental Health Act 1983 (usually section 3, but it could be a hospital order made under section 37, or a hospital direction made under section 45A or a transfer direction made under section 47 or 48).

[31] https://www.england.nhs.uk/wp-content/uploads/2015/04/guide-hlth-socl-care-practnrs.pdf

2.77 Section 117 services are considered to be services which:

- are provided in order to meet the individual's mental health needs;
- enable a person to return to their home or other community-based accommodation;
- minimise the likelihood of re-admission to psychiatric in-patient care.

2.78 Residential care is covered by section 117 after-care, but only if the need for that care arises from the patient's mental health condition which resulted in their detention under section 3. Since 2014 in Dorset the numbers of patients being detained and eligible for Section 117 aftercare have increased by 19%. with 50% of cases for people with Alzheimer's Disease. However, aftercare costs have increased by 52% with an extra £1m spend for a relatively few number of patients.

Other service developments

2.79 There are a wide range of co-terminus service developments that support the case for change but sit outside of the scope of this review. Details can be found in Appendix 1. These include:

- **Dementia Friendly Communities**
- **Support for carers**
- **Frailty Programme**
- **Social Care services and developments**
- **Care Homes**
- **Mental Health Psychiatric Liaison Review**
- **Acute and Community Hospitals**
- **Personalised Care**
- **End of life care**
- **Information Technology**
- **Workforce**
- **Dementia Research**

ECONOMIC CASE

3.1 The economic case considers the various choices and options for how the new pathway might be achieved, which different approaches and modalities. It will highlight from the wide range of potential options the shortlist which will represent the best possible balance of benefits, cost and risk.

3.2 This chapter gives a summary of the new service elements designed and developed through the co-production design stage and some existing services thereby covering the dementia care pathway from an NHS health commissioning basis. Building on the detail within the Strategic Outline Case with the design of a long list of options which over a period of time was narrowed down by the stakeholders into a final four model options and a preferred option which was consulted upon. The results on the consultation are included and then details on the proposed model which was revised following the consultation.

Initial Design options

3.3 The project methodology utilised was described earlier in the Introduction section. Following an Innovation Event, three core groups made up of a mixture of knowledge, experience and perspectives including people living with dementia, carers and various health and social care workforce were established in Dorchester, Bournemouth and Poole respectively. These groups developed the initial design ideas and suggested proportional allocations of financial resources across the pathway. Following the Five Stage Business model framework the long list of options was narrowed down to eventually reach four options and a preferred option agreed by stakeholders.

3.4 The care pathway was broken into the following elements:

- Preventing Well
- Diagnosing Well
- Living Well (low level needs)
- Supporting Well (high level needs)
- Supporting Well in Crisis

The Long list of options

Figure 35. Summary of long list of design options

Ref	Preventing Well Service options	Description
1.1	Local telephone helpline	Service aligned with low intensity dementia service **or**
1.2	National Dementia helpline	Utilising an existing dementia helpline or
1.3	Via 111	Signposting from 111 **or**
1.4	Helpline within new Mental Health Connections	Embedding the helpline within the new Connections Crisis line
	Diagnosing Well Service option	
2.1	Model 1: Secondary care based service with registered triage and assessment team	GP Screening Desk based triage by registered staff Memory Assessment Nurse assessment Diagnosis by medical specialist
2.2	Model 2: Primary Care Triage Service with 2 referral routes	GP screening Non clinical triage Two referral routes: Advanced dementia/Less advanced Diagnosis by medical specialist
2.3	Model 3: Primary Care based nurse led clinic	GP screening Primary care Memory Assessment Nurse GP diagnosis (advanced dementia) Medical specialist diagnosis for more complex/requiring scans
2.4	Model 4: As Model 1 but 50% diagnosed by Nurse Consultant	GP Screening Desk based triage by registered staff Memory Assessment Nurse assessment Diagnosis by medical and nurse specialists
2.5	Neuropsychology	Neuropsychological assessment to assist with diagnosis particularly complex cases. Aligned within Memory Services
	Living Well Service option	
3.1	Dementia Co-ordinators all settings	Dementia Coordinators supporting individuals diagnosed with dementia and family carers along dementia pathway through groups, 1:1 and signposting. Aligned Dementia team and MDT.
3.2	Dementia Co-ordinators with care homes having different input	As above but input predominately settings other than care homes (In-reach service into care homes)
3.3	Early onset Dementia Co-ordinators	As above but age appropriate for those under 65 years and their family carers.
3.4	Living well with dementia education & memory roadshow sessions	Education session offered to all newly diagnosed and family carers. Meet all key support services. Enable peer support
3.5	Carer's emotional support training	Small group sessions specifically for family carers aimed at developing resilience and dealing with loss and change
3.6	Cognitive Stimulation Therapy Groups	Brief, closed, structured therapy groups for up to 10 clients each group.
	Supporting Well Service Options	
4.1	Dementia Nurses (from OP CMHT)	Step up provision from Dementia co-ordinator Higher intensity, clinically based service when needs of patient increase or become more complex *Based on organic/dementia needs not functional*
4.2	Admiral Nurses	Providing support for family carers to manage complexity and avoid crisis. Support practice of other professionals
4.3	Maintain the day hospitals operating as currently	Offering clinically based assessment and treatment
4.4	Close day hospitals	Patients where appropriate move under social care day provision. Resources released into NHS Dementia services
4.5	Align day hospitals to intensive support team	Haymoor is currently operating this model where intensive support team (ICSD) utilise the resource during daytime and prevent an inpatient admission

Ref	Supporting Crisis Well Service options	Description
5.1	Intensive Support team (ICSD) across all Dorset	Formally commission Intensive support service for West of county and retain the existing East commissioned service
5.2	In-reach Service across whole of Dorset	Formally commission the In-reach service for the West of the county and retain the existing East commissioned service
5.3	Crisis helpline 24/7	Provide a 24/7 crisis helpline (consider alongside telephone helpline service)
5.4	40 Inpatient beds at Alderney Hospital, Poole	Provide 40 beds
5.5	40 Inpatient beds at Alderney Hospital, Poole. Step up and Step down in community hospitals and care homes	Provide 40 beds at Alderney. Step up/down provision in community. Reviewing bed numbers again in future when community services in place
5.6	Specialist Dementia Inpatient provision within Poole general hospital	Following meeting with Poole Hospital this option was discontinued

Options Appraisal and Shortlisting

3.5 Through the Design stage the long list of options was co-produced with a wide range of stakeholders. To shortlist the most acceptable options against the Critical Success Factors to be presented for consultation two events were held with stakeholders: a 'Cross Check' on 11th April 2018 followed by 'Final options' event on 5th September 2018.

3.6 At the Cross check event a SWOT analysis and scoring was given against each option to narrow down the 'Long list'. Then more detailed analysis was completed at the 'Final Options' event where different permutations of options were analysed against the critical success factors including more detailed costing enabling 'affordability' aspects to be more carefully considered.

3.7 Figures 36 – 40 show a final summary of the options framework with critical success factors measured against 'scope', 'solution', 'delivery' and 'implementation' options across each element of the dementia pathway. This options matrix identifies the process followed to reach the shortlisted options with a recommended 'preferred way forward'. The following codes were used:

Reject

DM – do minimum

SL – shortlist

PWF – Preferred way forward

Figure 36 Preventing Well options framework

Preventing Well	1	2	3	4	5
Scope	All people diagnosed with dementia and their families have access to information, advice and guidance	100% population of Dorset have access to information, advice and guidance on dementia			
	DM	PWF			
Solution	Local internet based Dementia Directory	Local helpline & local Dementia Directory	Signpost to a national helpline & local Dementia Directory	Integrated with a Mental Health Crisis telephone helpline	Integrated with NHS111
	DM	SL	PWF	REJECT	REJECT
Delivery	Local 3rd / Voluntary sector	Local Authority	Local Mental Health Service provider		
	DM	PWF	REJECT		
Implementation	Immediate	Operational in 6 mths	Operational within 1 year		
	PWF	DM	REJECT		

Figure 37. Diagnosing Well options framework

Diagnosing Well SUMMARY	1	2	3	4	5
Scope	100% NICE compliant diagnostic model. neuropsychology. diagnosis within 6 weeks of referral	Partially NICE compliant diagnostic model (limited neuropsychology). Diagnosis within 6 weeks of referral	100% NICE compliant diagnostic model + neuropsychology that delivers diagnosis within 12 weeks of referral	Partially NICE compliant diagnostic model (limited neuropsychology) that delivers diagnosis within 12 weeks of referral	
	PWF	SL	SL	DM	
Solution	GP Screening Desk based triage by non-registered staff Memory Assessment Nurse assessment Diagnosis by medical specialist	GP screening Non clinical triage Two referral routes: Advanced dementia Less advanced dementia Diagnosis by medical specialist	GP screening Primary care Memory Nurse Assessment GP diagnosis (advanced dementia) Medical specialist diagnosis for more complex/scans	GP Screening Desk based triage by registered staff Memory Nurse assessment Diagnosis by medical and nurse specialists	GP Screening Desk based triage by registered staff Memory Nurse assessment Diagnosis by medical specialist
	DM	REJECT	REJECT	PWF	SL
Delivery	Primary Care (screening) + Secondary Care Specialist Provider	Primary Care only (screening, triage, assessment & diagnosis)	Primary Care (screening). Voluntary Sector (triage) + Secondary care specialist provider (assessment & diagnosis)	Specialist Secondary care provider only (screening, triage, assessment & diagnosis)	
	PWF	REJECT	DM	REJECT	
Implementation	Within 3 months of decision	Within 6 months of decision	Within 12 months of decision		
	SL	PWF	DM		

Figure 38. Living Well options framework

Living Well SUMMARY	1	2	3	4	5	6	7
Scope	All people living with dementia in all community based care settings	All people living with dementia in community based care settings with different offer to care homes	People living with dementia excluding early onset				
	SL	PWF	REJECT				
Solution	Dementia Co-ordinators Memory Roadshow Carers emotional support groups	Dementia Co-ordinators Memory Roadshow. Early onset Co-ordinators. Carers emotional support groups Cognitive Stimulation Therapy (those not able to benefit medication only)	Dementia Co-ordinators Memory Roadshow	Dementia Co-ordinators Memory Roadshow Early onset co-ordinators Carers emotional support groups	Dementia Co-ordinators Memory Roadshow Early onset co-ordinators Carers emotional support groups Cognitive Stimulation Therapy (all)	Dementia Co-ordinators Memory Roadshow Early onset co-ordinators	Dementia Co-ordinators Memory Roadshow Cognitive Stimulation Therapy (vascular only)
	REJECT	PWF	DM	SL	SL	REJECT	REJECT
Delivery	Standalone contracts – two or more providers	Lead provider with sub-contracting arrangement	One provider delivering all elements				
	REJECT	PWF	DM				
Implementation	Staged Within 3 months of decision	Staged Within 6 months of decision	Staged Within 12 months of decision				
	REJECT	PWF	DM				

Figure 39. Supporting Well options framework

Supporting Well Summary	1	2	3	4	5
Scope	All people diagnosed with Dementia across all settings	People diagnosed with dementia in limited settings			
	PWF	REJECT			
Solution	CMHT In reach team (care homes) Day Hospital	CMHT In-reach team (care homes) Step Up & down Community Beds	CMHT Day Hospital (assessment & support) Admiral Nurses (support for family carers**)**	CMHT In reach team Step Up Community Beds Admiral Nurses (support for family carers**)**	CMHT Day Hospital (assessment & support) In reach team Step Up Community Beds
	DM	PWF	REJECT	REJECT	REJECT
Delivery	One single provider of all aspects pan Dorset	Multiple providers	Lead provider sub-contracting to others		
	PWF	REJECT	DM		
Implementation	Staged Within 3 months of decision	Staged Within 6 months of decision	Staged Within 12 months of decision		
	REJECT	PWF	DM		

Figure 40. Supporting Well in Crisis options framework

Supporting Well in Crisis	1	2	3	4	5	6	7
Scope	All people living with Dementia						
	PWF						
Solution	Pan Dorset Intensive Support Team. In-patient Specialist Dementia Beds on one site (40 Beds).	Crisis Helpline. Intensive Support Team. 1 Day hospital (aligned to intensive support). In-patient Specialist Dementia Beds on 3 sites (76 Beds)	Crisis Helpline. Intensive Support Team. 1 Day hospital (intensive support) In-patient Specialist Dementia Beds on two sites – (40 Beds)	Crisis Helpline. Pan Dorset Intensive Support Team. 2 Day hospitals (Intensive support). In-patient Specialist Dementia Beds on one site (40 Beds).	Crisis Helpline. Intensive Support Team. 2 Day hospitals (intensive support). In-patient Specialist Dementia Beds on two sites (40).	Crisis Helpline. Intensive Support Team. In-patient Specialist Dementia Beds on two sites – east & west (40 Beds).	Crisis Helpline. Intensive Support Team. In-patient Specialist Dementia Beds on one site (40 Beds).
	DM	REJECT	REJECT	PWF	REJECT	REJECT	SL
Delivery	One Provider of all elements	Each component delivered by separate providers	Lead provider sub-contracting to others				
	DM	REJECT	PWF				
Implementation	Staged Within 3 months of decision	Staged Within 6 months of decision	Staged Within 12 months of decision				
	REJECT	PWF	DM				

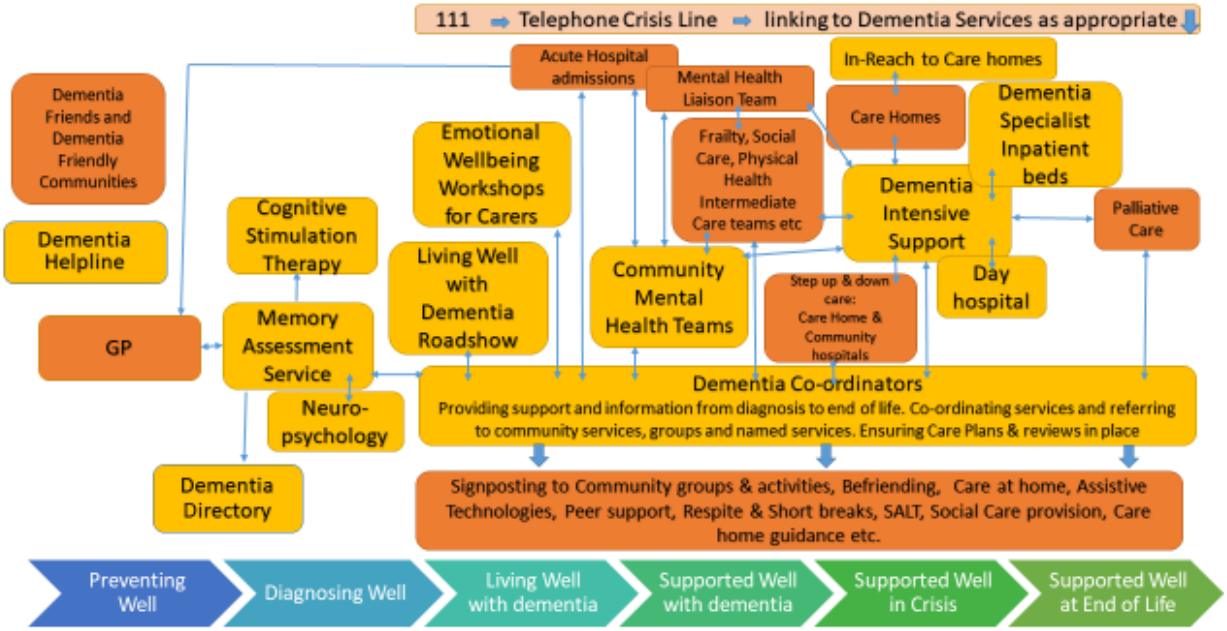
Figure 41. Summary of dementia care pathway options for year 1 (pre-consultation) based 17/18

Core – minimum offer Option A		Preferred option B		Option C		Option D	
Cost £000		Cost £000		Cost £000		Cost £000	
Info	-	Info & General helpline	-	Info & General helpline	-	General helpline	-
Memory Assessment Service 23.43 WTE	1,282	Diagnostic model 4 30.7 WTE	1,476	Diagnostic model 4 30.7 WTE	1,476	Diagnostic model 4 30.7 WTE	1,476
Neuropsychology (limited) 0.51 WTE	29	Neuropsychology (all) 2.3 WTE	147	Neuropsychology (limited) 0.51 WTE	29	Neuropsychology (all) 2.3 WTE	147
Memory Advisors as current 18 WTE	591	Dementia Co-ordinators (different offer to care homes) & Memory Roadshow 30.8 WTE	803	Dementia Co-ordinators & Memory Roadshow 42.9 WTE	1093	Dementia Co-ordinators & Memory Roadshow 42.9 WTE	1093
		Early onset Co-ordinators 0.9 WTE	24	Early onset Co-ordinators 0.9 WTE	24	Early onset Co-ordinators 0.9 WTE	24
Psychology 2.87 WTE	138	Psychology 2.87 WTE	138	Psychology 2.87 WTE	138	Psychology 2.87 WTE	138
		Cognitive Stimulation Therapy (those not able to have dementia meds) 0.7 WTE	57	-		Cognitive Stimulation Therapy (all) 4.0 WTE	311
		Carer emotional support 1.5 WTE	65	Carer emotional support 1.5 WTE	65	Carer emotional support 1.5 WTE	65
OP CMHT (based 54% of budget) 50.89 WTE	2068	OP CMHT (based 54% of budget) 50.89 WTE	2068	OP CMHT (based 54% of budget) 50.89 WTE	2068	OP CMHT (based 54% of budget) 50.89 WTE	2068
In-Reach Team 4.60 WTE	191	In-Reach Team 4.60	191	In-Reach 4.60	191	In-Reach 4.60	191
Intensive Support Team 52.96 WTE	2138	Intensive Support Team 52.96 WTE	2138	Intensive Support Team 52.96 WTE	2138	Intensive Support Team 52.96 WTE	2138
Day hospitals with different models 10.03 WTE	294	2 day hospitals aligned to Intensive support 10.03 WTE	294	-		2 day hospitals aligned to Intensive support 10.03 WTE	294
Modern Matron 1 WTE	53	Modern Matron 1 WTE	53	Modern Matron 1 WTE	53	Modern Matron 1 WTE	53
		Crisis helpline	-	Crisis helpline	-	Crisis helpline	-
40 Inpatient beds 125.36 WTE	4,303	40 Inpatient beds 125.36 WTE	4,303	40 Inpatient beds 125.36 WTE	4,303	40 Inpatient beds 125.36 WTE	4,303
Cost (year1)	**11,087**		**11,757**		**11,578**		**12,301**
Variance	**-**		**(670)**		**(491)**		**(1,214)**

Preferred option and consultation

3.8 From this the above was summarised into the final options and the preferred option (in shaded boxes) which was agreed would be consulted upon with the wider public.

Figure 42. Summary of preferred option pathway (with interdependent services in orange)



Preventing Well

3.9 Preventing Well looked at how to ensure local people had access to dementia advice and guidance.

		Preferred option
An internet based directory of services	A local phone helpline and directory	A local directory of services, supported by signposting to a national helpline

3.10 The local directory of services supported by signposting to a national helpline was identified as the preferred way forward. This was because it can be delivered immediately and is more sustainable as it makes use of an established and well regarded national resource.

Diagnosing Well

3.11 Diagnosing Well focused on how to ensure people living with dementia, and their carers/families have timely access to memory assessment, diagnosis, advice and support.

	Preferred option	
GP screening	GP screening	GP screening
Desk-based triage **by non-registered staff**	Desk-based triage **by registered staff**	Desk-based triage **by registered staff**
Referral to memory nurse assessment	Referral to memory nurse assessment	Referral to memory nurse assessment
Diagnosis by **medical specialists**	**Diagnosis** by **medical** and **nurse specialists**	**Diagnosis** by **medical specialists**

3.12 The co-production group chose the preferred way forward on the basis that:

- It provides a better experience of care and addresses concerns raised in the view seeking about the process being too fragmented.
- It offers the most sustainable solution in the terms of workforce, as there is a shortage of medical specialists.
- It is in line with best practice and provides a consistent level of quality and a more integrated approach.

Living Well

3.13 Living Well focused on helping people living with dementia to live well in their community and ensure they have the right support and care to meet their needs. This also included looking at how to make sure people with a dementia diagnosis are aware of and signposted to the various community services provided by organisations and groups which help people feel less isolated and supported.

Preferred option			
Cognitive Stimulation Therapy groups for patients who currently would not benefit from anti-dementia medication (e.g. vascular dementia)	---	--	Cognitive Stimulation Therapy (for all diagnosed with dementia)

Dementia Co-ordinators with dedicated Young Onset Co-ordinators. Co-ordinators aligned to each care home.	Dementia Co-ordinators (excluding dedicated Young Onset Co-ordinators)	Dementia Co-ordinators with dedicated Young Onset Co-ordinators. Including co-ordinators allocated to everyone in care homes	Dementia Co-ordinators, with dedicated Young Onset Co-ordinators. Including co-ordinators allocated to everyone in care homes
Dementia Roadshow	Dementia Roadshow	Dementia Roadshow	Dementia Roadshow
Emotional wellbeing workshops for family carers	--------	Emotional wellbeing workshops for family carers	Emotional wellbeing workshops for family carers
—	Day hospitals offering social care type support	------	------

3.14 The preferred option was chosen as it was identified as the most sustainable, affordable and did not duplicate support. It would ensure all people with a diagnosis, including those with young onset dementia, have access to a Dementia Co-ordinator throughout their dementia journey as well as ensuring carers' emotional needs are supported. A Dementia Co-ordinator would be allocated to support each care home rather than each individual and work with the staff already supporting residents with extra support through the Dementia In-Reach team.

3.15 Offering Cognitive Stimulation Therapy to all those diagnosed was considered carefully, but this would be far less affordable and not all people diagnosed would be suitable for this therapy. Targeting this offer at those who do not benefit from medication, such as those with vascular dementia, offered greater long term financial sustainability.

Supporting Well

3.16 Supporting Well looked at how to meet the needs of those with a higher level of need due to their dementia and possibly other health or psychological issues. The focus was also on how to ensure care homes are supported to care for their residents with dementia.

	Preferred option
Community Mental Health Team providing higher intensity support alongside an In-Reach team for care homes	Community Mental Health Team providing higher intensity support alongside an In-Reach team for care homes and access to 'step up' and 'step down' community beds across Dorset

3.17 The preferred option was considered to be highly deliverable, affordable and aligns with wider developments associated with the Clinical Services Review.

Supporting Well in Crisis

3.18 Supporting Well in Crisis focused on how to meet the needs of both those living with dementia and their family carers who are experiencing a crisis situation or where the family carer is struggling to look after their loved one with dementia because of their behaviour or other psychological distress.

	Preferred option
---	A crisis telephone helpline
Intensive Support offer (Intermediate Care Dementia Service) offered across Dorset	Intensive Support offer (Intermediate Care Dementia Service) offered across Dorset
Closure of both day hospitals	Two day hospitals both offering assessment and treatment during the daytime
40 specialist inpatient dementia beds on one site at Alderney Hospital, Poole	40 specialist inpatient dementia beds on one site at Alderney Hospital, Poole

3.19 The preferred way forward was chosen as it addresses key workforce sustainability issues, provides an equal service across Dorset, promotes care closer to home and helps prevent people from needing to be admitted to hospital.

3.20 The co-production group carefully considered the location of and the number of beds required. In the medium list of options (see our website www.dorsetccg.nhs.uk/dementia) we considered a number of options for inpatient beds. These options included:

- closing all beds and providing all treatment within care homes
- reopening the temporarily closed wards
- providing the specialist dementia inpatient beds within an acute hospital
- providing the specialist dementia inpatient beds on one site.

3.21 Within the evaluation process of the different models, the option to close all beds and provide beds within care homes or in an acute hospital was not taken forward to the shortlisted options. Staff working on these wards need to have a high level of specialist dementia skills to support patients who exhibit very challenging behaviour and psychological distress. It was felt this support needed to be provided in a specialist unit.

3.22 Reopening the closed wards was ruled out because of the issues recruiting and retaining specialist staff in these areas and evidence that the demand on these specialist beds has been reduced. Since the closure of the two wards in 2013 and 2016 services have moved forward. The Intermediate Care Service for Dementia has developed and has been very successful in supporting more people in the community reducing the need for people to be admitted to hospital. The closed units are now used by other mental health services and the money has been reinvested in dementia services.

Consultation findings

3.23 NHS Dorset CCG commissioned the Market Research Group to assist in the consultation process. The Market Research Group (MRG) is an independent market research agency based within Bournemouth University. The full report can be found at www.dorsetccg.nhs.uk/dementia

3.24 There was a total of **503 r**esponses through the various consultation methods. These included:

- 277 online responses to main consultation questionnaire
- 136 postal responses to main consultation questionnaire
- 5 responses via e mail or letter
- 69 online responses to Easy Read survey
- 16 Postal responses to Easy Read survey

3.25 Overall as can be seen in Figure 43 below the summary of responses to the main consultation and Easy Read in Figure 44 have been significantly positive overall with many elements over 90% in agreement.

Figure 43. Summary of responses to main consultation material

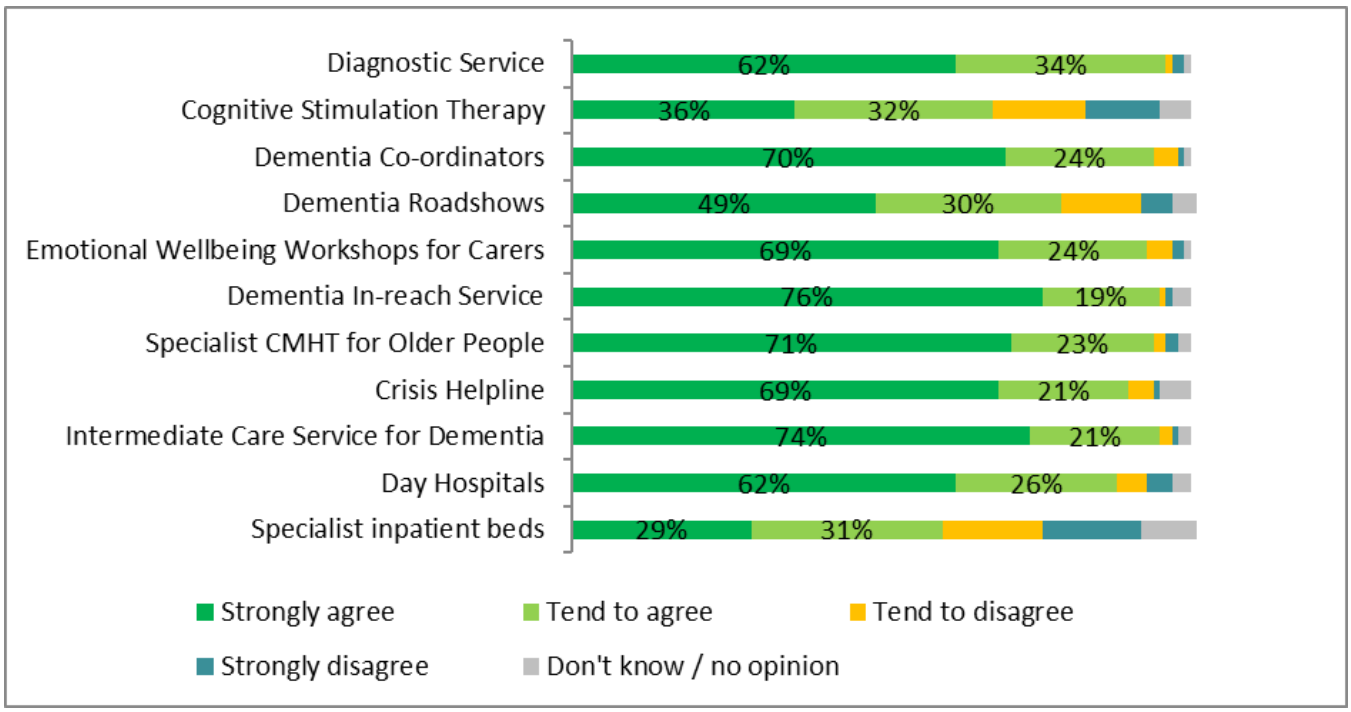


Figure 44. Easy Read survey agreement:

Diagnostic Service

3.26 The vast majority of respondents to both the main survey and the Easy Read version agreed with the proposal to revise the dementia diagnostic service (96% and 92% respectively).

3.27 A total of 316 comments were made by respondents to the main survey in relation to the diagnostic service and 21 from Easy Read. From both types of survey more than half of these comments were positive comments about the proposal (229 comments). A further 75 comments were suggestions for improvement, while only 14 comments were concerns relating to the proposal.

3.28 Positive comments relating to the revised dementia diagnostic service were mostly related to the need for quicker diagnosis of dementia, it is a good change compared to the previous pathway and that the revised service will provide continuity and support a greater number of people.

Utilising skills of advanced nurse practitioners to free up consultants is an effective use of resources and seems to be a common sense

Quicker referral and diagnosis will be beneficial to both patients and carers

3.29 The few concerns of this proposal were about nurse practitioners being responsible for diagnosing dementia and the amount of resources available.

3.30 The main themes to emerge from the suggestions for improvement regarding the revised dementia diagnostic service were having a more joined up approach and ensuring patients do not experience a delay.

Cognitive Stimulation Therapy

3.31 More than two-thirds of respondents to the main survey strongly agreed with the proposal to offer Cognitive Stimulation Therapy only to those who do not benefit from anti-dementia medication (69%). However, a number of respondents disagreed with the proposal for a limited offer of Cognitive Stimulation Therapy (27%). Four-fifths of the Easy Read survey respondents agreed with the proposal (80%), while 15% indicated that they don't agree with it.

3.32 There were a total of 311 comments made by respondents to the main survey in relation to the proposal for Cognitive Stimulation Therapy and 24 from Easy Read. Of these comments, half were suggestions for how the proposal could be improved (175 comments), and 126 were positive comments. Only 15 comments were concerns about the proposal.

3.33 The positive comments relating to the proposal for Cognitive Stimulation Therapy were mostly from respondents who think it is good to offer an option to people who cannot benefit from medication and those who understood the financial constraints behind the decision to not offer the therapy to all.

About time. Those patients for whom medication is inappropriate have just been discharged without any further advice/support - nothing

3.34 The majority of the suggestions for improvement were that Cognitive Stimulation Therapy should be offered to everyone and not just those who do not benefit from anti-dementia medication.

3.35 The few concerns about this proposal were whether the therapy would have any benefit in some cases and that vascular dementia patients would not want to participate in the groups or would struggle to attend.

There is a clear evidence base for CST for people with dementia regardless of whether they can take anti-dementia medication - therefore this should be available to all."

Dementia Co-ordinators

3.36 The vast majority of respondents to both the main survey and the Easy Read version indicated that they agree (94% and 97% respectively) with the proposal to create Dementia Co-ordinators.

3.37 There were a total of 317 comments made by respondents to the main survey relating to Dementia Co-ordinators and 23 from Easy Read. More than half of these comments were positive comments about the proposal (204 comments). A further 98 comments were suggestions for improvement, while only 27 comments were concerns about the proposal.

A person to contact would be wonderful for those affected by dementia diagnosis, and their families. To have a designated person who can get to know individuals and their unique circumstances will bring invaluable help and reassurance to all those involved

3.38 The main themes to emerge from the positive comments were that Dementia Co-ordinators will provide a consistent person to communicate with, it is a good change compared to the previous pathway and it will better support people with Young Onset Dementia.

3.39 The concerns about this proposal were from respondents who felt that the Co-ordinator role duplicated other services already offered or that the role was not clearly defined, and concerns about the funding required to create the Dementia Co-ordinator roles.

3.40 Respondents suggested Dementia Co-ordinators should be easily accessible, they need effective training and leadership, they need to provide a personable and hands on service, and they need to effectively work in collaboration with other organisations and teams.

Dementia Roadshows

3.41 More than three-quarters of respondents to the main survey agreed with the proposal to introduce Dementia Roadshows (79%). Just less than one-fifth of respondents indicated that they disagree (18%) with the proposal to introduce Dementia Roadshows. The majority of Easy Read survey respondents agreed with the proposal to introduce Dementia Roadshows (88%).

3.42 There were a total of 321 comments made by respondents to the main survey relating to the Dementia Roadshows and 27 from Easy Read. Of these comments, 153 were positive about the proposal, 102 were concerns about the proposal and 89 were suggestions for improvement.

Roadshows have proved popular and successful where they have been run so far

3.43 Positive comments included that any additional support is a great idea for patients as well as their carers and families. Other positive comments were that the roadshows would help to reduce stigma and help those in denial, and from respondents who had attended a roadshow previously and found it helpful.

3.44 Concerns about the proposal were mostly that the roadshows are not a good use of funding or resources, that people will not attend or that there are other sources or ways to provide the same information.

To have roadshows running regularly would be wonderful. Patients, carers and family can then visit to get the latest updates and care."

3.45 The main theme to emerge from the suggestions for improvement were that the roadshows need to be easily accessible, occur regularly, well publicised and are friendly and open to all.

Emotional Wellbeing Workshops for Carers

3.46 The vast majority of respondents to both the main survey and the Easy Read version indicated that they agree (93% and 97% respectively) with the proposal to create Carer Emotional Wellbeing Workshops.

3.47 There were a total of 329 comments made by respondents to the main survey in relation to the Emotional Wellbeing Workshops for Carers and 25 by Easy Read. Half of these comments were positive comments (176 comments), while a further 155 were suggestions for improvement. Only 17 comments were concerns about this proposal.

3.48 The majority of positive comments were made by respondents who are supportive of the workshops because carers are important and are also in need of support and information.

We as a society rely heavily on unpaid care and this would undoubtedly benefit, strengthen and give greater resilience to those caring the majority of time for dementia patients

3.49 However, the 17 concerns were respondents who thought that the workshops would not be useful.

Absolutely vital! I would add regular, drop in sessions after the workshops which would really help, as well as access to counselling as needed.

3.50 The main themes to emerge from the suggestions for improvement were that there needs to be care available for the patients while carers attend the workshops, the workshops need to be easily accessible, further elements should be added to the workshops and that carers need more direct, practical support.

Dementia In-Reach Service

3.51 Almost all respondents to both the main survey and the Easy Read version agreed with the proposal to provide the Dementia In-Reach services across all of Dorset (95% and 96% respectively).

3.52 There were a total of 283 comments made by respondents to the main survey in relation to the Dementia In-Reach Service across Dorset and 15 from Easy Read. The majority of these comments were positive comments about the proposal (223 comments). There were 34 suggestions for improvement and 23 concerns.

3.53 Positive comments made by respondents were mostly related to that it is good for staff to have this kind of support and information, it is good to expand the service to the whole of the county and that it is good patients will be treated with respect and patience.

There should be equity across the county and no postcode lottery

3.54 The few concerns raised by respondents were that organisations should be responsible for their own staff training and that this service already exists.

3.55 The suggestions for improvement were related to the need for the service to be expanded and the functionality of the service.

Specialist Community Mental Health Team for Older People

3.56 The vast majority of respondents to both the main survey and the Easy Read version indicated that they agree (94% and 99% respectively) with the proposal for the specialist Community Mental Health Team for Older People to continue to provide support across Dorset.

3.57 A total of 262 comments were made by respondents to the main survey in relation to the Community Mental Health Team for Older People and 17 from the Easy Read. More than half of these comments were positive comments (158 comments), while 78 suggestions for improvements were made. Only 24 comments were concerns.

3.58 Positive comments about the proposal for the Community Mental Health Team for Older People were mostly related to co-operation and continuity among teams, enabling people to remain independent and relieve pressure on other services, and that the service will help if a person's condition deteriorates and will help avoid a crisis.

Working together with expertise from a specialist CMHT team and dementia co-ordinators should improve the service to the patient

People should live in their own home as long as reasonably possible, so this is welcomed

3.59 The few concerns raised by respondents were about the Community Mental Health Team and its capacity to help those with dementia, and some who do not think the proposed changes will work.

3.60 The main themes which emerged from the suggestions for improvement were staff roles and responsibilities and offering an enhanced service.

Crisis Helpline

3.61 The majority of respondents to the main survey indicated that they agree (90%) with the proposal to provide a crisis helpline through the new Connections service run by Dorset Healthcare, while 86% of Easy Read survey respondents agreed with this proposal.

3.62 There were a total of 285 comments made by respondents to the main survey relating to the crisis helpline and 26 from the Easy Read survey. The majority of these comments were positive comments (137 comments) or suggestions for improvement (117 comments). There were also 42 concerns about the proposal.

Hopefully will prevent some of the unnecessary acute hospital admissions which can occur in a crisis arising because of dementia

3.63 Respondents were positive about the proposal to utilise the crisis helpline because it will help when dealing with a crisis, it provides instant support and will help to ease pressure on other services.

3.64 The main concerns about this proposal was that people with dementia would find the helpline difficult to use.

3.65 Suggestions made relating to the crisis helpline were mostly related to the need for it to be properly designed and advertised, that staff operating within the helpline need to be properly trained and the helpline should be available for carers to use.

In a crisis people need help as soon as they can! This could prevent unnecessary suffering for both patients and carers

Intermediate Care Service for Dementia

3.66 The vast majority of respondents to both the main survey and the Easy Read version agreed with the proposal to expand the Intermediate Care Service for Dementia (95% and 96% respectively).

3.67 There were a total of 287 comments made by respondents to the main survey in relation to the Intermediate Care Service for Dementia and 15 from the Easy Read survey. Of these comments, more than half were positive about the proposal (210 comments), and 58 were suggestions for improvement. There were only 17 concerns.

My experience is that dementia patients are much more settled if in their own familiar surroundings

3.68 The main themes to emerge from the positive comments made about the proposal was that it is good to expand the service across the whole of the county and that it will enable people with dementia to remain at home for longer. Other comments were from respondents who thought the service would be good for when in a crisis and those who were positive about the existing service.

I have had first-hand experience of this excellent Service. It was literally a lifeline and prevented hospital admission for the person I cared for, for some time and it should be available across the county."

3.69 The few concerns raised by respondents were about the adequacy of the Intermediate Care Service itself, and those who felt there is a greater need for more inpatient beds and care homes across the county.

ICSD offer an invaluable service. It should be available county-wide

3.70 The main themes which emerged from the suggestions for improvement were the design of the service in terms of staff and connections with other services, accessibility of the service and respite for carers.

Day Hospitals

3.71 The majority of respondents to both the main survey and the Easy Read version indicated that they agree (88% and 91% respectively) with the proposal to maintain the two day hospitals and align the service they provide.

3.72 A total of 270 comments were made by respondents to the main survey in relation to the proposal regarding the day hospitals and 15 from the Easy Read survey. The majority of these were positive comments (147 comments) or suggestions for improvement (111 comments). Only 14 comments by respondents were concerns about the proposal.

This could provide additional support for carers and enable people to stay at home for longer provided they do not live alone

3.73 The main themes to emerge from the positive comments for this proposal were that it is good to allow people to remain in their own home for longer, equality of services and services will be more coordinated.

Important to have a consistent approach, whichever part of the county you live in

3.74 A few respondents had concerns about the proposal because they felt day care is not suitable for people with dementia, or they feel that the provision of day care is inadequate.

The logistics of a day hospital in the West needs careful thought as to where they might be based and how they would be staffed to work with the intensive care service for dementia

A good move but what about other parts of Dorset that do not have the specialised service available?

3.75 The majority of suggestions made by respondents were related to the need for this service across the whole of the county. Other suggestions were related to expanding the service offered and extending the hours of this service.

Specialist Inpatient Beds

3.76 Three-fifths of respondents to the main survey indicated that they agree with the proposal to maintain the specialist dementia inpatient beds only at Alderney Hospital (60%). However, one-third indicated that they disagreed with this proposal (32%). Only half of the Easy Read survey respondents agreed with this proposal (51%), while one-third of respondents did not agree with the proposal to keep specialist dementia inpatient beds only at Alderney Hospital (33%).

3.77 There were a total of 293 comments made by respondents to the main survey in relation to the proposal for the specialist inpatient beds and 34 from the Easy Read survey. More than half of these were concerns about the proposal (193 comments). There were 76 positive comments, and a further 42 suggestions for improvement.

Far better to have one sustainable service that provides excellent care, than struggle to run two and create staffing issues across them both

Accept the reality that it's hard to get specialist staff in rural Dorset, but ideally there would be a specialist inpatient unit in each half of the county.

3.78 Positive comments were mostly from respondents who understood the rationale for having one inpatient unit and from those who liked that support for families visiting was considered in the proposal.

3.79 The main concerns about the proposal were that inpatient beds are needed across the whole county and that carers should not have to travel such long distances to visit loved ones in different parts of the county.

It may be difficult for elderly spouses to travel from all of Dorset to the hospital in Poole, maybe consideration given to transport/accommodation for the patient's spouse?"

Beds need to be available all over the county not just in the affluent East

3.80 Suggestions for improvement were mostly related to alternatives to inpatient care for people with dementia and that this proposal needs further development and clarification.

Other comments

3.81 There were 270 other comments within the main survey and 12 Easy Read comments. Comments related to the dementia care pathway, the needs of carers and the need for more respite care. Comments also were around other services and groups and improving communication and collaborative working, day care, care at home, activities and information provision. Comments also on staff working in services receiving better remuneration and training. There were positive comments about the consultation in general and supportive of the proposals. Some felt this is very forward thinking and a great step forward.

I have promised my husband I will not put him in a home. I would move heaven & earth to make sure I can keep this promise so I think this is an excellent idea

These proposals will only work if there is a considerable increase in money invested into the service. This is long overdue.

"It is excellent that the needs of people with dementia are being considered and thought given to the provision of future services, and you are to be commended for this initiative

New service details following consultation findings

Preventing Well

National Telephone helpline

3.82 A telephone helpline was considered important for patients and family carers to be able to access help and information from the point they are concerned to end of life care. The most cost effective option to offer general advice and guidance prior to ascertaining a dementia diagnosis and dementia services is to signpost people via website and other sources of information on dementia services to national dementia helplines. Utilising a national commissioned helpline will also be cost neutral.

3.83 Two prominent national helplines are:

- Alzheimer's Society National Dementia Helpline. Promoted as 'Looking for information, support or advice about dementia? Our helpline is here for you on 0300 222 1122. Further information can be found at: https://www.alzheimers.org.uk/get-support/national-dementia-helpline. Furthermore, this site signposts to other national helplines as offers 'Talking Point' which is an online community for people with dementia, their family, friends and carers.
- Dementia UK dementia helpline. Promoted with 'Call our Dementia Helpline for free on 0800 888 6678' the service offers Admiral Nurses to listen and give advice and support with no time limit. The service also encourages to contact via e mail to helpline@dementiauk.org. Further information can be found at https://www.dementiauk.org/get-support/dementia-helpline-alzheimers-helpline/

Dorset Dementia directory

3.84 Within the view seeking there was a clear message around the need for clear, accessible up to date information around dementia. As a 'quick win' within the Dementia Services Review, the existing Dorset Dementia Directory was revised and updated. https://www.dorsetccg.nhs.uk/wp-content/uploads/2018/04/Living-well-with-memory-loss-and-dementia-in-Dorset-2018.pdf.

3.85 It is proposed to maintain this as a web based resource that this is updated regularly via NHS Dorset CCG or another commissioned organisation and for this to be reviewed annually with a re-print if required. Stakeholders have continually requested hard copies of the Directory and costs for an update and print run of 10,000 copies is proposed.

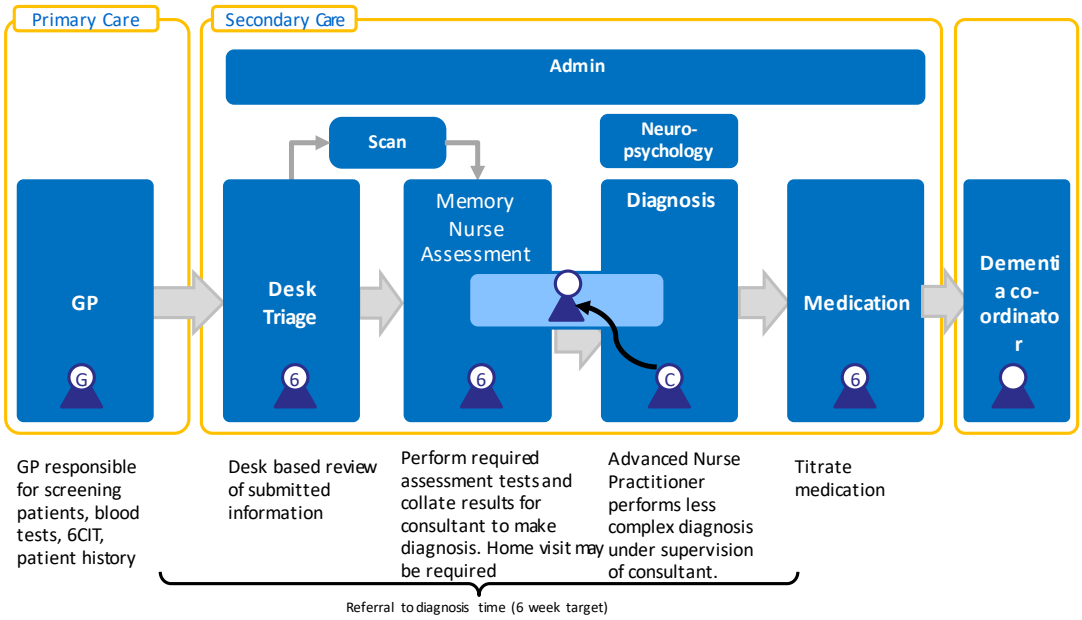
3.86 It is planned that this will align with wider information sources provided through the Local Authorities and others.

Diagnosing Well

Memory Assessment Service

3.87 The consultation findings gave very strong support for the proposed new model of diagnostic service. This model would include initial screening within General Practice. This would be followed for those with suspected dementia with a desk based triage by registered staff and then referral for a Memory Nurse assessment. If appropriate diagnosis would be through an appointment and possibly further tests and scans by medical and nurse specialists.

Figure 45. Diagnosis Model 50% of cases diagnosed by Nurse Practitioner under supervision of consultant.



Neuropsychology

3.88 Neuropsychology is currently offered in a very limited way. The proposed model included neuropsychology to form a key function of Clinical Psychology input in relation to supporting diagnosing well within Memory Assessment teams specifically to:

- Offer neuropsychological assessment (as recommended by NICE and MSNAP guidelines) to assist with diagnosis and differential diagnosis, particularly in complex cases;
- Identify the person's cognitive strengths in relation to helping with developing coping strategies;
- Supervise and train Memory Assessment staff in selecting/administering and interpreting cognitive screening tests/assessments and aspects of pre and post diagnostic counselling.

Living Well

Dementia Co-ordinator role

3.89 Living Well focused on helping people living with dementia to live well in their community and ensure they have the right support and care to meet their needs. The proposed option was to ensure all people with a dementia diagnosis have access to a Dementia Co-ordinator throughout their dementia journey as well as ensuring carers are supported and signposted to relevant support services. The proposal for Dementia Co-ordinator service has been highly supported with 94% and 97% across the two surveys in agreement from the consultation findings.

3.90 The needs of those with young onset dementia would be met through a bespoke 'Young onset Dementia Co-ordinator. Furthermore, Dementia Co-ordinators would be aligned to offer support to all care homes across Dorset and work with the staff supporting residents with extra support through the Dementia In-reach team.

3.91 Dementia NICE guidance[32] highlights the need for a named health or social care professional who is responsible for coordinating care and developing a care and support plan. This includes:

- Agree and review it with the involvement of the person, their family members or carers (as appropriate) and relevant professionals;
- Specify in the plan when and how often it will be reviewed;
- Evaluate and record progress towards the objectives at each review;
- Ensure it covers the management of any comorbidities;
- Provide a copy of the plan to the person and their family members or carers (as appropriate).

3.92 The Dementia Co-ordinator would hold responsibility for ensuring this co-ordination of care is provided and whilst they may hand the 'baton' of responsibility over to another health and social care professions at certain stages of the dementia journey crucially each patient would still remain under the Dementia Co-ordinator service from diagnosis to end of life.

[32] https://www.nice.org.uk/guidance/ng97/chapter/Recommendations#care-coordination

3.93 A draft Job description is in Appendix 2**.** In summary:

- Support people along their journey: 'walk with them' offering information and 'low level' support, being integrated with Memory Assessment Service teams and other community teams based in Primary Care locality hubs;
- Offer advice, guidance, signposting, continuity of care and provides a coordination role linked with multidisciplinary teams including primary care, frailty teams, acute hospitals liaison services and dementia teams across Dorset;
- Monitoring of needs and Advance Care planning;
- Ensuring care plan is in place and reviewed annually as a minimum (recorded onto GP Practice registers) with reviews completed by appropriate service;
- Support and advice to maintain independence – finance, benefits, local resources, assistive technologies and equipment, practical assistance;
- Ensure that people are aware of local advocacy services;
- Offering advice and guidance for Carers and signposting to relevant services. Including access to technology, information, respite, advice, carer assessments;
- Working with a range of health and social care services including social prescribing and linking with Dementia Friendly Communities.

Young onset Dementia Co-ordinator role

3.94 The preferred option recognised that those with a dementia diagnosis and are under the age of 65 may have significantly different needs to those of much older patients. For example, they may hold family responsibilities or be in employment. The function of a co-ordinator would include:

- Providing age appropriate groups across the county for people under 65 years;
- Developing and encouraging peer support groups;
- Offering relevant guidance & signposting. Eg employment support, financial information;
- Providing similar functions to above co-ordinator role including linkages to the voluntary sector, social prescribing and Dementia Friendly Communities.

Dementia Co-ordinator service

3.95 Ideally this service could be provided through a voluntary sector provider recognising the social value that many such organisation offer into communities and recognising that recruitment may be easier. However, it is crucial that this service does not get fragmented from the wider dementia services and the ideal contracting approach would be through a prime provider model.

3.96 The Dementia Co-ordinator service is proposed to operate within the 18 newly formed Primary Care Networks across Dorset. Modelling has been based on numbers of people diagnosed with dementia living in their own homes with each Dementia Co-ordinator having a case load of around 200 people. In addition, a further 0.2 WTE has been added based on supporting care homes (per 200 residents). 1 WTE Young Onset Co-ordinators are included.

3.97 The plan will be for a total of 31 Dementia Co-ordinators to work across all Primary Care Networks supported by additional managers and administration.

Figure 46. Modelling Dementia Co-ordinators with Primary Care Networks (Sept 2019)

Primary Care Network	Dementia diagnosis numbers in own home	Dementia diagnosis numbers in care homes	% diagnosed in care homes	Estimated Dementia Co-ordinators
Central Bournemouth Primary Care Network	222	149	40%	1.1
Christchurch Primary Care Network	508	194	27.6%	2.7
South Coast Medical Group	261	209	46%	1.5
Bournemouth East Collaborative Network *	260	161	38%	1.4
North Bournemouth Primary Care Network	292	110	27%	1.6
Poole Bay and Bournemouth Primary Care Network	225	168	43%	1.3
Wimborne and Ferndown Primary Care Network	327	198	38%	1.7
Crane Valley Primary Care Network	207	141	41%	1.2
Poole North Primary Care Network	421	168	28%	2.3
Shore Medical *	367	289	44%	2.1
Poole Central Primary Care Network	434	263	38%	2.4
Mid Dorset Primary Care Network	254	268	51%	1.6
The Vale Primary Care Network	293	127	30%	1.6
Sherborne Area Network	181	68	27%	1.0
Blandford Primary Care Network	151	81	35%	0.9
Weymouth and Portland Primary Care Network	452	330	42%	2.6
Jurassic Coast Primary Care Network	246	135	35%	1.3
Purbeck Primary Care Network	293	156	35%	1.6
Young onset				1.0
Grand total	**5394**	**3215**		**30.9**

* data from 1 practice not submitted

Living well with Dementia – 'Memory Roadshow'

3.98 Noting the rural issues for Dorset, visits and information from other services across the country revealed a useful model being run in rural Cornwall. This is called STEM 'Support, Talks and Educational Memory Sessions' by Cornwall Partnership NHS Foundation Trust. This model is underpinned by Plymouth University research that focused on rural issues and dementia; highlighting a reluctance to ask for help and travel issues alongside a lack of support services.

3.99 STEM offers a holistic access point within the community where patients and carers could meet and gain information and awareness of service provision from a wide range of attending organisations and agencies, receive a short education talk on dementia alongside having a review of their needs by the Mental Health Trust. It had been evidenced these sessions offer both continuity of care and support as well as on-going monitoring. An audit in March 2016 highlighted a saving of £23,000 per year for a caseload of 360 patients through reviewing at STEM community sessions.

3.100 Based on elements of this model two pilots were run in Dorset on 30 May 2018 and 22 May 2019. Evaluation highlighted that this pilot service was of genuine value to those whom attended with the benefits of meeting people, feeling more informed about different services, have information about local services and the request for more to be held.

3.101 79% and 88% of respondents supported this model within the two consultation survey findings. Learning from these pilots suggests key functions of such a roadshow would be to:

- Offer a workshop type session open to anyone interested on a regular basis in local areas and ensure all people newly diagnosed with dementia and their carers are invited;
- Offer a short educational talk and information on dementia and available services;
- Bring together all key services in one place for people to meet and have opportunity to talk to services;
- Enable peer support and meeting others.

Cognitive Stimulation Therapy (CST) groups

3.102 Cognitive Stimulation Therapy based groups support those living well with dementia by offering brief, closed, structured groups that follow a programme of themed activities designed to actively stimulate and engage people with dementia, promote cognition (e.g. memory, language and executive function) and quality of life. This is particularly beneficial for those with mild to moderate dementia and would enable a treatment offer to be given to patients whom currently do not benefit from the various dementia medications such as vascular dementia.

3.103 During the consultation period whilst two thirds of respondents agreed with the proposal there was a large percentage of comments stating that this should be not limited to those not currently benefited from anti-dementia medications and should be widely accessible to all.

3.104 However, during the consultation events it was identified that other organisations such as Age UK and individuals were already offering these groups across Dorset. Some exploration following the consultation found Age UK run 7 sessions across Dorset in various locations and have provided support for 64 individuals in one year.

3.105 This suggests there is still a significant gap with availability for all diagnosed with dementia whom may wish to participate so extra resources have been included in final costings to ensure the offer is available to all.

Carer Emotional Wellbeing Workshops

3.106 Based on carer needs identified within the view seeking stage as a further 'quick win' a set of 'Carers Emotional Support training' courses were commissioned as a pilot with Dorset HealthCare running and evaluating the sessions over 2018/19. This proposal was highly supported within the consultation findings with over 90% in agreement.

3.107 The objectives of the pilot workshops included:

- Understand the different dementia's and the different ways people are impacted;
- Enable the carer to understand the process of change both physically and emotionally;
- Enable carers gain knowledge on coping mechanisms for stress management;
- Gain skills to manage behaviours that challenge others, depression and anxiety;
- Encourage ongoing peer support at the end of the sessions.

3.108 Feedback included excellent course, sessions informative and not rushed, lots of information for accessing help, having explanations regarding behavioural changes and advise of caring for ourselves and knowing one is not alone. Knowing how to cope when things get difficult. Feeling 'the fog' has been lifted and better equipped with knowledge and skills.

3.109 Outcome measures were utilised: Alzheimer's Disease Knowledge Scale – ADKS and the Warwick-Edinburgh Mental Well-being Scale – WEMWBS. The outcome measures showed significant increase particularly with the knowledge basis. This therefore suggests some refinement may be necessary to ensure the wellbeing score is increased in future courses.

Figure 47. Evaluation of carer workshop pilots

Carer group	Attendance no	ADKS 1st attendance average score	ADKS last attendance average score	WEMWBS 1st attendance average score	WEMWBS last attendance average score
Shaftesbury Oct – Dec 2018	16	22.8	26.2	44.5	42.6
Weymouth March – April 2019	13	21.7	26.6	46.9	49.3
Bridport June 2018	8	19	22.6	48.14	50.16
Dorchester April 2018	8	21.5	29	38.37	47.57

Supporting Well

3.110 Supporting Well looked at how to meet the needs of those with a higher level of need due to their dementia and possibly other health and psychological issues. The preferred option was in the event that a patient and/or family care needs escalate and require higher levels of support and clinical expertise than the Dementia Co-ordinator then they would hand over the provision of care to the Community Mental Health Team. These teams will provide higher intensity support alongside an In-Reach team for care homes and access to 'step up' and 'step down' transitional community and care home beds. This proposal was highly supported within the consultation findings.

Dementia Specialist Team / Community Mental Health Team

3.111 The functions of this team will be to offer:

- A step up service referred from Dementia Co-ordinator;
- A higher intensity, clinically based service when needs of patient increase or become more complex;
- Assessment of needs, specialist advice and guidance on dementia, psychological support and groups, treatment management;
- Prevention management – pro-active service. Works jointly with the intensive support team (ICSD) in the event of crisis;
- Management of health problems, guidance and advise and pain management;
- Guidance on managing behaviours that challenge (Behavioural and psychological needs) to carers – informal and formal;
- Referrals to other services as appropriate and step down to Dementia Co-ordinators;
- Care plans and reviews;
- Aligned with Primary Care Networks and working alongside the Dementia Co-ordinators and intensive support service as a local Dementia Team.

Supporting Well in Crisis

3.112 Supporting Well in crisis focused on how to meet the needs of both those living with dementia and their family carers who are experiencing a crisis situation or where the family carer is struggling to look after their loved one with dementia because of their behaviour or other psychological distress.

Crisis helpline

3.113 Providing people with a phone number that can give both support and guidance as well as mobilising appropriate services will lead to far better outcomes for patients and their families and alleviate many anxieties. During the consultation this was highly supported and it was raised that this should be particularly aimed at family carers and friends and this was the intention of offering to both those living with dementia and their families and friends whom have serious urgent concerns through the new Connections Service and 111.

Intermediate Care Service for Dementia (ICSD)

3.114 The proposal includes the current 'Intermediate Care Service for Dementia' to be formally commissioned across the whole of Dorset. This service offers intensive support and treatment for up to six weeks in the person's own home to those experiencing a crisis in order to try to maintain the person in their own home if possible. This was very highly supported through the consultation.

3.115 Rebranding to be clearer on the function of this service to 'Intensive Care Service for Dementia' would ensure the same acronym ICSD and minimise confusion.

In-Reach Service to care homes

3.116 The In-reach service based in the East of Dorset provides hands on and formal training with advice, support and training to care homes, day centres and community hospitals to better enable staff to manage crisis situations and particularly behaviours and psychological issues that challenge them. Within the consultation respondents were highly supportive for the service to be available across Dorset.

Day Hospitals

3.117 Currently there are two day hospitals in Dorset operating with different models. The consultation findings supported the proposed model of care of offering a safe environment for those experiencing crisis and to align the Day Hospitals with the 'Intensive (Intermediate) Care Service for Dementia' to ensure equity across Dorset. However, whilst there was high support within the consultation findings concerns were raised around ensuring this offer is available across Dorset and not just in two locations. Therefore, this will need to be explored further in the future.

Specialist Dementia Inpatient provision

3.118 Offering 40 specialist dementia inpatient beds at Alderney Hospital in Poole was the proposed model with the formal closure of the temporarily closed units in Blandford and Weymouth. Both of these units had been closed due to the inability to recruitment and retention issues of registered staff. It is envisaged that by centralising specialist in-patient provision on one site, should provide greater workforce resilience and the opportunity to co-produce a dementia 'Centre of Excellence' on the Alderney site in the future.

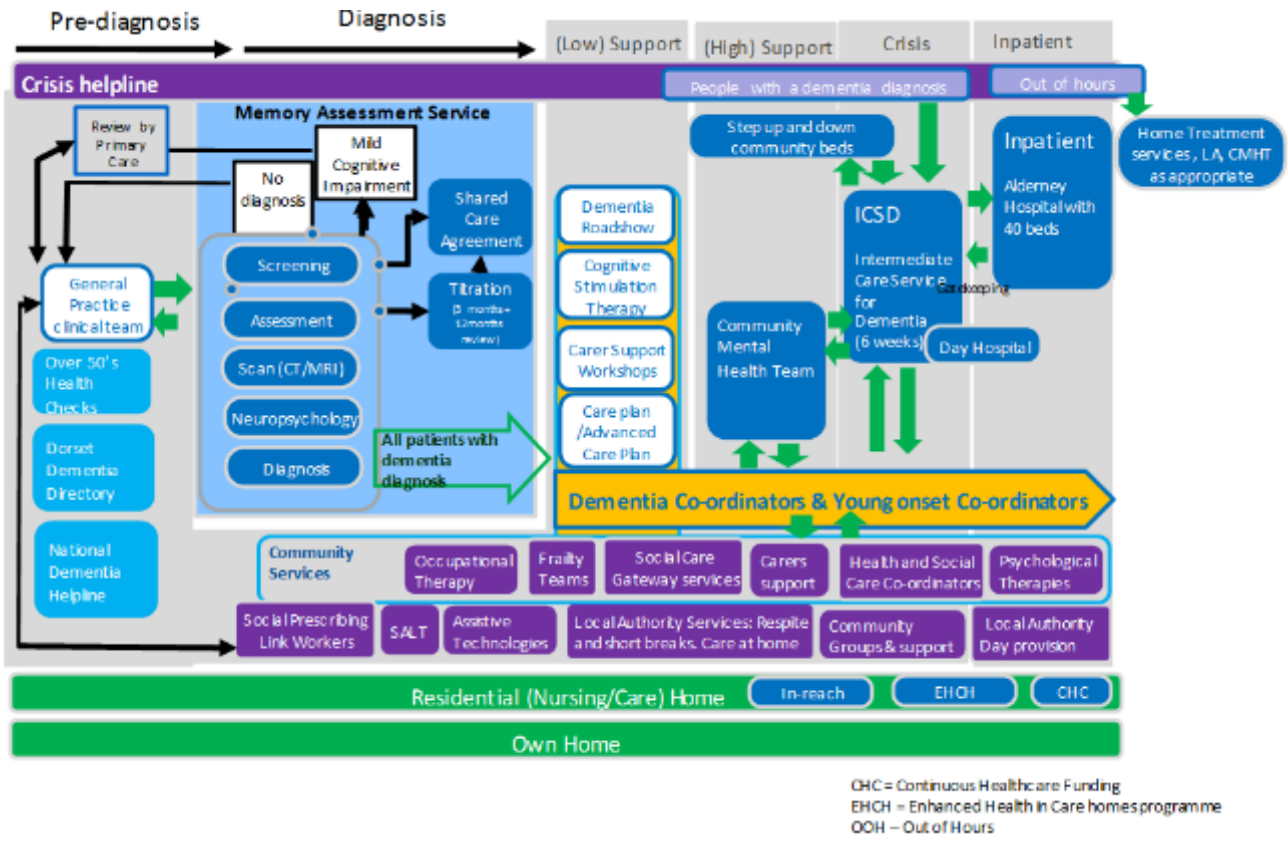
3.119 These specialist beds which are for patients with a very high level of acuity and are usually detained under the Mental Health Act will be complemented by larger numbers and more local community and care home transitional beds often referred to as 'Step up' and 'Step down' beds across Dorset.

3.120 The consultation findings found 60% in agreement from the main consultation survey and 51% from the Easy Read. Particular issues raised were the view that another unit should be available in the West of the county. This is being addressed by offering financial support for public travel costs outside a radius of 30 miles and offering costs to cover reasonable overnight accommodation to support visiting by family carers.

New proposed Care pathway

3.121 The new care pathway is below. Detail on the interdependent services are in Appendix 1.

Figure 48. Proposed new dementia care pathway



CHC = Continuous Healthcare Funding
EHCH = Enhanced Health in Care homes programme
OOH – Out of Hours

Summary of potential benefits and outcomes

Benefits for people living with dementia

3.122 From the available evidence it suggests greater investment into the community services will ensure people living with dementia and their families find services easier to access, they feel more supported, have less crisis episodes and patients can remain in their own homes longer.

3.123 The new diagnostic model will offer a more streamlined, less fragmented service so patients will be seen quicker, experience less delays and for those with more complex cases or early onset the diagnostic process will be supported by neuropsychology input.

3.124 Systematic reviews evaluating the effectiveness of cognitive stimulation in dementia have shown significant and consistent benefits. These include improving cognitive function for people with dementia and is also associated with benefits of quality of life and communication. Furthermore, these benefits are in addition to any medication effects.[33]

3.125 The new Dementia Co-ordinators acting as a crucial workforce across all ages based within locality hubs will assist people navigate the health and social care systems and will ensure both people living with dementia and their family carers have a single point of contact for advice, guidance and signposting to other community services from the point of diagnosis to end of life. When higher levels are support are required the Dementia Co-ordinator will be able to enable access to other health and social care including secondary care dementia services.

3.126 Maintaining people within their own homes through the intensive support service and day hospitals potentially will reduce stress and cognitive decline and is far less disruptive and confusing for individuals than becoming an inpatient inappropriately.

Benefits for family carers

3.127 Family carers are often crucial in enabling those living with dementia to live well. Therefore, it is imperative that family carers are well informed, signposted to appropriate services and supported. The Memory Roadshows will offer an opportunity for both those diagnosed with dementia and their family carers to understand more about dementia particularly at the point of receiving a dementia diagnosis and have opportunity to meet staff from the various services.

3.128 The carer emotional training courses will build on the current generic dementia training that is offered through local authorities and other agencies. This training will benefit carers by providing a safe environment for them to learn more around their life changes as a result of caring for someone with dementia and the emotional impact of 'unrecognised grieving and loss' they may be experiencing. This should enable them to develop more resilience, greater understanding of the emotional impact on them as a carer alongside meeting other peers.

[33] https://www.sciencedirect.com/science/article/pii/S1568163712000955

Organisational and workforce benefits

3.129 This new model will give greater NICE compliance ensuring people diagnosed with dementia have a named co-ordinator, have neuropsychology offered within the diagnostic processes and cognitive stimulation therapy available.

3.130 The new diagnostic model will utilise 50% Nurse Practitioners for diagnosis and therefore will be more cost effective and offer greater service sustainability with the current shortage of psychiatrists nationally. The overall service provides greater efficiency and less fragmentation across the pathway.

3.131 A reduction in inappropriate inpatient admissions into acute hospitals and the reduction of need for dementia specialist beds has been evidenced by the current Intensive Support Service (Intermediate Care for Dementia) leading both to cost benefits and also improved quality for people living with dementia.

3.132 Return on Investment and cost benefits are noted under the financial case in the following chapter. Evaluation framework for the new model can be found in the Management Case.

4. FINANCIAL CASE

4.1 The purpose of the financial case is to set out the likely financial impact of the investment proposal and gives an indication of return on investment. It details the financial implications of all the service element options including the do minimum option (business as usual option) along with key activity assumptions that have been used to underpin the modelling of costs.

Operational budget

4.2 The current operational budget is below in Figure 49 and represents the 'Business as usual' option.

4.3 In 2012, the operational budget for Betty Highwood, Blandford was £706,000 and with the closure of these beds these funds were reinvested into Older People inpatient and Community Services. In 2015, the operational budget for Chalbury Unit in Weymouth was £1,375,000 prior to the temporary closure. These funds were reinvested into developing 'Intermediate Care Service for Dementia' pilots in each locality in the West of the county. There is £47,000 remaining which is included within the budget lines for inpatients.

4.4 To note Dementia specialist inpatients includes Herm, St Brelades and remaining budget from Chalbury (£47k) after creating Intermediate Care Service for Dementia (ICSD) West. ICSD includes Social Care budget in addition to the ICSD East and West Teams (recurrent budget).

4.5 Whilst there was no extra investment identified at the inception of the Dementia Services Review it became apparent as the review progressed that extra investment would be required to deliver the new model of care, ensure the outcomes and objectives are delivered and meet the future and predicted demand.

Figure 49. Current Dementia Services Operational budget (19/20)

Service	Operational Budget £	WTE
Memory Support and Advisory Service	596,510	18.00
VOLUNTARY SECTOR TOTAL	**596,510**	**18.00**
Memory Assessment Service	1,009,635	23.47
Memory Assessment Service Medics	201,391	1.60
Memory Assessment Drugs and Scans (notional)	89,419	-
Day Hospitals	314,887	10.63
ICSD (Intensive Support Service)	2,232,876	58.56
Dementia Specialist Inpatients	4,379,256	125.65
ORGANIC SERVICES TOTAL	**8,227,464**	**219.91**
Older People CMHT (54% of total service)	2,149,858	50.49
OP Psychology (54% of service)	138,417	2.40
OP Psych (notional) Neuropsychology	29,365	0.51
OP Inreach (Functional and Organic)	182,203	4.00
Modern Matron (Functional and Organic)	56,625	1.0
INTEGRATED SERVICES TOTAL	**2,556,469**	**58.40**
GRAND TOTAL	**11,380,442**	**296.31**

Financial modelling

4.6 Financial modelling was undertaken to determine the cost of future service delivery.

- **Activity driven models** – Where a new service or significantly reconfigured service is proposed then an activity model was created to determine staff and non-pay costs based upon agreed modelling assumptions.
- **Staff driven models** – Where a service exists and there is no plan to significantly change the staffing model, then a staff driven model has been included.

Figure 50. Basis of modelling of services

#	Title	Model Type	Comment
1	Dementia Information Line	None	Separate costing
2.1	Diagnosis Service (Option 1)	Activity	Four options evaluated for the diagnosis service (choice of one from four)
2.2	Diagnosis Service (Option 2)	Activity	
2.3	Diagnosis Service (Option 3)	Activity	
2.4	Diagnosis Service (Option 4)	Activity	
2.5	Cognitive Stimulation Therapy	Activity	New service
2.6	Neuropsychology	Activity	New service
3.1	Dementia Coordinators (option 1)	Activity	Three options for dementia co-ordinators (Either option 1/2, and P)
3.2	Dementia Coordinators including into care homes (2)	Activity	
3.3	Early Onset Coordinators (Option 3)	Activity	
3.4	Carer education	Activity	New service
3.5	Emotional Wellbeing Memory Roadshow	Activity	New service
5.1	Intensive Support (Model 1)	Activity	Additional funding
	DHC OP CMHT	Staff	Existing service
	DHC ICSD (+ WEST)	Staff	Existing service
	DHC Inpatient	Staff	Existing service
	DHC Day Hospital	Staff	Existing service
	DHC In-Reach (+ WEST)	Staff	Existing service
	DHC Occupational Therapy	Staff	Existing service
	MSAS (Alzheimer Society)	Staff	Existing service

Costing of new model

4.7 The costs for the new model with full year effect are shown below including notes on the key activity assumptions. To note existing overhead costs within Dorset Health Care have been excluded at this stage and are assumed to be covered within the existing block contract arrangement. Furthermore, existing services not subject to requiring investment have not been modelled for future years as this will be covered within the block contract negotiations.

Dorset Dementia Directory

4.8 The existing Dorset Dementia Directory was revised and updated in 2018. It is proposed to maintain this as a web based resource that this is updated regularly via NHS Dorset CCG or another commissioned organisation and for this to be reviewed annually with a re-print if required. Stakeholders have continually requested hard copies of the Directory and costs for an update and print run of 10,000 copies are £11,000 with design completed in-house and postage and distribution included.

New Diagnosis model

4.9 Secondary care based diagnostic service with telephone triage function, nurse assessment and diagnostic appointments. Modelling based on 3,200 referrals per annum with 75% of referrals triaged to assessment. Assuming 50% of cases diagnosed by nurse practitioner, a 7% DNA rate and 65% of diagnosed patients requiring medication with an initial medication session and four follow ups.

Type	Post	Band	WTE	£
Medical	Consultant Psychiatrist		2.19	247,841
Medical	Associate Specialist		-	0
			2.19	**247,841**
Admin	Appointments Clerk	2	2.40	52,463
Admin	Office Administrator	3	6.63	156,392
Admin	Team Lead	4	1.00	26,776
Nursing	MAS Nurse - Assessments	6	5.22	211,322
Nursing	MAS Nurse - Meds	6	8.34	337,830
Nursing	Triage Nurse	6	3.13	126,920
Nursing	Team Leaders	7	2.00	96,996
Nursing	Advanced Nurse Practitioner	7	1.83	88,912
			30.56	**1,097,610**
PAY			**32.74**	**1,345,451**
Medication	Alzhemier medication (60%)			64,800
Testing	CT/MRI/SPECT Scans			115,008
Office Supplies	£100 per wte			2,071
Training	£50 per wte			1,036
Staff Travel	42p per mile based on activity			37,273
NONPAY				**220,187**
2.4 TOTAL RECURRENT COST			**32.74**	**1,565,638**
Setup costs				
IT	Laptops			5,260
IT	VPN			263
Comms	Phones			789
Premises	Office set up, etc.			
2.4 TOTAL SET UP COSTS YEAR 1				**6,312**
			32.74	**1,571,950**

Neuropsychology

4.10 Assumptions based on 1,411 with 10% requiring neuropsychology. 15 hours required for diagnosis. 2.31 WTE Band 8a Therapists and specific set up testing equipment.

Type	Post	Band	WTE	£
Medical	Consultant Psychiatrist		-	0
Medical	Associate Specialist		-	0
			-	**0**
Psychologist	Neuropsychologist	8A	2.31	134,616
PAY TOTAL			**2.31**	**134,616**
Testing	Neuropsychological tests			1,300
Staff Travel	Travel			4,396
NONPAY				**5,696**
2.6 TOTAL RECURRENT COST			**2.31**	**140,312**
Set Up Costs				
Testing	Testing Kit			16,000
IT	laptops			2,000
IT	VPN and Phone			200
2.6 TOTAL SET UP COST YEAR 1				**18,200**
2.6 TOTAL COSTS			**2.31**	**158,512**

Dementia Co-ordinators

4.11 Based on Figure 46 modelling within the Economic Case, activity assumptions are based on 5394 people diagnosed with dementia living in the community modelled to a caseload of 200. Dementia Co-ordinators would be linked to support each care homes in each local area (modelling of 0.2 WTE per 200 people diagnosed residing in care homes) Modelling suggests 31 WTE Band 4 Dementia Co-ordinators and 2 Managers. This includes Young Onset Dementia Co-ordinators which based on estimated 200 people under 65 years equates to 1 WTE. Also included are costs for 24 Memory Roadshows. As estate costs within Primary Care Networks are currently uncertain a nominal 2% has been included to cover hosting charges.

Type	Post	Band	WTE	£
Management	Team Leads	6	2.00	80,173
Nursing	Dementia Co-ordinators	4	31.00	829,934
Admin	Roadshows	3	0.40	9,337
Admin	General	3	2.00	47,177
PAY TOTAL			**35.40**	**966,621**
Room Hire	Room hire for roadshows			6,000
Staff Travel	Roadshows only			806
Staff Travel	Co-ordinator travel			18,350
Office Supplies	Stationery			2,000
Office Supplies	Postage			4,500
Telephone	Telephone calls			1,200
Training	Training			1,520
Premises	PCN venue hosting Co-ordinators			20,020
NONPAY				**54,396**
3.2 TOTAL RECURRENT COST			**35.40**	**1,021,018**
Set Up Costs				
IT	Laptops			29,000
IT	VPN			1,500
Comms	Phones			4,500
Premises	Office set up, etc.			5,000
3.2 TOTAL SET UP COSTS YEAR 1				**40,000**
3.2 TOTAL COSTS YEAR 1			**35.40**	**1,061,018**

Carer Emotional Wellbeing Courses

4.12 Activity assumptions have been based on 24 small group courses annually with a course totalling 40 hours including travel and planning time. Modelling based on 0.63 WTE Band 6 Dementia Nurse Specialist with a Healthcare Assistant and Administration.

Type	Post	Band	WTE	£
Nurse	Dementia Nurse Specialist	6	0.63	25,537
Nurse	Health Care Assistant	3	0.63	14,874
Admin	Service admin	3	0.25	5,949
PAY TOTAL			**1.51**	**46,360**
Room Hire	Venue hire & refreshments			18,000
Staff Travel	Travel			2,880
Training				
NONPAY				**20,880**
3.5 TOTAL RECURRENT COST			**1.51**	**67,240**
Set Up Costs				
IT	Laptops			
IT	VPN			
Comms	Phones			
Premises	Office set up, etc.			
3.5 TOTAL SET UP COSTS YEAR 1				**0**
3.5 TOTAL COSTS YEAR 1			**1.51**	**67,240**

Cognitive Stimulation Therapy offered all

4.13 Brief, closed, structured therapy groups for up to 10 clients in each group. Modelling based on 71 courses with 14 sessions per course for 3 hours. Uptake of 800 people per annum. 2.01 Band 6 Nurse Lead and 2.01 STR Worker. Room hire £50 session

Type	Post	Band	WTE	£
Medical	Consultant Psychiatrist		-	0
Medical	Associate Specialist		-	0
			-	**0**
Nursing	Nurse Lead	6	2.01	80,576
Nursing	STR Worker	3	2.01	46,921
			4.02	**127,497**
PAY TOTAL			**4.02**	**127,497**
Room Hire	£50 per room hire			49,384
Staff Travel	20 miles per session x 2 staff			39,507
Office Supplies				0
Training				0
Staff Travel				0
NONPAY				**88,891**
2.1 TOTAL COST			**4.02**	**216,388**
Exclude Medical Staff costs			0.00	0
			4.02	**216,388**

Travel and accommodation for visiting at Alderney Hospital, Poole

4.14 Appendix 3 shows the estimated modelling to support family carers to visit their loved ones with dementia in Alderney Hospital when they are unable to drive. The costs have been based on covering public transport journeys from an external radius of 30 miles from the hospital and also to cover overnight accommodation at a reasonable cost in a guest house.

4.15 It is recognised that this is difficult to estimate bearing in mind different locations, accessibility and amount of visits therefore this budget of an initial £13,768 will be carefully monitored and adjusted accordingly.

Financial summary

4.16 The existing recurrent budget is £11,380,442. Services that have not been included within the modelling have been based on year 1 costs throughout. These include psychology, CMHT, In-Reach Team, Intensive Support Team and Inpatients.

4.17 The service elements subject to financial change are summarised in Figure 51 below with the first year set up costs included.

Figure 51 Summary of services subject to financial change with full year costs

Service model	WTE	Set up costs	Recurrent - pay	Recurrent - non-pay	Total recurrent
2.4 Diagnosis Model 4	32.74	£ 6,312	£ 1,345,451	£ 220,187	**£ 1,565,638**
2.6 Neuropsychology	2.31	£ 18,200	£ 134,616	£ 5,696	**£ 140,312**
3.2 Dementia Co-ordinators (2)	35.40	£ 40,000	£ 966,621	£ 54,396	**£ 1,021,018**
3.5 Emotional Wellbeing	1.51	£ -	£ 46,360	£ 20,880	**£ 67,240**
3.6a Cognitive Therapy for all	4.02	£ -	£ 127,497	£ 88,891	**£ 216,388**
Family/Carer travel to Inpatient setting				£ 13,768	**£ 13,768**
Information & Directory					**£11,000**
Total		**£ 64,512**	**£ 2,620,545**	**£ 403,819**	**£ 3,035,364**

4.18 The proposal will be to take forward a phased approach for implementation. See Figure 64 in the Management Case for the implementation plan. Key elements that will be phased in are:

- Dementia Co-ordinator to commence from April 2021 (with one-month prior payment for lead in/staff training);
- Enhanced Neuropsychology service to commence April 2021;
- Cognitive Stimulation Therapy groups to commence April 2021.

4.19 The first year investment is lower than the subsequent years to take into account new services being implemented at different times during the year.

- Year 1 requires £823,021. This includes non-recurrent set up costs of £64,512 and recurrent pay and non-pay costs of £758,509 above the baseline funds.
- Year 2 and thereafter requires £1,108,554 recurrent pay and non-pay above the baseline fund.

4.20 Figure 52 below highlights the original service and costs for year 1 and 2 with a phased implementation during the first year.

Figure 52. Summary of current service provision and new model of care costs for year 1 and 2

Current service provision 19/20		NEW MODEL			
				Phased	Full Year
Operational budget £000			WTE	YEAR 1 Cost with set up £000	YEAR 2 Recurrent Cost (excluding uplift costs) £000
Info	-	Info & General helpline & Directory		11	11
Memory Assessment Service 23.47 WTE	1,300	Diagnostic model 4 From April 2020	32.74	1,572	1,566
Neuropsychology 0.51 WTE	29	Neuropsychology	2.31	75	140
Memory Advisors as current 18.00 WTE	597	Dementia Co-ordinators & Young onset and Memory Roadshow (incl 3x managers)	35.40	884	1021
Psychology 2.40 WTE	138	Psychology	2.40	138	138
		Cognitive Stimulation Therapy	4.02	126	216
		Carer emotional support	1.51	67	67
OP CMHT (based 54%) 50.49 WTE	2150	OP CMHT (based 54% of budget)	50.90	2150	2150
In-Reach 4.00 WTE	182	In-Reach Team	4.60	182	182
Intermediate Care Service for Dementia 58.56 WTE	2,233	Intensive Care Service for Dementia	52.90	2233	2233
Day hospitals - different models 10.63 WTE	314	2 day hospitals aligned to Intensive support	10.00	314	314
Matron 1.00 WTE	57	Modern Matron	1.00	57	57
		Crisis helpline		-	-
40 Inpatient beds 125.65 WTE	4,379	40 Inpatient beds with travel and accom	125.30	4,393	4,393
Cost	**11,380**			**12,202**	**12,488**
Variance	**-**			**823**	**1,109**

Return on Investment and cost benefits

Return on Investment

4.21 Identifying strong evidence on return on investment is challenging particularly due to the scarcity and low methodological quality of available studies overall. However, an economic evaluation of early assessment for Alzheimer's disease in UK identified that although this has significant up-front costs identifying dementia at an early stage results in costs savings and health benefits with a suggested average per person of £2,100 in health care cost savings and £5,700 in societal costs[34] .

4.22 Research by the Alzheimer's Society on Dementia Advisors (with a similar role to the Dementia Co-ordinators) in 2016 highlighted the potential to reduce costs through more timely care in the community and ensuring that people with dementia and their carers can access the health and social care services they need. The findings found for every £1 invested in post diagnostic support from Dementia Advisors resulted in nearly £4 worth of benefits[35]. This would equate to approximately £4 million return on investment in Dorset.

4.23 Analysis of Peer Support for people with dementia based on three groups in Southwark, Lambeth and Croydon create positive social value for people with dementia, carers and volunteers that is greater than the cost of investment. For every pound (£) of investment, the social value created by the three groups ranged from £1.17 to £5.18. The Memory Roadshows based on a spend of £27,079 would potentially offer a return on investment of £140,269 per annum (based on one roadshow per annum in each Primary Care Network). The carer workshops based on an annual spend of £65,000 would equate to a return on investment of £336,700 per annum.

4.24 Research has identified there is cost effectiveness evidence on pharmacological therapies for dementia and regarding non-pharmacological treatments: cognitive stimulation therapy, tailored activity programmes and occupational therapy were more cost effective than usual care[36].

[34] https://www.alzheimersanddementia.com/article/S1552-5260(10)02187-4/pdf
[35] https://www.scie-socialcareonline.org.uk/dementia-advisers-a-cost-effective-approach-to-delivering-integrated-dementia-care/r/a110f00000Kvpz1AAB
[36] http://eprints.lse.ac.uk/45540/1/Knapp_Dementia_care_costs.pdf

Cost benefits

4.25 Examples of areas whom have taken whole system approaches to improving dementia services have evidenced a range of positive clinical outcomes and financial savings. The dementia service redevelopment in Mersey Care NHS Trust (2012) has evidenced net savings of £2.1m, or 246,000 per 100,000 population based on a reduction in hospital bed days, length of stay and a reduction in older adult beds[37].

4.26 The STEM project audit (2016) in Cornwall on which the Dementia Roadshow option is based highlighted a saving of £23,000 per year for a caseload of 360 patients. Based on the current numbers diagnosed across Dorset this would indicate estimated savings of £95,833.

4.27 Analysis of the impact of the 'Intermediate Care Service for Dementia' (ICSD) has shown this service is very cost effective as well as highly regarded by people using the service. It is providing a crisis service maintaining people within their own homes for broadly half the cost of a dementia specialist inpatient service and supporting nearly four times more people in the course of a year.

4.28 This is apparent when applying a basic unit cost to both services (see Figure 53). An estimated cost per head for ICSD is £4,741 whereas the Dementia specialist inpatient beds are £34,424 per head based on 2019/20 data.

Figure 53. Costs per head based on service cost and average activity

ICSD operational cost £	Average patients 18/19	Unit cost £	Dementia operational Inpatient bed cost £	Average patient numbers 18/19	Unit cost £
2,138,000	451	4,741	4,303,000	125	34,424

4.29 Figure 54 shows the number of admissions prevented by ICSD across Dorset which averages 366 for a 12-month period. Relating this into costs savings by utilising a bed rate of £536.09 for an admission on Herm Ward and basing on the average length of stay for females of 87 days this would equate to savings of £46,639 per patient which totals £17,070,177 for all 366 patients. A 10% reduction of dementia specialist inpatient admission (based on 125 admissions during 2018-19) would equate to £582,987 cost benefit annually.

Figure 54. Number of admissions prevented by ICSD (Dorset CCG Sept 2019)

	2015-16	2016-17	2017-18	2018-19 (April 18 – May 19)
ICSD East	291	357	325	286
ICSD West	-	57 (from Aug 16)	115	141
Total	291	414	440	427 (366 FYE)

[37] Mersey Care NHS Trust 2012

4.30 In terms of the proposal to align the day hospitals with the Intermediate Care Service for Dementia studies across psychiatric client groups cited by Lopes et al[38] (2012) have shown that this type of day care can achieve a substantial reduction in the numbers of people needing inpatient care where running a 30 place day hospital is roughly one third of those of a 30 bedded ward with a cost reduction of 22%. This could equate to an estimated £950,000 cost benefit savings for Dorset.

4.31 Various Studies have estimated from 10% up to 25% of beds in acute hospitals can be occupied by people living with dementia but varies by type of ward[39]. Their length of stay is often longer than people without dementia and there can be delays in supporting them to leave hospital. Estimations are that 20% of hospital admissions of people living with dementia are for preventable conditions[40]. Readmission rate for people living with dementia is far higher than for people without, 8.2% vs 3.5% for elective care and 25% vs 17% for non-elective care[41].

4.32 The Public Health England profile for dementia[42] highlighted that based on 2016-17 data comparing the South West region showed that Dorset and Poole in particular had higher numbers of short stay (less than 1 day) emergency admissions for people with dementia aged over 65.

4.33 Based on local SUS data during 2016-17 there were 5,627 emergency and short stay admissions with a primary or secondary diagnosis of dementia. During 2017-18. [43] this had reduced to 5291 with a total cost of £1,387,796 based on tariff costs.

4.34 For those with a primary diagnosis of dementia whom were emergency and short stay admissions for patients aged 65 and above there were 503 admissions during 2016-17 and 427 during 2017-18. This equates to potentially a 37% reduction of avoidable admissions through improved community support as proposed in the emerging model and a cost benefit saving of £278,000 per annum.

4.35 Across Dorset there has been a growth in people with dementia becoming eligible for Section 117 funding with a substantial increase in cost of circa £1m since 2014-15. With greater support and investment into community services, it is anticipated that crisis episodes will be minimised reducing the incidence of formal Mental Health Act admissions and subsequent Section 117 eligibility for those placed on a section 3 of the Act. Reducing Section 117 by only 10% would release savings of £295,472 to the overall health & social care system.

[38] Lopes R, Curral R (2012) Day Hospital in community psychiatry
[39] *QJM; 2016: 41–44*
[40] Alzheimer's Research UK at https://www.dementiastatistics.org/statistics/hospitals/
[41] The Right care: creating dementia friendly hospitals. Dementia Action Alliance
[42] https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia/data#page/0/gid/1938132893/pat/6/par/E12000009/ati/102/are/E10000009/iid/91300/age/1/sex/4
[43] Dorset CCG SUS data

Figure 55. Patients eligible for Section 117 Aftercare with a diagnosis of dementia.

	2014/15	2015/16	2016/17	2017/18
No of patients	152	173	172	181
Average weekly cost	347.69	384.04	408.86	403.35
Total costs £	**1,949,589.56**	**2,399,081.74**	**2,702,983.04**	**2,954,726.21**

4.36 Figure 56 below offers a summary of the estimated return on investment and cost benefits as a result of the new model of care. It is estimated that the direct cost benefit will be £2,201,820 per year, although some elements will not be cash releasing. In addition, the evidence summarised above indicates that there will be a substantial return on investment, that would be realised across the life of the patients.

Figure 56. Summary of estimated cost benefits and Return on Investment

Pathway element	Assumption	Cost benefit £	Return on Investment ratio
Living Well	Dementia Co-ordinators	95,833	1:4
	Dementia Roadshows		1:5
	Carer workshops		1:5
Supporting Well in crisis	10% Reduction in Dementia Specialist Inpatient admissions through ICSD (based average LOS)	582,987	1:9
	Day hospital provision instead of Dementia Specialist inpatient admission	950,000	
	37% reduction in inappropriate inpatient admissions to acute hospital	278,000	
	10% reduction Section 117	295,000	
Total		**£2,201,820**	

5. COMMERCIAL CASE

5.1 The commercial case is to demonstrate that the potential options are acceptable and that the service can be delivered in the area and by the best provider for the job.

5.2 NHS Dorset CCG, the three Local Authorities and Dorset HealthCare represented on the Project board are confident that the options outlined within the Dementia Services Review are able to be delivered. Implementation will need to reflect procurement processes for some aspects of the pathway and appropriate timescales to develop the workforce.

5.3 The partnership approach to this project with commissioning partners and the Dorset wide mental health provider involved from the beginning has been crucial alongside the wider co-production approach embedded throughout. Each stage of the project inputs has been co-produced with a range of stakeholders and where the proposed options have been developed, shaped and analysed with local stakeholders in line with best practice guidance and able to meet key elements identified within the view seeking report.

Integrated Care System

5.4 There is a long-recognised need for health and care services to be better integrated to improve people's care, reinforced recently by the House of Commons Health and Social Care Committee's support for improving integration of care.[44] In January 2019, the NHS Long Term Plan highlighted the intention to 'dissolve the historic divide between primary and community health services' and further stated:

'The NHS will be more joined-up and coordinated in its care. Breaking down traditional barriers between care institutions, teams and funding streams so as to support the increasing number of people with long-term health conditions, rather than viewing each encounter with the health service as a single, unconnected 'episode' of care'.

5.5 The NHS Long Term Plan sets out the centrality of integrated care systems (ICSs) to achieving this goal. In ICSs, commissioners and providers of NHS services, in partnership with local authorities and others, voluntarily take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve. Collaborations will also take place at different levels in the system, including through provider partnerships, such as networks of primary care providers. The NHS Long Term Plan committed to new investment of at least £4.5 billion over the next five years in primary medical and community services to deliver stronger integration and out of hospital care. This will support, for example, expanded community multidisciplinary teams aligned with new primary care networks, and a new offer of urgent community response and recovery support.

[44] The House of Commons Health and Social Care Committee Integrated care: organisations, partnerships and systems Seventh Report of Session 2017-19 [p17] can be found on the Government website: https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament2017/inquiry4/ (Information accessed 25 July 2018)

5.6 Despite the longstanding aim of improving integration there has never before been a commissioning contract designed specifically to promote an integrated service model including primary care, wider NHS and some local authority services. Though contracts alone do not deliver integration, commissioners want the opportunity to use a contract of this type to ensure contracting, funding and organisational structures all help rather than hinder staff to do the right thing and to define more clearly who has overall responsibility for integrating and coordinating care[45].

5.7 The development of the NHS Standard Contract (Integrated Care Provider) Contract ('ICP Contract') responds to the demand from some commissioners and providers for a single contract through which general practice, wider NHS services, and in some cases some local authority-funded services, may be commissioned from a single 'lead' provider organisation, responsible for delivering those services in an integrated fashion. Such a provider is termed an 'Integrated Care Provider' (ICP). ICPs are not new types of legal entity, but rather provider organisations (such as NHS foundation trusts) which have been awarded ICP contracts.

5.8 In 2016 local sustainability and transformation partnerships (STP) were formed across NHS organisations and local councils. Subsequently Dorset was designated as one of the initial integrated care systems and as a result providers and commissioners have been working together in many areas across health and social care.

5.9 The Integrated Care System in Dorset will enable local services to provide better and more joined up care for patients. For staff, improved collaboration can help to make it easier to work with colleagues from other organisations. And systems can better understand data about local people's health, allowing them to provide care that is tailored to individual needs. By working alongside councils, and drawing on the expertise of others such as local charities and community groups, the NHS can help people to live healthier lives for longer, and to stay out of hospital when they do not need to be there[46] In return, integrated care system leaders gain greater freedoms to manage the operational and financial performance of services in their area.

Contracting of dementia services

5.10 Dorset HealthCare NHS Foundation Trust is the provider for the secondary care elements of Dementia Services. Dorset HealthCare was recently awarded 'outstanding' by the recent CQC review. Currently there is a block contract for dementia services and the funding currently within this contract will remain. Through this review process this statutory provider has been clear on how it can restructure to meet the revised model and what can be delivered within the Dementia Services Review within the current budget, whilst maintaining and delivering services.

5.11 Alzheimer's Society have been delivering the Memory Support and Advisory Service since 2014 and this contract is due to end on 31 March 2021 following a number of contract extensions with NHS Dorset CCG Governing Body approval. With the development of a new dementia service procurement rules will need to be followed. The funding is recurrent and will form part of the new model of care.

[45] https://www.engage.england.nhs.uk/consultation/proposed-contracting-arrangements-for-icps/user_uploads/icp-consultation-response.pdf
[46] https://www.england.nhs.uk/systemchange/integrated-care-systems/

5.12 It is worth noting the value that voluntary sector organisations bring to the provision of social care needs for those with dementia and their family carers so providers from this market will be encouraged to tender.

5.13 Furthermore, learning from the view seeking around fragmentation across services and the problematic current operational issues around data sharing and IT systems across providers the option of having a prime provider model with sub-contracting arrangements is the most sensible and feasible option at this point in time. However, such a decision will require Governing Body approval due to the financial amount being above £500,000.

Procurement Strategy

5.14 NHS Dorset CCG believes that it will only be able to deliver its vision in collaboration with others and success will depend upon close partnership working with the local community, local authority and healthcare providers.

Supplier engagement and market sounding

5.15 There are various new elements of the service model which need to align with the service re-configurations and service improvements within Dorset HealthCare Services existing services and will need to be procured. These include:

- Dementia directory
- Dementia Co-ordinator service with Dementia Roadshows included
- Cognitive Stimulation Therapy

5.16 In terms of procuring these services it will be important to engage with the market prior to finalising the service specifications. This will ensure that the potential service is feasible, the market is capable of delivering and that there is sufficient capacity within the market.

5.17 Any potential supplier engagement will be treated with fairness and openness and the same information provided to all suppliers. A detailed audit trail will be maintained. For the Dementia Co-ordinator service with a higher contract value there will be a two stage process with a pre-qualification questionnaire to assess the financial and business suitability of an organisation before being invited to tender. Tendering will be based on the specification and the evaluation aligned accordingly. It will be important that sufficient numbers of organisations are encouraged to apply to give a short list of at least three organisations.

5.18 The invitation to tender and specification which follows will include:

- full details of the services required,
- specific details of supplier requirements,
- scope of the requirement (timescales, location etc),
- the outcomes to be delivered,
- the budget,
- contract conditions,
- Evaluation criteria

5.19 The purpose of the pre-qualification stage is to assess the capability of the respondents to deliver the services and is via a paper exercise that is evaluated by a panel that should include a member of Governance and Finance. Only organisations whom have proved this capability will be invited to submit a formal tender for the work.

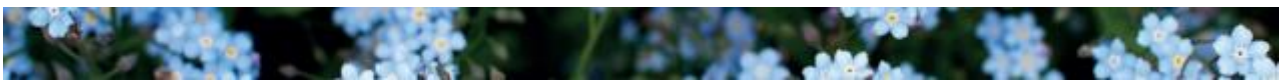
5.20 Tenders will be evaluated by a scoring panel whom will meet in accordance with an agreed timescales notified to potential bidders in the letter inviting them to tender. Conflict of interests will be noted and staff excluded if necessary from decision making. The numbers on the panel will reflect the value and importance of the service to be secured and include external stakeholders.

5.21 Shortlisted providers will be formally interviewed by the scoring panel with questions based on the specification. This gives opportunity for probing the potential supplier on how they would deliver the specification. Following the interview, references will need to be supplied and a possible due diligence exercise completed.

5.22 The timetable for the procurement elements following Governing Body approval is below.

Figure 57 Estimated timetable for procurement-(revised due to covid-19 and suspension of procurement)

	ACTION	TIMESCALE
	Developmental Phase	
1.	Docs needed for Market Engagement advert and prospectus, Specification, EOI form and pricing	**June 2020**
2.	Place advert for Market engagement event	**June 2020**
3.	Market Engagement event	**July 2020**
4.	Project team meeting and project plan • Agree procurement strategy • Roles and responsibilities • Dates • Commence Tender documentation • Ready to go checklist	**July 2020**
5.	Request TUPE information from existing provider if option is for a single provider	**July 2020**
6.	Sign off procurement checklist	**July 2020**
7.	Finalise tender documents and evaluation plan • Questionnaire • Weighting, evaluation criteria and guidance • Specification • Outcomes and Activity • Currency	**August 2020**
8.	Complete contract schedules	**August 2020**
9.	Receipt and sense check TUPE information	**August 2020**
10.	Place Advert and Prospectus on Due North – contracts finder and OJEU	**August 2020**
11.	Advert closes	**August 2020**
12.	Provider Briefing Meeting	**August 2020**
	Tender and Contract Phase	
	Tender 2-4 weeks	
13.	Invitation to Tender issued	**September 2020**
14.	Bidder clarification stage	**September 2020**
15.	Evaluation team training meeting	**September 2020**
	Evaluation 2 weeks	
16.	Receipt of proposals	**September 2020**
17.	Initial Tender evaluation	**September 2020**
18.	Successful Bidder's presentation and Interviews	**September 2020**
19.	Evaluation Panel Final meeting	**September 2020**
	Approval 1 week	
20.	Recommendation report for Governing Body **-Dorset HealthCare**	**October 2020**
21.	Governing Body approval to award contract **– Dorset HealthCare**	**October 2020**
	Contract award 2 weeks	
22.	Issue Alcatel standstill **10 calendar days**	**October 2020**
23.	Debrief providers and close Alcatel Standstill	**October 2020**
24.	Formal Award of Preferred Bidder/s	**October 2020**
25.	Commence due diligence and mobilisation planning	**October 2020**
26.	Draft and agree contract. Contract signed	**November 2020**
27.	Mobilisation: Setting up. Recruitment and training staff	**December 2020-April 2021**
28.	Contract Start date	**1 April 2021**



MANAGEMENT CASE

6.1 The management case highlights implementation issues and demonstrates that Dorset CCG and partners are capable of delivering and managing effectively the proposed service care pathway. This chapter includes risks associated with the review and implementation. It also captures the methodology for evaluating the impact of the new model of care and health utilisation benefits.

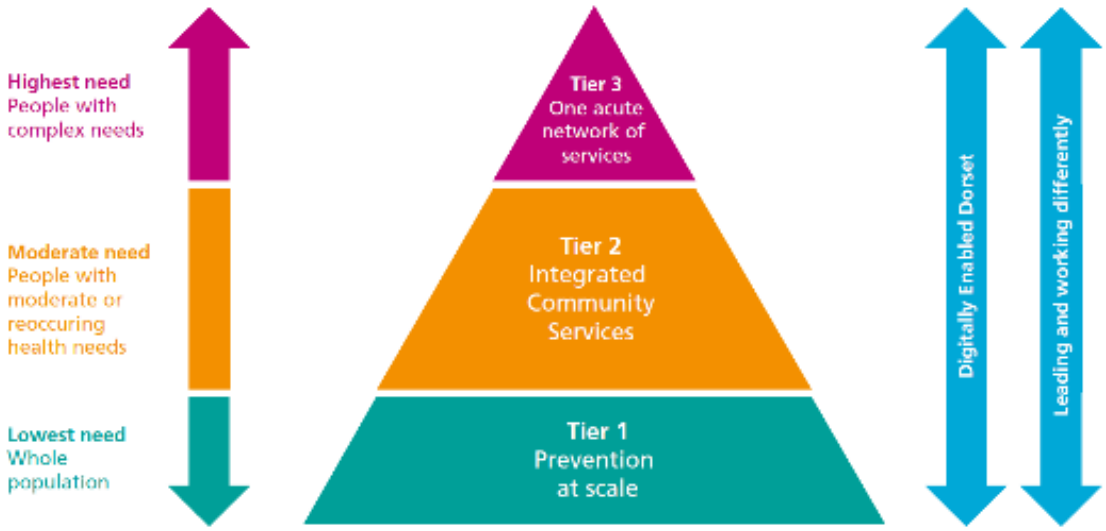
Sustainability and Transformation Plan for local health and care

6.2 In March 2017 NHS England published a report called Next Steps on the NHS Five Year Forward Plan which identified nine regions as having the potential to become England's first Integrated Care System (ICS) where there is the expectation of collective responsibility for resources and population health.

6.3 In June 2017 the Dorset wide NHS partners, along with local government partners applied to be an ICS (previously described as an Accountable Care System) and were selected as one of eight successful applicants. This builds on the already successful track record and strong commitment to collaborative working across health and care organisations and will enable the partners across Dorset to apply a single capitated budget to meet the health and care needs of the people of Dorset. This gives the opportunity to work together to deliver better health and wellbeing outcomes and deliver the 'Sustainability and Transformation Plan'.

6.4 'Our Dorset' (Sustainability and Transformation Plan) sets out the collective vision for Dorset's health and social care systems. There are currently three interconnected programmes of work and over the next 12 months this will be updated, particularly in the context of the NHS Long Term Plan.

Figure 58. Diagram showing the three tiers of care in the new model.



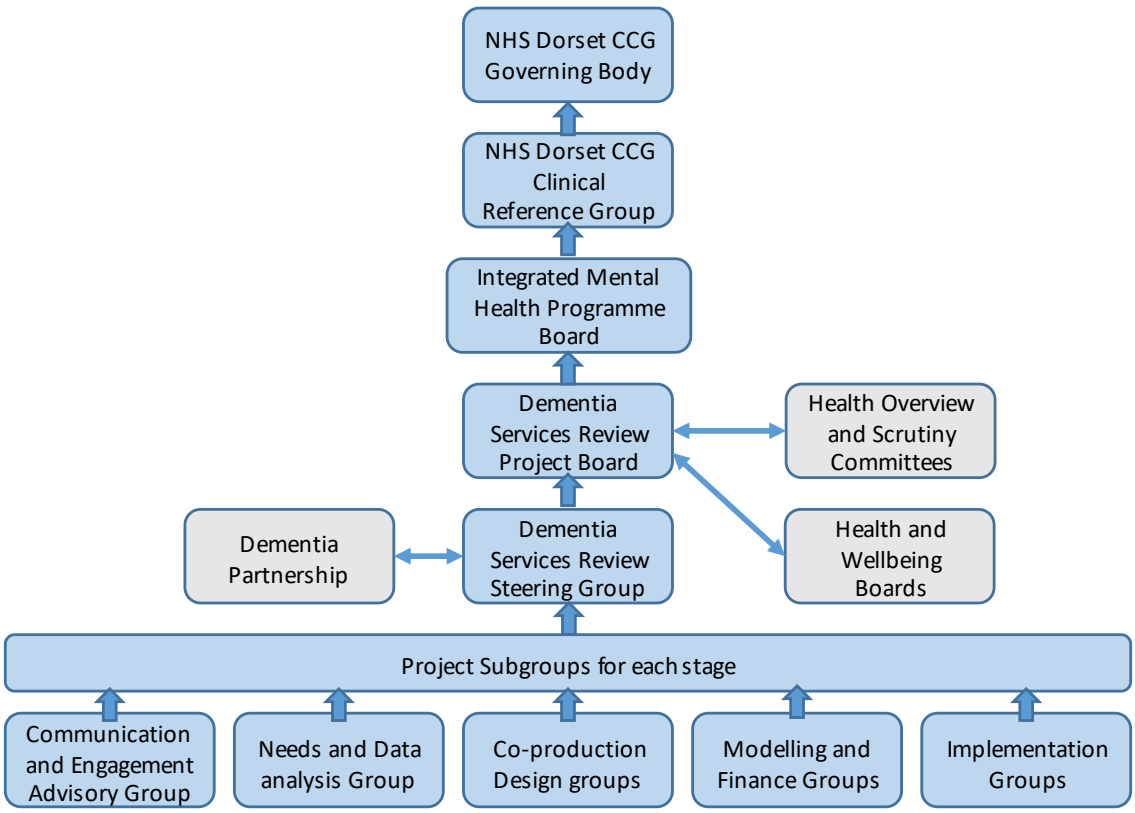
6.5 Integrated community services form the middle tier of the above model and this programme will transform general practice, primary and community health and care services in Dorset so that they are truly integrated and based on the needs of the local populations. The Dementia Services Review sits within the new model and has many interdependencies with other service developments so good linkages have been developed across programmes.

6.6 In particular the development of new Primary Care Networks across the whole of Dorset give an excellent structure to align the new dementia services and ensure integration across the health and social care system. In Dorset there are 18 Primary Care Networks and the new Dementia Co-ordinator Service has been modelled to ensure appropriate capacity for each local area.

Project management arrangements

6.7 Project governance for the Dementia Services Review is shown below. The local authority partners have been undergoing fundamental re-organisation as part of the Local Government Review. However, they have remained engaged with the review and are members of the Dementia Services Review Board. The ambition is for integrated working to go forward in the future.

Figure 59 Governance arrangements



6.8 Roles and responsibilities within the project are outlined in the table below.

Figure 60. Project management role and responsibilities

Role	Responsibility
Project Board	Collective and final responsibility for the approval to recommend the proposal to the approval authorities
Project Steering Group	Provides the Project Board with stakeholder and technical input t
Project Sponsor	Personal accountability and overall responsibility for the delivery of the successful outcome
Project Manager	Leading and managing the coordinating the Project Team on a day to day basis
Project Team	This team varies according to different stages of the project. Takes forward the decision of the Project Board or Project Steering Group and develops the operational elements of the project
Stakeholder groups	Provides the Project Board with further insight and advice on the detailed requirements of the project

Project Team

6.9 The Project Team is accountable to the Project Board and has responsibility for the day to day project and key deliverables and comprises of staff from across NHS Dorset CCG and Dorset HealthCare NHS Foundation Trust.

6.10 The Project Team are supported by a Project Steering Group which will continue as appropriate within the implementation stages. The Project Team and Steering Group comprises a mixture of staff across NHS Dorset CCG and Dorset HealthCare NHS Foundation Trust, the three local authorities, voluntary sector and carer representatives. This includes representatives from across Communications and Engagement, Finance, Business Intelligence, Quality, Commissioning and operational leads.

Project Sponsor and Manager

6.11 The Project has a project sponsor Dr Paul French who has overall responsibility for the delivery of the project. A project manager is also in place to ensure that the day to day work is carried out in line with the structured project plan. Diane Bardwell has been the overall Project manager with responsibilities noted below with support in particular by Jane Austin and Lorraine Bailey of NHS Dorset CCG Mental Health Team.

Figure 61. Project Manager responsibilities

Co-ordinate and implement the project	Ensure the project produces the required deliverables to the required standard, within the specified constraints
Run project within tolerances the Project Board approves	Ensure that Issues and Risks that have been identified are managed effectively
Plan and monitor the project	Direct and motivate the project team
Manage risks and develop contingency plans as agreed	Be responsible for project administration.
Report project progress at Project Board meetings	Report to the Project Board through Highlight Reports and
Prepare the Lessons Learned Report	Take responsibility for overall progress and use of resources and initiate corrective action where necessary

Risk Management

6.12 As part of the project management process a risk and issues log are kept and updated according to the project requirements and where appropriate new risks are incorporated onto the NHS Dorset CCG risk register. The risk register and mitigated actions is regularly updated and signed off at each Project Board.

6.13 A 'do minimum option' would result in a number of risks including:

- Poorer outcomes for people living with dementia and carers;
- Lack of equity of access to services across Dorset;
- Ongoing fragmented diagnostic services with long waiting times;
- Significant gap in post diagnostic support for people to 'live well' with dementia and support carers with increased risk of crisis;
- Lack of provision for people diagnosed with dementia whom are under 65 years;
- Increased risk of carer breakdown and more demand on current services;
- Inappropriate admissions to acute hospitals and dementia specialist beds;
- Patients utilising more high cost services.

6.14 A summary of overall key risks for the Dementia Services Review are noted below with their impact, likelihood and mitigating factors.

Figure 62. Summary of key risks (September 2019)

Risk type	Risk Title	Detail	Conseq	Likelihood	Score	Mitigation
Business	Investment available to develop the new model of care and implement	The preferred model will be at risk if funding is not secured	5	3	15	Financial case presented to key Boards and within investment priorities
	Reputational risk to CCG	If new model of care is not funded or implemented this will impact on the CCG reputation	5	2	10	Financial case presented to key Boards and within investment priorities. Implementation plan in place
	Interdependencies of other service reviews	Understanding the impact of other reviews and aligning	2	3	6	Linking with other reviews and attending key Boards.
	Memory Support and Advisory contract end Aug 2020	Contract comes to an end and potential for a service gap	5	3	15	FBC going to NHS Dorset CCG GB for decision in Nov 19 to get sufficient time to procure new service
Service	Dementia Workforce	Not retaining or recruiting workforce will impact on any delivery model	4	3	8	New model of care has revised roles which aims to be more sustainable
External	Economic or policy changes.	Unknown impacts				Monitoring changes and being prepared to be flexible to adapt

Implementation plan

6.15 Key milestones are in Figure 63. .

Figure 63. Milestone plan

Milestone	Completion Date
NHS Assurance on Strategic Outline Case	April 2019
Consultation & evaluation	September 2019
Full Business Case	October 2019
Governing Body decision	November 2019
New Services mobilised	July 2020- April 2021 *Delay due to covid-19

Figure 64. Implementation plan (updated September 2020)

	Jul	Aug	Sept	Oct	Nov	Dec	Jan-21	Feb	Mar	April
Covid Recovery										
Procurement of Dementia Co-ordinator service										
Dementia Co-ordinator service prepare										
Primary Care Networks hosting agreed										
MAS recruit ANP										
MAS recruit Neuropsychology										
Neuropsychology commence										
MSAS transition with referrals to MAS & contract close										
MAS begin new diagnostic model										
Dementia Co-ordinator contract commence 1st April										
Delivery of Carer Workshops										
Procurement Cog St Therapy										
Delivery of Cog St Therapy										
Delivery of Roadshows										
Crisis helpline include dementia										
Day Hospital project: feasibility, locations										
Day hospital new model commence										
Dementia Directory updated and printed										
Accommodation and travel for Alderney commence										
Evaluation and measures agreed										
Steering Group meet										

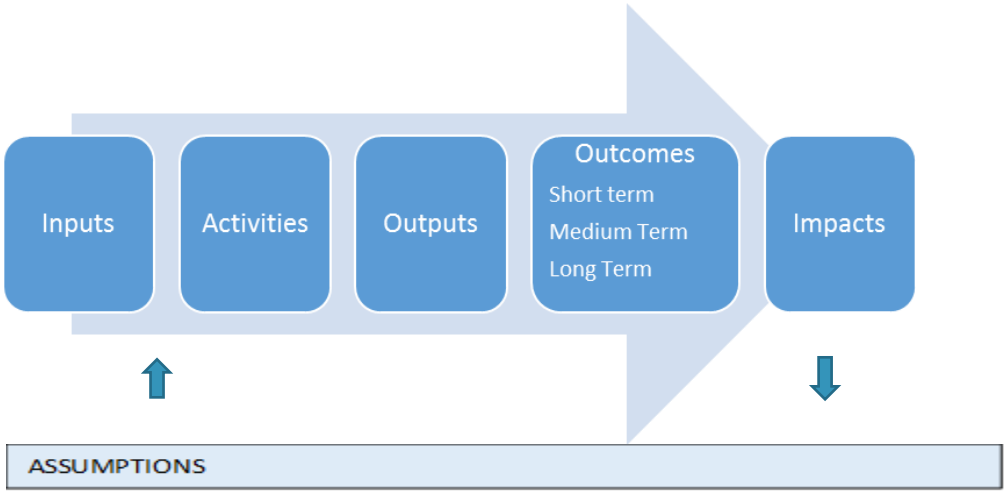
Monitoring and Evaluation Framework

6.16 An outcome and evaluation framework will be developed fully with the Dementia Review Steering Group and will be agreed and monitored by the Mental Health Integrated Programme Board.

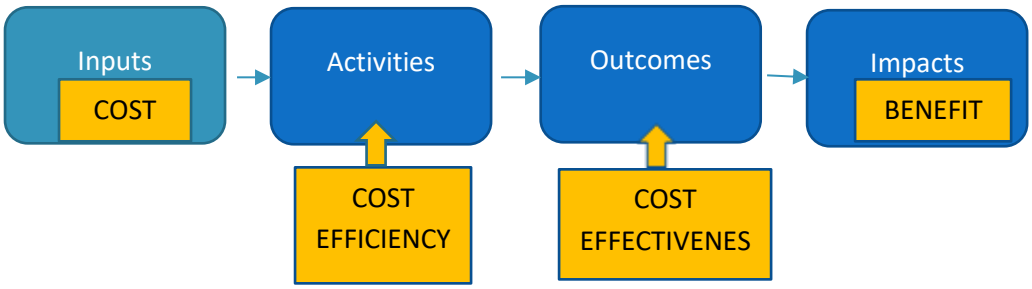
6.17 As the Dementia Services Review change programme works towards a range of long term outcomes it will involve different levels of complexity and uncertainty. Therefore, a theory based evaluation such as a logic model would offer a robust approach to measuring and articulating the underlying theory of change shaping this transformation. Unlike method-led approaches to evaluation which infers causation from the input and output of a project, theory-led evaluation aims to map out the entire process and produce 'clear box' evaluations.[47]

6.18 A 'Logic model' offers a framework that defines elements of the programme and creates a means of measuring expected actions with their desired impact and outcomes and is recommended as a robust evaluation method particularly for complex programmes[48]. Logic models need to be designed and adapted to accurately represent the underpinning theory of each specific intervention. Therefore, there is huge benefits of the co-production approach and utilising a range of stakeholders to define the critical aspects.

Figure 65. A Logic Model evaluation framework



6.19 The key strength of a logic model is it identifies both the inputs and outcomes but also what otherwise is in the 'Black box' with regards the processes and activities that turn inputs into outputs. Furthermore, this approach assists with economic analysis for cost benefits.



[47] Dickinson H (2008) Evaluating outcomes in health and social care. Community Care.
[48] HM Treasury (2011) The Magenta Book: guidance for evaluation. London: HM Treasury

Figure 66. Logic Framework example

	INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES
Preventing Well	Investment into Dementia directory and Roadshows Information sources	Update and print Directories Promotion of National helpline and other sources Provide Dementia Roadshows	Dementia directories People attend roadshows Helplines used	Patients and family carers have the knowledge to get what they need
Preventing Well Measurements	Investment amount	Numbers of roadshows held	Attendance at roadshows Numbers using helplines	Patient and carer questionnaire*
Diagnosing Well	Investment into diagnostic service Recruit Advanced Nurse Practitioners Recruit registered nurses for triage Neuropsychologists recruited	Advanced Nurse Practitioners diagnose less complex cases New triage process delivered in Memory Services Neuropsychologists assist in diagnostic process Neuropsychologists train and supervise other clinical staff	50% more clinics available 90% patients wait a maximum of 6 weeks for diagnosis (excluding scan) Complex diagnostic cases have detailed formulations Clinical staff trained	Improved waiting times for diagnosis Improved patient satisfaction Improved cost effectiveness Increased dementia diagnosis against NHSE target Improved quality of diagnosis
Diagnosing Well Measurements	Investment amount Numbers of staff recruited	Memory Service activity	Waiting times for diagnosis Numbers diagnosed	Patient and carer questionnaire* on I Statements Patient outcome measures: DEMQOL & ReQOL*

			Numbers of patients utilising neuropsychology service	NHSE targets improved: diagnosis rates and waiting times Staff feedback Service costs before and after
Living Well	Investment for Dementia Co-ordinators Investment for Carer workshops Dementia Co-ordinators recruited Trainers recruited for carer workshops Cognitive Stimulation Therapy investment	Dementia Co-ordinators offer post diagnostic support to patients and families Emotional Wellbeing Workshops offered to family carers Cognitive Stimulation Therapy groups offered to all diagnosed with dementia	Everyone diagnosed offered support by Dementia Co-ordinators All people diagnosed with young onset dementia offered support by Dementia Co-ordinators Carers attend workshops Integrated worked across health and social care Reduction in inappropriate admissions Attendance at CST Groups	Patients feel they have more personal choice and control Patients and family carers feel they have an enabling and supportive environment and feel valued and understood throughout Improved psychological wellbeing for patients and carers Maintain social functioning and quality of life
Living Well Measurement	Numbers of staff recruited Investment for service	Dementia Co-ordinator Service activity Numbers of Cognitive Stimulation Therapy (CST) groups held and locations Numbers of Emotional Wellbeing groups held and locations	Numbers of admissions to acute hospitals with primary diagnosis of dementia Numbers of people supported Numbers of people with young onset supported	Patient and carer questionnaire* on I Statements DEMQOL Health related quality of life for people with dementia tool* DEM QOL (mild to moderate) Quality of life for people with dementia*

			Numbers of people attending CST groups Numbers of carers attending workshops	QUALIDEM (moderate to severe) Quality of life for people with dementia* Carers Checklist and ReQOL* Alzheimer's Disease Knowledge Scale – ADKS Staff feedback & survey
Supporting Well	Community Mental Health Teams in place	Community Mental Health teams offer support, treatment and interventions	All patients with dementia with a higher level of need are supported Family carers of those with higher needs are supported and offered advice and guidance Reduced crisis interventions Reduction in inappropriate admissions	Patients feel they have more personal choice and control Patients and family carers feel they have an enabling and supportive environment and feel valued and understood throughout Improved health and psychological wellbeing for patients and carers Improved quality of life
Supporting Well Measurement	Numbers of staff	CMHT activity	Numbers of and cost of admissions to acute hospitals with primary diagnosis of dementia Numbers of referrals to ICSD	Patient and carer questionnaire* on I Statements DEMQOL Health related quality of life for people with dementia tool* DEM QOL (mild to moderate) Quality of life for people with dementia*

				QUALIDEM (moderate to severe) Quality of life for people with dementia* Carers: ReQOL
Supporting Well in Crisis	Crisis helpline in place Intensive Care Service for Dementia and Inreach commissioned across Dorset Day hospitals revised model implemented	Crisis line number shared with Patients and family carers ICSD support people in crisis across pan Dorset Inreach support care homes in crisis Day hospitals offer a safe daytime environment for those in crisis Dementia Specialist Inpatients	People utilise the crisis line for dementia Reduction in numbers of patients being admitted to dementia specialist inpatient beds Reduction in numbers of patients with a primary diagnosis of dementia being admitted to acute hospitals inappropriately Reduction in Mental Health Act assessments and detentions	Improved equity of outcomes across Dorset Improved quality of life and reduced stress for people with dementia and families Reduced use of dementia specialist inpatient beds Reduced inpatient costs Sustainable workforce
Supporting Well in Crisis Measurement	Staff numbers	Numbers of dementia related calls to crisis line Activity of ICSD Activity of day hospitals Activity of Dementia Specialist inpatient units	Numbers using the crisis helpline Numbers and cost of admissions to acute hospitals with primary diagnosis of dementia Numbers and cost of admissions to specialist dementia inpatient Numbers of MHA	QUALIDEM (moderate to severe) Quality of life for people with dementia* Carers: ReQOL Staff retention

6.20 The outcome measure tools with * noted in table can be found at:

- 'I Statement' outcomes measure tool at: http://healthinnovationnetwork.com/system/resources/resources/000/000/395/original/HIN_Measuring_Outcomes_in_Dementia_Services_V2.pdf
- Carers Checklist: https://www.choiceforum.org/docs/demcarerchk.pdf
- Health related quality of life tool http://dementiakt.com.au/doms/domains/qol/demqol/
- Quality of life tool (mild to moderate dementia http://dementiakt.com.au/doms/domains/qol/qol-ad/
- Quality of life tool (moderate to severe dementia) http://dementiakt.com.au/doms/domains/qol/qualidem/
- Recovering Quality of Life (ReQOL) https://www.reqol.org.uk/p/overview.html

6.21 The table above offers an example that could be utilised as a starting point. Once the logic model has been developed with stakeholders then a measurement framework can be built around the components selected.

6.22 Testing of the logic model and analysing the data will need to be done on an agreed timeframe. This will enable analysis of the outcomes, the factors that contributed and considerations of how areas can be improved and should offer genuine evidence of impact of the new service model for dementia services across Dorset.

APPENDIX 1 Interdependent services and other dementia developments.

Information and guidance

Providing information and advice is a statutory requirement of the Local Authorities known as the 'Front Door' and is continually being developed in particular with the digital offer and self- service. Advice, information and access to services is offered through single point of contact phone lines – Dorset Direct, ASSIST and Care Direct including providing a duty 'Out of Hours' service. Information is also available through My Life, My Care at https://www.mylifemycare.com/ including information for carers through a 'Carers hub'.

The existing Dementia Directory created in 2015 has been highly valued it was felt a 'quick win' within the Dementia Review was to update and redesign. '*Living well with memory loss and dementia in Dorset: a directory of services and support'* is now available in hard copy or on various websites including NHS Dorset CCG. www.dorsetccg.nhs.uk.

NHS Health Checks

Including dementia within the NHS Health Checks for over 50 years has been suggested within the Design Groups. Current Health Checks particularly focus on cardiovascular risks and vascular dementia.

Dementia Partnership

In 2012 the Dementia Partnership was established as a means of sharing good practice and networking. The group continues to meet on a quarterly basis and has a wide range of stakeholders across health and social care including people living with dementia and their family carers.

Dementia Friendly Communities and Dementia Champions

In 2018 it was estimated that there were 22,300 Dementia Friends in Dorset whom have undertaken dementia awareness training. There are numerous dementia friendly communities across Dorset. Activities created by communities include forest schools, allotments, reading groups, carer groups, dementia friendly churches, reminiscence groups, museum groups, knit and natter, art sessions and singing groups. Many businesses are signed up in each community to support being dementia friendly.

Unfortunately, since the withdrawal of the Alzheimer Society DFC co-ordinators this has reduced the support offered to 'Dementia Friendly Communities' and some dementia friendly communities have struggled to continue operating although at a local level many communities are still taking forward their own excellent initiatives.

The three acute hospitals in Dorset provide dementia awareness tier 1 training for all staff and tier 2 for more specialist staff. In addition, the acute hospitals have dementia champions to help raise awareness. Local authority staff receive dementia awareness training and are dementia friendly organisations.

Community pharmacies can now apply to become dementia friendly. Three events were held in Dorset for pharmacies and their staff to attend to receive training on the framework and how to implement in 2017. Most pharmacies have at least 90 people with dementia on their registers plus carers and family members.

There was a project called 'I SPACE' which is aimed at General Practices becoming dementia friendly. Practices are offered training, encouraged to keep carers registers, carry out medication reviews, develop a dementia policy, increase dementia diagnosis and complete care plans. There has been excellent progress across Dorset with the majority of practices having achieved this status.

Personalised Care

Within the NHS Long Term plan a key element is personalised care[49] . Personalised care means people have choice and control over the way their care is planned and delivered, based on individual strengths and needs. Personalised care takes a whole-system approach, integrating services around the person and encompassing both mental health physical health support.

Local Authorities resource communities to support early intervention and prevention approaches. Dorset Council in recognition of the rural isolation faced in some areas of Dorset has established a Community Catalyst pilot in North Dorset. Furthermore, a growing number of micro enterprises offering support and some personal care will be linked to demand through a new digital resource known as Bronze lab. This aims to meet demand for 'eligible' need through increased use of personal budgets whilst providing benefits for the wider population

Social Prescribing Link workers

Under the Personalised Care agenda 'Social prescribing link workers' have been developed as one of five additional roles being funded within primary care, to bring additional capacity into the multi-disciplinary team, under the Network Contract DES. The other roles are clinical pharmacists, physician associates, community paramedics, and physiotherapists.

Social prescribing will enable primary care staff and local agencies to refer people to a link worker and supports self-referral. Working under supervision of a GP, link workers will give people time and focus on what matters to the person, as identified through shared decision making or personalised care and support planning. Link workers work within multi-disciplinary teams and collaborate with local partners to support community groups to be accessible and sustainable and help people to start new groups and activities.

In Dorset there is investment for each Primary Care Network to employ one Social Prescribing Link worker. In addition, Help and Care are commissioned to provide 8 Social Prescribing Link workers, 4 to the east and 4 to the west. Some practices are employing their own and others are going through Help and Care.

Frailty programme

The Dorset Framework for Frailty has been developed by Dorset Clinical Commissioning Group (CCG) through multi-sectorial collaboration with health and social care providers, voluntary and third sector

[49] https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf

organisations, patients and their representatives. It is endorsed by the Dorset Frailty and End of Life Care Reference Group.

The development of the framework is a response to the request for a common approach to the early recognition and identification of frailty as a long term condition, promoting early detection through case-finding, appropriate assessment, risk stratification; and backed up by planned and coordinated care and support. There is a high level service specification outlining outcomes for those identified with moderate and severe frailty registered with a GP in Dorset.

Social Care Day opportunities

Dorset Council want to provide a truly personalised community-based offer that promotes independence, choice and control for those eligible to receive services. Their community-based opportunities programme is all about giving people choices about how they are supported to live their lives based on their strengths, interests and abilities. A key part is identifying and developing local community-based resources and supporting people to access these.

Arts, culture, horticulture, with proven benefits to people with dementia will be part of a personalised approach to activities and is being trialled in Weymouth. The ambition is to decrease reliance on buildings-based day care and stimulate an offer which is more personalised and accessible for all.

It is recognised that there will be a place for day care for people with high needs and to offer respite for carers but new models are being explored. The Filo project, originating in Devon offers an example of a different approach, now developing into West Dorset (Lyme Regis and Bridport) and offers day care for people with dementia in a homely, small group environment hosted by training informal carer.

Homecare Strategy – registered care at home

Demand for complex personal care is rising; currently there are growing shortages in the care market which result in an average of 50 people ‘waiting’ for care each week rising to over 80 including continuing healthcare packages.

Dorset Council is working with a range of stakeholders including the market and Public Health to develop a transformational model for personal care at home which improves workforce recruitment, retention and skills levels in the ‘short call’ market, which is particularly significant for person centred care dementia care.

Complex care and live in care are to be retendered by CCG & Dorset Council, a significant proportion of which is geared to intensive long-term support for people with dementia. BCP council still commissions a Dementia Homecare service in the Poole locality.

Support for carers

BCP has a carers lead offering a range of support including information, groups and the development of the carer passport. Recently Dorset Council awarded a contract for a new ‘front door’ approach for carers of all ages to be known as Carer Support Dorset. This will enable the relocation of early carer support into community settings away from the council and will contribute significantly to a collective model of early intervention throughout Dorset.

The Pan Dorset Steering Group with representatives across the system has refreshed its commitment beyond the Local Government Reorganisation and is developing a proposal to refresh the current joint Vision for Carers (2016 – 2020) toward a new five-year plan. A key priority for carers in Jan 2020 is a review of respite provision/ short breaks – both community and bed based and the development of one Carers assessment across the whole footprint (for those who need this)

Carers Passports

Within the NHS Long Term plan 'Carer Passports' are included. This is a record which identifies an informal carer in some way and sets out an offer of support, services or other benefits in response. Across Dorset through the Local Authority Carers Lead, Carers are given the 'Carers Card' (passport) when they join the Carers Information Service in Dorset and this offers carers discounts at a range of businesses.

The hospitals across Dorset are also developing separate passports for carers who are spending a significant amount of time there so they can access other benefits, such as free parking. All the hospital canteens/restaurants recognise the Carers Card and give discounts. Further Information can be found at https://carerspassports.uk/ .

Transitional care home and community beds and extra care housing

Short term beds in care homes and community hubs are being commissioned to provide step up and step down rehabilitation, reablement and end of life care and support within a defined timeline for patients who are unable to receive this service at home or where admittance to an acute hospital ward is not required. There is flexibility with the numbers of step up and down beds utilised.

Anticipated Community Hub Transitional beds.

Community Hub	Total Community Beds	Anticipated no of transitional beds (step-up and step down) rehabilitation care
Wimborne	27	8
Swanage	15	5
Blandford	24	8
Shaftesbury	15	4
Sherborne	30	10
Bridport	24	8
Westhaven, Weymouth	34	12
Alderney, Poole & PHT	72	16
RBCH site	48	13
Wareham Care Home Beds	TBA	4
Weymouth Care Home Beds	TBA	4
Bridport Care homes	TBA	
(New) Figbury Lodge Care Home, Poole	80	20
(New) Coastal Lodge, Bournemouth	48	30

Schemes such Care Villages and Extra Care housing are being developed across Dorset that enable more responsive services to meet increasing needs and are examples of cross sector working to provide a broader range of housing options.

More people are being supported in their own homes for longer in common with the national picture. Some of this housing is unsuitable for people as they age and become frailer. The rapid increase of private retirement schemes (new investment in retirement housing, including affordable housing, now outstrips care homes) and development of housing with care schemes is an opportunity to gear design around the needs of people who have or develop dementia, and meet accommodation needs more imaginatively and in line with changing expectations.

Care homes

There are 63 nursing homes and 147 residential homes in total across Dorset and this includes provision for those with a Learning Disability. Within these homes (September 2019) there were 3200 people diagnosed with dementia. This is 37% of the overall total of people diagnosed with dementia in Dorset currently.

Dorset Council is purchasing around 21% of all available placements in Dorset council area. They have noted an increasing gap between specialist dementia beds and an overprovision in generic residential care.

The View-Seeking phase of the Dementia Review assisted the new BCP Council to scope new and innovate staff development opportunities for care home staff, namely relationship building and communication skills; participating care homes are helped to provide meaningful and stimulating environment for their residents. As well as investing in staff, BCP Council has contributed to funding of improvements to care home buildings and to equipment.

Grants continue to be offered to care homes with the purpose of improving the experience of their residents. BCP have seen the use of the grant to purchase the Tovertafel table with excellent outcomes for residents.

Enhanced Health in Care Homes

The Enhanced Health in Care Homes Framework which Dorset is part of was developed as part of the New Models of Care work undertaken by 6 Vanguard sites in 2015/16 which focused on various elements, including adopting a proactive approach to joined up health and social care.

Dorset Red Bag Scheme

The ‘Red Bag’ is the most visible part of an agreed Hospital Transfer Pathway; it helps provide a prompt, safe and efficient transfer of clinical care, when a resident moves between a care home and other clinical settings, such as hospitals or ‘step up’ and ‘step down’ beds. When a resident becomes unwell and is assessed as needing hospital care, care home staff pack a dedicated red bag that includes the resident’s standardised paperwork and their medication. The pathway includes an assessment of the functional level of the resident when they are well. This information allows the hospital team to understand the functional level they should be aiming for to support discharge. The ambition is for this pathway documentation to made available digitally. The scheme was re-launched in June 2019 to ensure full adoption across the

system. Local champions have been identified across the system to support the embedding and promotion of this initiative.

Respite provision

Local Authorities continue to purchase respite from residential settings in accordance with the needs of individual service users and carers, to include needs associated with dementia/cognitive impairment.

Dementia Quality Standard

In light of the lack of a national dementia standard for Care Homes with the Care Quality Commission, the former Bournemouth Borough Council created an accreditation standard that supports homes to meet the needs of individuals with higher needs. This is complemented by a differential fee rate that incentivises homes to make the leap to be accredited. BCP council is now scoping out how this can be rolled out to shape their market for dementia care.

Mental Health Liaison Review

Nationally it is estimated two-thirds of beds in general hospitals are occupied by older people, most of whom have multiple and complex health problems. The most common conditions being delirium, depression, and dementia.[50] Furthermore, it is evidenced that people with dementia and concurrent physical conditions have poor-quality care, higher mortality, and worse clinical outcomes than people with the same conditions without dementia.[51] It has also been estimated that failure to organise dementia liaison services leads to excess costs of £6 million a year nationally with hospital stays increased by 66% for the over 75 years.[52]

A review of Mental Health Liaison services is currently underway across Dorset and includes dementia. Within the Mental Health Five Year Forward there is the expectation of an all age service to be available in emergency departments and inpatient wards by 2020-21. [53]

Acute and Community Hospitals

Across Dorset there are three district general hospitals and various community hospitals all of which have significant numbers of patients attending as outpatients or inpatients with dementia. Representatives from these hospitals meet regularly with NHS Dorset CCG to discuss dementia and improve provision. Within the view seeking of this review the range of issues have been developed into an action plan which the group is taking forward. This includes trying to achieve greater integration across community services with the acute hospitals.

Furthermore, various initiatives are being delivered such as improved delirium pathways, John's Campaign offering family carers extended rights to stay with their loved ones in hospital, education and training of staff and improved identification of people with dementia through a local financial lever (CQUIN).

[50] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3754487/
[51] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3754487/#b24-cia-8-1101
[52] https://www.rcpsych.ac.uk/pdf/Tadros%20George.pdf
[53] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

End of life care

In some areas, beds will be provided to support End of Life (EOL) care for people who have expressed a wish to die in a care home bed. These beds will primarily be available for adults in the last days of life who are likely to need symptom control with prescribed individualised anticipatory medicines and daily assessment of hydration status with discussion about the risks and benefits of hydration options. A Fast track pathway tool for NHS CHC is due to be implemented. The plan is this tool will only be used when the individual has a rapidly deteriorating condition and may be entering a terminal phase.

Rapid Home to die is a scheme the community hospitals are engaged with to fast track people whom wish to die at home.

Workforce

Workforce developments are underway with care and support provider staff specifically relating to improving their skills, knowledge and confidence when feeling challenged when working with people living with dementia.

Assistive and information Technology

Across Dorset the 'Dorset Care Record' and other developments will enable greater information sharing across health and social care. There are a range of telehealth and telemedicine options available currently. Various technology developments are being explored such as new technologies for diagnosis of dementia through virtual reality. Also a non-invasive tracking tool that sits within everyday footwear is being trialled as a means of alerting the carer if the person using them wanders outside of a set distance.

Dorset Council is currently tendering for a new equipment service and an Assistive Technology development partner. The Dorset Technology Team is increasing access to a range of assistive technology in the home which can be used to support speech, hearing and sight, navigation, safe walking, memory and understanding; daily activities and socialising; lighting & sensor tech, self-activating and technical reminders.

BCP Council is looking at options for improving access to digital information and advice about the availability of care and support services. The aim is to provide dynamic information about available capacity (e.g. bed spaces), price and quality.

Dementia research

The Ageing and Dementia Research Centre[54] within Bournemouth University brings together cross-faculty research expertise in areas of ageing and dementia. Research areas include:

- Developing ageing and dementia friendly environments
- Nutrition and wellbeing. Activity and social inclusion

[54] https://research.bournemouth.ac.uk/centre/ageing-dementia-research-centre/

Appendix 2 Dementia Co-ordinator Job Description

JOB DESCRIPTION

JOB TITLE: Dementia Coordinator

LOCATION: Designated Primary Care Network/s

REPORTING TO: Memory Assessment Nurse

GRADE/SALARY: Band 4

RESPONSIBLE FOR: The co-ordination of health and social care support for a designated caseload of people living with dementia within a defined locality, alongside ensuring care plans are in place and signposting both people living with dementia and their informal carers to activities and community support as appropriate.

PURPOSE:

1. To work as part of the Dementia Service and support the work in a designated 'Primary Care Network' locality.
2. To provide customers and their carers' whom are residing in their own homes in the community with encouragement, advice and support to develop strategies to live well with dementia, maintain their independence and engage in their communities.
3. To act as a key worker for a designated caseload of customers in a local area, and co-ordinate the support received, liaising with other services as agreed and appropriate.
4. Assess basic care and support needs and ensure ongoing monitoring
5. To ensure those living with dementia and their carer's have ongoing support and co-ordinate support from relevant health and social care services and signposting as appropriate to meet needs from the point of a dementia diagnosis to end of life.
6.To assist in the running of 'Dementia Roadshows' and facilitate local support groups following best practice guidelines in dementia care and under guidance of Dementia Nurses.
7. To provide support and advice around dementia to nominated care homes within the designated Primary Care Network in conjunction with the Dementia Inreach service.
8. To support awareness of and signpost carers to relevant services: eg for carer assessments, support with completing advance care plans, respite.
9. Carry out assessments for social care.

DUTIES AND RESPONSIBILITIES:

Customer responsibilities

1. To support the work of the Dementia Service in a defined Primary Care Network providing exemplar customer care throughout the customer's journey with the Dementia Co-ordinator service from the point of diagnosis to end of life.
2. Offer a responsive service for all newly diagnosed people and their family carers, identify needs, care plan including advance care planning and discuss what the dementia services offer and ensuring people are aware of local advocacy services.
3. To hold a caseload of around 200 customers recognising different levels of needs.
4. Ensure a care plan is in place with relevant clinical and social care input and updated.
5. Ensure the customer receives a service pack on introduction to the Dementia Service and has the contact telephone numbers including the Crisis Line.

6. Provide one to one support and signposting for people with dementia and their carers helping them to access activities and their communities including Dementia Friends and volunteers to befriend.
7. Providing emotional support to both people living with dementia and family carers as appropriate through face to face meetings or telephone contact, within a defined Primary Care Network/s.
8. Help people maintain independence through living skills, adaptions and enablement approaches and simple safeguards.
9. Regularly review and monitor customer's needs and situation.
10. Refer to named services as appropriate and assist in the co-ordination of other health and social care provision and liaise with all relevant stakeholders –GPs, hospital staff, family, community networks to ensure a coordinated and personalised approach to support.

Co-ordinating and facilitating activities
1. To assist in the organisation and running of the locally based Dementia Roadshow, ensuring appropriate venues and presence of other local agencies and a dementia education talk and advertising. Risk assess venues when required.
2. To support the Dementia Service, Dementia Friendly Communities and other groups in the delivery of dementia activity sessions in the defined local area.
3. Maintain appropriate records of customer attendance at activities in line with GDPR and Charity Log practices.
4. To review customer satisfaction, identifying opportunities for development following best practice, and customer suggestion.
6. Deliver activities as agreed with the Dementia Nurses, providing cover for colleague's groups as needed.
7. To support customers to access the Dementia Roadshows and other activities.
8. To facilitate Dementia Friends sessions as requested, maintaining Dementia Friends Champion registration

Compliance Responsibilities
1. To work in line with Policies and Procedures relevant to the role, particularly data protection and confidentiality.
2. To monitor Health and Safety compliance of volunteers and customers reporting any problems or deviation from health and safety best practice
4. To ensure Equal Opportunities policies, principles and practices are observed and implemented throughout service delivery.
5. To work with the Dementia Nurses within Dorset HealthCare NHS Foundation Trust to ensure quality systems are upheld, monitored and reviewed.

Service Responsibilities
1. To uphold and demonstrate to others how the values and behaviours of the organisation are upheld, including the adherence of Standards of Appearance Policy.
2. To provide accurate and timely management information as requested and comply GDPR.
3. To ensure effective networking and liaison with other services including multi-disciplinary teams by participating in relevant meetings and representing the values and policies of the organisation
4. Represent the organisation externally as appropriate
5. To work flexibly to support other services as needed
6. To attend training in dementia care and related activities as requested and appropriate
7. To participate in monthly case supervision with the Dementia (Memory Assessment) Nurse, to discuss customer support, case management and other service/work issues.
8. To participate in personal development review and engage in training/development activities
9. To ensure confidentiality of information and data protection regulations are followed

PERSON SPECIFICATION	ESSENTIAL	DESIRABLE
EDUCATION & TRAINING	• NVQ level 3 in Health & Social Care or same level qualification in a similar field • Demonstrable understanding and working knowledge of the Care Act 2014	• NVQ level 4 in Health & Social care or same level qualification in similar field • Knowledge of Health & safety • Completed training in Cognitive Stimulation Therapy or other dementia training • Trusted assessor training
EXPERIENCE	• Experience of supporting people, their families and carers in a related role (including unpaid work) in the Voluntary Sector, NHS, Public Health or Social Care. • At least 1 years' experience of working with people with dementia and/or their families and carers	• Experience of case management • 2 years or more of working with people living with dementia • Experience of carer support activities • Working with people with young onset dementia and their families • Experience of delivering activities specifically for people with dementia • Experience of providing person centred care • Experience of current issues relating to people with dementia and their families and carers • Experience of partnership/collaborative working and building relationships across a variety of organisations
SKILLS	• Effective team working • Ability to identify the appropriate level of support for a person with dementia • Ability to provide support respectively and sensitively • Ability to deal with sensitive issues with compassion and sensitivity eg advance care planning • Ability to work on your own in the community and use initiative • To be able to liaise and work cooperatively and appropriately with a wide range of other professionals, carers, managers, advocates and representatives of other organisations • Ability to converse at ease with customers and provide advice in accurately spoken English • Self-motivated and able to prioritise workload	• Full UK Driving License and access to a car for work • Electronic record keeping • Networking skills

	• Ability to problem solve and use own initiative, making basic decisions without supervision, • IT skills including Word, Outlook • General report/letter writing skills	
KNOWLEDGE	• Knowledge and skills in positively involving and enabling individuals • Knowledge of services and resources available in local area • Relevant policies and procedures including confidentiality, safeguarding, lone working, information governance and Health and Safety	• Knowledge of how to initiate and build links with local resources • Knowledge of the issues involved in the care and control of medication
PERSONAL QUALITIES AND ATTRIBUTES	• Ability to actively listen, empathise with people and provide person centred support in a non-judgmental way. • Flexible approach. • Able to get along with people from all backgrounds, communities and respecting lifestyles and diversity. • Have a strong awareness and understanding of when it is appropriate or necessary to refer people to other health professionals. • Ability to reflect on personal performance and learn from experiences.	
OTHER	• Full driving licence and access to a car. • Meets DBC reference standards and criminal record checks. • Willingness to work flexible hours when required to meet work demands.	

Appendix 3

Summary of estimated travel and accommodation costs September 2019

It is difficult to estimate accurately the costs of providing travel and overnight accommodation to family carers wishing to visit their loved one when an inpatient at Alderney Hospital in Poole and living some distance away and requiring public transport. The following estimations have been based on an external radius of 30 miles from the hospital location and based on current travel costs. There is on average 100 admissions per year.

This budget will be monitored and adjusted accordingly to best meet needs. Noting that a wider review of transport is currently progressing across Dorset and may offer new solutions for this significant issue for many people whom are unable to drive.

Location	**Approximate travel fares based August 2019**
Weymouth to Alderney	Train return £15 per visit Bus Alderney return £4 = £19
Weymouth to Alderney	Taxi return £140
Lyme Regis to Alderney (3 ½ hours one way)	2 buses plus train return=£33
Lyme Regis to Alderney	Taxi return £250
Sherborne to Alderney	Bus return £25
Sherborne to Alderney	Taxi return £180
	Estimated Total £662 monthly = £7,944
Accommodation (B&B up to 3 mile radius from Alderney hospital average per week night £56)	**£56 based 2 requests per week per annum = £5824**
Estimated total cost per annum	**£13,768**