Report to:	**SINGLE COMMISSIONING BOARD**
Date:	31 October 2017
Officer of Single Commissioning Board	Stephanie Butterworth, Director of Adult Services
Subject:	**IMPROVING DEMENTIA SERVICES IN THE NEIGHBOURHOODS**

Report Summary:

There are an estimated 2,691 people in Tameside and Glossop with dementia. As part of the Care Together development Tameside and Glossop committed to improving the lives of people living with dementia and, through this, reduce reactive costs associated with the high volume of activity in unscheduled and long term care. In 2016 in Tameside, the rate of emergency admissions, aged 65+ with dementia was 4,839 per 100,000 population, compared to the rate for England of 3,046 per 100,000 population.

10 days in a hospital bed (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80 Gill et al (2004) studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity and social activity.

The overall vision for Tameside and Glossop is linked to the development of a rich, post diagnostic support offer to support people living with dementia and their carers to make informed choices, be empowered to take control of their lives and maintain their well-being and independence for as long as possible.

This business case has three main objectives:

1. Establish a pilot with Alzheimer's Society for Dementia Support Workers (DSW) in each Neighbourhood in Tameside.
2. Establish Dementia Practitioners (DPs) in each neighbourhood team by investing in three new roles to add to existing Pennine Care Foundation Trust Community Mental Health Team nurses, Willow Wood Dementia Nurse and Integrated Care Foundation Trust Admiral Nurse capacity.
3. Agree an Executive Lead Champion for dementia. This individual will have delegated responsibility from the locality partnership to represent the locality in all regional discussions about the strategic direction and performance of dementia services.

It is proposed that Dementia expertise is embedded within the Integrated Neighbourhood Teams by integrating a Dementia Practitioner into each Neighbourhood Team.

Dementia support is increased in each of the Tameside Neighbourhoods by investing in a three-year Dementia Support Worker pilot from the Alzheimer's Society through Adult Social Care Transformation Funding.

This business case supports the Single Commission's Quality, Innovation, Productivity, and Prevention (QIPP) agenda. It is anticipated that as the cost savings from reduced unscheduled admissions will ultimately allow movement of money within the system that ensures the implementation is sustainable in the first instance, and cost saving in the medium and long terms.

Recommendations:

The Single Commissioning Board is recommended to:

(1) Recognise the current position regarding unscheduled admissions related to dementia and the need for additional resources and actions to enable us to progress towards reducing a figure that is an outlier at a national level and contradicts the progress delivered in diagnosis.

(2) Agree that the development of a rich post-diagnostic community offer supported by the clinical delivery of Dementia Practitioners and the co-ordinating role of the Dementia Support Workers will be a significant step in improving dementia care in Tameside.

(3) Agree to Phase 1 – the investment of non-recurrent Adult Social Care Transformation budget to establish a pilot with the Alzheimer's Society to embed Dementia Support Workers in the Tameside Neighbourhood Teams to support people living with dementia from diagnosis to end-of-life care.

(4) Recommend that compliance with procurement standing orders be waived to enable this pilot to be established from the Alzheimer's Society who are a specialist provider.

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

Budget Allocation (if Investment Decision)	Phase 1 funding requirement £0.326m total over initial 3 year period. £0.105m recurrent funding required from 2020-21 onwards Phase 2 funding requirement of £0.143m per annum to be agreed
CCG or TMBC Budget Allocation	Funding of £0.326m has been agreed from the Adult Social Care Non Recurrent Transformation Grant until 2019-20.
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Section 75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	Single Commissioning Board
Value For Money Implications – e.g. Savings Deliverable, Expenditure	The current estimated cost of avoidable Dementia related acute admissions is £0.5m

Avoidance, Benchmark Comparisons	per year in Tameside. It is hoped that by increasing specialist Dementia support in the community a significant proportion of these costs can be avoided. Cost reductions in this area will allow continued community investment whilst also contributing towards closing the Tameside locality funding gap.
Additional Comments Recurrent funding of £0.105m per annum from 2020-21 onwards requires further discussion as at this stage the proposal is not affordable. It is important to quantify and track the cash releasing benefits in acute to enable continued investment in the neighbourhood based speciality teams.	

Legal Implications:

(Authorised by the Borough Solicitor)

The Council is obliged to follow its own procurement standing orders which include provision to make a direct award where there are exceptional circumstances to justify such a course of action and it will not contravene any legal obligation.

The proposed contract value is below the current threshold (£589,148) for Social or Other Services (which is also known as the light touch regime) and therefore there is no requirement to run an OJEU exercise.

Due to the nature of pilot, the specialisms of Alzheimer's Society and their current involvement in developing the Dementia United Strategy, driving quality across Greater Manchester in all sectors, it would not be unreasonable to proceed with the pilot. Any subsequent longer term contract must be let in accordance with the Public Contract Rules.

The proposed arrangements will undoubtedly involve the transfer of sensitive personal data about individuals. The contract between the parties should include appropriate information governance provisions to safeguard service user data.

Members must by law have regard to the Equality Impact Assessment attached to this report before making their decision

How do proposals align with Health & Wellbeing Strategy?

The "Improving Dementia Services in the Neighbourhoods" business case aligns with the following Health and Wellbeing Board strategic priorities:

- Integration;
- Improve the health and wellbeing of local residents throughout life;
- support to those with poor health to enable their health to improve faster;
- Prevention and early intervention;
- Local action and responsibility for everyone;

	• Public involvement in improving health and wellbeing.
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Healthy Lives (early intervention and prevention) • Community development • Enabling self-care
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Patients and communities being empowered to care for themselves and to work together to support local health and wellbeing; • Identification and support of "at risk" people; • Fewer overnight stays in hospital and more community based care.
Recommendations / views of the Professional Reference Group:	The Professional Reference Group recommends this paper is agreed by the Single Commissioning Board as the first step towards a much greater focus on supporting people with dementia in the community in order to reduce the high rate of unscheduled admissions and pressures on Continuing Healthcare.
Public and Patient Implications:	There are implications for people with dementia and their families/carers.
Quality Implications:	There is evidence that Improving Dementia Services in the Neighbourhoods will deliver the following patient outcomes: • **Better quality of life** and enhanced health and well-being; • **Fewer crises** that lead to unplanned hospital and institution care; • **Enhanced experience of care** through better coordination and personalisation of health, social care and other services.
How do the proposals help to reduce health inequalities?	By offering people living with dementia more support, choice, control and flexibility in relation to managing their own health.
What are the Equality and Diversity implications?	It is anticipated that the proposal will not have a negative effect on any of the protected characteristic group(s) within the Equality Act. An Equality Impact assessment has been completed and is attached (**Appendix 3**)
What are the safeguarding implications?	Safeguarding assurance is integral within all service delivery.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	This will be completed if required.
Risk Management:	No risks identified.

Access to Information :

The background papers relating to this report can be inspected by contacting:

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1. EXECUTIVE SUMMARY

1.1 The proposal is to build dementia expertise and support by embedding Dementia Practitioners (Dementia Nurses and Admiral Nurses) within each of the five Neighbourhood Teams and, in Tameside, commissions a pilot scheme from the Alzheimer's Society to provide a Dementia Support Worker in each neighbourhood through the Adult Social Care Transformation Funding.

1.2 It is recommended that post-diagnostic dementia provision is developed in two phases; Phase 1 includes allocating some capacity from the existing resources in the Older Peoples Mental Health Team in Pennine Care Foundation Trust and the Admiral Nurses in the Integrated Care Foundation Trust as well as commissioning a Dementia Support Worker Pilot from the Alzheimer's Society. To turn the curve on the high rate of unscheduled admissions for people with dementia it is recommended that dementia practitioner capacity is extended to focus on early intervention and prevention capacity in Phase 2.

1.3 The benefits and effectiveness of these recommendations is provided with an overview of wider NHS and Social Care policy contexts and drivers, as well as qualitative and quantitative evidence of the benefit to the health and social care system.

2. OUTLINE DESCRIPTION

2.1 There are an estimated 2,468 people in Tameside and Glossop with dementia. As part of the Care Together development, Tameside and Glossop committed to improving the lives of people living with dementia and, through this, reduce reactive costs associated with the high volume of activity in unscheduled and long term care.

2.2 10 days in a hospital bed (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80. Gill *et al* (2004) studied the association between bed rest and functional decline over 18 months; they found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity and social activity.

2.3 The Alzheimer's Society 'Counting the Cost: *caring for people with dementia on hospital wards' (2009)* reported:

- *Over a quarter of hospital beds in the UK are currently occupied by people with dementia;*
- *One third of people with dementia who go into hospital for an unrelated condition NEVER return to their own homes;*
- *47% of people with dementia who go into hospital are physically less well when they leave than when they went in;*
- *54% of people with dementia who go into hospital are mentally less well when they leave than when they went in.*

2.4 The overall vision for Tameside and Glossop is linked to the development of a rich, post diagnostic support offer to support people living with dementia and their carers to make informed choices, be empowered to take control of their lives and maintain their wellbeing and independence for as long as possible.

2.5 It is proposed that dementia expertise is embedded within the Integrated Neighbourhood Teams by integrating a Dementia Practitioner into each Neighbourhood Team. There are two phases to achieve this:

Phase 1	Phase 2
Integrating time from existing postholders (currently working in Pennine Care FT, Willow Wood Dementia Nurse and the ICFT Admiral Nursing Team) into each of the Neighbourhood Teams.	Increasing capacity with additional funding/redesigning neighbourhood team skill mix to ensure that sufficient dementia expertise is in place to reduce unscheduled care demand.

- The focus of these roles will be to reduce the rate of hospital admissions and to promote 'dying in usual place of residence.' Further work is required to identify the capacity and responsibilities for Dementia Nurses, Willow Wood Dementia Nurse and Admiral Nurses as the roles are complementary but different. See **Appendix 1** for a description.

- It is proposed to invest in additional dementia provision in each of the Tameside Neighbourhoods by funding a three-year Dementia Support Worker pilot from the Alzheimer's Society through Adult Social Care Transformation Funding. See **Appendix 2** for a description.

3. BACKGROUND

3.1 There are a number of national policy positions which have informed this business case; in 2009, the 'Living Well with Dementia: A National Dementia Strategy' provided the strategic framework within which to make quality improvements to dementia services and address health inequalities. In 2012, 'The Prime Minister's Challenge on Dementia' provided a challenge to the whole of society as well as government to focus on driving improvements and creating dementia friendly communities and better research. In 2013, 'A State of the Nation Report on Dementia Care and Support in England' acknowledged dementia as being one of the most important health and care issues the world faces as the population ages; and projected a doubling of prevalence nationally over the next 30 years.

3.2 The 'Prime Minister's Challenge on Dementia 2020' (2015) sets out what this government wants to see in place by 2020 in order for England to be the best country in the world for dementia care; it also sets out what people with dementia self-report as the type of society that is important to them, in which they are able to say:

- *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 and 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;*
- *I know that there is research going on which will deliver a better life for people with dementia, and I know how I can contribute to it.*

3.3 NHS England has been prioritising equitable access to high quality services and support for people diagnosed with dementia and as a result, the National dementia team developed a 'Well Pathway for Dementia' which is being used as the benchmark for the GM dementia transformation programme - "Dementia United."

Current Situation

3.4 A focus on improving the dementia diagnosis rate from 69.6% in April 2016 to 75.1% in March 2017. Reducing waiting times from 24 weeks for the Memory Assessment Service

for a first appointment to the national target of six weeks has resulted in significant improvement; however there is a high rate of unscheduled hospital admissions.

3.5 In 2016, the rate of emergency admissions (aged 65+ with dementia) was 4,839 per 100,000 population, compared to the rate for England of 3,046 per 100,000 population.

3.6 The level of unscheduled admissions is considered to be a marker for good community care. Analysis provides evidence of the main causes of admission (falls and delirium), that will be used to support the development of a robust pathway and strengthening community care that will spot and prevent crisis leading to a reduction in unscheduled admissions.

What the business case seeks to commission/re-design

3.7 This business case has three key objectives within **Phase 1** as follows:

<table>
<tr>
<td>1. Establish a pilot with Alzheimer’s Society for Dementia Support Workers (DSW) in each Neighbourhood in Tameside –December 2017 - Alzheimer’s Society to establish a DSW as an integral member of each Tameside neighbourhood team, each supported by a volunteer. When fully operational the DSWs are expected to support 192 cases of people affected by dementia every month; the DSWs will:
- provide post diagnostic support to people and their families and work with dementia practitioners (DPs) to support an allocated caseload, providing emotional support and promoting access to emotional support/mental health pathways;
- be a consistent relationship across primary/acute/secondary care and collaborate with local resources and, with DPs, build capacity/capability in primary care, community services and the voluntary and community sector;
- liaise with and, through monitoring their role, provide advice to Primary Care annual care plan reviews and support access to advocacy services;
- provide a communication conduit for individuals admitted into hospital and ensure continuity of care plans and support discharge planning;
- link with Palliative Care Team;
- facilitate and support peer to peer support through a rich community offer
- support specialist DPs.

(Note: - Dementia support is available in Glossopdale through the High Peak Alzheimer’s Dementia Support worker and through the Derbyshire Dementia Reablement Service).</td>
<td>2. Establish Dementia Practitioners (DPs) in each neighbourhood team by investing in three new roles to add to existing PCFT CMHT nurses, Willow Wood Dementia Nurse and ICFT Admiral Nurse capacity:
DPs will:
- provide expert training, advice and support to all colleagues regarding dementia assessment, monitoring, support and intervention;
- supervise the Dementia Support Workers in their role;
- Dementia Nurses will undertake assessments and provide care plans for people with complex dementia;
- carry a caseload of patients/and or carers who require additional support;
- work with Neighbourhood colleagues to monitor and take preventative action to reduce crisis. Where crisis occurs, provide support to reduce escalation, including preventing avoidable hospital admissions and expediting safe discharges;
- work with partners to deliver a rolling training programme in the locality;
- support the community and voluntary sector provision of a rich choice of carer and peer support;
- promote high quality psychosocial interventions;
- Willow Wood Dementia Nurse will also offer support and consultation for dementia end of life across Tameside and Glossop.</td>
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<tr>
<td colspan="2">3. Appoint an Executive Lead champion for dementia. This individual will have delegated responsibility from the locality partnership to represent the locality in all regional discussions about the strategic direction and performance of dementia services.</td>
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3.8 To turn the curve on the high rate of unscheduled admissions for people with dementia it is recommended that dementia practitioner capacity is extended to focus on early intervention and prevention capacity in **Phase 2.**

4. VALUE OF THE PROPOSAL

Phase 1	Phase 2
• Dementia Practitioners – move some existing resources into each of the Neighbourhood Teams; • Dementia Support Workers – commission a pilot from Alzheimer's Society; • The estimated costs for this option are **£117,295** (year 1), **£103,692** (year 2), **£104,753** (year 3) or **£325,740** for the three years requested within this business case.	Dementia Practitioners – add three additional roles. The estimated costs for this option are **£144,000** per annum.

5. REASONS: NATIONAL, STRATEGIC AND LOCAL CONTEXT

5.1 The Implementation Guide and Resource Pack for Dementia Care (formally known as the Evidence Based Treatment Pathway (EBTP), was published on the NHS England website July 2017) - priority areas identified for quality improvement by NICE are set out in the Support in Health and Social Care and Independence and Wellbeing Quality Standards for Dementia Care.

5.2 These state that people with:

- Suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia;
- Newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local areas;
- Dementia are enabled, with the involvement of their carers, to access services that help maintain their physical and mental health and wellbeing;
- Dementia have an assessment and an ongoing personalised care plan, agreed across health and social care that identifies a named coordinator of care and addresses their individual needs;
- Dementia with the involvement of their carers, have choice and control in decisions affecting their care and support;
- Dementia receive care from staff appropriately trained in dementia care.

5.3 The Five Year Forward View for Mental Health (2016) is based on economic evidence that investment in the priorities will result in savings within the system. The Mental Health Five Year Forward View is the basis for Greater Manchester Mental Health:

5.4 There are gaps in Mental Health provision:

- In primary care for low level mental health needs;
- between Healthy Minds and Secondary Care in both psychological therapy and mental health expertise;
- For people with chronic and relapsing mental health needs;

- In post-diagnostic dementia support.

5.5 As well as redesigning existing mental health investment there is new funding from GM, the Single Commission (CCG and Tameside MBC) and within Care Together – aligning this will ensure no duplication and no gaps.

5.6 This business case also links to Greater Manchester Mental Health and Well-being Strategy priorities for 2017/19 that include:

- **Dementia United**
  - Diagnosis
  - Post-diagnostic support
  - Carers, and

- **Crisis care**
  - A&E Psychiatric liaison – Core 24 / RAID
  - All-age acute care pathway redesign (including CRHTs and Primary care mental health)
  - Crisis care triage / support
  - Custody / liaison and diversion

Links with Single Commission's Strategic Plan and Health and Wellbeing Board

5.7 This business case supports the "Care Together Commissioning for Reform Strategy 2016-2020" commissioning priorities for improving population health and supporting positive mental health.

5.8 This also supports the ambition to deliver integration of primary, community and secondary physical and mental health care, public health programmes and social care services as well as co-ordinating and commissioning services from other providers e.g. voluntary and faith sectors.

Supporting the Single Commission's Quality, Innovation, Productivity and Prevention Agenda

5.9 **Quality:**
- better service user and carer experience;
- better integrated health and social care approach;
- provision that meets NICE Dementia Quality Standards;
- better developed and trained workforce.

Innovation:
- integration of primary and secondary care, health and social care and physical and mental health care;
- reduction in unnecessary referral and administration;
- incorporates best evidence to support a whole-system change.

Productivity:
- reduced demand for acute inpatient provision
- reduced demand for specialist mental health inpatient provision
- increased discharge rates and shortened length of stay from acute and specialist mental healthcare to primary care and home support
- increased response times
- increased numbers of people receiving specialist assessment
- release of resources so that more treatment can be provided in the community and home settings

Prevention of

- inappropriate hospital admissions;
- people having to lose their independence;
- admissions to care homes;
- inappropriate drug prescribing;
- crises through good monitoring and early intervention in the community;
- delayed discharges.

Key Partners / Stakeholders involved in the business case

5.10 Further to the original dementia; "Care Together Programme - Business Case" in 2015, the development of this business case has involved the public, NHS and Social Care professionals and community and voluntary sector provision in Tameside and Glossop.

5.11 The dementia workstream has been developing over the last five years. Initially there were a series of public consultations (five documented) with carers and the public to develop the existing joint dementia strategy. In support of this the Dementia Local Implementation Group (LIG) took forward the intentions of the strategy with carer representation.

5.12 The post diagnostic offer has been further developed and agreed by the Dementia Strategic Group; chaired by the Clinical Lead for Dementia and attended by all the major stakeholders; Integrated Care Foundation Trust, Clinical Commissioning Group, Alzheimer's Society, Age UK, Pennine Care Foundation Trust, Tameside MBC Public Health and Adult Services.

6. OUTCOMES AND BENEFITS

Anticipated Outcomes

6.1 There are clear opportunities for innovation and improvement in the delivery of dementia care in Tameside and Glossop, which will:

- improve integration;
- deliver better outcomes for individuals;
- and achieve efficiencies across the local health economy.

6.2 The major outcomes described in section 2.3: 'QIPP' are all achievable, but the major outcome of improved care and monitoring within the community will be the reduction in unscheduled admissions for people living with dementia.

6.3 It is anticipated that as the cost savings from the unscheduled admissions will ultimately allow movement of money within the system that ensures the implementation is sustainable in the first instance, and cost saving in the medium and long terms.

6.4 The potential cost savings to the health and social care economy are outlined in **Appendices 1** and **2.**

Measurable Improvements

6.5

- The reduction in unscheduled admissions will be influenced by the addition of dementia expertise in the neighbourhoods.

- Unscheduled admissions are monitored at a Greater Manchester level through Dementia United and our Locality Dashboard.

- The other measures will include patient and carer satisfaction and the activity that is created as a result of having a single point of access to wider health and social care services for people with dementia from newly diagnosed to palliative/end of life care.

- These measures will be monitored through data collection on activity, staff and patient surveys and local patient satisfaction as of the measures being implemented as part of the Dementia United Programme.

- The National Expert Reference Group for Dementia recommended that three outcome tools should be used routinely in memory assessment services; these are equally applicable to community based dementia support services. These are:

  - **Health of the Nation Outcome Scale-65 (HoNOS-65):** a 12-item scale measuring behaviour, impairment, symptoms and social functioning in older adults.
  - **Friends and Family Test (FFT):** a single-item scale measuring service user experience.
  - **New Models for Measuring Patient Experience Questionnaire:** a 20-item scale that measures service user experience.

- The business case will be monitored on a monthly basis for the first 12 months to ensure that the progress is as expected.

7. EVIDENCE BASE

7.1 The financial cost of dementia is enormous. Today, it costs the UK economy over £26 billion annually and this is increasing (Alzheimer's Society, 2014).

7.2 The drive to deliver better integrated health and social care provides a unique opportunity to transform dementia services. Indeed a wide range of initiatives have already started to recognise the importance of dementia and are making dementia a key part of their delivery plans. These include:

- Sustainability and transformation plans;
- NHSE new models of care vanguards;
- Better care fund programmes.

7.3 The Department of Health's implementation plan to the Prime Minister's Challenge on Dementia 2020 stated, *"we heard a consistent message from people who reported that on receiving their diagnosis, they faced a bewildering future and felt alone in facing this. People with dementia and carers told us of their urgent need for information, advice and support both immediately after diagnosis and to help them through the stages of their journey with dementia*." (Department of Health, 2016).

7.4 The Alzheimer's Society commissioned 'NEF' Consulting to evaluate the dementia support worker role, using services in Bexley and West Lancashire as case study locations.

7.5 The Social Cost Benefit Analysis (SCBA) found that the key outcomes with the greatest value created were:

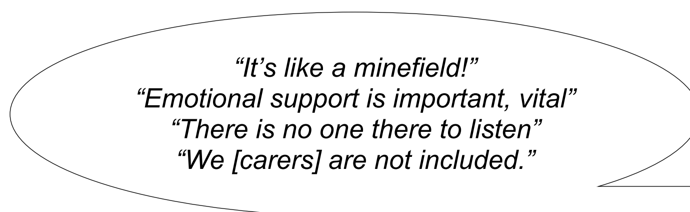
- a reduction in the cost of mental health services to the state, by avoiding carer breakdown;
- an increase in information and knowledge for carers as evidenced by their awareness of support services available in the community, knowledge of strategies that help them to cope with caring for someone with dementia, and their ability to keep the person they care for safe from harm;
- an increase in building peer support for both people with dementia and carers from having more contact with other people with dementia or carers.

7.6 The South West Dementia Partnership published "An evaluation of dementia support worker roles" in November 2011 and concluded the DSW role, *"…will not only improve the quality of life and independence of the increasing number of people living with dementia, but ensure that public resources are used effectively and delivering a significant value for money*."

7.7 The proof in Tameside will be developed as we gather evidence that the service has started to significantly reduce the 56 avoidable admissions and 7 readmissions per month that were reported the "Dementia Initial Baseline Data Report" published by the Greater Manchester Health and Social Care Partnership in 2016.

Local Consultation

7.8 People living with dementia and their carers were consulted to gather evidence to support the development of the original Care Together Dementia Business Case. Their comments included:



7.9 Patients and carers suggested that the following areas need to be prioritised to improve dementia care:

- ensure flexible, joined up services, with reduced bureaucracy and duplication; and better communication across services and departments, providing emotional as well as practical support, both one to one, peer support and dementia training, within primary care and community settings;
- better information on how to seek help; access to information about what services are available, support groups and signposting;
- offering a clear pathway; single point of access for advice and support;
- provision of a community based 'dementia adviser' and specialist staff to provide support throughout a person's entire dementia journey;
- ongoing consultation with carers, on a regular basis, in order to plan flexible and responsive services which support the caring role is needed; active inclusion of carers as 'partners' within a person's care package/treatment;
- reduced waiting times for memory assessment and diagnosis and equality of service provision;
- dementia specialist social work assessment, expertise and practice;
- reliable domiciliary care service, with alternate models of care, such as more flexible duties, emotional support, responding to needs of someone with dementia differently than people without memory or cognitive problems, better understanding of dementia from staff, creative activities and provision to provide support outside of the home;
- access to respite care, without disruption to a person's routine care package (e.g. day care); respite alternate to weekly blocks of bed-based care, considering 'day' respite
- social care support provided on a needs-led basis, rather than a diagnosis-led basis for specialist provision;
- prompt and flexible Adult Social Care response during crisis, offering reablement where needed;
- improved discharge planning and advanced care planning;
- access to medical records.

8. FINANCIAL CONSIDERATIONS

8.1 As stated in Section 1.3, the anticipated costs are outlined and broken down below:

Cost: Alzheimer's Society Dementia Support Workers	**17/18**	**18/19**	**19/20**
Dementia Support Workers x 112 hrs. pw	£73,444	£74,223	£75,010
Service Administrator x 4.2 hrs. pw	£2,449	£2,476	£2,503
Dementia Support Manager x 14 hrs. pw	Will be line managed in Neighbourhood Teams		
Service Manager x 3.5 hrs. pw	Funded by the Society		
Alzheimer's Society Supervision for workers x 7 hrs pw	£4,862	£4,916	£4,970
Volunteer Expenses	£806	£814	£822
Staff Mileage and Travel Costs	£7,158	£7,230	£7,302
Office Consumables, Phones IT Hardware & Software	£16,233	£3,000	£3,000
Learning & Development	£1,680	£1,697	£1,714
Organisational Overheads	£10,663	£9,336	£9,432
Total	**£117,295**	**£103,692**	**£104,753**
Phase 2 Cost: Dementia Practitioners/Admiral Nurse x 3 (5 Days)	**FYE**		
Dementia Practitioners/Admiral Nurse x 3 (Mid-Point Band 6)	£116,025		
Non-pay	£5,802		
Overheads/Surplus	£21,441		
Total	**£143,268**		

8.2 **Phase 1:** Adult Social Care Transformation Funding - The non-recurrent single commission Care Together transition budget. This was an initial non recurrent pooled budget sum of £6.38 million. This is a Section 75 collaborative commission for the Integrated Commissioning Fund Section.
Phase 2: To be agreed.

9. PERFORMANCE MONITORING, EVALUATION AND EXIT STRATEGY

9.1 The Single Commission will monitor performance against the anticipated outcomes as follows:

- Reporting will be on a monthly basis. This will allow us to closely monitor the development of the project within the agreed parameters and collate the evidence to demonstrate impact.

- Reporting on activity:
    - Report monthly on number of patients and carers and face to face contacts with supported and categorised against the Well Pathway elements: Living Well, Supported Well, Dying Well

- Contact 100% of the people newly diagnosed with dementia via the Memory Assessment Service in Tameside and offer opportunities to them to find out more about support available within their neighbourhood/Tameside
    - Contact 20% of people living with a diagnosis of dementia and inform them of support available, in the first six months
    - Contact 40% of people currently diagnosed with dementia and inform them of support available in the first 12 months
    - Report on the number of people in each neighbourhood attending DSW facilitated group/activities

- Patient reported outcomes – through standardised outcome reporting tools, (to be agreed) e.g. PREM/PROM (based on I statements), Health Innovation Network (HIN) Ask Dementia Outcome Measure (ADOM), Carer's Stress Index, to demonstrate impact of the service on:
    - Carer Stress
    - Meaningful occupation such as engagement in regular activity that supports them and their carer's health and mental well-being; e.g. regular attendance at a Memory Café, Active Tameside (Health Walks), etc.
    - Satisfaction with services provided
    - Awareness of support available in the locality

- Reporting on partnership working/referrals and outcomes for people living with dementia and their carers and families.
    - Demonstrate effective working within the INTs through 360 degree review
    - Contact a wide range of partnership organisations (Health/Social Care Care/VCS/Faith/Private Sectors/etc.) in the first six months to inform them of the DSW Role for people living with dementia
    - Demonstrate effective partnership working with a wide range of partnership organisations within 12 months.

- Quality assurance monitoring through case study narrative and comprehensive reporting requirements:
    - Against the Well Pathway elements: Living Well, Supported Well, Dying Well each DSW to develop 2 case studies per quarter illustrating the situation at the starting point of contact, the inputs required from them and partnership organisations to support the person living with dementia and their carers, and the immediate outcomes and medium and long term outcomes anticipated

- The evaluation of the newly funded DSW role will form part of a wider understanding and evaluation of the total changes within the system the impact on the health and social care of people living with dementia and their carer's.

9.2 The exit strategy and sustainability for this proposal is based upon the savings generated by reducing the unscheduled admissions and CHC requests. Formal evaluation of the proposal will seek to prove that savings generated are equal to or greater than the cost of implementation

10. SUPPORTING INFORMATION

10.1 Scarcity of public resources means that value-for-money for interventions for people with dementia requires closer scrutiny (Knapp, Lemmi, & Romeo, 2013). Studies suggest that peer support may lead to direct healthcare savings by equipping people with coping mechanisms and providing emotional support, which can lessen the risk of crises and subsequent, potentially avoidable and expensive interventions by the statutory sector (Arksey, 2003; Banerjee & Whittenberg, 2009; Clarke et al., 2013; Hall Long, Moriarty, Mittleman, & Foldes, 2014; Spijker et al., 2009). Traditionally, cost-effectiveness and cost-

benefit analyses have been used to assess value-for-money of health and social care interventions.

10.2 However, the value produced by participating in peer support groups can be subtle and is difficult to measure (Knapp et al., 2013). As such there is a scarcity of research on the wider social, economic or environmental value they create.

10.3 An integral part of this business case will involve facilitating and supporting existing peer to peer support for people with dementia and carers, which is routinely advocated in national strategies and policy as a post-diagnostic intervention.

10.4 A study "*Quantifying the benefits of peer support for people with dementia: A Social Return on Investment" (SROI)*" (Willis, Semple, & de Wall, 2016) looked at three dementia peer support groups in South London to evaluate what outcomes they produce and how much social value they create in relation to the cost of investment.

10.5 A Social Return on Investment (SROI) analysis was undertaken, which involves collecting data on the inputs, outputs and outcomes of an intervention, which are put into a formula, the end result being a SROI ratio showing how much social value is created per £1 of investment. Findings showed the three groups created social value ranging from £1.17 to £5.18 for every pound (£) of investment, dependent on the design and structure of the group. Key outcomes for people with dementia were mental stimulation and a reduction in loneliness and isolation. Carers reported a reduction in stress and burden of care.

11. RECOMMENDATONS

11.1 As set out on the front of the report.

APPENDIX 1

DEMENTIA PRACTITIONER / ADMIRAL NURSE ROLE

Dementia Practitioner/Admiral Nurse roles have a strong evidence base for efficacy in a range of different settings. An analysis of the caseload over one month (November 2013) in **NHS Telford and Wrekin** showed cost savings of over £17,000 in terms of savings on GP contacts and respite provision (Lee, T, et al, 2014). This evidence has been built upon by the most recent cost benefit analysis of the Norfolk Admiral Nursing Service which showed savings of over £440,000 over a 10 month period with a team of 3 Admiral Nurse/Dementia Practitioners (Aldridge and Findlay, 2014). These savings included delayed admissions to care homes, a reduction in hospital admissions (both acute and mental health), and a reduction in the referrals to psychological therapies. Additionally, surveys carried out as part of this evaluation showed 60% of GPs reporting a reduction in contact time as a result of the Admiral Nursing Service.

The results of the first year evaluation for Sutton have been extremely positive and indicate that the service is bringing positive outcomes for the families it aims to support as well as saving the health and social care economy in Sutton money by avoiding inappropriate admissions to hospital and care/nursing homes.

The independent evaluation of the specialist dementia support service in **Norfolk** found that the combination of the counselling role and knowledge and information provided by the Admiral Nurse/Dementia Practitioner had profound effects on the carers, improving their mental health and increasing their ability to carry on; 12 cases were identified which without the support of the Admiral Nurse/Dementia Practitioner would have resulted in the carer being referred to mental health services.

The evaluation suggested that Admiral Nurse/Dementia Practitioners reduced the contact time between other services and avoided eight mental health bed admissions.

Professionals reporting reduced contact time:

- 60% GPs
- 16% Nurses
- 100% Social Workers

A cost/benefit analysis undertaken as part of the evaluation estimated that the Admiral Nurse/Dementia Practitioner pilot resulted in direct savings to health and social care of over £443,593 over the period from June 2013 and April 2014.

- £63,074 Acute Health Care costs - reduced hospital admissions due to early identification and management of health conditions and support with end of life care.
- 8 mental health hospital admissions.
- £20,760 Continuing Health Care costs.
- £16,992 (approx.) Improving Access to Psychological Therapies /Counselling.
- £342,767 care home costs.

The evaluation concludes that the Admiral Nurse/Dementia Practitioner Service has achieved outstanding results throughout the pilot, providing much needed appropriate support and is a "life line" to carers and in addition to this has the potential to create savings for both Health and Social Care.

APPENDIX 2

DEMENTIA (MEMORY) SUPPORT WORKER/DEMENTIA NAVIGATOR ROLE

Published research from Professors Louise Robinson (2010), Dawn Brooker (2010), Sube Banerjee (2003 and 2007) and David Weimer et al. from the USA supports the provision of community dementia support and demonstrates genuine cost benefit.

Evidence shows that providing people with dementia and their families with a Memory Support Worker/Dementia Navigator to support them accessing the health and social supports available to them reduces stress and improves outcomes.

The South West Dementia Partnership has produced an evaluation that includes both qualitative and quantitative benefits to local health and social care systems.

The majority of existing Dementia Support Worker/Dementia Navigator roles function as named contacts for people with dementia, their carers and families. A few roles provide active liaison between primary care, secondary care and third sector providers, including advocacy. This seems to be particularly beneficial to carers, resulting in them being less susceptible to stress or depression and therefore less likely to stop being able to care for the person with dementia. A paper published by the Alzheimer's Society (2011) supports the commissioning of "brokerage" services to facilitate and empower access to personal budgets among people with dementia.

There is evidence that some people living with dementia have been able to stay in their homes for longer, some to end of life. Dementia Support Worker/Dementia Navigators have been shown to improve access to care, medication, services and support and to have delivered in partnership a more holistic service for the person with dementia and carers or families.

The full benefit realisation may not be possible for at least four years from the first provision of a new Dementia Support Worker/Dementia Navigator role (Department of Health, 2008). This is because there is a delay to measurable reduction in permanent care home placement cost, although there will be more immediate measurable savings/reduction in costs in areas such as acute hospital admission, prescribing and community mental health team referrals.

Within the South West Dementia Partnership report it has been difficult to estimate savings to the system but these vary between £5.27 and £300 per person with dementia.

The Alzheimer's Society study "Qualitative Analysis and Cost Benefit Modelling of Dementia Services" suggests that key savings result from three areas of improvement:

1. People with dementia
    - Building peer networks
    - Vitality
    - Reduced anxiety

2. Carers
    - Building peer networks
    - Knowledge and information
    - Reduced anxiety

3. Savings to the state
    - Reduced cost to mental health services through avoided carer breakdown

APPENDIX 3

Equality Impact Assessment

Subject / Title	**Improving Dementia Services in the Neighbourhoods**

Team	**Department**	**Directorate**
Personal Health Budgets	MH and LD Commissioning Team	Commissioning

Start Date	**Completion Date**
September 2017	*December 2017*

Project Lead Officer	Pat McKelvey
Contract / Commissioning Manager	Pat McKelvey
Assistant Director/ Director	Clare Watson

EIA Group (lead contact first)	**Job title**	**Service**
Pat McKelvey	Head of MH and LD	Commissioning
Dr Tim Dowling	Clinical Lead for Dementia	CCG
Geoff Holliday	Commissioning Development Manager	Commissioning
Sandra Whitehead	Assistant Executive Director	Adult Services

PART 1 – INITIAL SCREENING

1a.	**What is the project, proposal or service / contract change?**	1. Establish a pilot with Alzheimer's Society for Dementia Support Workers (DSW) in each Neighbourhood in Tameside 2. Establish Dementia Practitioners (DPs) in each neighbourhood team by investing in three new roles and developing existing PCFT CMHT nurses and ICFT Admiral Nurses.
1b.	**What are the main aims of the project, proposal or service / contract change?**	A focus on improving the dementia diagnosis rate from 69.6% in April 2016 to 82.0% in July 2017. Reducing waiting times from 24 weeks for the Memory Assessment Service for a first appointment to the national target of six weeks has resulted in significant improvement; however there is a high rate of unscheduled hospital admissions. In 2016 the rate of emergency admissions (aged 65+ with dementia) was 4,839 per 100,000 population, compared to the rate for England of 3,046 per 100,000 population. The level of unscheduled admissions is considered to be a marker for good community care. Analysis provides

		evidence of the main causes of admission (falls and delirium), that will be used to support the development of a robust pathway and strengthening community care that will spot and prevent crisis leading to a reduction in unscheduled admissions. Dementia expertise is embedded within the Integrated Neighbourhood Teams by integrating a Dementia Practitioner into each Neighbourhood Team. This will require the integration of an existing postholder (currently working within either Pennine Care FT or the ICFT Admiral Nursing Team) into each of the Neighbourhood Teams. Dementia support is increased in each of the Tameside Neighbourhoods by investing in a three-year Dementia Support Worker pilot from the Alzheimer's Society through Adult Social Care Investment Funding.

1c. Will the project, proposal or service / contract change have either a direct or indirect impact on any groups of people with protected equality characteristics? Where a direct or indirect impact will occur as a result of the project, proposal or service / contract change please explain why and how that group of people will be affected.				
Protected Characteristic	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**
Age	x			There are currently around 850,000 people in the UK with dementia. It mainly affects people over the age of 65 (one in 14 people in this age group have dementia), and the likelihood of developing dementia increases significantly with age. However, dementia can affect younger people too.
Disability	x			People with learning disabilities, particularly those with Down's syndrome, are at increased risk of developing dementia. If a person with a learning disability develops dementia, they will face different and additional challenges to people who do not have a learning disability.
Ethnicity	x			More than 25,000 older black and minority ethnic (BME) people live with dementia in the UK, in part due to vascular risk factors such as hypertension often found in African-Caribbean and South Asian UK populations. In other ethnic groups such as Irish and Jewish, there is a demographically-older population so with the link between age and dementia, prevalence is likely to be higher.
Sex / Gender			x	Overall, dementia incidence is similar for men and women.
Religion or Belief			x	Dementia can be developed to people of all religion/beliefs so there may be an indirect impact but no direct impact is anticipated in terms of religion/belief.
Sexual Orientation			x	Dementia can be developed by people of all sexual orientations so there may be an indirect impact but no direct impact is

				anticipated in terms of sexual orientation
Gender Reassignment			**x**	No direct impact is anticipated in terms of gender reassignment
Pregnancy & Maternity			**x**	No direct impact is anticipated in terms of pregnancy/maternity due to the age range predominantly affected by dementia
Marriage & Civil Partnership			**x**	No direct impact is anticipated for those who are married or who are in a civil partnership
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health	**X**			People with dementia and mental health needs will be impacted by the introduction of this service.
Carers	**x**			This business case will positively impact on carer health and will contribute to preventing carer breakdown
Military Veterans			**x**	Dementia can affect everyone so there may be an indirect impact but no direct impact is anticipated in relation to military veterans
Breast Feeding			**X**	Dementia usually directly affects those beyond child bearing age and there is no direct impact is anticipated in terms of this particular characteristic.
Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (*e.g. vulnerable residents, isolated residents, low income households)*				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**
None				The anticipated age range for people affected by dementia makes this unlikely.

1d.	**Does the project, proposal or service / contract change require a full EIA?**	**Yes**	**No**
			x
1e.	**What are your reasons for the decision made at 1d?**	The changes proposed are seeking a positive impact and the contractual monitoring within the implementation of the proposal will monitor impacts for the target group.	