Report to:	**East Sussex Health & Wellbeing Board**
Date of meeting:	**19 December 2017**
By:	**Director of Commissioning & Deputy Chief Officer, HWLH CCG**
Title:	**Support for people with dementia in the Connecting 4 You area**
Purpose:	**To update the Board on the implementation of the High Weald Lewes Havens Clinical Commissioning Group's model of Dementia care**

RECOMMENDATION

The Board is recommended to note the report

1 Background

Context

1.1 A diagnosis of Dementia can be devastating and can severely affect families, relationships and the quality of life that they all experience.

1.2 There are expected to be 2,620 people of all ages living with dementia in the High Weald Lewes Havens (HWLH) area and approximately a quarter of hospital beds are occupied by someone who has a dementia. The total cost of the disease is higher than the cost of cancer, strokes or heart disease combined.

1.3 As with other diseases, it makes a difference if dementia can be identified and treated as early as possible. Evidence also proves that a psycho-social model of support can help people with a diagnosis (and their families) to live as well as possible with the condition; this is why the Department of Health's National Dementia Strategy was titled, 'Living Well'.

The Case for Change

1.4 Local clinical enquiry, including a Quality Impact Assessment undertaken by the Clinical Commissioning Group (CCG), indicated that the existing dementia pathway fell short of meeting the needs of patients and carers and did not provide adequate support or quality of care. This cumulative picture was leading to dementia patients presenting in acute and emergency settings, in what was considered to be an avoidable poor state of health. As such, the system was viewed as ill-equipped to support patients and carers with dementia.

1.5 Based on these findings, the CCG engaged in an extensive clinical review and stakeholder engagement exercise. It formalised a partnership with Sussex Partnership NHS Foundation Trust (SPFT), Primary Care, Community Services and the Voluntary Sector and established a Clinically-led Committee to support the co-production of The Dementia Golden Ticket model of care. This wholly new approach to dementia care and support involved an extensive re-design of dementia care across the system, with a focus on integrated and holistic care (of both the person with dementia and their family carer), and a shift from Secondary Care interventions to pro-active Primary Care management and post-diagnostic support. It also included a range of psycho-social interventions to help people live with the condition as well as possible for as long as possible.

1.6 Having successfully piloted the model of care at Buxted Medical Centre, the CCG was able to demonstrate with some assurance, compelling evidence that The Dementia Golden Ticket approach improves outcomes for patients and carers, delivers economic benefits to the health and social care system, and is preferred by the workforce (in comparison to the historical dementia pathway).

1.7 Externally, it has been commended as a model of best practice, winning a number of awards and interest continues to grow about its applicability at scale, including nationally.

2 Supporting information

Implementation and Mobilisation

2.1 Further work and refinement, together with the completion of a Primary Care Education package in partnership with Brighton and Sussex Medical School (BSMS), now sees the partnership framework in a state of mobilisation to roll-out the model of care in a phased approach based on 'Waves' of implementation in Primary and Community Care. There is a 2 year incremental model of delivery in Secondary Care due to workforce implications. This approach was approved by the CCG's Governing Body as the most supportive method of rolling out a new model of care and the safest means of managing the transfer of patients from Secondary to Primary Care.

2.2 As of the 02 October 2017, 5 Practices went live with The Dementia Golden Ticket with Wave 2 launching in January 2018 (an additional 3 Practices), with plans for another 5 to roll-out from April 2018. The remainder will come on stream, quarterly thereafter.

2.3 The following services are in place as part of the Dementia Golden Ticket model of Care:

- A new GP referral pathway, making it easier and more streamlined to refer to Secondary specialist services.
- A new Memory Assessment and Management Service undertaking comprehensive assessments and diagnosis in peoples' own homes (carried out by SPFT)
- A Dementia Guide Service, providing contact within 2 days after diagnosis, face to face contact within 10 days and on-going practical and emotional support to the person and family living with dementia. (East Sussex County Council Carers Engagement and Respite Service)
- GP surgeries (signed up to the Locally Commissioned Service) delivering post-diagnosis review within 10 days of diagnosis, 6/12 review meetings and weekly, proactive 'Blip' Clinics. All appointments under the framework are up to 40 minutes long.
- Advanced Care Planning documents have been developed for The Golden Ticket model of care and are mandated to be completed by the GP Practice and Dementia Guide Service, within 6 months' of diagnosis.
- 7 weekly Memory Wellbeing Cafes in Ringmer, Buxted, Crowborough, Peacehaven, Ticehurst, Newick and Uckfield. (Know Dementia)
- 3 Leisure Centres providing weekly Dementia Exercises Classes in Peacehaven, Lewes and Uckfield, rising to 4 in January 2018, to include Crowborough. (Freedom and Wave Leisure)
- 3 Weekly Musical Activity Sessions, in Lewes, Uckfield and Newhaven, rising to 5 localities in 2018. (Know Dementia)
- Free Transport for those people that need it, to access community interventions coordinated by the ESCC Transport Hub.

- 2 hour daily 'Hotline' from Primary to Secondary Care for direct and timely support of the Primary Care workforce. (SPFT)
- 2 half day Education Package delivered in partnership with BSMS, to enable identification of a Lead Primary Care Practitioner and GP for every practice rolling out The Dementia Golden Ticket. Next education package to support Wave 3 scheduled for January and March 2018.

2.4 The Dementia Golden Ticket is providing the following benefits to patients and carers and the health and social care system**:**

Patient and carer benefit

- Additional time allocated to this patient group (with appropriate multi-agency support) will help to deliver an enhanced quality of service.
- A shift from acute provision to community-based care, closer to home.
- A model of care which meets the holistic needs of the family situation; improving quality of life, independence and patient and carer experience.
- Patients and carers access good quality and timely information, advice and support, which enable them to self-manage the condition, for as long as possible.
- Carers will receive support, as well as equal access to psycho-social interventions, which enables them to continue in their caring role, for as long as possible.
- Advance Care Planning will be the norm instead of the exception; resulting in improved condition management, and patients and carers having their wishes and preferences respected.
- Practices know their patients (and their families) best and are therefore best-placed to manage their condition.
- Self-reported improvement in patient and carer wellbeing.
- Reduced carer crisis leading to inappropriate admissions to care settings.

Primary Care benefit

- A Primary Care Practitioner-led service, which would previously have relied on GP appointments, will release GP capacity to see more non-dementia patients. This contributes to Primary Care sustainability in the longer term.
- Meeting the holistic needs of the patient and carer will reduce overall GP consultation time and release capacity back into the practice.
- Practices will have the capability to treat all physical health problems 'through the lens of dementia' and to manage the patients' needs holistically.
- Primary Care staff (and other inter-disciplinary workers) feel equipped and empowered to manage slow declining dementia in the community.
- The system will re-orient from reactive crisis response to planned and proactive care; which will enable practices to re-organise the way they see patients and assist with overall resource management.

Secondary Care benefit

- Secondary Care resources are aligned to the most specialist and complex case-work; with additional capacity aligned to support Primary Care in a timely and responsive way.
- The new Memory Assessment and Management Service will provide a higher quality comprehensive assessment in peoples' own homes, delivering the diagnosis in the best possible way, e.g. in peoples' own homes.
- The multi-disciplinary specialist team will meet twice weekly, to proactively manage and support the most complex cases.
- The system will re-orient from reactive crisis response to proactive care, which will assist with overall resource management.

System benefit
• Primary Care Review and 'Blip' clinics, utilising the 'eyes and ears' of the community and support circle, will maximise opportunities for preventing deterioration and crisis, and thereby reduce admittance to inappropriate care settings. • There will be a wider spread of dementia knowledge and awareness. • Easy accessibility to patient information and ability to share information electronically as part of the integrated team. • Clarity of roles and responsibilities across multi-agencies in the dementia care pathway will prevent patients and carers 'falling through the gaps' and being 'funnelled' through a system of inappropriate and costly care. This should improve patient and carer experience. • Patients, carers, and health and social care professionals know where to go and who to contact when the person with dementia and/or carer gets into difficulty. This heightened awareness will result in a proactive, integrated and timely response from services, which will help to avoid crisis and admittance to inappropriate care settings. • Reduced District General Hospital (DGH) admissions. • Reduced acute dementia bed admissions. • Reduced carer crisis leading to inappropriate admissions to care settings. • Delaying/reducing care home usages (based on standardised national evidence base for earlier intervention). An increase in discharges back to original place of residence. • In year 1 there is a total anticipated system benefit of £74k, rising to £929k in year 2 and £1,452k in year 3. Not all of this benefit is immediately cash releasing.

Governance and Partnership

2.5 Over-sight of implementation of The Dementia Golden Ticket model of care across HWLH is by an Executive Steering Group for Dementia and a Joint SPFT Implementation Steering Group.

2.6 As ambitions to recruit Admiral Nurses (specialist Nurses of Carers of people living with Dementia) progresses, a partnership Steering Group including multiple Agencies, (including the Voluntary Sector), will be developed.

Awards

2.7 The Dementia Golden Ticket model of care has won the following accolades:

- The National Primary Care Awards 2016 - Winners of 'Pathway Innovation of the Year Award'
- National Dementia Care Awards 2016 - Shortlisted in top 5 for 'Outstanding Dementia Care Innovation'
- The Dementia Golden Ticket Pilot won Gold in the SPFT 'Partnership in practice', award for effective partnership working across groups, within an integrated team, with patients and carers, other teams and organisations. It also won Silver in the 'Team' Category.
- The Dementia Golden Ticket won the Health Foundation's Innovation for Improvement Programme Award.

2.8 It was shortlisted in the Primary Care Team category of The BMJ Awards (22 November 2017) and GP Awards (30 November 2017) for Primary Care innovation.

2.9 The Dementia Golden Ticket has been show-cased nationally and internationally, as a model of best practice.

3. Conclusion and reasons for recommendations

3.1 In summary:

1. There has been an extensive re-design of dementia care across the system in HWLH that:
    - focuses on integrated and holistic care (of both the person with dementia and their family carer)
    - shifts care from Secondary Care interventions to pro-active Primary Care management and post-diagnostic support
    - includes a range of psycho-social interventions to help people live as well as possible, for as long as possible with the condition.
2. Successful piloting in one GP practice and a comprehensive business case, secured commitment and resources to roll-out The Dementia Golden Ticket model of care in 'Waves' within a 2 year period.
3. Externally, it has been commended as a model of best practice, winning a number of awards and interest continues to grow about its applicability at scale, including nationally.

3.2 The Board is recommended to note the report and presentation which describes the CCG's co-production of a new model of dementia care and its respective implementation plan across the HWLH area.

Appendix 1

The Dementia Golden Ticket – Full Model of Care