Dementia Business Case

# Dementia Services Transformation Model South East Essex

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# Executive Summary

The full business case makes a case for an enhanced community model that ensures early diagnosis and good post-diagnostic support. A community model is optimally provided with system partners in primary care and is able to respond proactively to those with dementia or suspected dementia and their carers in their own homes and community settings.

There are many reasons why the dementia community offer needs to be transformed. There is an increasing older age population which unfortunately has a direct increase on the numbers of people that will be diagnosed with dementia in the coming years. A diagram on page 16 of the business case outlines this increase and impact visually.

There is an expectation that 85% of people with suspected dementia will be diagnosed within six weeks from April 2021. The post diagnostic support offer will comprise of a fully comprehensive shared care plan, available on S1, for all professionals to view.

As a system we are seeking to drive through changes that put the person and their families at the centre of their care. The premise is wellbeing and living longer, fulfilling lives in the community for as long as possible. We want to manage rising risk take a preventative approach and avoid crisis by deploying resources pro-actively. The desire includes the mobilisation of all the assets at our disposal (within Local Authorities, Health and 3rd Sector) which can be used to engage communities and empower a supportive functionality.

The opportunity to test in the south east arose in November 2018 due to a requirement to reconfigure dementia inpatient beds in order to provide additional mental health beds. A small augmentation to the South Essex Dementia Intensive Support Service (DISS) service, alongside operationalising the proposed integrated model and new ways of working resulted in a significant reduction in admission to dementia beds.

The key to the success of this trial in South East Essex was the implementation of the new ways of integrated working. Those with a diagnosis of dementia go into hospital as a consequence of a range of issues but rarely as a consequence of dementia. It is usually the system around the person with dementia that fails: e.g. an inability to recognise and treat infections appropriately, a break down in care arrangements, inability to recognise environmental triggers or non-recognition of end of life indicators.

Care at home supports the mantainance of independence and function and further maintains significant family and community relationships. Suppoort for carers is central to the community dementia model of care. The model identifies carers support as a system wide responsibility. Support will be reviewed by health, social care and third sector practitioners whenever there are touch points with their services. It is important to emphasise this component of the model.

The options appraisal describes a range of options and the recommends the GOLD option. This option comprises of the following components:

- Care Home including Speech and Language Therapy
- Locality Teams providing dementia diagnostic phasing
- Clinical assessment services
- Single Point of Access
- Dementia Intensive Support Team

## Introduction and Background

The transformation journey began five years ago with the initial consideration of remodelling. i.e. South East Essex Memory Service (SEEMS) model (see appendix I). Essex Partnership University Trust (EPUT) have also committed to transforming dementia community services a diagram of their model can be found on page 20

The model has been developed with clinical and non-clinical colleagues along with consultation and engagement with people living with dementia and those who care for them. Development was undertaken collaboratively with a range of EPUT clinical and professional staff, Southend, ESSEX and Thurrock CCG commissioners, local authority commissioners, third sector and patient carer representatives.

The model was informed by the Five Year Forward View and the integration ambitions of the STP, the Southend, Essex and Thurrock Dementia Strategy and the clinical model for mental health in Essex, the mid and South Essex STP transformation plan. The overarching principles of the model were guided by the NHSE 5 Well Pathway, The Prime Ministers Challenge 2020, NICE Guidance and associated research and guidance documents published by the Department of Health and special interest groups such as the Alzheimer's Society

In November 2018, following discussion of the closure of Maple Ward, Dr Jose Garcia was asked to chair a clinical group to look at; the current offer, what the new wraparound model would need to look like to ensure minimal disruption to the patient and to identify any gaps in knowledge and data

The group membership was broad and included GP's and CCG Clinical Leads, Southend Hospital Geriatricians, Southend Borough Council Commissioners, Multiple professionals from EPUT, Colleagues from Primary Care. (see appendix J for full invite list)

The group met eight times over eight months to understand and support Dementia Community Services address the needs of those patients who would have previously been detained to Maple Ward after the planned closure. The discussion, planning and projects enabled the dementia teams to develop best practice and essential learning by making small changes to the way the current staff and teams work together.

The creation and delivery of a number of test and learn and pilot projects are listed below along with other factors that influenced and help develop the new model and the move to change the way we support those with a concern about their cognitive function and those who care for them.

The numbers of people that will be diagnosed with dementia over the next 5, 10, 20 years will continue to increase and we have been working over the last four years to look to 'future proof' our dementia offer. During this time we have identified gaps, barriers and broken parts of the system.

These include inappropriate care home placements (resulting in higher cost placements; high admission/re-admission to SUHFT; carer breakdown and escalating Continuing Health Care costs,) lack of care home training and support plus the ability for clinical services to access care packages and advise on care packages in the community. An important feature of support and training to the care homes staff has been around swallowing and Dysphagia in people with dementia. This is also a need for those living in their own homes where without a considered plan can result in unnecessary

hospital admissions and consequently someone being discharged from hospital to a care home. Care homes have identified 265 individuals who they believe need a review by the Speech and Language Therapist for swallowing issues. The roles within the new model have been identified to enable a more preventative strengths based approach to be applied to dementia practice.

People with dementia can be described as the most vulnerable in the community and should expect to live well with their diagnosis. We know that as well as a diagnosis other factors contribute to the dementia experience such as social isolation, stigma, depression and anxiety, housing and feeling safe and understood in your surroundings.

This model enables carers and people with dementia to have a better quality of life wherever the live in the community. They should be able to benefit from assets enabling a preventative and inclusive approach that challenges stigma and discrimination. This serves as a reminder of the national dementia statements, such as, 'We have the right to continue the day to day and family life without discrimination or unfair cost to be accepted and included in our communities and not to live in isolation or loneliness'.

This knowledge and understanding of the dementia experience for the person seeking diagnosis and those around them enabled us to develop the Principles of the new model. There can be summarised as:

- Easy access, no wrong door approach to our service, pre, peri, post diagnosis through to end of life. Not only for people with dementia and their carers but for our partners throughout health, social care and the community. This provides seamless care with no visible hand offs to the people we support.
- The service wraps around people living with dementia and their carers, empowering and enabling them to live the life they would like with their diagnosis.
- The service is driven by and directly influenced by the voices, experiences and opinions of people with dementia and their carers
- We pride ourselves on supporting all those involved in a diagnosis and work with both the person and their families to identify rising risk and enhancing positive risk taking rather than reacting to a crisis response. This compliments the strength based approach that we promote as a team.
- Services are responsive, appropriate, integrated with whole locality systems and provide right care, right place and right time interventions and support.
- Provide bespoke training packages which are used to enhance knowledge, skills and understanding in how to support a person with dementia across the systems. E.g. hospital, care home, community, family carers. Support and care wherever possible is provided in the persons home community whatever that home setting may be.
- Where inpatient care is required that is planned, purposeful of optimal length and has clear value to the person admitted.

## Wraparound outcomes

**Listening exercises and consultation as outlined later in this document**.

Attendance at and presenting to **NHS Clinical Network** and acting on **NHS Improvement** recommendations to increase the Dementia Diagnosis Rate and post diagnostic support offer.

**Risk Stratification:** Potential use of the Risk Stratification tool by the Arden and GEM to identify people who have not been to their GP practice for some time but are at risk of being a high frequency user. As such this could be an important tool in supporting us to identify those people with dementia, mild cognitive impairment or a dual diagnosis such as dementia and a learning disability who are at risk of being in crisis. This tool could also support delivery of existing services and the development of PCNs

**Test and learn projects:**

- **Dementia Friendly GP's** - Encouraging GP Practices across Castle Point and Rochford to become Dementia Friendly to support the increase in the Dementia Diagnosis Rate (DDR). This has resulted in 17 out of 23 GP Practices achieving iSPACE accreditation in 12 months.
- **Floating Consultant** funded to explore various primary care and novel diagnostic pathways. E.g. Complex diagnosis in care homes, acute diagnostic work in SUFHT and mild Cognitive Impairment (MCI) review.
- **Dementia Pathways – Scenarios**. Looked at the journey of the five most common reasons most people living with dementia and/or their carers will find themselves in a crisis type situation. The scenarios were, Carer Unwell, Carer unable to cope, Person with dementia has other physical health needs, Behaviour that is seen as challenging and a Person with dementia living in a care home. All are real life situations faced by the Dementia Services staff and the responses given at that time with the addition of what could be achieved with further service developments.
- **Workforce support and medication risks to people with dementia living at home**. Discussion between clinical professionals in the group about medication changes of prescribing professional completing a welfare check or a GP home visit and how this is then acted upon by care agency workers without instruction in the person's care plan. This coincided with concerns raised from a Domiciliary Care Provider that there is an increase in care staff sickness. The result was the creation of the Dementia Friendly Domiciliary Care Toolkit with pathways for staff to follow to support learning and create robust relationships with other professionals. The pathways included Medication, Personal Care and Nutrition & Hydration.
- **EQUIP** – GP Practice Dementia validation Exercise, completing an audit before and after initial changes to establish impact and demonstrated good practice within the service.
- **SystmOne and Clinical tasking**. Ensuring patients go on QOF by using SystmOne. Benefits in terms of DDR and post diagnostic support.
- **DQT** – also identified good practice and allows GP practice to check on outcomes of referrals.
- **MCI – review project**. Historically patients with a diagnosis of MCI were discharged on diagnosis. New model offers psychological support and psycho education and delays further cognitive decline.
- **SPOA**: Team able to assess and access packages social care
- **Care Home MDT** being trailed at Rose Martha Court. Fortnightly meeting with Dementia Nurse Specialist, Speech and Language Therapist, Care Home Manager and Senior Staff member, Social Worker and Adult Social Care Occupational Therapist. The MDT identifies

rising risk, avoiding escalation of safeguarding referrals, maximising staff support and training and increasing resident quality of life.

- **Board Round at Southend Hospital**: Windsor Ward attend on Monday, either Dementia Navigator or DIST. Princess Anne Ward attend daily. Usually a quick discussion about the patients on the ward to ascertain if they are ready for discharge, what care is needed on discharge, equipment and if any referrals need to be completed. Dementia Navigator receives a list of the patients on both wards in the morning from the ward clerk so they can check if they are known to the team and have a diagnosis of dementia. Any referrals for the team are then taken.
- **Hospital MDT –** attend on a Wednesday. Southend and Essex Social workers attend; the ward physio, nurses and doctors attend. The MDT is more in depth discussion of the patients on the ward but do cover the same things.
- **Dementia Care Plan** which includes Mild Cognitive Impairment (MCI) and Frailty and continued roll out across South East Essex
- **Dementia Navigators access to SystmOne.** As part of an integrated service Southend Borough Council Dementia Navigators will have access to and training on the same patient record system as EPUT health colleagues.
- **Outcome Delivery Plans** - Member of the team based in SPOA at Southend-on-Sea Borough Council
- **Family carers** - 6 week family carers training and support in partnership with Improving Access to Psychological Therapy (IAPT).

**The integration between Dementia and Older Adults Community Mental Health Service and the Dementia Community Support Team:**

- Offering bespoke support pre-diagnosis through to end of live for people living with dementia and their carers.
- The use of the same electronic patient record system for both teams to align health and social care and unify patient support.
- Locality hubs and community spaces housing team members.
- Incorporating primary and secondary care along with gatekeeping the Mental Health Wards,

The vision for the south east is underpinned by the Essex Dementia System that has a shared vision for the future where 'people living with dementia are recognised as unique individuals who are actively shaping their lives and their care whilst being able to remain as physically and emotionally healthy for as long as possible.' Key to meeting this vision is integrated and collaborative working across all health, social care and community settings.

## Strategic Context

Dementia is a growing challenge. 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 England it is estimated that around 676,000 people have dementia. In the whole of the UK, the number of people with dementia is estimated at 850,000.

Dementia mainly affects older people, 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.

There are around 540,000 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. Half of them are employed and it's thought that some 66,000 people have already cut their working hours to care for a family member, whilst 50,000 people have left work altogether.

There is a considerable economic cost associated with the disease estimated at £23 billion a year, which is predicted to triple by 2040. This is more than the cost of cancer, heart disease and stroke.

- Dementia is a key priority for both NHS England and the Government. In February 2015 the Prime Minister launched his Challenge on Dementia 2020, which set out to build on the achievements of the Prime Minister's Challenge on Dementia 2012-2015.

It sets out NHS England's aim that by 2020 we are:

- the best country in the world for dementia care and support for individuals with dementia, their carers and families to live; and
- The best place in the world to undertake research into dementia and other neurodegenerative diseases.
- Some of the key aspirations of this vision are:
- Equal access to diagnosis for everyone
- GPs playing a lead role in ensuring coordination and continuity of care for people with dementia
- Every person diagnosed with dementia having meaningful care following their diagnosis
- All NHS staff having received training on dementia appropriate to their role.

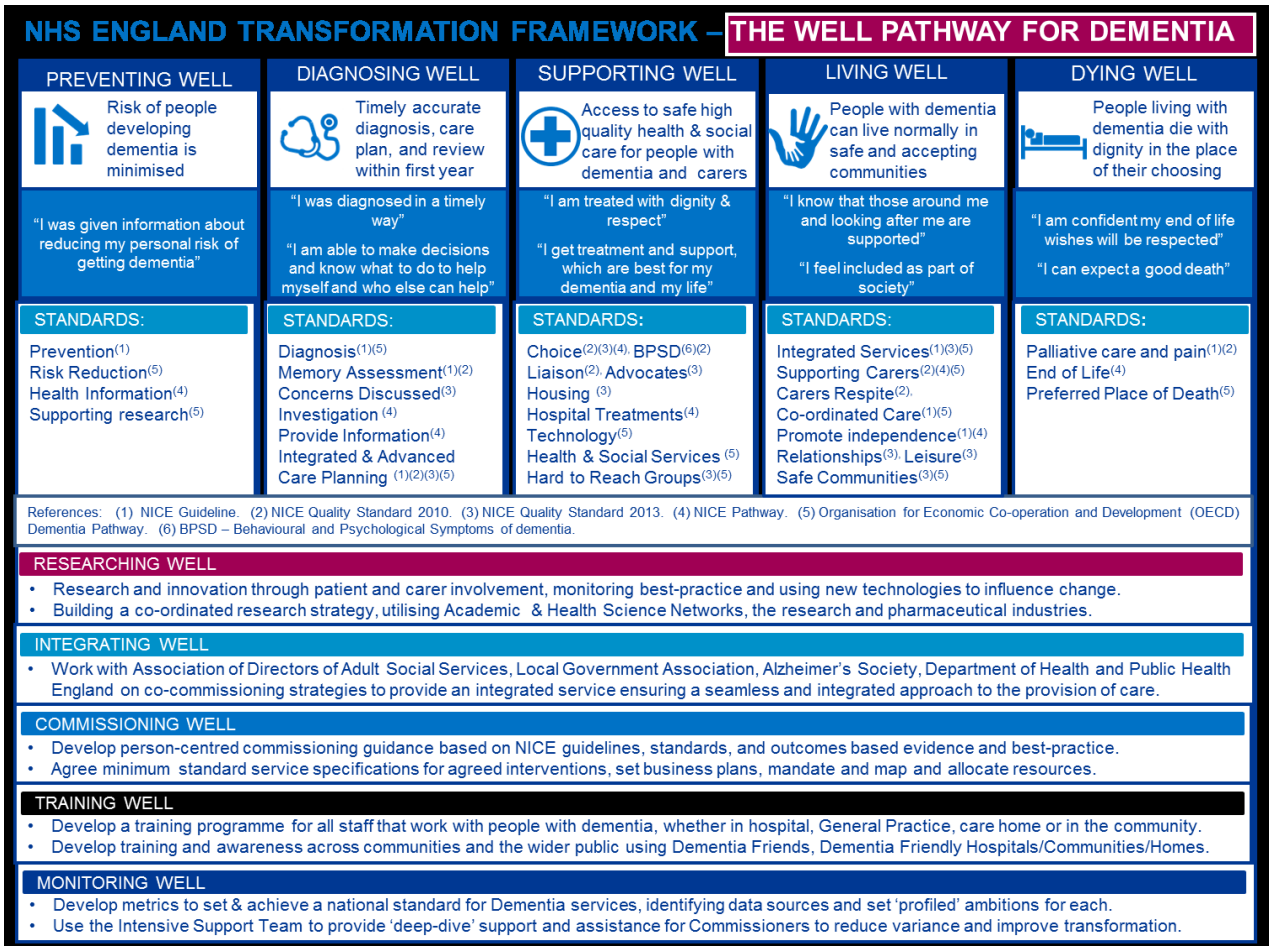
The implementation plan (Prime Minister's Challenge on Dementia 2020 Implementation Plan Implementation Plan Annex 2: Roadmaps to 2020 delivery) outlines how the 50 commitments set out within the challenge will be met, these plans are set out across 4 key themes, risk reduction, health and care, awareness and social action. The implementation plan recognizes that many of these commitments can only be met through the joint efforts of multi-organisations.

**Key deliverables for 2020** are the provision of a 0-6 week referral to diagnosis pathway for 85% of those referred. All those diagnosed will have a care coordinator the majority of which will be provided from primary care community or third sector services. All those with dementia will have a dementia care plan which is reviewed annually. By adopting the new model we think this will be achievable as care planning will be initiated on referral and the new diagnostic phasing will create more options and greater chance of achieving the 0-6 week pathway as suggested in NHSE & NICE guidance.

In 2018 an update on The Prime Minister's Challenge on Dementia 2020 was initiated to review progress against the key commitments, the report on the phase 1 of the review was published in February 2019. Phase 2 of the plan is to be delivered over 2018-2020 and builds on the outcomes of the review.

## Five Well Pathway

NHSE have designed the transformation of dementia care as a "Five Well Pathway" (see below).




This pathway frames the commissioning and delivery intentions for the achievement of the ambitions as set out in the Prime Ministers Challenge.

## NHS Five Year Forward View (October 2014)

The Five Year Forward View states the requirement to distinguish means from ends, so that systems flex in pragmatic ways to support the work that needs doing, that out-of-hospital care needs to become a much larger part of what the NHS does and services need to be integrated around the patient. It states that across England, commissioners and providers across the NHS and local government need to work closely together to improve the health and wellbeing of their local population and make best use of available funding.

As people live longer the NHS needs to adapt to their needs, helping frail and older people stay healthy and independent, avoiding hospital stays where possible. To improve prevention and care for patients, as well as to place the NHS on a more sustainable footing, the NHS Five Year Forward View called for better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and care homes.

## Next Steps Five Year Forward View (March 2017)

This reports that early results from parts of the country that have begun to implement the Five year Forward recommendations are seeing slower growth in emergency hospitalisations and less time spent in hospital compared to the rest of the country. The difference has been particularly

noticeable for people over 75 who often face a revolving door of emergency admission, delayed discharge and then hospital re-admission. These partnerships are described as more than just the 'wiring' behind the scenes, they are a way of bringing together GPs, hospitals, mental health services and social care to keep people healthier for longer and integrate services around the patients who need it most. The partnerships are further described as a forum in which health leaders can plan services that are safer and more effective because they link together hospitals so that staff and expertise are shared between them. At their best, they engage front-line clinicians in all settings to drive the real changes to the way care is delivered that they can see are needed and beneficial and they are vehicles for making the most of each pound of public spending.

## NHS Long Term Plan (January 2019)

NHS 10 year plan www.longtermplan.nhs.uk was published. The plan sets out an NHS model of delivery which builds on the Five year Forward View commitments with the ambition of patients receiving better support, and properly joined-up care at the right time in the optimal care setting. To achieve this ambition the plan sets out the creation of multidisciplinary teams aligned with new primary care networks (PCNs). PCNs are based on neighbouring GP practices that work together typically covering 30-50,000. Implementation of the plan will result in fully integrated community-based health care.

The NHS and partners will move to create Integrated Care Systems everywhere by April 2021, building on the progress already made. ICS's bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. They will have a key role in working with Local Authorities at 'place' level, and through ICSs, commissioners will make shared decisions with providers on population health, service redesign and Long Term Plan implementation.

## The Care Act (2014)

The 6 principles of the Care Act are;

- Empowerment, Protection, Prevention, Proportionality, Partnership and Accountability.

The Act places significant emphasis on prevention through local authorities integrating care and support with other local services, it requires local authorities to carry out their care and support responsibilities with the aim of joining-up the services provided. This general requirement applies to all the local authority's care and support functions for adults with needs for care and support and for carers.

The duty applies where the local authority considers that the integration of services will promote the wellbeing of adults with care and support needs or of carers in its area, contribute to the prevention or delay of the development of needs of people, improve the quality of care and support in the local authority's area, including the outcomes that are achieved for local people.

## Consultation & Engagement

From the 11th to the 22nd March 2019, the Dementia Intensive Support Team (DIST), Dementia Community Support Team (DCST) & Care Coordination undertook consultation and engagement work with the public regarding dementia services that they had received.

In total 22 people with dementia and their carers were consulted.

Of the 22; 10 accessed DAU, 12 accessed A&E and in 3 cases detention was considered.

The Carer's were asked whether anyone had spoken to them to find out about their needs as a carer. 16 said that either DIST, ward staff, the Dementia Navigators or OPCMT had asked about their needs as a carer. The 6 that said they weren't asked had accessed A&E rather than DAU.

14 of the carers said they had been kept up to date with what is happening with the person they care for. The 8 that said they hadn't been kept up to date had accessed A&E rather than DAU.

When asked if they thought there was any overlap between the people involved with the carer or person with dementia, 4 said yes but in a positive way. 15 of the people said there was no overlap and 3 either did not know or said there was no one involved with their care.

The carers that were seen in DAU were asked to comment on their experience. All that attended gave positive feedback which included: "Professional, friendly, caring", "DAU was fantastic, staff very understanding and caring" and "Very pleased. Whole family were able to attend. Nothing was too much trouble"

The carers that were seen in A&E were also asked to comment on their experience. Apart from one comment all gave negative feedback of the experience; "busy and distressing for my mum. No quiet place, too much noise", "horrible, could not understand what was going on, no one spoke to me" and "to make a person with dementia sit in A&E for 5 hours is not right. So stressful for family".

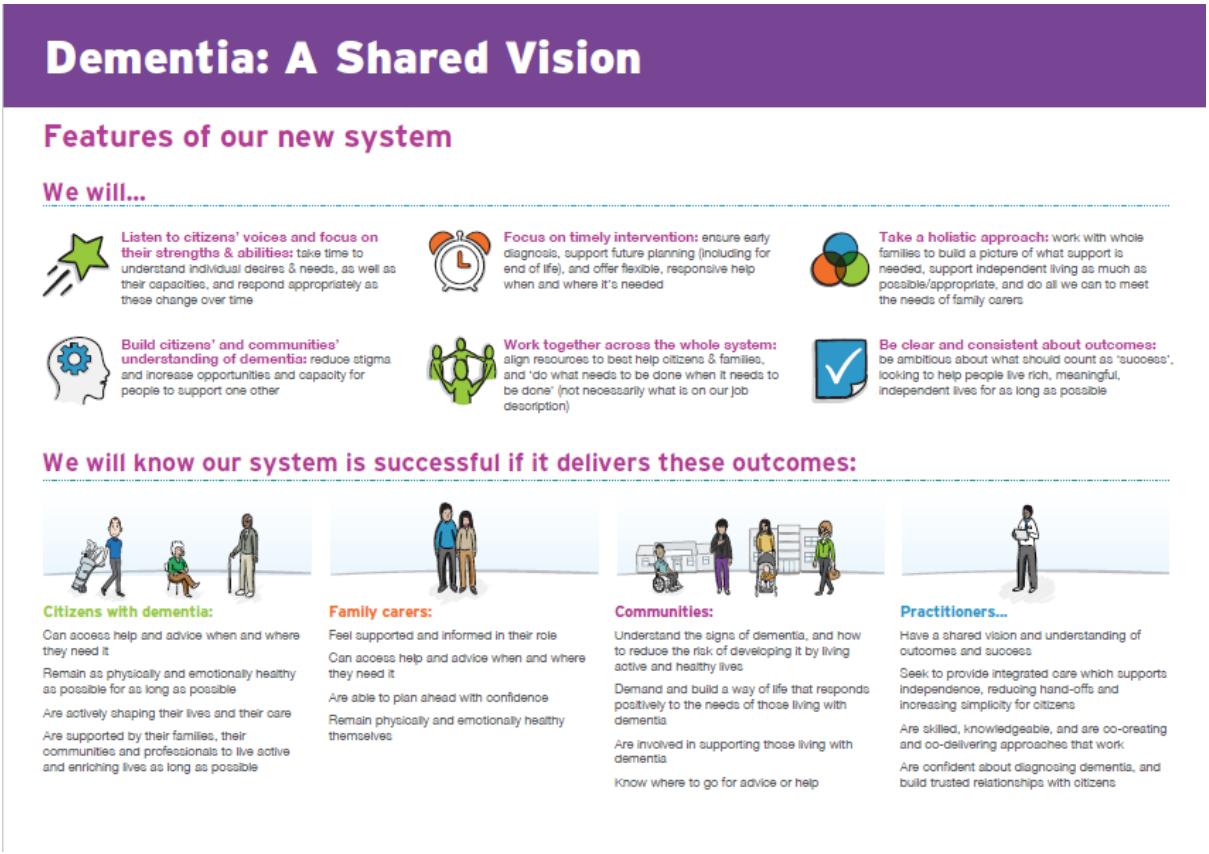
**Consultation:**
Throughout 2016 extensive consultation and engagement was facilitated with people living with dementia, carers, general public, stakeholders and provider organisations, Adult Social Care, Care Homes and Domiciliary Care Providers.

**The following main points came from the consultations**

- Information available and accessible when and how you want and need it
- Having one point of contact from the first sign of possible symptoms through to End of Life care, who will navigate the service pathway and support the person diagnosed and their carer. This same person to be the link and liaison between the person with dementia and health, social care and third sector providers.
- Improved coordination and integration between health and social care services to enable smooth transition through the dementia pathway for patients and carers.
- Being able to take part in community life

The results of the consultations are reflected in the new Dementia Community Model and offers residents of Southend and CP&R holistic support concentrating on wellbeing and living well with dementia.

In 2015 Essex County Council (ECC) carried out an extensive consultation with the Public Office to establish community views and priorities for future dementia support. The diagram below is a summary of the findings. The main report can be found in Appendix C.




*Extract from Essex County Council Public Office Consultation; Rethink Dementia 2015 – a Collaborative Enquiry. Please see Appendix C for full document*

## Local Context

### The Southend, Essex and Thurrock Dementia Strategy 2017-2021

The strategy is for everybody in Southend, Essex and Thurrock, (Greater Essex), who is living with dementia or supporting someone who is. It describes what support for people with dementia will look like in the future. The principles of which are summarized as; intervening early to prevent needs from increasing and help people to continue to live independent lives, building on their strengths and the resources available to them within their personal network and the wider community

For those people who need ongoing support, the aim is to ensure that this support responds to the needs of individuals and supports the wider family network. The Strategy identifies 9 key priorities:

- Prevention
- Finding Information & Advice
- Diagnosis & Support
- Living well with Dementia in the Community
- Supporting Carers
- Reducing the Risk of Crisis
- Living well In Long Term Care
- End of Life
- A Knowledgeable and Skilled Workforce

## Mid and South STP - The STP Plan updated and published in further detail in October 2016

The plan describes the STP vision as "to unite our different health and care services around you and all of your potential needs" with physical, mental health and social care working together. The principles of the plan are based on prevention and early treatment, early response and ease of access to emerging difficulties via a range of access options optimising technological opportunities.


## Integration and Place based Models of Service Delivery

Each of the 5 CCGs within the Mid and South Essex STP are developing or implementing place based, integration models which reflect the STP ambition and accord with the 5 year forward view and NHS 10 year plan. Each CCG area is at varying stages of development of place based integrated services. The NHS 10 year plan has provided a further driver for delivery with the requirement for surgeries to have committed to local Primary care networks (PCNs) by July 2019 (though not compulsory will have financial implication for those surgeries that do not sign-up). The Primary Care Networks of circa 30-50,000 population size will become the key vehicle for delivering many of the commitments in the long-term plan and providing a wider range of services to patients. They will become the footprint around which integrated community-based teams will develop building on exiting hub and neighbourhood configurations. Community and mental health services will be expected to configure their services around these Primary Care Network boundaries. These teams will provide services to people with more complex needs, providing proactive and anticipatory care.

## Southend Essex and Thurrock local Authority Priorities

Adult Social Care models across each local authority embrace the strengths/prevention imperatives of the Social Care Act 2014 and the ambitions of the NHS FYFV and the NHS long term plan. Recognise that current service remains primarily a crisis model of delivery and that a whole-system

approach is required which will require partnership working with communities, locality partner organisations and the private sector to shift resources towards preventative well-being services and community solutions. Each local authority has a range of initiatives to meet these ambitions, examples of which are; Thurrock First which is a single point of contact for Adult Social Care, Health and Mental Health and the initiation of four Integrated Medical Centres across Thurrock. Similar integrations initiatives are underway in both Southend and Essex, with local authority services aligning with locality hubs and the development of a single point of access. In Southend and CPR social care workers have aligned with the rapid response health and dementia services to provide out of hospital options.

### Essex Partnership University Trust Transformation Priorities

The merger of North Essex Partnership Trust (NEP) and South Essex Partnership Trust (SEPT) into the Essex Partnership University Trust (EPUT) in April 2017 brought with it an explicit requirement to transform operational mental health services to deliver both increased effectiveness and outcomes for those using EPUT services and deliver financial efficiencies to the health economy.

The transformation programme which was initiated prior to the merger reflected the Southend Essex and Thurrock Mental Health and Dementia strategic plans and National guidance primarily the FYFV. The vision of EPUT was through transformation to achieve;

"By 2020/21, adult community mental health services will provide timely access to evidence-based, person-centred care, which is focused on recovery and integrated with primary and social care and other sectors…… best utilising workforce by engaging with national initiatives re training upskilling and collaborative working"

The commitment is therefore to develop accessible and responsive services which meet the needs of local populations whilst delivering consistent and highest quality services wherever they are accessed across the Trust, are Primary Care facing, evidence a needs led rather than process led approach to care delivery and work in partnership with all partners to deliver on the ambitions and intentions of local CCGs STP local authorities and National requirements.

## South East Essex Population – Dementia Growth

NOMIS is a service provided by the Office of National Statistics (ONS), and provides the most detailed and up to date UK labour market statistics - for example population figures and economic activity such as employment. The mid-year population is published at the end of June for each year. This figure gives us our population estimates for the UK and breaks down for Local Authorities. The mid-year population figure for Southend-on-Sea in 2017 was 181,800; and this figure has now changed to **182,500** for 2018. Southend has 35 GP practices and works within four localities. In terms of PCN's Southend is split five ways. East and West mirror the locality footprint but East and West Central share a fifth PCN called North Road Plus.

Population for CPR is currently recorded at 182,000 over 27 GP practices spread over four localities. CPR's four PCN's mirror the four localities.

POPPI has recently updated it dementia rate predictions using the most up to date data from the Dementia UK: Update (2014).

The data is extrapolated from a figure produced by the JSNA in 2008, where the diagnosis figure for Essex would rise from 22,300 to 35,500 by 2025.

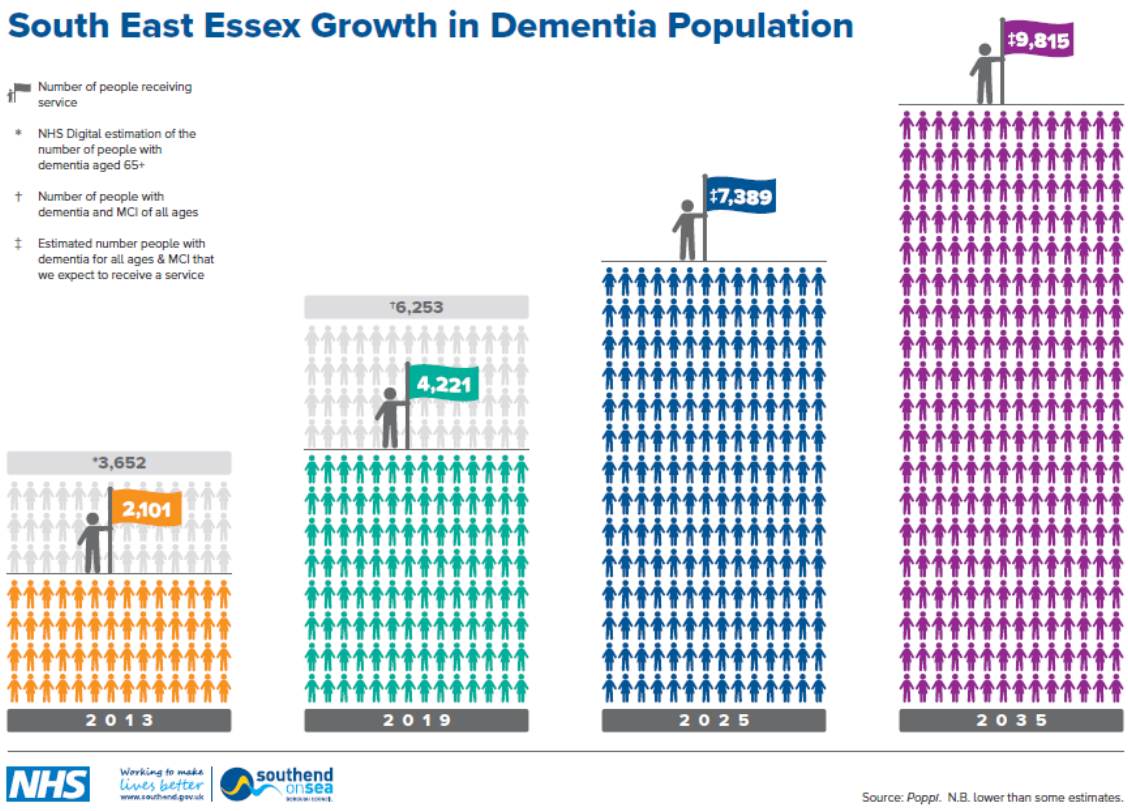
It was recognised at the time that this was substantially lower than Alzheimer Society research, which suggested a figure of 40,750 by 2025 for Essex (14% more than the JSNA estimation).

This 2008 JSNA figure is calculated from POPPI (Projecting Older People Population Information) predictions and uses the MRC CFAS II prevalence figures.

There are a number of published rate estimation percentages and the 2007 Dementia UK prevalence estimates were increased in 2014. Which is contrary to the thinking that prevalence is reducing. These in turn are both lower than those estimated in the World Alzheimer's report for Western Europe.

All of these have higher estimation percentage rates than the Medical research Council (MRC) Cognitive Function and Ageing Study II (CFAS II), which is employed in the National NHS DDR calculation. Therefore this is probably a pretty safe estimation for future planning. The CFAS II estimated percentages appear to be the lowest of any data set.

Population growth from POPPI. Extracting local data for our three LA areas Southend, Castle Point and Rochford, calculated estimated DDR using MRC CFAS II and The World Alzheimer's Report for Western Europe percentages to show the possible level of increase.

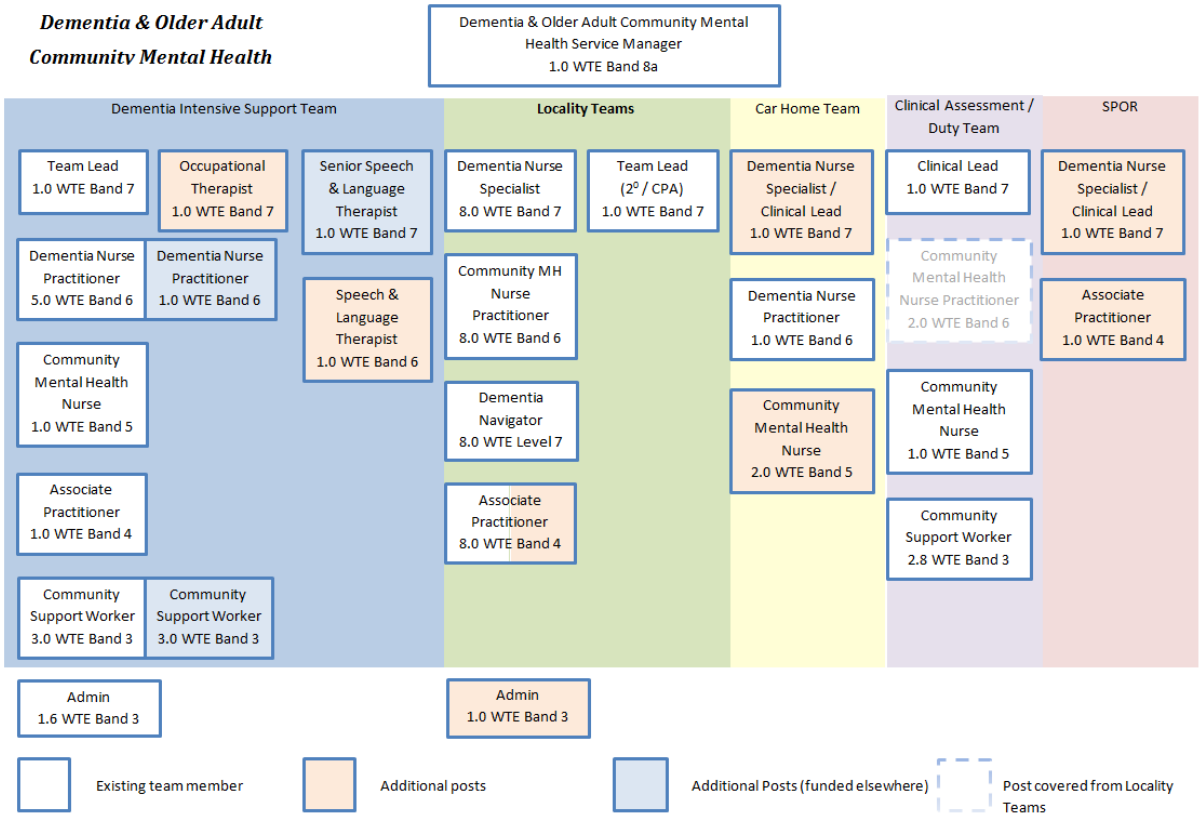



The infographic shows the rise in people with Dementia in South East Essex over the next 15 years. The person standing on top represents the current service. As shown if the number of people with dementia rises as expected the current service will not be able to safely manage and support the number of people required.

The growth numbers indicate that the number of people with dementia is likely to increase up to 4 times the current rate. However, rather than simply quadrupling the staffing numbers the business

case introduces a smarter model with a more diverse range of skilled staff which will enable the service to safely support the increase in demand for the service at a lower cost.

Table below shows the variation of spend on community dementia services across the STP. This does not include any spend on crisis teams. For the South East this is the totality of the health spend




## Dementia Spend £000

| CCG | CPR | SND | BB | THU | MID |
|---|---|---|---|---|---|
| Memory Assessment Service | 714 | 993 | 1,199 | 392 | -* |
| DIST | 192 | 197 | 813 | 397 | 465 |
| Community Dementia Nurses | 129 | 134 | 173 | 105 | -* |
| BCF Dementia Nurses | - | - | - | 114 | - |
| | 1,035 | 1,324 | 2,185 | 1,008 | 465 |

| | | | | | |
|---|---|---|---|---|---|
| **Estimated prevelance** | **2803** | **2420** | **3306** | **1512** | **5021** |

## Dementia Diagnosis Rates (DDR)

All CCG's are required to meet the constitutional target of 66.7% diagnosis rate against the estimated prevalence of those calculated to be living with dementia. Southend continues to reach and exceed the target. The most recent (July 2019) diagnosis rate was 79.4% which meant that a total of 1,922 people with dementia had a diagnosis compared to 2,420 who are thought to be living with the condition.

In Castle Point and Rochford there has been an ongoing struggle to meet the DDR. CPR met DDR in October 2018 and has teetered around the 66.7% mark for approximately 6 months. There was a slight dip in February and then the DDR slipped in May to 65.2% and increased slightly in July 2019 to 65.6%. July statistics portray that out of a possible 2,803 people with dementia 1,839 have a diagnosis.

## Costed MH Delivery Plan

Following the increase in funding to DIST to improve admission avoidance to SUHFT, there was a knock on effect in the usage of the Organic MH bed base in SEE. With occupancy reduced for an extended period to 50% (approximately). This low level of occupancy allowed a transfer of funds to increase the provision of acute adult MH beds in SEE where there were high levels of demand and consolidate Organic MH beds in Meadowview.

To ensure Southend and CP&R patients are not admitted to Meadowview (in Thurrock) an investment has been made in DIST of 1.0 WTE band 6 Nurse and 3.0 WTE band 3 support workers, to support alternatives to admission. In addition 10 beds have been identified in Rawreth Court and Clifton Lodge (5 in each) to support step-down for patients admitted to Meadowview, when assessment is completed, and step-up for short-term enhanced support, while appropriate care-package is arranged. The DIST have developed a strong working relationship with DAU and SWIFT to help support the admission avoidance process.

The investment in urgent response (DIST) is currently able to meet the current need in SEE and have kept admission numbers very low. However, it is noted that between 2019 and 2025 there will be an estimated increase in population of 28% in the 75 to 84 years age group and 17% in the over 84 age group (with a reduction in the 18 to 54 population), with an estimated increase in people with Dementia in the area to a little under 7,000. This figure does not include those diagnosed with dementia who are under 65 years of age or those diagnosed with Mild Cognitive Impairment. It is realised to support this increasing older population and numbers of individuals with Dementia, and those supporting them, an investment in wrap-around integrated community services is required, to avoid an overload of the urgent response teams and the knock on admissions to SUHFT and Organic MH beds.

## Southend's 2050 vision

There is a desire from all partners to invert our existing model of care, for future solutions to be driven by the lived experiences of the public and staff within an area – for they know and appreciate the challenges faced within communities. The desire includes the mobilisation of all the assets at our disposal (within Local Authorities, Health and 3rd Sector) which can be used to engage communities and empower a supportive functionality.

It is the ambition for the system to move from a reactive model of care and enable an improved focus on prevention, self-care, personal responsibility, empowerment and wider community resilience. The model will articulate how support individuals require can be delivered against this backdrop that is person centred, integrated and that provide the best possible outcomes for the individual.

Our shared ambition has five themes; Pride & Joy, Safe & Well, Active & Involved, Opportunity & Prosperity and Connected & Smart.

Each theme has a number of outcomes and dementia services and support are directly influenced by a number of these such as;

Safe & Well:

- We are all effective at protecting and improving the quality of life for the most vulnerable in our community.
- Southenders are remaining well enough to enjoy fulfilling lives, throughout their lives.

Active & Involved:

- The benefits of community connection are evident as more people come together to help, support and spend time with other.
- A range of initiatives help communities come together to enhance their neighbourhood and environment
- More people have active lifestyles and there are significantly fewer people who do not engage in any physical activity

Connected & Smart:

- People have a wider choice of transport options.
- Southend is a leading digital city with world class infrastructure, that enables the whole population

**The Five Year Roadmap timeline to 2023.**

We are already responding to some of the milestones for 2019, such as; ***Increased numbers of active people*** and ***community based social work practice embedded***. We are aligned with localities and Primary Care Networks to help us meet the 2020 milestones ***Localities – integrated health and social care services provided locally*** and are working with colleagues to be integrated with the ***New social care home operational*** and ***More integrated transport provision*** and ***Campaign for a new hospital for Southend.***

**Locality Working - A Place-Based Approach**

In line with national direction there is local move to adopt a place based approach, focusing on the needs of local communities as opposed to the amalgamated needs within traditional organisational boundaries.

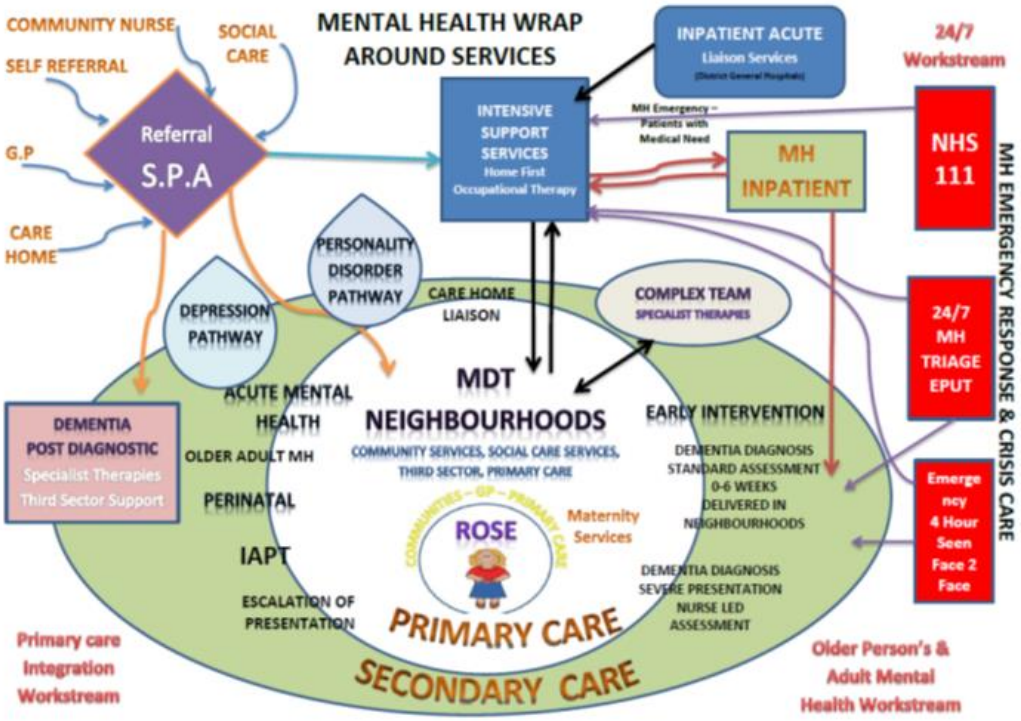
The national agenda of public service reform and the integration of health and social care emphasise the growing requirement for localised responses to the demands and challenges facing health and social care in particular, and the public sector more generally.

This aims to enable people to exercise choice and exert greater control over the types of support needed for better personal health and wellbeing outcomes by engaging partners with the flexibility

and scope for innovation. Place-based approaches may be one way of encouraging this way of working and may help to generate innovative ways to tackle some of these issues.
Place-based working is a grass roots, person-centred, approach used to meet the unique needs of people in one given location by working together to use the best available resources and collaborate to gain local knowledge and insight. By working collaboratively with the people who live and work locally, it aims to build a picture of the system from a local perspective, taking an asset-based approach that seeks to highlight the strengths, capacity and knowledge of all those involved.
Within South East Essex we have identified 8 Localities to work across in terms of a place-based approach, 4 in Southend and 4 across Castle Point and Rochford.

Essex Partnership University Trust (EPUT) have also commited to transforming dementia community services.An infographic of the model canbe found below.

## EPUT transformation drawing and community model.




## Intermediate Care Beds:

There are many different intermediate care beds available across the system as described below. The CCG is going to start a review of all intermediate care beds in order to ascertain the provision that is available across the south east. As it stands there is generally confusion and lack of clarity in terms of purpose, usage and referral pathway to the different resources. At this point it is difficult to say whether any of the facilities listed below could offer a reliable alternative to the ring fenced beds at Clifton and Rawreth.

Intermediate Care units commissioned by the CCG:

| | |
|---|---|
| CICC | 22 |
| Rosedale | 10 |
| Clifton | 35 |
| Rawreth | 35 |
| Uplands | Up to 10 on a spot purchase framework |
| Total | **108 to 118** |

The majority of referrals into the community beds come from Southend Hospital for a variety of reasons, most commonly; Rehabilitation, Community Health Care (CHC) funding, and Discharge to Asses (D2A).

CICC: Primarily a Southend resource. Rehabilitation Beds up to six weeks with a view to discharge to own home or residential placement as an interim or long term.

Rosedale: Primarily an Essex resource. Rehabilitation Beds up to six weeks with a view to discharge to own home or residential placement as an interim or long term.

Clifton: Primarily a health resource. (Southend) Discharge from hospital most likely triggering a CHC assessment.

Rawreth: Primarily a health resource. (Essex) Discharge from hospital most likely triggering a CHC assessment.

Uplands: Primarily a Southend resource. Rehabilitation Beds up to six weeks with a view to discharge to own home or residential placement as an interim or long term.

Southend Borough Council has 20 discharge to assess beds in total:

| | |
|---|---|
| Astral Lodge | 4 |
| Delaware | 8 |
| Priory House | 8 |
| Total | **20** |

Astral Lodge: D2A from hospital, medically fit patients who trigger a Social Care or CHC assessment

Delaware: D2A from hospital, medically fit patients who trigger a Social Care or CHC assessment

Priory: D2A from hospital, medically fit patients who trigger a Social Care or CHC assessment

## Dementia Community Support Team Offer:

The Dementia Community Support team are a unique dementia community team offering bespoke support pre-diagnosis through to end of live for people living with dementia and their carers.

The team is made up of:

- Dementia Navigators
- Dementia Network Coordinator
- Dementia Action Alliance Coordinator
- Peer Support Group Facilitators
- Community Engagement Worker
- Team Manager

The Dementia Community Support Team is part of an integrated service that supports people with dementia and their carers pre, peri and post diagnosis through to end of life.

The service wraps around people living with dementia and their carers, empowering and enabling them to live the life they would like with their diagnosis.

We provide an easy access, no wrong door approach to our service. Not only for people with dementia and their carers but for our partners throughout health, social care and the community. This provides seamless care with no visible hand offs to the people we support.

Our work is driven by and directly influenced by the voices, experiences and opinions of people with dementia and their carers which in turn drives the work streams of our dementia steering group.

We believe that dementia is everybody's business and therefore develop bespoke training packages which we use to enhance knowledge, skills and understanding in how to support a person with dementia across the systems. E.g. hospital, care home, community, family carers.

We are passionate that all environments and services should be dementia friendly and have created dementia friendly toolkits and resources for a variety of settings and services, such as; GP practices, care homes, domiciliary care, sheltered accommodation, dentists and funeral directors.

We pride ourselves on supporting all those involved in a diagnosis and work with both the person and their families to identify rising risk and enhancing positive risk taking rather than reacting to a crisis response. This compliments the strength based approach that we promote as a team.

We offer information, practical advice and support to understand dementia and the day to day challenges it may bring enabling independence, choice and control. Our services offer support and guidance through every step of the dementia experience, including hospital inpatient stays and residential care. We are also the crucial link to all health, social care and community support in our area.

Our aim is to help people living with dementia and those who care for them to live well by promoting health, happiness and wellbeing through a variety of ways such as:

- Promote understanding of dementia and the ways in which people can be affected, through information and education.
- Support community services to include people living with dementia in all aspects of community life by creating better access to social opportunities
- Work with all our community partners to build peer led social opportunities which are age appropriate and reflect individual interests and hobbies.

## Dementia Pathways – Scenarios.

The following scenarios looked at the journey of the five most common reasons most people living with dementia and/or their carers will find themselves in a crisis type situation. (see appendix E for scenarios)

In the table below we have described real life situations faced by the Dementia Services staff and have given examples of the added response and service (in bold) we will provide with the Silver Model and ongoing development of services.

| Scenarios | Model Silver |
|---|---|
| Carer unwell | Ambulance called by Mr A exacerbation of a chest infection. Ambulance came and took Mr A to Hospital ED and left Mrs A at home. The Ambulance service did not know Mrs A's diagnosis of dementia. Daughter alerted by hospital that dad was there and she made her way to the house. Daughter told by neighbour that mum had been seen walking along the street looking for her husband. Daughter did not know mum was home alone. Daughter went looking for mum and found her, brought her home and called DIST. DIST visited, alerted SPOR and an interim care package was implemented for mum to stay at home with regular updates on Fred's care from DIST which reassured her.<br>Mr B suffering acute issues with prostate but was refusing to attend hospital appointments due to leaving his wife who has dementia. SWIFT alerted DIST to concerns and DIST arranged with daughter that she would bring both Mr and Mrs B to DAU for the day to undergo all tests. This worked extremely well for the couple who were always together and reassured the daughter too.<br><br>**Further developments within the service:**<br>• Will ensure the dementia care plan will be available to all to ensure updated info on both patient and carer.<br>• Training and awareness to 999 / 111 services to understand care plan / dementia needs and who to go to.<br>• Tweak the alignment in terms of Social Care packages and speed of the response to requests. |
| **Carer unable to cope** | Mrs C rang GP about mum, saying Mum unable to cope at home, wandering, delusional, and psychotic. GP contacted DIST for a Mental Health Assessment for possible detention. DIST visited immediately. Due to DIST concerns SWIFT visited and took physical health tests. From these results she came into DAU for a treatment plan. Stepped up into a DIST bed at Clifton due to delirium and behaviours. She remained on Clifton for 3 weeks then returned home with a small care package.<br>Daughter of couple is a health professional. Dad has Lewy Body dementia and mum finds it difficult to understand the illness and behaviour. Daughter visited parents and due to the difficulties at home including behaviour and carer stress and breakdown, took dad to A&E with the view to detention. Dad was assessed in A&E as DAU was closed and Dr W assessed him in AMU where EOL was identified. He was eventually was |

| | |
|---|---|
| | admitted to a bed in Rawreth, where he stayed for 2 weeks and was then moved to residential care where he settled and recently died.<br><br>**Further developments within the service:**<br>• DAU being open would have been less stressful for dad and the family and this would have reduced the length of stay in hospital as he would have been assessed quicker.<br>• Ensure departments are better informed of DIST services and build on relationships**.** |
| **PWD -** Physical Health needs | 83 year old Female with Alzheimer's. Husband referred to DIST due to carer stress and felt he could not cope and wanted his wife in hospital. He was presenting with:<br>Rapid acute confusion<br>Behaviour and Systemic symptoms of infection,<br>Agitation,<br>Aggression,<br>Repeat falls / Reduced mobility.<br><br>DIST received referral and completed the initial visit. Assessment of the patient for deterioration of their organic condition completed and support offered to her husband.<br>During visit potential signs of infection noted - Referral to SWIFT made over phone whilst with the husband. SWIFT on request of referring professional attended to the patient. Physical assessment was completed including bloods within 30 minutes.<br>Mr D - PWD brought into hospital and seen by DIST in AMU as family could no longer cope Mr D had severe COPD and cardiac failure. Behaviour became increasingly difficult when feeling physical unwell. Due to DIST knowledge of the patient from community dwelling, they were able to speak to an appropriate care home who they knew would be able to meet the needs of Mr D. Called the care home and arranged for assessment. Was discharged to their care. Negated the need for CHC funding, which was the only option according to AMU.<br><br>**Further developments within the service**:<br>• Parity of services across the 2 boroughs<br>• Access to the Care Plan for all<br>• Education and constant reminders to contact services as early as possible.<br>• Ascertain whether DIST or DCST know the patient in community |
| Behaviour that challenges | PWD Mrs E contacted 999 for ambulance every day. She lived in sheltered accommodation. Sheltered accommodation wanted her to leave, hospital unhappy with repeat attending, DIST did a joint assessment on DAU with Geriatrician. Identified that admissions were cause by her forgetting she had COPD and not taking her AM meds. This resulted in multiple |

| | |
|---|---|
| | attendance from paramedics and A&E. DIST visited at home with signs to instruct her to take her medication and reminding her that she had COPD, which gave reassurance and to only call 99 if her meds were not working,. She has attended A&E once in 9 months following a fall in the street.<br>Care Home over the course of 9 months requested multiple requests for resident Mrs E to be detained due to behaviour supported by ASC. DIST identified it was environment placement issues and following a discussion with the Senior Social Worker over the course of a day at the home observing it was recommended that MRS E was moved to more appropriate care home where she still happily lives privately funded without incident.<br>Mr F was wandering. DIST staff visited and was clearly not engaging with staff. Staff stopped her from getting run over. Staff contacted police to attend for her safety. Contacted manager who alerted 136 suite. Police attended and hospital admitted her Beech Ward overnight and moved into a care home the next day where she has remained without incident.<br><br>**Further developments within the service**:<br>• Quick access to appropriate therapies<br>• Increased access to community beds<br>• Increased Police awareness and training |
| **PWD In care home:** | Toolkit & support from DIST and DCST to enhance understanding and support available including training for Care Home staff. MDT pilot to begin soon in Rose Martha Lodge. Ashley SLT supporting homes with dysphagia. Involving DIST in pre placement discussions.<br><br>**Further developments within the service**:<br>• Able to access the same services in a residential home that you would in your own home.<br>• Reduce inappropriate A&E visits direct from care home environmental issues.<br>• Care Plan for all.<br>• MDT approach for care home placement. |

## Options Appraisal

The tables below outline the options to be considered. The following outcomes, taken from Dementia Action Alliance – National Dementia Declaration have been included in each option where they are deemed to have been appropriately impacted:

Desired outcomes for people with dementia and their carers

The Dementia Statements

'*We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.'*

*'We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.'*

*'We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.'*

*'We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.'*

*'We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia and be supported to take part.'*

<table>
<tr><td colspan="2">OPTIONS</td></tr>
<tr><td colspan="2">Option 1<br>Do Nothing</td></tr>
<tr><td colspan="2">Description:</td></tr>
<tr><td colspan="2">This option would mean that we continue to offer the same existing service.</td></tr>
<tr><td>Benefits:</td><td>Outcomes:</td></tr>
<tr><td>No upfront investment required but lack of community/prevention interventions would mean that other statutory services continue to increase their expenditure due to lack of preventative/community model.</td><td>Positive outcomes would be limited as services become overburdened and resources stretched to beyond capacity.</td></tr>
<tr><td colspan="2">Risks:</td></tr>
<tr><td colspan="2">Increased risk to patients due to lack of post diagnostic support options available for people with dementia and their carers.<br>Lack of quality support due to staff stress and burn out.<br>Increased costs to the system due to the increase in predicted numbers of people predicted to have dementia in the south east over the next X years.<br>More crisis support needed.<br>Increased admissions to SUHFT.<br>Increased CHC spend.<br>Increased residential care packages and social care spend.<br>More detentions under the mental health act.</td></tr>
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<table>
<tr><td>OPTIONS</td></tr>
<tr><td>Option 2:<br>Bronze standard</td></tr>
<tr><td>Description:</td></tr>
<tr><td>Bronze standard is a lower cost higher risk option that offers some increased capacity as per Silver/Silver</td></tr>
</table>

Plus option but is unable to infiltrate the system in a way that more resourced model can. The community support would be more limited and rather than offer preventative and rising risk support across all areas, the system would have to focus on particular areas.

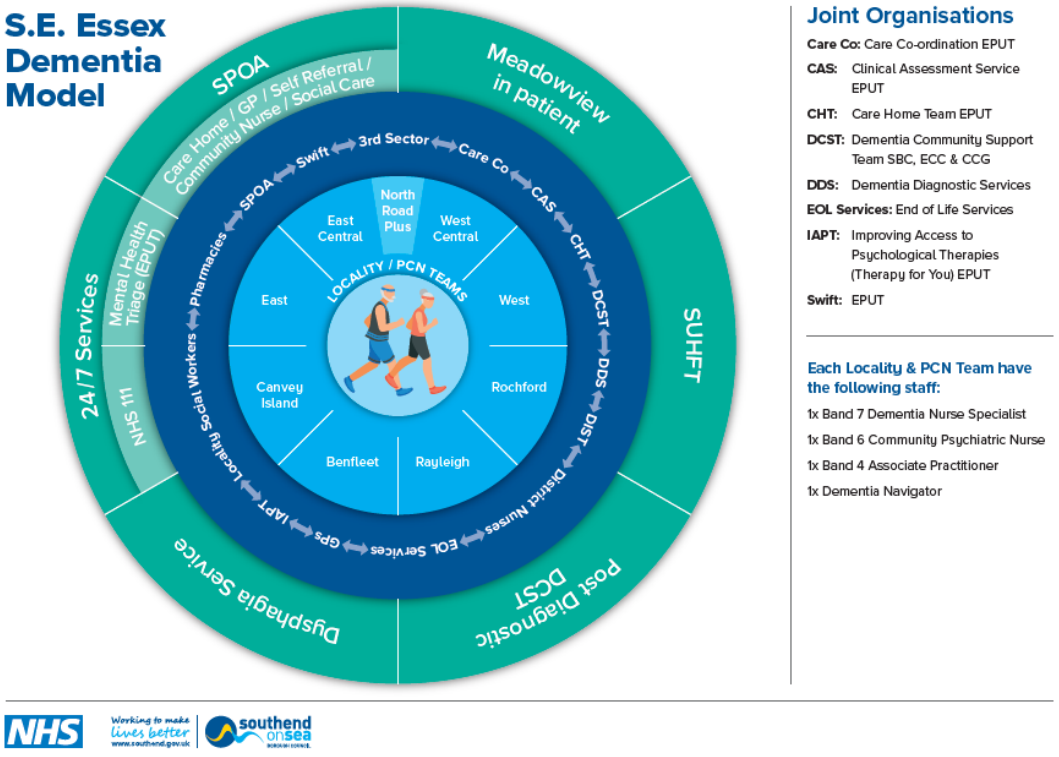
The numbers of people that will be diagnosed with dementia over the next 5, 10, 20 years will continue to increase. Work is being carried out to look to 'future proof' our dementia offer and during this process gaps and barriers/broken parts of the system have been identified.

These include inappropriate care home placements (resulting in higher cost placements; high admission/re-admission to SUHFT; carer breakdown and escalating CHC costs), lack of care home training and support plus ability for clinical services to access care packages and advise on care packages in the community. Swallowing and Dysphagia in people with dementia is also a need within care homes/community; without a plan this can result in unnecessary hospital admissions and consequently someone being discharged from SUHFT into a care home. Care homes have identified 265 individuals who they believe need a review by SLT for swallowing issues. The roles below have been identified to enable a more preventative strengths based approach to be applied to dementia practice.
People with dementia can be described as the most vulnerable in the community and should expect a decent quality of life. The plan to resource the roles below enables carers and people with dementia to have a better quality of life. This is in both their own homes and care homes, and use of community assets enables a preventative and inclusive approach that challenges stigma and discrimination. This also chimes with the national dementia statements, such as, 'We have the right to continue the day to day and family life without discrimination or unfair cost to be accepted and included in our communities and not to live in isolation or loneliness'.
**2 x band 5 Nurses:** can offer training and support to care homes on site which will enable staff to develop their understanding of clients; understand challenging behaviour; less A&E 'dumping' and to support the movement between care homes to enable people worth dementia to have the best and most appropriate care. They can help develop care home multi disciplinary team meetings with their dementia expertise and pick up a diagnosis of Mild Cognitive Impairment (this converts to a dementia diagnose in 1 in 3 cases).
**1 x Band 4 worker or equivalent to have a triage role in SPOA:** to work in SPOA to triage and allocate referrals and offer advice and support to other professionals in SPOA and hubs as needed. This is to avoid people coming to the memory services via multiple routes and being inappropriately referred. With this role all referrals could come through one point and allow them to be appropriately triaged to the right service in a timely manner. Help to act as a gatekeeper to inappropriate placements. These roles can offer a preventative element as they will be able to ensure the best use is made of community assets to support people to remain independent of services for longer.
**1 x band 6 nurse Speech and Language Therapist role:** This role will support the band 7 SLT nurse role due to the high numbers of people both in care homes and community who need support and a swallowing/dysphagia plan to help them to live independently for longer.
**1 x band 7 Dementia Specialist Nurse:** All these roles will require clinical supervision and generate work for community dementia services in terms of increased diagnosis and increased follow up care.

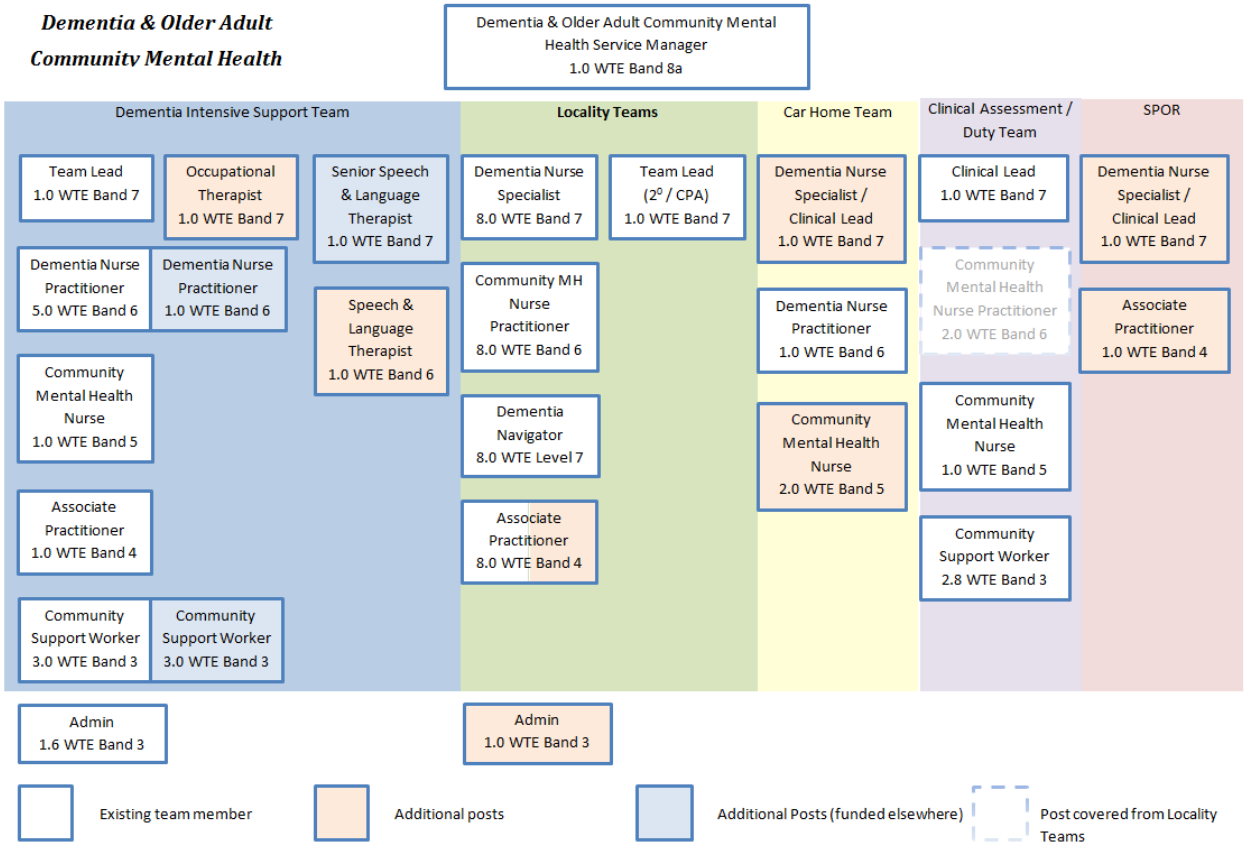
| Benefits: | Outcomes: |
|---|---|
| Lower costs<br>Care home staff training and support increased<br>Support for SPOA to triage and allocate<br>Less hand offs as dementia staff will be located with SPOA<br>Increased support for Speech and Language / Dsyphasia and swallowing problems<br>Identify rising risk to prevent escalating care home costs | ***We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.***<br><br>***We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.*** |

| | |
|---|---|
| Better quality of life for people with dementia and their carers<br>Support to discharge back to own home from hospital setting with a bespoke care plan | ***We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.***<br><br>***We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.*** |
| | |
| Risks: Using the forecasted growth for increasing dementia cases this level of resourcing is not considered to be a sustainable solution and reflects the short term picture | |

| OPTIONS |
|---|
| Option 3<br>Silver Standard |
| Description: |
| Silver standard is about introducing an effective system solution that encourages a preventative offer for people with dementia, their carers and families as well as the capacity to manage rising risk by wrapping the community offer around the person so they are considered as individuals. Based on the principles on page 2. |



## EPUT Staffing structure chart




**Team narrative:**

**Care Home Team including SLT**

A Dementia Nurse Specialist leads the Care Home Team offering expert advice and supports GP's when diagnosing. Registered Nurses can offer training and support to care homes staff on site which will enable development and understanding of their clients; understand and respond appropriately to behaviour that can be challenging and identify rising risk; This will help to reduce A&E visits and support the movement between care homes to enable people with dementia to have the best and most appropriate care. They will help develop care home multi-disciplinary team meetings with their dementia expertise and pick up a diagnosis of Mild Cognitive Impairment (this converts to a dementia diagnose in 1 in 3 cases).

The Speech and Language Therapist supports care home staff with training on Dysphagia and practical help to improve the care for residents who need support and a swallowing/dysphagia plan to help them to live independently for longer.

Locality Dementia Navigators also support the home to achieve dementia friendly accrediatation and continue to support the care home staff with basic dementia training and education around environments and offering peer support for residents families

**Locality Team providing Dementia Diagnostic Pathway**

The Locality Team are aligned with each of the eight localities and nine Primary Care Networks. The locality team are the point of contact for the GP's, Practice staff and patients. All members of the locality team will have access to the same patient record system as GP's and the other services that wraparound the patient, and all will be able to input into and update the dementia care plan. We aspire to work with

PCN's as they develop to explore how they can compliment the dementia locality offer. It is envsiaged both will work closely together.

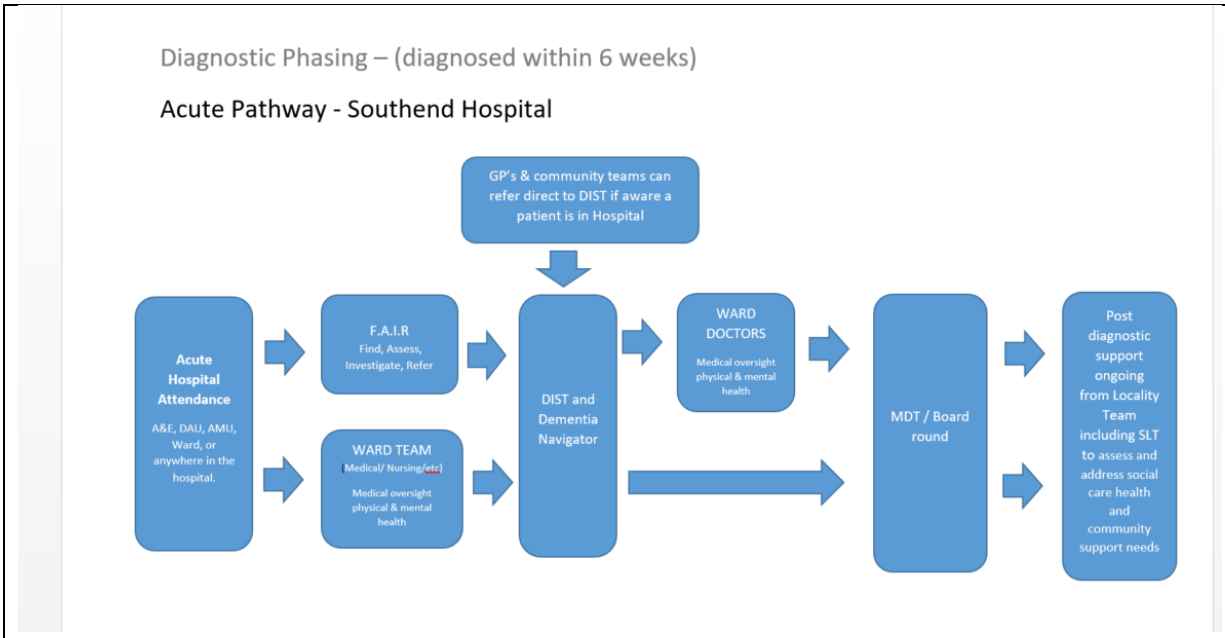
The communication between the integrated services and GP's will be greatly enhanced by the care plan and gives all professionals the opportunity to have the most up to date information on intercations with patients.

On completion of a home assessment the locality team will bring the patient to MDT where further assessments and tests can be undertaken. After this the opportunity to discuss the diagnosis will be offered.

**Clinical Assessment Service**
Offering a specialist assessment service for older adults not previously known to Mental Health services. It is an intermediate service that gives a greater level of clinical expertise in assessing a patient. This expertise ensures that individuals are referred efficiently and effectively into the most appropriate onward care pathway, including consultant lead secondary care services**.**
The service consists of a Mental Health Nurse Practitioner, Community Mental Health nurse and Community Support Workers to support comprehensive assessment and appropriate support in completing actions identified in assessment.

**SPOA**
Staffed with a Dementia (Mental Health) Nurse Specialist and an associate practitioner, this will provide a single access point to community Dementia and older adult mental health services, triaging and passing to the appropriate team/team member. They will also offer advice and support to other professionals in SPOA in providing appropriate MDT responses to referrals.
**DIST**
The Dementia Intensive Support Team work jointly with community health services, mental health, primary care, the acute trust and other agencies (including social services and ambulance services) to reduce unplanned emergency admissions to acute hospitals. The service operates from a community base but link directly with Southend General Hospitals A+E Department, DAU (Day Assessment Unit) and SPOR (Single Point of Referral). The interventions offered by the Service are aimed at managing the crisis that led to the potential need for hospital attendance and enabling people with dementia and their carers to be supported in the community to avoid an unnecessary admission. Should people with dementia be admitted to Southend University Hospital the service will support/facilitate early than usual discharge where able. The Dementia Navigator is also a part of the team, within SUHFT, attending board rounds and ensuring carer / family support is place where requested and onward referrals to the community Dementia Navigators are completed, ensuring a smooth transition between inpatient stay and community residence.

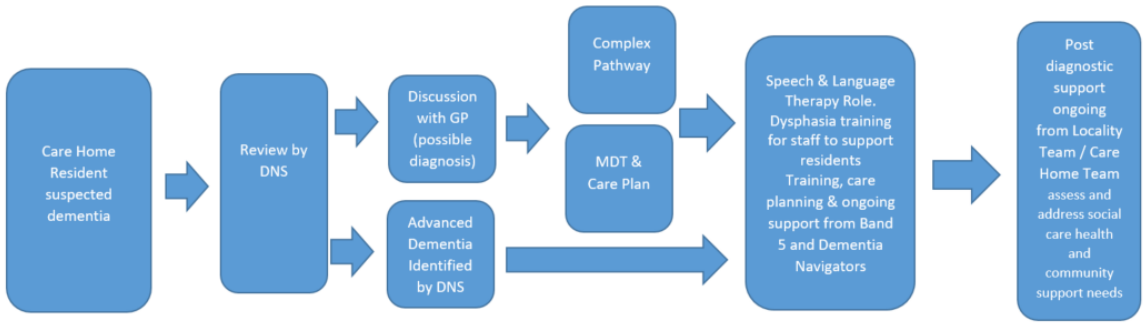
## Diagnostic Phasing




**Completed by DIST staff**
Team Lead
Dementia Nurse Practitioners
Community Mental Health Nurse
Associate Practitioner
Community Support Workers
Dementia Navigator
Admin

The Dementia Intensive Support Team work jointly with community health services, mental health, primary care, the acute trust and other agencies (including social services and ambulance services) to reduce unplanned emergency admissions to acute hospitals. The service operates from a community base but link directly with Southend General Hospitals A+E Department, DAU (Day Assessment Unit) and SPOR (Single Point of Referral). The interventions offered by the Service are aimed at managing the crisis that led to the potential need for hospital attendance and enabling people with dementia and their carers to be supported in the community to avoid an unnecessary admission. Should people with dementia be admitted to Southend University Hospital the service will support/facilitate early than usual discharge where able. The Dementia Navigator is also a part of the team, within SUHFT, attending board rounds and ensuring carer / family support is place where requested and onward referrals to the community Dementia Navigators are completed, ensuring a smooth transition between inpatient stay and community residence.

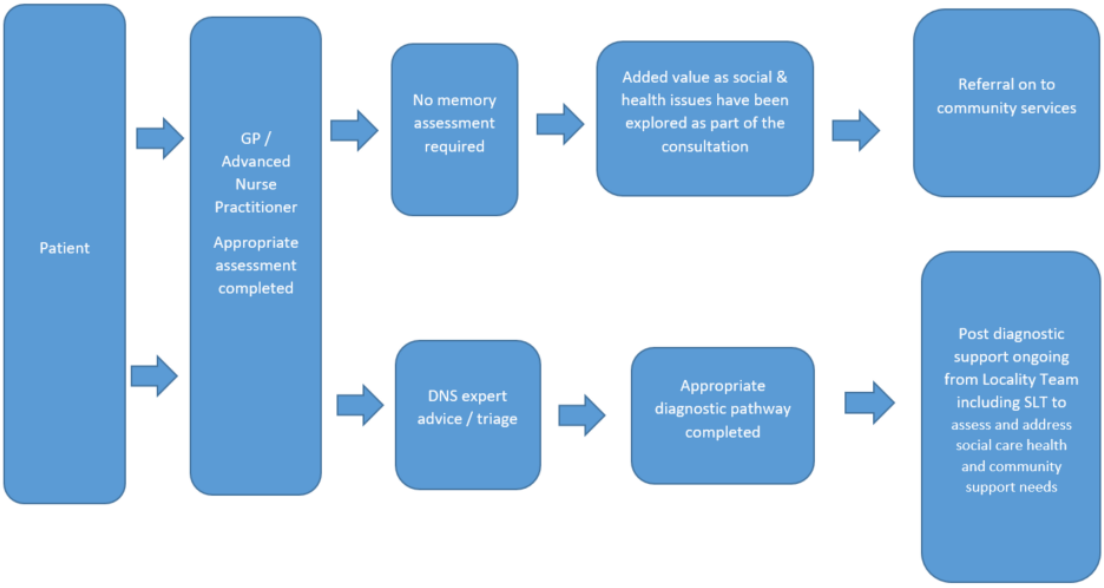
Care Home Pathway (Locality / Care Home Teams)




**Completed by Care Home Team staff**
Dementia Nurse Specialist
Dementia Nurse Practitioner
Community Mental Health Nurses

Dementia Nurse Specialist leads the Care Home Team offering expert advice and supports GP's when diagnosing. Registered Nurses can offer training and support to care homes staff on site which will enable development and understanding of their clients; understand and respond appropriately to behaviour that can be challenging and identify rising risk; This will help to reduce A&E visits and support the movement between care homes to enable people with dementia to have the best and most appropriate care. They can help develop care home multi-disciplinary team meetings with their dementia expertise and pick up a diagnosis of Mild Cognitive Impairment (this converts to a dementia diagnose in 1 in 3 cases).
The Speech and Language Therapist supports care home staff with training on Dysphagia and practical help to improve the care for residents who need support and a swallowing/dysphagia plan to help them to live independently for longer.
Locality Dementia Navigators also support the home to achieve dementia friendly accreditation and continue to support the care home staff with basic dementia training and education around environments and offering peer support for residents families

GP Pathway

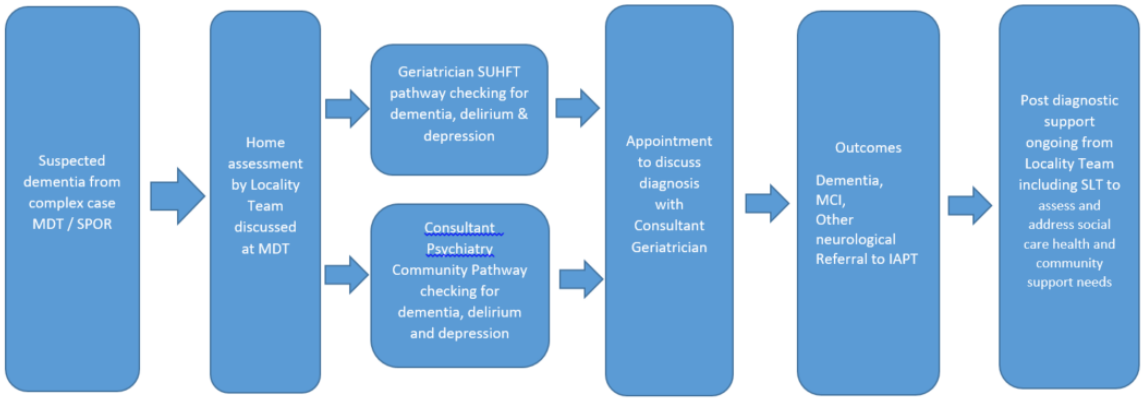


**Completed by Locality Team staff**
Dementia Nurse Specialist (DNS)
Community Mental Health Nurse Practitioner
Dementia Navigator
Associate Practitioner

The locality team are aligned with each of the eight localities and nine Primary Care Networks. The locality team are the point of contact for the GP's, Practice staff and patients. All members of the locality team will have access to the same patient record system as GP's and the other services that wraparound the patient, and all will be able to input into and update the dementia care plan.

The communication between the integrated services and GP's will be greatly enhanced by the care plan and gives all professionals the opportunity to have the most up to date information on interactions with patients.

Complex Dementia Diagnostic Pathway.




**Completed by Locality Team**
Dementia Nurse Specialist
Associate Practitioner
Consultant Psychiatrist / Consultant Geriatrician

On completion of a home assessment the locality team will bring the patient to MDT where further assessments and tests can be undertaken. After this the opportunity to discuss the diagnosis will be offered.

| Benefits: | Outcomes: |
|---|---|
| Better patient outcomes.<br>Resilience building for both the person with dementia and their carer.<br>Expert support available in the person's locality and PCN.<br>Free up primary care resources.<br>Reduction of reliance on social care.<br>Locality working which will better utilise community assets and a strength based approach.<br>Appropriate placements for care homes. | ***We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.***<br><br>***We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or*** |

| | |
|---|---|
| Close working with GPs and PCNs | ***loneliness.***<br><br>***We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.***<br><br>***We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.*** |
| Risks: | |
| Using the forecasted growth for increasing dementia cases this level of resourcing is not considered to be a sustainable solution in the long term.<br>Recruitment<br>Procurement<br>Funding | |
| | |

| OPTIONS | |
|---|---|
| Option 4:<br>Silver Standard Plus | |
| Description: | |
| Silver standard is about introducing an effective system solution that encourages a preventative offer for people with dementia, their carers and families as well as the capacity to manage rising risk by wrapping the community offer around the person so they are considered as individuals. Based on the principles on page 2. The difference between Silver and Silver Plus is that Silver Plus reviews on a yearly basis and adds costs in real terms year on year to account for growth in numbers of people with dementia.<br><br>The transformation model uses team members in support worker, associate practitioner and qualified roles, in bands 3, 4, 5, 6 and 7, allowing a carer pathway and personal development within the service, while still gaining a broad range of experience, across the service functions and will allow support staff to train in service to become registered nurses over time. This 'grow your own' model also increases staff retention and job satisfaction | |
| Benefits: | Outcomes: |
| Better patient outcomes.<br>Resilience building for both the person with dementia and their carer.<br>Expert support available in the person's locality and PCN.<br>Free up primary care resources.<br>Reduction of reliance on social care.<br>Locality working which will better utilise community assets and a strength based approach.<br>Appropriate placements for care homes. | ***We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.***<br><br>***We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.***<br><br>***We have the right to an early and accurate diagnosis,*** |

| | |
|---|---|
| | ***and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.***<br><br>***We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.*** |
| Risks: | |
| Using the forecasted growth for increasing dementia cases this level of resourcing is not considered to be a sustainable solution in the long term although this model is closer to reflecting the short to medium term growth by looking at additional resources required year on year.<br>Close working with GPs and PCNs. | |
| | |

| OPTIONS | |
|---|---|
| Option 5:<br>Gold Standard | |
| Description: | |
| Gold standard offers all that is available in Silver Plus but does takes a longer term view of services by using the Silver Plus short to medium term model but also commits to modelling a longer terms solution once Silver Plus has been in operation for three plus years. The thinking behind this is that this enables the community model to embed and integrate with other parts of the system plus explore cost effective ways to develop an offer for the future. The aim is to offer digital solutions and interventions too which may be in their infancy at this point in time. | |
| Benefits: | Outcomes: |
| Better patient outcomes.<br>Resilience building for both the person with dementia and their carer.<br>Expert support available in the person's locality and PCN.<br>Free up primary care resources.<br>Reduction of reliance on social care.<br>Locality working which will better utilise community assets and a strength based approach...<br>Appropriate placements for care homes.<br>Allows the system to grow and evolve organically to enhance integration and maximise community assets plus the best digital technology. | ***We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.***<br><br>***We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.***<br><br>***We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.***<br><br>***We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and*** |

| | |
|---|---|
| | ***make decisions about the future.*** |
| Risks: | |
| Using the forecasted growth for increasing dementia cases this level of resourcing is not considered to be a sustainable solution in the long term although this model is closer to reflecting the short to medium term growth by looking at additional resources required year on year.<br>Close working with GPs and PCNs.<br>XXXX | |
| | |

## Finance:

Table below shows the financial resource required for each option. A breakdown can be found in Appendix H.

| OPTION WITH COSTS | |
|---|---|
| Option 1 | £0 |
| Option 2 Bronze. 1 x Band 7. 2 x Band 5, 1 x Band 4 | £188,000 |
| Option 3 Silver. | £569, 945 |
| Option 4 Silver + | £569, 945 (plus year on year growth costs) |
| Option 5 Gold | £569, 945 (plus year on year growth costs) and commitment to review long term sustainability once Silver Plus been operational for a few years to look to cost effective longer term solutions. |

## Preferred Option

The preferred option is option 5, Gold because as well as bringing in short to medium term solutions it takes a wider, longer term view that aims to secure person centred community focussed dementia interventions, to people with dementia and their carers, that aligns to both the ageing population and forecast of increased diagnoses. This option will cost £569,945 in 2020/21 and will need the following roles to be funded:

- 2 x Band 7
- 1 x Band 6
- 2 x Band 5
- 5 x Band 4
- 1 x Band 3

The final destination for the business case and cover paper is People Scrutiny on 8 October. Once this approach has been endorsed through both CCG and SBC/ECC Governance during August and September.

## Workforce

The workforce challenges to health and social care are well known, with a 9% vacancy rate across the NHS currently reported by NHS Improvements. In developing the future model of

dementia/older adult community mental health care we have tried to manage a number of workforce challenges.

Without workforce planning being deeply imbedded in the new model the situation would only worsen. The reduction in Organic bed base in itself brings challenges to workforce development as staff progression was traditionally based on a ward to community model. Where post-registration nurses underwent preceptorship and developed the specialist dementia skills needed, then transferring to community with a good grounding in dementia care. In the future this pool will be greatly reduced, with the majority of dementia specialist roles in the community to support care at home away from acute settings both physical and mental health.

The challenge is heightened by the increasing numbers of residents over 65 and a reduction in those of working age in South East Essex over the coming years. Any model without future investment is unsustainable will eventually become overloaded, by new ways of working and upskilling the workforce we have built in a level of sustainability in the model as efficiencies should develop in the system as the model matures and workforce development takes place and is embedded in practice.

The transformation model uses team members in support worker, associate practitioner and qualified roles, in bands 3, 4, 5, 6 and 7, allowing a career pathway and personal development within the service, while still gaining a broad range of experience, across the service functions and will allow support staff to train in service to become registered nurses over time. This 'grow your own' model also increases staff retention and job satisfaction.

By integrated locality working skill-sets can be maximised, but still ensuring the highest quality of care. The service model allows the flexibility to have team members who are mental health and general nurse, looking to have duel competent/qualified nurses.

With further integration, and possible colocation, with non-mental health community services, building on the current work with teams such as SWIFT, Care Co-ordination Team, SUHFT Frailty Team amongst others, team members skills can be maximised with increased opportunity to develop a broad skill base in all practitioners, while maintaining specialist roles.

The nurse specialist in taking the role of the coordinator of care will work with a locality team including a band 6 CPN (secondary care mental health), band 4 Associate Practitioner and Dementia Navigator, with the GP and other community and primary care services in their support of those with dementia and their carers. The specialist nurse would give clinical over-sight, but others would be delegated to complete elements of review, care planning and support according to individual need, clinical indication and individual competence.

By using this model the nurse specialist (a number are non-medical prescribers and we are training more) will free time for the GP by seeing individuals for dementia related issues, hopefully within practices or at home, the associate practitioners will free time from other professionals, including the nurse specialists, GPs and consultants, by undertaking medical and physical health reviews, but having clear access to clinical support and escalation pathways for identified issues.

By using a shared electronic patient record and a shared care plan it is hoped that there will be a significant reduction in duplication and an increase in patient satisfaction (and outcome) by reducing repetition. This single care plan will also support all professionals involved in care as a single point to communicate changing needs, interventions and patient wishes for future care.

With roles also in SPOA, care home support, clinical assessment service, etc. team members in the service can develop a wide range of skills while receiving support from experienced practitioners.

## Recommendations

The recommendation is for Option 5 Gold standard as it takes a longer term view of services. This time will give us the ability to roll out current pilot projects and better understand the needs of our growing population. This will also enable the new community model to embed and integrate with other parts of the system providing high quality support, care and treatment.

## Implementation Plan

| Objective | Milestone |
|---|---|
| Business Case Agreement | October 2019 |
| Transformation oversite group | November 2019 |
| Consultation with Primary Care & other Stakeholders | November 2019 |
| Consultation with staff & Restructure | November 2019 |
| Press release | November 2019 |
| Recruitment | November 2019 |
| Stabilizing posts and use temporary staff while recruitment underway. | January / February 2020 |
| 3all posts recruited to | February – March 2020 |
| New service up and running. | April 2020 |

## Benefits Realisation

| **Desired benefit** | **Stakeholders Impacted** | **Enablers required to realise benefit** | **Outcomes displayed if benefit realised** | **Current Baseline measure** | **Who is responsible?** | **Target date** |
|---|---|---|---|---|---|---|
| Increase dementia Diagnosis | All residents of South East Essex and its health and social care economy. | Public health awareness, Dementia series embedded within primary care, improved electronic referral tools. | More people with dementia have a formal diagnosis and receive appropriate diagnostic tools. | DDR June 2019 Southend 79.4% Castle Point & Rochford 65.6% | Primary Care in collaboration with EPUT dementia services | Both areas to reach and maintain target by September 2019. All areas continue to sustain and |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | improve as o going measure. |
| Increase crisis prevention | All residents of South East Essex and its health and social care economy. | All those with a dementia diagnosis have a comprehensive dementia primary care care plan.<br><br>All Primary Care networks have aligned dementia practitioners who actively participate in dementia and frailty MDTs. | Those with a diagnosis of dementia have their care provided in the community with<br><br>Primary care. | TBC –System data required | Primary Care in collaboration with EPUT dementia services | Increase in recorded number of primary care dementia car plans by January 2020 |
| Increase crisis prevention response for people who live in the community | All residents of South East Essex and its health and social care economy | Full implementation of the community dementia model with associated additional staffing. Formal collaborative working arrangements with health and social care systems partners | Reduced number of in-patient admissions. | In-patient numbers fluctuate current numbers average 3 | Primary Care in collaboration with EPUT dementia services, social care, community and acute services. | Reduction in admissions to benchmarked figure of 20-2 beds by 31.03.2020. |
| Increase the numbers of those with dementia to die in their preferred place of | All those with a dementia diagnosis their carers and the health and social care economy | All those with a diagnosis have shared end of life care plans inclusive of preferred place of care and | Those with dementia to die in their preferred place of death | TBC – Primary Care data | Primary Care in collaboration with EPUT dementia services, social care, community | TBC –<br><br>Primary Care data |

| | | | | | | |
|---|---|---|---|---|---|---|
| death | South East Essex | death | | | and acute services. | |
| Increase the number of carers receiving appropriate support and advice | Carers of those with dementia and the health and social care economy of South East Essex | Increase in the number of recorded carers assessments | Carers receiving appropriate support and advice | Primary care data. | Primary Care in collaboration with EPUT dementia services, social care, community and acute services. | Primary Care recorded carers care plan in line with national target. |

## Risk Log

| Risk | Likelihood | Impact | Mitigation |
|---|---|---|---|
| **Clinical** | | | |
| Model is dependent on collaborative systems working | | | Robust implementation plan with options being developed |
| Recruitment – inadequate staff to deliver the new model | | | Development of a robust workforce recruitment collaborative working with system partners |
| **Financial** | | | |
| CCGs agreement to the investment and savings model | | | CCGs cognisant of the benefits to the whole health economy |
| Cost benefits of investments are not realised | | | Local and National modelling support a robust implementation plan to offset this risk |
| **Quality** | | | |
| Appropriate physical access to Primary Care Settings (GP practices / hubs) | | | Extensive engagement with GPs and pilot projects such as ISPACE and care plan pilot have previously been carried out successfully. Both CCG clinical chairs have endorsed this approach. |

# Appendices

## Appendix A: References

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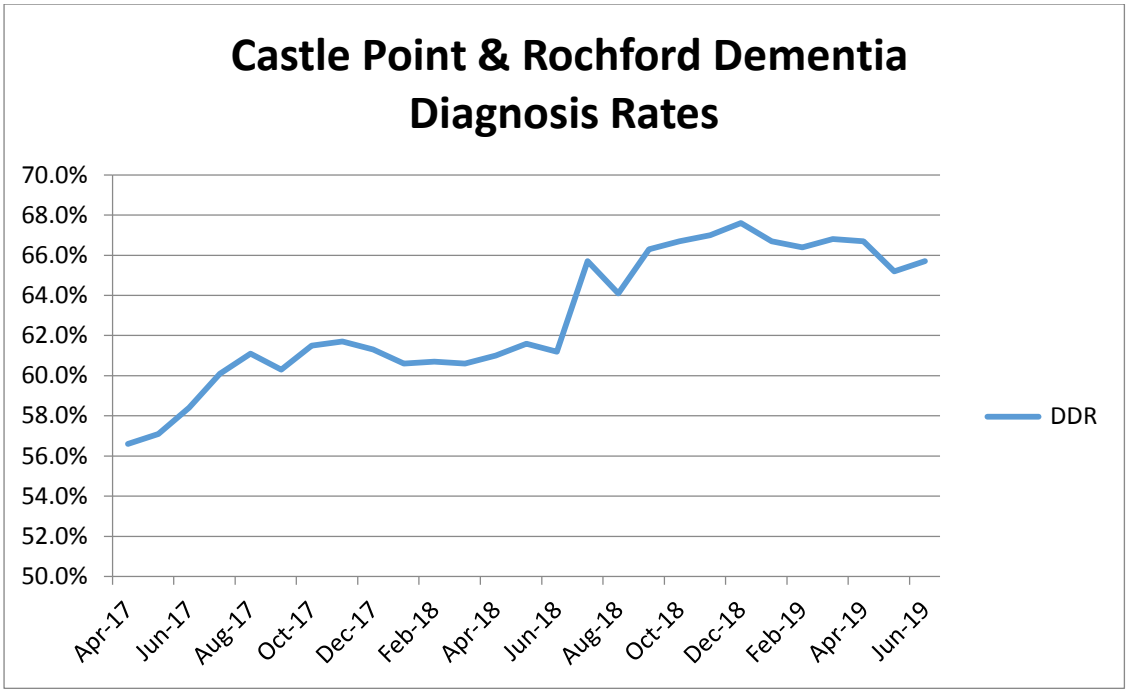
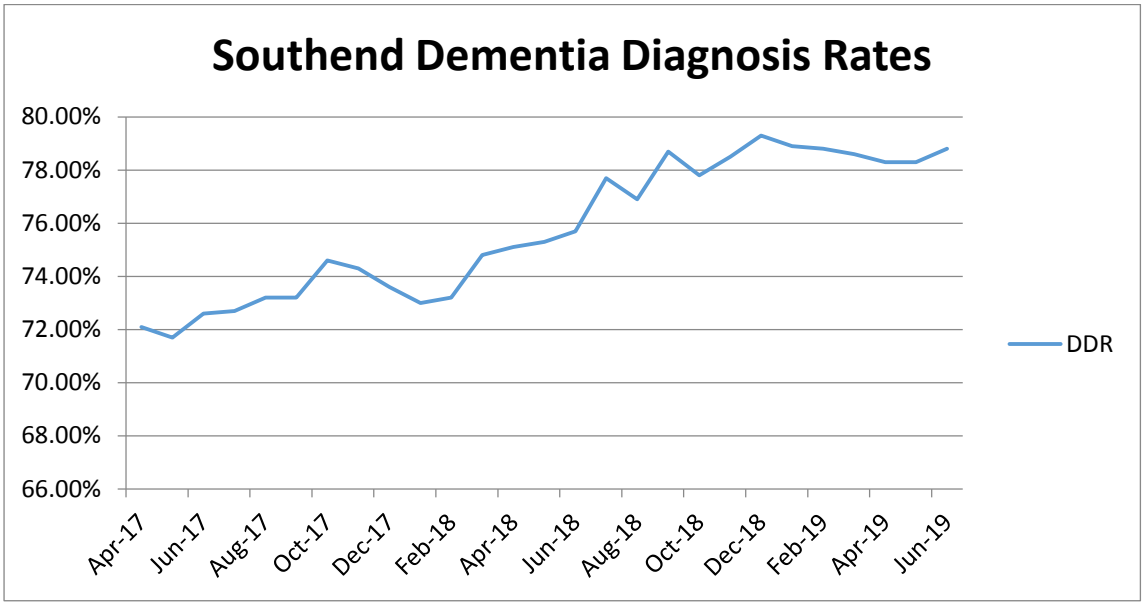
Appendix B: Dementia Diagnosis Rates

| Number of Patients with Dementia aged 65+ | Recorded | Estimated | Diagnosis rate % | Prevalence Rate Gap to meet 66.7% |
|---|---|---|---|---|
| **Jun-18** | | | | |
| Castle Point and Rochford | 1835.0 | 2794.3 | 65.7 | 28.8 |
| Southend CCG | 1902.0 | 2413.1 | 78.8 | |




Appendix C: Essex County Council Public Consultation:

RethinkingDementia_10Jan_FINAL.pdf

Appendix D: Southend 2050 vision and Locality Strategy

Appendix A_Locality Strategy Final.pdf

2050 and TT summary - one sider.p

Southend 2050 roadmap summary.pc

Southend 2050 Five Year Road Map to 202

## Appendix E: Scenarios

Wraparound support scenarios.xlsx

## Appendix F: The Dementia Statements

https://www.dementiaaction.org.uk/nationaldementiadeclaration

## Appendix G: Population growth

POPPI - Predicted To Have Dementia

| **Dementia - Southend** Bottom of Form | **2019** | **2020** | **2021** | **2025** | **2030** | **2035** |
|---|---|---|---|---|---|---|
| People aged 65-69 | 114 | 115 | 115 | 126 | 149 | 155 |
| People aged 70-74 | 268 | 265 | 265 | 244 | 269 | 318 |
| People aged 75-79 | 387 | 410 | 445 | 520 | 478 | 530 |
| People aged 80-84 | 597 | 607 | 607 | 714 | 926 | 852 |
| People aged 85-89 | 678 | 700 | 695 | 772 | 950 | 1,222 |
| People aged 90 and over | 687 | 687 | 687 | 804 | 980 | 1,275 |
| Total | 2,731 | 2,784 | 2,814 | 3,180 | 3,752 | 4,352 |

| Top of Form | **2019** | **2020** | **2021** | **2025** | **2030** | **2035** |
|---|---|---|---|---|---|---|

**Dementia - Rochford**

Bottom of Form

| | | | | | | |
|---|---|---|---|---|---|---|
| People aged 65-69 | 73 | 72 | 71 | 75 | 86 | 88 |
| People aged 70-74 | 183 | 183 | 179 | 153 | 161 | 186 |
| People aged 75-79 | 270 | 286 | 304 | 362 | 311 | 326 |
| People aged 80-84 | 406 | 416 | 416 | 486 | 617 | 547 |
| People aged 85-89 | 378 | 378 | 417 | 478 | 595 | 772 |
| People aged 90 and over | 299 | 327 | 357 | 416 | 564 | 740 |
| Total | 1,609 | 1,662 | 1,744 | 1,970 | 2,334 | 2,659 |

Top of Form

| **Dementia - Castle Point** | **2019** | **2020** | **2021** | **2025** | **2030** | **2035** |
|---|---|---|---|---|---|---|

Bottom of Form

| | | | | | | |
|---|---|---|---|---|---|---|
| People aged 65-69 | 65 | 65 | 64 | 69 | 80 | 81 |
| People aged 70-74 | 156 | 156 | 156 | 137 | 151 | 170 |
| People aged 75-79 | 228 | 240 | 263 | 316 | 275 | 303 |
| People aged 80-84 | 359 | 369 | 356 | 416 | 547 | 486 |
| People aged 85-89 | 356 | 378 | 378 | 439 | 517 | 672 |
| People aged 90 and over | 268 | 299 | 299 | 357 | 474 | 592 |
| Total | 1,432 | 1,507 | 1,516 | 1,734 | 2,044 | 2,304 |
| CP&R Total | 3,041 | 3,169 | 3,260 | 3,704 | 4,378 | 4,963 |
| Grand Total | 5,772 | 5,953 | 6,074 | 6,884 | 8,130 | 9,315 |

## Appendix H: Staff costs

| South East Essex Additional DISS Staffing Model 19/20 - Occupational Therapist | | | | | |
|---|---|---|---|---|---|
| **Pay Cost** | | | | | |
| **Roles** | **Service Description** | **Rota Type** | **Band** | **WTE** | **GBP £** |
| Occupational Therapist | Assessment for equipment in an emergency situation. Provide anxiety management and other urgent responses. | Mon-Fri 9-5 No AL,Sickness,Training cover | 7 | 1.00 | 50,400 |
| **Total Pay Cost** | | | | **1.00** | **50,400** |
| **Non Pay Cost** | | | | | |
| Travel | | | | | 1,400 |
| Mobile Phones | | | | | 450 |
| Training | | | | | 250 |
| Stationery | | | | | 220 |
| Laptops , PC & Connectivity | | | | | 851 |
| Miscellaneous | | | | | 252 |
| **Total Non-Pay** | | | | | **3,423** |
| **Total Pay & Non Pay Cost** | | | | **1.00** | **53,823** |
| Management Overhead | | | | | 5,382 |
| **Grand Total** | | | | | **59,205** |

| South East Essex Additional DISS Staffing Model 19/20 - Associate Practitioner (Triage) | | | | | |
|---|---|---|---|---|---|
| **Pay Cost** | | | | | |
| **Roles** | **Service Description** | **Rota Type** | **Band** | **WTE** | **GBP £** |
| Associate practitioner (Triage) | Integrated role within the Single point of referral supports right time right place referral pathways - improves efficiencies across the | Mon-Fri 9-5 No AL,Sickness,Training cover | 4 | 1.00 | 27,739 |
| **Total Pay Cost** | | | | **1.00** | **27,739** |
| **Non Pay Cost** | | | | | |
| Travel | | | | | 1,400 |
| Mobile Phones | | | | | 450 |
| Training | | | | | 250 |
| Stationery | | | | | 220 |
| Laptops , PC & Connectivity | | | | | 851 |
| Miscellaneous | | | | | 139 |
| **Total Non-Pay** | | | | | **3,310** |
| **Total Pay & Non Pay Cost** | | | | **1.00** | **31,049** |
| Management Overhead | | | | | 3,105 |
| **Grand Total** | | | | | **34,154** |

| South East Essex Additional DISS Staffing Model 19/20 - Dementia Specialist Nurses | | | | | |
|---|---|---|---|---|---|
| **Pay Cost** | | | | | |
| **Role** | **Service Description** | **Rota Type** | **Band** | **WTE** | **GBP £** |
| Dementia Specialist Nurses | To support increase in diagnostic and support pathways and achieving of the 0-6 week pathway | Mon-Fri 9-5 No AL,Sickness,Training cover | 7 | 2.00 | 100,799 |
| **Total Pay Cost** | | | | **2.00** | **100,799** |
| **Non Pay Cost** | | | | | |
| Travel | | | | | 2,800 |
| Mobile Phones | | | | | 900 |
| Training | | | | | 500 |
| Stationery | | | | | 440 |
| Laptops , PC & Connectivity | | | | | 1,702 |
| Miscellaneous | | | | | 504 |
| **Total Non-Pay** | | | | | **6,846** |
| **Total Pay & Non Pay Cost** | | | | **2.00** | **107,645** |
| Management Overhead | | | | | 10,765 |
| **Grand Total** | | | | | **118,410** |

| South East Essex Additional DISS Staffing Model 19/20 - Associate Practitioners | | | | | |
|---|---|---|---|---|---|
| **Pay Cost** | | | | | |
| **Role** | **Service Description** | **Rota Type** | **Band** | **WTE** | **GBP £** |
| Associate practitioners | Align to hubs support primary care in post diagnostic pathway | Mon-Fri 9-5 No AL,Sickness,Training cover | 4 | 4.00 | 110,955 |
| **Total Pay Cost** | | | | **4.00** | **110,955** |
| **Non Pay Cost** | | | | | |
| Travel | | | | | 5,600 |
| Mobile Phones | | | | | 1,800 |
| Training | | | | | 1,000 |
| Stationery | | | | | 880 |
| Laptops , PC & Connectivity | | | | | 3,404 |
| Miscellaneous | | | | | 555 |
| **Total Non-Pay** | | | | | **13,239** |
| **Total Pay & Non Pay Cost** | | | | **4.00** | **124,194** |
| Management Overhead | | | | | 12,419 |
| **Grand Total** | | | | | **136,613** |

| South East Essex Additional DISS Staffing Model 19/20 - Qualified Nurse | | | | | |
|---|---|---|---|---|---|
| **Pay Cost** | | | | | |
| **Role** | **Service Description** | **Rota Type** | **Band** | **WTE** | **GBP £** |
| Qualified Nurse | Provide Care home support/assessment review for non-complex prevent crisis | Mon-Fri 9-5 No AL,Sickness,Training cover | 5 | 2.00 | 67,774 |
| **Total Pay Cost** | | | | **2.00** | **67,774** |
| **Non Pay Cost** | | | | | |
| Travel | | | | | 2,800 |
| Mobile Phones | | | | | 900 |
| Training | | | | | 500 |
| Stationery | | | | | 440 |
| Laptops , PC & Connectivity | | | | | 1,702 |
| Miscellaneous | | | | | 339 |
| **Total Non-Pay** | | | | | **6,681** |
| **Total Pay & Non Pay Cost** | | | | **2.00** | **74,455** |
| Management Overhead | | | | | 7,446 |
| **Grand Total** | | | | | **81,901** |

| South East Essex Additional DISS Staffing Model 19/20 - Speech & Language Therapist | | | | | |
|---|---|---|---|---|---|
| **Pay Cost** | | | | | |
| **Role** | **Service Description** | **Rota Type** | **Band** | **WTE** | **GBP £** |
| Speech and Language Therapist | Support admission avoidance, care home training, support to primart and community care with dementia | Mon-Fri 9-5 No AL,Sickness,Training cover | 7 | 1.00 | 50,400 |
| Speech and Language Therapist | Support admission avoidance, care home training, support to primart and community care with dementia | Mon-Fri 9-5 No AL,Sickness,Training cover | 6 | 1.00 | 42,029 |
| **Total Pay Cost** | | | | **2.00** | **92,429** |
| **Non Pay Cost** | | | | | |
| Travel | | | | | 2,800 |
| Mobile Phones | | | | | 900 |
| Training | | | | | 500 |
| Stationery | | | | | 440 |
| Laptops , PC & Connectivity | | | | | 1,702 |
| Miscellaneous | | | | | 463 |
| **Total Non-Pay** | | | | | **6,805** |
| **Total Pay & Non Pay Cost** | | | | **2.00** | **99,234** |
| Management Overhead | | | | | 9,923 |
| **Grand Total** | | | | | **109,157** |

| South East Essex Additional DISS Staffing Model 19/20 - Admin Staff | | | | | |
|---|---|---|---|---|---|
| **Pay Cost** | | | | | |
| **Roles** | **Service Description** | **Rota Type** | **Band** | **WTE** | **GBP £** |
| PA / Admin | | Mon-Fri 9-5 No AL,Sickness,Training cover | 3 | 1.00 | 24,438 |
| **Total Pay Cost** | | | | **1.00** | **24,438** |
| **Non Pay Cost** | | | | | |
| Travel | | | | | 1,400 |
| Mobile Phones | | | | | 450 |
| Training | | | | | 250 |
| Stationery | | | | | 220 |
| Laptops , PC & Connectivity | | | | | 851 |
| Miscellaneous | | | | | 123 |
| **Total Non-Pay** | | | | | **3,294** |
| **Total Pay & Non Pay Cost** | | | | **1.00** | **27,732** |
| Management Overhead | | | | | 2,773 |
| **Grand Total** | | | | | **30,505** |

## Appendix I: SEEMS Model

SEEMS slides 051118.pptx

## Appendix J: Wraparound meeting attendees

| **Integrated Commissioning** | **(including CP&R and Southend CCG)** |
|---|---|
| Alison Birch | Head of Primary Care Development |
| Emily Francis | Integration Support Officer |
| Jose Garcia | GP/ Southend CCG Chair and Clinical Lead for Mental Health |
| Sunil Gupta | GP / Castle Point & Rochford CCG Chair and Clinical Lead for Dementia (CP&R CCG) |
| Jo Dickinson | Locality Development Manager (Dementia Lead Southend and CP&R CCG) |

| | |
|---|---|
| Hugh Johnston | Associate Director of Integrated Commissioning – Mental Health, Learning Disability and Dementia |
| Nancy Smith | Strategy and Commissioning Officer for Dementia & Dementia Community Support Team Manager |
| Paul Taylor | Associate Director of Integration and partnerships Southend and Castle Point and Rochford CCG |
| Jennifer Speller | Associate Director Primary Care |

**Southend Borough Council**

| | |
|---|---|
| Amanda Blake | Community Development Manager |
| Gemma Czerwinke | Integrated Discharge Manager |
| Jeremy Dorne | SPOA Team Manager |
| Lynn Scott | Head of Adult Social Care |
| Paul Mavin | Head of Service Business Support |
| Sarah Range | Head of Adult Mental Health and principle social worker - Adults |

**Essex County Council**

| | |
|---|---|
| Melanie Williamson | Integration & Partnership Delivery Lead - Essex County Council |
| Lorraine Mott | Dementia Commissioner Essex County Council |

**SUHFT**

| | |
|---|---|
| John Whitear | Associate Specialist in Medicine for the Elderly |
| Lindsay Popham | Dementia Nurse Specialist (Southend University Hospital) |

**EPUT**

| | |
|---|---|
| Flora Baafuo-Awuah | Team Leader, Care Co-ordination Team (Southend) |
| Subbalekshmi Reddy | Consultant in Old Age Psychiatry |
| Juliette Glackin-Fuller | Team Leader, Care Co-ordination Team (CP&R) |
| Rachel Lofthouse | Service Manager Dementia & Frailty |
| Nyssa Paige | Transformation Programme Manager |
| Kevin Mckenny | Deputy Director Integrated Care |
| Amanda Yeates | Matron Intermediate Care and Single Point of Referral Co-ordinator |
| Spencer Dinnage | Dementia & Older People's Community Mental Health (South East Essex) Team Manager |
| Stephanie Rea | Associate Director: Dementia and Older People Services |

**Other**

| | |
|---|---|
| Jacqueline Smith | Dementia Nurse Specialist & Frailty Nurse (Pall Mall Surgery) |

## Appendix K: Equality Impact Assessment

EIA - Dementia Business Case 19.08.

## Appendix L: Quality Impact Assessment:

QIA - Final.xlsx

## Appendix M: Dementia Friendly Toolkits

Care Home Toolkit.docx

Dementia Friendly Primary Care Practice

Dom Care F&F Flow Chart.docx

Dom Care P.Care Flow Chart.docx

Domiciliary Care Toolkit.docx

## Appendix N: Dementia Care Plan

Care Plan - SystmOne