A Proposed New System for Health and Social Services

Integrated Community Services: People Living with Dementia

Scheme-level Outline Business Case (OBC)

Version 2.0

13 June 2012

This document

Purpose of the Outline Business Case

The Green Paper, *'Caring for each other, caring for ourselves'*, was produced in May 2011. Following public consultation, eight service areas were selected for early service development in 2012 – 2015. Sustaining Acute Services was identified as being 'Business As Usual', and was removed from the OBC list, therefore, seven OBCs have been produced.

Each proposed service change has been developed robustly, with full involvement from stakeholders. Working groups have used an Outline Business Case (OBC) template when discussing and developing the service changes, in order to ensure that all relevant aspects have been considered. The template incorporates guidelines from the UK Government's website on Business Cases as well as the template on the Treasury & Resources website.

Once approved, each OBC will be progressed to Full Business Case (FBC) – this is anticipated to be by Autumn 2012. The FBC will provide detail on the service change, including detailed timescales and action plans for implementation. Service implementation commences once the FBC has been approved and fund secured from the Medium Term Financial Plan, which is due to be agreed in late Autumn 2012.

Structure of this document

This Outline Business Case presents the elements of service change that must be considered in order for plans to be robust, stakeholders to be fully engaged, and risks to be managed effectively.
The case for change for integrated dementia services is presented, building from the case for change in the Green Paper. The linkage with the HSSD strategic principles and with the relevant services' strategies is clearly identified. The outcome of the Green Paper consultation, and in particular the views of stakeholders received during the consultation period have been presented where applicable, in recognition of the importance of these views.

The OBC then outlines the proposed service change, and the elements thereof, for example, the impact on workforce, on costs and on service delivery / quality.

Indicative costs and benefits are outlined. Some rounding adjustments have been made. All costs are presented at prices relevant to the each year, to ensure that the full cost of the proposals is understood. Costs and benefits which are quantitative and qualitative, short and long term and relevant to patients / service users / carers / families, clinicians and the public have been considered.

Implementation considerations are then presented, including stakeholder engagement and communication, key risks and issues for both the implementation period and for the full service delivery.

Revision history

Version	Date	Author	Description
0.01	01.11.11	KPMG	Template
0.02	30.11.11	KPMG	Generic updates
0.03	21.03.12	Ian Dyer	Final draft
1.0	14.04.12	Rachel Williams	Final review and revision
1.1	12.06.12	Ian Dyer	Final review and SRO review
2.0	13.06.12	Rachel Williams	Finalisation

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Abbreviations and Definitions

Abbreviation	Definition
FBC	Full Business Case
HSSD	Health And Social Services Department
MAS	Memory Assessment Service
MTFP	Medium Term Financial Plan
NDS	National Dementia Strategy
OBC	Outline Business Case

1 Executive Summary

1.1 Introduction and background

In common with jurisdictions and countries across the world, Jersey faces substantial current challenges in ensuring the availability of high quality health and social care for its citizens within a financially affordable sum. The KPMG technical document and the Green Paper, both published in May 2011, demonstrated that health and social care services in Jersey are at a crossroads. Existing capacity is due to be exceeded in some services in the near future, the elderly population is rising disproportionately and almost 60% of the medical workforce is due to retire in the next 10 years.

In early 2011 the vision for health and social care in Jersey was agreed. This clearly stated that services must be safe, sustainable and affordable.

The public consultation on the future of health and social services in Jersey concluded on 22 August 2011. Since that time, a Working Group has been considering the service changes that are required urgently; this Outline Business Case is a result of that process.

1.2 Strategic Context

In 2009 the Department of Health in England published the National Dementia Strategy (NDS), *Living Well With Dementia*[1] which identified 12 recommendations to improve the lives of those living with dementia and their carers:

- Increased public and professional awareness of dementia
- An informed and effective workforce for people with dementia.
- Good quality early diagnosis and intervention for all
- Good quality information for those with dementia and their carers
- Continuity of support and advice
- Improved quality of care in general hospitals
- Improved home care for people with dementia
- Improved short breaks for people with dementia and their family carers.
- A joint commissioning strategy for dementia
- Intermediate care for people with dementia
- Improved dementia care in care homes
- Improved registration and inspection of care homes

All of these recommendations are either incorporated within this OBC or being already progressed.

The States of Jersey Strategic Plan 2009 – 2014[2] identifies the need to provide for the ageing population and to meet the needs of older people flexibly to enable them to live in their community for as long as possible. This OBC uses local and national strategy to help identify the most appropriate ways of providing community services for people living with dementia.

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[1] Living well with dementia: a National Dementia Strategy. Department of Health 2009

[2] States of Jersey Strategic Plan 2009 – 2014, Working together to meet the needs of the community 2009

1.3 The Case for Change

"Dementia" is a term used for progressive, terminal organic brain diseases, including Alzheimer's disease (the most common cause). Symptoms of dementia can include memory loss and the gradual loss of ability to perform all tasks of daily living.

Dementia predominantly affects people aged over 65. The prevalence for over 65's is 1.6%[3]; this increases to 21.2% for people over the age of 85. Accordingly, it is estimated that approximately 1,246 individuals in Jersey may have had moderate to severe dementia in 2010, but only just over 800 were known to the memory clinic. It is also estimated that within Jersey's population about 65 individuals aged 30 – 64 will have a moderate to severe dementia.

In addition to medical costs, the societal cost of dementia is enormous as many people with dementia require round-the-clock care.

There is increasing evidence of the service impact of dementia. A recent study[4] in the US revealed that hospitalisation rates were 41% higher for patients with dementia, and the Alzheimer's Research Trust suggests that dementia costs the UK twice as much as cancer, three times as much as heart disease and four times as much as stroke.

Because Jersey's population is ageing exponentially, there is an estimated projected increase in moderate and severe dementia of 38% by 2020 (to 1,716 people), with a 64% increase by 2025 (2,040 people) and a 154% increase by 2040 (3,167people)[5].

1.4 Service Objectives for Integrated Community Services for People Living with Dementia

The proposed service will deliver quality services for all people living with dementia on Jersey, irrespective of age or disability. It is based on three service principles:

- Proactively identifying people living with dementia, supporting independence and wellbeing to enable individuals to live in their own homes for as long as possible, thereby reducing admissions to acute care and placements in care homes
- Supporting the greatest "assets" for a person living with dementia (their carers and their family)
- Developing a person centered approach to care, with integrated services.

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[3] Alzheimer's Research UK, Dementia Statistics 2012 www.alzheimersresearchuk.org/dementia-statistics

[4] Association of Incident Dementia With Hospitalizations, Elizabeth A. Phelan, MD, MS; Soo Borson, MD; Louis Grothaus, MS; Steven Balch, MA; Eric B. Larson, MD, MPH JAMA. 2012;307(2):165-172.

[5] This estimate is based on the relationship between the statistical data taken from the Jersey Population Model 2009 (www.gov.je/Government/Pages/States/Reports) and Prevalence of dementia, European Collaboration on Dementia 2009 (www.alzheimer-europe.org/index.php/EN/Research/European-Collaboration-on-Dementia)

1.5 The Dementia Service by 2015

Dementia services will deliver person-centered care through a community-based multi-disciplinary team. The key service elements are:

- **Awareness and information** – developing an 'Active Ageing and Wellbeing Centre', which provides one point of access for information, support and advice.
- **Early Diagnosis** – to ensure people receive the right support, at the right time, in the right place, thereby reducing the need for crisis intervention.
- **Carers support** – providing support, information, advice and training to carers to enable the carer to continue in their caring role, in order to reduce the need for high cost formal health and social services support.
- **Psychiatric liaison service** - providing support to staff in the acute hospital and residential homes in dementia care to shorten length of stay in hospitals reduce admissions to acute hospital from residential homes
- **Enhanced community services** - increasing the supply of domiciliary care and developing specialised home care services for people with dementia. This will involve an increased use of 'Assistive Technology' such as telehealth and telecare.

Benefits include:

- Simplicity and clarity - a single point of access to services for older people
- Reduced duplication of services and increases integration and joint working
- Increased Third Sector, Parish and volunteer support
- Increased support to carers, including respite care, information and advice
- Assistance to regain lost skills and abilities, maximising the potential for individuals to live in their own homes as long as possible, promoting independence and dignity
- Sustained inclusion and wellbeing
- Improved proactive management and care
- Reduced acute admissions and length of stay in hospital
- Delayed admission to care homes and reduced breakdown of care in care homes

1.5.1 The Financial Case

The recurrent revenue cost for this OBC by 2015 (at 2015 prices) is £2.4m. Implementation costs total £131,000 over the period 2013-2015.

The service will require an additional 35 FTE, of which 28 will be recruited by 2015 with a further 7 in 2016 -2017.

The cost of overall investment is offset by an estimated annual cost containment of £1.9m (by 2015), which comprises (by Q2, 2015):

- an estimated reduction in bed days at the general hospital of 1,000 by the end of 2015 (the equivalent of releasing 3 General Hospital beds net p.a.)
- an estimated reduction in dementia assessment bed days of 1,000 (3 dementia assessment beds p. a.)
- a 3 month delay in residential care for 100 people (£600,000 pa)

The inherent risk of increasing capacity and costs within the community services but not achieving the level of intended disinvestments from the acute hospital and dementia assessment beds will be mitigated by:

- Identifying intended benefits carefully

- Monitoring the community dementia service and working collaboratively to ensure that maximum efficiency is achieved delivering a value for money service
- Monitoring the success of the service closely
- Making staged investments once the expected benefits are being realised.

1.5.2 Implementation Actions and Timescales

The new dementia service will be introduced in the period from 2013. It will be fully operational by 2015:

	2012				2013				2014				2015			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Awareness raising campaign																
Co-ordinate information sources																
Develop processes for integrated assessment and care planning																
Develop integrated community team (joint between physical and mental health)																
Review existing services (including memory assessment and community team)																
Introduce case finding, Parish support and link professionals																
Introduce an Active Ageing and Wellbeing Centre																
Enhance treatment, including psychology, and carers assessment and support																
Introduce care co-ordination																

Develop GP service, including dementia register																
Introduce carers support and respite																
Introduce individualised support, including assistive technology, additional equipment, support to carers.																
Improve Liaison Psychiatry to acute and care homes																

1.6 Stakeholders, risks, issues, dependencies and enablers

1.6.1 Stakeholders

The OBC was produced by a Working Group comprising Third Sector partners, including Alzheimer's Association, Carers Support and Age Concern, Family Nursing and Home Care, Care Homes (Parishes), a General Practitioner, existing H&SS providers (Consultant Psychiatrist Old Age, Community Mental Health Team, Psychology) and HSSD Human Resources and Finance.

Stakeholders to be engaged as the OBC develops into an FBC include Regulations and Inspections Team, Ministers, St John's Ambulance, General Practitioners, Private sector providers, Parishes and Acute services.

1.6.2 Risks and Issues

- Unrealistic expectation from service users, communities and professionals
- Recruitment and retention of appropriate staff
- Ageing workforce / retirement
- Risk averse service
- GP funding
- Accommodation availability for enhanced team
- Affordable location for the Active Ageing and Wellbeing Centre
- Operating an integrated I.T system, including upgrading FACE
- Development of community housing for people living with dementia

1.6.3 Dependencies

The new dementia service is supported by legislation, including Mental Health Law and Mental Capacity Law which (incorporating Curatorship), by changes in practice including nurse prescribing and by the sustainability of a range of providers through the Approved Providers List and Long Term Care Benefit.

1.6.4 Enablers

The development of dementia services will also require workforce development, as new ways of working will be required, both in terms of skills, locations and care delivery. IT and informatics will be critical to the service's success, as these will support multidisciplinary community working, support individuals in their own homes and provide visibility of outcomes, activity and benefits

1.7 Next steps

- Work with Primary Care Body to establish a referral pathway that provides a single point of entry for those needing assessment
- Develop detailed service impacts, ensuring the investment in community dementia services will reduce the numbers of people being cared for in institutional settings
- Develop an Older People's Strategy, incorporating this OBC, which identifies the direction of travel for the services over the next 10 years, including residential and nursing need
- Understand the impact of the Long Term Care Benefit
- Introduce FACE across the service and work with Social Security Department to review the Resource Allocation System within FACE as a potential tool to allocate long term care funding.
- Work with Jersey Property Holdings to scope the estate needs, and incorporate into capital bids
- Complete the Full Business Case, including developing detailed service design.

2 Introduction and background

2.1 A Global challenge

Every health and social care system is experiencing similar challenges:

- Demographic change is dramatically increasing demand on all health and social care systems.
- Technological advances are allowing efficiency and quality improvements but also creating major new costs.
- Societal change is altering the relationship between services and service users, professionals and the public and between the state and individuals.
- Increasing regulation in health and social care is increasing quality but also reducing freedom to act atypically.
- Service ethos is shifting from treatment to prevention and promoting independence.

Health, social care and Third Sector partners and multi-agency teams need to work closely with one another and with patients, service users and carers to provide tools and evidence-based services aimed at managing demand, promoting health and wellbeing, ensuring equality of access and protecting / safeguarding vulnerable people. Our aspiration is to enable people to be cared for in the most appropriate place, living as productive and independent lives as possible.

2.2 The Challenge for Health and Social Care in Jersey

Jersey is experiencing many of the same challenges as all other health and social care systems internationally, but it also has some unique challenges.

A small island

In normal circumstances our population of just under 100,000 would be considered too small to support comprehensive acute hospital services and very specialist social care services – this would normally be provided for a population of over 250,000. However, geographical isolation and infrequent but material travel difficulties mean that providing a significant level of acute and emergency services locally is essential, and that it is desirable to provide local care packages for people with complex needs.

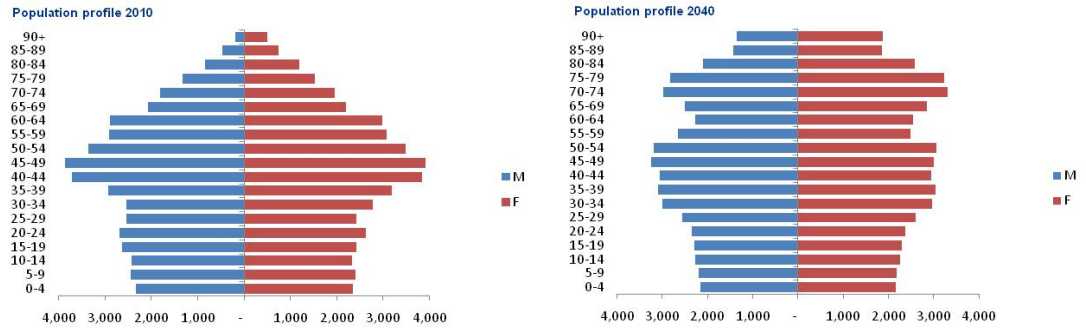
Accordingly, the unit cost of delivering hospital and social services in Jersey is higher compared with systems serving larger populations. This is because the fixed costs of key services such as Accident and Emergency, intensive care, and secure residential accommodation, which are still necessary to support relatively low levels of activity. This, along with the cost of living (including the cost of land and buildings) in Jersey leads to an additional funding “premium”, which increases unit costs. Secondly, it can produce vulnerable services due to workforce models, particularly in the medical workforce, which are relatively light, highly reliant on very small numbers of individuals and where the achievement and maintenance of specialist skills is difficult given relatively low patient numbers.

2.2.1 Demography

Given immigration controls the population of Jersey is rising only slowly. But it is ageing rapidly. Over the 30 years from 2010 to 2040 the numbers of residents over 65 is projected to rise by 95%; in the period to 2020 the increase is projected to be 35%. However, those people who experience

moderate to severe dementia are projected to increase by 154% from 2010 – 2040[6]. This demographic change will create a huge surge in demand for health and social care services which will overwhelm the current capacity of the existing services.

Fig 1. Demographic change in Jersey



Within 5 years, the current numbers of hospital beds, operating theatres, residential and nursing care beds and other key community services will be inadequate to meet demand. These services therefore need to be expanded, supplemented and/or changed urgently to ensure that services can be safely and sustainably provided for the growing elderly population.

2.3 Strategic Principles

The vision of services which are safe, sustainable and affordable was distilled into a set of strategic design principles in late 2010. These were developed by stakeholders across health and social care, and ratified by Ministers:

- Create a sustainable service model – efficient, effective, engaging the public in self-management and with consistent access and thresholds
- Ensure clinical/service viability – overcome the challenges of low patient volumes, delivering high quality care and minimising risk
- Ensure financial viability – reduce the impact of diseconomies of scale, with value for money, an understanding of the costs of care in Jersey and robust procurement
- How should we fund health and social care? – establishing a charging model that incentivises care and cooperation
- Optimising estate utilisation – ensuring the estate is fit for purpose and utilised to maximum efficiency
- Workforce utilisation and development – supporting and utilising the workforce to the best of their abilities
- Clinical governance – sustaining a culture of safety, learning and transparency
- Use of business intelligence - with robust data to support decision making based on fact, and including patients and the public in service design and decision making

[6] This estimate is based on the relationship between the statistical data taken from the Jersey Population Model 2009 (www.gov.je/Government/Pages/States/Reports) and Prevalence of dementia, European Collaboration on Dementia 2009 (www.alzheimer-europe.org/index.php/EN/Research/European-Collaboration-on-Dementia)

Service principles and assertions:

- Social care and health should be integrated as seamlessly as possible on a service user's/patient's life journey, with teams of social care, home care, medical, nursing, occupational therapy, psychology and other staff working together, working with the third sector and private sector providers
- Integration will be supported by an organisational and professional mindset that puts people first and at the centre of decision making about their care package, and ensures that needs drive services and not the reverse, to improve emotional, social and health wellbeing.
- Single, integrated care pathways, single assessment and a move towards personalisation and needs driven care will provide choice and empowerment. At present, complex services are provided by a multiplicity of providers, teams and professionals with different referral and access points, assessment frameworks, eligibility criteria and pathways. Simplifying and standardising the current range of approaches would improve co-ordination, providing a holistic, streamlined service which provides support, enablement and choice of care setting for older people and support for their carers.
- Services should be planned and delivered within partnerships brining together all sectors of our Islands community and economy
- Where appropriate, service provision should move away from residential care and institutionalisation within social care towards an increase in community provision to allow service users to integrate and lead independent and productive lives as much as possible.

2.4 Stakeholders and public opinion

Between November 2010 and April 2011 a number of stakeholders were interviewed to ascertain their views on the future for health and social care. The key themes were:

- The development of an overall strategic plan as an overarching context for the development of the above is essential. This should address any changes required in the structure of services and relationships between them, as well as future funding mechanism to ensure the changes in service provision required will be delivered
- There is a groundswell of appetite for change
- Considerable scope exists for improvement in the coordination, collaboration and communication between different services and service providers
- Some gaps in service provision exist
- Elements of the operational infrastructure would benefit from strengthening. This includes improved mechanisms for data collection and distribution, recruitment and retention of key staff, and improvement and better use of estate

2.5 Results of the Green Paper consultation

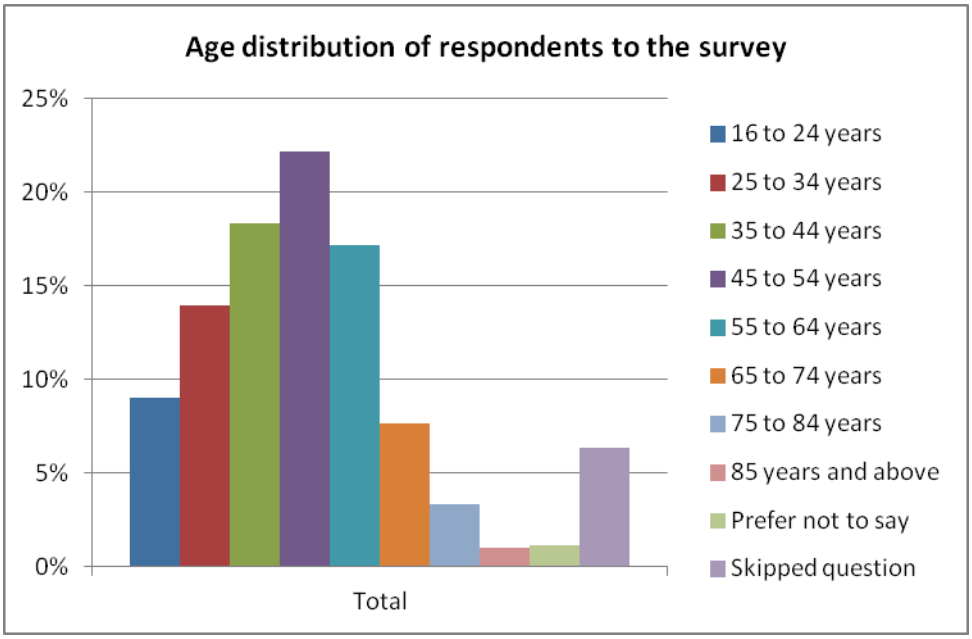
Between May and August 2010 HSSD consulted on the Green Paper 'Caring for each other, Caring for ourselves'. More than 1,300 Islanders responded to the consultation. The response was overwhelmingly in favour of redesigning health and social services so that they continue to be safe and affordable for the future (86%), and many respondents included detailed comments and viewpoints.

The Green Paper sought views on three scenarios for the future of health and social care:

- Scenario One: "Business as usual" – services continue to be provided in the same way and through the same structures as in 2010; spending increases to meet growing demand.

- Scenario Two: “A small increase in funding” – the funding allocation does not increase. Services have to be prioritised within this budget and many services will be subject to ‘means testing’ or will be stopped.
- Scenario Three: “A new model for health and social care” – prioritised changes to service delivery, to ensure health and social services are safe, sustainable and affordable and are able to meet projected increases in demand.

Responses were received from across all age groups. 69% of responses were received from individuals; 17% from organisations, such as Family Nursing and Home Care, dDeaf Awareness Group and Mind Jersey. More women than men responded.



Responses

The overwhelming message from the consultation was the positive views of Islanders about their health and social services. The majority of the respondents believe it is very (81%) or fairly important (16%) to continue providing a wide range of health and social care services on island. The remaining questions elicited the following responses:

- The majority find it very important (82%) or fairly important (16%) that in future these services are free, or affordable, and available to all.
- The vast majority of people (90%) agreed that “The States should ensure that preventing ill health is as important as curing ill health”. Some people felt that a large benefit could be gained from this area in the long term, whilst others were not sure whether this would be possible.
- Mixed views were received regarding having “responsibility for your own health” – whether this was for longer waiting times or increased charges for people who choose not to look after their own health. In particular, there were concerns about “self-inflicted” injuries or illnesses. Some respondents argued that it was not always possible for everyone to look after themselves and that vulnerable, ill or disabled individuals should not be disadvantaged.
- Most respondents agreed that “People should be able to live in their own home for as long as possible, providing they have the right health and social care support from the States of Jersey, the Third Sector and parishes.

- The vast majority of people (90%) agreed that “Instead of going to a hospital doctor or GP, I would be happy to be seen by a nurse, a pharmacist or other care professional, for appropriate minor procedures such as measuring blood pressure or monitoring my diabetes.”
- Most respondents said they would welcome qualified nurses working with GPs to free up their time, but others were not in favour of nurses doing what they considered to be the work of a GP. Some respondents commented that the GP system in Jersey was already very efficient and they were concerned about damaging patient-GP relations, and others were concerned about the cost of Primary Care to individual patients.
- Respondents also indicated that off-island travel was acceptable for some treatments. Some respondents would rather not have off island treatment, whilst others felt that going away for care to be inevitable on a small island like Jersey. Respondents also expressed views on whether patients should travel off island to see a doctor, or whether doctors should visit Jersey to treat patients.
- Professionals working together to deliver better integrated care was important, but some respondents noted that Jersey’s charities should receive more funding and support.
- The vast majority of respondents thought that health and social care should be accessible and affordable, if not free, to all. However, there was a range of views about who should fund this care, and how.
- The need for affordable care was often stressed, and many respondents felt payment and funding needed to be explored in more depth.
- Most respondents said that those who cannot pay should still enjoy high quality health and social care. Opinion was then split about whether the amount of free care available for each person should be capped, with respondents expressing concern about the costs of care for people with long term illnesses and whether they would be able to pay.
- Some respondents commented that if health and social care was capped, for some conditions or for all, this should be means tested. However, others disagreed with means testing and felt that if someone had worked all their lives, they should have as much right to free care as others.
- Some respondents felt it would be fair that those who had lived in Jersey all their lives received free access to treatment – but that people who have not paid into the system should not enjoy the same benefits.
- According to many respondents, significant numbers of people visit the Emergency Department rather than seeing a GP because there is a charge associated with the GP, while a visit to the Emergency Department is free. The majority agreed that if a charge applied to visit the Emergency Department for treatment of a minor condition, they would be more likely to go to see their GP. Many also suggested that GP consultation costs should be reviewed at the same time as Emergency Department costs.
- Many respondents felt that there are opportunities to improve current system. Suggested ways to improve efficiency included reducing bureaucracy in health and social services, improving communication between organisations and bringing in more third party and profit making organisations to provide care.

2.6 Development of the Outline Business Case

This Outline Business Case (OBC) presents the case for change for integrated community services for people living with dementia in Jersey. It explains, within the context of current and future safety, sustainability and affordability and against the strategic principles agreed by Ministers in late 2010, the reasons why 'do nothing' is not an option.

The OBC was developed by a Working Group between August and November 2011. Between November 2011 and March 2012, significant work was undertaken with Treasury to ensure that financial projections are within an indicative cost envelope and sufficiently detailed and accurate for the Medium term Financial Plan submissions in Summer 2012.

The OBC then outlines the features and timescales of the proposed service changes and assesses the potential impact against a range of factors, including workforce, cost and quality.

This OBC has been prepared by Ian Dyer after consultation with service providers, Third Sector organizations, service users and carers.

3 The Preferred Option

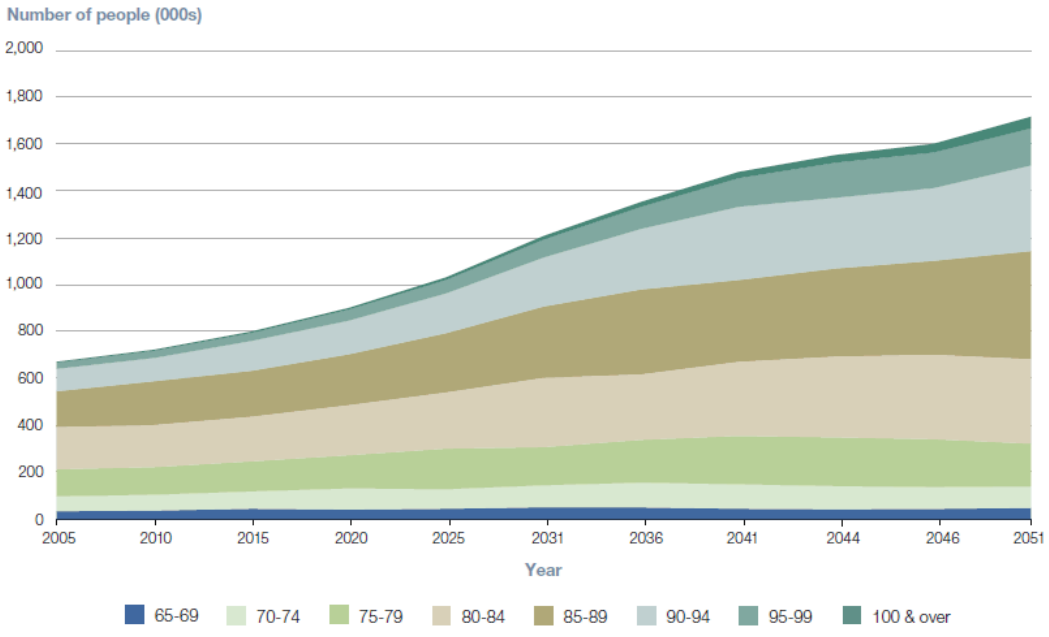
3.1 The Service Case

"Dementia" describes a range of progressive, terminal brain diseases It is a syndrome caused by a range of illnesses, most of which are currently incurable. They include among others, Alzheimer's disease (the most common cause), vascular disease, frontal lobe dementia and Lewy Body disease. Symptoms of dementia can include memory loss, difficulties with language, judgement, and insight, failure to recognise people, disorientation, mood changes, hallucinations, delusions, and the gradual loss of ability to perform all tasks of daily living. For many people it is viewed as a terrifying, perplexing disease.

There is no cure for dementia, and drugs that slow its progress do not benefit everyone. Promising scientific research is underway, and much can be done to promote quality of life for people with dementia, even in the very late stages. The average time from diagnosis to death is 7-11 years. Age is the main risk factor, but 12,000 people aged less than 65 years in England (estimated to be c65 individuals in Jersey) have young-onset dementia. Other factors, including genetic background, medical history and lifestyle can also increase the risk of dementia.

Figure 3

Projected increase in the number of people with late-onset dementia in the UK by age group



Source: Knapp, M et al. (2007) Dementia UK: Report to the Alzheimer's Society, Kings College London and London School of Economics and Political Science

Dementia is increasingly recognised as a world wide issue. The Alzheimer's Disease International World Alzheimer Report 2010 estimated that there were 35.6 million people living with dementia worldwide in 2010, increasing to 65.7 million by 2030 and 115.4 million by 2050.

In Jersey it is estimated that, in 2010, 1,246 people had moderate to severe dementia. 843 individuals were known to the Older Peoples Mental Health Service.

Using the Jersey population model 2009 (with nil migration) and comparing with the data obtained from Alzheimer's Research UK, the growth projection of moderate and severe dementia is a 38% increase by 2020 (to 1,716 people), with a 64% increase by 2025 (2,040 people) and a 154% increase by 2040 (3,167 people).

A common misconception is that dementia affects people only in old age. One study into the prevalence of moderate to severe dementia in people under the age of 65 years identified 67.2 cases per 100,000 at risk in the 30-64 years age group[7]. Applied to Jersey, this would indicate that there are c65 younger people with dementia on the Island - but less than 20% of this number are currently known to the memory clinic and there are currently very limited services and skills to meet the needs of this client group.

[7] Young Onset Dementia: Epidemiology, clinical symptoms, family burden, support and outcome. Dr Richard J Harvey MD MRCPsych 1998

Jersey's predicted increase in dementia 2010 - 2040.

The following table has been based on the relationship of data between statistics taken from the Jersey populatin Model 2009 (www.gov.je/Government/Pages/States Reports and Alzheimers Research UK Defeating Dementia (www.alzheimersresearchuk.org/dementia - statistics (2012)

Data includes prevalence of diagnosed & undiagnosed moderate to server dementia in population-based studies

	2010			2015			2020			2025			2030			2035			2040		
Bandings	Incidence	Population	Volume	Incidence	Population	Volume	Incidence	Population	Volume	Incidence	Population	Volume	Incidence	Population	Volume	Incidence	Population	Volume	Incidence	Population	Volume
Age 30-59	0.1%	40,000	40	0.1%	39,300	39	0.1%	37,400	37	0.1%	33,300	33	0.1%	30,600	31	0.1%	29,600	30	0.1%	29,200	29
Age 60-64	1.0%	5,900	59	1.0%	5,700	57	1.0%	6,400	64	1.0%	7,100	71	1.0%	6,800	68	1.0%	5,500	55	1.0%	4,700	47
Age 65-69	1.6%	4,300	69	1.6%	5,600	90	1.6%	5,500	88	1.6%	6,100	98	1.6%	6,900	110	1.6%	6,600	106	1.6%	5,300	85
Age 70-74	4.2%	3,800	160	4.2%	4,000	168	4.2%	5,300	223	4.2%	5,200	218	4.2%	5,800	244	4.2%	6,500	273	4.2%	6,300	265
Age 75-79	5.9%	2,900	171	5.9%	3,400	201	5.9%	3,600	212	5.9%	4,800	283	5.9%	4,800	283	5.9%	5,400	319	5.9%	6,100	360
Age 80-84	12.9%	2,000	258	12.9%	2,300	297	12.9%	2,800	361	12.9%	3,100	400	12.9%	4,100	529	12.9%	4,200	542	12.9%	4,700	606
Age 85-89	21.2%	1,200	254	21.2%	1,400	297	21.2%	1,700	360	21.2%	2,200	466	21.2%	2,400	509	21.2%	3,200	678	21.2%	3,300	700
Age 90+	33.6%	700	235	33.6%	800	269	33.6%	1,100	370	33.6%	1,400	470	33.6%	2,000	672	33.6%	2,400	806	33.6%	3,200	1,075
	2.0%	60,800	1,246	2.3%	62,500	1,417	2.7%	63,800	1,716	3.2%	63,200	2,040	3.9%	63,400	2,446	4.4%	63,400	2,808	5.0%	62,800	3,167
Year on Year Increase; volume	**0.0%**			**13.7%**			**21.1%**			**18.9%**			**19.9%**			**14.8%**			**12.8%**		
Increase measured against base year (2010); volume	**0.0%**			**13.7%**			**37.7%**			**63.7%**			**96.3%**			**125.4%**			**154.1%**		

Around 0.5% of the world's total population live with dementia. A high proportion of people with dementia need some care, ranging from support with activities of daily living (such as cooking or shopping), to full personal care and round the clock supervision. In some high income countries, between one third and one half of all people with dementia live in resource and cost-intensive residential or nursing home care facilities. Medical care costs tend to be relatively high for people with dementia, particularly in high income countries with reasonable provision of specialist care services[8].

The World Health Organisation (WHO) reports that worldwide, the costs of dementia are set to soar. They have tentatively estimated an 85% increase in costs to 2030, based only on predicted increases in the numbers of people with dementia.

The King's Fund has estimated the financial cost of dementia per year in England alone was £15 billion in 2008 and this was set to rise to £23 billion by 2018 if nothing is done to improve the cost-effectiveness of dementia services[9].

In 2007, the National Audit Office (NAO) report, "Improving Services and Support for People with Dementia in England"[10] found that spending on dementia is focused on people in the later stages of the condition and does not represent value for money. They stated that the provision of better quality dementia care represented an opportunity for releasing significant investment, and estimated that re-engineering systems for dementia could yield £6.5 million of acute Trust savings per year in Lincolnshire.

There is increasing evidence to support the impact dementia has on our services. For example a recent study[11] in the US revealed that hospitalisation rates were 41% higher for patients with dementia, 200 admissions per 1,000 patients per year for those without dementia versus 419 admissions per 1,000 patients per year after the onset of dementia.The economic impact on families is also insufficiently appreciated.

Research in the UK by the Alzheimer's Research Trust suggests that dementia costs the UK twice as much as cancer, three times as much as heart disease and four times as much as stroke. However, dementia often receives proportionately funding.

They also recommend that there is an urgent need to develop cost-effective packages of medical and social care that meet the needs of people with dementia and their caregivers across the course of the illness, and evidence-based prevention strategies.

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[8] The prevalence of dementia worldwide, Alzheimer's disease international 2008.

[9] Paying The Price: The cost of mental health care in England to 2026. Kings Fund 2008

WHO's message is that governments and health and social care systems need to be adequately prepared for the future, and must seek ways now to improve the lives of people with dementia and their caregivers. It is vital that Jersey recognises that the cost of dementia will continue to increase at an alarming rate and we must work to improve care, support services and treatment to people with dementia.

The aim of the redesigned dementia services is to support people living with dementia and their carers to live within their own homes, independently, for as long as possible. This is what service users want[12] and, if delivered effectively, will significantly reduce the financial burden of long term care within institutions and the acute hospital, whilst delivering better outcomes for patients.

Home-based models of care are especially effective for patients with multiple diagnoses and comorbidities with a high risk of hospitalisation[13]. The all party parliamentary group on dementia document *"The £20 billion question"* stated that at any one time up to a quarter of general hospital beds are occupied by people with dementia. For Jersey this would equate to about 50 patients at the general hospital having a dementia at any one time, although dementia would not necessarily be the reason for admission. It is widely accepted that many of these admissions could be prevented if individuals and their carers were better supported at home. The challenge is to ensure that any new service model gets to the heart of the unmet needs.

3.2 Current Services in Jersey

Dementia services in Jersey are currently provided by:

- HSSD's community mental health service
- The memory clinic based at the Poplars at Overdale Hospital
- The 14 bedded assessment in-patient unit based at St Saviours hospital
- 52 continuing nursing care beds currently provided in McKinstry Ward at Overdale and Maple Ward on the St Saviour site
- The Jersey Alzheimer's Association, which has an active membership and provides support to carers and tailored activities to people living with dementia
- The independent sector, who provide a number of residential beds, and more recently specialised nursing beds specifically for people with dementia.

[12] Alzheimer's Society (2011) Support. Stay. Save: Care and support of people with dementia in their own homes

[13] All Party Parliamentary Group On Dementia (2011) The £20 billion question: An inquiry into improving lives through cost-effective dementia services.

There are a number of challenges with the current service model, notwithstanding the future pressure on services caused by demographics:

Service design principle	Challenges of the current services
Create a sustainable service model	• Rapidly ageing population - the over 65 population forecast to increase by 95% between 2010 and 2040. In the UK, the incidence of dementia in over 65s is 1.6%, and 21.2% in over 85s. Therefore, in 2010 there were projected to be 1,246 individuals with moderate to severe dementia (including an estimated 65 individuals aged under 65). This is projected to increase to 1,716 in 2020, and 3,167 in 2040. • Significantly limited service provision due to the lack of 24-hour community service options • Large number of people admitted to institutional care • With no service redesign, the capacity of existing dementia services will be exceeded within two years • Limited service availability and waiting lists for nursing homes creates both an immediate impact on secondary care and a longer term impact on health and social care system • The National Audit Office[1] describes the excess cost of inappropriate care provided in general hospitals to people with dementia, for Jersey this would equate to over 1000 bed days per year • Analysis from KPMG in 2011 indicates that non-elective hospital admissions are driven by general medical patients. Acute hospital capacity is due to be exceeded by 2014; this can be significantly impacted by redesigning dementia services to reduce the need for acute care, as hospitalisation rates for individuals with dementia are 41% higher than for those without dementia. Jersey also has a high number of delayed hospital transfers which amounted to 369 incidences of delay in 2010, believed to be predominantly caused by the waiting list for Nursing/Residential Care home placements • Current service relies on GPs making referrals. However, evidence from the National Audit Office (NAO) Report *Improving Services and Support for People with Dementia*[1] reported that only 31% of GPs felt they had enough training to diagnose and manage dementia. Further, their survey of GPs in England identified widely held beliefs from GPs that little could be done for people with dementia, and as such there was a lack of urgency in diagnosing and addressing the condition • Limited ability to support carers and help them and the person with dementia remain living at home. When asked, the vast majority of people diagnosed with dementia and their carers (83%) want to remain in their own homes[14]. • Integration of existing services with Third Sector

[14] Alzheimer's Society Support. Stay. Save. Care and support of people with dementia in their own homes (2011)

Service design principle	Challenges of the current services
Ensure Clinical/service viability	• Recruitment and retention, especially for nurses. Almost 60% of the medical profession are due to retire within the next 10 years, and a number of staff working within the community older peoples service are approaching retirement age, with over 50% of our nursing staff having the option of retirement within the next 12 years • High costs of living in Jersey and increasingly competitive remuneration packages in the UK make recruitment of skilled staff difficult • Relatively low number of registered community nursing staff (including district nurses and other community nursing staff), meaning the level of support to people in their own homes is low • Waiting lists for nursing / residential care indicate a capacity challenge currently. However, this should be eased somewhat through the introduction of the new dementia service, which will support increasing numbers of individuals within their own homes and ease the pressure on both acute care and care homes • Opportunities will continue to exist for Third Sector organisations, with an increasing role within integrated teams providing dementia care and supporting carers and families.
Ensure financial viability	• The opening paragraph of the Executive Summary from the All-Party Parliamentary Group on Dementia states that *"The facts about the growing number of people with dementia in the UK and the associated costs are firmly established. It is well known that dementia is a significant and growing driver of demand for health and social care. The cost of dementia in the UK in 2010 was estimated to be £20 billion and this is expected to grow to over £27 billion by 2018. It is also clear that health and social care budgets are under extreme pressure and there is an urgent need to improve the cost-effectiveness of services"*[15]. • The elderly population projected to increase by 95% by 2040, and the current model of reactive institutionalised care is more costly than a proactive community model, which identifies individuals early in their pathway and supports them to live at home.

[15] The £20 billion question, An inquiry into improving lives through cost-effective dementia services, All-Party Parliamentary Group on Dementia (2011)

Service design principle	Challenges of the current services
Optimising estate utilisation	• Inpatient spells are projected to increase by 33% by 2020; the most significant increase being in medical beds. Current hospital capacity is inadequate to meet this demand, but such pressures can be reduced by the development of community services • Relatively high proportion of older adults in residential care homes, more than double the rate of UK comparators • Waiting list for States-funded access to nursing home and mental health inpatient beds, with 180 patients entering the long term nursing bed waiting list in 2010 • Requirement for older people's social care beds is projected to increase from 114 beds in 2010 to more than 180 beds in 2020 and more than 380 beds in 2040. This is not sustainable and many of these individuals could benefit from home care and/or home nursing support • Current estate for older people's community mental health services is of an acceptable standard, but is reaching capacity • As noted in the 2012 capital submission, the new build at Overdale will include provision for all older people's service community staff. This is planned to be available from 2020 • The Active Ageing and Wellbeing Center needs to be based in an accessible location. Jersey Property Holdings will be approached to ascertain which facilities are available within the SoJ property portfolio. A revenue budget of £100k p.a. has been identified for this.
Workforce utilisation and development	• The redesigned dementia service will require individuals and Multi-disciplinary teams to work in different ways, including expanded multidisciplinary teams, expanded roles and new locations • New ways of working, processes and procedures need to be developed in order to support clinical viability and to manage risk, especially as services expand in community and home-based settings • There is a need to increase training and support for all staff working with people with dementia (including those who work in the General Hospital and Primary Care). HSSD's Education Department currently employs a nurse trainer specialising in dementia care. The new dementia service will build on this established post and increase links with training provided by the Third Sector e.g. Jersey Alzheimer's Association • Other workforce developments will also impact dementia services, including nurse prescribing.

Service design principle	Challenges of the current services
Clinical governance	Clinical governance for this client group needs to be developed through: • Improved training and education • Informatics and data from the FACE IT system • Patients Advocacy Worker • Carers support • Continued and further developed external monitoring through the Memory Service National Accreditation Program.
Use of business intelligence	• Personal data relating to health and wellbeing is currently held in separate places – PAS for acute, Softbox for Social Care and FACE for Mental Health. This inhibits the co-ordination of services, as information is currently managed in silo environments and access to management information is limited • Accurate data and information on dementia is currently limited, with outcome information only obtainable anecdotally. This is not unique to Jersey; the UK has also struggled to obtain accurate information in relation to dementia.

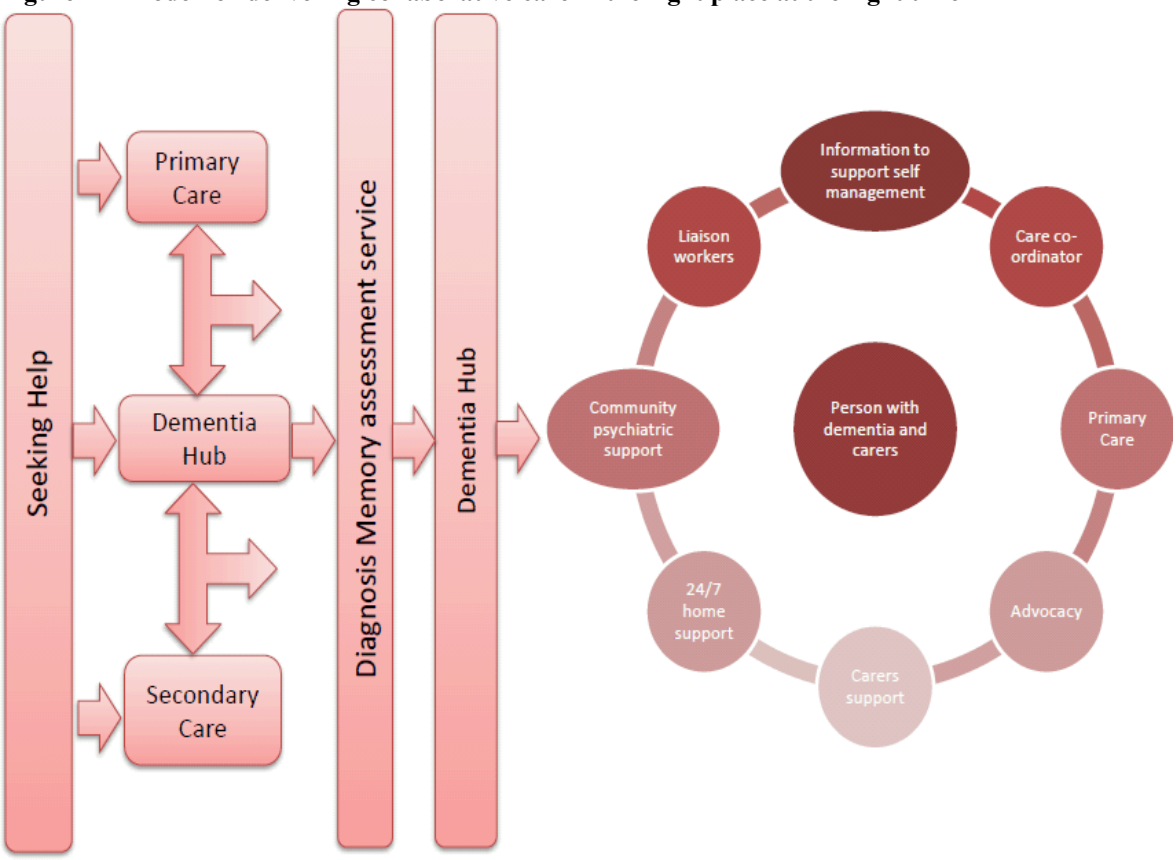
3.3 Description of Proposed Service

The high level dementia services framework is presented below. The redesigned services and pathway covers the continuum of care, to meet the needs of people living with dementia and their carers from 'first inkling' or symptoms of dementia to end of life.

The proposed model of collaborative care ensures the right care is delivered at the right time for people with dementia and their carers. It enables people to manage their care needs as independently as possible, and is driven by the underpinning principle of a person-centered approach.

The dementia pathway was developed through consultation and represents a series of steps or 'signposts', including provision of information, coordination and delivery of clinical, educational and social support services. The pathway reflects good practice in terms of services matching needs and requirements. The pathway incorporates best practice and outlines the activities and roles of health professionals, GPs and care workers in caring for the person living with dementia, their family and carers. The pathway will support improved quality standards; improved multidisciplinary communication and care planning; improved consumer/carer and provider communication and consumer/carer satisfaction; and will decrease unwanted practice variation.

Figure 1 A model for delivering collaborative care in the right place at the right time



The redesigned dementia service comprises:

- Awareness and information – developing an 'Active Ageing and Wellbeing Centre', which provides one point of access for information, support and advice.
- Early Diagnosis – to ensure people receive the right support, at the right time, in the right place, thereby reducing the need for crisis intervention.
- Carers support – providing support, information, advice and training to carers to enable the carer to continue in their caring role, in order to reduce the need for high cost formal health and social services support.
- Psychiatric liaison service - providing support to staff in the acute hospital and residential homes in dementia care to shorten length of stay in hospitals reduce admissions to acute hospital from residential homes
- Enhanced community services - increasing the supply of domiciliary care and developing specialised home care services for people with dementia. This will involve an increased use of 'Assistive Technology' such as telehealth and telecare.

3.3.1 Awareness and Information

To support early identification of dementia the Third Sector, e.g. Jersey Alzheimer's Association, Age Concern etc will provide information and advice to the public and professionals to raise awareness of dementia and promote early diagnosis. Information will be provided via printed information sheets, local media, internet etc. The Parishes will also play a vital role in supporting those people who may display the early signs of dementia and may need additional help to continue to live independently at home or seek a diagnosis.

The Active Ageing and Wellbeing Centre, possibly run by a Third Sector organisation, will be a building based resource for Older Adults, acting as a central point of access for information, advice and professional support, with a focus on maximising good health. Within this centre there will be a 'Dementia Hub' which will 'enable people with dementia, their carers and families to live well and have maximum choice and control over their lives by ensuring that all services are person centred, culturally appropriate and be able to recognise and deliver the many factors that contribute to good health and positive wellbeing'.

The Dementia Hub will offer a range of services:

- dementia café
- planning of activities that promote good physical health e.g. coastal walks, swimming etc (see http://dementiaadventure.wordpress.com/)
- day care facilities/drop in
- enabling service users to get specialist support and enjoy social activities while also giving their carers a period of respite
- therapy rooms
- meeting areas for use by carers' groups and community organizations
- expert help, training and support for informal carers
- training for organisations.

A team of multi-disciplinary, multi-agency staff will provide specialist support. They will be based full time or part time (according to service demand) at the Hub. These professionals will be able to co-ordinate an individual's care once the pathway is triggered, responding to individual need in a timely manner and reducing the need for multiple assessments and referrals to specialist services and organisations. For service users/patients and carers, the 'Hub' would offer choice, support and guidance in planning their care, and they would be navigated through their care pathway by a nominated care co-ordinator.

Outreach services will be provided to Parishes (dependant on population size and demand) to ensure activities and social integration is available to as many people living with dementia and their carers as possible.

Evidence: Carer support, promoting independence and maintaining social inclusion through social, recreational and preventative support services are highly cost effective in avoiding expensive institutional care. Pilot schemes in the UK around 'Better Government for Older People Network' and the Beacon Council programme on 'Promoting Independence' have established the value of a range of services and activities.

For example, the Community Care Centre in Staveley, Derbyshire was established[16] as the first of a full network of high quality Community Care Centers that became the focal point for delivering services to older people with more complex levels of need, promoting independence, well being and dignity. The aim of the Centre is to:

- act as a hub for services for older people with chronic ill health and other long term conditions, particularly dementia, who require intensive care management

[16] Department of Health (2011) Living well with dementia: A National Dementia Strategy Good Practice Compendium – an assets approach

- support carers; offering respite care, information and advice in a local setting
- provide more integrated services tailored to the needs of the communities they serve
- help older people, particularly those with dementia, to regain lost skills and abilities, maximising their potential to live in their own homes as long as possible, promoting independence and dignity
- provide better access to assistive technology including telehealth and telecare
- promote and sustain inclusion and well being
- provide a "one stop shop" with a range of facilities; including a Health and Wellbeing Zone supported by Health Trainers
- bring in voluntary and statutory bodies to provide information and advice on a host of topics including helping to maximise income
- provide accessible services in high quality, energy efficient, future proof dementia friendly buildings.

The achievements and benefits described by the centre are:
- Improved opportunities to live independently, through specialised care for people with dementia and care, advice and support to older people and carers within the surrounding community
- Easier access to a broad range of services and information
- Increased social inclusion for older people
- Improved choice and control
- Improved dignity and safety
- Improved preventative, early intervention and reablement services
- Community based peer support for carers
- Increased direction and leadership in the efficient use of resources
- Sustainable and energy efficient buildings
- Buildings that promote good, dementia friendly design and facilities of which present and future generations can be proud.

The above service includes residential provision as well as the day centre but this would not be needed within the Jersey context. By including other interventions that are related to active ageing, for example incontinence management and falls prevention, the service would be cost-effective and reduce stigma associated with dementia.

3.3.2 Early Diagnosis

The priority for Jersey is to identify people with dementia at an early stage (when they begin to show signs of cognitive impairment) and help them take decisions near the start of their journey to improve planning and prevent a crisis in the future. The current electronic assessment and recording keeping system FACE will be further developed to support a single assessment framework.

Evidence supports early diagnosis and intervention in improving quality of life and delaying unnecessary admissions into hospitals and care homes[17]. In addition to diagnosis, the Memory Assessment Service will provide information, and direct medical, psychological and social support for people with dementia and their family carers.

[17] Department of Health (2007), *The NHS in England: the Operating Framework for 2008/09*. London: TSO.

It is proposed that GPs will screen all individuals over the age of 55 annually. There will be an estimated 20,000 people in this age group by 2015.

GPs will be supported in developing a dementia register, building on the data that has been collected in the past 2 years.

The Memory Assessment service will be led by a Consultant Community Geriatrician. The aim is to prevent future crises by encouraging more effective and earlier help seeking and so reduce unwanted transition into care homes. The Department of Health has piloted this service model with positive results:[18]

- reduced care home placement of up to 28% by providing carer support and counseling at diagnosis
- improved quality of life of people with dementia following early diagnosis and intervention
- positive effects on the quality of life of family carers following early diagnosis and intervention.

Referrals will be accepted into the Memory Assessment Service from any appropriate care professionals and Third Sector partners. The Memory Assessment Service will make contact with other relevant health and social care professionals, including GPs, to gather a medical history. This will provide a patient-centred approach, and will reduce the need for multiple assessments and the patient and carer being transferred between numerous services.

Patients with a confirmed diagnosis of dementia will be placed on the register. Ongoing support and information will be offered and provided via 'Active Ageing and Wellbeing Centre'. Dependant on the level of need the patient may be assigned a care coordinator (see below).

Evidence: Analyses suggest[19] that the service needs only to achieve a modest increase in average quality of life of people with dementia, plus a 10% diversion of people with dementia from residential care, to be cost-effective.

However, in 2010 there were only 156 referrals to the Memory Assessment Service and a total of 711 appointments including follow-up and further assessment appointments.

Based on a population of 14,797 people over 65, UK prevalence rates of dementia indicate there should be 1,246 people with dementia (mild, moderate and severe) in 2010 rising to 1,716 in 2020.

This indicates that a significant amount of people with dementia are undiagnosed and not receiving the support and treatment needed. As the availability of increased information and advice increases and the Active Ageing and Wellbeing Centre a significant increase in referrals is anticipated – up to a 75% increase by 2015.

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[18] Banerjee S,Willis R, Matthews D, et al. 2007. Improving the quality of dementia care – an evaluation of the Croydon Memory Service Model. Int J Geriatr Psychiatry 22: 782–788.

[19] Clinical and cost effectiveness of services for early diagnosis and intervention in dementia; INTERNATIONAL JOURNAL OF GERIATRIC PSYCHIATRY, Int J Geriatr Psychiatry (2009)

3.3.3 Carers support

Unpaid family carers deliver a large proportion of day to day care, which can affect their own physical and mental health.

Carers Support Budget: - up to £50 p.w and £2,500 per annum, ringfenced to meet carers' needs, once these needs are identified via a carer's assessment. Carers eligible to access the budget would be residing in the same property as the cared for person and providing a 'substantial' amount of care. In exceptional circumstances carers who are not residing with the cared for person would be able to access the Carers Support Budget.

An assessment of emotional, psychological and social needs would be undertaken by a Carers Support Worker. Interventions would then be identified in a care plan, e.g. promote the carer's social inclusion – particularly where there are one off needs or for respite.

Evidence*:* One study found that 65% of the intervention group were living at home after 30 months, compared to 26% in the control group[20], while another study showed that the median time of residing in the community following a period of comprehensive support was 647 days in the intervention group and 396 days in the control group[21].

The **Carers Support Workers** would also:

- Provide advice on available peer support
- Offer specialist advice and information on dementia-specific services
- Ensure that 24-hour information and support service is relevant to people with dementia and their carers
- Identify and develop a range of social activities to be jointly available to the person with dementia and their carer
- Offer or signpost access to specific carer education programmes relevant to different points in the progression of dementia
- Promote the inclusion of carers in planning and decision-making and support individual carers to participate as required
- Offer advice and practical support to help the carer of the person with dementia maintain employment
- Promote access to carer support services for people living with dementia who may be hard to reach or reluctant to seek or accept advice or support

Evidence: The ECCEP study of community care in England and Wales found that social work and counseling were highly cost-effective in reducing subjective carer burden compared to other interventions.

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[20] Brodaty H, Gresham M and Luscombe G, The Prince Henry Hospital dementia caregiver's training programme. *International Journal of Geriatric Psychiatry*, 1997; 12(2): 183–92.

[21] Eloniemi-Sulkava U, Notkola IL, Hentinen M, et al., Effects of supporting community-living demented patients and their caregivers: a randomized trial. *Journal of the American Geriatrics Society*, 2001; 49(10): 1282–87

3.3.4 Psychiatric Liaison

The community team based within Active Ageing and Wellbeing Centre will provide an in-reach liaison service to the hospital and care homes. The aim is to provide expert mental health skills to support the good quality general care of patients provided by ward and home staff. The service will contribute to training and education to meet skills gaps so that staff become competent to deal with routine older adults' mental health needs.

The Psychiatric Liaison service will:

- Advise and support high-quality accurate diagnosis of dementia and other mental health problems. This will include providing advice or support in more complex cases or more routine cases as required.
- Provide timely advice and support to staff to manage behaviours that challenge after ward staff have followed the local protocol as appropriate and in line with NICE Clinical Guideline 103 (delirium). This includes providing urgent response advice to the Emergency Department and Medical Admissions Unit on cases where non-hospital options might be possible.
- Provide advice on care planning and delivery of optimum care to advise ward and home staff, patients and carers, to assist in making decisions about timely discharge and appropriate place of discharge. This includes advice on options for support in the community, intermediate care, reablement and referral to community services in order to promote early discharge opportunities

Evidence: an innovative project in the West Suffolk and Ipswich Hospitals in 2010[22] provided improved support to the acute hospitals for patients presenting with delirium and dementia, including the appointment of specialist nurses and health care support workers. The project found that when working closely with mental health liaison services readmission rates reduced by 70%.

The Leeds Liaison service follow-up study revealed that the average length of stay within the acute hospital for people with dementia fell by 54% from 30 to 13.9 days saving 1,056 bed days per year. This is supported by the BMA written evidence to the All Party-Parliamentary Group on Dementia who stated "with 300 referrals per annum (to old age psychiatry services), there is a potential saving of 1500 days waiting per acute hospital, if only half of these patients discharge planning were delayed as a result of waiting for a psychiatric opinion then this would equate to 750 bed days".

3.3.5 Enhanced Community Services:

Enhanced Community Services are aimed at providing a wide range of support to enable patients and service users to be cared for in their own homes, thereby reducing the need for admission to an (often high cost) care home and providing a longer independent life. This includes:

- 24 hour home nursing and domiciliary care support (including night sitting and rapid response)
- Parish support
- Care co-ordinators
- Advocacy services
- Assistive Technology

24 hour nursing and domiciliary care support in order to provide support to people in their own homes throughout the day and night, a night sitting service will be available to support older adults living alone or provide carer respite. This is identified and costed within the Intermediate Care OBC, however there would be a requirement for 12 members of the enhanced community team to gain

[22] Department of Health (2011), Living well with dementia: A National Dementia Strategy Good Practice Compendium - an assets approach

knowledge and experience of the specific service elements to support people living with dementia to:

- ensure that a person with dementia is treated as an individual and that they are always treated with dignity and respect
- deliver care on a flexible basis, both in terms of times and tasks and plan appropriately for possible fluctuations in the behaviour of the person with dementia
- ensure continuity of care by minimising the number of staff involved in a person's care
- aim to achieve the best match in care workers in terms of ability to respond to the particular needs of the person with dementia and also to provide appropriate carer support
- plan appropriately to respond to behaviour that challenges and plan for the different needs of the person with dementia, through to end of life care
- ensure that staff have appropriate communication skills to respond to the needs of a person with dementia
- help enable carers to work alongside staff and ensure that they are included in planning and decision making
- ensure that staff are vigilant about physical health needs that the person with dementia may not be able to explain pain management.

Parish support. Parishes and other community based organisations have the potential and capability to support the delivery of services for older adults to remain independent for longer within their own homes. The Intermediate Care OBC is leading on the role of the Parish support. Each Parish will have a link professional identified from the community dementia services to provide advice and ongoing support. The historic contribution of the Parishes in the wellbeing of older people is fully recognised and the partnership approach outlined in this model presents the opportunity to develop this further. The Parish system will support people with dementia by providing services that are outreached from the Active Ageing and Wellbeing Centre and the 'Neighbourhood Return' scheme, which will build up a network of volunteers who will respond to a text by looking for the lost person in their immediate neighbourhood and help them to return home safely.

Parish Link professionals will be members of the enhanced community team, and will provide a point of contact for each Parish.

NICE guidelines state that "People with dementia should have an assessment and an ongoing personalised care plan, agreed across health and social care, that identifies a named care coordinator and addresses their individual needs." **Care co-ordinators** will be key in driving forward the personalisation agenda on the Island. People will be supported to identify their needs and outcomes, which will enable them to remain living independently in their own home e.g. home care, meals on wheels, specialist equipment etc. The care co-ordinator then navigates the individual through the system, linking with the Active Ageing and Wellbeing Centre and the relevant care professionals and Third Sector organisations to produce an integrated, personalised care plan.

Advocacy Services seek to help the person express his/her views, and to ensure the person's voice is heard when decisions about their life are being made. This is necessary because dementia may impair the person's ability to communicate effectively, and increase further the lack of control experienced by many service users. Some occasions when advocacy would be used would be:

- a conflict or difference of opinion between a person with dementia and a carer
- 'Adult Safeguarding' cases
- different service providers having different views about care

- a person with dementia being sectioned under the Mental Health Law
- a professional seeking support to enable person with dementia to live with an element of risk in the face of opposition from family, neighbours or other services
- a professional wanting someone to independently assess the views of a person with dementia whom the professional thinks may be being 'bulldozed' by others into an action they do not want.

Advocacy may be most appropriately provided by an organisation independent of mainstream health and social services. It will be embedded as a core component of the enhanced community services, as identified in the UK National Dementia Strategy[1].

Evidence: *"[Advocacy] can be invaluable in helping a patient to express his or her views if there are difficulties in communication. As the advocates are neither a relative nor associated with the health care facility, they can offer assistance without being influenced by conflicting interests*". (BMA and RCN, 1995, p 38)

Assistive Technology: Assistive technologies will enable patients to be cared for in their own homes and will reduce the need for residential care. Telecare can support a range of physical health and social care needs by reducing the reliance on intensive support from care professionals.

Preventative telecare systems, for example smoke alarms, door alarms, flood alarms alerting that a tap has been left on, fall sensors and enuresis sensors, are passive alarm systems that alert a monitoring centre when triggered and an appropriate response is then co-ordinated. These systems are designed to enable service users to live in their own homes rather than being admitted to long term residential care – they offer choice, independence and increased confidence and can have a significant impact on the lives of service users and their carers. In addition to preventative telecare, reactive telecare can be used to monitor vital signs against an individual's parameters; these systems can be used to identify distress or inactivity, which may indicate a medical emergency such as a fall.

Individuals would be offered assistive technology in order to:
- ensure that the person with dementia and their carer are included in decision making and that their consent sought and given. Where appropriate, this includes an advocate and compliance with the Mental Capacity Policy
- ensure that no one is coerced into using technology if it is not right for them
- consider whether small changes in daily activities may be enough to overcome a particular problem faced by a person with dementia
- ensure that simple solutions are not overlooked. This may include a noticeboard for a reminder of appointments, a permanent place to keep important items such as keys and labelling of cupboards to help remember where things are
- ensure that use of assistive technology for a person with dementia is consistent with SCIE best practice[23]:
- ensure that use of telecare accords with SCIE's ethical framework: Ethical issues in the use of telecare, SCIE, 2007 www.scie.org.uk/publications/reports/report30.pdf

[23] www.scie.org.uk/publications/dementia/environment/assistive.asp

Evidence: a project in the West Midlands developed a shared specialist intermediate care service, including the use of assistive technology. An early evaluation showed savings of over £180k against an £80k investment for 37 individuals, and 57% of people at risk of being in long term nursing and residential care still being at home after a year.

Assistive technology is identified and costed within the Intermediate Care OBC.

3.4 Activity Impacts

It is estimated that 1,246 individuals in Jersey had dementia in 2010. This is projected to increase to 1,716 by 2020.

Service	Activity impact
Awareness and information	At present, information on dementia is provided through national publications, the Memory Assessment Clinic or Jersey Alzheimer's Association. It is suggested that a Third Sector organisation could lead the provision of the awareness and information elements of the new dementia service, including the Active Ageing and Wellbeing Centre. The lead provider would co-ordinate the input from other charitable, statutory and private sector organisations, and from Parishes. Independent advocacy workers will support service users express their views and represent them were appropriate. It is assumed that, in 2014, the Active Ageing and Wellbeing Centre will have 250 contacts. This will increase to 400 in 2015.
Early Diagnosis	It is estimated that, in 2010, 1,246 had mild to severe dementia. However, just over 800 individuals were known to services. By 2020, this will have increased to 1,716. In 2010 there were 156 referrals to the Memory Assessment Service (for a population of 26,600 over 55 year old). It is assumed that the number of individuals being assessed for potential dementia will be: 2013: 180 2014: 210 2015: 250

Service	Activity impact
Carers Support	Carers support budgets have been demonstrated to increase the length of time carers can support the person with dementia in their own home. One study found that 65% of people in the intervention group remained at home after 30 months compared to 26% in the control group[24]. A further study identified that those with comprehensive care packages remained at home for almost 50% longer then those without such packages[25]. The recent study from the Alzheimer's Society "*Support, Stay, Save*" (2011) highlighted 52% of carers felt they were not getting sufficient support for them to carry out they caring role. It is assumed that the number of carers being actively supported will be: 2013: 60 2014: 90 2015: 120
Psychiatric Liaison	Psychiatric Liaison in the acute hospital is intended to reduce the length of stay - following the introduction of the Leeds Liaison service the follow-up study revealed that the average length of stay within the acute hospital for people with dementia fell by 54% from 30 to 13.9 days saving 1,056 bed days per year.

[24] Rothera (2008). An evaluation of a specialist multiagency home support service for older people with dementia using qualitative methods. International Journal of Geriatric Psychiatry. Vol 23(1). 65-72

[25] Schoenmakers et al (2010). Supporting the dementia family caregiver: the effect of home care intervention on general well-being. Ageing and mental health. Vol 14(1). 44-56

Service	Activity impact
Enhanced Community Services	There will be increased activity in the community as early diagnosis increases the number of individuals diagnosed with dementia, early intervention increases caseloads and an increase in community team capacity enables increased contact. In 2010 there were over 5,000 contacts with community staff. This is projected to increase to 5,200 in 2013, 5,700in 2014 and 6,000 in 2015. It is proposed that each care coordinator will hold a caseload of 25, and that the total caseload will be: 2013: 225 2014: 300 2015: 400 Care coordinators will reduce duplication of work and demand on other professionals. The evidence from a study in Barnsley identified a 20% reduction in admissions to dementia assessment wards. In 2010 there were 5,475 occupied assessment bed days for dementia. The 24/7 community service in South West London led to a 70% reduction in mental health bed usage, therefore, by 2015, there will be an estimated 3, 650 occupied bed days. It is estimated that up to 50-60 people per year will benefit from telehealth.

3.5 Workforce Impacts

Service	Staff	Number	Comment e.g. timing
Awareness and Information	Independent Advocacy worker	2 FTE	1 FTE June 2014 1 FTE in 2017
	Registered Mental Health Nurse - training coordination, supervision and support for the third sector delivering services for dementia	1 FTE	2015
	Centre Manager	1 FTE	June 2013
	Centre workers, administration, reception and information coordinators	2 FTE	Commencing 2014, to support the activity from the wellbeing centre 6 days/week)
Early Diagnosis	Old Age Psychiatrist Associate Specialist	1 FTE	June 2014
	Consultant Geriatrician	1 FTE	June 2014, this role will include the work generated by the intermediate care service
	Community Psychiatric Nurses	2 FTE	2014 and 2016
	Psychologist	1 FTE	June 2014
	Admin	1 FTE	June 2014
Carers Support	Counselors	2 FTE	June 2014 and January 2017
	Carers support worker	1 FTE	June 2013

Service	Staff	Number	Comment e.g. timing
Psychiatric Liaison	Community Psychiatric Nurses	2 FTE	June 2013 and 2016 The treatment team and memory assessment team will also input to this service. It will also provide training across all services including the hospital, care homes and staff involved in delivering dementia care service
Enhanced Community Services	Senior Social Worker	1 FTE	October 2013
	Social Workers	2 FTE	January 2014 and January 2015
	Psychologist	1 FTE	January 2013
	CPN N&M	2 FTE	January 2013 and 2017
	Occupational Therapist	2 FTE	October 2013 and January 2015
	Community Psychiatric Nurses	1 FTE	Specialising in falls prevention and incontinence management June 2014
	Administrator	1 FTE	October 2013
	Health professionals	4 FTE	Care co-ordinators Mental - June 2013, January 2014, 2015 and 2016
	Social work assistants	4 FTE	June 2013, January 2014, 2015 and 2016. This team will cover 7 days with a shift pattern
	Help at home, enhanced community services and telecare workforce implications are contained within the Intermediate Care OBC		

The community multidisciplinary teams will comprise medical, nursing and therapy staff working with generic health and social care support workers. The redesigned dementia service will deliver a change in traditional roles, moving to a more community based model. Social services, physical and

mental health and Third Sector staff will need to develop the skills, competencies and new ways of working within the integrated dementia pathways, with improved communication in order to avoid duplication and gaps in the service.

For the new dementia service to succeed, community staffing numbers have to increase in order to provide the necessary volumes and quality of home care and respite care. The skill mix will also change, to include specialist nurses and healthcare support workers.

Staffing levels will be constantly monitored and reviewed to ensure the workforce is at the level required for caseload volumes and intensity.

The service will be available 24 hours, therefore working hours will change for some members of staff.

The service will also be co-located, therefore the base location may also change for some members of staff.

Some difficulties in recruiting and sustaining the correct number of staff may be experienced, due impending retirements and difficulties in attracting the calibre of workers due to immigration and residency restrictions in Jersey. The employment of additional Registered Mental Health Nurses or nurses with a special interest in dementia care is of particular concern.

St John's Ambulance can provide training for carers to enable understanding of the caring role and prevent breakdown in care. These carers will be supported through the active ageing centre.

3.6 **Infrastructure Impacts**

Estates

The majority of clinical appointments will take place either at the Poplars day centre, the Active Ageing and Wellbeing Centre, at peoples homes at the general hospital (for inpatients) or in a GPs surgery. The community multidisciplinary team will be based in appropriate office accommodation we will provide appropriate shared office accommodation. The office will need to be identified from current estate, which we have been informed is available, until the new facilities are built at Overdale. The Overdale feasibility plan is included as a capital bid in the Medium Term Financial Plan for 2013 – 15. We estimate that the site will not be completed until 2019. Capital funding for upgrading office accommodation of £53,000 will be required in 2013. The estate management for this OBC is coordinated within the cross cutting Estates and Facilities workstream.

The Active Ageing and Wellbeing Centre including the "dementia hub" will be centrally based and will provide a "hub and spoke" service to Parishes. The Centre will also provide all relevant information and access to services for active ageing including falls prevention, continence management, support groups, consulting rooms and a meeting place/café. The service may be run by Third Sector providers. This project will need to be developed in more detail for the FBC; it is estimated that the revenue requirement for such a building on a rental agreement could be £100,000 p.a.

IT

The Old Age Psychiatry service currently uses the FACE patient record and assessment system. There will be an increased cost for the monitoring and analysis of data which will need to be included in the IT cross Cutting workstream. Each of the new staff have an implementation cost assigned to them for computers etc. A citizen's portal will act as a single point of information for planning, receiving and delivering care for all those involved in a patient's care. The cross cutting IT workstream is coordinating this.

The citizens' portal will enable care to be designed by the individual and care professional, based on the individual's needs and, where appropriate, they choices. It will also enable care packages to be delivered and monitored in a coherent and co-ordinated manner.

The citizen's portal will provide real time information regarding service availability, self care, family support groups etc, to assist the child and family with feeling more in control of their situation.

3.7 Service Delivery Impacts including benefits

The new dementia services will provide support to enable patients and service users to be cared for in their own homes, maintaining privacy and dignity. The systems used and services provided offer patients/service users choice, independence and increased confidence and can have a significant impact on the lives of patients/service users and their carers. In addition, being able to determine their care plans and packages (where appropriate) allows for choice and improves patient experience.

Enhancements and integration will improve access to services, aided by the citizens' portal that will provide real time information on service availability, and will provide seamless care, thus improving patient/service user experience. Improved access to services and support, along with increased patient confidence, will have an impact on outcomes. This business model will be further strengthened with the introduction of the Long Term Care Benefit funding from Social Security Department which will allow people, following appropriate assessment of need, to receive care and support in their own homes.

Anticipated benefits include:

Awareness and Information

- Access to information regarding service availability, supported by a care navigator

Early Diagnosis

- Increasing the number of people diagnosed with dementia
- Care managed services against the estimated prevalence of population
- Enhanced clinical audit of dementia

Carers Support

- Enhanced support for carers, including respite care, to ease the physical and psychological pressure
- Improve quality of ratings for dementia care homes

Psychiatric Liaison

- Improve support to staff working in hospital and care homes
- Early identification and assessment of individuals who may have dementia

Enhanced Community Services

- Increased number of people receiving support in the home and increased independence, from a range of services provided 24 hours enhancing service user's privacy and dignity

- Common Assessment Framework reducing duplication and an agreed care plan/care pathway with coordinated service provided from a multidisciplinary team
- Appropriate, targeted, evidence based care pathways which meet the holistic needs of the patient/service user
- Home adaptations and equipment more readily available, further supporting individuals to live productive and independent lives, and relieving some of the burden on carers
- Reduced unnecessary admissions to hospital or nursing care due to strengthening of care in the community and the introduction of telecare to monitor patients/service users
- Reduced duplication, with staff working together to deliver co-ordinated services
- Enhanced roles of staff, providing more attractive career paths
- Improved team working to improve communication
- The ability of staff to support more service users and carers in their own homes, which should increase job satisfaction
- Services designed to meet individual needs, with choice by the service user/patient
- Improved independence and choice increases the service use's/patient's perception of the quality of care delivered
- Increased co-ordination between organisations and professionals reduces risk and improves integration of care with needs
- Support for a vibrant Third Sector
- Improved partnership working
- Improved equity for all people diagnosed with dementia irrespective of age or pre-morbid condition

3.8 Anticipated risks

Anticipated risks include:

- Availability of funding
- Timing of Long Term Care Benefit funding
- Ability to recruit staff
- Securing appropriate estate
- Capacity to engage with a range of providers and stakeholders, including Primary Care and Third Sector
- Identifying individuals with dementia
- Resistance to changing working practices and patterns
- Public acceptability of choosing their own care
- Limited supply of Housing specifically for Older People

3.9 Dependencies and Enablers

Interactions with:

- The entire range of services provided for individuals and their carers
- Other States Departments
- Older Adults Policy group
- Third Sector organisations

And with:

- HSSD Business Plan 2012
- States Strategic Plan
- Medium Term Financial Plan
- Health and Social Services White Paper

- Older Adults Strategy being developed during 2012

Workforce:
See section 3.5

Estates:
See section 3.6

Commissioning:
New dementia services will be robustly commissioned. Services will be provided transparently, with visibility on activity, outcomes and value for money. The provider market will be supported, in order to sustain Jersey's vibrant Third Sector and other providers. This will include the development of an Approved Provider List, and services developed and delivered in partnership.

Metrics and outcome measures, including Patient Reported Outcomes, will be collected in order to assess the benefits provided by the new dementia service, to contribute to future commissioning and to demonstrate value for money.

Primary Care:
Primary Care services are integrated to the delivery of the new dementia service. This includes case finding, assessment and provision of ongoing care and support to individuals with dementia and their carers and families. In particular, a dementia register will be developed.

IT:
Awareness and information will require a range of media, including the citizen's portal.
In addition, IT will be required to support the community multidisciplinary team working, and telehealth / telecare are essential elements of the new dementia service.

Informatics:
Data and information will need to be improved in order to maintain the dementia register, to monitor activity and to assess the benefits of the new dementia service (both qualitative and quantitative, and in terms of outcomes).

Finance:
The introduction of the Long Term Care Benefit will support the sustainability of dementia services delivered in the community and in care homes. It will also support an individual's choice and will assist with the personalisation agenda.

Legislation:
- Mental Health Law
- Mental Capacity Law which will incorporate Curatorship
- Regulation of Care Law
- Hospital Charges Law

3.10 The Financial Case

3.10.1 Revenue costs

The total additional recurrent revenue cost increases to an additional £2.4m p.a. by 2015.

The revenue cost is estimated to be:
2013 - £742,000
2014 - £1.813m
2015 - £2.436m

In addition, non-recurrent implementation costs of £131k are estimated to be incurred over the period 2013 - 15.

Enhancement of community care for people with dementia will require an additional 35 medical, nursing, therapy and support staff working in an integrated community team which also includes generic health and social care support workers.

Implementation costs include recruitment of staff, setting up the Active Ageing and Wellbeing Centre and supporting the Third Sector:

Summary costs 2013 -2015	2013	2014	2015
	£'000	£'000	£'000
Implementation Costs	59	68	4
Recurrent revenue costs	742	1,813	2,436
Capital costs	53	-	-
TOTAL	**854**	**1,881**	**2,440**

3.10.2 Revenue savings

A number of benefits are anticipated by the second quarter of 2015, including:

- Estimated reduction in bed days at the general hospital of 1,000,p.a. by Q2 2015 which supports the hospital in managing the predicted future pressures (£400,000 p.a. – equivalent to 3 beds released for capacity pressures).
- Estimated reduction in dementia assessment bed days of 1,000 (£170,000 p.a – equivalent to 3 dementia assessment beds released for capacity pressures).
- Delays the need for residential care by.3 months for 100 people (£600,000 p.a.)

3.10.3 Capital costs

£53k capital costs will be incurred in estates refurbishment.

3.10.4 Funding

It is envisaged that services for people with dementia and their carers will continue to be delivered free within acute and community settings. In the coming years the Long Term Care Benefit is due to commence. This will provide funding for individuals to make choices, against a range of Qualified Providers, regarding their ongoing long term care needs.

3.10.5 Managing risk

In order to minimise the financial risk, the following actions must be taken:

- Identify intended benefits carefully
- Monitor the community dementia service and work collaboratively to ensure that maximum efficiency is achieved delivering a value for money service
- Monitor the success of the service closely
- Make staged investments once the expected benefits are realized

3.10.6 Sensitivity analysis - scenarios

3.10.7 Assessment of affordability and value for money

Based on the total anticipated activity, the revenue cost for redesigned dementia services is estimated to increase by c£2.4m p.a by 2015. In addition, non-recurrent implementation costs of £131k are estimated to be incurred over the period 2013 - 15.

The estimated capacity release in acute hospital beds, mental health assessment beds and reduced long term care costs is anticipated to be equivalent to £1.9m p.a. by the end of 2015.

3.10.8 Verification procedures and assumptions

The following assumptions have been made:

- Staffing – it will be possible to recruit and retain appropriate staff (in terms of grade, staff type, seniority, experience, skill mix and numbers)
- Activity – will increase in accordance with the KPMG analysis, at prevalence levels similar to those experienced in the UK
- Parish and third sector – will be willing to develop and deliver services, working in partnership with HSSD
- GP funding - will be available, supported by the Quality Improvement Framework (QIF)
- The Curatorship office will be enhanced through business as usual

3.11 Implementation Actions and Timescales

		2012				2014				2014				2015			
Timescale	**Action**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Awareness and Information	Develop service specification and tender documentation																
	Commencement																
Active ageing and wellbeing Centre (the dementia 'hub')	Appoint centre manager																
	Identify appropriate building																
	Develop service specification and tender documentation																
	Opening of the centre																
Early Diagnosis	Commence detailed package of training for GPs																
Memory assessment support service	Commence the recruitment process starting with psychologist and admin. This process will occur annually until 2015																
	New staff commence																
Psychiatric liaison	Recruit to post																
	Commence service																
Enhanced Community Service	Business planning to develop the community team																
	Advertise and recruit to community team roles																
	New staff commence																
	Introduce supporting independence budgets																
Care co-ordinators	Advertise and recruit for 1 qualified staff and 1 x support staff																
	New staff commence employment																
	Advertise and recruit for 1 qualified staff and 1 x support staff																
	New staff commence employment																
	Advertise and recruit for 1 qualified staff and 1 x support staff																
	New staff commence employment																

4 Stakeholders

4.1 Stakeholder involvement in service model development

The preferred model for service development was identified over the course of three workshops which ran from October – November 2011. Follow up discussions with key stakeholders outside the workshops allowed the model to be developed, reviewed and refined during the two month period.

Name	Organisation	Responsible	Accountable	Consulted	Informed
Richard Jouault	Community and Social Services	✓			
John Cox	Community and Social Services	✓			
Tina Lightfoot	Service Manager Older Peoples Service	✓			
Dr Lesley Wilson	Consultant Psychiatrist		✓		
Andrew Le Feuvre	Team leader Community Mental Health Service		✓		
Gill Rattle	Occupational Therapist	✓			
Helen Hooper	Service Manager Older Peoples in-patient services		✓		
Jean Hinks	FNHC			✓	
Jo Cummins	Jersey Alzheimer's Association			✓	
Dominique Caunce	Housing			✓	
Philippa Venn	GP			✓	
Linda Norman	Human Resources		✓		

Mark Queree	Finance		✓		
Hugh Neylan KPMG facilitator	Public Health Department				
Robert Gardner	Special Needs Service			✓	
Patricia Winchester	MIND Jersey			✓	
Sian Wareing-Jones	Voluntary sector			✓	
Pearl Thebault	Jersey Care Federation			✓	
Mark Richardson	ESS			✓	
Julie Crocker	Consultant Psychologist			✓	
Jackie Jolly	Jersey Care Federation			✓	
Ian Dyer	Service Director for Older People	✓			

4.2 Communications to Internal Stakeholders

Internal communications regarding the monitoring and performance of the pathway would be communicated through the community and hospital governance structure. Performance and monitoring of General Practice would be completed by the Primary Care Unit. The Integrated governance group would receive whole system monitoring reports on an annual basis.

4.3 Communications to External Stakeholders

The provider workshops included a large number of stakeholders due to the complexity of this OBC. The key next stage is to incorporate the parishes with the key stakeholders. During the OBC process face to face communication has continued with Jersey Alzheimer's Association, the care federation and MIND Jersey.

5 Conclusion and Next Steps

5.1 Conclusion

The demand for dementia services will increase significantly in future years due to the projected increase in older adults.

Individuals with dementia, and their carers, want to be able to remain at home for as long as possible.

Redesigned dementia services will enable early identification of need and the provision of co-ordinated, integrated multidisciplinary services to meet an individual's need and support their carer. Care co-ordinators will support individuals and a range of community services will be available, 24 hours, to ensure the individual has choice and the ability to be maintained in their own homes for as long as possible.

Redesigned services should release capacity in the acute hospital and in nursing homes. They should also improve outcomes, improve service user and carer experience and provide value for money. The role of the Third Sector will be supported, sustained and enhanced, with services working in partnership.

In order to deliver the redesigned dementia services, recurrent revenue funding needs to increase to £2.4m by 2015. Implementation costs of £131k will be incurred over the period 2013 - 15.

5.2 Capacity and project management requirements

The development of the Full Business Case will require additional resourcing.

Robust project management will be required in order to develop and deliver the revised dementia service within the stated timescales. Commissioning expertise is also required in order to ensure opportunities for the Third Sector are developed, and a key dependency exists with the development of quality contracting for Primary Care.

5.3 Next steps

This OBC will be finalised in the Full Business Case (FBC) in Autumn 2012. The FBC will aim to:

- Verify the continuing need for investment in the project
- Demonstrate that the preferred solution represents value for money
- Establish that the HSSD is capable of delivering the project
- Confirm that the planned investment is affordable
- Demonstrate that HSSD is capable of managing a successful implementation and subsequently sustaining success
- Provide an essential audit trail for decisions taken
- Identify how benefits will be realised and monitored
- Confirm the investment decision

The FBC will need to be approved and provide sufficient assurance to senior management that the project can proceed and resources can be committed. The FBC is used as a reference point in the event of any business changes during the project lifecycle and in the event of a post project review or equivalent major review following implementation of the project.

Sign off by Minister

……..

pe *(who does this enefit e.g. service users, staff)*	Short term or long term?	How will the benefit be measured	What is the baseline	Target *(where can we get it)*
vice User and family	Ongoing	• Outcome assessments and reviews • Service user/carer feedback • Outcomes reporting suite	JASS Survey 2010	30% improvement in QOL measure
ulation of Jersey rofessionals	Ongoing	• Decrease in demand for expensive professional support • Decrease in duplication of services • Increase in third sector, Parish and volunteer support	KPMG technical doc	
ent /Service user te hospital nary services	Ongoing	• Decrease in crisis intervention. • Decrease in hospital admissions	Trakcare info	
vice Users Tax ers family, staff	Ongoing	• Decrease in proportion of older people being admitted to nursing homes / residential homes	2007 – 2010 referral rates	30% reduction
vice user/Carer, SS, public	Ongoing	• Number of individuals on dementia care register • Number of carers on dementia care register	KPMG technical doc	
vice users/carers	Ongoing			

What is the benefit	Type *(who does this benefit e.g. service users, staff)*	Short term or long term?	How will the benefit be measured	What is the baseline	Target *(where can we get it)*
Increased support to care homes	Service users, family and staff	Ongoing	• Decrease in breakdown of care in care homes • Decrease of GP intervention in care homes		
Increased support to acute hospital	Service users, family and staff	Ongoing	• Decrease in length of stay in hospital • Decrease in admissions from Emergency Department	In 2010 there were 410 delays per 100,000 population	• Reduction in LOS by 30% • Reduction in delayed discharges by 10% • Reduction in readmission 30%
Clear, individualised pathway	Service users, carers, professionals	Ongoing	• Increase in early diagnosis • Decrease in inappropriate referrals		
Integrated, co-ordinated team	Service users, carers, workforce	Ongoing	• Improved retention and recruitment improved • Increase in morale • Decrease in acute admissions • Decrease in carer breakdown	KPMG technical doc	
Consistent support, information and training to carers	Service users, carers and formal care services	Ongoing	• Decrease in the need for formal care • Delays in admission to acute or long term residential care • Carer feedback		

Appendix 2 - Stakeholder log

Stakeholder Identified	Are they...			
	Responsible *(will work to deliver the OBC)*	**Accountable *(answerable for the delivery of the OBC)***	**Consulted *(opinions sought)***	**Informed *(kept up-to-date on progress)***
Service Users and Carers			✓	✓
Provider Market: Care Homes Domiciliary Care agencies Family Nursing & Home Care			✓	✓
Workforce Training	✓		✓	✓
GPs	✓		✓	
Parishes			✓	
Social Security			✓	✓
Housing Department			✓	
Planning Department				
Treasury & Resources Department	✓			
Ministers	✓	✓	✓	✓
HSSD Psychiatric services		✓	✓	✓
Day Centres	✓		✓	✓

Stakeholder Identified	Are they...			
	Responsible ***(will work to deliver the OBC)***	**Accountable** ***(answerable for the delivery of the OBC)***	**Consulted** ***(opinions sought)***	**Informed** ***(kept up-to-date on progress)***
Third Sector • Alzhiemers • Age Concern • CAB etc			✓	✓
HSSD Community Teams	✓	✓	✓	✓

Appendix 3 - Risk log

Risk	Likelihood *(High / Medium / Low)*	Impact *(High / Medium / Low)*	Overall Risk Rating *(Likelihood x Impact)*	Controls/Actions
Lack of knowledge and skills in dementia care	H	H	H	• Ongoing programme of flexible training, including training for informal carers
Staff resistance to change	M	M	H	• Leadership, change management, communication and engagement
Lack of data and informatics	M	M	M	• Invest in FACE to support comprehensive data collection • Agree metrics and outcome measures
Recruitment and retention of skilled staff	H	M/H	M/H	• Targeted recruitment • Comprehensive training and development Succession planning for all staff
Third Sector engagement and agreement to new models of care	M	M	M	• Professional Officer support • Building relationships • Co-production of plans • Strong commissioning • Training support
Unwillingness to change practice	H	H	H	• Introduction of a multi-agency risk panel • Enhanced governance • Clear policies and procedures
Lack of supported housing	H	M	M	• Develop extra care housing
Lack of political commitment	H	H	H	• Robust business case • Develop ‘Invest to save’ culture
Underestimate level of demand	M	M	M	• Improve data collection • Health Intelligence • Improve risk stratification and case finding

Appendix 4 - Issue log

Description	**Impact** *(High/Medium/Low)*	**Lead**	**Comments** *(What can we do to work around the issue?)*
Current state of the estate from which services are being / will be delivered – need for urgent upgrade in some locations			
Lack of an integrated and/or shared IT system	H		Funding is needed in the Transition Plan
States Housing and development of extra care housing	H		Develop a joint workstream with Housing

Appendix 5 - Dependency and enabler log

Description of Dependency	Dependency Lead	Dependency 'Strength'	Comments
Assisted transport	?	M	Review assisted transport
Enable nurse practitioners to prescribe medication as part of 24/7 service and CPN support	RN	M	Obtain timeline Explore options if not possible
Long Term Care Benefit	MR	High	Introduction in July 2013. Increased demand on already stretched resources Issue of transfer from IC to LT care
Inspections and Registration New law	CB	High	Update on progress. Can amendments be made in interim to new law
Commitment from Ministers		High	Develop a robust communication system with ministers to promote partnership working
Integrated IT/informatics		High	To ensure accurate data capture to inform service delivery
Planning for extra care, sheltered for people with dementia		High	All planned supported housing should be able to accommodate people with dementia
Mental Health Law	I.D.	High	Dependant on external factors • Timeline – end 2014 • Policy on Capacity being developed
Court of Protection	I.D	High	Mental Capacity Law needed to support Safeguarding and safe management of finances
Communication Systems Clarity of governance Leadership		High	Strong leadership needed (at all levels) with support of project management

Appendix 6 - Financial Analysis

Note: the costs shown in the table below, and throughout the document, have been inflated to reflect the relevant prices for each year.

Initiative title and resource requirements	Additional FTE required	Implementation date	Capital Costs £ ('000)	Implementation £ ('000)	2013 revenue £ ('000)	2014 revenue £ ('000)	2015 revenue £ ('000)
A) PREVENTION & IDENTIFICATION							
Active Ageing and Wellbeing Centre containing 'Dementia Hub	2.00	2014	-	2	-	30	62
Centre Manager 1 x FTE CS commencing June 2013	1.00	2015	-	2	-	-	64
Centre workers, administration, reception and information coordinators 2 x FTE CS (to support the activity from the wellbeing centre 6 days a week) Commencing 2014		2014	-		-	43	44
		Jan-13	-	-	42	54	66
		Jan-13	-	-	21	21	22
	3.00	Jan-13	-	31	28	254	261
B) ASSESSMENT & DIAGNOSIS- EARLY INTERVENTION AND TREATMENT							
Memory Assessment Service Old age psychiatrist Assoc specialist – This role would include governance 1 x FTE commencing June 2014 Consultant Geriatrician to commence June 2014, this role will include the work generated by the intermediate care service 1 x FTE	2.00	2014	-	4	-	56	57
Community Psychiatric Nurses 2 x FTE N&M one to commence 2014 the second in 2016	1.00	Jan-14	-	6	41	83	85
Psychologist 1 x FTE CS to commence June 2014	1.00	Jun-14	-	8		52	107
Admin 1 x FTE CS to commence June 2014	2.00	Jan-13	-	12	33	108	178
Treatment Services Senior Social Worker 1 x FTE CS to commence October 2013 Social Workers 2 x FTE CS one to commence January 2014 and the second in January 2015 Psychologist 1 x FTE CS to commence in January 2013 CPN 2 x FTE N&M one to commence in January 2013 and the second in 2017	4.00	Phased from 2013 to 2016	-	16	49	161	227
Occupational Therapist 2 x FTE CS one to commence in October 2013 and the second in January 2015 CPN specialising in falls prevention and incontinence management 1 x FTE N&M to commence in June 2014	3.00	Jan-13 Jun-14	-	7	61	94	129
Administrator 1 x FTE CS to commence in June 2013	2.00	Jun-13	-	8	29	60	123
	1.00	Jan-13	-	6	81	83	85
Care co-ordinators Mental Health professionals 4 x FTE CS or N&M The first commencing in June 2013 then one in January 2014, 2015 and 2016 Social work assistants 4 x FTE CS The first commencing in June 2013 then one in January 2014, 2015 and 2016. This team will cover 7 days with a shift pattern	8.00	Jun-13	-	13	48	196	301
C) LIVING WELL WITH DEMENTIA							
Carers Support Counsellors 2 x FTE CS the first to commence June 2014 with the second in January 2017	2.00	Jun-14	-	2	-	28	57
Carers support worker 1 x FTE CS to commence June 2013	1.00	Jun-13	-	2	28	47	48
Non-staff resources for the 3rd Sector to strengthen current services plus £200k to support carers with respite		Jan-13	-	8	147	215	265
Supporting independence Budget to make home environments safer and more convenient (£130k)		Jan-13	-	-	95	118	143
D) END OF LIFE							
Hospital and Care Home liason/in-reach: CPN 2 x FTE N&M the first to commence June 2013 with the second commencing 2016	2.00	Jun-13	-	4	28	56	57
The treatment team and memory assessment team will also input into this service which will also provide training across all services including the hospital, care homes and staff involved in delivering dementia care service			-	-	11	54	55
Property budget required for refurbishment to improve property			53	-	-	-	-
Total Capital and Revenue Costs	**35.00**		**53**	**131**	**742**	**1813**	**2436**