Ref: **Current Stage:** *Ver 0.1* **Author:** *D Saunders*	Business Case Dementia Early Diagnosis	NHS Oxfordshire

ITEM JHO8(a)

Proposal:	Early Diagnosis in Dementia service
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Author:	Duncan Saunders
Directorate:	PMO

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Contents List

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Distribution List

PMO **must** review all Business Brief and Business Cases

Role	Name	Position	Scope
SDM	Duncan Saunders	SDM; Older Peoples Mental Health	Memory assessment service redesign

Issue/Amendment Record

Status	Version	Release	Issue Date	Reason For Issue/Changes Made
Draft	0.1	No	26/04/2010	First Draft
Draft	0.2	No	15/05/2010	Changes following discussion with John Walton
Draft	0.3	No	2/6/2010	Changes following discussion with Suzanne Jones
Draft	0.4	No	7/6/2010	Changes following discussion with Pauline Smith

Executive Summary

Executive Summary

Early diagnosis for people with dementia has been shown to have benefits in terms of patient and carer quality of life and independence; there is also evidence to show that there is a financial benefit as a result of delayed need for residential care.

In Oxfordshire, Quality and Outcomes Framework (QOF) data shows that 34% of people currently receive a diagnosis of dementia. Memory clinics exist, provided by both Oxford Radcliffe Hospitals Trust (ORHT) and Oxfordshire and Buckinghamshire Mental Health Trust (OBMHT). There is currently no clear pathway and no agreed service specification, leading to uneven levels of service and post diagnostic support. There is confusion among GPs around where to refer a patient with suspected dementia.

Building on recommendations in the National Dementia Strategy, the proposal is to commission an integrated Memory Assessment Service involving both providers working together to maximise the strengths of both. The need for an increase in the numbers receiving a diagnosis and current capacity issues would be partially addressed by enabling a specialist dementia nurse to undertake routine follow up appointments, moving the follow up appointments into community settings such as GP surgeries and freeing up consultant time for diagnosis and more complex cases. Agreed information and support would be provided at, or shortly after, diagnosis.

Background

The National Dementia Strategy was published in February 2009, containing 17 objectives. The implementation of the strategy is overseen by the Dementia Development and Implementation Board, and involves a commissioning team from both Oxfordshire PCT and Oxfordshire County Council. Early Diagnosis in Dementia is objective 2 of the National Dementia Strategy and forms one of the priority areas for Oxfordshire. Lead responsibility for this project is with Oxfordshire PCT.

A review of memory assessment services was undertaken in 2008, which underpins this document and the wider project.

There are many reasons for robustly commissioning a memory assessment service for the early diagnosis of people with dementia. In its guidance on Commissioning Memory Assessment services, NICE lists some of the potential benefits as increasing the number of people seen for early diagnosis and intervention, reducing total care expenditure by delaying the time to nursing home admissions and other costly outcomes, breaking down the stigma of dementia and improving the quality of life of people with dementia and their carers by promoting and maintaining independence. According to the NICE guidance, “Early detection and intervention enables more timely access to treatments and ultimately reduces total care expenditure by delaying the need for long-term care and other costly outcomes.”
“It is…well recognised that dementia has a significant economic impact on the health care system, on patients, on family and friends who provide unpaid care, and on the wide economy and society.” (Dementia 2010 report, Alzheimer’s Research Trust 2010)

Currently, the level of dementia diagnosis in Oxfordshire is 34% based on the estimated population with dementia and QOF data, so only around 1/3 of people with dementia have a diagnosis.
There are tensions in this locally; memory clinics currently undertake diagnosis and follow up monitoring of dementia; capacity issues mean that follow up is commonly less frequent than NICE guidance suggests. Also, Oxfordshire’s population is ageing and Community Mental

Health Team (CMHT) resources are likely to decrease with pending reorganisation, thus exacerbating these issues.

The 2008 report reveals some examples of good practice but significant variation exists between clinics across the county. There is variation in staff resources between clinics, leading to variation in service and follow up support. There is also inequitable access to structural imaging, which often falls short of NICE clinical guidelines.

There is currently a dual system in place with two providers; OBMH and ORH both provide memory assessment services for dementia. There is an identified need for a clear point of access and single service across the county, alongside a clear care pathway.

Proposed Solution

The proposal will build on existing good practice within Memory Clinics in Oxfordshire. The proposal would see the establishment of a single Memory Assessment Service within the county, providing an integrated service between the providers with a clear pathway and a single point of access for Memory assessment services in Oxfordshire.

The single point of access for both providers will receive referrals from GPs, removing current confusion around where to refer, building on recommendations from the National Dementia Strategy that "such services would need to provide a simple single focus for referrals from primary care, and would work locally to stimulate understanding of dementia and referrals to the service." Triage will be provided at this point, with referrals assigned according to clinical criteria. Domiciliary visits will take place as required at this point, to assist in triage.

Patients will have access to a structural imaging appointment to assist in assessment if clinically required. An appointment will then take place in a diagnostic memory clinic; this will be at the closest clinic geographically, unless the patient has requested otherwise. Home visits for diagnosis will be available if necessary. It is proposed that there would be 5 memory clinics for diagnosis occurring within the county on a weekly basis, in suitable locations around the county.

If a diagnosis is given, this will be communicated according to NICE guidance at the clinic. A letter detailing this diagnosis will be sent to the patient's GP, with a copy sent to the patient if requested. Post diagnosis follow up and ongoing monitoring will take place in the community; either at GP surgeries or another suitable location. Initial follow up will include information provision and referral to appropriate services.

Given the current capacity issues, the need to increase levels of diagnosis and future demand for the service, it is anticipated that Consultant Psychiatrists would no longer be involved in all follow up appointments. This work would be undertaken by a registered mental health nurse (memory clinic nurse), operating in a community setting such as a local GP surgery. Referral to the CMHT for more complex cases would then be based on clinical criteria.

The possibility of involving GPs with Special Interest (GPSI) in diagnosis and follow up support is also included within the pathway. Currently, there are no such GPs within Oxfordshire.

Development funding of £116,000 has been included within the PCT operational plan for the support of this pathway. This is recurring funding, so would be available to support the service in future years.

Current Memory Clinic provision:

OBMH:
Didcot: 4 clinics
Witney: 2 clinics
Banbury: 12 clinics
Abingdon: 1 clinics
Henley: 4 clinics
Oxford: 7 clinics

ORH:
OXMAC: 8 clinics
Total: 38
These clinics are used for diagnosis and follow up.

Under the proposed pathway, the number of clinics per month would be 22; 5 clinics happening weekly = 20 per month, plus equivalent work outside clinic (domiciliary diagnosis, etc) for 2 more per month. Locations for these will be confirmed in discussion with providers. These clinics would be used for diagnosis.

Follow up would take place through appointments equivalent to 24 clinics per month, in community settings. Routine follow up would be undertaken by memory clinic nurses.

Investment:
The proposed use of the £116,000 is as follows:

£31,350.4: Band 6 Memory Clinic Nurse (4 day post)

If we were to commission three such posts as part of the service:

£94,051.2: 3 Band 6 Memory Clinic Nurses (4 day posts)

£9,400: Training and on-costs (10%)

£103,451.2

This leaves £12,548.8 for service costs; this will offset the costs of training other professionals such as GPs, additional venue costs, publicising the new service and recruitment costs.

The assumption is that the remainder of the service is “cost neutral”; in other words, that the existing number and grades of staff will continue to operate within the memory clinic system, that the venue costs will be comparable with current costs, that the current arrangements with regard to the provision of scans will continue to be sufficient and that administrative / support costs will remain at current levels.

The additional staff will be located within the existing CMHT structure, and will thus receive management support and clinical supervision from the existing support arrangements within the CMHT.

Assumptions

The following assumptions have been made:

- Early diagnosis and appropriate support for people with dementia and their carers has been shown to reduce the overall long term care costs in national evaluation
- Managers and clinicians support exists to deliver the project and the changes that will

accompany it

- Early diagnosis will result in fewer crisis interventions and delayed admission to intensive support services in the longer term
- Any future restructuring due to the integration of OBMHT and Community Health Oxfordshire will not have an impact on the service.

Risks

The following risks have been identified for the project:

Risk	Mitigation
Risk that there may be opposition by clinicians to the service specification and procurement strategy developed by the group resulting in disengagement and failure to support the changes to the service.	This is being managed by the presence of primary and secondary care clinicians on the project group, and the engagement of clinicians more widely in the project as part of the consultation.
Risk that planned service developments may be hindered due to a lack of resources.	This is partially mitigated by planned investment of up to £116,000, and by planned service redesign to increase capacity. However, future planning will need to look at this issue carefully given the population profile and anticipated increases within the county. Regular reviews of capacity and resources will be required for the service to meet projected demand.
Risk that project will not deliver the required outcomes.	This should be offset by the incorporation of clear, evidence based practice into the redesigned service. There will also need to be appropriate KPIs built into the service through a clear, structured service specification, with regular review of the service against these indicators. Training for professionals within the healthcare system and awareness programmes among the general public will be needed to help increase diagnosis levels.
Risk that memory assessment services will be unable to cope with increased demand.	The planned service is designed to include current and increased demand; however, this will need to be monitored on an ongoing basis, as mentioned above.
Risk that there will be significant user or public opposition to the planned developments.	The presence of a carer representative on the project group, and the wider consultation involving users and carers helping to shape the new service should ensure that the service takes the views and needs of users into account. As the planned developments also seek to provide a clear pathway of care and equitable access to service provision, major opposition to the redesigned service is not anticipated.

Key Stakeholders

The following have been identified as the key stakeholders for the project
NHS Oxfordshire
Oxfordshire County Council
Older Adult CMHTs,
Memory Clinic staff; both OBMH and ORH
GPs
Voluntary sector organisations working in the field of dementia, and with older people more generally
People with dementia, their carers and families

Project Sponsor: Suzanne Jones
Project manager: Duncan Saunders

Communications

The project team has held monthly meetings since the project launched; these have been documented, and the notes distributed to group members. The project sponsor has received monthly highlight reports tracking progress of the project and of the project status. A Communication strategy for the project has been created; a user involvement event was held on May 18th, where the draft pathway was examined. A web based consultation on the proposals was launched May 7th, following the General Election purdah period. Further user and stakeholder involvement was sought through the dementia awareness day on May 23rd and further involvement will be sought prior to implementation of any significant changes to the service.

Supporting Information

Scope

The project **INCLUDES** the following as part of its scope:

- Organisational Scope: primary care, public health, community health and social care services, acute providers of service, voluntary organisations as interest groups
- Client Group: People with dementia or suspected dementia, carers and families of people with dementia
- Funding Streams: health and social care commissioning of dementia care
- Information for staff, service users and carers, through a communication strategy
- Public and patient involvement in dementia developments
- All age groups

The project **EXCLUDES** the following as part of its scope:

- Organisational Scope: generic older peoples services
- Organisational restructuring into workforce required to support new pathway
- Provision of long term care home placement, intermediate care, continuing care
- Marketplace Redesign
- End of life – this will be covered in the end of life project work

Critical Success factors/ KPI's

The critical success factors for the proposal are as follows:

- An increase in the rate of diagnosis for dementia in Oxfordshire
- Diagnosis provided earlier in the course of dementia and a related reduction in the numbers of "crisis diagnoses"
- An equitable service provided countywide to agreed standards

Dependencies

The areas below have an impact on the project work, as work is happening at National or SHA level on dementia development and support, or generic work currently underway will inform the pathway outputs. The pathway can be developed and delivered without them; however they will enhance the pathway delivery. In the case of the DOH Dementia Advisor demonstrator site work, this will impact on the information and support provided to people with dementia and their carers in the mid to long term. In the case of the Dementia Workforce Development Project, this will impact on the delivery of training to allied healthcare professionals, such as GPs.

1. DOH Dementia Advisor demonstrator site phase 2 work
2. Dementia information prescription project work, tied in with (1), above
3. Dementia Workforce Development Project
4. Vascular prevention e.g. Vascular checks for adults at high risk
5. Older people's prevention strategy in Oxfordshire
6. Extra care housing developments
7. Delayed Transfers of Care (DTOC) demand and capacity work

Procurement

It is not anticipated that procurement will be required. However, advice will be sought if this is unclear at the implementation stage.

Constraints

There are possible impacts on the project and on the NHS more widely after the Emergency Budget; these are currently unknown but could have a significant impact on the project delivery in this and future years.

Approach

As suggested in the OBMH Review report, a phased implementation may be appropriate, with providers working together more closely prior to full implementation. If the business case is accepted, the proposal is to establish an implementation group to oversee the implementation of the redesigned service. This will be a time limited group, working towards the implementation of the proposal through a series of milestones to an agreed timescale.

Timescales

Following acceptance of the business case, timescales for implementation need to be established; full implementation is expected by April 2011.

Equality Impact Assessment

An EIA has been completed for this project; an action plan has been drawn up to address potential inequalities. Addressing potential inequalities identified in the EIA will form part of the implementation phase of the project.

Consideration of Green Issues- “Saving Carbon, Improving Health”

While the proposal will reduce the number of diagnostic clinics and potentially require users to travel slightly further to these clinics, there will be fewer appointments at the diagnostic clinics, with follow up support being delivered closer to home. Environmental impact is anticipated to be negligible.

IT Requirements

Diagnostic memory clinics will require internet access, at a suitable bandwidth to enable clinicians to access the ORH PACS system, in order to view patient scans as required. Access will also be required for appropriate databases, such as PCIS and DEEPARC.

Information Governance Impact

The service will use existing secure databases and information systems. There are therefore no anticipated impacts with regard to security of information.

Alignment with WCC – Health outcomes

The proposal aligns with WCC competencies 1; Locally lead the NHS, 4; Collaborate with clinicians, 8; Promote improvement and innovation and 10; Manage the local health system. Strategically, the project forms part of the implementation of the National Dementia Strategy, a key commissioning priority of the Ageing Successfully strategy for Oxfordshire, 2010-2015.

Quality Controls and Audit

Key Performance Indicators will be agreed as part of the contract for the service. These will include but not necessarily be limited to:

- Number of appointments within the service, to be broken down by location, first appointment / follow up and referral source. The number of home visits for assessment and diagnosis will also be recorded.
- Number of diagnoses given by the service, to be broken down by dementia sub type (including Minimal Cognitive Impairment), location and GP practice.
- Number of missed appointments: Cancellations / DNAs
- Staff absence and vacancies within the service.
- Average referral time from referral to assessment, and assessment to diagnosis.
- Percentage of diagnoses notified to GP within 5 working days.
- Results from patient satisfaction survey.
- Patient Gender / Ethnicity breakdown against all of the above.

The above measures will be measured by month and cumulatively for each year.

Post Implementation Review

Following implementation, there will be a review after 6 months and a further review after one year; subsequent reviews will take place on an annual basis. This will look at how far the overall pathway has been implemented against key milestones, any significant obstacles encountered and changes to the agreed timescales, including reasons for these. Action plans will then be updated to reflect the new position, with reports provided to stakeholders; this process will be managed under the governance of the Dementia Development and Implementation Board. KPIs and user satisfaction information will be used to ascertain performance against agreed targets on a monthly, quarterly and annual basis.

Measuring Success of Project Performance

The measures of success are mostly captured within the KPIs. The key metric is the rate of diagnosis for the county; currently at 34%, year on year increases to this will be agreed.

Project Team and Clinical Leads

Public Health lead	Kate King
Communication & PPI lead	Sara Price
Finance Lead	Julia Boyce
Clinical lead - OBMH	Dr Rupert McShane
Clinical lead - OBMH	Dr Carol Bannister
Clinical lead - ORH	Dr Gordon Wilcock
Social care lead	Liz Maughn
Community lead	Claire Du Feu
GP lead	Dr Mary Akinola
Management lead - OBMH	Sam Gillanders
Carer / User representative	Meg Barbour
Age Concern Oxfordshire	Andy Buckland

Service Options

Option 1- Do Nothing, Continue with the Current Services

The impact of the ageing population in Oxfordshire, alongside the current capacity pressures on the service mean that taking no action will not lead to an increase in the numbers of people who receive a diagnosis of dementia; it is far more likely that these numbers will reduce as a percentage of those within the county who have dementia. This will in turn have an impact on services for those with more severe dementia, as services will receive an increased demand.

Option 2 - Improve Current Services with this proposal

Details of the proposal are as listed above; this is the preferred option for improving Memory assessment services within Oxfordshire and increasing the rate of diagnosis. Early diagnosis for people with dementia has been shown to reduce the need for residential services by significant amounts; more detail is contained within the cost analysis, below. The Department of Health Operating Framework for 2008/9 said "…providing people with dementia and their carers the best life possible is a growing challenge, and is one that is becoming increasingly costly for the NHS. Research shows that early intervention in cases of dementia is cost effective and can improve quality of life for people with dementia and their families…"
As a key example of this,
"early provision of support at home can decrease institutionalisation by 22%" (Gaugler JE, Kane RL, Kane RA and Newcomer R (2005). 'Early Community-Based Service Utilization and Its Effects on Institutionalization in Dementia Caregiving'. The Gerontologist, 45, 177–185.) However, achieving this is reliant on early diagnosis. The above proposal would facilitate this.

Option 3 - Outsourcing

The current service is provided by OBMH and ORH; the potential for joint working to improve the overall service is accepted by both sides, as documented in the review of Memory Assessment Services undertaken in 2008 and repeated during the work of this project. Evidence, including that gathered nationally from GPs themselves suggests that a specialist service is necessary for diagnosis of dementia as opposed to GPs providing this diagnosis; as the current providers have worked over many years to develop expertise in this area, there is no real benefit to be gained by doing so, as opposed to the uncertainty that such a move would cause. Additionally, as the current arrangement provides good links to the support provided by Older Adult CMHTs, the breaking of this link would be to the detriment of the patient and suggests against altering the provider.

Implementation Milestones

A phased approach to implementation would be important for the sustainability of the service and to ensure that there is minimum disruption in the provision of the service to current and new patients.
The following key milestones would need to be met in the implementation of the new service pathway:

1. The establishment of an implementation group. Membership of this group would need to include representatives of provider organisations (management and clinicians), PCT commissioners, voluntary sector representatives and users/carers.

2. The creation of a detailed implementation plan, based on this specification and outline milestone plan. This would include target dates and lead areas of responsibility.
3. The establishment of the agreed point of referral across both providers.
4. The employment of the additional Memory Clinic Nurses, to increase capacity.
5. Increased integration between providers, leading to
6. A programme of training and awareness raising for allied health professionals such as GPs.

All of the above will lead to full implementation; the initial target date for this is April 2011.

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Cost Analysis

Potential Investment:

Capital: n/a

Revenue: £116,000 recurring, in addition to current memory clinic costs

Please describe the investment required and expected funding source:

The investment is included within the operational plan 2010/11. This will be used to fund the single point of access / triage, and the increase in activity required over and above the service redesign in order to achieve the increase in numbers of people with dementia receiving a diagnosis.

Potential Annual Savings:

Capital: n/a

Revenue:

Please describe how it is anticipated that these savings will be achieved, i.e. will they be derived from a reduction in activity or a transfer of activity from one setting to another:

Savings will be whole system savings and will be realised in the longer term. Savings are as identified in "The clinical and health economic case for early diagnosis and intervention services in dementia", published by the Department of Health in 2008[1] . This document contained three potential levels of saving; by comparing these to the known and projected picture within Oxfordshire, we obtain the results shown here.
A 6% reduction in the number of people with dementia entering a care home would result in savings in Oxfordshire of £1,620,000, based on current costs.
A 10% reduction would result in savings of £2,700,000.
A 20% reduction would result in savings of £5,400,000.

While these savings are only partially offset by the need for other services such as home care, they do not take account of potential reductions in uptake other acute or intensive services, such as NHS continuing healthcare.
Given that the average length of stay in a care home is 2.5 years, the above savings would be achieved over a similar period. If one takes the smallest figure, a saving of 6%, this provides a saving of £648,000 per year. Removing the additional investment of £116,000, the resultant shortening of stay in residential care is likely to lead to a saving of £532,000.

[1] Banerjee, S and Wittenberg, R (2009) "The Clinical and Health Economic Case for early diagnosis and intervention services in dementia." *Department of Health.*

Appendix A
Cost Benefit Analysis

		Existing £s	**Proposed £s**	**Additional Impact £s**
One Off Investment				
	Capital			
	Revenue			
Less Savings				
	Capital			
	Revenue			
Net Impact				
Recurrent Cost		*Per annum*	*Per annum*	*Per annum*
	Capital			
	Revenue			
	- Pay	863,132	116,000	
	- Non Pay			
	- Capital Charges			

		863,132	116,000	
Less Savings				
	6%			648,000
	10%			1,080,000
	20%			2,160,000
Net Impact				331,132 (6%)

Appendix B

Extract from July 2008 Approved SCHEDULE OF MATTERS DELEGATED TO OFFICERS (V3)

Delegated matters in respect of decisions, which may have a far-reaching effect, must be reported to the Chief Executive. **The delegation shown below is the lowest level to which authority is delegated. Authority can be delegated upwards with no further action being required.** However, delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders. All financial limits in this schedule of matters delegated to officers are subject to sufficient budget being available.

DELEGATED MATTERS	AUTHORITY DELEGATED TO
Business Cases	
a) Up to £49,999	a) Deputy Director of Finance / Executive Director
b) £50,000 to £249,999	b) Director of Finance / Executive Director/ Chief Executive
c) £250,000 to £499,999	c) **Non clinical –** Chief Executive **and** Director of Finance **and** Director not associated with business case **Clinical** – as above **plus** Medical Director
d) £500,000 to £999,999	d) Director of Finance **and** Chief Executive
e) Over £1,000,000	e) Full business case for Board approval

NB: This schedule aligns to the Oxfordshire PCT Scheme of Delegation (V3)