Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
Wednesday 20th November

Report of: Sheffield Health and Social Care NHS FT
Sheffield Clinical Commissioning Group

Subject: Memory Management Services development options

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Summary:

This report outlines the plans being explored by Sheffield Clinical Commissioning Group (SCCG) and Sheffield Health and Social Care NHS FT (SHSC) to improve access to memory services for the people of Sheffield. This report is provided on behalf of both organisations.

It summarises the current position and outlines the areas being explored to inform future service development planning within Sheffield.

The development is being progressed jointly by the SCCG and SHSC. Together both organisations have delivered a range of improvements over previous years, and remain committed to ensuring future improvement remains a priority and are delivered upon.

This report is provided at the request of the Committee.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	**X**
Other	

The Scrutiny Committee is being asked to:

The Committee is asked to

- note the plans being explored and the proposed direction of travel to deliver improvements
- and provide comments and views regarding the proposed way forward.

Background Papers:
List any background documents (e.g. research studies, reports) used to write the report. Remember that by listing documents people could request a copy.

Category of Report: OPEN

Memory Management Service developments report.

1. Introduction/Context

1.1 During March 2013 Sheffield Health and Social Care NHS FT presented to the Scrutiny and Policy Development Committee its draft Quality Account.

1.2 During the review and discussion on the progress made across services, the Committee noted its concern regarding the waiting times experienced by people accessing Memory Service, when compared to other types of services provided.

1.3 The Committee asked the Trust to explore in conjunction with the Clinical Commissioning Group what steps could be taken to further reduce waiting times for memory management services, and to report on the Trust's initial thoughts on this issue.

1.4 The purpose of this report is to update the Committee on the progress made and for members to comment and on the solutions being explored and proposed.

2. Main body of report, matters for consideration, etc

An appendix is provided with more detailed information to support this summary

2.1 Background

2.2 Sheffield Clinical Commissioning Group (and the previous Sheffield Primary Care Trust) and Sheffield health and Social Care Trust have been working together over the last several years to improve experiences and access to Memory Services for the people of Sheffield.

2.3 The main strategies and plans that have been followed have been to

- Raise awareness across primary care and related services and improve signposting of people with possible problems to the right services
- Incentivise Sheffield Teaching Hospitals NHS FT, through the CQUIN scheme to identify, assess and refer people with possible memory problems to the relevant services
- Improve the effectiveness of current services available through the Care Trust.

2.4 These approaches have had considerable success. More people have been accessing services, and waiting times had improved. However, as we continue to identify more people who need services demand is increasing. Both the Commissioning Group and the Care Trust have been exploring how best to respond to this and deliver further improvements at the same time.

2.5 Development plans

2.6 Reviews undertaken of the current client group supported by the existing memory services suggests that most people receiving follow up support have non-complex problems and needs. They require ongoing monitoring and periodical re-assessments as required. However currently this client group is supported and re-assessed by the city wide specialist services when best practice evidence indicates that their needs can be effectively and appropriately provided for within primary care services.

2.7 A key area of focus has been how to improve capacity within primary care services to enable them to provide ongoing re-assessment support. Achieving this is expected to deliver the benefits of care closer to home and free up resources within the city wide specialist services for them to see more people.

2.8 The expectation is that this freed up capacity will allow the city wide service to see more people for their first initial assessment and diagnostic support needs, and to see them within more acceptable timescales.

2.9 The preferred approach to achieving this is based upon a hub and spoke model of care. This would consist of initial assessments being provided through a city wide specialist service, and ongoing support and monitoring of progress being provided in primary care. Key features would be;

- Care pathways within primary care, complementing the broader development of primary care services.
- Specialist nurse led support within primary care to work alongside and within primary care services.
- Further improvements to existing service models in respect of diagnostic testing support.

2.10 The expected outcomes are intended to be

- More people would be able to access assessment and diagnosis services quickly – which will improve people's experiences and the care outcomes of the support and treatment provided.
- Follow up care will be better integrated within the broader primary care provision resulting in more integrated care for the individual
- Follow up care and reviews will be provided more locally – resulting in better experiences for people and less inconvenience regarding travelling and disruption.

2.11 The resource implications of the proposed model are still being considered and evaluated. It is expected that some of the existing resources from the city wide model can be allocated to provide outreach support/ specialist community nurse input to the primary care pathway. Additional resource needs may be highlighted but this hasn't been determined at this stage.

3 What does this mean for the people of Sheffield?

3.1 This plan aims to ensure that people who are worried that they may be experiencing problems with their memory are able to access appropriate assessments, advice and support quickly. This is key to delivering effective care and providing positive experiences for people.

3.2 The plans being explored will result in future proposals for how improvements will be delivered. While this hasn't been finalised at this stage, the preferred option will mean that people in Sheffield will get their ongoing needs met more locally within their local primary care services if this is felt appropriate.

4. Recommendation

The Committee is asked to

- note the plans being explored and the proposed direction of travel to deliver improvements
- and provide comments and views regarding the proposed way forward.

Project Aim and Objectives

Aim

To provide a high quality service that can assess, diagnose and review people with dementia in Sheffield in a timely manner, the most appropriate setting and deliver the best value for money in achieving this aim.

Objective
It is proposed that this can best be delivered by:

- A hub and spoke model of care
- A single site location for the assessment and diagnostic elements of the service (hub)
- Provision of an 'outreach' service from the single site to enable assessment of patients admitted to STH (hub)
- Development of a memory service community provision that will undertake bi-annual review of patients within general practice (spokes)

Outcomes & Project Benefits

Quality Improvements

The proposal supports achievement of the following NHS Framework Outcomes:

- Domain 2,Enhancing the quality of life for people with long term conditions by;
  - Ensuring people with dementia get a timely diagnosis (aiming to deliver this within 6 weeks form referral), thus enabling people to cope better with their condition
  - Enabling independence and improving quality of life through effective review and improved community based presence
  - The proposal is modelled on the basis that 1,270 more people will be supported and, 4,500 people will receive ongoing follow up in a more community appropriate setting, and a waiting time to access services of 6 weeks.

- Domain 4, Ensuring people have a positive experience of care by;
  - Ensuring people experience an integrated care pathway that enables effective access minimises repetition providing specialist advice and interventions in appropriate settings

Resource Releasing

Re modelling of the current provision will require some re-alignment of resources (re-allocation of staff to community setting) and some investment to provide for the projected demand

Drivers

There are a number of drivers for the proposal which are a combination of local, regional and national agendas and priorities.

NICE guidelines and the NHS Outcomes framework require both commissioners and

providers to comply with specific criteria. There are 10 NICE quality standards relating to care for people with a dementia;

1. Training to ensure appropriately trained staff
2. Referred to Memory service
3. Client/carer info provided
4. Named care coordinator
5. Legal affairs discussed with patients/carers
6. Carer assessment undertaken
7. Non cognitive assessment and interventions where required
8. Access to liaison services
9. Palliative care planning
10. Respite access for carers

Delivering improved outcomes in line with the NHS Outcome framework.

The current memory service has historically been accredited by MSNAP (the national organisation that reviews memory services) as an excellent service. Locally the service is viewed as providing a high standard of care and treatment. It is recognised that the service locally has achieved much to improve waiting times and increase its capacity to see more people through improving pathways, systems and processes. However further improvements are required to respond to unmet need and future demands (see below).

Strategically within Sheffield there is a drive to integrate care pathways seamlessly across primary and secondary care, and to ensure care is delivered within primary care where appropriate.

Problem

Backgound - performance and developments

In 2012, there were 6,494 people predicted to have dementia (diagnosed and undiagnosed) in Sheffield. Of these, 4,130 have a diagnosis on the GP Quality Outcome Framework dementia register which means that Sheffield is now estimated to have diagnosed 63.6% of people with dementia. In 2011, Sheffield had 3,621 people with a diagnosis on the dementia register and was estimated to have diagnosed 56.7% of people with dementia. This therefore represents significant progress.

When compared to other Clinical Commissioning Groups in England and Wales, Sheffield now ranks 2nd for the diagnosis of dementia however, there is still some way to go and we continue to work to increase diagnosis rates. In 2013/14 a number of initiatives will help with this:

- Year 2 of the national dementia CQUIN for STH
- Increased diagnostic capacity in the SHSC memory service
- Specialist input to primary care to support case finding
- Public awareness campaigns – national and local
- Workforce development
- GP DES on case finding

Progress on the diagnosis of dementia in Sheffield is demonstrated by the steady growth in the proportion of people who have been diagnosed, as summarised in the table below.

Year	% Diagnosed	AS Ranking (England and Wales)
2006-2007	44.98	
2007-2008	47.58	
2008-2009	50.78	13th
2010	53.2	6th
2011	56.7	3rd
2012	63.6	2nd

From the England and Wales data for 2012, Yorkshire and Humber SHA has an average diagnosis rate of 48.6%. In South Yorkshire; Barnsley has 46.1%, Doncaster 53.7% and Rotherham 55.7%.

At the same time the Memory Services within the Care Trust have been increasing their ability to see and support more people each year. This has been achieved through a range of service and productivity improvements.

Year	Numbers assessed & diagnosed	Waiting times
2010-11	749	21.2 weeks
2011-12	876	14.5 weeks
2012-13	918	16.3 weeks

Over the last 3 year period the service has managed to see 22.5% more people to provide an assessment and diagnosis support service, and reduce waiting times by 23%.

However it remains the case that access arrangements need to improve both in terms of increasing the numbers of people supported and further reductions in waiting times. While currently the 2nd best performer in England regarding diagnosis rates and identifying people effectively, the evidence suggests that there are still 36% of people in Sheffield who haven't yet been identified by services. Looking ahead to the future, there are currently estimated to be 6,494 people with dementia in Sheffield and it is anticipated this will rise to 8,108 by 2025. This represents a 25% growth by 2025.

Current position

The following highlights a number of difficulties the service is experiencing/facing:

- Facing increasing waiting list from referral to assessment (16 weeks)(current wait is between 18 – 22 weeks)
- Duration of wait from assessment to diagnosis (6 – 8 weeks)
- Service located across two sites creates inequalities in access and unnecessary costs
- Projected increase in service demand

Sheffield is the 2nd best performer in England re diagnostic rates. However there is still a diagnosis gap of c. 37% in Sheffield with only 4,130 of those currently estimated to have dementia on GP Dementia registers, so we are not offering early treatment which would help people manage their disease and delay its onward progression. At consortium level, the following gives an indication of the cases to find currently:

Cases to find 2011	
Central	745
HASC	965
North	369
West	561

Diagnosis capacity required

An additional 1,2700 people will require specialist assessment by 2016 if we are to case-find the backlog and meet estimated growth in this population to that date. The Memory Service is currently funded to undertake 800 assessments per year and therefore needs to reconfigure capacity within its existing investment for the additional assessments as follows:

Table 1: Additional Diagnostic Capacity at Memory Service				
Memory Service	12/13	13/14	14/15	Total
Current Contract	930	930	930	2,790
Extra Required	59	65	100	219
Revised Total	989	995	1000	3,009

Follow-up

Previous reviews with the Memory Service, we have identified that 2,500 patients being followed up. Our assumption is that all of these are clinically appropriate to be transferred into primary care for follow up in 13/14

Assuming the above diagnosis demand this will impact on an increased demand for follow up appointments in primary care (of this population approximately 1,500 patients reside in nursing homes) requiring a phased increase in capacity

Table 2: Additional Review Capacity in Primary Care				
	13/14	14/15	15/16	Total
Number of patients	2,500	4,010	4,500	11,010
Number of reviews	5,000	8,020	9,000	22,020

Options Appraisal

1. **Do nothing**

Impact:

- Continue with secondary level care only, with variable connection to primary care services – failing to progress city wide vision for primary care based care and treatment.
- City wide modelling of demands/ needs arising from people with dementia has been previously undertaken. The costs of doing nothing to the local health community have been estimated (by 15/16) as:
    - An £830k increase in care home placements
    - An £880k increase in the costs of hospital admissions
    - A £200k increase in Community Mental Health Team contacts

2. Move to a single site and continue existing specialist service model/care pathway

Impact:

- Continue with secondary level care only, with variable connection to primary care services – failing to progress city wide vision for primary care based care and treatment.
- Does not provide the capacity to meet the demand/not effective use of resources

3. Move to a single site and undertake reviews in primary care

Impact:

- In line with city wide vision for primary care based care and treatment. Fits with MSNAP and Alzheimer's society recommendations
- Best value for money - Increase ability to meet demand/Improved use of resources
- Provide care closer to home

4. Move all provision to general practice

Impact

- Not adequate capacity or skill base within general practice to meet demand
- Not logistically viable to have mobile memory service covering general practice
- Does not provide in reach into teaching hospitals to facilitate assessment,

5. Invest in existing service model

Impact

- Would provide for increased capacity required
- However poor value for money
- failing to progress city wide vision for primary care based care and treatment

Preference

The above information highlights that in order to meet the increase in assessment (and subsequent review) demand the current service needs to re-configure to enable the current bottleneck of increased reviews to be addressed within general practice

Current position

(Hub building based provision)

Assessment	918
Diagnosis	918
Review Provision	2,500
(Spoke - primary care provision)	0
Review (nursing home patients)	300

Proposed Service

(The following calculations are estimates and need clarifying with additional demographic information)

(Hub building based provision)

Assessment	1250 (2014/15 to address waiting list)
Diagnosis	1250
(Spoke – primary care provision)	
Review	4,500
Review (nursing home provision)	0

Resource Required
(The following figures are estimates and require further clarification as they are dependent on clarification of demographic information)

Some flexibility of current resource and additional staff will be required to meet the demand over the next 5 years
Estimates on the projections highlighted above indicate an additional 5.3 WTE staff will be required

Solution Selection

Proposal:
Move to a single site and undertake reviews in primary care

Benefits:
The proposal highlights significant cumulative benefits to health and social care – totalling £1.6m over 5 years from the total health economy – if dementia care was redesigned. The benefits of the proposal includes;
early diagnosis, improved carer support, reviewed liaison psychiatry and improved rapid response functions, including in-reach to care homes. This development plan is focussing on the first step (early diagnosis) and we are not therefore suggesting that on its own it will therefore generate saved admissions.

Evidence
The dementia rationale is spelt out in the QOF Guidance for GMS Contract 2011/12.

Further information: NICE clinical guideline 42 (2006). Dementia. Supporting people with dementia and their carers http://guidance.nice.org.uk/CG42/NICEGuidance/pdf/English

Comparisons are drawn as well to services for people with Diabetes. 10 years ago all care for Diabetes Types I & II was mainly delivered in consultant led hospital based services, with people attending c.3 times per annum for review and check-up. Now it is all mainly community care delivered, supported by specialist nurse input when required.

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