Appendix

1. Case for Change

- Bromley is underperforming against the national dementia diagnosis target of 67% (currently 49.99% as at January 2015)

- The Memory Service has seen a 76% increase in referral activity since 2011. The current level of demand for assessment, diagnosis and follow-up treatment is unsustainable within existing resources.

- Waiting times for assessment and diagnostic appointments are growing (currently averaging eight weeks waiting from referral to diagnosis) as the service struggles to meet demand through cancellation of groups etc., which adversely impacts of the follow up support diagnosed patients receive.

- Information from the British Geriatrics Society, 2011 indicates that 4% of people over 65 live in care homes, rising to more than 20% of people over 85. Bromley has 45 care homes (excluding those for people with physical disability and learning disability) with a total of 1,591 beds.

- For example - 41% of care home residents could not access specialist dementia services (British Geriatrics Society 2012a).

- Supporting GPs – Bromley GPs have expressed they are reluctant to refer their patients for diagnosis because they do not see the benefits in terms of post diagnosis support. Currently our memory service has drawn back from post diagnosis support e.g. cognitive stimulation groups, occupational therapy input, psychological support etc. and all staff are working full time on assessing and diagnosing.

- GPs have also said that they do not feel well supported in managing people discharged from the Memory Service e.g. when carers report deterioration in daily living skills or concerns about safety.

- Oxleas Community Mental Health Services are available only when the criteria for secondary mental health care are met.

- Social care supports people who meet the threshold for service and support the voluntary sector in the provision of information, advice, training and practical support. Increasing numbers of people with dementia and higher diagnosis rates will further increase the pressure on social care services.

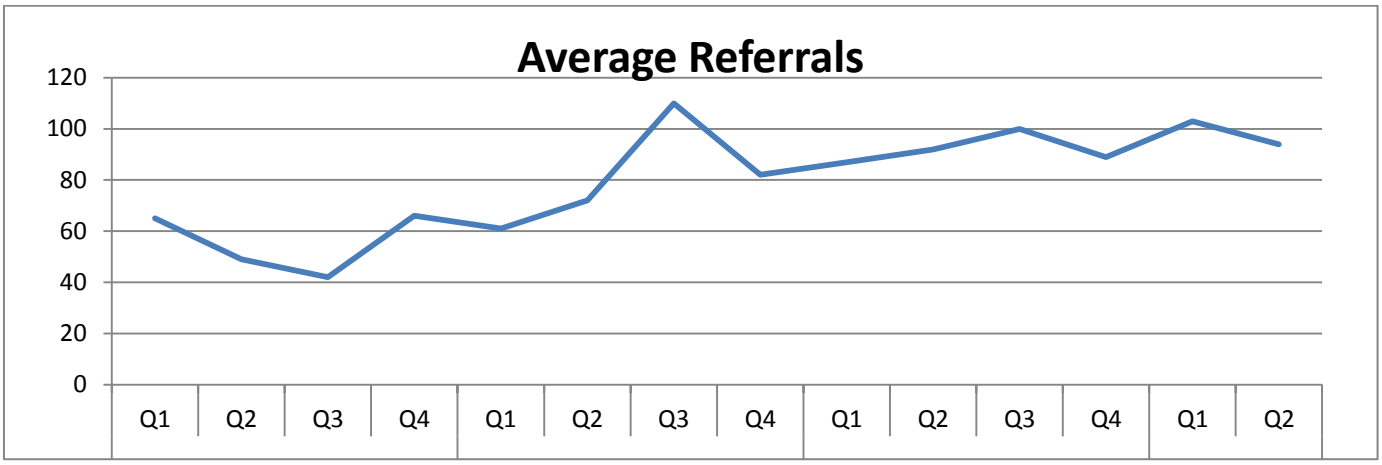
Meeting the challenge

- For Bromley CCG to achieve and maintain the national 67% diagnosis target the increased demand described above will need to be maintained and improved. The existing Memory Service will need to become more visible in the community, for example in care homes.

- The need for continuous work within the care homes has been identified following the recent Bromley Dementia Diagnosis Acceleration work-stream.

- In addition, the memory service will reconfigure to improve liaison with and support to primary care as well as to ensure improved post diagnostic support.

Baseline of current provision
Referrals: The chart below highlights the increasing trend of new referrals to the Bromley Memory Service over the last three years during which time average monthly referrals have increased from 42 per month (Q1-2011) to 104 per month (Q4-2014).



There were 1175 referrals in 2014, which exceeds current capacity by 47%. Additional recurrent investment is required to increase assessment capacity by this amount.

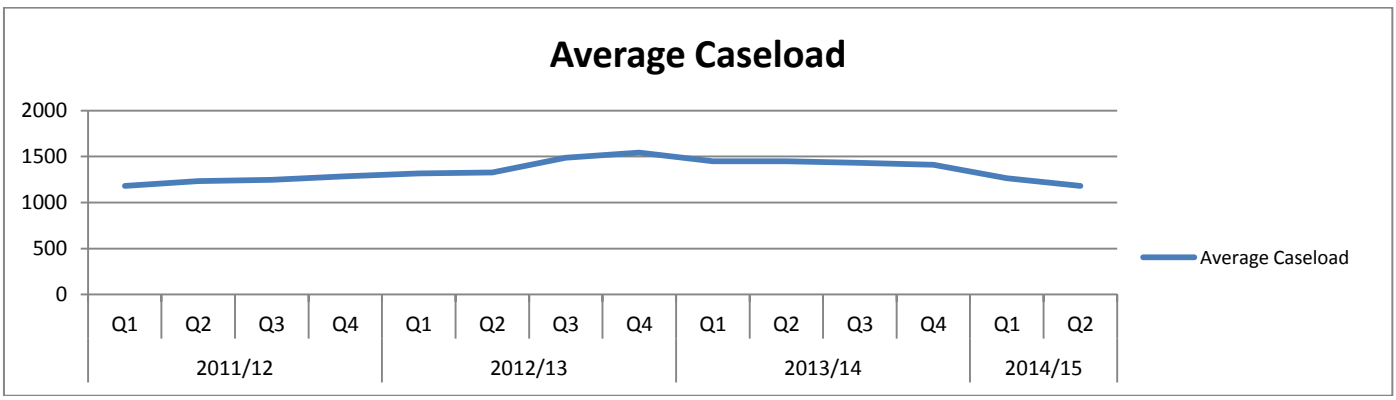
Diagnosis

- Currently, of the referrals into the memory service, 64 % receive a dementia diagnosis. DNA, cancellations and inappropriate referrals are low at approximately 10%.

- The outcome for the remaining 26% of referrals includes clients with non-dementia, existing dementia, signposting/onward referrals and MCI (mild cognitive impairment).

- The service routinely reviews all MCI cases with the objective of the individual re-attending an outpatient clinic for the purpose of reassessment and diagnosis of dementia.

Caseloads
The caseload chart below shows the average Memory Service caseload since April 2011. It highlights an increase in caseloads to a maximum of 1543 in Q4 2012/13 since which time there has been a graduated reduction to 1182 in Q2 2014/15.



Waiting times for assessment and diagnostic appointments have been increasing and now exceed our quality standard of 10-12 weeks. The current average wait from Referral to Diagnosis is approximately 14 weeks.

Care homes

- Care home residents tend to have the most complex needs, and levels of dependence have risen. We need to ensure that they remain as well as possible to avoid deterioration and complications.

- It is estimated that 75% of people in residential homes and 60% in nursing homes would be expected to have a diagnosis of dementia. Nationally 90% of these numbers do not currently have a formal diagnosis and therefore it is recognised that there is a significant gap in identification and support to these vulnerable adults.

- Therefore in Bromley almost 1,000 care home residents would be likely to have dementia.

2. Proposed service model

The **memory clinic service** will meet NICE Guidance requirements including assessments, CT scans, therapies and on-going support

- Oxleas plan to reconfigure current staff and services to provide the following enhancements to the current Memory Service. Individual job plans will be adjusted to mainstream the following developments:
- Re-introduction of a NICE compliant post diagnostic pathway, to include cognitive stimulation therapy and other prescribed interventions.
- In recognition of GPs views, the service will introduce an outreach function, whereby staff will be aligned to GP localities to assist with timely screening and post diagnosis support in the primary care setting.

Care homes:

- A new specialist team of nurses, psychologist and psychiatrist, who will work to a planned schedule of contact with each care homes (without the direct need for GP involvement) to identify residents with signs of cognitive impairment who may have dementia.

- Whilst the primary function of the specialist mental health nurse is to assess for dementia, they will also be able to carry out a holistic initial assessment of needs enabling them to identify other mental health problems (such as depression) and physical health problems.

- Based on the learning from the assessment, a plan will be developed to progress diagnostic work and to identify other health care professionals who need to become involved in the person's care. Based on assessed need, onward referrals can be directly made e.g. to the falls team, to local community health or mental health services, to St Christopher's Bromley for end of life care or to the community pharmacist for medication review.

- We anticipate that the increased funding for the memory clinic, requested above (1), will absorb the new demand created by this in reach work. However we anticipate there will also be an impact on Older Peoples Community Mental Health Teams. We have experienced an increase in referrals and caseloads over the last two years in the Community Mental Health Teams and the Home Treatment Team. Some of this increase has been the need to work with people with more complex dementia who need assessment and psychiatric treatment, and has been focused on supporting care home staff to manage signs of distress without the need for hospitalization. We therefore need to include two additional band 6 nurses in this business case for these teams.

- This will increase care co-ordination capacity in the teams by 50, and enable a rapid response to GPs and care homes to assess and treat people whose symptoms are worsening and need more intensive support from the Community Mental Health Team.

Specification for care homes

- Each specialist nurse will be aligned to half the borough – linking directly to the GP practices, community health services and secondary mental health teams in their area. Our staff will be set up to work remotely using tablets. If licences were agreed to access EMIS, a summary of the assessment could be added directly to the primary care record to aid communication and rapid access to necessary interventions and treatment. If cognitive impairment is identified, at this point, carers/family members will be contacted and participate in the planning and information sharing process. Expected pathways will be:
  - Further assessment based on additional information with diagnosis given, where appropriate.
  - The specialist nurse will ensure that the responsible GP is informed of the new diagnosis to ensure that GP QoF registers are suitably updated.
  - Onward referral to the Oxleas Memory Clinic for specialist assessment and investigations (including tests/scans etc.). This may result in diagnosis of dementia. The Memory Service will inform the GP of the new diagnosis to enable updating of their QoF register in this situation.
  - Onward referral to the Oxleas Community Mental Health Team for complex cases including behavioural problems.
  - Signposting to third sector agencies to provide support as identified.
  - The team will work independently of the Bromley Care Home Team but will communicate issues to inform their schedule and work plan, where appropriate.