Surrey Public Service Transformation Programme

Outline Business Cases

Outline Business Case Template

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Strand title	Health & Social Care Collaborative Dementia Friendly Surrey
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1. Aims and objectives

The health and social care collaborative was established with clinical commissioning group and Borough partners following a workshop that explored and identified work streams that will improve health and social care services as well as delivering efficiencies across the whole system. The health and social care collaborative will become the overarching framework within which decisions in integrated pathway designs and allocation of whole systems partnership money will be decided. The initial workshop with partners identified areas where we will establish new models of care that are seamless and return the ownership of people's health and social care to the individual citizen and communities, reducing dependency on public services. The areas identified are:

1. **Establishing seamless health and social care primary care services**
2. **Establishing friends, family and supportive communities throughout the county**
3. **Focus on early intervention and delayed hospital discharge that reduces the admissions to the 5 acute hospitals in the county and links timely discharge to support people to return home safely.**
4. **Establishing Dementia Friendly Surrey with a focus on North West Surrey.**

Whilst the first three of these need further work in order to develop a business case, the fourth area, **Dementia Friendly Surrey,** is sufficiently developed to establish a project beginning April 2014. This Outline Business Case, as a result focuses, on this area of collaborative work. The approach taken with Dementia Friendly Surrey will act as a pilot, learning from which will feed into the development of subsequent stages which will be broader in both service scope and geographical range.

All areas identified in the health and social care collaborative are underpinned by 3 shared principles.

1. That the public sector bodies cannot continue to deliver services simply by responding conventionally to the increased demand they face individually. In Surrey all public services will communicate with the public the size of the challenge and the efficiencies required, collectively, and will seek to tackle the challenges collectively.
2. That public services in Surrey will focus on early intervention and prevention, determining what shared risk taking looks like.
3. The residents of Surrey are aware of dementia and that responsibility for one's own health and lifestyle begins with them.

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The desired outcomes the initiative will deliver are:

- Increase in the ability to live independently
- Increase in autonomy and ability to make own decisions
- Increase in confidence and caring capabilities
- Increase in support network
- Improvements in general health and well being
- Improvements in memory and cognitive abilities
- Improvements in fitness and nutrition
- Improvements in feelings of being safe and secure
- Improvements in the relationships between the person with dementia and their carer
- Reduce care giver burden
- Reduce social isolation and increase the ability make new friends
- Reduce levels of anxiety and depression
- Reduce emergency admissions to hospital
- More opportunities for respite care
- More opportunities for participating in leisure/community activities
- Less likely visits to the GP

The objectives of the initial Dementia Friendly Surrey public service transformation strand are to:
- Establish a dementia friendly community in North West Surrey that is sustainable and locally owned.
- Improve the quality of life for individuals with dementia in North West Surrey by keeping them connected with their local community in a safe and ordinary manner.
- Facilitate the learning which will inform broader approaches

Further work to develop the case for change for the other areas of health and social care collaborative are underway and will be the subject of a separate outline business case in due course. The outline business case that follows is specifically focused on **Dementia Friendly Surrey.**

2. Case for change

Dementia is the fastest growing disease that society has to deal with. In Surrey it is estimated there are 15,500 people over 65 with dementia and this is expected to rise to over 17,000 by 2020. However, fewer than 6,000 people over 65 have a formal diagnosis. Demand on services is increasing at a time of significant financial pressures on all agencies. For example social care in Surrey County Council has to devise efficiencies of £44 million in 2013/2014.
In North West Surrey it is estimated there are 4,243 people over 65 with dementia. The diagnosis rate is 46% which equates to 1,952 people with a formal diagnosis.

We currently have a Dementia Friendly Surrey project operating across all of Surrey which has five work strands.

- There is an initiative to recruit 20 Dementia Champions in each of the 6 Clinical Commissioning Group (CCG) areas across Surrey.
- We will be offering training to local businesses and groups
- We are examining how best we can support carers who do most of the support for people with dementia.
- We have just launched a major community awareness campaign in September 2013

distributing over 50,000 posters to organisations, individuals and communities.

- We have created an innovation fund of £50,000 where we are inviting submissions for local projects that will enhance the quality of life for both people suffering from dementia and their carers.

In North West Surrey we intend to build on this work by creating local community alliances that will design their own local support services which are owned by the community and not led by professionals.

People with dementia are over-represented in acute care. They occupy up to a quarter of hospital beds at any one time. Evidence gathered nationally and for the whole place community budget pilots demonstrates that those who have a secondary diagnosis of dementia are much more likely to be admitted to acute care for the same primary medical cause as those without dementia; they stay on average ten days longer, are much more likely to be readmitted, and much more likely to be discharged to residential care. And yet the ideal setting for people with dementia is the familiarity of their own home where possible, or whatever is their normal place of residence.

There is a close link between the physical health of a patient with dementia and their mental state. The majority of admissions for people with dementia have a medical cause – and often it is the compounding of an infection or a fall with the corresponding deterioration in mental state that provokes a crisis that leads to the admission. Therefore a high proportion of such admissions are preventable and primary care, community services and social care have a key role to play.

The joint strategic needs assessment highlights that people with dementia are more likely to have co-morbidities that consequently increase the risk of hospital admissions and once admitted tend to stay longer in hospital as a result of the effects of dementia. A comparison between the in patient lengths of stay for those with dementia related diagnosis and the general hospital population over 65 shows that the general hospital population stays less than 7 days compared to those with dementia related diagnosis 56%.

If we do nothing, the numbers of people going into residential care or nursing care will increase because we do not have robust services in place to reduce avoidable admissions. The quality of lives of individuals is reduced because lengthy stays in an acute hospital will often contribute to deterioration in physical and mental capacity limiting informed choice.

3. Proposed new delivery models

This initiative will build on the work already taking place in the Dementia Friendly Surrey programme in North West Surrey. The added benefit this initiative will deliver lies in the ambition to create an alliance of local neighbourhood support systems for people with dementia across the 4 Borough Councils, ensuring they are able to offer the following:

(a) Each person with dementia will have their own support system that will ensure they are safe and connected to the things they like doing;

(b) Businesses and local amenities will be more receptive to knowing and supporting the individual with dementia. This could be the local swimming pool in Egham offering a safe environment for an individual with dementia to swim once a week;

(c) Identification of people with dementia who live alone and an offer of light touch befriending to ensure they are safe and supported to alleviate loneliness.

(d) Focus on ensuring individuals with dementia has a good hydration plan that will reduce their risk of infections and avoidable admissions to St Peter's Hospital A&E department.

(f) We see employers sponsoring local initiatives to make them sustainable and we will be working with general practitioners to raise the level of diagnoses from its current 46% to 66% by April 2015.

This enhanced model of working will see new local support systems owned by local neighbourhoods and communities, reaching out to a greater number of people with dementia aligned to local sponsorship by businesses for ideas that work. We want to engage the local communities in becoming partners in care for people with dementia, signposting them for advice to dementia navigators and establishing the four Wellbeing Centres as community hubs/service information outlets for people with dementia and their carers. We want a greater focus on keeping people with dementia in our community and away from expensive medical environments which diminish the quality of their lives.

The guiding principles of the initiative are:

- **Think neighbour and act local**
- **Local volunteering enriches local communities.**
- **Reduce professional interventions to the minimum to provide the best conditions of neighbourhood support**
- **Take control of your own health & social care needs**

4. Changes required

There needs to be a culture change, both within the working practices of health & social care professionals and the citizens who live and work in Surrey. We will need our public health partners to support a community awareness campaign that will help us make the most of communities as our most valuable asset.

There needs to be much more local knowledge embedded in the initiative to identify mentors and nurture community leaders and organisations. We need to work closely with the faith leaders to ensure BME communities are part of the solution, as well as faith leaders and community activists.

The paradigm of thinking has to change to ensure that support systems are part of community assets and should be recognised and awarded financial support to keep them going. The County Council could sponsor an annual community award promoting self-reliance and more supportive safe communities.

The Dementia Local Implementation Group (DLIG) should be positioned to oversee the programme of work and should have a devolved community budget contributed to by all public agencies in North Surrey to oil the wheels of change in local communities.

This initiative has the support and backing of the main public sector organisations in North West Surrey which includes Ashford & St Peter's Hospital, North West Surrey Clinical Commissioning Group, Spelthorne, Woking, Runnymede and West Elmbridge Borough Councils.

Representatives from these organisations will act as an advisory group on the implementation and will advise on the evaluation process to determine what success looks like.

We will complete an equalities impact assessment by the end of December 2013.

Government change
This initiative will establish a wealth of learning about local communities and the support systems that work for them. It will highlight the diversity of communities and inform constructive approaches about establishing sustainable networks of social neighbourhood support. We would want the department of communities and local government to continue to support the initiative and facilitate access to the relevant government departments in developing this new delivery model of local support.

5. Financial case

This initiative has to be seen in the wider context of the existing demanding targets for social care savings and the ambitious health and social care collaborative programme. Whilst the dementia programme will not deliver additional savings, it will help to create the conditions – by developing the potential of improved support from friends, family and community to reduce expenditure across statutory health and social care services – to make a reality of existing savings programmes in both social care and health (the social care ambition alone of for £50m of savings over 2013-17 through those means). By way of illustration, if we can delay an individual with dementia going into residential care through enabling help from friends, family and community , that will typically avoid costs of £11.5k per annum. that being the difference between typical residential cost and typical support costs in the community. The initiative will also make an impact on reducing the avoidable admissions to St Peter's Hospital, which currently account for 70% of the costs of dementia care.

- Cost avoidance / better delivery of savings initiatives across social care and health
- Less likely to require early residential care
- Less likely to require hospitalisation.
- Learning for how parallel benefits might be gained on a broader basis

6. Implementation plan

Steps	Date	Risks
Agree scope of new service including partner buy-in	October to December 2013	Lose momentum and partners' buy-in
Agree business case and cost benefit analysis methodology	October 2013	Getting the balance right between outcome and efficiencies
Prepare cost benefit	October to January 2014	Agreeing cost of initiative
Run Co-Design Workshops	October to March 2014	Not sustainable unless co-designed
Agree implementation plans	February 2014	Project support availability
Begin implementation	April 2014	

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