Final report

Innovating for Improvement

The Dementia Golden Ticket – An emerging new model of care

Buxted Medical Centre

The Health Foundation

About the project

Project title: The Dementia Golden Ticket – An emerging new model of care

Lead organisation: Buxted Medical Centre

Partner organisation(s): High Weald Lewes Havens Clinical Commissioning Group

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Contents

About the project 2
Part 1: Abstract 3
Part 2: Progress and outcomes 8
Part 3: Cost impact 19
Part 4: Learning from your project 22
Part 5: Sustainability and spread 28

Appendix 1: Resources and appendices 42

Part 1: Abstract

Sussex has more people living with dementia than anywhere else in the country. A local clinical review identified deficiencies in the current dementia care pathway, including that access to information and support is fragmented, that primary care is often ill-equipped to manage slow-declining dementia, that post-diagnostic support is limited, and that there is no formalised approach to advanced care planning. These issues are resulting in poor outcomes for patients and high costs to the NHS.

The project was led by Buxted Medical Centre, a GP Practice in a semi-rural area of High Weald Lewes Havens Clinical Commissioning Group, in East Sussex. It sought to address local issues and embed recommendations in the National Dementia Strategy and the Prime Minister's Challenge on Dementia 2020, whilst fundamentally improving the quality of life of patients and carers affected by the condition.

The project involved developing a new approach to the management of dementia in primary care, (moving from a secondary care focus), including multi-agency post-diagnosis community support, with foundations in pro-active care and social wellbeing.

The model includes: interventions to ensure timely access to health and social care pathways; coordinated and supported access to personalised psycho-social interventions; primary care based Review and 'Blip' clinics for when patients begin to decline and the new role of the 'Dementia Guide', introduced to formalise an approach to personalised advanced care planning. Its innovation is based upon a composite approach, which integrates health, social care and the community in a way, which is seamless from the perspective of the patient and carer and pro-active in principle.

Set-up and Initiation Phase

Setting up the project was a challenge, given that we had to develop a new 'mini', integrated health and social care system, for a cohort of patients at one GP practice, which would run parallel to existing services all within the context of services already at maximum capacity.

However, engagement and commitment from multi-agencies was secured through stakeholder meetings which articulated that a different way of working had the potential to deliver efficiencies (both in cost and workload), whilst improving patient/carer experience and quality of life. 'Buy-in' at senior level from multiple provider organisations, (with differing priorities), took several months. Added to that, market availability of community-based support for people with dementia in the patch was limited and a phase of market testing and dialogue had to take place, in order to secure providers that could 'start-up' quickly, with one-off funding to support the project, at least through the evaluation phase.

Once this was achieved, Task and Finish Groups, (including patient and carer representatives working alongside health and social care professionals) were tasked with planning, developing and setting up the following:

Table 1 Set-up actions and task and finish group work

Set up a new multidisciplinary secondary care team to diagnose and manage complex cases.
Establish new diagnosis protocols for assessment in peoples' own home; including taking into account the needs of carers.
Secure MRI scanning provision from a private provider.
Establish a weekly primary care Review Meeting within 10 days of diagnosis, run by a Primary Care Practitioner with GP support. This involved the development of new review templates on the practice system.
Develop a weekly medication's review which was undertaken by the practice's Superintendent Pharmacist utilising associated new templates.
Set-up a weekly 'Blip' clinic to pick up patients and carers in decline or risk of deterioration in order to respond proactively. This would be run by a Primary Care Practitioner with GP support and Clinical Nurse Specialist (SPFT).
Develop protocols and referral for a 'Carer's Prescription' to a voluntary organization, (Care for Carers).
Develop a navigation handbook, to support conversations and actions for future planning. (Written in consultation with carers of people with dementia). (Appendix 1).
Develop a service directory.
Create protocols for Advanced Care Plans (ACPs).
Develop a new role called the 'Dementia Guide' to promote timely information and advice and emotional support and secure a voluntary organization to deliver it (Know Dementia).
Develop a 'Community Coordinator' role with another voluntary organization (Rotherfield St. Martin).
Set up community-based psycho-social interventions in support of physical wellbeing, (with a local leisure centre, Freedom Leisure), emotional wellbeing, (establishing a café in the local pub, The Buxted Inn), occupational wellbeing, (with an outdoor activities organization, Wilderness Wood) and memory wellbeing, (establishing a monthly cognitive stimulation and reminiscence club in a local community hall).
Establish patient transport to access interventions.
Set-up a 'hotline' to the secondary care team, to support primary care workers in the project.
Work with Buxted Medical Centre, (with the aid of a specialist adult social care Occupational Therapist) to become 'dementia friendly'. This involved de-cluttering the practice space, purchasing new dementia friendly signage, clock and artwork and enhancing the outdoor space to be more peaceful and sensory enhancing.
Establish a new secondary care 'Crisis Team', (covering out of hours).
Secure a Mental Health Specialist Social Worker to support the project.
Work with the Patient Participation Group (PPG) to promote dementia awareness within the local community, businesses and social groups. This involved

developing a 'Tips Booklet' for people coming into contact with people with dementia[1].
Deliver advanced and awareness raising sessions to up-skill about dementia but specifically to educate about the expectations of the new roles within The Dementia Golden Ticket model of care.
Secure external evaluators and design quality, quantitative metrics and methodology for data capture and analysis.

Testing Phase

The 'Testing Phase' of the pilot ran for 3 months (October 15 – December 15) and included a sample of the population of those registered at Buxted Medical Centre. As a key feature of the pilot was to evaluate the impact on peoples' independence and quality of life (including family carers,) a cohort of 40 patients was selected from a list of diagnosed (and newly diagnosed) patients, who were living in their own home and by definition, would in all likelihood, be living with a family carer.

Patients were limited to this number mainly due to time pressures of the 12-week evaluation phase, yet being significant enough to demonstrate thematic outcomes. Due to a number of patients withdrawing from the pilot, the final cohort consisted of 37 patients; 13 of which were previously only known to primary care, 18 from secondary care and 5 transferring from the existing Memory Assessment Service. One further referral was received during the course of the pilot programme.

The 12 week 'Testing Phase' consisted of external qualitative evaluation by an independently commissioned service evaluator (Dr Adam Gill Projects Ltd) and a validation exercise by the Kent Surrey and Sussex Academic Health Science Network, (AHNS). A number of source material was used to inform the evaluation, namely; SUS data, real-time survey feedback (Questback), consultation events, on-line surveys, (Survey Monkey), a Clinical Audit by the CCG Clinical Lead for Dementia, a Medicine's Management Evaluation by the CCG's Medicine's Management Team and a comprehensive financial modelling exercise undertaken by the CCG.

The qualitative evaluation demonstrated that outcomes for patients and carers, improved across all domains, (shown below in Table 2):

Table 2. patient and carer reported experience themes:

1.	Quality of life for patients living with dementia improved
2.	People involved felt able to live more independently
3.	There was a reported improvement in access to information and advice
4.	Wellbeing interventions were hugely beneficial to patients and carers
5.	Mental health and wellbeing improved for patients involved
6.	Carers' experience and reported outcomes improved
7.	Golden Ticket workforce believed it offered an improved patient experience

[1] http://www.highwealdleweshavensccg.nhs.uk/our-programmes/dementia-golden-ticket/

The validation of all available material and evaluation sources also concluded that the new model of care was viable.

Table 3. AHSN conclusions based on the validation of evaluation sources:

1	Potentially economical
2.	Likely to deliver value to patients
3.	Potentially sustainable
4.	More robust than currently in place
5.	Likely to improve patients' lives

Challenge

The challenge of the implementation phase related to scaling up aspects that worked well, from one GP Practice to 20 and from 40 patients to a projected diagnosed population of 1,800 across High Weald Lewes Havens CCG. Further challenges relate to primary care appetite and capability to take on perceived 'new work' under a Locally Commissioned Service (LCS), secondary care appetite to 'release' activity from the existing contract, market readiness for community interventions to be scaled-up by locality and adult social care (ASC) capacity to support the new way of working, in the current climate of austerity. It is anticipated that these challenges will be mitigated by demonstrating the positive outcomes of the pilot and how the Golden Ticket approach can save money and release capacity in the system and improve patient/carer experience and quality of life.

Learning

Taking the learning from the pilot and positive emerging themes from early findings, further consultation and engagement took place, culminating in an 'Open Space' event 5 February 2016 with patients and carers and a second event, with providers and wider stakeholders.

One surprising aspect of the learning was that despite patients and carers telling us that they wanted a 'handbook' to support their journey with dementia, this 'toolkit' was underutilised and recipients reported that they'd prefer face-to-face contact in the form of the Dementia Guide role.

Learning from the pilot also suggested that the MDT would have benefitted from social services and third sector representatives at their meetings to improve communication and for this reason both social care and the Dementia Guide service will connect with the MDT on a weekly basis, in the new service model.

Outcomes and associated recommendations from these stakeholder events were then taken to a series of meetings (in 2016) for consideration of options for scaling-up and rolling out across HWLH. These included the Clinical Sub-Committee,

Executive Steering Group for Dementia and Primary Care Working Group.

The outcome of these discussions and rationale informed the final proposed model of care and associated business case.

Part 2: Progress and outcomes

Old Model

The existing Dementia Pathway (Figure 1 below.) illustrates how patients are referred by their GP to a Secondary Care Memory Assessment Clinic (MAS) and after diagnosis, discharged back to Primary Care. Complex cases continue to be supported in Secondary Care but note that the system does not cater for crisis situations or dual Patient/Carer support. Patients often do not have an Advanced Care Plan (essential to NICE approved dementia services) and their transitions, safety at home and continued care may not be picked up by relevant services. Lastly, (but most importantly), the quality of care that patients receive is inadequate. It leads to dementia patients presenting in acute and emergency settings, in what was considered to be an avoidable poor state of health. As such, the system was viewed as ill-equipped to support patients and carers with dementia.

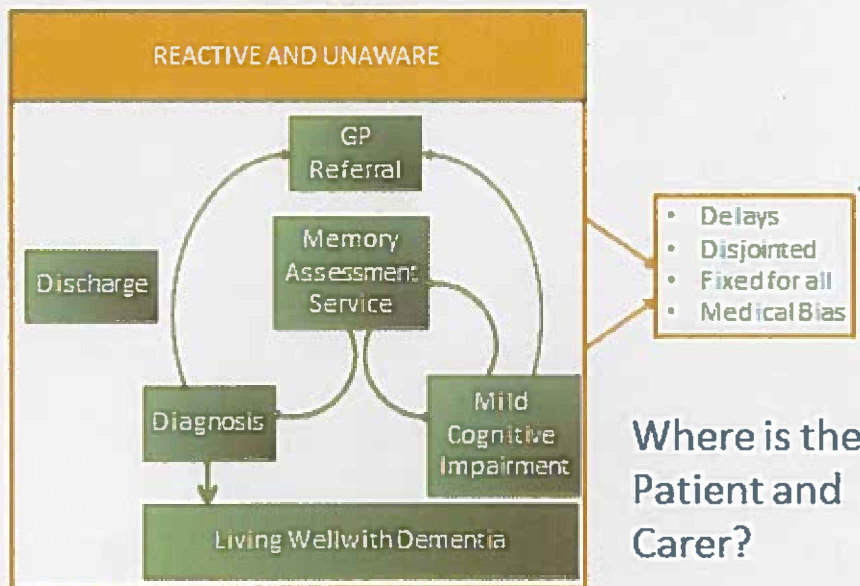

Figure 1

New Model

The new vision depicts how patients are referred from their GP to a new, multi-disciplinary team (MDT), within which, an appropriate member is allocated to undertake a comprehensive assessment of the person with cognitive impairment and take into consideration the needs of any family carer, within their own home. Assessment information is taken back to the MDT, (together with other information such as CT scan), for the Team to make a diagnosis. If a diagnosis is made, the same Team member will deliver the diagnosis well, back in the person's own home.

At this point, a 'Golden Ticket' is activated, where the patient and carer will be introduced to a composite model of intervention that is coordinated, held and delivered in primary care. The MDT member will notify the Dementia Guide Service of the diagnosis and make the Primary Care follow-up appointment.

Within 2 working days, the Dementia Guide Service will make contact with the family and offer a face-to-face contact within the next 10 working days. This service will coordinate interaction with the commissioned psycho-social interventions in the community. The service will also work with the patient and family to complete an Advanced Care Plan within 6 months of diagnosis, which will be signed off by the GP.

Within 2 weeks of the diagnosis, a trained, Band 6 Primary Care Practitioner (Nurse or Paramedic for example) will undertake a 'health and holistic well-being check', in a Golden Ticket Review Meeting, liaising with the Lead GP where necessary and utilising a MDT phone-line, to coordinate rapid access to multiple pathways. A medication review will also be undertaken as part of the Review.

A Memory Café will run along-side the clinic, offering peer support and direct access and signposting to other wellbeing services, including Physical, Memory, Emotional and Occupational Wellbeing.

In addition, a weekly 'Blip' Clinic will be held at the Practice, utilising the 'eyes and ears' of the community and support circle for information of changing circumstances in order to coordinate rapid interventions which will delay or prevent deterioration. If a crisis does occur, then rapid access to assessment and intervention can be achieved through the 'Hotline' to Secondary Care or the Out of Hours/ Crisis Team.

Adult Social Care works closely with the Team to ensure timely access to appropriate services, (including respite) in urgent cases.

The Dementia Golden Ticket – Emerging Model of Care

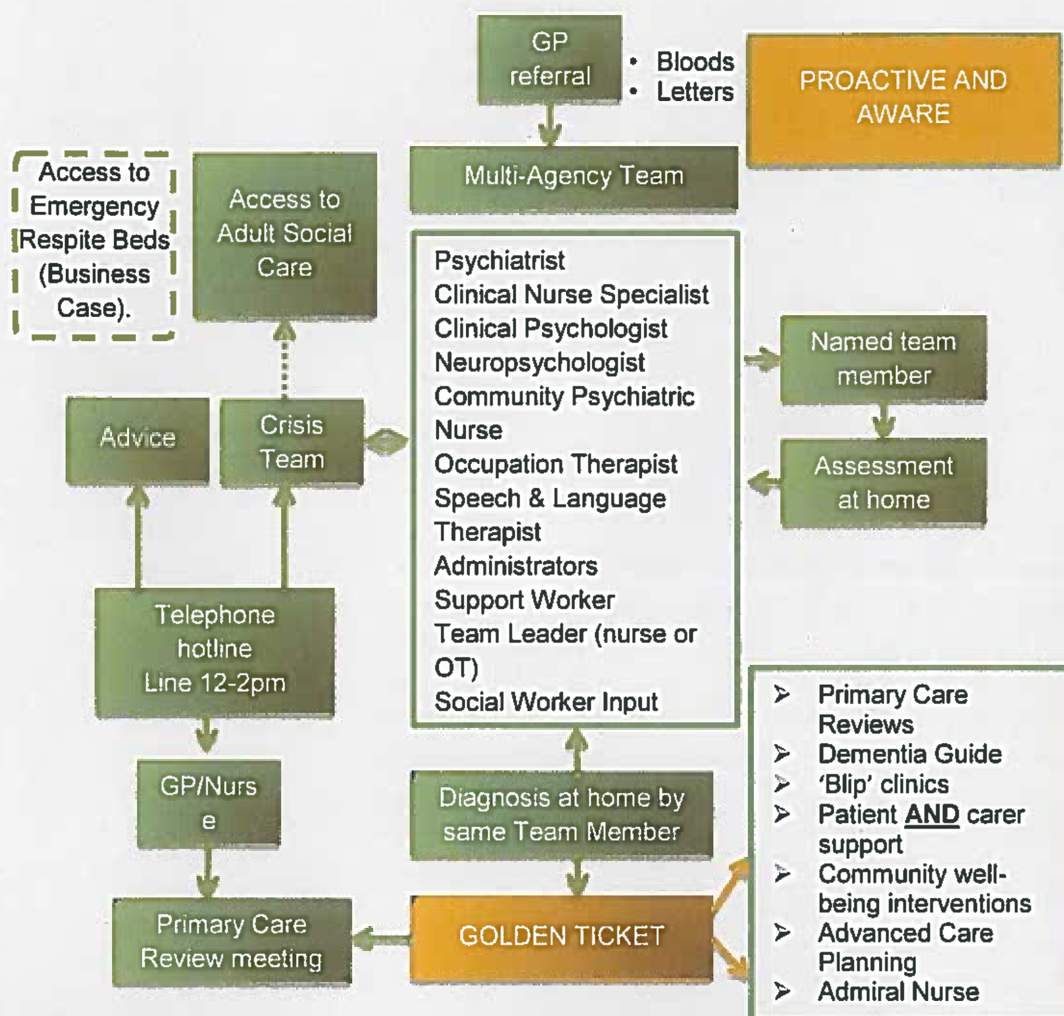

Figure 2. New Model

Measuring Impact

The Kent, Surrey and Sussex Academic Health Science Network, (KSS AHSN) advised that research conducted by SASH Library Services (2015) found no similar pilots or pathways with an available framework to use for an evaluation. On this basis, a list of metrics was initially developed with the AHSN and the CCG to get a thorough perspective of the outcomes they may be able to gauge from The Dementia Golden Ticket approach and model of care.

These are described in Table 4 below:

Table 4. Summary of metrics

	Name of Measure	Category
1	Time from GP referral to diagnosis	quantitative
2	Testing pro-active care	quantitative
3	Improved Carer experience and outcomes based on better Carer Support – Direct comparison between access to existing Carer Services and a potential Admiral Nurse model	qualitative
4	Prevention from deterioration and crisis due to proposed 'Blip' Clinics	quantitative
5	Shift in activity from Secondary Care to Primary Care and associated outcomes and implications on capacity and cost.	quantitative
6	Advanced Care Planning and associated benefit	quantitative
7	Patient Experience and outcomes	qualitative
8	Access to information and advice	qualitative
9	Memory Support Service intervention compared with proposed Community-based 'Well-being interventions'	cost
10	Frail and Complex Care e.g. reduction in Falls, improved continence management and enabling people to live more independently for longer	quantitative
13	Quality of life measure	qualitative
14	Testing mental health and well being	qualitative
15	Testing independent living	qualitative
16	Testing patient information	qualitative
17	Reduced Hospital admission (emergency admissions, planned admissions, outpatients attendances, A&E attendances)	quantitative
18	Discharge destination from hospital (decrease in nursing / residential care discharge destination)	quantitative
19	Cost savings (system wide)	cost
20	30 day re-admittance to hospital for those attending BLIP clinic.	quantitative
22	LOS in hospital	quantitative
23	Emergency admission into nursing and residental Care	quantitative
25	Potential measure: Increase diagnosis rate	outcome
26	NICE Quality Statements	outcome

Stakeholders provided information about their experience and findings of the pilot both qualitative and quantitative. **The metrics fall into the following 4 groups:**

1. **Qualitative data** (attained from independent service evaluator), Dr Adam Gill. This is supplemented by on-line surveys, (Survey Monkey) and real time Questback technology on patient and carer wellbeing, before and after attending a community wellbeing intervention. See Appendix 2.
2. **Quantitative data**, (received from hospitals that have HWLH patients in their catchment areas in relation to admissions). This is then compared with the same list of patients the year before to determine whether the service has improved their outcomes and wellbeing. This has been supplemented with a clinical audit by the CCG Clinical Lead and the Medicine's Management Team.
3. **Cost**; cost estimations and actuals will be provided by HWLH CCG and validated by the KSS AHSN, which will provide an analysis of financial sustainability at scale.
4. **Outcome**; outcomes data surmised from both the qualitative and quantitative evaluations and contextualized within the 'before and after' picture.

Data Limitations

The number of patients in the pilot was relatively small, and statistical analysis could have been unreliable as one patient's admission may have skewed results significantly. For this reason, plans are in place for a more comprehensive evaluation, as the new model of care is rolled out across the HWLH.

Experience from Enhancing Quality and Recovery (EQR) and other studies (e.g. Nuffield evaluation of Trafford and Inner North West London) showed that demonstrating impact of service change takes time. Decision makers need to beware of assuming that the pilot or early stages of the project could detect statistically significant changes in a short period of time. For example, the impact of EQR on outcomes, such as mortality, only became evident 2.5 years into the programme - and even now causality is yet to be determined.

Based on these data deficiencies the KSS AHSN and Health Foundation Consultant recommended that qualitative methods would be more useful to analyse results on a project such as this and for this reason, a stronger emphasis was put on the qualitative reporting.

In addition, given that proactive care is equally difficult to measure, (by the nature of attempting to measure a 'never event'), a stronger emphasis was given to the primary care clinical audit. Given this learning, the CCG and KSS AHSN has revised its evaluation and metric framework to constitute more of a narrative basis with case study examples and a focus on an economic evaluation, which sits within a business case framework.

Qualitative Evaluation

A qualitative service evaluation was undertaken to find out whether The Dementia Golden Ticket had improved the quality of life for those living with dementia. The aim was to capture the patient and carer story, including their experience within the pilot and to understand how the service had begun to impact on their lives. The evaluation employed a three-part investigation method utilising interviews, observations and surveys to understand how patients, carers and staff demonstrated or reported improvements in their wellbeing and/or healthcare services.

This approach was taken in order to go beyond what is usually deemed as engagement within the NHS and gain insight into the lived patient and carer experience. Insights were tested at several stages of the service evaluation. Investigations were semi-structured and observational in nature. Insights were captured to inform future service delivery across the wider HWLH CCG locality and to ensure its sustainability.

The service evaluation involved an investigation into the following key areas:

- Quality of life for patients living with dementia
- Ability to live independently
- Access to information and advice
- Outcomes attributed to the community wellbeing interventions
- Mental health and wellbeing for patients and carers
- Sustained or improved physical health
- Carer experience and outcomes as a result of participation
- Workforce perception of system improvements.

To see the full qualitative evaluation, together with other evaluative resources see Qualitative Service Evaluation of The Dementia Golden Ticket Pilot at Buxted Medical Centre (Gill, 2016) (Appendix 1).

By virtue of the Health Foundation's Innovation Award, the CCG has had access to and worked closely with a Health Consultant, who has provided advisory support on the evaluation process. By-monthly reporting to the Health Foundation, together with sharing information about proposals for development and roll-out, has also attributed another level of scrutiny to the robustness of the evaluation process and respective findings.

The qualitative evaluation proved the following:

1. The model was good for patients and carers
• The new service was clearly preferred to the old service. In interviews, responses demonstrated that the service before The Dementia Golden Ticket was inadequate and caused some level of stress for people accessing it. 95% of people offered the opportunity to be involved in the pilot, signed-up and at least half of the cohort participated in the majority of the community wellbeing

interventions

- People generally felt extremely well supported as a result of participating in The Dementia Golden Ticket (Gill, 2016). Quality of life for patients living with dementia improved
- People involved felt able to live more independently
- There was a reported improvement in access to information and advice
- Community wellbeing interventions were hugely beneficial to patients and carers
- Mental health and wellbeing improved for patients involved
- Carers' experience and reported outcomes improved
- More patients had Advanced Care Plans (ACP) in place than before the pilot.

Quotations:
"The Golden Ticket gave me my life back. I can go out and be myself. I have a totally different life (now)."

Carer quote: "The project has been an astounding success – we would view it as a loss (if it were to end). The café helps people to swap ideas and information, there is a good atmosphere there and a community has built up around it and the interventions."

"It keeps me going."

Direct responses when asked what life would be like without The Dementia Golden Ticket were:

"Dreary and lonely"
"Tough"
"Feel on your own and no one to talk to"
"Boring, lonely and worrying"
"Would be very scared"
"Life would be a lot harder".

Emotional Wellbeing

Physical Wellbeing

Memory Wellbeing

Occupational wellbeing

2. The model worked for providers and the workforce

- Staff largely reported that they thought The Dementia Golden Ticket was 'better for the patient' and enhanced patient experience and improved outcomes
- They reported that having third sector partner 'eyes and ears' on the ground and primary care staff working closely with them was best for the patient
- The new MDT diagnosis process offered an improved quality service and was well placed to deal with complex cases meeting the whole needs of the person with dementia and their family carer.

Quotations:

"Very much so – one lady (recently deceased) was housebound and for the first time (she) was able to get out and about with her husband – a wonderful gift!"

"I thought it gave patients and carers a (chance) to be open and say things they wouldn't usually say (e.g. depression and withdrawal); and I could check with the carer as to whether they were in agreement with what the patient was saying or not."

"Patients felt abandoned before the clinics started and they didn't know where to go. Now they feel relieved."

"Very beneficial to patients and carers. One person said 'I can't believe that so many people are looking after me.'"

"I've only received positive feedback from patients and carers – having someone spend time to listen and take care. This is the missing bit. As a clinician this is challenging due to complexity, but I like it. Lots of clinicians feel they can't do it – it requires a team effort as it's not always a clinical issue. We need to be looking at the patient and carer holistically."

"It's a nice opportunity to build up relationships and for peers to engage and socialise with each other – it's a really good model."

3. The model worked for GPs

- Having 'clinics' enabled the practice to organise skills, time and resources in a planned way, which helped with the over-all capacity and demand management at the practice. (Only 20% of patients from the pilot had to be scheduled urgent appointments, outside of planned activities)
- Working with the secondary care Clinical Nurse Specialist in Blip clinics, supported educational learning and development
- The Primary Care Practitioner led service, reduced over-all GP time. In addition, this approach appeared to fulfil patients' wishes better than a conventional secondary care approach
- Allocating more time to this cohort of patients, (average 30 minutes), ensured that the quality of care greatly improved and because issues were dealt with comprehensively it resulted in less people returning to the practice e.g. there was a 20% reduction in GP consultations.

Quotations:

"The pilot was designed by GPs, for GPs– this has developed from a tiny seed of an idea and has been formed into a tangible, workable model with our needs in mind. It was important from the start that other practices considering adopting a similar approach, felt that the model could be delivered by *any* practice without the need for specialist input, though that is available, if required."

"There is a comprehensive, continuous support package that doesn't require lots of GP time. We work with allied health professionals who are able to provide us with far richer information on the patient than I would ever get in a 10-minute consultation. It's as if I can then act as a GP consultant – this is how we can reduce the overall workload."

"The Golden Ticket had enabled her to have better quality consultation time with patients. This is because other concerns that the patient had were addressed and managed well in other parts of the system."

"This is about being proactive rather than reactive. The patient knows best what to do; where and when to go to appointments, or community interventions. When the patient comes to us as GPs, we are there to do what we do best."

"The joined up approach that The Golden Ticket model encourages, benefits everyone involved. The practice is at the heart of the project – but now it isn't all about the GP."

4. The model was good for the wider system

- 20% reduction in GP consultations for the cohort three months prior, compared with during the pilot, (£35 cost per consultation saving)
- 18 patients already receiving secondary care services were transferred to primary care as part of The Dementia Golden Ticket Pilot. This represents a 47% shift in activity
- When compared with during the pilot, there was a 25% reduction in acute admissions/A&E contacts for three months prior to the pilot for the same cohort of patients
- There was a 15% reduction in falls at Buxted Medical Centre
- 13 Patients had interventions that resulted in changes (savings) to the cost of prescribed medication.

A video of the project was undertaken to describe the benefits of the model of care. Please see below:

1,195 words

Part 3: Cost impact

In partnership with SPFT, (by means of a Clinical Sub-Committee) secondary care activity has been modelled extensively by each clinical intervention and patient category of cluster, if Payments by Results (PbR) had been applied and then run through a demand and capacity software tool, (shown in section 5, Figure 3) resulting in new workforce proposals to deliver the model of care, together with assumptions about a reduction in activity. This is based on the premise that secondary care should specialise in the most complex and difficult cases and a proportion of people historically managed in secondary care, could more appropriately transfer to primary care.

On the basis that the 'money follows the patient', this would result in an alignment of resources to primary care.

Primary Care costs were based on sessional times, supported by a workforce identified in the pilot project, e.g. namely that of a Primary Care Practitioner (Band 6) with GP support and then applied to predicted activity based on the model of care and dementia registers achieving a 67% diagnosis rate. This likely demand and capacity was also run through the software tool, to model the likely cost of supporting the new activity in Primary Care by way of a Locally Commissioned Service (LCS).

All other services contributing to the composite model e.g. Dementia Guide Service, Admiral Nurse Service and community interventions were added into the cost-modelling, as existing or assumed contract prices.

A growth factor of 3% has been applied to all costs and savings year on year. Health care savings and wider system costs and savings were estimated based on national validated evidence. Medication savings were calculated from the pilot and Admiral Nursing savings from an Admiral Nursing case study. The transition is assumed to be over 3 years with Buxted Medical Centre continuing with the new service after completion of the pilot, 4 GP's transferring in 2017/18 quarter 3 and two GPs per quarter moving forwards.

The implementation of the model generates a non-recurrent implementation gap in year 1 of £147,000. It is proposed that the CCG would manage this implementation impact by drawing on the Better Care Fund to fill the gap given the evidence of social care savings, particularly in future years.

A cost benefit analysis has demonstrated both cash-releasing and non-cash releasing benefits to the system – See below in Table 5.

Table 5. Cost benefit to the system

Cash-releasing benefits to the CCG	System benefits
When compared to the new model costs there shows a High Weald Lewes Havens non-recurrent implementation gap in year 1 of £147k **Cash releasing benefit to the CCG thereafter:** **– Year 2 savings £57k** **– Year 3 savings £228k** **– Year 4 savings £457k,** **– Year 5 savings £700k,** **– Year 10 savings £915k**	Total Savings in: - Year 1 £517,000 - Year 2 £1,058,000 - Year 3 £1,587,000 - Year 4 £2,195,000 - Year 5 £2,838,000 - Year 10 £3,394,000

The model of care and associated costings support strategic objectives in the reduction of secondary care services and shift in activity and resources into a primary care setting. It also proposes a model of care which realises system benefit and savings to address the health economic challenges in the locality.

All financial assumptions have been validated externally by the KSS AHSN in their report 'Validation of Dementia Golden Ticket model at High Weald Lewes Havens Clinical Commissioning Group' (2016). The report highlights that the model of care is:

- Potentially economical
- Likely to deliver value to patients
- Potentially sustainable
- More robust than currently in place
- Likely to improve patients' lives.

Summary of benefits attributed to savings, delivered by the new approach:

- A Primary Care Practitioner led service, which would previously have relied on GP appointments, will release GP capacity to see more non-dementia patients. This contributes to primary care sustainability in the longer term

- Meeting the holistic needs of the patient and carer, (as demonstrated in the pilot) will reduce over-all GP consultation time and release capacity back into the practice

- People with dementia and their family carers are already presenting in primary care, often in crisis and in a way which is work-intensive for practices, with few options to offer patients and carers for support. This will be addressed in the new model of care

- Primary care review and Blip clinics, utilising the 'eyes and ears' of the

community and support circle will maximise opportunities for preventing deterioration and crisis and therefore, admittance to inappropriate care settings

- Increased, higher quality assessment and diagnosis
- Reduced District General Hospital (DGH) admissions
- Reduced acute dementia bed admissions
- Reduced carer crisis leading to inappropriate admission to care settings
- Delaying/reducing care home usages, (based on standardised national evidence base for earlier intervention). Clinical and cost effectiveness of services for early diagnosis and intervention in dementia; Banerjee and Wittenburg (2009)
- An increase in discharges back to original place of residence
- Reducing GP appointments (saving highly qualified healthcare professionals' time)
- Reducing hospital admissions (this cohort of patients are expensive to treat in hospital and secondary care may not be the best suited for the treatment of these patients)
- Treating people with dementia in a primary setting keeps them in their own homes for longer
- Multidisciplinary teams bring value for money in discussing these complex patients
- Increasing the known prevalence of dementia patients who are grossly under diagnosed currently
- Swapping care to wellbeing services keeps patients active and motivated.

Part 4: Learning from your project

Success Factors

Enabling a cultural shift

The Dementia Golden Ticket model of care is built on the premise of managing slow declining dementia in primary care, which is a cultural shift from the historic management in secondary care.

A key enabling factor to assist in the cultural shift was strong and consistent communication of the benefits of a new way of working, namely;

- That primary care is best placed to coordinate and manage, post-diagnosis care and support because it;
    - Knows the patient and family best
    - Has closer connectivity with the community and community assets in which patients live
    - De-stigmatises dementia by managing the illness like any other Long Term Condition in general practice
    - Is the most effective 'hub' for managing information flows about the patient and carer, which will more easily facilitate pro-active care management
    - Builds on the trusting relationship between the patient and GP/Nurse, in order to increase take-up of low level and preventative services.

In addition, it;

- Provides better economic and system flow by clarifying roles and responsibilities of dementia management in primary and secondary care
- Addresses system deficiencies identified in a clinical review and stakeholder engagement
- Could provide a more pro-active response to information received from the care and support community and prevent or delay deterioration and inappropriate admission to care settings
- Supports the carer relationship and access to appropriate services in a way which helps them to carry out their caring role for longer
- Promotes independent living and quality of life
- Provides better value for money in the health and social care system.

Stakeholder collaboration and co-production

Another enabling factor in the cultural shift was strong stakeholder collaboration and co-production to find solutions to the local system challenges.

In developing a system model, we engaged, worked and co-produced with a number of stakeholders, not least:

- Sussex Partnership NHS Foundation Trust (SPFT)
- East Sussex County Council (Adult Social Care and Carer's Respite and Engagement Service)

- Sussex Community NHS Foundation Trust (SCFT)
- Primary care (GP practices)
- Voluntary Sector (Rotherfield St. Martin, Know Dementia, Alzheimer's Society, Care for the Carers, British Red Cross)
- Patients, carers and public.

We also sought advice from a number of 'Leading Lights' in the field of dementia and their time and expertise is noted here with thanks

- Brighton and Sussex Medical School (BSMS), Professor Sube Banerjee
- Dr Nicola Decker, Oakley and Overton Partnership and Clinical Chair of North Hampshire Clinical Commissioning Group.

Clinical leadership and co-production

Much of the success of the model's development and testing came from the collaboration and partnership working between SPFT and the CCG's clinical lead and management team. A Clinical Sub-Committee was established and conversations centred on patient and carer benefit and clinical best practice, rather than contracting and resources, which enabled a freedom of discussion, which enabled innovation to flourish.

This relationship was commended at the SPFT's 'Positive Practice Awards', winning Gold for 'Partnership in Practice'. There were 22 nominations. The Dementia Golden Ticket also won Silver in the 'Team' category with over 40 nominations, for making an outstanding contribution to the work of the Trust.

Voluntary sector – equal partnership

Critical to establishing a new approach to dementia care, was establishing relationships with organisations that lived and breathed the ethos of holistic care and support. Early relationships were established with Rotherfield St. Martin and its CEO at the time, Jo Evans, who established the charity and had been developing a dementia-friendly community, well-before the name gained the kudos that it has today.

Jo was pivotal in the early developmental thinking of how dementia care could be delivered differently, in a way that ensured that people with dementia and their families didn't feel alone in their journey. As a pivotal role in the stakeholder engagement group, the charity also promoted a way of working with GP practices, as an equal partner with nurses and GPs, in order to offer the highest quality of patient care and support. The charity's culture and behaviour enabled this to feel, a natural and desired phenomenon, rather than a commissioned 'add-on'.

Another important relationship was established with the West Sussex Charity Know Dementia, which had similarly been working with people with dementia and their families for many years and embodied the sort of operational practice, which seemed to be at the heart of the principles of the emerging model. Support, kindness, patience, hand-holding, specialist advice and support were all skills and behaviours that appeared to be the pillars of The Dementia Golden Ticket and already delivered in essence, by the charity.

Utilize community assets
There were many other collaborators, born out of early community engagement, which contributed to the pilot in the way that we could not have imagined but demonstrates that non-commissioned community assets can play a large part in establishing a dementia-friendly community in its true sense. Recognition must be given to the Buxted Patient Participation Group (PPG) representatives, as well as the Buxted Inn, who were willing to house (and home) the peer support group and Memory Wellbeing Café. All staff in the pub undertook dementia awareness sessions in support of the initiative.

Things that didn't work out as planned:

The Dementia Golden Ticket Guide Role and Navigation Handbook
Consistent messages from stakeholders in the engagement phase highlighted a perceived gap in information, advice, hand-holding, navigation and practical support. Patients and carers also reported that they'd like a 'handbook' to refer to for guidance including things like a directory of services and key contact information, what actions they should think about in the future and what to expect in the journey ahead. See Figure 2. For pictures of the guidebook.

Figure 2.

An interesting outcome of the evaluation of the pilot was that this resource was under-utilised and people preferred face-to-face contact with the Dementia Guides, even though they had previously stated this support pack was much needed.

Learning and Outcomes

- Both research and evidence from the pilot demonstrated that a holistic approach is best tailor made plans and multiple interventions from a range of agencies, best serve the needs of the patient and carer. It was particularly noted that cases could be better managed if the Social Worker and Dementia Guide were part of multi-agency discussions.
- The pilot evidenced that a comprehensive assessment of the person with cognitive impairment AND their family carer resulted in a higher quality, holistic assessment of need, if it was undertaken in the home, rather than a clinic setting.
- The best place to deliver the diagnosis was in the person's own home, by the person that knew the family by the fact that they had undertaken the initial assessment.
- An MDT approach, (working in conjunction with other services) delivered the best opportunity for proactive care, when all needs of the family were identified and met, at the earliest possible stage.
- The pilot demonstrated that a percentage of people with a diagnosis of dementia, (historically managed in secondary care), could be more appropriately and safely cared for in a primary care setting. This would ensure that secondary care services supported the most complex cases.
- The MDT would have benefitted from social services and third sector representatives at their meetings to improve communication and for this reason both social care and the Dementia Guide service will connect with the MDT on a weekly basis, in the new service model.
- The pilot demonstrated CT scans were an appropriate diagnostic tool for dementia diagnosis and MRI merited only for complex cases or for research purposes. In addition, not all cases required scanning.
- The pilot tested the utilisation of a telephone hotline, which was serviced by a Band 6 RMN, with rapid access to a Consultant Psychiatrist, providing advice and support to primary care staff for two hours a day from 12.00-14.00, five days a week. Whilst this service offer was not used heavily, primary care staff reported that when they did use the hotline, it was of huge benefit and enabled them to act responsively to patient need, without onward referral to secondary care.
- The evaluation of the pilot established that the dementia crisis team is an essential part of The Dementia Golden Ticket service model.
- Whilst the pilot tested an extended out of hours service during the week and the weekend, this was found not to be significantly utilised.
- Evidence and the pilot also suggests that a primary care approach can provide a more responsive care-style, is felt to be 'closer to home' and when combined with planned interventions, can be more proactive in nature.
- The pilot also established that enhanced, (not accredited) education and awareness was needed to enable staff to feel confident and equipped in the proactive management of dementia in the community.
- A health and holistic review meeting (for both the patient and the family carer)

was hugely beneficial in proactive care planning and establishing the management relationship, at a primary care level. People also felt that it de-stigmatised the condition by enabling the diagnosis to be discussed in the practice, as opposed to a 'specialist clinic'.

- Primary Care Review meetings were tested and proved to be capable of being delivered safely by an adequately trained and competent Primary Care Practitioner (Band 6). During the initial stages of the pilot, the GP undertook these sessions but as the practitioner gained in confidence, the GP was able to continue their own sessions and advise and support, between patients. A nurse role and paramedic role were tested in the pilot, with the paramedic undertaking most Primary Care Reviews and Blip clinics.
- Additional support offered via the daily 5-day secondary care hotline, and involvement of other agencies in The Dementia Golden Ticket, made supporting the patient less time-consuming and more efficient for the practice e.g. Guide Role, Advanced Care Practitioner and Admiral Nurses (to be commissioned).
- The pilot demonstrated that Blip clinics worked best in terms of providing responsive and timely care and support, when secondary care specialist and Primary Care Practitioners worked together.
- Blip clinics are the fundamental component of efficient use of resources in primary care which facilitates proactive and dedicated resource to manage a group of patients which would otherwise be seen routinely, often in crisis and without the practice's ability to draw down on other support.
- During the pilot, (and supported by national patient and local feedback), it was demonstrated that some people (approximately 50%) needed more regular reviews e.g. every 6 months. This is now included in the new LCS.
- A key finding in the evaluation phase, was that the practice's endeavours to become more dementia-friendly, (both in terms of environment and staff education), was a key contributing factor to the change in culture and way of working, necessary to deliver The Dementia Golden Ticket model of care.
- The pilot demonstrated that a dedicated Social Worker was not merited and at worse, (where there was additional capacity), endangered duplication of other roles in the pathway, such as the Dementia Guide for example.
- The greatest benefit derived from Social Worker input appeared to be in the MDT discussion of meeting the holistic needs of the patient (and any associated assessment or referral derived from the discussion) and the fluidity and response to issues being flagged as a 'Golden Ticket' by virtue of the fact that adult social care were integrated in the model of care.
- Community interventions were reported in the pilot as offering the greatest psychological and emotional benefit to patients and carers. The success of the wellbeing interventions, were reliant on the following key features:

    - Receiving encouragement, support and direct coordination into the wellbeing interventions e.g. referrals, bookings and transport was coordinated by an organisation
    - Being as close to home as possible
    - Providing a variety of choice, which would meet the interests, preferences and abilities of a range of people
    - Wellbeing interventions were inclusive of both the person with dementia AND their family carer

- Transport was provided, for those in greatest need
  - Wellbeing interventions were not time-limited.

- Together with the Guide Service, the Physical Exercise and Memory Wellbeing Cafés were the most liked and utilised activity of all interventions provided in the pilot phase.

Advice to others attempting a similar project
Patient/Carer contribution

The pilot project tested free access to community wellbeing interventions based on the premise that charging for activities would create a barrier to full participation. However, resoundingly, participants felt that it wasn't the sole responsibility of the NHS to pay for these kinds of activities and making a small financial contribution, protected pride and gave a sense of worth to the interventions. Therefore, don't assume barriers and fully and consistently engage with patients and carers throughout the process.

Transport

If the premise of 'Living well' is based upon offering well-being interventions which contribute to a system benefit of increased independence and less reliance on statutory services, then equally, it makes sense to remove barriers to realising these benefits.

For too many years the funding debate about what NHS and adult social care funds has got in the way of seamless, integrated and good quality care for patients and carers. For this reason, the CCG felt strongly that providing transport, to assist accessibility was fundamental to reaping full benefit of the interventions and therefore, preventing or delaying patient deterioration for as long as possible. Our advice therefore, is to base innovation on what is clinically best for the patient and the system as a whole, and then work with partners to secure reciprocal gain.

Scale

It is fully recognised that the pilot project was small scale; time limited and encompassed a degree of positive bias. However, future assumptions have been based upon national validated evidence for the applicability for cost effectiveness (Banerjee and Wittenburg, 2009) at scale. In addition, the detailed system modelling undertaken by the CCG can demonstrate a degree of diligence and methodology in producing an accurate system picture. This was achieved by relying on thematic evidence of the pilot but adjusting potential savings down to a modest level to take into account potential positive bias. This system picture has been validated by the KSS AHSN which concludes and agrees with the assumptions made by the CCG.

Therefore, pilots don't have to be large to be valid but assumptions do have to be pragmatic and evidence based. Furthermore, evaluation must be robust, objective and validated. These components are critical to ensure that confidence can be gained in a pilot's findings to enable investment and the necessary decision-making to scale-up in order to reap benefits of the innovation, for the whole of the CCG population.

Part 5: Sustainability and spread

Based on the compelling outcomes of the Buxted Medical Centre Pilot, together with robust financial and capacity modelling, HWLH CCG continues to be committed to the roll-out of the model of care. This will ensure the sustainability and spread of The Golden Ticket model of care.

Modelling capacity, demand and system flow
The challenge relating to scaling up aspects of the pilot that worked well, from one GP Practice to 20 and from 40 patients to a 67% diagnosed population of 1,800 across High Weald Lewes Havens CCG, whilst taking into account geographic nuances of urban and rural communities and contrasting levels of deprivation, was significant. It became evident very quickly that the system impact 'at scale' would require whole system modelling to capture the complexity of the pathway and provide information at a micro-level that could inform a detailed expansion plan and any cost assumptions related to it.

Utilising a software system modelling tool, the Clinical Sub-Committee, together with CCG management support, plotted the future pathway, with anticipated activity and simulated a number of scenarios to ensure effective system flow and capacity of those people with an existing diagnosis and expected newly diagnosed. This tool was able to monitor the impact of the model of care and clinical interventions, across the system, ensuring that no waiting lists were created and that the model was efficient. It was particularly helpful in modelling the primary care impact, for Review meetings, Blip clinics, annual reviews and MCI reviews.

It is fully recognised that the pilot project was small scale; time limited and encompassed a degree of positive bias. However, future assumptions have been based upon national validated evidence for the applicability for cost effectiveness at scale (Banerjee and Wittenburg, 2009)[2]. In addition, the detailed system modelling undertaken by the CCG can demonstrate a degree of diligence and methodology in producing an accurate system picture. This was achieved by relying on thematic evidence of the pilot but adjusting potential savings down to a modest level to take into account potential positive bias. This system picture has been validated by the KSS AHSN which concludes and agrees with the assumptions made by the CCG.

Therefore, whilst the CCG recognises that the Buxted pilot is not replicable to an exact standard, the work that has underpinned assumptions for scaling up, validated by external partners, can produce a degree of assurance about the sustainability of scaling up the full model of care.

See Figure 3 for an overview of the system modelling of the new dementia pathway.

2

http://onlinelibrary.wiley.com/doi/10.1002/gps.2191/abstract;jsessionid=D7508DEDB3046FA307FE05C1DA9CC84D.f02t04

Figure 3.

Primary care sustainability

Predicted primary care activity clearly reflects the variation in practice prevalence rates. However, previous queries around practices not having enough activity to warrant a service, is not born out in the modelling exercise, with all practices anticipating weekly appointments or clinics.

The primary care Locally Commissioned Service (LCS), has been specified and costed based on this system modelling which, demonstrates feasibility to deliver The Dementia Golden Ticket model of care at scale, utilising average 30 minute appointments or four hour sessions. For example; based on practices' dementia registers, the modelling predicts a minimum of three appointments per week, up to a maximum of three sessions a week at the practice with the largest dementia register. The LCS therefore endeavours to build in resources on a sustainable footing to support primary care to facilitate enhanced levels of care depending on its capacity and demand.

Secondary care sustainability

The pilot demonstrated that a percentage of people with a diagnosis of dementia, (historically managed in secondary care), could be more appropriately and safely cared for in a primary care setting. This would ensure that secondary care services supported the most complex cases.

SPFT have identified a caseload to be discharged to primary care, estimated as follows:

- Cluster 18 – 100%
- Cluster 19 – 60%
- Cluster 20 – 0%
- Cluster 21 – 40%.

This shift in activity will mean that SPFT will be left with the most complex cases.

It has been assumed that all patients who are currently on the SPFT caseload only for prescribing of anticholinesterase inhibitors will be returned to primary care as these are likely to be the least complex cases. This will include patients who were diagnosed prior to 2012.

In order to model the most appropriate skill-mix of future need in a gold standard service, the Clinical Sub-Committee worked through every assessment, clinical intervention, output and intended outcome, for patients with mild to severe and complex need, (clustered into a Payment by Results (PbR) framework to define the most appropriate workforce to support the patient population best served by secondary care specialities. This was a significant piece of work and culminated in the following proposal of the workforce to deliver the model of care.

To see workforce proposals for the new Memory Assessment and Management Service see Table 6.

Table 6. Secondary care workforce to deliver new Memory Assessment and Management Service (MDT)

Role	Grade/ Band	WTE
Psychiatrist	Consultant	1.0
Psychiatrist	SAS	0.59
Clinical nurse specialist	7	1.55
Clinical Psychologist	8a	0.96
Clinical Neuropsychologist	8b	0.02
Community Psychiatric Nurse	6	5.5
Community Psychiatric Nurse	5	1.0
Occupational Therapist	6	2.0
Occupational Therapist	5	0.5
Speech and Language Therapist	7	1.0
Administrator	4	0.6
Administrator	3	3.18
Support Worker	4	2.0
Team Lead (Nurse or OT)	7	1.0

Risks

The CCG recognises risks inherent in change management processes required to embed a new model of care, particularly when this involves complex whole systems and adaptions to workforce and organisational practice.

The Executive Steering Group for Dementia has given significant consideration to the following risks and has provided associated mitigating actions. See tables 7-9.

859 words

Table 7. Delivery risks and mitigating actions

Delivery Risks	Mitigating Actions
In previous initiatives such as the Dementia Enhanced and National Enhanced Service for Dementia, only 75% of local practices signed up to a local contract. If this was replicated for The Dementia Golden Ticket LCS it would create inequalities in service provision and potentially de-stabilise the proposed model of care, given that this proposal is reliant on a reduction of secondary care activity and increase in primary care activity	The Primary Care Strategy Group considered these risks together with alternative options for delivery and endorsed a LCS approach based on the fact that The Dementia Golden Ticket offered attractive benefits to primary care, which would contribute to the resolution of existing issues such as stretched GP capacity and frustration with the existing dementia pathway in supporting practices to manage this group of patients. In addition, a comprehensive support package has been aligned to the implementation plan to encourage and support participation. In the event that there is insufficient practices signing up to the LCS alternative methods of delivery will be investigated. To date, a larger number of practices have registered an interest to participate in the first year, than expected.
Workforce availability to deliver new model of care, (specifically Clinical Nurse Specialist role in secondary care)	Risks have already been identified and plans have been put in place for staff development and workforce planning to ensure model delivery by September 2017. The primary care element of The Dementia Golden Ticket was proven in the pilot to be able to be delivered by a range of primary care practitioners, with appropriate training. This flexibility should support practices in being able to maintain a sustainable workforce, particularly with additional investment.
Varying degrees of knowledge, training and competency to manage dementia in primary care	A small cohort of CCG staff and clinicians are attending the BSMS Fellowship, (Sept 16-Mar 17) with a view to developing a local programme of primary care education to support the aspirations of The Dementia Golden Ticket. Resources have already been secured from BSMS to work in partnership with the CCG to deliver the programme in May and June 2017 in anticipation of delivering the LCS.

Remobilisation of secondary care services	Since 2015, SPFT have worked closely with the CCG in developing The Dementia Golden Ticket model of care, which included piloting the model for 3 months, alongside existing services. Robust modelling has since specified the necessary skills that would be required to support implementation and initiatives such as workforce planning and leadership considerations are already complete. A Joint Implementation Steering Group has been established and a shared Project Manager Post has been aligned to manage the transfer of care and patients to the new model of care.
Voluntary and market sector capacity to respond to demand and geographical coverage of semi-rural patch in East Sussex	Pre and post-pilot engagement has contributed to a more encouraging market picture for the provision of dementia services and recent stakeholder and market engagement events led by ESCC have also strengthened the local landscape. Further market engagement events are planned for the Autumn 2017.
Adult social care capacity to respond to rising demands from the pilot, in an environment of austerity cuts	Operational understanding and sign-up to the new way of working, has already been established through the evaluation phase. Future strategic and partnership arrangements will be progressed through the multi-agency governance framework for HWLH (Connecting 4 You).
KSS AHSN has identified the following risks: • **Ease of setup may not be straight forward once pilot is rolled out to multiple sites** • **Leading of project on multiple sites may become difficult to manage by the project team**	The CCG has proposed a phased plan including both SPFT transitions and primary care wave implementation. This approach endeavours to mitigate risks associated with scaling up and will ensure quality of delivery at an individual practice level, excepting two practices per quarter onto the scheme.

Table 8. Financial risks

Financial Risks	Mitigating Actions
Realignment of existing resources, (currently embedded in existing contracts)	With SPFT's full partnership to the clinical development of 'The Dementia Golden Ticket' pilot there is organisational commitment from the CCG and the Trust to work together to achieve the full roll out of 'The Dementia Golden Ticket' across the whole HWLH area.

Economic sustainability	Whilst there are risks inherent in any assumptions KSS AHSN have validated the CCG's quantitative analysis of the proposed model of care. The associated report states that the model delivers value to patients, is potentially economical and sustainable, and is more robust than the current pathway.
Modelling capacity and flow	Significant endeavours have been made to limit the risks inherent in such a complex model of care, which includes system costs and assumed benefits. These have been mitigated by utilising a software simulation tool. Furthermore, national validated evidence has been drawn upon and assumptions tested with leading lights in the field in dementia, including BSMS and the Health Foundation.
Benefits realised in pilot aren't replicated	It is recognised that the pilot itself consisted of a small group of patients over a short period of time. In addition, by the very nature of being a pilot, it will be influenced by positive bias, of all stakeholders wanting it to be successful. That noted, all stakeholders in the future model have a keen appetite for the continued success and multiple methods have been used, (engagement, modelling, scenario-running) in order to be assured of a system benefit return. For the reasons acknowledged, financial assumptions of savings have been modelled below the rate of success achieved in the pilot. To provide an added degree of assurance based on implementation of a new approach, a longer term evaluation will be pursued, which presents an opportunity for continued review and refinement to ensure that benefits are delivered.
The KSS AHSN has recommended that if the wellbeing elements are not realised the impact of savings will be much reduced	The Dementia Golden Ticket model of care and associated cost modelling recommends a full programme of community wellbeing interventions. Approval of a case for change encompasses approval for commissioning of these interventions and therefore, all wellbeing interventions modelled will be provided.

Table 9. Governance of risks

Governance Risks	Mitigating Actions
Delivery risks (governance)	Governance around the delivery will be overseen and monitored by the Executive Steering Group for Dementia and will report to the CEC and Governing Body.
Finance risks (governance)	If CEC and Governing Body approves the economic case for change, within acceptable range of variation the Executive Steering Group for Dementia will be delegated to oversee risks. Any assumption in the implementation which arises outside of the acceptable rate of variation would be deferred back to the Clinical Executive Committee for consideration.

Implementation

It is recognised by the CCG, that implementation of the primary care component of The Dementia Golden Ticket, is complex and requires significant workforce and operational planning.

For this reason, the CCG is offering a significant package of support, (see Table 11.) and a roll-out programme which aids and manages any associated risks with scaling up a complex model of care.

It is therefore envisaged that the CCG will be seeking to gauge initial expressions of interest to sign up to The Dementia Golden Ticket LCS, with a view to accepting practices onto the contracted scheme in 'waves' of implementation. This might include for example, accepting two practices onto the LCS every three months in year 1, amounting to four waves in the first year.

Early conversations suggest a slightly higher rate of take up in year 1 than previously modelled, with potentially eight practices expressing an interest in signing up to the LCS in 2017/18.

Prioritisation of access into the waves will be determined by submitting plans, which assure of operational readiness and quality of service offer.

This approach has been considered by the Executive Steering Group for Dementia as the best approach to ensure that the CCG could offer sufficient support at an individual practice level, to assist with roll-out in a managed and sustainable way and to mitigate risks associated with service change and implementation of a new care approach.

Potential roll out over three years therefore, may look like Table 10.

Table 10. Potential roll-out model

Implementation year	Wave 1	Wave 2	Wave 3	Wave 4	No. practices
Year 1	2	2	2	2	8 40%
Year 2	2	2	2	2	8 40%
Year 3	1	1	1	1	4 20%

A review of wave 1 implementation will inform wave 2 roll out with the ability to shorten/expand/increase or change wave 2 depending on the outcomes of the review.

Acceptance onto wave 1 will be prioritised according to readiness and ability to demonstrate embracing the ethos and quality standard behind The Dementia Golden Ticket model of care. In the early stages of roll out geographic representation across HWLH will be important but not critical access criteria.

The Executive Steering Group for Dementia has considered and taken into account requirements for geographical clustering. However, the group felt that the preference for geographical representation provides greater benefit to the HWLH population than practice based clustering. This is because practices will have the opportunity to learn from each other via the educational programme (rather than geographical closeness); and post diagnostic support via the third sector will be based on geographical spread as per the five Memory Wellbeing Cafés already established in the patch. In addition, SPFT will be located in two geographical locations spread North and South and therefore this will align to the geographical representation of wave implementation.

Implementation package of support

If this business case is approved by the CCG's Governing Body, it is recognised that the system model of The Dementia Golden Ticket will take time to transform, mobilise and embed, not least because it requires people to work in a different way and inherent in this, is a change of culture, which evidence proves is one of the most challenging change management processes to influence.

Table 11. Implementation package of support

In consideration of these issues a number of initiatives have been proposed and costed in the model, as follows:	
GP Clinical Lead mentoring and support	
Education and Training	It is envisaged that training will be available twice a year to align with wave implementation in year 1 and

	2. The education package will be reviewed according to practice feedback and in line with implementation roll out.
The Dementia Golden Ticket resource pack	The CCG will compile a resource pack for system stakeholders including a 'Step-by-step guide' of interventions and expectations inherent in The Dementia Golden Ticket; contact information; referral forms; and new templates to assist with review meetings.
Dementia-Friendly Communities	The project officer instrumental in working with Buxted Medical Centre implementing environmental changes to the practice will be available to offer advice and support in the implementation of the ISPACE toolkit.
Management and IT support	Stakeholders will have access to information, advice and support from a project manager. Stakeholders will also have access to support from the Primary Care IM&T Team, for advice and assistance on things such as up-loading templates and record cleansing as part of the maintaining the dementia register incentive within the LCS.
Secondary care specialist input	Built into the model of care, is a hotline to secondary care services for two hours a day, Monday to Friday; this will facilitate timely access to advice and support. In addition, there will be a programme of support and education to enable primary care practitioners who carry out reviews and Blip clinics to develop key competencies and increased autonomy of practice. This will be led by the Clinical Nurse Specialist and will comprise both attendance at Blip clinics and other educational and support activities.

Indicative implementation milestones

Key Milestones	Due	Status
Memory Wellbeing Café roll-out	From March 2016	Complete
Contractual changes signalled in commissioning intentions to providers	October 2016	Complete
Launch of Dementia Guide service (interim solution)	01 October 2016	Complete
LCS service specification approved by PCCC and CEC **LMC negotiations started 9 December** **LMC negotiations completed and revised cost-modeling included in business case**	6 December 2016 9 December 2016 11 January 2017	Completed
Commissioning of transport solutions across HWLH in the localities of the Communities of Practice	Market testing Jan-March 2017 Service in place from April 2017	On track
SFPT Partnership support of The	6 January 2017	On track

Dementia Golden Ticket Model of care achieved. Detailed contract and scaling up discussions to be held		
Continue to engage and consult with patients, carers, stakeholders and public utilising existing and already established networks e.g. Healthwatch	9 January 2017	On track
Walking for Health	Engagement with patients and carers 10 January 2017 Rollout to Memory Wellbeing Cafés from April 2017	Complete and on track
SPFT planning, mobilisation and implementation workshop	20 January 2017	Complete
Full business case to CCG Governing Body for approval	22 March 2017	On track
Commissioning of Admiral Nurses	Recruitment and selection April-July 2017 Admiral Nurses in HWLH by September 2017	On track
Commissioning physical exercise classes across HWLH in the localities of the Communities of Practice	Service in place from April 2017	On track
GP education and training programme for primary care committed to signing up to LCS- Session 1	May 2017	On track
Changes to prescribing protocol to be presented to APC	28 February 2017	On track
GP education and training programme for primary care committed to signing up to LCS- Session 2	June 2017	On track
Singing programme	Roll-out to HWLH April 2017	On track
Business case for Emergency Respite Beds (Better Care Fund) to be developed. If resources are secured, purchase beds in the community	May - July 2017	On track
SPFT mobilisation and phased implementation aligned to delivery of the primary care component of The Dementia Golden Ticket	Phased implementation from April 2017. Delivery from September 2017	On track

Primary care LCS Year 1 (anticipated uptake 40%) Year 2 (anticipated uptake 40%) Year 3 (anticipated uptake 20%)	Wave 1 Apr-Jun 2017 Wave 2 July-Sep 2017 Wave 3 Oct-Dec 2017 Wave 4 Jan-March 2018	On track
Market engagement and review of Dementia Guide service	August/September 2017	On track
Community Dementia Crisis Team (re-configuration of inpatient services)	6 months prior to the new site opening at St Gabriel's	On track

Shared learning and recognition

2014

- Public CCG events e.g. 'Shaping our future' - October 2014

2015

- Think Tank' consultation, holding a workshop at the King's Fund Conference on dementia - February 2015
- ESSA Health & Community Care Theme Group - March 2015
- Dementia Fellowship Consultation (Brighton and Sussex Medical School) - April 2015
- Dementia Fellowship - April 2015
- East Sussex Older Peoples' Partnership Board - June 2015
- Protected Learning Events:
  - 29 June 2015
  - 30 July 2015
- International Carer's Conference, Gothenburg, (4-6 September, 2015)
- KSS AHSN Dementia Collaborative - November 2015

2016

- Commissioning for Quality (Brighton Medical School MSc Programme) - March 2016
- East Sussex Assembly Annual Conference - September 2016
- 11th UK Dementia Congress, Workshop Presentation - November 2016
- Prime Minister's Rural Dementia Task and Finish Group – December 2016
- Protected Learning Events:
  - 22 September 2016

2017

- Scientific Programme Committee accepted poster presentation at the 32nd International Conference of Alzheimer's Disease International to be held in Kyoto, Japan from 26 April to 29 April 2017.

The Golden Ticket has been recognised both nationally and internationally:

- The National Primary Care Awards- Winners of 'Pathway Innovation of the Year Award' 2016

- 2016 Positive Practice Awards (Sussex Partnership Foundation Trust)-
  - The Golden Ticket Pilot won Gold in 'Partnership in practice', awarded for effective partnership working across groups, within an integrated team, with patients and carers, other teams or organisation.
  - The Golden Ticket also won Silver in the 'Team' Category. Awarded for teams which have made an outstanding contribution to the work of the Trust.
- National Dementia Care Awards- Shortlisted in top 5 for 'Outstanding Dementia Care Innovation'

Press coverage

Globally

- 6th International Carers Conference
  Recognition of presentation re-tweeted by E Sibling Project and CEO of British Association of Carers

Nationally

- Kings Fund
  http://www.kingsfund.org.uk/sites/files/kf/media/Dr%20Elizabeth%20Gill.pdf
- The Health Foundation
  http://www.health.org.uk/programmes/innovating-improvement/projects/dementia-%E2%80%98golden-ticket%E2%80%99-%E2%80%93-emerging-new-model-care
- BBC One Show- February 2016

Locally

- Uckfield News
- http://uckfieldnews.com/buxted-chosen-for-pilot-scheme-leading-the-way-in-dementia-care/
- The Argus, 2015: "Dementia scheme receives £75k cash boost"

  Newspaper Article1.pdf

  http://www.theargus.co.uk/news/13951767.Innovative_dementia_project_gets_funding_boost/
- Dementia Cafés, Sussex Express
  http://www.sussexexpress.co.uk/news/village-news/peacehaven-1-7391509
- Sussex Express- Alive Inside printed news report
- Kent and Sussex Courier- "£75,000 is just the ticket for dementia suffers", 2015

  Newspaper Article2.pdf

Appendix 1: Resources and appendices

Please attach any leaflets, posters, presentations, media coverage, blogs etc you feel would be beneficial to share with others.

1. **Golden Ticket Handbook**

A5 main doc V5 web.pdf

2. **Qualitative Service Evaluation of The Dementia Golden Ticket Pilot at Buxted Medical Centre, (Gill 2016)** (including case studies, quotations and photographs)

GoldenTicket Service Evaluation 25.04.16 I

3. **'Tips for Businesses' booklet**

Dementia concertina.Final.pdf

4. **Step-by-Step Pathway** (How to deliver the Dementia Golden Ticket) Presentation

Appendix 6 Step-by-step Guide- H

5. **Profile-Raising and Media Coverage**

Profile Raising and Media Coverage of th