AGENDA

SELECT COMMITTEE - DEMENTIA

Friday, 8 April, 2011, at 1.30 pm

Swale 1, Sessions House, County Hall, Maidstone

Ask for: **Christine Singh/Sue Frampton**

Telephone **01622 694334/694993**

Tea/Coffee will be available before the meeting

Membership

Mrs T Dean (Chairman), Mrs A D Allen, Mr D L Brazier, Mr A R Chell, Mr L Christie (co-optee), Mr J D Kirby, Mr S Manion, Mr K H Pugh Mr A Sandhu, MBE

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

1.30 - 2.15 pm Interview with **Justine Leonard**, Service Line Director for Older Adults and Specialist Services, Kent and Medway NHS and Social Care Partnership Trust (1 - 2)

2.30 - 3.15 pm Interview with **Anne Tidmarsh**, KASS Director of Commissioning and Provision (and County-wide QIPP Lead for Dementia), and **Emma Hanson**, Joint Commissioning Manager, Dementia, West Kent KASS and NHS (3 - 4)

3.30 - 4.15 pm Interview with **Hazel Price**, Programme Manager, Kent Whole Systems Demonstrator Project (5 - 8)

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

At the end of the public session, Members of the Committee should remain in the meeting room for 20 minutes for summing up

Peter Sass
Head of Democratic Services and Local Leadership
(01622) 694002

Thursday, 31 March 2011

Dementia Select Committee – Hearing 8th April 2011

Justine Leonard (1.30 pm)

Biography

Justine is Service Line Director for Older Adults & Specialist Services, Kent & Medway NHS & Social Care Partnership Trust.

Themes & Questions

1. Could you please introduce yourself and your role and give an overview of how KPMT services in relation to dementia are set up - are these similar across the county and what, if any changes are envisaged in the future?
    a. How quickly can people access memory clinics after being referred from primary care?
    b. Where and how often do clinics take place?
    c. Once people are in touch, how long does it take for people to obtain a diagnosis,
    d. What is involved and how is the diagnosis monitored?

2. How does KMPT currently work with other health and social care professionals - what joint/integrated work is taking place or planned in the future?
3. Could you please comment on any differences in approach regarding diagnosis, treatment and support for people experiencing younger onset dementia and their family/carers.
4. Are resources currently evenly spread - where are the gaps across the county?
5. What information is provided to people with dementia and their families to help them understand local services and the level of quality and outcomes that they can expect? Is there guidance on family involvement and confidentiality at the point of diagnosis? What is the involvement of the Voluntary Sector?

6. The Carers Joint Needs Assessment document for Kent highlights that 'Caring for someone who has dementia is a risk factor for depression and that one third of people who care for someone who has dementia have depression. How are carers needs addressed by KPMT in order to support their role and provide some protection against depression?

7. Could you comment on shared care with respect to dementia and on the likelihood of a greater role for GPs in the prescribing of dementia drugs – what happens currently and what developments do you believe could contribute to improved care and support for people with dementia and their families/carers in the future?

8. In your view, what innovations in dementia treatment and care are helping to transform services?
9. Mental health professionals are skilled in identifying differences between delirium, depression and dementia – how can knowledge transfer take place between professionals, and more widely to aid in the early diagnosis of dementia.
10. What are the three most important changes which needs to happen to shift the experience of people with dementia and their carers in Kent from one portrayed to the select committee of a carer coping largely unassisted and a diagnosis being obtained quite late on in illness progression to one of early signposting to IAG, early diagnosis and personalised, good quality care with improved quality of life for both the family/carer(s) and cared for person?

Dementia Select Committee – Hearing 8th April 2011

Joint interview (2.30)

Biographies

Anne Tidmarsh

Anne is KASS Director of Commissioning & Provision (County-wide QIPP Lead for Dementia)

Emma Hanson

Emma is Joint Commissioning Manager Dementia West Kent Adult Social Services & West Kent NHS. She has worked for Kent County Council since qualifying as a social worker in 1996 and has always chosen to work in older people's services. She has had various roles in the organisation and is committed to improving the quality of experience for users and carers. When newly qualified she worked as a care manger in the Maidstone area and for almost seven years was the team leader of a busy care management team supporting the Gravesham area. As well as operational roles she has also held three strategic roles as a policy officer, policy manager and now as a strategic commissioner. As a policy manager she had the county lead for Carers issues which led her to her current role as West Kent Dementia Commissioner.

Her aim is to ensure that Dementia viewed as a long term condition and to support the change necessary to deliver a new model of care which will be more proactive and community focused. She is fully committed to integration with the NHS and thinks this is the best way to provide seamless proactive services and make the best use of joint resources. Emma believes that the next few years will be very interesting as GP colleagues are supported to become commissioners and she will be working hard to keep Dementia high on their agenda and maintain the positive changes that have been made since the publication of the National Dementia Strategy.

1. Could you please introduce yourselves and briefly outline your respective roles in relation to dementia in Kent.

2. Could you tell us about QIPP, KCC’s involvement in it, and how this will impact on dementia services in Kent. How do you envisage the ‘dementia pathway’ changing and what measures of progress have been put in place?

3. What links does KCC have with the various groups working on dementia in Kent including the Collaborative, Dementia Forums and the Dementia Strategy Group for Maidstone & Tunbridge Wells NHS Trust. Do other Trusts in Kent have similar strategy groups – how is all this work co-ordinated?

4. Since the CQC’s report Independence, Wellbeing and Choice how has planning for additional support to cater for growing numbers of people with dementia progressed. What is the outlook for, and planned pathway of those people who are not lucky enough to have family carers and may or may not be self-financing?

5. How is the ‘core offer’ of dementia services and support being identified from the best practice within the county and elsewhere? How can we ensure that small, experienced local providers in the Voluntary Sector are retained within that framework in order to provide quality and continuity to people with dementia and their carers in Kent?

6. Could you please highlight any substantial differences between the East and West Kent Dementia Strategies and whether the people of Kent who are affected by dementia can expect a consistent approach throughout the County regardless of where they live?[1] What are the barriers to having a Kent-wide Dementia Strategy?

7. A proportion of the people who receive community care services are people with dementia yet these services are non-specialist, generic and may not be sensitive to the particular requirements of this group of people. For example the select committee has heard about a lack of continuity in care staff causing additional problems, over and above those that might otherwise be expected – and an apparent lack of awareness of (or ability to handle) behaviours that may be associated with dementia - what is being done to address this e.g. through contracts or training?

8. How is (non-ringfenced) money from the PCT for carers, including those for people with dementia, being spent?

9. People may encounter gaps between KASS and Health and one area of inconsistency would seem to be continuing care – what protocols or policies are in place to ensure that people know what they are entitled to?

10. A proportion of people with dementia will not want carers though they need them for taking medications etc. If in addition a person is required to pay for any care they might (reluctantly) receive – what measures are in place to safeguard them?

11. What are the three most important changes which needs to happen to shift the typical pattern of experience of people with dementia and their carers in Kent from one portrayed to the select committee of a carer coping largely unassisted and a diagnosis being obtained quite late on in illness progression to one of early signposting to IAG, early diagnosis and personalised, good quality care with improved quality of life for both the carer and cared for person?

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[1] The Select Committee currently has access to the West but not the East Kent Strategy.

Dementia Select Committee – Hearing 8th April 2011

Hazel Price (3.30)

Biography

Hazel is Programme Manager for the Kent Whole Systems Demonstrator Project one of thee such pilots in the country, the others being in Cornwall and the London Borough of Newham.

1. Could you please introduce yourself and give us a brief overview of the components of the Whole System Demonstrator Project – relevant to dementia care.
2. What outcomes have there been and what is the future of the different components.
3. Has Telecare been well received by people, and are there any particular issues that have been highlighted regarding use of Telecare to support people with dementia and their carers.
4. The Select Committee have heard about particular technology products to support people with dementia and carers such as mobile phones, the use of CCTV in the home and products like the Carer's Watch – do these all come under the heading of Telecare?
5. What are the issues around funding for Telecare – who 'qualifies' for it and who pays? Are products available for private purchase/lease by self-funders and to people using direct payments?
6. What advice and guidance is available for people on the different products available and who provides this? How is the quality of products assured and who carries out maintenance?
7. If vulnerable people and those caring for them are reliant on Telecare to maintain their independence and safety – what contingency is there for products using mains electricity in a power cut?
8. Following an alert, via Telecare, of a problem or difficulty being experienced by a person with dementia (or indeed other service user) what is the planned response – which group or organisation provides this cover and how is this funded?
9. In your view, and from any results know from Kent and the other pilots, what role could Telecare play in helping to maintain the independence of people with dementia to assist both them and their carers?

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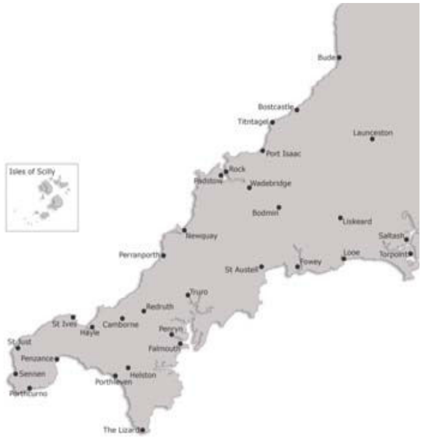
Three WSD sites

CORNWALL

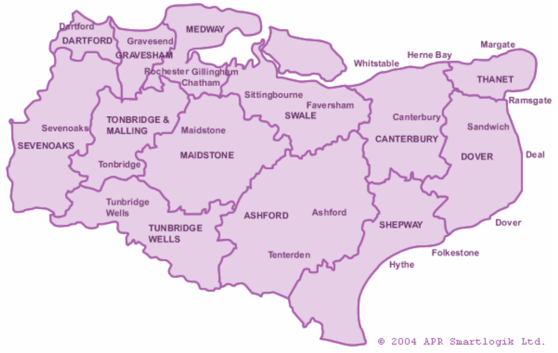


- The poorest County in England, with a dispersed rural population
- Population of >500,000
- 46% of the population live in settlements of <3,000 people
- 99.1% White British
- 10.3% of the population are aged 65+; 7.2% 75+ and 2.6% 85+
- 21% of the population report a limiting long term illness

NEWHAM

- One of the most deprived areas in the UK
- Population of 270,442 - GP registered population of 300,000
- Population increasing at a higher rate than the London average
- 2nd most diverse population in the UK - >68% BME; >140 first languages
- 8.5% of the population are aged 65+
- 17.3% of the population have a limiting long term illness
- Highest death rate from stroke and COPD
- Highest diabetes rate in the UK
- 2nd highest CHD rate in London

KENT



- Combination of rural and urban populations
- Population of 1.37m (excluding Medway UA). Two areas already piloting telehealth Ashford / Shepway population of 211,100 & Dartford / Gravesham / Swanley population of 210,000
- 3.5% BME
- 17.3% of the population are aged 65+; 8.4% 75+ and 2.2% 85+
- Within the target population, individuals report having an average of 1.6 of the three target conditions of HF, COPD, Diabetes

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