AGENDA

SELECT COMMITTEE - DEMENTIA

Wednesday, 23rd March, 2011, at 1.00 pm Ask for: **Christine Singh/Sue Frampton**

Wantsum Room, Sessions House, County Hall, Maidstone 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, 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 Pat Brown, Admiral Nurse Clinical Lead (East Kent) and Fiona Martin, Admiral Nurse Clinical Lead (West Kent) (1 - 2)

2.30-3.15 pm Edith Megbele, Community Mental Health Nurse (3 - 4)

3.30-4.15 pm Dr John Ribchester, Senior and Executive Partner for Whitstable Medical Practice, and Chairman of the WISH Integrated Care Pilot Project (5 - 6)

Additional briefing documents are attached as background reading for today's session:- (7 - 24)

- Admiral Nurses Response to Consultation on National Dementia Strategy
- Dementia UK Activity in Kent and Medway
- Community Mental Health Services
- Dementia Services Health Check (SMT report, with appendices on request)

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

Tuesday, 15 March 2011

Dementia Select Committee – Hearing 23rd March 2011

1.30-2.15 Joint interview, Pat Brown and Fiona Martin

Pat and Fiona will make a presentation to incorporate as many of the suggested themes as possible, following which any remaining questions, or questions arising, can be asked.

Biographies

Pat Brown, Admiral Nurse Clinical Lead, East Kent Admiral Nursing Service, Kent & Medway NHS and Social Care Partnership Trust

Pat has been a trained mental health nurse since 1994. Since completing the 'Thorn' training in family work (Institute of Psychiatry, London) Pat has continued her interest in supporting and working with families affected by mental illness. She joined the new East Kent Admiral Nurse team in 2008 as Clinical Lead.

Admiral Nurses support families who are living with dementia and have a clear focus of supporting and enabling the family carer. The Admiral nursing approach has strengthened her passion for working with families affected by dementia. Works in secondary care

Fiona Martin, Admiral Nurse Clinical Lead, West Kent Admiral Nursing Service, Kent & Medway NHS and Social Care Partnership Trust

Fiona has been a trained mental health nurse 1984 and was one of the first nurse prescribers in Kent. Her work in the past has been with older people but now she works also with people who have younger onset dementia, and their families.

She believes passionately in the rights of people with dementia to a clear and concise diagnosis. She took up her current post last January with the remit to work within GP surgeries to try to break down barriers between getting a diagnosis and family support so while building up the role of Admiral Nursing within Primary care, she is also pioneering needs of people with dementia and their families.

Themes & Questions

1. Could you please give us an overview of the Admiral Nursing Service, how it is funded and provided in Kent and whether there are any threats to the service or plans to develop it.
2. Could you tell us for example about the ratio of nurses to people/families requiring support and your capacity to provide help where needed?
3. Do Admiral Nurses work similarly across the county or does the role differ – are the same services available to people living in different

areas of Kent e.g. in terms of location, referral mechanisms or integrated working?

4. What in your view could help to improve continuity of support for people with dementia and their carers, and eliminate gaps within or between services?

5. Please could you tell us about the specialist training that Admiral Nurses receive and whether you offer training to others?

6. Are you able to support only people/families who receive a diagnosis of dementia?

7. Dementia UK's response to the National Dementia Strategy spoke of 'bespoke dementia services' – how do you envisage these would look and how could they be achieved in Kent while protecting existing good practice in care and support?

8. In light of the government's current awareness-raising campaign, does more need to be done to get across the message (to professionals such as GPs as well as the public) that if there are suspicions of dementia, getting a diagnosis as early as possible is the right thing to do? Is it always the right thing to do?

9. If anyone is concerned about a person they know, or loved one who is showing signs believed to be of dementia – what is your advice?

Dementia Select Committee – Hearing 23rd March 2011

2.30-3.15 Interview - Edith Megbele

Biography

Edith has a degree in mental health nursing and currently works as a Community Mental Health Nurse in the Home Treatment Service. She works with older adults with a diagnosis of dementia, providing support either in the person's own home, in care homes or in hospitals. Her work is geared towards preventing admission into a mental health ward or to assist families during the transitions from home to care home or from hospital back to home. She also provides support to care homes in managing challenging behaviours associated with dementia. She is an advocate for and supporter of older people with dementia and their families.

Themes & Questions

1. Could you please introduce yourself and outline your role and its setting, in relation to dementia care?

2. How can different health services and social care services work more effectively together – where are the sticking points and what are your suggestions for the best way forward?

3. What kinds of support or service are most effective in supporting people to remain at home with dignity and a greater quality of life?

4. Can you comment on the level of awareness of dementia and recognition of it among the nursing and caring professions in general, with reference to Kent?

5. What are the risks of not recognising dementia in a patient attending either a primary or secondary care setting on another medical issue?

6. In your experience are the views, knowledge and needs of carers for people with dementia taken into account by the various medical professionals who may be involved and if not – what should be happening to address this?

7. Could you please comment on the 9 Steps – from your experience in Kent, and knowledge of practice elsewhere – where do we need to concentrate our efforts and what innovations are contributing to reaching these goals?

8. Is the Big Society the answer – what can all of us do to play our part?

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Dementia Select Committee

Biography – Dr J M Ribchester

Dr John Ribchester is Senior and Executive Partner for Whitstable Medical Practice, which is an NHS commissioning exemplar site. It is also currently a single practice GP commissioning Pathfinder site. He is GP Commissioning Lead and a Practice Pathway Clinician. Dr Ribchester is a GP with a Special Interest (GPwSI) for the East Kent Surgery in Primary Care Scheme and is Chairman of the Whitstable Integrated Social and Health Care (WISH) Integrated Care Pilot Project. Previously he has been a GP Advisor to the Department of Health, a Medical Manager for a Fundholding Multifund Consortium, Primary Care Group Chair and PCT Co-Chair. His main interests are in developing integrated healthcare and improving the design of clinical pathways with the aim of producing a better patient experience, closer to home and at less cost to the NHS.

Suggested Themes & Questions

1. Could you please introduce yourself and tell us briefly about your role in relation to the integration of health and social care in Kent and the WISH pilot project.
2. Could you please comment on the ways in which 'care closer to home' might contribute to better experiences for people with dementia and their carers. How can we ensure that the 'invisible' savings from reduced hospital admissions are invested in high quality community care?
3. Could you comment on development of a clinical pathway for dementia?
4. Kent does not compare well with other counties on the proportion of cases of dementia that remain undiagnosed (and this is very variable across the county) – what are some of the factors that, in your view, impact on the rate of referral/diagnosis and how can we increase the rate of diagnosis to redress the imbalance now as well as preparing for the higher prevalence of dementia in Kent in the future.
5. Can you comment on the training GPs have historically received on recognising the symptoms and signs of dementia – do GPs feel adequately equipped to do so and if not, what strategies or methods would a GP use to follow up on their concerns?
6. Can you comment on the level of awareness within GP practices of support services for people with dementia and families/carers within their communities? How are people signposted towards the help and support they may wish to access at some point? What tools are available for this?
7. If someone has concerns about a relative or friend who may be showing signs of dementia – how can the complexities of patient confidentiality be overcome in this regard? What are the difficulties a GP faces?
8. What are your views about the ongoing care of people who receive a diagnosis of dementia – in your view are the 'lines of communication' between primary and secondary care strong enough – what are the challenges to a shared model of care?

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Summary of Admiral Nurse response to National Dementia Strategy consultation: September 2008

Admiral Nurses welcome the commitment to improving the quality of dementia care driven by the development of a National Dementia Strategy and are keen to contribute towards the further development of recommendations and their implementation.

The main messages from Admiral Nurses in relation to this consultation include:

- The views of people with dementia and their families must develop and shape future provision
- For significant investment, proper funding and clearer directions for improvements to be successful.
- To develop bespoke dementia services rather than trying to fix current systems which struggle to meet the needs of people with dementia and their families.
- To acknowledge the trajectory of the illness and to include a bigger emphasis on the complex needs of those at the end of life, as part of the Strategy.
- To recognise that dementia is a complex illness that needs a comprehensive and flexible but dedicated solution.
- To understand that people with dementia and their carers sometimes have different needs which may conflict and/or be interdependent; these must be acknowledged and balanced in a commitment to providing family centred care.
- To recognise that people with dementia and their carers needs and deserve support from knowledgeable, skilled professionals whose development is supported through clear education and training pathways.
- To ensure that quality education/ training that is embedded within organisational, systematic approaches to change and in which practice is adequately supervised and supported in order to develop.
- For an assessment of competence, knowledge and skills in relation to dementia to be included as a part of pre-registration education for all health and social care professionals
- To recognise that nurses have a significant contribution to make in delivering dementia care in a variety of settings and for dementia specialist nurse roles to be developed in support of this.

Admiral Nursing offers a model for developing specialist dementia nurse roles and are committed to improving the lives of families affected by dementia.

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Activity in Kent and Medway July 2010

There are 16 Admiral Nurses working across Kent and Medway. In addition Dementia UK training offers training courses to both Kent Adult Social Care (KASS) and Kent & Medway NHS Social Care and Partnership Trust (KMPT).

Admiral Nurses work collaboratively in such a way that the family and the person with dementia can guide the pace and nature of the support and clinical intervention that is offered by the Admiral Nurse. The model is relationship-centred and all the people involved are considered by the nurse as part of a whole unit. The Admiral Nurse will assess the mental and physical well-being of both the family carer/s and the person with dementia.

Admiral Nurses run the following services:
Clinics for family carers in Ashford, Tenterden, Dover, Deal, Thanet, Sittingbourne, Maidstone. A survey of the Admiral Nursing 'Clinic' Service held in four local Age Concern Day Centres in Thanet has been carried out with the audit department of KMPT (copy available from Jackie Tuppen, Admiral Nurse, Thanet).

Post diagnosis Memory Services in Ashford, Sittingbourne Folkestone, Margate

Clinics for the Continuing Care Ward and Admission Ward, Frank Lloyd Unit, Sittingbourne, and the Wimslow Ward, Ashford

Carers Education Programmes in Canterbury/Coastal, Maidstone, Medway, Dartford, Gravesham & Swanley, Dover/Deal

Admiral Nurses also have a broad role in education and training and work across organisations. This over laps with their case work. There are three parts:

- With carers, families living with dementia

- With organisations, statutory, voluntary and private sector
- General awareness raising of dementia

Joint working with Crossroads Care, Thanet. Admiral Nurse supports and mentors the Dementia Care Support Worker.
Partnership with Sing for your Life and the Silver Song Club project promoting mental and physical well-being of people with dementia and their carers.
Joint working on a dementia pathway with local hospices in East Kent and Maidstone. Admiral Nurses provide dementia knowledge and expertise and family carers can access training provided by the hospices.

Joint facilitation of carer support groups with the Alzheimer's Society in Dover/Deal, Folkestone, Tonbridge, Tunbridge Wells and Maidstone. Joint working with the Sunlight Centre and Age Concern in Medway. Support group held in a local GP surgery in Medway. Support groups are individually evaluated to ensure they meet the needs of people attending and are then redefined accordingly.

Development of Resource and Information Pack for Residential and Nursing Homes, that has been piloted in Maidstone. This is now being adapted in a joint pilot with East Kent Admiral Nurses to be used for family carers and hopefully a pilot study in local care facilities for people with learning difficulties.

Primary Care Project in West Kent. Admiral Nurses are piloting a new way of working in GP practices in Maidstone, Tunbridge Wells and Sevenoaks. They are holding clinics to improve access to services for both the person with dementia and their family/social network. This is aimed at increasing the number of people on the GP dementia registers.

Dementia UK Training provides courses for KASS residential care staff and for health care assistants on inpatient wards in Dartford. Negotiations are in hand to extend this to other areas.

Dementia UK Training provided the induction training in dementia for the Medway Dementia Adviser Service.

Dementia UK is a member of the Dementia Education and Practice Development Group, a partnership between the Dementia Services Development Centre South East (DSDCse)and Christ Church Canterbury University (CCCU).

Dementia UK is one of the funding partners for the DSDCse, together with the Avante Housing Association and CCCU. The Director is an Admiral Nurse.

Jacqui Wharrad
Dementia Pioneer
13 July 2010

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By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee – 26 November 2010

Subject: Community Mental Health Services

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1. An Overview of the Structure of Mental Health Services

(a) The following is an overview of the structure of mental health services to provide the broader context within which community mental health services operate.

(b) Across England, 90% of those receiving care for mental health problems do so within a primary care sector, yet around 80% of mental health NHS spending is spent of inpatient services. The last 30 years have seen a scaling back of psychiatric hospital services[1].

(c) GPs treat many patients, and usually refer those they cannot help directly to community mental health teams (CMHTs) or psychiatric outpatient clinics. CMHTs are the main source of specialist help for mental health problems. These teams can include social workers, community psychiatric nurses, doctors, psychologists, occupational therapists and support workers.

(d) The people for whom CMHTs provide services can be divided into two groups:

1. Patients with time limited disorders who can be referred back to GPs after a certain period (weeks or months);

2. Patients, a substantial minority, who will remain with the team for a number of years for ongoing care and monitoring[2].

(e) The details around structure, and indeed name, of local teams are down to local discretion.

(f) CMHTs assess and monitor mental health needs using two specialist systems – care programme approach (CPA) or care management. The CPA has been part of mental health services since 1991 and describes

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[1] The NHS Confederation, *The NHS Handbook 2009/10*, pp.101-103.
[2] The Department of Health, June 2002, *Mental Health Policy Implementation Guide Community Mental Health Teams,* p.7, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_085652.pdf

the process by which mental health needs were assessed, care plans developed and reviewed[3].

(g) Some of the ways in which mental health services have been developed in the community include[4]:

1. Early intervention teams which aim to treat psychotic illness during its early onset.

2. Assertive outreach teams to provide intensive support for those difficult to engage in traditional services.

3. Crisis resolution home treatment teams (CRHTs) providing acute care in patients' homes in crises (a 24-hour service).

(h) The introduction of CRHT teams formed part of the 1999 National Service Framework for Mental Health[5]. The intention was to ensure inpatient care was used appropriately. CRHT teams were to carry out a 'gatekeeping' role for inpatient mental health services. Where appropriate, CRHT teams were to provide intensive support/acute care for people with mental health crises in their own homes. The provision of this service was also intended to enable earlier discharge from acute settings.

1. CRHT teams are usually made up mainly of mental health nurses, with input from consultant psychiatrists, social workers, occupational therapists and psychologists.

2. Many teams around the country evolved from previously existing services, such as primary care crisis intervention teams, day services and A&E Mental Health Teams.

(i) Recent years have also seen the development of the Improving Access to Psychological Therapies (IAPT) programme aimed at extending 'talking therapies' and encouraging provision outside hospitals.

(j) In the acute sector, acute admission wards provide inpatient care with intensive support for patients in periods of acute psychiatric illness. Inpatient Assessment Units assess functional and organic type illness in older adults, and take referrals from Community Mental Health Teams for Older People, GPs and Consultant Psychiatrists. Patients who are in an acutely disturbed phase of a serious mental health

[3] The Department of Health, March 2008, *Making the CPA Work for* You, p.5, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_083652.pdf

[4] The names given to services can vary between areas of the country.

[5] Available at: http://collections.europarchive.org/tna/20100509080731/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4077209.pdf

disorder, are detained in designed Psychiatric Intensive Care Unit (PICU) facilities.

(k) Other mental health inpatient services aim to provide rehabilitation services and provide care to people with an enduring mental illness and for whom a residential placement in the community has been judged to be unsuitable.

(l) Forensic mental health services are there to deal with patients whose behaviour is beyond the scope of general psychiatric services and who may require a degree of physical security. Some will be mentally disordered offenders. These services fall into three categories:

1. Low-security services, often near general psychiatric wards in NHS hospitals.

2. Medium secure services operating regionally with locked wards.

3. High-security services provided by the three specialist hospitals of Ashworth, Broadmoor and Rampton.

(m) Child and Adolescent Mental Health Services (CAMHS) services are arranged in four linked tiers. These range from tier 1 services which contribute to mental healthcare, but where it is not the primary function, such as schools, to tier 4 dealing with the most severe and complex cases and includes inpatient and specialist services such as eating disorders.

(n) According to the Department of Health Business Plan 2011-2015, a cross-government strategy for mental health services and public mental health will be published in December[6].

2. Mental Health within the NHS Financial Framework

(a) Under the current system, Primary Care Trusts control around 80% of the NHS budget. In 2010/11 this amounted to £84 billion (out of a £103 billion NHS budget). This is allocated to PCTs using a weighted capitation formula. £26 billion will be spent using Payment by Results (PbR). The other £58 billion includes prescribing, primary care and those health services not currently included in PbR, such as mental health.[7]

[6] Department of Health Business Plan 2011-2015, p.13, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_121413.pdf

[7] The Department of Health, September 2010, *A Simple Guide to PbR*, pp.62-63, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_120254.pdf

(b) Mental health has been identified as the main priority for the expansion of PbR[8]. *High Quality Care for All* contained a promise to have a mental health currency available for 2010/11 and this was met.[9] The NHS White Paper contained the promise to "implement a set of currencies for adult mental health services for use from 2012/13"[10]. The financial framework being developed for mental health services will operate differently to PbR for acute services.

(c) The distinction between a currency and a tariff is as follows:

1. "Currencies are the unit of healthcare for which a payment is made. They can take a number of forms, covering different time periods – for instance, in acute physical PbR, outpatient attendances are paid on a contact basis, whilst for long term conditions we are looking to develop annual payments adjusted for complexity, which would be more like the care cluster approach. Our initial commitment in mental health is to develop currencies that are being used nationally.

2. "Tariffs are set prices for a given currency unit. The collected nationally determined prices for HRGs are sometimes referred to as the tariff. We have committed to examining the case for a national mental health tariff following the establishment of national currencies. Without a national tariff, prices for a given currency can be set locally or regionally (i.e. at SHA level)."[11]

3. HRGs, Healthcare Resource Groups, are the chosen currency for acute healthcare in England. They are "standard groupings of similar treatments which use similar levels of healthcare resources."[12]

(d) The national mental health currency published in 2010/11 is the 'care cluster'. It was developed by the NHS in the North East and in Yorkshire and Humber.

1. "(T)he clusters identify patient need over a given period of time, and apply to both admitted patient and community care. They therefore balance the risk between commissioners and providers. Commissioners do not have to pay extra for each

[8] Ibid., p44.
[9] Ibid., p.44.
[10] The Department of Health, July 2010, *Equity and Excellence: Liberating the NHS*, p.25, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf
[11] The Department of Health, February 2010, *Payment by Results Guidance for 2010/11,* p.95, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112970.pdf
[12] The Department of Health, September 2010, *A Simple Guide to PbR*, p.20, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_120254.pdf

contact and intervention. Providers know they will be get paid for each patient they care for and they also have an incentive to innovate and support the patient in the most cost effective setting. "[13]

2. "Mental health providers will allocate their patients to the care clusters by the end of 2011. In 2012-13 the clusters will be used as the contract currency, with local prices agreed."[14]

3. There will be exceptions to the services covered by the care clusters, such as CAMHS, secure services, learning disability services and specialised services.[15]

(e) A number of specialised services where the number of affected patients is relatively small are commissioned either regionally by one of the ten Specialised Commissioning Groups, or nationally by the National Commissioning Group. In mental health this includes secure services and some personality disorder services.

3. The Care Quality Commission survey of community mental health services.

(a) On 14 September 2010, the Care Quality Commission published a national survey of community mental health services. The survey involved 17,000 services users at 66 NHS Trusts between July and September 2009. The briefing note by the CQC outlining the national results can be found at Appendix 1[16] and the report on Kent and Medway NHS and Social Care Partnership Trust can be found in Appendix 2.[17]

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[13] Ibid., p.44.
[14] Ibid, p.44.
[15] The Department of Health, February 2010, *Payment by Results Guidance for 2010/11,* p.102, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112970.pdf
[16] The Care Quality Commission, September 2010, *Supporting Briefing Note: Community Mental Health Survey 2010*, http://www.cqc.org.uk/_db/_documents/MH10_Briefing_note_v7_FINAL_201010262348.doc
[17] The Care Quality Commission, September 2010, *Survey of people who use community mental health services 2010 Kent And Medway NHS And Social Care Partnership Trust* http://www.cqc.org.uk/_db/_documents/KentAndMedwayNHSAndSocialCarePartnershipTrust_RXY_MH10.pdf

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By:	Michael Thomas-Sam, Head of Policy and Service Standards
To:	SMT Health (External) – 23 July 2010
Subject:	**DEMENTIA SERVICES HEALTHCHECK**
Classification:	Unrestricted

Summary:	This paper sets out activities against the 17 objectives of the National Dementia Strategy for England. This is in response to the proposed reviews of dementia services by the Department of Health, Health Overview and Scrutiny Committee and Adult Social Services Policy Overview and Scrutiny Committee, to take place in Autumn 2010.

1. Introduction

(1) Dementia represents a significant issue for both health and social care. The nature of the disease and the way it presents itself requires close, collaborative working between health and social care. A whole system approach is necessary, so that the best quality care possible for people with dementia (PwD) and their carers can be provided.

(2) In a letter sent to Primary Care Trust (PCT), Strategic Health Authority (SHA) and Local Authority (LA) Chief Executives on the 1st April 2010, Sir David Nicholson (NHS Chief Executive) highlighted some of the findings identified in the National Audit Office (NAO) report 'Improving Dementia Services in England' published in January 2010. The key findings were:

- Direct costs of dementia to the NHS and social care are in the region of £8.2bn annually
- Potential efficiency savings of at least £284m per year
- 570,000 people in England with dementia – this number is expected to double in the next thirty years
- 40% of people admitted to hospital have dementia
- At least 50% of long term care residents have dementia

(3) In response to this report, Sir Nicholson identified 3 key areas for implementation by SHA's, PCT's and wider partners:

- By 31 March 2010 each locality to jointly produce an action plan setting out how clear goals for dementia services will be developed in light of the National Dementia Strategy objectives
- The NHS to have a clear plan in place for achieving efficiency savings and the redeployment of 2% of funds to support dementia service transformation
- The care pathway for older people with dementia to be improved, specifically appropriate and timely discharge from hospital

(4) The letter referred to the national audit of dementia services to be undertaken by the Department of Health in 2010. It is understood that the review will focus on dementia activities currently in place and how these fulfil the objectives set out in the National Dementia Strategy (NDS). It is anticipated that further information on the review criteria will be provided in July 2010.

(5) It is also understood that the joint Health Overview and Scrutiny Committee (HOSC) and Adult Social Services Policy Overview Committee (ASSPOSC) will commence with a separate review of dementia services in autumn 2010. The criterion for this review is not yet known, but it is anticipated that it will share similarities with the Department of Health's national review criteria.

(6) This report is in response to these review proposals, it sets out the current dementia activities taking place in Kent against the objectives of the National Dementia Strategy, see Appendix 1 (East Kent) and Appendix 2 (West Kent). The intention is to use the information to encourage a coordinated joint response with partners in preparation for the proposed reviews.

(7) The response will, in-part be based upon the findings of the Baseline Review Reports, which are currently being re-drafted by the Department of Health's regional support team so that they are specific to individual organisations (East and Coastal Kent PCT, West Kent PCT, Medway Pct and Kent County Council). Each report provides a description of the dementia strategy for each organisation, a summary profile, and suggestions to support the implementation of the National Dementia Strategy. The Department of Health's regional support team anticipate that the final versions of each report will be sent to each CEO before July 2010. It is understood that the main suggestion identified as a priority for all organisations will be the need for high level sign up to all strategies going forward.

2. Policy Context

(1) The Department of Health (DH) published the "Living well with Dementia: A National Dementia Strategy" on 3rd of February 2009. The aim of the Strategy is to ensure that considerable improvements are made to dementia services across three key areas: **improved awareness**, **earlier diagnosis and intervention**, and a **higher quality of care**.

Appendices 1 and 2 give a fuller description of each objective.

(2) In the National Dementia Strategy report submitted to SMT on the 1st of May 2009 it was agreed that some issues were more prevalent in Kent and that these required a consistent approach to ensure an economy of scale. The efficient use of combined resources to ensure that effort was not duplicated was a requirement. As a result the following 5 objectives were deemed priorities for local health and social care partners.

Objective 1 Improving public and professional awareness and understanding of dementia.
Objective 3 Good-quality information for those with diagnosed dementia and their carers.
Objective 11 Living well with dementia in care homes
Objective 13 An informed and effective workforce for people with dementia
Objective 16 A clear picture of research evidence and needs.

(3) In July 2009, the Kent and Medway Dementia Collaborative was established to fulfil these 5 objectives. The Collaborative consists of members from NHS, Local Authority and Voluntary organisations.

(4) The Dementia Collaborative Agreement formalised the arrangement and set out the role and aims of the group. The Agreement is to be reviewed in July 2010.

- Informing the design and Commissioning of services that respond to the findings of the 2009 Dementia Joint Strategic Needs Assessment
- Delivering an integrated best practice dementia care pathway
- Determining a quality framework, which includes clinical standards and protocols across pathways.
- Supporting innovation and the sharing of best practice
- Facilitating service redesign and reconfiguration to improve pathways and maximise use of available resources and quality of care through multi-disciplinary care models.
- Undertaking audit and research of the approaches and practices adopted to ensure continual improvement and innovative delivery of high quality dementia service.
- Reduce avoidable duplications in assessment, planning and delivery of services, and
- Seek improvements in services and the quality of life for people with dementia and their carers.

(5) The status of activities against the key 5 objectives is outlined in Appendix 1.

(6) In addition, the Kent and Medway Dementia Joint Strategic Needs Assessment (JSNA), was completed in spring 2009. It was undertaken using robust methodology taking a systematic review of national and local epidemiological and demographic data, national and local policy directives, current services resources and activity and planned developments across the whole health and social care economy.

(7) The JSNA results indicated that by 2023 the numbers of people with dementia will have increased dramatically. In west Kent estimations based on known prevalence rates and population numbers estimate that there are currently 7716 people with late onset dementia, in 15 years time by 2023 this number will have increased by 50% to 11574. Similarly in east Kent currently there are an estimated 8706 people with late onset dementia this is set to increase by 43% to 13059 by 2023. Dementia therefore presents a significant challenge to both health and social care but this increase will also mean that many more carers will be supporting people with dementia.

(8) In November 2009, in response to an independent study into the prescribing of anti-psychotic drugs ('The use of anti-psychotic medication for people with dementia: Time for Action' by Prof Sube Banerjee), the Government supported the proposal that anti-psychotic drugs should only be prescribed to people with dementia when necessary, and are not used when non-pharmacological approaches can be equally effective. Progress against this objective will be reviewed by the National Clinical Director for Dementia, Professor Alistair Burns, and will involve the following:

- Professor Burns to report on a six monthly basis to the Minister for Care Services on progress against the recommendations contained in the report (see Appendix 1, Objective 18 for recommendations)

- Professor Burns to lead a national audit to generate data on the prescribing of anti-psychotic drugs to people with dementia in each PCT in England. The first audit to be completed within 6 months of his appointment (January 2010), and repeated on an annual basis for at least the next 3 years to measure progress.

Progress on auditing the prescription of anti-psychotic drugs to people with dementia, and reducing current levels of prescription, will from now on form part of the programme for implementing the Strategy (see Appendix 1, Objective 18).

3. Health Check against the National Dementia Strategy (NDS)

(1) The National Dementia Strategy (NDS) identifies 17 key objectives which, when implemented, should result in significant improvements in the quality of services provided to people with dementia and their families, and promote a greater understanding of the causes and consequences of dementia.

(2) The DH sets no expectation that all objective areas will be implemented within five years, but sets out the following principals that should be adhered to when implementing the strategy locally;

- **Co-production:** implementation must be discussed and decided in partnership with the NHS, local authorities and key stakeholders.
- **Subsidiarity:** where necessary, the DH will play an enabling role, but wherever possible, the details of implementation will be determined locally.
- **Clinical ownership and leadership:** DH staff must continue to be active participants and leaders as the strategy is implemented and the necessary changes are made.
- **System alignment:** the wider system needs to be aligned around the same goals, enabling combined leverage to drive up quality across the system.

(3) No strategy sits alone. The national dementia strategy must be read and interpreted in the context of two other key strategies: the National Carers Strategy and the National End of Life Care Strategy. The National Dementia Strategy (NDS) states that 'family carers are the most important resource available for people with dementia' and that active work is needed to ensure that the provisions of the carers' strategy are available for carers of people with dementia. Likewise people with dementia and their carers to be involved in planning end of life care, and that local work on the end of life care strategy should consider dementia.

(4) The account of how local services have responded to the NDS based on the health check in Appendix 1 is encouraging. All the same, this report has identified that more needs to be done in certain key areas.

(5) In preparation for the proposed reviews it will be necessary to discuss progress against the NDS objectives. Appendix 1 sets out the 17 objectives and the activities which have taken place in Kent since February 2009. In the light of the different partnership arrangements in East and West Kent (PCT and KASSS), SMT Health is asked to confirm which local groups will be responsible for informing further work on this. The intention is to have a joint response developed against the 17 criteria by September 2010.

4. Recommendations

SMT Health is asked:

a) To **NOTE** and **COMMENT** on the issues raised in this report

b) **AGREE** a coordinated response to DH, and the joint HOSC and ASSPOSC topic review.

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Background Information:
Sir David Nicholson Letter (1st April 2010)
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_116313
Improving Dementia in England (National Audit Office)
http://www.nao.org.uk/publications/0910/improving_dementia_services.aspx
Living well with Dementia: A National Dementia Strategy (Department of Health)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094058
National Carers Strategy (Department of Health)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006522
National End of Life Care Strategy (Department of Health)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277
Government response to Prof Sube Banerjees' recommendations on anti psychotic drugs
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108303

Useful Information


My_name_is_not_de
mentia_report.pdf

My name is not dementia (Interviews with dementia sufferers) – Report published by the Alzheimers Society


The Use of Anti
Psychotic Medicines P

The use of anti psychotic Medication for people with dementia: Time for Action – By Prof Sube Banerjee (Commissioned by the Government 2009)