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?