

**Notes from the Kent Health & Wellbeing Board Workshop**  
**7.00 – 8.30 pm on 20 July 2011**  
**County Hall, Maidstone**

The summary below is based on the discussions which took place after the JSNA and dementia presentations and also captures what the HWB should do to address dementia in Kent.

**JSNA**

- Will the Kent wide JSNA be relevant at the CCG level? What will the local arrangements be?
- There needs to be a strong locality element and it should be more bottom up than top down
- The JSNA website needs to be user friendly. A good example is the Nottingham website
- How will the JSNA add value to community strategies and how wide does JSNA influence go?
- Can JSNA information be made available to GPs on a population basis rather than a geographical basis?
- Can email alerts be provided to GPs so that they know when new information has been uploaded onto the JSNA website.
- GPs need to be better linked in to Public Health professionals

**Dementia**

***What needs to happen within acute and community care to improve dementia services in Kent?***

***Early diagnosis***

- Greater emphasis on the need for early diagnosis of dementia and for an analysis of what and where the need is and what is the gap in service
- One of the problems in the Dover area is that GPs are unsure of the pathway to access dementia services
- It was important that where there was good practice in relation to dementia services this is shared
- One of the GPs expressed the view that where the service was “rubbish” for dementia patients why diagnose it?
- In the Maidstone area Admiral Nurses played a significant role in supporting dementia patients. However, it was evident from the table discussion that not everyone was aware of the Admiral Nurse Service.
- Health checks in GP surgeries would help with early diagnosis

### ***Integrated model***

- 2 pronged approach is needed – single referral process (one-stop shop) *and* Integrated Team (multi-disciplinary)
- This should be via 1 dementia provider to deliver the entire service. Each GP Clinical Commissioning Team would tender providers separately.
- KCC and its partners would need to unpick the contracts it currently has in place for the provision of dementia services. Decommission services in preparation for the 'new' commissioning of services via Clinical Commissioning Groups.
- It was commented that we need a mechanism to force the dementia services to work together cooperatively. Specialist Teams working in silos don't work. We need to bring together a multi-disciplinary team combined of specialist workers. This would be part of the tendering specification. Specific KPIs in place to measure performance.
- There was a discussion around Community nursing which was considered good in the Maidstone area. It was felt that the model which needed to be developed was an Integrated Model broader than Health and Social Care but needed to include Housing, Admiral Nurse and all other agencies involved in the provision of services for dementia patients and carers
- Health and Social care co-ordinators should be employed in primary care settings. Torbay has an integrated service. These teams can work with those who receive an early diagnosis
- Need a crisis/rapid response team integrated with Social Care and Health in the community that has varied skills. Care could then be provided at home.

### ***Accessible care pathways***

- It was important to develop a care pathway which could be accessed, One GP spoke of an excellent model he had experienced in Bedfordshire which had worked well. Here there was an aligned Social Worker to each GP practice one day a week.
- Need to have a Quality Strategy for Dementia and a clear pathway for dementia sufferers and their carers.
- Need a Communication Strategy.
- Treatment and assessments tend to happen in secondary care and out of hours care is also focused on acute care. This needs to be shifted to community care
- Memory Clinics work well and there is a good example in Croydon
- Concentrate on getting this to work right in one area first
- Up skill GPs and build relationship with social and intermediate teams
- Has anyone else in the country got this right? Look for examples in the UK and internationally
- The current care pathway recommends that patients call their GP. GPs are not aware of all of the services available. GPs need to be made aware of all of the options available.

- Another suggestion was to have practitioners who have skills in both dementia and Health. More care homes are moving towards EMI.
- If more patients are diagnosed with dementia earlier, the support networks must be there and in place for them.
- People don't like to talk about them having dementia but we need to ensure that they plan their future and discuss it.

***What can the big society/community prevention do to assist in the shift from acute to community care?***

- Education, Education, Education!
- Communication, Communication, Communication!
- Where is the Carers Pathway?
- Integrate the voluntary sector into an integrated model.
- Explore the possibility of an Independent agency/charity taking the lead for example Help the Aged
- Whilst the achievements in improving the service for dementia patients was acknowledged i.e. 24 hour helpline – was there a way of improving the awareness of these services are available to the general public and those who commission the service.
- Through the Local Delivery Frameworks and Section 106 agreements ensure that Community Services are provided.
- Early access to services without having to have a diagnosis and easy access.
- The classic model of diagnosis and treatment is not always helpful for dementia patients. You might want to give someone support but they are in denial of having dementia.
- Life Planning is essential. Perhaps to make the change of moving to a bungalow. Drugs treatment is not recommended as can make things worse.
- A huge number of people have no access to treatment at all and so they don't get diagnosed. Access through the carer support function is therefore sometimes better to enable a proper diagnosis.
- In the delivery of an integrated model it was suggested that community organisations could assist KCC and its partners to break down what services are already in place i.e. unpick dementia delivery across Kent. Identify what the key performance deliverables should be.

***As a Shadow Health and Wellbeing Board what are we now going to do with this? What outcomes do we want to achieve?***

- Ensuring that information on Dementia Services and support for Carers is available to **ALL**.
- All stakeholders/agencies taking a responsibility for the delivery of high quality dementia services.
- The Health and Wellbeing Board should:-
  - (a) Agree the Strategy;
  - (b) Set out the standards and a quality framework;

- (c) Drive the strategy and standards through the Clinical Commissioning Groups and the established infrastructure for Health and Wellbeing; and
- (d) Be the vehicle for braking log jams and overcoming barriers.

- Dementia should be a key priority for the Health and Wellbeing Board
- Dover is running in parallel with the local Health and Wellbeing Board. Dementia remains a key priority there too.
- The Health and Wellbeing Board can make links with District Councils looking at awareness and also to ensure that people have an awareness that more people are going to get older and potentially suffer from dementia.
- Pooling of budgets and resources. KMPT wants to come on board with us and pool budgets.
- The Torbay Model is a good way forward. It is very small but has made the life of GPs much easier. In Torbay they have a rapid response social care package to keep people at home for a few days until their package services kick in.
- The Health and Wellbeing Board should be an enabler and a promoter.
- Needs to be aware of the wider population and what they need.
- The out of hours rapid response team is more critical than in hours.
- The HWB should ask CCGs what they are already doing to address dementia for residents
- More publicity regarding the data sets available to GPs
- Promote local delivery
- Ensure equity for everybody
- HWB need to recognise that GPs are commissioners – they are not concerned with the operational side/or how a provider delivers a service unless there are performance issues and the provider is not performing against the contract specification.
- The GPs' job is to simply request tenders from providers against the relevant specification (steered by the JSNA and HWB Strategy), commission the most suitable provider and then monitor performance against KPIs. Need to move away from a historical public sector approach of getting involved at every level of service delivery.
- HWB should identify the strategy (without political interference) i.e. based on JSNA and HWB Strategy and not politicians' agendas.
- HWB need to provide information on how KCC and its partners should decommission services in preparation for the commissioning of services.
- GPs felt that there was a need to address risk aversion in primary care i.e. why do GPs always default to a secondary care referral?
- Agreed that there needed to be a link from locality Groups/Boards established around Health and Wellbeing to the Strategic Health and Wellbeing Board for Kent.