

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

15 JULY 2010

DEMENTIA UPDATE

Report from: Rose Collinson, Director of Children and Adults

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Summary

Members are asked to consider an update received from NHS Medway on the proposed new model of care in the community for dementia that is fully integrated with health and social care services.

1. Budget and Policy Framework

- 1.1 Under Chapter 4 – Rules, paragraph 22.2 (c) terms of reference for Health and Adult Social Care Overview and Scrutiny Committee has powers to review and scrutinise matters relating to the health service in the area including NHS Scrutiny.

2. Background

- 2.1. Attached to this report, as Appendix A, is an update briefing paper for the Strategic Outline case for the integrated care pathway for dementia. The Head of Commissioning for Older People will introduce the report.

3. Financial and legal implications

- 3.1 There are no financial, legal or risk implications specifically arising from this report.

4. Recommendations

- 4.1 Members are asked to comment on the attached report.

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Background papers - none

MEDWAY PRIMARY CARE TRUST

**BRIEFING PAPER FOR THE STRATEGIC OUTLINE CASE FOR THE
INTEGRATED CARE PATHWAY FOR DEMENTIA**

1. Background

In Medway we want to see care for people with dementia transformed to deliver increased choice and control. This will require significant changes to the way in which we assess and deliver services. Working in partnership between NHS Medway and Medway Council will develop integrated services that reduce admissions to hospital and nursing/residential care by developing more effective provision of community services. When people do experience a hospital stay they will be actively supported to return to their family home in a timely manner.

The Strategic Outline Case for dementia care has been developed as a direct response to our joint commissioning intentions for Older People, to gain approval and commitment to delivering radical improvements in the health of local people through the transformation of local health services provided in both the primary and secondary care sector, and through partnership working with all the partner organisations, voluntary groups and local residents. Currently services for people with dementia are provided by different organisations. This makes the planning, commissioning and delivery of services more complex and fragmented than they need be.

Our vision is to develop a new model of integrated care in the community that is fully integrated with health and social care services providing maximum access to services across a range of dimensions such as:

- Geographical accessibility to services
- Opportunities for patient and carer participation in care planning including increased self management
- The development of a clinical pathway that bridges the current gaps between primary, community and secondary care services

2. Case for Change

A review of the current care pathway identifies:

- Currently there is no single 'dementia service'. This leads to many key and unnecessary issues for people with Dementia and their carers.
- Medway has a significantly higher spend on people with organic mental health problems than its neighbours.
- Recorded vs. expected prevalence figures show a two-thirds shortfall in the likely numbers of people with dementia with around 1500 remaining unidentified or undiagnosed.
- There is an over-reliance on secondary care beds where there may be a lack of in depth understanding of dementia.
- Whilst there are some strong community-based services which will provide a sound basis for the further development of the pathway, the overall care pathway is fragmented.
- There is no access to support 24/7 for people with dementia.
- Patients who are referred do not benefit from an integrated health and social care assessment, with diagnosis linked to care planning across health and social care and leading to integrated service delivery; similarly many carers are not having their needs assessed.
- Patients with undiagnosed dementia often enter the health or social care system in crisis resulting in otherwise avoidable admission to hospital, nursing, or residential care with attendant distress to patient and the family, and substantial cost to the health and social care system.
- Medway lacks capacity to respond appropriately to patients and family carers in times of crisis and are frequently unable to provide care and support in the patient's home. This can result in admissions which would otherwise be avoidable. The confusion that patients with dementia experience when they move from one environment to another frequently exacerbates their condition.
- There are no 'step up or step down' facilities or services that respond to people with dementia.

3. Commissioning Intentions

We propose to:

- Evaluate the Dementia Adviser Demonstrator programme (Medway specific)
- As part of the Kent & Medway Dementia Collaborative determine the service model for Dementia Advisers and Peer Support to be rolled out across Kent & Medway.

- Establish a number of flexible, community based memory assessment services that provide outreach support for GP practices and care homes.
- Mainstream the Dementia Adviser programme
- Implement NICE guidance for structural imaging prior to confirmed diagnosis
- Develop a joint strategic plan with clear statements about investment and disinvestment intentions to achieve better outcomes and greater efficiencies.
- Remodel the current Community Dementia Team provided by KMPT and develop multi-disciplinary home treatment dementia teams that will proactively case manage people with dementia especially those with challenging behaviour. These teams will be integrated with health, mental health and social care linked to geriatricians and mental health specialists. Adopting a locality based proactive integrated approach to identifying and managing people with dementia should reduce unanticipated crises, acute episodes and reduce/defer the admissions to residential/nursing care.
- Redesign inpatient services with appropriate bed capacity to ensure the availability of a small number of short term (8-10 weeks) intensive management beds.
- Review the current bed stock for residential, nursing care and intermediate care beds.
- Implement the model of care that will ensure a variety of services both bed based and non bed based to meet individual needs more appropriately.
- Commission a variety of beds adopting the step up and step down approach for intermediate care, short term intensive management beds, and a defined number of longer term nursing beds.
- Place a particular emphasis on intermediate care and rehabilitation, particularly for the most vulnerable and dependent people within the community.
- Support primary care by providing rapid access to diagnostic services and specialist opinion
- Provide enhanced community services that will support the person with dementia and their carer to remain cared for at home.

Wendy Alleway
Head of Commissioning for Older People
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