Living Well with Dementia in Herefordshire
A Joint Commissioning Plan for
NHS Herefordshire & Herefordshire Council

Transforming the quality and experience of
dementia care for the people of Herefordshire

A local response to the National Dementia Strategy

2010 - 2013
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1. Introduction

Dementia is one of the most important issues that we face as the population ages. It has become increasingly clear both locally and nationally that dementia is one of the biggest challenges facing the health and social care economy. With the number of people living with dementia expected to rise substantially over the next 25 years dementia has to be a key local priority. It is predicted that the number of older people with dementia in Herefordshire will rise from 2,821 to 5,572 in 2030 an increase of 92%. Dementia also affects people under 65; an estimated 54 people under 65 will have young onset dementia. This picture is compounded by the additional data which shows that those with Dementia will have a number of health and social care needs relating to the presence of other co-morbidities or needs associated with increasing frailty.

It is projected that the global cost of dementia this year will be £388 billion, which is more than 1% of the gross domestic product (GDP). The World Alzheimer Report 2010 figures include medical bills for treating the condition, the cost of social care and unpaid care by relatives. The study, completed at the Karolinska Institute in Sweden and King's College London, reveals that these costs are expected to rise steeply over the next few years, but warned that governments are ill-equipped to cope. The report, which was commissioned by Alzheimer's disease International (ADI), expects the number of people with dementia to double by 2030 and triple by 2050.

Given the reliance of people with dementia on a large range of health and social care services, getting dementia care right will underpin work to move care out of acute into the community. In addition, the personalisation agenda in ‘Putting people first’ will not be deliverable unless the range of solutions available to support community based care is dementia friendly. Self-directed support cannot be secured in the scale envisaged across a local health and social care community unless people with dementia are supported to access a larger and more diverse range of services. Alongside this, proposals for a new adult social care system will need to respond specifically to the challenge of dementia if it is to deliver a sustainable solution which guarantees quality of life. This is why dementia must form a key strand in forward plans to deliver independence, well-being and choice.

Putting people first The vision set out in the Department of Health publications, ‘Our health, our care, our say’ and the World Class Commissioning programme seeks to move the current sickness and crisis revolution response to a more developed system of prevention and community based care where people are in control of their health and care. Given the significant and rising needs of people with dementia, this vision cannot succeed unless the challenge of dementia is tackled. NHS Herefordshire and Herefordshire Council have drawn up this Joint Commissioning Plan to address the objectives of the National Dementia Strategy 2009 (NDS). The purpose of this document is to inform the operational plans and budget cycles of the Primary Care Trust (PCT) and Local Authority and demonstrate how we plan to improve services for people with dementia. It is informed by World Class Commissioning guidance and the specific guidance on World Class Commissioning for dementia developed to support the NDS. Analysis is based on best practice, the Herefordshire Joint Strategic Needs Assessment; the Herefordshire Dementia needs analysis; the recent ‘Dementia
Postcard Campaign’, and we have drawn on the views of people with dementia, their carers, health and social care staff and clinicians. People with dementia are or will become elderly and it is envisaged that improvements to the early assessment and identification of dementia will sit within the Frail and Elderly Care Pathway.

1.1 Dementia: Different conditions

Although dementia can affect people at any age, it is most common in older people and becomes more prevalent with increasing age. Nationally, just over 15,000 people are thought to have young-onset dementia (onset before the age of 65), in comparison with nearly 669,000 who have developed it later in life. The likelihood of experiencing dementia doubles every 5 years in later life. By the age of 95, one in three people are affected.

Dementia describes a group of symptoms caused by the gradual death of brain cells, leading to the progressive decline of functions such as memory, orientation, understanding, judgement, calculation, learning, language and thinking. Dementia is a terminal disease where patients are expected to live three to nine years after diagnosis. The principles of good dementia care are those of Palliative Care and advanced care planning – this is where the real benefits of good dementia care lie. In the same way as patients with a terminal illness such as cancer should be consulted about their care patients with dementia should also have the opportunity to plan the care they would wish for in the future.

Dementia subtypes

Dementia can affect people of any age, but is most common in older people. Dementia can be caused by a number of neurodegenerative diseases in which there is progressive decline in memory, reasoning, communication skills and the ability to carry out daily activities. Changes in behaviour are not uncommon, such as depression, psychosis, aggression and wandering. There are many different dementing illnesses further details of which can be found at Appendix A

1.2 The Vision for Herefordshire

By 2012 all people in Herefordshire with a suspected or confirmed diagnosis of dementia, including those with Mild Cognitive Impairment, will be able to access an integrated, seamless, proactive and high quality locality based service that encompasses all the expertise required to meet needs of the people with dementia and those of their carers. The emphasis will be on personalisation and choice.

The aim of this plan is to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention and a higher quality of care. This strategy should be a catalyst for a change in the way that people with dementia are viewed and cared for. Recent reports have highlighted the shortcomings in the current provision of dementia services in the UK and Herefordshire is reflective of the national position.
**Fundamental Principles** We believe that dementia services should be developed using the following principles:

<table>
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<tr>
<th>Personalisation</th>
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<th>Maximising Independence</th>
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| - That people are able to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual needs for independence, well-being, and dignity.  
- To delivering greater personalisation, choice and improved quality.  
- The whole care system, health and social services, should be joined up to help people living with dementia and their carers. | - Every person who receives support, whether provided by statutory services or funded by themselves, will be empowered to shape their own lives and the services they receive in all care settings  
- The person with dementia and their carers should be the focal point of commissioning.  
- The care provided should be focused on the individual, not the environment in which it is provided. | - Promotes independence through the personalisation programme, assistive technology, housing and community based services. |

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All areas of care and health should be trained and skilled in dementia care.

- Specialist practitioners must be available with the skills to manage younger people with dementia and people with learning disabilities and dementia, and  
- The 'specialist', whether they are registered professionals or trained staff, must be able to provide suitable evidence of the knowledge they have in caring for people with a diagnosis of dementia. They may be employed by a variety of agencies but work together to form a specialist service within given geographical areas.

To ensure that services are fit for purpose and organised in sustainable configurations which are able to both drive service improvement and deliver real efficiency.

- To ensure better use of resources across the entire system by investing in early intervention to ensure that the new systems are embedded at a local level.

All vulnerable adults have the right to live full and meaningful lives, without fear from any abuse, regardless of age, sexual orientation, physical and intellectual ability, gender, cultural background or religion.

- To ensure that safe systems are in place to prevent all abuse (including neglect) wherever possible.
1.3 Solutions for Herefordshire – how will we achieve the vision / what does it look like?

This Plan will enable us to commission services that are fit for the future, particularly in relation to workforce skills and competencies across all organizations, by learning from our experience in relation to feedback from compliments, complaints, safeguarding issues and by establishing a quality framework for delivery. There are now opportunities to achieve real joint working on dementia between health and social care and provide an opportunity to increase the priority given to older people’s mental health services.

The National Dementia Strategy (NDS) has and continues to raise the expectations of the public and professionals as well as those with dementia, their families and carers. The NDS expects the positive transformation of dementia services; a system where all people with dementia have access to the care and support they need. It would be a system where the public and professionals alike are well informed; where the fear and stigma associated with dementia have been allayed; and where the false beliefs that dementia is a normal part of ageing and nothing can be done have been corrected.

Where families affected by dementia know where to go for help, what services to expect, and where the quality of care is high and equal wherever they might live. This Plan endorses the goal of the NDS to help people with dementia and their carers to live well with dementia. The NDS and the subsequent DH publication ‘Quality outcomes for people with dementia: building on the work of the National Dementia Strategy’ has identified some key priority objectives for delivery:

- good-quality early diagnosis and intervention for all;
- improved quality of care in general hospitals;
- living well with dementia in care homes; and
- reduced use of antipsychotic medication.

More generally, the improvement of community personal support services is integral to and underpins the four priorities as it supports early intervention, prevents premature admission to care homes and impacts on inappropriate admission to hospital and length of stay. These priorities do not deflect from the work that is required in parallel on key aspects of the NDS such as workforce development, support for carers and the provision of information following diagnosis.

The current pathway is heavily reliant on the specialist older person’s mental health services to accept all referrals, screen, assess and refer on to other services and it tends to respond in the main to referrals for people in the later stages of dementia, often at a time of crisis. There are already a disproportionate number of older people in the county of Herefordshire and this is predicted to increase more rapidly than nationally. This potentially huge growth in demand is both a national and local issue for funding, and service capacity, including workforce. The current pattern of care for older people and those with dementia is therefore simply unsustainable. There is a need to shift towards early diagnosis and intervention.
1.4 Governance
The Health and Social Care Commissioning Programme was introduced and agreed by the NHS Herefordshire Board and Joint Management Team in Spring 2010. The programme is designed to deliver our Health and Social Care Commissioning programme – that builds upon our Herefordshire Public Services’ Corporate Plan, World Class Commissioning Strategy and Adult Social Business Plan. It also has clear link to other key bodies for example the Children's Trust and Herefordshire Strategic Partnership.

The alignment of the six work streams which make up the commissioning programme directly connects commissioners to the strategic level Health & Social Care Programme Board. This new structure aims to ensure delivery of the ten outcomes in the World Class Commissioning strategy and key objectives in the Adults Social Care Business Plan. In order to achieve a higher world class commissioning level, with provider input, there is also direct involvement of clinicians and practitioners at a senior level within work streams.

Details of the governance arrangements and structure charts can be found at Appendix B

1.5 National Drivers, Guidance and Research
Until recently, dementia has suffered from poor awareness and understanding, combined with the stigmas attached to both mental illness and old age. For a number of years, the voluntary sector has highlighted concerns over the appropriateness and quality of health and social care for people with dementia. The Audit Commission’s ‘Forget me not report’ also found that GPs tend to treat the diagnosis and treatment of dementia with a lack of urgency. Dementia received some mention in the 2001 National Service Framework for Older People (NSF), a ten–year programme to set new national standards and service models of care across health and social services for all older people. Clear policy guidance on how health and social care should commission and provide specialist services for older people with mental health problems (including dementia) in an integrated way was published in 2005 under the title, ‘Everybody’s Business’.

The National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) have also issued joint guidance on the treatment and care of people with dementia in health and social care. For the first time, healthcare professionals working within the NHS will be following the same guidelines as social workers and care workers in nursing homes. 2007 saw a critical mass of research findings and reports developing, with two key reports – from the Alzheimer’s Society and the National Audit Office – highlighting the significant and urgent challenge to health and social care presented by dementia – particularly in light of their prediction that there will be over a million sufferers in England by 2025.

The Government followed this with an announcement in August 2007 that it would produce the first ever National Dementia Strategy, to meet the demographic challenge of increasing numbers and the failure of the current system to serve dementia sufferers and their families well. Work was co-ordinated by Care Service Improvement Programme and involved all the key stakeholders from the health and social care fields. Practical guidance to local authorities and health communities on how to make a strategic shift to prevention and early intervention was issued in 2008. This guidance drew on the experiences and evidence emerging from the first two years of the
Partnerships for Older People Projects (POPP) programme and other related initiatives such as the Department for Work and Pensions’ Linkage Plus programme.

The National Dementia Strategy (NDS) was published in February 2009. Details of the 17 objectives contained in the NDS can be found at Appendix C together with details of the relevant national guidance and research. In order to secure and monitor the delivery of “Living well with dementia”, the Department of Health (DH) has established a National Programme Board for older people and dementia. With cross Government representation and involvement from people with dementia and their carers, it will monitor progress, highlight best practice and work to remove barriers to successful implementation. The Programme Board will link to the regional tier through the Deputy Regional Directors for Social Care (DRDs), who progress the Department’s business in the Regions, and with the Strategic Health Authorities (SHAs).

In September 2010 the DH issued ‘Quality outcomes for people with dementia: building on the work of the National Dementia Strategy’. This document presents the Department of Health’s revised, outcomes focused implementation plan for ‘Living Well with Dementia – A National Dementia Strategy’, which is an England only strategy, published in February 2009. It updates the previous implementation plan for the Strategy, which was published in July 2009.

Draft synthesis of outcomes desired by people with dementia and their carers

By 2014, all people living with dementia in England should be able to say:

- I was diagnosed early
- I understand, so I make good decisions and provide for future decision making
- I get the treatment and support which are best for my dementia, and my life
- Those around me and looking after me are well supported
- I am treated with dignity and respect
- I know what I can do to help myself and who else can help me
- I can enjoy life
- I feel part of a community and I am inspired to give something back
- I am confident my end of life wishes will be respected, I can expect a good death

A comprehensive list of relevant drivers and guidance can be found at Appendix C
1.6 Local Drivers for Change

Given the significant numbers of people with dementia using health and social care services, transforming services for people with dementia will be fundamental to achieving world class commissioning, personalisation and the recommendations of the Darzi review. Dementia presents a significant and urgent challenge to health and social care in Herefordshire in terms of both numbers of people affected and cost. It is also a major personal challenge to anyone experiencing early symptoms and seeking diagnosis, which merits the seriousness accorded to, say, cancer. Parallels can be drawn between dementia now and cancer in the 1950s, when there were few treatments and patients were commonly not told the diagnosis for fear of distress.

Currently in Herefordshire there is no single ‘dementia service’. This leads to many challenging issues for people with dementia and their carers. These issues include lack of access to services, lack of continuity within and between a range of services and service providers, inconsistencies between funding sources during the disease journey and lack of advanced care planning. A noticeable absence of any advanced care planning is evident for end of life care for people with dementia. It is particularly important to start such decision making processes while people with dementia have capacity. Much of this reactive focus to care leads to crisis situations which could be prevented and which often result in inappropriate use of unscheduled care. There is national and local evidence that people with dementia experience under-diagnosis, increased delayed discharges from acute and community hospitals and multiple re-admissions, premature admissions to care homes, and general lack of appropriate services.

There is currently a ‘Cycle of Stigma’ that prevents people seeking help and services from offering help. This Plan proposes a number of commissioning actions that are intended to break this cycle through a public health information programme. This will be assisted by joint work with Children’s Services to ensure that non-stigmatising information is included in school curricula and through community engagement activities. Factors affecting a person’s experience of dementia and their rate of decline in independence include the type of dementia, their physical condition and emotional strength and the support available, from family and formal care services. Older people with dementia are often frail and suffer from other long term conditions and often depression whereas younger people with dementia are often very fit physically with a range of different care needs; less physical care tasks/ more psychological well being and activity tasks. Every person’s experience of dementia is unique and their needs range from physical and psychological to emotional and spiritual. This Plan supports a “whole person” approach in dementia care.

People have rising expectations of publicly-provided services, including the care and support system. We expect higher standards and greater choice over our lives than our grandparents did, and our children are likely to expect more than us. People want a system that meets their needs whatever age they are which recognises that people’s priorities can change during the course of their lives. The support people receive should be flexible and adaptable to suit different needs, should keep them safe if they are in vulnerable situations, and should give them as much control as possible over their own care. These changes in expectations will continue to be a key driving force for reform to care and support in the future.
Links to other programmes and strategies

- Herefordshire Carers Strategy
- Safeguarding and Mental Capacity Act
- End of Life Strategy & Workforce Development Plan
- Putting People First – Transforming social care and the modernisation / personalisation programme
- The Older People’s Joint Commissioning Strategy
- Frail and Elderly Care Pathway
- Safeguarding and Mental Capacity Act
- Mental Health New Provider Arrangements
- Lifetime Homes, Lifetime Neighbourhoods

2. Stakeholder engagement
The NDS states that priorities for improvement should be decided locally. Herefordshire’s priorities have been developed through working with a wide range of people in public and third sector services who work with people with dementia and their carers in health, social care and housing. We have also drawn on public consultation and development work on carers’ services, end of life services, housing options for older people, and day opportunities. A Dementia Clinical Reference Group comprising representative from across health, social care, third sector with a representative carer has been formed to progress the local implementation of the NDS.

2.1 Consultation
The engagement process for dementia has a number of strands:

- A ‘Living with Dementia’ Listening Event held in November 2009 involving, professionals, providers, services users, their families and carers.
- A direct engagement campaign through the ‘Living Well with Dementia’ Post card response scheme where 3,000 postcards were given out to older people asking for ways to improve dementia services in Herefordshire – April 2010
- A consultation campaign through ‘Herefordshire Matters’ where people were asked to contact us with ideas for improving dementia services in the county
- Dementia Clinical Reference Group
- Mental Health Procurement Project

2.2 Findings from engagement
The findings from the above consultation have been grouped into eight main themes with four priority areas identified in each theme.
A summary of the direct consultation can be found at Appendix D
3. Needs and Market Analysis

3.1 Current picture and future trends

In Herefordshire the predicted increase in dementia prevalence is expected to climb from 2903 in 2010 to 5572 in 2030 – a rise of 92%. This is probably a very slight underestimate as it may not include people with learning disabilities or people with dementia in NHS continuing care facilities. This rise in expected prevalence is not new. As far back as 1999, service demands were predicted to rise substantially. The prevalence predicted then was under reported with actual figures being substantially higher than predicted and there has been no increased funding to meet this rise. Nearly two thirds of these people live in the community and a third in residential care or nursing homes.

These figures are based on the best available evidence. However, for a variety of reasons we feel that this projection is likely to be an under-estimate. There is no reason to believe that Herefordshire differs from the rest of the country. Locally, there are a substantial number of dementia sufferers who are not known to services. Overall numbers are of little use on their own in identifying future resource and service requirements. A key feature of our modelling has been the identification of the proportion of people likely to be experiencing mild, moderate or severe symptoms. The model we have used classifies 55.4% as having ‘mild’ dementia, needing little or no care. A further 32.1%, with ‘moderate symptoms, are likely to need some care every day. Most significantly 12.5% will need constant care or supervision. The table and graph below shows the estimated numbers of people in Herefordshire at each level of severity of dementia.

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild Dementia</td>
<td>1608</td>
<td>2190</td>
<td>3087</td>
</tr>
<tr>
<td>Moderate Dementia</td>
<td>932</td>
<td>1269</td>
<td>1789</td>
</tr>
<tr>
<td>Severe Dementia</td>
<td>363</td>
<td>494</td>
<td>697</td>
</tr>
</tbody>
</table>

The consequences of this are not only the massive projected rise in the number of those with dementia but many of those with dementia will also develop other co-morbidities. A recent study indicated that 61% of patients had three or more co morbidity medical illnesses. Dementia is one of the main causes of disability in later life. The majority of people with dementia will have other long term conditions such as Coronary Heart Disease, Diabetes, Respiratory Disease and progressive frailty associated with old age. They are also more likely to experience loss of confidence associated with their condition and experience recurrent falls, failing eyesight and hearing. Dementia, however, has a disproportionate impact on capacity for independent living.

3.2 People with learning disabilities

The life expectancy of people with learning disabilities has increased more quickly than that of their non-disabled counterparts. For example, life expectancy for someone with Down’s Syndrome is now estimated at over 50 years, an increase of ten years since the 1980s.
The improved life expectancy that people now experience is due to improvements in standards of living and improved access to appropriate medical care. As the number of older people with a learning disability and specifically Down’s Syndrome has grown, so too has the number of people with a learning disability who are diagnosed with dementia.

3.3 Dementia in Rural Areas

While rural life can enhance quality of life for many older people, it also carries a number of risks. Isolation, including lack of opportunity to develop a social network, is a primary risk of living in a remote setting such as a farm or hilltop hamlet. Chronic isolation has been implicated in late life depression including that linked to dementia, and is a contributor to the loneliness of long term dementia carers. The stigma associated with mental health problems can be particularly evident and severe in a small community; a strong culture of self-sufficiency can also mean people are reluctant to seek help. Poorer health and quality of life outcomes for people with dementia are not only linked to limited availability of social and secondary care services in rural areas but also to the need to travel longer distances to visit their GP. Prohibitive transport costs are also an issue which specifically undermines the ability of those on low incomes to access care services, support groups, shops and post offices.

3.4 Unmet Need

Under the current Quality and Outcomes Framework, as part of the GP contract, GPs keep registers of the numbers of people with dementia on their patient lists. It is possible to take these numbers and compare them to estimated numbers of people with dementia in a PCT area. At present the ratio of GP recorded prevalence to estimated population prevalence of dementia in Herefordshire is 32%. This compares to 33% across West Midlands and 38% across England. The ratio of GP recorded prevalence to estimated population prevalence of dementia confirms there is widespread under-diagnosis of dementia; a lack of diagnosis means a lack of specific treatment and care for those with dementia. This means that there are currently 68% of those expected to have dementia who are not receiving services to meet their needs. A comprehensive capacity and demand baseline analysis was undertaken in 2010.

The results of this analysis appear at Appendix E

3.5 Cohort Analysis

There is no way to link a diagnosis of dementia with health and social care service use. To identify heath and social care needs of these clients, we identified a cohort of people with dementia and analysed their needs through a case note review. We are aware of the limitations of this data; however in the absence of more robust data we will use it to provide a snapshot of the needs of these clients. The files of 50 individuals suffering from moderate and severe dementia (25 moderate and 25 severe) were reviewed and a list of all service they received was complied.

Table 1 below shows the current level of need of care needs for a cohort of individuals who are currently suffering from dementia in Herefordshire. This cohort did not examine people with mild dementia.
Table 2 shows the breakdown of individual’s level of need and the percentage who receive additional support and care from unpaid carers.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Level of Need</th>
<th>%</th>
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<tbody>
<tr>
<td>Independent</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Care needed once a week</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>More than once a week but less than everyday</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>2 visits or less a day</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>More than 2 visits a day</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Critical (residential/nursing home)</td>
<td>28</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Level of Need</th>
<th>% receive additional support/care from unpaid carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Care needed once a week</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>More than once a week but less than everyday</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>2 visits or less a day</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>More than 2 visits a day</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Critical (residential/nursing home)</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Additional support and care received from unpaid carers – Although individuals are receiving support and care through agencies, day care, respite and residential placements, 50% of the cohort of individuals reviewed receive additional support and care from unpaid carers for example family or friends.

A detailed breakdown of this cohort analysis can be found at Appendix F Details of the financial analysis of this cohort can be found at 3.8

3.6 Current services – everybody’s business but no one’s responsibility

Andrew Chidgey, Head of Policy and Campaigns at the Alzheimer's Society, says: "At the moment we do not have a health and social care system that is set up to recognise dementia. There needs to be clear ownership of dementia and structures that allow people to be treated quickly and efficiently.” In the main, the same can be said of Herefordshire.

As part of the preparation to inform this commissioning plan, a mapping exercise was undertaken to find out what we have already in Herefordshire. It is recognised that there are constant changes in the county and that we may have missed some services. We will build on this as we extend the work over the next five years. The mapping has proved to be difficult as many of the services provided to people with dementia do not specifically record dementia as part of the needs of the individual. Although some of the provision identified in Herefordshire is excellent, it is clear that there are not enough services to meet the needs of these people at this time, and it is clear that demand for those services will grow.
Many people with dementia and their families have multiple needs, which can be identified, assessed and addressed by more than one agency or sector. In particular people with dementia may receive support from both or either of the health and social care systems. Differences between the finance arrangements and responsibilities, eligibility and ways of accessing health and social care services can be a source of both confusion and distress. An added complication is that the support and care needed by people with dementia and their families could be delivered by government, private or voluntary organisations. However, most support and care is not provided through structured organisations but by individuals, whether unpaid family members, other unpaid caregivers or, increasingly, by individuals employed under direct payment or individual budget arrangements.

Dementia services in Herefordshire currently straddle Mental Health Services for Older Adults as well as for working age people alongside any primary care input, Social Care, Acute Care, Care Homes, Independent, Charity and Voluntary sectors. However while dementia care is everybody’s business, there is no one overall responsible service. Thus no coordinating overarching service holds, steers, navigates, oversees or reviews a person with dementia throughout their disease experience. This situation is made worse where different services are responsible for different aspects of care and where there are different funding sources for services at different points in the disease journey.

Young Onset Dementia (YOD) is an example that clearly demonstrates the extent of current service fragmentation. Working age people fall between dementia services for older people and general Adult Psychiatric services. Their needs are different to older people with Dementia, and the diagnosis is much more difficult to make. Some present through neurology clinics. Most encounter difficulties accessing an accurate diagnosis both in primary care and with specialist services.

- Capacity issues within the range of community services available mean that many of these units have difficulty in operating as efficiently as possible.
- Further work to reduce inappropriate admissions and reduce delayed discharges will be addressed in the commissioning intentions, and shifting the balance of resources towards community based intermediate care provision/admission avoidance activity.
- There are very few local providers who are able to support people with dementia
- There are not sufficient competent providers locally who can support people with complex health and social care needs. Capacity therefore will need to be identified to manage the market.

Outline details of services are listed in Appendix G.

3.7 Current Resources

The financial costs of dementia are significant to the NHS, social care, families and society. In 2007, the London School of Economics estimated that the annual cost of dementia in England is £15 billion per year (more than cancer, heart disease and stroke combined). This amounts to an average of £25,000 per person with dementia per year.
Dementia is already placing significant strains on councils and primary care trusts. Two-thirds of care home residents have dementia, with 70% of the cost borne by the state. An estimated 60% of acute hospital beds are taken up by older people, 40% of whom may have dementia.

In Herefordshire we know that we are spending a significant sum of money across the agencies on people with dementia. It is difficult to produce an exact figure because a lot of people have multiple needs which are met by a wide range of services. Social care service are provided on the basis of need and the clients are therefore not classified as having dementia on Framework i. Many services provide for older people with functional illness as well as dementia, services do not have distinct staffing, and budgets are configured in different ways. The amount budgeted for specific Older Peoples Services appears below:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Indicative Budget 2010 / 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing Healthcare</td>
<td>£2,615,908</td>
</tr>
<tr>
<td>DMHOP</td>
<td>£526,685</td>
</tr>
<tr>
<td>Nan Bellville Day Hospital</td>
<td>£269,555</td>
</tr>
<tr>
<td>Adult Social Care</td>
<td>£14,820,000</td>
</tr>
<tr>
<td>Total</td>
<td>£18,232,148</td>
</tr>
</tbody>
</table>

A significant proportion of all the older people receiving a service through Adult Social Services have a dementia as a factor leading to them and their carers need for social care support. The Social Care budget for Mental Health Services for those over 65 yeas of age appears below.

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross budget over 65s</td>
<td>£6,193,284</td>
<td>£6,445,987</td>
</tr>
<tr>
<td>Net budget over 65s</td>
<td>£4,590,159</td>
<td>£4,865,321</td>
</tr>
</tbody>
</table>

The financial impact of increased demand from demographic changes will impact in the medium and longer term. The major financial concerns will be the impact in the medium or longer term of increasing service demand from demographic changes upon services. Provision for this will need to be considered as part of both the PCT and Council’s overall annual budget setting processes.

Over time, it should be possible to redesign services to deliver better value for money. However, in the short term, it is unlikely to be possible to deliver significant savings for reinvestment, given the low level of services for people living with dementia and their carers. The new model of care needs to show value for money and be comparable to the cost of institutional care. Further details of the national financial picture can be found at Appendix H.

3.8 Cohort Financial Modelling

The local patterns of service types and costs for people with different stages of dementia were identified to inform planning. This is not a full health economic model which would include costs of disease due to absence from work, costs to carers etc; but is limited to a range of costs for Herefordshire Public Services. An additional 70 cases were added to the cohort identified above in order to produce a larger, although less detailed, basis for a snapshot of service use and costs. Local service use and costs reflected at a local level the national pattern reflected in the report
“Dementia UK 2007” The proportion of people with mild, moderate or severe dementia using services is shown below (based on sample of 120 cases):–

This pattern of services was reflected in the weekly costs shown below:–

The financial cohort details can be found at Appendix H

3.9 Workforce

With a growing and ageing population, increasing demand on older people’s services workforce planning, needs to recognise the specialist skills required to meet the standards of dementia care expected by the people of Herefordshire. Actions with this Plan address the needs of improving skills and training in particular the core training and on-going development to assure the skills, knowledge and awareness to manage most effectively the needs of older people. Further workforce development is required to plan and forecast future need in line with growing demand.
People with dementia and their carers need to be supported and cared for by a trained workforce, with the right knowledge, skills and understanding of dementia to offer the best quality care and support. Dementia is largely a progressive incurable condition with a prolonged disease progression generally spanning many years. The age profile of paid and unpaid carers combined with the growth in single person and single pensioner households presents real challenges to planners. The increasing needs and demands of an ageing carer ‘workforce’ is a major feature to systematically address. Generating new responses and solutions to support this ‘workforce’ will be key to meeting the health needs of this growing population.

4. Gap analysis

Given the predicted rising demand in both overall numbers and in severity of the condition, there is a need for more of the existing services; memory assessment services or clinics, memory cafes, and far more specialist services: home care, day care, extra care housing, residential and nursing care, and far more support for carers.

The current pathway is heavily reliant on the specialist older person’s mental health services to accept all referrals, screen, assess and refer on to other services. The lower level community services do support people with dementia but they lack the confidence and skills to retain people in their services when the condition starts to markedly progress.

All services work hard, are fully committed and are in the main highly valued by service users and carers. But given the current service model there is little or no community based multidisciplinary service available to people with dementia regardless of age that can provide the early support package designed with the specific needs of dementia in mind. Our view is that currently there is an over reliance on residential and nursing home care for people with dementia locally and an over reliance on out of area residential placement for younger adults with dementia.

Herefordshire older persons’ mental health services currently have only very limited capacity for early diagnosis and support for people with dementia and their carers. The services have not been structured or resourced to provide an early assessment service and as a result tend, in the main, to respond to referrals for people in the later stages of dementia, often at a time of crisis. There are clear areas where there is no provision at present, notably day care and residential care for people with young onset disease and there is a small, but growing, need for more specialised services for people with Down’s Syndrome who have also developed dementia.

There is a lack of specialist dementia training in most health and social care disciplines, and little training in the detail of how to care for people with dementia. There is also a lack of old age psychiatric liaison in acute hospitals.

An analysis of the current provision in Herefordshire against the West Midlands Dementia Care Pathway was undertaken. Details of this can be found at Appendix I.

To summarise, the main weaknesses in services identified are:
Improving public and professional awareness

- Lack of core training, education and support for statutory agency staff and carers
- Lack of health promotion
- Difficulty in accessing information about numbers of people with dementia as well as resources
- Difficulty in financially assessing the cost of services for people with dementia
- Difficulty in determining quality and dignity of care in care homes and hospitals
- Lack of carer awareness training for professionals that links into hospital discharge and carer involvement
- Lack of awareness of Welfare Rights that can assist and advise in maximising income

Early diagnosis and intervention

- Limited early awareness and information services both prior and at the point of diagnosis of dementia
- No commissioned or resourced early assessment and care service for all those prior to a diagnosis of dementia and issue re the capacity of these services to assess all new referrals for memory problems if the numbers increase significantly as predicted.
- Lack of awareness within primary care of mental health difficulties and needs of people with dementia
- Lack of clarity regarding referral routes for GP
- Lack of intermediate care facilities, both beds and support in the community

High quality care and support people with dementia and their carers

- Services for older people with dementia and younger people with early onset dementia are limited and inadequate to meet current needs and future demands. There is a need to develop a clear referral pathway for tertiary opinion for YOD patients who present in a complicated way.
- Insufficient services to meet both the current and forecasted needs of future years
- Limited comprehensive respite breaks services which include specialist day services, sitting services, skilled support in the home and appropriate respite care
- Lack of specialist support for carers to include support, information provision and easy access to services when required
- Limited facilities to support people to live at home e.g. extra care
Continuous improvement in care home services

While this plan has indicated that there are weaknesses and gaps in current services for people with dementia, it is important to acknowledge that there are also strengths and opportunities within the current system that will assist in the design and implementation of future provision. Mainly, the motivation and willingness across agencies and sectors to work together on tackling issues associated with dementia.

4.1 The cost of doing nothing

The cost of doing ‘more of the same’ in delivering current dementia services in the West Midlands outstrips any conceivable rate of increased funding.

- QOF data for 2008/09 indicates that 873 patients across Herefordshire are registered as having dementia – this represents only 32% of the cases we would expect to see in Herefordshire.
- Key findings from the National Audit Office’s publication “Improving Services and Support for people with Dementia” (2007) indicate that almost two thirds of patients live in the community and one third are in care homes.
- The local mapping and needs analysis for dementia strongly suggests that the current numbers are not manageable and that the balance of care is weighted towards high dependency and long term care. Given the predicted increase in prevalence shown above there is no ‘do nothing’ option with dementia care.
- A series of reports in the last 12 months have also shown that in care homes, where one in three people with dementia live, services are struggling to deliver good quality dementia care.
  i. Alzheimer’s Society Home from Home report found that people with dementia socially interact for two minutes in an average six hour period in a care home.\(^{21}\)
  ii. The Commission for Social Care Inspection report ‘See me, not just the dementia’ found that over half of all care homes surveyed are failing to provide good dementia care.\(^{22}\)
  iii. The All Party Parliamentary Group on Dementia report ‘Always a last resort’ found that over 100,000 people with dementia are being inappropriately prescribed sedative antipsychotic drugs due to inadequate care.\(^{23}\)

- Predicted demographic trends, the economic situation and changing expectations have created new challenges for the care and support system. Without reform, there is likely to be pressure on families to provide increasing levels of care and adults may go without the care and support they need.

4.2 Summary of Risks

- Risk of not achieving national and local policies resulting in poor CQC ratings
- Cost implications for PCT and Council if not invested in as dementia prevalence is already predicted to rise at a higher rate than the average for England.
- If we do not implement the new proposed model of care we are at risk of not addressing our key strategic objectives – Early Detection and Prevention as part of CSP objectives.
- We will fail to meet the high patient and carer expectations arising from the publication of the National Dementia Strategy
- Failure to help to reduce the burden of Continuing Health Care escalating costs
- Increased risk of no appropriate bed availability, major impact on Intermediate Care, Community and Domiciliary Care
- In the absence of new investment the proposed redesign of the dementia model of care will face significant delays
- More people diagnosed with dementia supported within the community without any additional resource, this will create capacity issues on a range of health and social care services
- Potential impact on Local Authority priorities in relation to prevention, individualized budgets and direct payment

5. Priorities for Action

Contrary to the general view, there is a great deal that can be done to help people with dementia. Services need to be refocused to ensure that dementia is diagnosed early and appropriately so that people with dementia and their families can receive the treatment, care and support that will allow them to live well with dementia, following diagnosis.

Both the Council and the PCT can save money and improve outcomes by investing jointly in dementia services. There needs to be a drive to reduce beds provided by Continuing Health Care and out of county placements; to reduce the number of admissions to and length of stay or acute inpatients beds and shift resources towards prevention and early intervention as the central object of a revised model of care. It is anticipated that we would be able to generate a reduction in the cost base of between 6% and 8% for re-engineering and re-investment.

By supporting people diagnosed with dementia at an earlier stage and helping them to remain in the community there will be a positive impact on Hospital admissions, residential placements, nursing provision and Continuing Health Care. This will need to be balanced with the increase in support required across some parts of Social Care, Intermediate Care, Domiciliary Care, Voluntary sector, community services and other mainstream services (e.g. Sports and Leisure, Arts etc.)

5.1 The Design of Future Provision

This plan will enable us to commission services that are fit for the future, particularly in relation to workforce skills and competencies across all organisations by learning from our experience in relation to feedback from compliments, complaints, safeguarding issues and by establishing a quality framework for delivery. The complex nature of dementia requires a whole systems response, cutting across health and social care services, (linking into housing, the voluntary sector, benefits advice etc.) physical and mental health and mainstream and specialist care. Efficiency in health and
social care services will improve outcomes for service users and their carers and achieve savings across the health economy.

People with dementia are significant users of health and social care services. In the next ten years the number of people with dementia will grow significantly. In addition the biggest growth in dementia will be amongst the ‘oldest old’ – people with dementia in their 80s and 90s with particularly complex needs compounded by a range of co-morbidities. This will put significant pressure on services that are already unable to respond effectively unless change is delivered. The emphasis of these commissioning intentions is to shift the balance of care for older people with dementia needs in line with local and national priorities.

There will be less emphasis on the use of hospital based or institutional care and more of an emphasis on providing services in the person’s own home or in the community, supported by a strong integrated community nursing and social care infrastructure. There will continue to be a need for residential and nursing care both in the short term and the long term to support carers and community based services however, the quality of care requires further work.

Day services and day hospitals will need to be effective in delivering meaningful programmes of activities for people with dementia. However, in Herefordshire we will both seek to provide more community based care that promotes choice, improved health and independence and is supported by a robust structure of quality health, social care, and independent and voluntary sector services. There needs to be an increase in respite care and crisis accommodation which maintains skills and avoids institutionalization thereby allowing the person to return home once the crisis is over.

It is proposed that statutory services will work closer together in order to deliver services through an integrated approach. This should result in an improvement in the way that services are delivered, with a more joined up approach to jointly treating mental and physical conditions. The use of direct payments and personalisation should also be increased. In order to achieve the above, it should be acknowledged that services may need to be decommissioned in order for the commissioning of specific services identified in the action plan.

5.2 Return on Investment – New Models of Service Delivery

The Partnerships for Older People Projects (POPPs) were ambitious projects designed to provide evidence about how best to help older people stay well and independent. These projects have also produced one of the first analysis on the return of investment from upstream funding. The projects have shown that investing in preventative approaches, and working together, really can work. Not only have the projects led to a reported better quality of life for individuals, but they have also demonstrated the potential for considerable savings. On average, across a range of projects there has been an almost 50 per cent drop in the number of overnight hospital stays and an almost 30 per cent drop in A&E visits after people received a POPP service compared with the situation before they used the service.

Interventions across the programme have produced an average saving of around £1.20 in emergency bed days for every extra £1 spent on the POPP service. The costs of the POPP programme were examined by two different means.
1. The first assessed the cost of the individual projects per user. These varied considerably with the focus of projects: those aimed at primary prevention cost £4 per user per week, compared to £7 for projects aimed at secondary prevention. These costs are low compared with other social and health care interventions. Such findings must be treated with caution, due to some probable inaccuracies in reporting and a high level of missing data.

2. The second analysis focused on the impact of the POPP projects on the use of hospital emergency beds, using areas without a POPP programme as a comparison. It was found that POPP projects appeared to have a significant effect on emergency bed days, and this has stabilised over time. The effect was such that an additional investment of £1 in POPP services would produce greater than £1 savings on emergency bed days.

The projected figure varies with assumptions about management overhead costs: under an assumption of 10% management costs, a £1 additional spend on POPP projects would lead to approximately a £1.20 reduction in required spending on emergency bed occupants at the mean. This is the headline estimate drawn from a statistically valid range of an £0.80 to £1.60 saving on emergency bed days for every extra £1 spent on the projects.

<table>
<thead>
<tr>
<th>Older People over 65 as a cohort 2009 / 2010</th>
<th>Herefordshire</th>
<th>Reductions identified in PoPPS evaluation</th>
<th>Projected savings / reductions for Herefordshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overnight stays over 65’s</td>
<td>177 spells (5,052 bed days)</td>
<td>47% reduction</td>
<td>83 spell (2,374 bed days)</td>
</tr>
<tr>
<td>A &amp; E Visits over 65’s (Herefordshire Registered Patients attending HHT)</td>
<td>8,954 visits</td>
<td>29% reduction</td>
<td>2,596 visits</td>
</tr>
</tbody>
</table>

The NDS impact assessment included information on the financial benefits (and costs) of its proposals. These highlighted that:

- The additional costs of early diagnosis and support would be offset by savings elsewhere, especially in social care. In addition there is evidence that such support, and early carer support, could reduce care home admissions by over a fifth,
- The costs of people inappropriately being cared for in acute hospitals – perhaps from ‘emergency’ or ‘crisis’ treatments especially where dementia is not diagnosed – costs on average around £6m for each hospital annually, as well as leading to poorer outcomes for people with dementia, and
- Good quality care homes for people with dementia have the same costs as poor quality homes.

5.3 Model of Care

The work which has been undertaken in Herefordshire has included developing a Model of Care for dementia services. This has incorporated the recommendations from all key guidance and national best practice. Clinicians have been involved in the development of this model.

The model needs to demonstrate value for money and costs for an individual need to be comparable with costs that would have been incurred in an institutional setting. There are three key elements that are incorporated within the Model of Care:
Shift resource towards a focus on prevention and early intervention thereby reducing the length of stay in acute settings and placements. The provision of an Early Assessment & Care Service is central to delivery of this model of care.

- Reduce admissions to, and length of stay in, acute inpatient beds
- Reduce the number of placements provided by Continuing Health Care

An outline of this model of care and the care pathway for the Early Assessment & Care Service appears at Appendix J

5.4 Commissioning Intentions

These Commissioning Intentions are designed to enable a move away from a purely medical model of care for those with dementia to a holistic social / clinical model of care that provides early intervention to support people in their own homes thereby reducing the need for crisis responses and emergency admissions.

5.4.1 Pre-diagnosis services

Public awareness about dementia, its symptoms, the importance of getting a diagnosis and the help available is very limited. The result is that people with dementia are diagnosed late and often receive inadequate and inefficient support and care. Poor understanding of dementia and its consequences is currently leading to under diagnosis, late diagnosis and an inadequate care response.

This all creates an inefficient use of resources. For example, people who go in for similar procedures can stay twice as long in hospital if they also have dementia. Serious medical conditions are not being identified early and care packages in the community are put in place too late. Without significant focus on improving care across health and social care, outcomes will get worse and resources will be squandered.

People over 65 have been found to be much more worried about developing dementia than they are about cancer, heart disease or stroke, and yet they currently wait up to three years before reporting their symptoms to their doctor. At the same time 70% of their carers report being unaware of the symptoms of dementia before diagnosis while 58% of carers believe that the symptoms are just part of ageing. Of equal concern, 31% of GPs believe that they haven’t had sufficient training to diagnose and manage dementia.

There is clear evidence that early diagnosis and intervention improve outcomes for service users and unpaid carers. Without diagnosis, no interventions or services can be offered.

Early diagnosis is helpful so that the person with dementia and any carers can be better equipped to deal with the disease and to know what to expect. A diagnosis is the first step towards planning for the future. There is no simple test to make a diagnosis. The diagnosis of dementia is made by
taking a careful account of the person’s problems from a close relative or friend, together with an examination of the person’s physical and mental state, supported by investigations such as neuropsychological testing, blood tests and brain scans as appropriate. The ageing of the population will lead to a rapid increase in number of dementia cases and an increasing burden for the working-age population. However, even modest prevention efforts could lessen the impact.

Commissioning Intentions

1. A local public information programme will be developed to raise awareness of dementia, drawing on, and aligned with the national campaign, and will include awareness of the risks of developing dementia at a younger age

2. Significantly raise awareness of dementia amongst primary and secondary care services

3. Joint work will be undertaken with Children’s Services to ensure that they are aware of the National Dementia Strategy, and are provided with suitable information for inclusion in Personal Social Health & Economic Education (PSHE) and Citizenship Education

4. To design and deliver services that will delay the onset of dementia by 5 years or more by optimizing the prevention and early intervention opportunities for people at a higher risk of developing a dementia syndrome. This will include, for example, those with cerebrovascular risk factors, hazardous alcohol consumption, Subjective Cognitive Impairment (SCI) and Mild Cognitive Impairment (MCI).

5.4.2 Earlier diagnosis and intervention

One of the priorities of the National Dementia Strategy is to ensure that there is ‘good-quality early diagnosis and intervention for all’. At present only about one-third of people with dementia receive a formal diagnosis at any time in their illness. Even in the minority of cases where a diagnosis is made, it is often too late for the person with the illness to make choices, and often takes place at a time of crisis which might have been avoided if proper assessment and support had taken place earlier. This can be particularly notable for younger adults who develop dementia, who may be more likely to get a late diagnosis of the condition.

In order to transform the model of care and adjust the balance towards early detection and support, using specialist and high dependency care only in absolute necessity once individuals have reached this stage, the development of the Early Assessment and Care Treatment Service (EACTS) is required. This is a direction supported by patients, carers and professionals. The new EACTS service is intended to sit alongside and complement the work currently undertaken by old age psychiatry, geriatrics, neurology and primary care and are considered likely to benefit from the core involvement of third sector organisations. It will be a central place for all referrals with the ability to respond quickly (within 48 hours following receipt of referral) and ensure that requests for help are screened and acted on according to priority and level of need.
Early diagnosis and intervention has been shown to improve the quality of life of service users and carers, reducing levels of anxiety and depression, and allowing them to plan for the future, at the same time as accessing help, support and treatments. Such services have also been shown to be cost effective, significantly reducing the level of care home and acute hospital admissions.

Commissioning Intentions

1. An Early Assessment, Care and Treatment Services (EACTS) for all people with dementia (irrespective of age) and their carers will be commissioned for Herefordshire

2. Shift resources towards prevention and early intervention as a central objective of a revised model of care by:
   - Reducing the number of inpatient admissions to acute beds
   - Reducing the inpatient acute bed length of stay
   - Reducing the number of beds/placements provided through Continuing Health Care (CHC)
   - Looking at the opportunities for reinvestment and realignment of existing services to release funds for reinvestment in (EACTS)

3. Increased use of personal budgets, services should aim to promote and maintain independent functioning for both carers and appropriate clients/patients

4. Supporting voluntary and community sector organisations to continue to deliver and develop high quality locally focused support and early intervention services to reduce social isolation.

5.4.3 A higher quality of care

Most people want to remain living in their own homes for as long as possible. This message is consistently given by the public, by older people generally and by people with dementia specifically, be they young or old.

Most family carers want to be able to provide support to help the person with dementia stay at home, but they sometimes need more assistance than is currently routinely available. Residential care may be the most appropriate and effective way of meeting someone’s needs and providing a service of choice. But it should always be a choice.

All too often people with dementia (particularly older people) find themselves on a conveyor belt that takes them into long-term residential care because it appears that there are no alternatives available. This is especially the case if the person is admitted to hospital after a crisis. This is partly because a lack of knowledge and understanding about dementia leads some professionals to the
erroneous assumption that residential care is the only option. It is also due to home care staff and family carers not receiving training and advice in dementia, and so not having the skills and competences to provide appropriate care.

There is often a lack of co–ordination between hospitals and care providers at the point of discharge, with delay in access to care packages such as home care and intermediate care that might enable successful discharge. There is a clear need therefore to improve the quality of care provided for people with dementia in general hospitals. The proposed improvements in core and continuing professional training set out in the next chapter should improve quality of care.

Pathways out of hospital and to avoid hospitalisation, such as intermediate care, often exclude people with dementia, meaning that they cannot access rehabilitation services that could enable them to return home or prevent their admission to hospital. Specialist intermediate dementia or mental health care services that enable discharge from the general hospital setting are rare. Staff working in intermediate care may be reluctant to offer people with dementia the opportunity to benefit from the service because they feel they are likely to need longer than the usual six weeks, and are therefore perceived to not meet the criteria. There is often the false assumption that people with dementia cannot benefit from rehabilitation. Local criteria for services have therefore often specifically excluded people with dementia. Pressures to reduce lengths of stay in acute care, combined with risk–averse discharge planning, can mean that people with dementia are rushed into long–term residential care prematurely. Improving quality across home care, hospital care, intermediate care and in care homes will require significant focus and new investment. However, the NAO found that there are also ways to make money available by providing better care and over time this will release significant investment.

The shift in moving care closer to home results in the need to have a more flexible workforce able to work across care pathways. Re–skilling and retaining the workforce to include skilling secondary care staff to work more autonomously in primary care, enabling primary care to acquire more specialist skills. Improving the ability of the health and social care workforce to respond to dementia will improve quality of life by supporting independence and well–being and reducing over–reliance on services. The best arrangements it suggests are where health and social care system work together to develop their workforce. The development of the local social care workforce will need to take account of ‘Working to Put People First: The Strategy for the Adult Social Care Workforce in England’ (2009).

Commissioning Intentions

<table>
<thead>
<tr>
<th>1. Map and review access arrangements to existing intermediate care services ensuring sufficient capacity and skill mix to support improved provision</th>
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<tbody>
<tr>
<td>2. Review and develop effective local arrangements for dementia training and education</td>
</tr>
<tr>
<td>3. Review and develop a range of day opportunities for those with dementia – A review of all day services is underway as part of the Adult Social Care Transformation –personalisation</td>
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of services work stream. This includes a mapping exercise of all day services.

4. Map and develop a specialist housing model to support people with dementia and their carers

5. Increase specialist domiciliary care to support people with dementia

6. Develop an options appraisal and business case for the use of Telecare to support people with dementia

7. Work with providers and CQC to ensure that all local services are providing services that are good/excellent and special support is given to those only achieving poor or inadequate rating and develop a set of ‘Herefordshire Standards for Care’ in residential and nursing homes.

8. Work with providers to ensure specialist dementia services are improved to provide high quality care to those patients with dementia and complex needs, psycho behavioural problems and high risks which are beyond what could reasonably be provided by generic services

9. Reduce the use of antipsychotic medication

10. Promote the development of a skilled workforce specialising in the needs of people with dementia and their carers.

11. Increasing the competence of staff in primary care community services, community hospitals and acute hospitals will be essential to ensure the needs of people with dementia are ‘everybody’s business’.

Details of the Implementation Plan can be found at Appendix K.

6. Conclusion

All people with dementia, and those that care for them, have the right to the best possible healthcare and support. We know that early diagnosis, along with effective intervention and support from diagnosis through the course of the illness, can enable people to live well with dementia. We also know that improving health and social care outcomes in dementia in the short and medium term can have significant benefits for society, both now and in the future. Transforming the quality of dementia care in Herefordshire is a huge challenge for all parts of the health and social care systems. People with dementia, their carers, the public and professionals will all expect to see steady progress.
Dementia is one of the most severe and devastating illness facing the current and future generations. It is also very common with approximately 570,000 people with dementia in the UK. On this basis there is a considerable impact to be gained for a high number of services users and carers by improving the services for the management of dementia. The impact of specific areas of improvement for service users and carers include;

- A greater public understanding of dementia and depression can reduce the stigma associated with these conditions
- Better information about local services and how to access
- Better informed users and carers through early diagnosis, enables improved management of a condition from the outset
- Continuity of support through single point of access to advice and support
- Improved management of dementia if physical health requires hospital admission
- Greater access to rehabilitation services improving chances of return to a home environment
- Improved therapeutic management within care homes
- Services more flexible and responsive to individual’s needs

Particularly:

- Identification of a Lead Clinician to address the needs of older people within general hospital settings, requiring mental health support
- Specialist older people’s mental health liaison
- Improved care home management of mental health
- Utilising the opportunity to raise awareness of depression
- Utilising the opportunity to increase professional and support worker knowledge and understanding

The National Dementia Strategy provides a clear and concise direction of travel that will ensure the improvements to managing dementia happen quickly. This document demonstrates the direction and actions required within Herefordshire to ensure delivery of the national strategy. This has been set within the context of local prevalence and demography and within the overarching vision statement for Herefordshire.
7. References


5 ‘Forget me not’. Audit Commission. 2002


7 'Everybody's Business.' Care Services Improvement Partnership. 2005

8 'Dementia: supporting people with dementia and their carers' National Institute for health and Clinical Excellence and Social Care Institute for Excellence (2006)

9 'Dementia UK,' Alzheimer's Society. February 2007

10 'Improving services and support for people with dementia'. National Audit Office: July 2007

11 'Putting People First: Making a Strategic Shift towards prevention and early intervention’ DH Oct 2008


19 Caring for people with Dementia: It’s Really Time To Do Something Now! West Midlands Dementia Clinical Pathway Group April 2008

20 Alzheimer’s Society, ‘Dementia UK’, 2007

21 Alzheimer’s Society, ‘Home from home’, 2007

22 Commission for Social Care Inspection, ‘See me, not just the dementia’, 2008

23 All Party Parliamentary Group on ‘Dementia, Always a last resort’, 2008


