Health Needs Assessment for
Dementia in Bromley

Final v 1.0 May 2012
(First draft sent to stakeholders Sept 2011)

Dr Rob Aldridge
Public Health Directorate
London Borough of Bromley
Foreword

In response to national dementia strategy, Bromley’s older people’s mental health partnership group developed an integrated care pathway for people with dementia in the borough. The pathway adapts the national strategy to Bromley’s needs and considers the course of people with dementia and their carers from the initial diagnosis up until the end of life.

To enable the vision of the national strategy to be achieved, and to ensure success of the local integrated care pathway, all sectors should recognise complex nature of dementia. People with dementia, by the nature of their condition, will have difficulty accessing services. To ensure these obstacles are overcome it is important that local services indentify and remove any barriers to high quality care provision.

This report assesses the health needs of people with dementia in Bromley, the degree to which these needs are being met, and makes recommendations on how deficiencies identified may be addressed. The needs assessment has been driven by requests from health, social care and housing services for a comprehensive review of care and services for people with dementia in Bromley. It would not have been possible to generate this report without the active involvement of all the stakeholders who contributed by attending the workshop and by drafting and reviewing early versions of the report. We would like to thank and acknowledge all of these individuals - a full list of contributing stakeholders is available in the accompanying appendix.
Table of contents
Foreword.................................................................................................................................2
Table of contents....................................................................................................................3
Executive summary..................................................................................................................4
Background ............................................................................................................................6
Aims and objectives of this work...........................................................................................10
The policy context...................................................................................................................11
Demographics of people in Dementia..................................................................................17
How many people have dementia? ......................................................................................24
Special dementia populations ..............................................................................................38
Stakeholder dementia workshop .........................................................................................42
Health services for people with dementia in Bromley .........................................................59
Costs and cost effectiveness...................................................................................................90
Conclusions and recommendations.....................................................................................95
References..........................................................................................................................100
Appendix 1. .........................................................................................................................102
Executive summary

- Dementia is progressive and largely irreversible syndrome that is characterised by a widespread impairment of mental function.
- This report assesses the needs of people with dementia in Bromley, the degree to which those needs are being met, and makes recommendations on how deficiencies may be addressed.
- Bromley has a greater proportion of its population in the over 65 age category compared to the rest of London, but is similar to the English average.
- A variety of training exists for staff working with people with dementia.
- A comprehensive integrated care pathway exists for people with dementia in Bromley (see figure below).
- The memory service in Bromley is generally held in high regard by users and other sectors.
- Advance statements and advance decisions to refuse treatment are not widely used or promoted amongst patients with dementia.
- Carers of people with dementia are able to access an assessment of emotional, psychological and social needs, however, it is not always promoted by services and in many cases must be requested by the carer.
- An important minority of people have young onset dementia. This group, along with those with learning difficulties (who are at greater risk of developing dementia at an earlier age), require services tailored to their specific needs.
- There is good evidence regarding the costs and benefits of implementing the national guidelines for dementia.

Integrated Care Pathway for Dementia in Bromley.
Recommendations for areas of improvement

- Training should be focused to a greater extent on person centred care.
- Mechanisms for continual improvement should be put in place for care homes and respite staff.
- Expansion of the memory service, to the levels set out in the national dementia strategy, should be strongly considered as this will improve the levels of early diagnosis and in the longer term should be either cost neutral or saving.
- Many separate organisations disseminate excellent information about dementia. However, stakeholders felt there was a need for these to be better coordinated which would reduce overlap and any inconsistencies that currently exist between the multiple providers.
- Processes should be put in place to ensure all individuals are offered a social needs assessment, rather than having to request one or be specifically referred for a review.
- People with dementia, while they have capacity, should have the opportunity to discuss the use of advance statements, advance decisions to refuse treatment. Local protocols should be put in place to formalise these arrangements and discussions.
- The development of psycho-educational and peer support programmes for carers should be supported.
- Additional work should be carried out to determine the requirement for a liaison service over and above the current informal provision, which may not be sustainable in the longer term, as such a service is important for the quality of inpatient care for people with dementia.
- Greater flexibility of respite care provision should be promoted as this was felt important for stakeholders.
Background

What is dementia and why is this work important?

Dementia is a progressive and largely irreversible syndrome that is characterised by a widespread impairment of mental function.

The Alzheimer’s society describes dementia as follows:

“The term 'dementia' is used to describe the symptoms that occur when the brain is affected by specific diseases and conditions. Symptoms of dementia include loss of memory, confusion and problems with speech and understanding.”

A more medical definition of dementia is provided by the World Health Organisation(1):

“a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Consciousness is not clouded. The impairments of cognitive function are commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation. This syndrome occurs in Alzheimer's disease, in cerebrovascular disease, and in other conditions primarily or secondarily affecting the brain.”

Dementia is an important condition because it common, complex and challenging to manage. It is estimated that around 700,000 people have dementia in the UK. The exact number of people with dementia is uncertain due to the complex nature of the disease and its diagnosis. Patients diagnosed with dementia have multiple needs and some of these individuals have high levels of dependency and morbidity which means that they require complex medical and social care. This care can be
challenging for both the patient and the carer and the needs of those affected often require multiple skills and capacity of carers and available services.

What is a health needs assessment?

A health needs assessment (HNA) is “a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.”(2)

Why undertake a health needs assessment?

Health needs assessments are a key public health tool, which we use for the following reasons:(2)

- HNAs provide evidence about a population on which to plan services and address health inequalities
- HNAs provide an opportunity to engage with specific populations and enable them to contribute to targeted service planning and resource allocation
- HNAs provide an opportunity for cross-sectoral partnership working and developing creative and effective interventions

How this health needs assessment was undertaken

The general methodology used for this piece of work was as set out by Raftery and the NICE guidelines for performing a health needs assessment.(2,3) The work was led by Dr Rob Aldridge who in early 2011 met with key stakeholders working in dementia, including the statutory, voluntary, health service sectors and the older people’s mental health partnership group. During these meetings the scope of the project was discussed and clarified.

A literature review was carried out to determine the key policy documents driving current dementia strategy and care in the UK. To establish the burden of dementia in
Bromley, data was extracted from the following sources and presented in a section on the epidemiology of dementia:

- Projecting Adult Needs & Service Information
- Projecting Older People Population Information
- ONS Population Estimates/Projections
- ePACT (NHS Prescription Services' Prescribing Database)

On 11 April 2011 a stakeholder workshop was held with patients, carers, statutory, voluntary and health service sectors from a wide range of services in Bromley. A full list of attendees and the stakeholders engaged with for the scoping of this work is presented in Appendix 1.

A series of introductory sessions on dementia in Bromley were presented, after which stakeholders were split into groups to discuss three broad themes, structured around the NICE quality standards for people with Dementia. These standards provide specific, concise quality statements with definitions of high-quality care for dementia. The themes discussed were (facilitator in brackets):

1. Diagnosis and assessment of dementia (Sarah Dowling)
2. Principles of care (Nada Lemic)
3. Support and interventions for carers (Rebecca Jarvis)

In each group, stakeholders were consulted on the following three questions for each NICE quality standard:

1. Where we are now?
2. Where we want to go?
3. Recommendations as to the best way to get there.

Notes were taken at each of the workshops and a summary of the discussions and the outputs of each groups are presented later in this report.

Finally the needs assessment presented in this report was drafted with the support of several stakeholders (see acknowledgements section for details). The report was...
then sent out to all attendees of the stakeholder event between September 2011 and December 2011 and as a result this final version contains some data which is up to 12 months old at the time of producing this final version. Recommendations have been reviewed and prioritised by the Older Persons’ Mental Health Partnership group.
**Aims and objectives of this work**

**Aim**
To assess current and future health needs of adults with dementia in order to inform future commissioning.

**Objectives**

- To describe the national and local context for this work
- To provide epidemiological information on the prevalence of dementia in adults
- To examine the size and severity of health issues and inequalities within the area to provide an assessment of needs
- To examine current service utilisation and identify unmet needs
- To consult with key stakeholders including carers to obtain a wide range of views on local needs
- To make recommendations for further action to improve care and outcomes for individuals with dementia
The policy context

Key Points:
- The National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) systematically reviewed the evidence in 2006 and created: ‘Dementia: Supporting people with dementia and their carers in health and social care’ guidelines
- The Department of Health created a national dementia strategy in 2009, building upon the NICE guidelines
- The national strategy was reviewed in an interim report was produced by the National Audit Office in 2010
- Healthcare for London produced a dementia services guide in 2010 containing a London wide Health Needs Assessment for dementia
- The Older Persons Mental Health Partnership Group in Bromley have produced an integrated care pathway building upon the NICE guidelines and National Dementia Strategy

National guidelines and policy

Several recent documents have been produced that have been key in defining the delivery of care for people with dementia, including:

- National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) clinical guideline 42 ‘Dementia: Supporting people with dementia and their carers in health and social care’ (4)
- National Audit Office, ‘Improving services and support for people with dementia’ (5)
- Department of Health, ‘Living well with dementia: a national dementia strategy’ (6)
• Department of Health, ‘The use of antipsychotic medication for people with dementia: Time for action’(7)
• National Audit Office, ‘Improving dementia services in England: an Interim report’(8)
• National Institute for Health and Clinical Excellence (NICE). ‘Dementia quality standard’(9)

In 2006 NICE produced detailed guidance on supporting people with dementia and their carers in health and social care. In producing this report, NICE carried out a systematic review of the literature to determine the best available evidence in relation to dementia. As a result key priorities for implementation were specified as:

1. **Non-discrimination.** People with dementia should not be excluded from any services because of their diagnosis, age (whether designated too young or too old) or coexisting learning disabilities.

2. **Valid consent.** Health and social care professionals should always seek valid consent from people with dementia.

3. **Carers.** Health and social care managers should ensure that the rights of carers to receive an assessment of needs, as set out in the Carers and Disabled Children Act 2000 and the Carers (Equal Opportunities) Act 2004, are upheld.

4. **Coordination and integration of health and social care.**
   a. Health and social care managers should coordinate and integrate working across all agencies involved in the treatment and care of people with dementia and their carers, including jointly agreeing written policies and procedures.
   b. Care managers and care coordinators should ensure the coordinated delivery of health and social care services for people with dementia.

5. **Memory services.** Memory assessment services should be the single point of referral for all people with a possible diagnosis of dementia.

6. **Structural imaging for diagnosis.** Structural imaging should be used in the assessment of people with suspected dementia to exclude other cerebral pathologies and to help establish the subtype diagnosis.
7. **Behaviour that challenges.** People with dementia who develop non-cognitive symptoms that cause them significant distress or who develop behaviour that challenges should be offered an assessment at an early opportunity to establish the likely factors that may generate, aggravate or improve such behaviour.

8. **Training.** Health and social care managers should ensure that all staff working with older people in the health, social care and voluntary sectors have access to dementia-care training (skill development) that is consistent with their roles and responsibilities.

9. **Mental health needs in acute hospitals.** Acute and general hospital trusts should plan and provide services that address the specific personal and social care needs and the mental and physical health of people with dementia who use acute hospital facilities for any reason.

Following this in 2007, a report by the Department of Health identified 17 key objectives to be implemented largely at a local level. The aim was to create significant improvements in the quality of services provided to people with dementia, promoting a greater understanding of the causes and consequences of the condition. The objectives the report outlined to be implemented were:

1. Improving public and professional awareness and understanding of dementia.

2. Good-quality early diagnosis and intervention for all.

3. Good-quality information for those with diagnosed dementia and their carers.

4. Enabling easy access to care, support and advice following diagnosis.

5. Development of structured peer support and learning networks.

6. Improved community personal support services.

7. Implementing the Carers’ Strategy.

8. Improved quality of care for people with dementia in general hospitals.

9. Improved intermediate care for people with dementia.
10. Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers.

11. Living well with dementia in care homes.

12. Improved end of life care for people with dementia.

13. An informed and effective workforce for people with dementia.


15. Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers.

16. A clear picture of research evidence and needs.

17. Effective national and regional support for implementation of the Strategy.

In 2010 NICE looked at a series of 18 quality standards which form the basis of the description of health services in this needs assessment and are therefore described in detail in this section of the report.

The National Audit Office’s report ‘Improving Dementia Services in England – an Interim Report’ in 2010 identified three risk areas it felt required urgent attention if the dementia strategy was to be achieved. These risk areas were:

- **The strategy.** Although the Strategy focuses on outcomes and was developed with strong consultation and consensus, the information on current and future costs and benefits, and sources of savings, remains inadequate and there is a risk that decisions made locally on prioritisation and service design will not be sufficiently well-evidenced or informed.

- **Leadership.** National and regional leadership is strong and should be strengthened further with the appointment of a national clinical lead, but at the local commissioning and provider level much more needs to be done to identify and support leaders who have the skills to ignite passion, pace and drive. Workforce capacity and capability was a serious concern in 2007 and
continues to be a weakness in the implementation planning. Unless significant progress is made on leading this at the national level, the implementation of the Strategy is likely to be compromised.

- Delivery. The lack of strong levers for improving dementia care means there is a risk that NHS and social care delivery organisations will not give it the priority status expected by the Committee and the general public, and service improvements will lag well behind the desired pace.

**Local policy and context**

In response to the national policies and guidelines highlighted above, Healthcare for London created a dementia services guide, which presented the results of a needs assessment that was performed across the capital. The needs assessment highlighted the following key issues for London in relation to dementia:

- Local models of care need to be based on national guidelines and on evidence of efficiency and cost effectiveness, however, specific service requirements will vary across the capital
- Population size and composition varies widely
- All PCTs will see an increase in the ethnic diversity of their older populations, and many face challenges associated with detecting dementia and providing support for more vulnerable groups
- There appear to be very substantial differences and inequalities in current service provision
- Implementation of the *National Dementia Strategy* offers the opportunity to develop more consistent care pathways while taking local differences into account

In 2010 Bromley's Older People’s Mental Health partnership group produced an integrated care pathway. This pathway takes the guidelines from the national dementia strategy and implements them at the local level(Figure 1). The pathway considers the management of patients with dementia from identification and
diagnosis, through to treatment and end of life care. It involves primary and secondary care, as well as the voluntary and statutory sectors in the management of dementia patients. The pathway is discussed in further detail in the health services section of this report.

![Integrated Care Pathway for Dementia in Bromley](image)

**Figure 1. Integrated Care Pathway for Dementia in Bromley.**
Demographics of people in Dementia

Key Points

- Bromley has a greater proportion of its population in the over 65 age category compared to the rest of London but is similar to the average in England
- In 2010 it was estimated that there were just under 4,000 people with dementia in Bromley
- There is a relatively small but significant population of black and minority ethnic groups with dementia and also individuals with young onset dementia in Bromley
- Alzheimer’s, Vascular, and mixed dementias account for the vast majority of cases of dementia in Bromley
- It is estimated that there are just under 500 people with severe dementia in Bromley
- Prescriptions for dementia in Bromley are similar to national rates
- Hospital admission rates associated with dementia in Bromley are comparable to the rest of London

This section of the report outlines some of the key demographic features of Bromley’s population age and ethnic structure. These features drive population level characteristics and determine the overall number of cases, as dementia is a condition that is strongly associated with the age of a population. Key characteristics of people with dementia in Bromley are discussed in detail, including the prevalence and total numbers of people with the condition, broken down by the main types to establish a total burden of disease. Finally, factors that relate to the provision of medication and health care services for people with dementia are considered, including: a comparison of the number of prescriptions for dementia medication in Bromley with other areas; the number of patients recorded on GP practice registers;
levels of access to social care; and levels of hospital admissions for people with dementia.

Population structure

Compared to the rest of London, Bromley has a larger proportion of its residents aged 65 and over (Figure 2), 15.9% in Bromley vs. 11.5% for London in 2007. However, the number of people in this group is around the national average when compared to England where the proportion of the population that is 65 and over was 16.0% for 2007. Dementia is a condition that increases in prevalence with age, therefore the number of people aged 65 and over will be the main driver of the total number of people with dementia in a local population.

Figure 2. Population estimates based on 2008 projections, comparing Bromley and London 2011.

Source: ONS Population Estimates/Projections. Figures rounded to nearest 100. Graphic by ONS Data Visualisation Centre.
Ethnicity

Population projections by the Greater London Authority suggest that there are just under 40,000 individuals in the BME groups in Bromley in 2011. As shown in Figure 3, many of these individuals are of working age population, however, the number of individuals in the over 65 groups is set to increase rapidly as this population ages.

Ethnic minority groups are a relatively young population in London, and as such there are fewer people in these groups aged over 65. The Greater London Authority (GLA) estimated that there were a total of 107,151 Londoners aged 65 years and over in the black and minority ethnic (BME) groups in 2007. This is expected to increase to approximately 251,232 people by 2021. In Bromley in 2010 it was estimated that the total BME population size in the over 65s was 1986 people (Figure 4), which is predicted to rise to 3087 by 2021(10).

Therefore these demographic changes in the population of BME groups should be accounted for in the future provision of appropriate services. Whilst the BMS population may appear to be small in terms of total numbers, they are a group of individuals that is actually set to grow in size rapidly over the coming years. Culturally sensitive services for these groups are particularly important if inequalities in provision are to be avoided as generally such groups have greater difficulty in accessing Mental Health Services.(11)
Residential status

Because of the large numbers of people in the over 65 category it is not surprising that Bromley has a large number of people living in care homes. However, in comparison to the other South East London boroughs fewer people live in Local
authority care homes compared to privately operated homes (Figure 5). It is estimated that the total number of beds (capacity in borough) is 1657, of which 543 are elderly mentally infirm beds. LBB fund 489 of these placements.

The number of females living alone is highest in terms of total numbers in Bromley. The number of men in this group is very similar to other boroughs (Figure 6). More than twice as many females as males aged 65 and over Bromley live alone. The numbers of both males and females over the age of 65 years living alone is greater in Bromley than for the other South East London boroughs.

![Figure 5. People aged 65 and over living in a care home with or without nursing by local authority / non-local authority.](image-url)
Figure 6. People aged 65 and over living alone by gender.

Data sources: General household survey (accessed from www.popi.org.uk)
Carers  
The total number of people providing unpaid care to a partner, family member or other person was estimated at 6022 in 2010 and is set to rise to 8310 by 2030 (Figure 7). It should be noted that this relates to all care, not just dementia related. The majority of these individuals are in the younger age groups of 65-84, but there are still a surprising number of individuals in the greater than 85 year category, estimated at 355 in 2010.

The increasing needs of this care group should be recognised, and in particular the potentially more vulnerable groups in the highest age categories that are more likely to have conditions themselves requiring input from various health care services.

Data sources: ONS [accessed from www.poppit.org.uk]

Figure 7. People in Bromley aged 65 and over providing unpaid care to a partner, family member or other person, by age, projected to 2030.
How many people have dementia?

Prevalence of dementia by age and gender

Dementia becomes more common the older a person gets, therefore the total number of people with dementia is directly related to how many older people there are in a certain population (Figure 8). The prevalence of dementia in Bromley has remained fairly static over the last four years in the over 16s based on data from the quality and outcomes framework (Figure 9).

As a result of its relatively older population structure in comparison to the rest of London, it is estimated that Bromley has greater numbers of people with dementia when compared to other local authorities in South East London (Figure 10).

In total it is estimated that there were just under 4,000 people in Bromley with dementia in 2010 (Table 1). Although the prevalence of dementia is lower in women, there are actually more women than men with dementia in Bromley because life expectancy is higher. By 2030 the number of people with dementia in Bromley is set to increase to 6153.

The provision of services appropriate to age and gender should be considered in relation to dementia, particularly given the greater proportion of females with a diagnosis.
Figure 8. Estimated prevalence of dementia in Bromley by age group.

Figure 9. Dementia Prevalence in Bromley (Quality and outcomes framework data 2006 to 2011)
Figure 10. Estimated total number of people with dementia by Local Authority in 2010.
<table>
<thead>
<tr>
<th>Age group</th>
<th>Prevalence (%)</th>
<th>Total number of people with Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>65-69</td>
<td>1.5</td>
<td>1</td>
</tr>
<tr>
<td>70-74</td>
<td>3.1</td>
<td>2.4</td>
</tr>
<tr>
<td>75-79</td>
<td>5.1</td>
<td>6.5</td>
</tr>
<tr>
<td>80-85</td>
<td>10.2</td>
<td>13.3</td>
</tr>
<tr>
<td>85-89</td>
<td>16.7</td>
<td>22.2</td>
</tr>
<tr>
<td>90+</td>
<td>27.9</td>
<td>30.7</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1. Estimated prevalence and total number of people with dementia by gender and age group in 2010.

Source: Dementia UK and ONS\(^1\) from www.poppi.org.uk version 5.1 on 16/02/11

Figure 11. People in Bromley aged 65 and over predicted to have dementia, by age, projected to 2030.\(^2\)

\(^1\)The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia in 2010.

\(^2\)Individuals with dementia aged < 65 years (young onset dementia) included in a separate section.
Risk factors for dementia

The strongest risk factor for dementia is age, and as shown in Table 1, the prevalence of dementia increases with age. Dementia onset below the age of 65 is rare, although this group of patients have particular characteristics and are given additional consideration in this report because of their differing needs. Several genes have been identified to have links with Alzheimer’s disease, and although these genes increase the risk of the disease, studies of identical twins have shown that it is not uncommon for one twin to suffer with dementia but the other not to. Therefore this suggests that factors in the environment are also extremely important in the development of disease(12).

Other common risk factors for dementia include:

- Smoking
- Vascular disease and vascular risk factors (such as high blood pressure and high cholesterol)
- Head injuries
- Depression (however, depression is an early presenting symptom of Alzheimer’s and therefore may not be causal of the disease)

Although certain risk factors have been identified for dementia there is currently limited evidence on the prevention of disease and therefore NICE guidelines currently state(9):

“1.3.1.1 General population screening for dementia should not be undertaken.

1.3.1.2 In middle-aged and older people, vascular and other modifiable risk factors for dementia (for example, smoking, excessive alcohol consumption, obesity, diabetes, hypertension and raised cholesterol) should be reviewed and, if appropriate, treated.”
Types of dementia

Using data from national surveys(12) it is possible to estimate the number of people with the more common types of dementia in Bromley (Table 2). Alzheimer's disease accounts for the greatest proportion of cases in the borough, followed by vascular and then mixed dementias. These three conditions together account for 89% of cases of dementia.

<table>
<thead>
<tr>
<th>Type of dementia</th>
<th>Proportion of people with dementia</th>
<th>Number in Bromley</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer's disease (AD)</td>
<td>62%</td>
<td>2461</td>
</tr>
<tr>
<td>Vascular dementia (VD)</td>
<td>17%</td>
<td>675</td>
</tr>
<tr>
<td>Mixed (AD and VD)</td>
<td>10%</td>
<td>397</td>
</tr>
<tr>
<td>Dementia with Lewy bodies</td>
<td>4%</td>
<td>159</td>
</tr>
<tr>
<td>Frontotemporal dementia</td>
<td>2%</td>
<td>79</td>
</tr>
<tr>
<td>Parkinsons' dementia</td>
<td>2%</td>
<td>79</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
<td>119</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>3969</td>
</tr>
</tbody>
</table>

Table 2. Number of people with common types of dementia in Bromley.

Dementia is typically categorised as mild, moderate or severe. National data suggest that around 55% of the dementia population will have mild disease, 32% moderate and 13% severe. Severity increases with age as the disease progresses(12). The national data also estimates that around 63.5% of individuals with late onset dementia live in their own home, with 36.5% in a care home.

The dementia needs assessment recently performed by Healthcare for London estimated the number of people in Bromley with mild, moderate and severe disease (Table 3). Those with the most severe forms of the condition will have much higher medical, social and mental health needs in comparison to those with mild or
moderate disease who by comparison may be able to function relatively independently.

<table>
<thead>
<tr>
<th>Severity of dementia</th>
<th>Number aged 65 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>2008</td>
</tr>
<tr>
<td>Moderate</td>
<td>1190</td>
</tr>
<tr>
<td>Severe</td>
<td>482</td>
</tr>
<tr>
<td><strong>Total</strong> &lt;sup&gt;3&lt;/sup&gt;</td>
<td><strong>3680</strong></td>
</tr>
</tbody>
</table>

Table 3. Estimated number of people with late onset dementia by level of severity in Bromley.

**Progression of dementia**

The progression of dementia will vary with each individual, however, the different forms of dementia have the general patterns of progression as described below(13):

- Alzheimer’s disease, Fronto-temporal dementia and Dementia with Lewy bodies all tend to be progressive as the structure and chemistry of the brain becomes increasingly damaged over time.
- Because vascular dementia is commonly caused by a stroke, or a series of mini strokes, the progression tends to be steady with sudden declines.

**Mortality**

Estimating the contribution of dementia to an individual’s death is very difficult to estimate and there is much variability around the length of time that someone will live once diagnosed with dementia. One study in the UK estimated that the median survival after a diagnosis of Alzheimer’s disease was 7.1 years (95% confidence intervals, 6.7–7.5 years) and for vascular dementia 3.9 years (3.5– 4.2 years). Table 4 presents data on the estimated number of deaths annually that can be attributed to dementia and the proportion of all deaths attributable to dementia (PARF). The total

<sup>3</sup>Note this total differs slightly to results in the rest of the report due to the differing nature of the data sources.
number of deaths peaks in the 80-89 year old categories for both men and women. However, the proportion of deaths due to dementia increases with age group for women, but for men peaks in the 85-89 year old category.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Males</th>
<th>Females</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group</td>
<td>Total deaths (for the year 2009)</td>
<td>HAAR (proportion of deaths annually attributable to dementia)</td>
<td>Number of deaths annually attributable to dementia</td>
</tr>
<tr>
<td>65-69</td>
<td>23,903</td>
<td>0.02</td>
<td>487</td>
</tr>
<tr>
<td>70-74</td>
<td>33,360</td>
<td>0.03</td>
<td>896</td>
</tr>
<tr>
<td>75-79</td>
<td>43,826</td>
<td>0.07</td>
<td>2,031</td>
</tr>
<tr>
<td>80-84</td>
<td>49,648</td>
<td>0.12</td>
<td>6,719</td>
</tr>
<tr>
<td>85-89</td>
<td>34,322</td>
<td>0.18</td>
<td>6,335</td>
</tr>
<tr>
<td>90-94</td>
<td>19,404</td>
<td>0.14</td>
<td>2,735</td>
</tr>
<tr>
<td>95+</td>
<td>5,500</td>
<td>0.15</td>
<td>825</td>
</tr>
<tr>
<td>Total</td>
<td>210,155</td>
<td>0.10</td>
<td>219,761</td>
</tr>
</tbody>
</table>

Table 4. Total deaths (England, Scotland and Wales) for 2005, and the proportion and number of deaths theoretically attributable to dementia

Source: Alzheimer’s Society. Dementia UK: Full Dementia UK report 2007

Residential status

The prevalence of dementia is estimated as 79.9% in residents of Elderly Mentally Infirm (EMI) registered homes, 66.9% in nursing homes, and 52.2% in residential homes. Therefore the burden of disease in these locations is particularly high and staff working in these settings must be appropriately trained in dementia care as it is likely to be a significant part of their workload.

The Commission for Social Care Inspection data estimated that there are 1.3 places in homes registered to take older people with dementia per 100 people aged 65 and over in Bromley, putting it in the seventh decile (lowest) of local authorities in England.(12) This compares to East Riding of Yorkshire which has the highest at 5.0 places per 100 people aged 65 and over and the lowest in Coventry which has 0.1 places. Further work should be undertaken to review the accuracy of these figures and establish whether this level of provision is felt appropriate for Bromley after adjustments are made for age and sex differences in the borough.
Ethnicity

Using prevalence rates from Dementia UK applied to population data from 2001 census and 2021 GLA projections, Healthcare for London estimated that the number of people from BME groups with dementia in 2001 was 84, and is predicted to rise to 227 in 2021. This reflects both the size of the BME population in Bromley and its young age relative to the rest of the population in London. As discussed in the previous section, services in the future will need to specially take this growth into account.

Primary care

The Quality and Outcomes Framework (QOF) records for Bromley in 2010 show that a total of 1385 patients have been recorded on local GP registers as having dementia. Therefore 34.9% the 3969 estimated people with dementia in the Borough have a recorded diagnosis with their GP, which compares to 37% across London(14).

It is not expected that everyone with dementia will appear on the GP register, because as shown in the previous section, 55% of cases will be in the early stages of the disease with ‘mild’ symptoms and therefore may not have sought medical attention. Additionally, there are many other reasons why individuals might not be recorded as part of QOF, relating to service and infrastructure around the diagnosis and management of dementia, as well as patient preference or access to care.

Patients on a GP register are eligible to be reviewed by the practice at least every 15 months. In Bromley 76.5% of patients received this review in 2010. Across London, in 2007/8 83% of people had a review by their GP. Some patients may be excluded from QOF data for reasons such as the particular circumstances of the patient such as terminal illness or frailty.

Whilst the number of patients on primary care registers is comparable to that of the rest of London, efforts should be made to increase the number of people registered with a dementia diagnosis as this will improve care for these people. Similarly more
people with dementia should receive a review as this will also improve the quality of care those diagnosed with the condition.

Prescriptions

There are four main drugs used for the cognitive and memory symptoms of people with dementia. These medications are often prescribed alongside a package of care and other non-medication related treatments such as psychological therapies. Reviewing the number of prescriptions for dementia in Bromley provides useful insight into whether the levels are as expected when compared to other areas, indicating whether or not people are getting an appropriate access to treatment.

NICE recommends that the three acetylcholinesterase (AChE) inhibitors (donepezil, galantamine and rivastigmine) can be used for managing mild to moderate Alzheimer’s disease under the following conditions:

- Only specialists in the care of patients with dementia (that is, psychiatrists including those specialising in learning disability, neurologists, and physicians specialising in the care of older people) should initiate treatment. Carers’ views on the patient’s condition at baseline should be sought.
- Treatment should be continued only when it is considered to be having a worthwhile effect on cognitive, global, functional or behavioural symptoms.
- Patients who continue on treatment should be reviewed regularly using cognitive, global, functional and behavioural assessment. Treatment should be reviewed by an appropriate specialist team, unless there are locally agreed protocols for shared care. Carers’ views on the patient’s condition at follow-up should be sought.
- If prescribing an AChE inhibitor (donepezil, galantamine or rivastigmine), treatment should normally be started with the drug with the lowest acquisition cost (taking into account required daily dose and the price per dose once shared care has started). However, an alternative AChE inhibitor could be prescribed if it is considered appropriate when taking into account adverse event profile, expectations about adherence, medical comorbidity, possibility of drug interactions and dosing profiles.
Memantine is recommended as an option for managing Alzheimer’s disease for people with:

- moderate Alzheimer’s disease who are intolerant of or have a contraindication to AChE inhibitors or
- severe Alzheimer’s disease.

Donepezil and Rivastigmine are anticholinesterase inhibitors, which work by increasing the concentration of acetylcholine at sites of neurotransmission which is lower in patients with dementia. Galantamine is also an anticholinesterase inhibitor, but also modulates activity at nicotinic receptors, also important in cognition. Memantine works by blocking the effects of elevated levels of glutamate that may lead to dysfunction of neurons (cells in the brain).

We reviewed the prescription data available locally to compare Bromley to national and local levels using weighted average daily quantity (ADQ), a measure of how much of a drug is being prescribed. It provides an estimate for the total quantity of a drug that has been prescribed after differences in age and sex across geographical populations have been taken into account. This therefore allows basic comparisons of prescription levels across these areas to be made, but does not take into account complexities in prescribing such as differing amounts of tablets prescribed to individual patients. However, this should not be a major issue with dementia prescriptions.

Historical prescribing data is provided in this section of the needs assessment for Bromley PCT, comparing it to the National and Strategic Health Authority (South East London) averages.

Donepezil prescriptions in Bromley are slightly higher than both the National and Strategic Health Authority amounts and show a trend of increasing levels (Figure 12). Rivastigmine, Galantamine and Memantine are all slightly lower than the National and Strategic Health Authority, although all show a trend of increasing (Figures 13 -15). Donepezil is the drug used in the highest quantities nationally and locally, with much lower levels for both Rivastigmine and Galantamine. As the newer of the four drugs, it is not surprising that Memantine has the lowest levels of
prescriptions nationally and locally. Memantine was not approved for use in the NICE technology appraisal published in 2006 for the treatment of moderate to severe Alzheimer’s and this would explain the low uptake of the drug.

Prescription levels for dementia medications in Bromley are broadly in line with the strategic health authority and national areas. This provides an additional indication that the number of diagnoses in Bromley is in line with other geographical areas, and also that those individuals are likely to be receiving an appropriate medication. However, although this analysis is reassuring, it provides a relatively crude review and should be interpreted with some caution.

![Figure 12. PCT, National and Strategic Health Authority weighted average daily quantity per 1,000 patients per prescribing period for Donepezil.](image)
Figure 13. PCT, National and Strategic Health Authority weighted average daily quantity per 1,000 patients per prescribing period for Rivastigmine.

Figure 14. PCT, National and Strategic Health Authority weighted average daily quantity per 1,000 patients per prescribing period for Galantamine.
Social care

According to figures from Healthcare for London for 2006/7, 240 people in Bromley newly diagnosed with dementia aged 65+ had completed social care assessments. It was also estimated that the number of people aged 65+ receiving social care for mental health problems, compared to estimated prevalence of late onset dementia, was 1540. This figure represents 42% of all people with dementia in Bromley, compared with an estimated 22% across London. This would suggest that Bromley is performing more strongly than the rest of London, however, many assumptions have been made in calculating these numbers and the results should therefore be interpreted with caution.

Hospitals

Using data from Hospital Episode Statistics, the number of people admitted to hospital in Bromley as inpatients with a primary diagnosis of dementia in 2007/8

---

4This rate was calculated using data derived from DH return A1.1d and national prevalence data
5Primary diagnosis refers to the fact that dementia is the main cause for the hospital admission
was 174, which provides an admission rate per 1,000 of people with dementia of 46.4(14). This compares to an average of 36 per 1,000 people with dementia across London. However, these figures should be treated with caution as it is likely to be an underestimate of the total burden of admissions as it is actually not very common for a person with dementia to be admitted solely this condition and therefore they don’t appear within these statistics. In addition to this, differences in the way that local hospitals code admissions can cause a great deal of variation in the collection of this data.

It is therefore more helpful to look at the total number of people admitted to hospital as inpatients with any diagnosis of dementia compared to estimated prevalence, for the same period which was 1000 giving a rate of 266.4 per 1000 of the population with dementia per year. This figure is very similar to the London rate of 264.9 per 1000 of the population with dementia per year and reassuringly shows that people with dementia in Bromley are not presenting to hospitals with medical complications that require admission at higher rates than the rest of London.

**Special dementia populations**

**Young onset dementia**

- An important minority of people in Bromley have young onset dementia, estimated at around 74 individuals, but likely to be higher due to under diagnosis
- Many individuals are diagnosed at specialist centralised services due to the complex presentation and nature of the condition which may inhibit their access and knowledge of local services for this group of patients
- Specific consideration of this patient group has been given in Bromley’s integrated care pathway

Young onset dementia is defined as dementia diagnosed before the age of 65 years. Across the UK it is estimated that there are more than 16,000 individuals with the
condition. As with other forms of dementia, there are different sub-types including vascular, fronto-temporal lobar degeneration, dementia with Lewy bodies, alcohol-related dementia and other rarer forms of dementia. In Bromley it is estimated there are approximately 74 people with early onset dementia, however, this is likely to be an underestimate as awareness of the condition is poor amongst medical staff and as a result it is likely to be under diagnosed.

In addition to issues highlighted in the previous sections, there are a number of additional considerations that should be taken into account in relation to those with young onset dementia, including:

- **Diagnosis.** A diagnosis of dementia in this group can take longer due to a lack of awareness of the possibility of dementia in this age group. The condition is frequently misdiagnosed as depression, or other mental health or neurological conditions. Often individuals with young onset dementia are diagnosed centrally at the tertiary referral centre at the National Hospital for Neurology and Neurosurgery as they investigated for other conditions before a diagnosis of dementia is made.

- **Age as a barrier to care.** Because dementia is generally perceived as affecting older people, those with young onset disease can have difficulty in accessing services and facilities.

- **Specialist services.** It is important that individuals with young onset dementia have access to specialist services. In Bromley, the integrated care pathway does not exclude individuals, and explicitly states that this shouldn’t be the case. However, many people with young onset dementia receive specialist services at the National Hospital for Neurology and Neurosurgery and therefore access services outside of the area, which may complicate the issue of care and management of this condition locally.

- **Support.** As the condition is rare, it can be difficult for individuals with the condition to find others who understand and appreciate their particular set of circumstances. People with young onset dementia tend to be more likely to be still at work or have dependent children compared to older dementia patients. The carers of individuals with young onset dementia also tend to be younger and as a result age appropriate support is important. Because of these
differences the needs of this population and their carers needs to be taken into account.
Learning difficulties

The Community Team for Learning Disabilities has a disability memory service specifically designed to meet the needs of this group. A draft pathway for this service is outlined below in Figure 16. This pathway describes the situations in which a patient with Learning difficulties would access these services.

---

**Figure 16. Protocol for the assessment of dementia in people with learning disabilities**
Stakeholder dementia workshop

On 11 April 2011 a stakeholder workshop was held with patients, carers, statutory, voluntary and health service sectors from a wide range of services in Bromley. A full list of attendees and those invited is presented in Appendix 1.

The event consulted on the current services and needs of people with dementia in Bromley and their carers. A brief series of introductory lectures were given on the following topics:

1. Overview of dementia in Bromley: Rob Aldridge (Bromley Public Health Dept)
2. Commissioning of dementia services in Bromley – present and future: Rebecca Jarvis & Angela Clayton-Turner (London Borough of Bromley)
3. Voluntary sector perspective: Jill Jilani (Bromley Mind)
4. Carer perspective: Lynne Powrie (Carers Bromley)
5. Health care perspective: Melanie Place (Oxleas)

After these introductory lectures, stakeholders were split into groups to discuss three broad themes, structured around the NICE quality standards for people with Dementia. These standards provide specific, concise quality statements with definitions of high-quality care for dementia. The themes discussed were (facilitator in brackets):

4. Diagnosis and assessment of dementia (Sarah Dowling)
5. Principles of care (Nada Lemic)
6. Support and interventions for carers (Rebecca Jarvis)

In each group, stakeholders were consulted on the following three questions for each NICE quality standard:

4. Where we are now?
5. Where we want to go?
6. Recommendations as to the best way to get there.

Notes were taken at each of the workshops and the following sections outline the discussions that were held in each of these groups and therefore represent the
opinions of stakeholders who attended the meeting and not necessarily the authors of this report. Unfortunately it is not possible to ascribe individual comments or quotes to individual stakeholders as these details were not collected as part of the event record keeping.

**Workshop 1: Diagnosis and assessment of dementia**

Summary of main points from discussion in workshop 1:

1. Awareness needs to be increased about the fact that it’s everyone’s responsibility to do something about assessment and referral for dementia, not just traditional medical services.
2. Dementia patients and carers need information about dementia but in addition to this it must be followed up and repeated if it is to be remembered and understood.
3. A summary health condition details card would be useful for all involved as it would provide a synopsis of a patient’s individual situation.
4. A dementia navigator, affiliated to a GP, advisor practice would be useful and would facilitate those with a diagnosis in navigating services and information.
5. Ongoing care coordinator e.g. nurse who can visit and reassess is required.

**1. Memory assessment services (QS2)**

“People with suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia.”

**Where are we now?**

- The way people do or don’t get in to these services is not clear
- There is variability of younger people with dementia’s ability to access memory services
- Anecdotally from carers, it is felt that numerous visits to a GP are required before a referral is made
• Reluctance to be assessed can on occasions be due to an unwillingness on behalf of the patient or carer, not just access to services (Recommendation 4)
• Patients can be referred for carer support even if not diagnosed with dementia
• Communication can be poor between services for people with dementia, including respite care
• There is a general uncertainty about what happens in terms of follow up for those seen in acute care and suspected of having dementia
• In memory clinics the focus can be on patient and not on what carer is telling the memory clinic
• The traditional pathways of diagnosis and assessment are less clear today and may come in discharge letter 2-3 weeks later

Where do we want to go?
• All individuals with suspected dementia need to have other causes ruled out as dementia can be confused with previous mental health issues

How do we get there?
• There is a need to evaluate carer experience of memory services
• Need to support acknowledge those referred to memory services regardless of whether they are ultimately diagnosed with dementia or not, which might include writing to GPs on carers behalf
• There needs to be greater clarity of who can refer/pick up/highlight individuals with dementia to GP services
• Stakeholders highlighted other models of memory service clinic provision in South East London (such as Alzheimers Society in Croydon and MindCare in Lewisham) and urged that lessons could be learnt on how these provide cost effective services.
2. Written and verbal information (QS3)

“People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area.”

Where are we now?

- People with dementia:
  - do not remember all verbal information alone
  - Can’t always do anything with written information – may need support to read/understand/remember
- Initial information received may be overwhelming (Recommendation 8)
- Lots of well written information is already provided
- Follow up of dementia patients depends on the diagnosis e.g. those with Alzheimer’s and on medications are followed up but those with vascular dementia are not.
- Information on the support for carers is less good, and support is not always available at the appropriate time – there needs to be more choice and variety
- GPs find it difficult to know who’s involved in the care of a single individual with dementia
- Lots of carers are frail elderly people themselves and need support which they may not ask for
- There are multiple organisations providing care, information and services for people with dementia but they do not always link well (Recommendation 7)
- There is not great awareness amongst community services such as podiatry, physiotherapy, police, neighbourhood teams about how to provide information and referrals for people with or suspected to have dementia
- People feel overwhelmed initially with the information provided as they are still coming to terms with the implications of diagnosis
- Memory café talks provide useful information about the various aspects of care after diagnosis
- Insufficient evening groups for carers – some work and have other commitments during normal working hours
- Emotional support is very important
- People are currently visited at home if they can’t attend secondary care which is very helpful
- Dementia advisor available but not well known, they can act as a navigator
- Community pharmacies are paid for signposting

Where do we want to go?

- Information needs to be provided in both verbal and written formats in clear in plain English or other appropriate language
- Information provided needs sensitive follow up and support
- A patient held record would be useful
- There needs to be a dementia advisor
- Sensitive reinforcement of information is required
- Someone should be with the patient and carer at appointment to take notes
- Frail older carers need advocates such as age concern
- Need a key worker in the community as GPs can’t cope
- The social prescribing model could work well for dementia
- Support services such as liaison required – not just acute but also in GP surgeries

3. Assessment and personalised care plan (QS4)

“People with dementia have an assessment and an ongoing personalised care plan, agreed across health and social care that identifies a named care coordinator and addresses their individual needs”

Where are we now?

- Local authority care managers currently do assessments for referral but mainly concentrate on the eligibility criteria to MIND and other commissioned
providers, but this information is inadequate and therefore MIND do an additional assessment which includes:
  o Health care needs
  o Risk assessment
  o Social background
• MIND also do a carers assessment if requested which they share with the local authority
• Local authority tends to ask closed questions in their assessments
• If not done carers cope and struggle at home alone
• Carers assessments may be sent out by post but then they are not properly completed and therefore unhelpful as sometimes the forms are not understood by those filling them in
• Self assessment under represents need
• The voluntary sector produce personalised care plans for people with dementia
• Carers need confidential space for their assessment; the patient is often there as well which will inhibit/influence responses
• Website portals and one stop shops are not useful for a large proportion of patients and carers
• Care managers close cases when they are referred to a different care manager
• Social service assessment not really adequate for MIND needs therefore MIND do their own
  o This assessment is kept on record and can be added to and reassessed when required or if it needs to be changed
  o Carers assessment goes to the local authority
• People are not getting the assessments they need due to
  o Closed questions
  o If they have a good coping strategy then they will not be picked up
• Assessments and how they fit into a personalised care is performed in the private sector and at Oxleas, however, it was felt like these weren’t shared appropriately when required.
• Need an information sharing protocol to get the best outcomes for the individual
• Named care coordinator: there is one in Oxleas but this does not cover all patients and a substantial proportion of patients will not be in service
• Resources for people with dementia exist, but they are not as coordinated as they could be
• It is perceived that availability of recommended services is due to luck

Where do we want to go?
• Home visits important – they tell you what is going on with a patient outside of the healthcare setting where the ‘real situation’ and it’s complexities can be hidden
• Interface issues: there needs to be clearer pathways between services
• Named care coordinator required for all individuals: at present there is someone in the mental health service but this is not available to everyone (Recommendation 10)
• Help filling out forms: self assessment not appropriate as people commonly exaggerate their abilities
• Mental health services carry out different assessments to other services, there should be a greater level of consistency
• A single assessment process would be better
• An individual with dementia should be able to flexibly use services regardless of complexity of their dementia

Workshop 2: Principles of care in dementia

1. Appropriately trained staff (QS1)
“People with dementia receive care from staff appropriately trained in dementia care.”

Where are we now?
• Levels of training is ‘patchy’ but has improved
• Basic training is available, but better and broader training required
Where do we want to go?

- Training programmes and individual support for staff required in:
  - Domiciliary care and care homes
  - Day centres
  - Staff on acute wards (although some training available)
  - A local authority service should be provided for all
- Better coordination of training is required
- Liaison team from mental health trust should be involved in the design and delivery of training due to their expertise
- Sustainable, rolling programme of training required
- Needs to be a focus on person centred care training

How do we get there?

- Domiciliary care, care homes etc need more follow up than at present
- Person centred care should have greater emphasis (Recommendation 1)
- Ongoing training especially for staff in the acute trusts needs to be multidisciplinary
- Focus on the area which can have the most impact
- Barbara, the dementia care lead should be used to a greater extent
- Better communication between agencies about training is required
- Staff in care homes need to have personal knowledge of patients to give confidence to family and carers – more staff required

2. Decision making (QS5)

“People with dementia, while they have capacity, have the opportunity to discuss and make decisions, together with their carer/s, about the use of:

- Advance statements
- Advance decisions to refuse treatment
• **Lasting Power of Attorney**
• **Preferred Priorities of Care”**

**Where are we now?**

- Very difficult to help people make decisions
- Two to three years ago the position was not good
- Documents long and complicated and therefore not often used (Recommendation 11)
- This is perceived as a very complex area, people often do not want to do it

**Where do we want to go?**

- Need to have information to ‘signpost’ patient and carers to the right source of help and guidance at the right time (limited serviced from dementia advisors)
- Memory service is appropriate place for this to be picked up

**How do we get there?**

- Need to audit practice as people go through diagnosis and follow up process
- Information sessions should be provided via key support services/helplines/carers groups e.g. MIND, AS, carers Bromley
- Publicity of these services required
- Specialist training and advice for staff
- Solicitors should be asked to come to voluntary groups for free to advise on things
- Strategic marketing required
- Good timing with an individual approach required
- Better co-ordination of information provision required
3. Non-cognitive symptoms and behaviour that challenges (QS7)

“People with dementia who develop non-cognitive symptoms that cause them significant distress, or who develop behaviour that challenges, are offered an assessment at an early opportunity to establish generating and aggravating factors. Interventions to improve such behaviour or distress should be recorded in their care plan.”

Where are we now?

- There is some professional education and awareness of the triggers although this is mainly within specialist services
- At present this is probably not routinely put in care plans but a care home project is in progress
- Often considered as part of the disease and alternative causes not always investigated
- This is not often done and if it is then only really by the memory service nurse for a minority of individuals (Recommendation 14)
- It is recorded in the care plans once an individual enters the mental health service

Where do we want to go?

- Incorporate into ‘normal’ activities and reduce boredom and frustration of people with dementia
- Ways of reducing stress i.e. ‘distressed not difficult’
- Look for triggers
- Coordinated care plans
- Sensory rooms for severe difficulties are very helpful
- Pathway stages: individual treatment and management throughout the various stages
How do we get there?

- Co-ordinated care plans – person centred and adapts to the changes in a person’s condition

4. Liaison services (QS8)
“People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older people’s mental health.”

Where are we now?

- There used to be a specialist liaison psychiatrist, there are now only two sessions per week provided at the goodwill of the consultant

Where do we want to go?

- A service similar to Greenwich which is multidisciplinary and has an evidence base (Recommendation 16)
- More resources are required including an MDT team
- Good evaluation of any new service is required

How do we get there?

- Commissioners need to see the bigger picture and look at the evidence i.e. ‘enlightened commissioning’
Workshop 3: Support and interventions for carers

1. Emotional, psychological and social needs of carers (QS6)
“Carers of people with dementia are offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs.”

Where are we now?
- Several voluntary organisations provide good levels of services for carers
- Constant care is sometimes needed, but difficult to access
- Carers group at memory services doesn’t cover everyone
- Care assessment needs to focus on the social needs of the carer more
- There is a conflict of interest if the same person is doing the care assessment for the patient and carer
- Need for regular input in patients once diagnosed. For example, the memory clinic provides no long term follow up for individuals diagnosed with dementia other than Alzheimer’s (Recommendation 12)
- There is a social services line available. This service can direct patients and carers to appropriate services and facilities such as MIND, age concern and works well for those that use it
- There is a need to emphasize or make people with dementia more aware that there is the basic right to an assessment, which is free of charge.
- There is a wide variation in the quality of assessments
- Several stakeholders felt they were being penalised for having money and were unhappy about being means tested. They felt that they weren’t ‘poor’ enough to get services for free but also weren’t rich enough to be able to afford help or for example self fund respite.

Where do we want to go?
- Clarify and promote the routes to assessment
- Psychological input needed in assessment
- Joining up health and social care assessments required
• Information required on the next steps after an assessment i.e. who to contact
• Referrals from health to social services should be automated in some way and it shouldn’t have to be the carer having to facilitate this
• A more continuous review of patients is required e.g. every 6 months, not just at the initial assessment
• More communication required on how to access assessment and services
• Support networks required for emotional support
• More support required for ex-carers
• Forms shouldn’t be online only as this isn’t accessible to many individuals
• Clearer information required for who to go to if when problems arise
• Reduction in form filling for patient with dementia required

How do we get there?
• A separate individual should do the carer’s assessment which would enable the carer to be more honest with someone who had not had contact with the person they were looking after
• Creation of a prompt list for future needs allowing for early planning and research would enable better planning of carers needs
• Unclear as to what services are available in this area for carers e.g. counselling services in GP and whether this was suitable or enough for the needs of the carers.

2. Respite services for carers (QS10)
“Carers of people with dementia have access to a comprehensive range of respite/short-break services that meet the needs of both the carer and the person with dementia.”

Where are we now?
• There are some specialist day services for dementia, some with an open door policy
• If patients are difficult to look after at these services, they are referred back to social services
• Mind Care has a sit in service which is currently free but a charge that is about to be introduced
• Carers Bromley and Mind Care offer over a service for overnight stays of up to two weeks
• There is a respite/residential unit which provides longer stay respite
  o There are spare beds specifically for dementia but carers found they are difficult to access and locate, for example it is not possible to book in advance (Recommendation 19)
  o Currently there is no specific provision for people with advanced dementia.
• Currently many people are being told that there is no space in a residential home for respite due to beds being full with long term residents
• There is extra care housing whereby people own their flat. This service is similar to sheltered housing but provides a greater level of care.

Where do we want to go?
• There needs to be a service for emergency access
• More respite beds are required such as beds in residential homes with places specifically allocated for dementia respite only, as this would allow a ‘rolling respite’ service (Recommendation 18)
• More bookable beds required (Recommendation 18)
• More support for self funders is required when trying to find respite beds (Recommendation 18)
• Better information, advice, guidance and signposting is required (Recommendation 18)
• Day centres need to provide a 7 day service (Recommendation 18)
• More flexibility is required, including: (Recommendation 18)
  o 2 sessions of day care – one suggestion was provided that day could be split into a morning and afternoon sessions in order that a half or whole day could be booked. This would allow better coverage of the hours in the day so that if carer’s had to go to work or do tasks this would comfortably cover their working day hours or enough time for them to actually complete the task.
How do we get there?

- Consider subsidising the voids where they exist such as empty beds. These beds should be made available for respite rather than being left empty
- There will be a growing need as number of people with dementia increases

Additional notes from across the workshops

Communication issues:

- Care homes and respite care – carers may recognise problems with patient but not feel able to do anything about it
- Greater number of undiagnosed dementia than realised in Bromley
- GPs may struggle if patient doesn’t want to be referred to memory clinic
- Carer can still be referred even if patients dementia has not be diagnosed
- SLHT surgical ward 3 – unofficial dementia ward works well. Good feedback personal knowledge of staff to relative, well staffed.
- Lack of understanding and or poor communication some other wards

People not diagnosed via GP but in acute care:

- Diagnosis usually on discharge summary and concerns about this being formally given to other services
- Liaison service sees only very complex cases

Young onset

- May end up in neurology clinics
- Fewer physical problems
- Should have clearer pathway for this group

Sarah Dowling closing comments

- Greater clarity could be made on the pathways of care for dementia

6 Note: what these issues consisted of was not elaborated on
• Inclusion of vulnerable groups needs to be emphasised
• There needs to be a greater linkage between services for people with dementia, providing better ‘joined up’ care and information
# Health services for people with dementia in Bromley

## Key Points

- A good variety of training exists for staff working for people with dementia in Bromley, although person centred care should be promoted more widely.
- Individual organisations have flexible mechanisms to ensure their staff are trained appropriately according to their roles and responsibilities.
- The memory service in Bromley is generally held in high regard by users and other sectors and sees around 1,300 individuals with dementia annually.
- The memory service is currently not staffed at the levels as set out in the national dementia strategy and increasing its capacity and services should improve the number of people being diagnosed in the earlier stages of disease.
- A good variety of information in a number of different formats is provided to people with dementia and their carers.
- A range of interventions are offered to individuals who develop non-cognitive symptoms as set out in the integrated care pathway.
- At present there are opportunities to discuss and make decisions regarding Lasting Power of Attorney and Preferred Priorities of Care in both secondary and voluntary care sectors.
- People with dementia and their carers should have the opportunity to discuss the use of advance statements, advance decisions to refuse treatment and local protocols should be put in place to formalise these discussions.
- Carers of people with dementia are able to have an assessment of emotional, psychological and social needs, however, it is not always offered and in many cases must requested by the carer.
- A range of respite/short-break services are available for carers and the person with dementia in Bromley and are offered in a variety of forms including day centres, respite at home, over-night services and residential services.

The dementia care pathway in Bromley was created by Bromley’s Older People’s Mental Health partnership group (Figure 1). It builds upon the national dementia strategy and considers the management of patients at the following specific points:

1. Identification of dementia
2. Assessment and diagnosis

3. Early interventions and treatments

4. Living well with dementia

5. End of life

Figure 17. Integrated Care Pathway for Dementia in Bromley.

The pathway promotes the multidisciplinary and joint working that is required for the successful provision of high quality services for people with dementia, and outlines how primary and secondary care, alongside voluntary and statutory sectors need to work together in the provision of that care.

In reviewing health services for people with dementia in Bromley this report has been structured around the NICE quality standards for dementia. The 10 quality standards are reviewed in the follow chapter. The standards have been used to define what is
required to provide high quality care for people with dementia for Bromley and are designed to fall under five areas of care:

1. Principles of care
2. Diagnosis and assessment of dementia
3. Early stages of dementia
4. Middle and later stages of dementia
5. Support and interventions for carers

In each section the standard is defined to provide an explanation of what constitutes high quality care. This introduction to each standard is followed by a description of services currently provided in Bromley along with feedback from the listening event with stakeholders and relevant discussion for each standard. Finally, conclusions in relation to each standard are made.
**Principles of care**

**QS1. People with dementia receive care from staff appropriately trained in dementia care.**

Appropriate training is important to ensure that patients get the best care and advice possible. This quality standard states that service providers should ensure that all health and social care workers are appropriately trained in dementia care according to their roles and responsibilities.

In Bromley, people with dementia encounter a wide range of services and organisations. The London Borough of Bromley (LBB) has a training consortium which provides a number of specific modules appropriate for individuals working with people with dementia, including:

- Dementia Awareness
- Moving & Handling
- Fire Safety
- First Aid
- Administering Medication

Therefore a wide range of training takes place. In addition to this, LBB is currently commissioning training and support from MindCare for some residential providers and re-ablement services which have been delivered to about 160 individuals in the past year. This package of training includes an option for individual follow-up coaching and consultancy to embed good practice. Additional details of the training specific to organisations working with service users are detailed below.

Oxleas:

- A number of training opportunities are in place for staff, including:
  1. Support Worker training programme which includes training in dementia care
  2. Person centred care and dementia care mapping
3. Challenging behaviour

4. Interagency training with colleagues from LBB, SLHC, Bromley Healthcare, voluntary sector

- Dementia care training is not mandatory although staff are expected to participate in the above. All staff have a personal development plan where specific needs would be identified and supported.

All Oxleas staff are expected to attend mandatory training and contact will be appropriate for individuals working with people with dementia.

Age Concern:
- Staff working with clients with dementia will generally have had previous experience. However, staff at Age Concern attend training courses that are available in the Borough and from organisations such as Mind. Volunteers receive training from experienced staff members and Trustees. In addition to this, Age Concern have arranged for its Information & Advice volunteers to receive training on communicating with people with dementia, and basic dementia awareness training.

Alzheimer's Society
- Staff and volunteers all receive ongoing training provided both with the training department of the Alzheimer's Society and external training as required.

- All training is person centred and all staff within the organisation (whether face to face with clients or otherwise) are required to have knowledge of dementia.

- During an induction process to the organisation, all client facing staff are require to undertake a two day 'Dementia awareness and person-centred approach' course to give an overview of the issues faced by people with a diagnosis of dementia and the impact this can have on their lives. In addition
to this basic training requirement, advanced dementia training is also available dependent on the needs of the individual staff member / volunteer.

- Safeguarding courses are offered to all staff and other specific courses available include Infection control, incontinence training, and teaching about the Mental Capacity Act is completed via a workbook as part of a standard training requirement.
- All training is carried out by accredited trainers using established in-house courses designed by experts in the field of dementia.

**Bromley Mind:**

- Bromley Mind requires all staff (Domiciliary & Day care) to have NVQ Level 2 or 3 in Health & Social Care. Those who join without such a qualification are enrolled on a course at Orpington College as a matter of priority.
- Staff working in the registered service (Domiciliary care) are obliged to undertake, Moving & Handling training and Food hygiene. Bromley Mind aims to have all staff trained in these areas plus Safeguarding Vulnerable Adults.
- Bromley Mind is a member of LBB’s training Consortium who offer a wide range of courses as detailed above and sends staff on these courses as appropriate.
- Bromley Mind offers all staff training from the ‘In House’ Dementia Skills Coach (DSC) including ‘How the brain works’, ‘Signs & Symptoms of dementia’; ‘the Experience of Dementia’; ‘Coping with Challenging Behaviour’. The DSC also offers free group training sessions for carers or individual sessions within the home.
- Bromley Mind sends staff on appropriate external courses provided by Care UK e.g. Activities for people with dementia; Chair exercises for dementia clients.

**Carers Bromley**

- Carers Bromley does not require staff to be trained in any medical or health related conditions as that is not their remit (which is to support carers caring
for any health conditions). However, Carers Bromley does offer staff ad hoc training when they request it and, sometimes, they request speakers at staff meetings that they can gain info from about specific topics about a specific condition such as dementia.

Feedback from the listening exercise:

- Basic training is available and is patchy but has improved recently
- Broader training is required for domiciliary and care homes which need additional mechanisms to be put in place to ensure all care homes and respite services across Bromley meet the standards required for appropriately trained staff
- In the future better coordination of training is required with the liaison team from the mental health trust being involved in a sustainable, rolling programme of training
- Training should have a person centred care focus

Conclusions:

- A good variety of training exists for staff working with people with dementia in Bromley
- LBB should consider commissioning specialist dementia training and support courses for other organisations across the borough as part of the training consortium.
- Individual organisations have flexible mechanisms to ensure that staff are appropriately trained according to their roles and responsibilities
- Stakeholders felt that in the future training should focus more on person centred care
- Concerns were raised by stakeholders that broader dementia training was required for domiciliary care and care homes and that additional mechanisms are needed to ensure all care homes and respite services across Bromley meet the standards required for appropriately trained staff (Recommendation 961)
• It was felt that specialist input from the mental health trust would improve training provision in the future, whilst recognising the importance of a psychosocial, person-centred approach (Recommendation 2).

**QS8. People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older peoples’ mental health.**

This quality standard states that a liaison service specialising in dementia and older people’s mental health should be available in acute and general hospital settings to assess inpatients and emergency department attendances with suspected or confirmed dementia. This ensures that people with suspected or known dementia admitted to acute and general hospital settings can expect, if clinically appropriate, to receive an assessment by a liaison service specialising in dementia and older people’s mental health.

Currently in Bromley the Older Peoples Mental Health Directorate from Oxleas provide two inpatient liaison sessions per week although this arrangement is informal and is provided at the goodwill of the consultant as there is no formal commissioned liaison service for older people.

**Feedback from the listening exercise:**

• An expansion of the liaison service requires more resources than there are at present.
• Any expansion of the liaison service should follow an MDT approach to the management of patients.
• The introduction of any new service should be accompanied by evaluation of service requirements.
Conclusions

- At present there is no formally commissioned inpatient liaison service for people with dementia in acute and general hospital settings (Recommendation 15)
- An informal liaison service operates at Princess Royal University Hospital providing two sessions per week at the goodwill of the consultant
- Stakeholders felt that a service similar to the one currently provided in Greenwich should be examined as a potential model for liaison services in Bromley, but it should be accompanied by an appropriate evaluation of service requirements (Recommendation 16)

Diagnosis and assessment of dementia

**QS2. People with suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia.**

Memory services are a key part of national guidelines and local services. They aim to provide earlier and more accurate diagnosis, with referrals to specialist services at an earlier stage in the condition. Some of the key benefits of memory clinics include(14):

- Cost effective system for early diagnosis and intervention
- Reductions in costs of dementia related care by delaying time to nursing home admission
- Stigma reduction by breaking down the barriers to diagnosis and reducing refused referrals
- Improvements in the quality of life for individuals with dementia and their carers by promoting and maintaining their independence and reducing morbidity
- Improving performance and patient-centred clinical care through implementing the recommendations outlined in NICE-SCIE clinical guidelines CG42 on dementia
- Inequality reduction by increasing access to care
For the memory clinic to be effective, health and social care professionals working with those with a potential diagnosis of dementia should be aware of the process by which referrals can be made to the local memory assessment service.

The memory clinic caseload for Bromley was 1240 at the end of March 2012. From April 2010 - March 2011 there were 1292 referrals to the service for assessment and approximately 75% of all these referrals had a cognitive problems identified after investigations were carried out.

The Memory service in Bromley is run by Oxleas at an approximate cost of £300k per year. However, as the clinic is commissioned as part of Oxleas older adults service there is inevitably some flexibility and crossover of roles between it and other parts of the pathway. A detailed breakdown of staffing currently commissioned is presented below (Table 5.)
Table 5. Breakdown of staffing levels at the memory clinic.

* Each Consultant runs 3 memory clinics per week from Community Mental Health Team

** Admin time comes from existing staff in community mental health teams

*** Posts and drugs specifically funded to support memory service.

The memory services in Bromley are split into east and west sides of the borough, each of which provide three clinics a week, and in terms of staffing levels consist of:

West side:
- Monday afternoon clinic (Consultant, junior doctor and Nurse specialist)
- Thursday morning clinic (Nurse specialist)
- Friday morning clinic (Consultant, junior doctor and staff grade doctor)

East side:
- Monday morning clinic (specialist registrar)
- Tuesday all day (Consultant, Junior Doctor) Morning clinic only (nurse specialist) and specialist registrar attends an afternoon clinic once a month in the afternoon
- Thursday morning clinic (Consultant, junior doctor and nurse specialist)

In a recent health needs assessment, Healthcare for London outlined the indicative resources and costs required for a population of 50,000 over 65s of early diagnosis
and intervention in dementia (Table 6). Bromley had an estimated population of over 65 year olds of 51,500 in 2010, therefore the numbers are relatively generalizable to Bromley.

Table 6 details the number of doctors, nurses and other healthcare staff required in relation to memory services and support for existing community mental health teams (CMHTs) for older people. It also outlines the estimated yearly cost at the level of the PCT which is estimated at £600,000 for the memory services.

<table>
<thead>
<tr>
<th>Service</th>
<th>Indicative staff requirement</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory services (five day a week service with 600-800 referrals a year)</td>
<td>1.5 wte doctors</td>
<td>£600,000 pa for an average PCT</td>
</tr>
<tr>
<td></td>
<td>3.0 wte nurses</td>
<td>PCT</td>
</tr>
<tr>
<td></td>
<td>1.0 wte psychologist</td>
<td>£95 million pa nationally.</td>
</tr>
<tr>
<td></td>
<td>2.0 wte care managers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.0 wte occupational therapist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.5 wte administrators</td>
<td></td>
</tr>
</tbody>
</table>

Table 6. Indicative additional resources modelled for a PCT with a population of 50,000 people aged 65+.

More detailed guidance on the costing and service specification of a memory service is provided by the NICE guideline which contains the commissioning and benchmarking tool for memory clinics. Using the benchmark data for Bromley provided in the tool, it is possible to estimate the costs required to run a memory clinic service for this population (Table 7&Table 8). This service specification was developed using the evidence based NICE guidance and considers that the key components of a memory assessment service for the early identification and care of people with dementia are:

- early identification and referral of people with a possible diagnosis of dementia
developing a high-quality service for dementia assessment, diagnosis and management

The specification assumes that all patients are given one initial appointment which lasts two hours, followed by an appointment for the initial diagnosis. The service includes appropriate levels of primary, secondary clinical staff, clinical psychologists, and administrative staff.

<table>
<thead>
<tr>
<th>Patients per year</th>
<th>Current</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>First appointments per patient</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Length of first appointments (hours)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Initial diagnosis appointments per patient</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Length of initial diagnosis appointments (hours)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Average number of additional appointments per patient</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Length of additional appointments (hours)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total clinic time (hours)</td>
<td>2,870</td>
<td>2,870</td>
<td>2,870</td>
<td>2,870</td>
<td>2,870</td>
</tr>
<tr>
<td>Clinic length (hours)</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Number of clinics</td>
<td>718</td>
<td>718</td>
<td>718</td>
<td>718</td>
<td>718</td>
</tr>
</tbody>
</table>

Table 7. Recurrent provider costs for memory service based on NICE commissioning and benchmarking tool.
Table 8. Detailed breakdown of recurrent provider costs for memory service based on NICE commissioning and benchmarking tool.

<table>
<thead>
<tr>
<th>Recurrent cost element</th>
<th>Current year</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unit cost (£)</td>
<td>Units</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant, per clinic</td>
<td>434</td>
<td>718</td>
</tr>
<tr>
<td>GP with a special interest, per hour</td>
<td>108</td>
<td>0</td>
</tr>
<tr>
<td>Clinical psychologist, per hour</td>
<td>51</td>
<td>0</td>
</tr>
<tr>
<td>Nurse, per hour</td>
<td>21</td>
<td>2,870</td>
</tr>
<tr>
<td>Administration staff, per hour</td>
<td>12</td>
<td>2,870</td>
</tr>
<tr>
<td>Other staff, per hour</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>Magnetic resonance imaging (MRI)</td>
<td>165</td>
<td>574</td>
</tr>
<tr>
<td>Electroencephalography (EEG)</td>
<td>214</td>
<td>43</td>
</tr>
<tr>
<td>Computed tomography (CT)</td>
<td>128</td>
<td>0</td>
</tr>
<tr>
<td>Functional imaging - HMPAO SPECT</td>
<td>223</td>
<td>86</td>
</tr>
<tr>
<td>Functional imaging - FP-CIT SPECT</td>
<td>600</td>
<td>29</td>
</tr>
<tr>
<td>Medication, per patient</td>
<td>1000</td>
<td>287</td>
</tr>
<tr>
<td>Consumables, per clinic</td>
<td>20</td>
<td>718</td>
</tr>
<tr>
<td>Stationery, per clinic</td>
<td>20</td>
<td>718</td>
</tr>
<tr>
<td>Overheads, per clinic</td>
<td>80</td>
<td>718</td>
</tr>
<tr>
<td>Accommodation, per clinic</td>
<td>120</td>
<td>718</td>
</tr>
</tbody>
</table>

Feedback from the listening exercise:
- There may be a reluctance to assess or attend memory clinic services on the behalf of patients or carers
- It was felt that there is a lack of clarity about who can highlight potential problems or concerns around potential cases of dementia to GPs
- Benefits of diagnosis not entirely clear to patient or carers

Conclusions
1) The memory service in Bromley received generally positive feedback from stakeholders
2) The service reviewed just under 1,300 people with suspected dementia based on figures from 2011/10
3) The commissioned memory service receives £300,000 per annum, however, the indicative requirement for a population the size of Bromley is expected to be higher than this.

4) According to the indicative staff requirements for such a services it should include an additional (Recommendation 3):
   a) 0.5 WTE doctor
   b) 1 WTE nurse
   c) 2.0 WTE care managers
   d) 1 WTE occupational therapist
   e) 1 WTE administrators

5) Stakeholders felt there may be a reluctance to attend memory clinics by patients and carers as the benefits of diagnosis were not always clear (Recommendation 4)

6) Stakeholders felt that referral pathways into the memory clinic were not entirely clear and should be clarified for organisations other than primary care. Many organisations outside of primary care work with individuals at high risk of dementia, how these organisations can identify and refer potential cases of dementia should be clarified (Recommendation 5).

**QS3. People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area.**

This quality standard states that locations where the diagnosis of dementia are given should ensure that written information about dementia, treatment and local area support options is available to staff. This means that written and verbal information about dementia, treatment and local area support options, once a diagnosis of dementia is established, should be given to patients.

All individuals with suspected dementia are seen by Oxleas’ intake team first at home and are then referred to memory clinics if appropriate for formal diagnosis and ongoing review. This means that the majority of people with dementia will be diagnosed via the memory assessment clinics. The memory clinics provide people
with dementia information about the items highlighted above upon diagnosis and as the disease progresses.

Age Concern keeps written information and resources from many local and national organisations which cover topics such as dementia, power of attorney, welfare benefits, community care. The organisation also provides information appropriate to an individual’s circumstances and signposts and refers clients to services provided by other organisations.

Alzheimer Society’s clients are referred to the organisations in various different ways and therefore the provision of information reflects this diversity. Currently, a dementia advisor attends one of the memory clinics in Bromley and will therefore meet people who self refer at this point. All people going through the memory clinics are sent an Alzheimer’s Society leaflet informing them about the support provided by the organisation and various additional information leaflets are provided once the diagnosis has been made. Individuals can arrange to meet with Alzheimer’s Society face to face or access carers support services which offer support and information to these individuals. Alzheimer’s Society has a drop in centre that offers clients the opportunity to arrive and get information and support on their diagnosis or ongoing care.

Bromley Mind does not provide information routinely as it is given out by Memory Clinic staff at the point of diagnosis. Bromley Mind has a supply of booklets ‘Understanding Dementia’ produced by National Mind. These are handed out to families/carers at the discretion of the assessment officer.

Carers Bromley supplies information to carers which informs them of current training, signposts them to dementia services, informs them about their rights to a carers assessment and how to access breaks.

Feedback from the listening exercise:
- Information should be provided in a variety of formats including written and verbal as
different individuals have different requirements

- It was felt that there could be better coordination between the different agencies that provide information and services for dementia as overlap and inconsistencies exist
- Initial information received at diagnosis may be overwhelming and needs to be followed up with appropriate support
- Information on the support for carers is currently lacking and support is not always available at the appropriate time – there needs to be greater choice and variety
- A solution to the various sources of information was that of a patient held record containing information on the patient as well as the majority of future information that would be required and referred to by patients, carers and medical staff throughout the progression of the disease
- Anecdotally at the listening exercise there was not a high level of awareness of the dementia lead for the borough
- Services attended by individuals with potentially undiagnosed with dementia, such as community health services, podiatry, physiotherapy, the police and neighbourhood teams, should be made aware of the routes to assessment and support

### Conclusions

- At present information is provided to people with dementia upon diagnosis and then throughout the patient journey
- In addition to the information provided by health care services, a number of voluntary organisations also provide information about dementia
- The information is provided in a number of different and appropriate formats
- Stakeholders felt there was an overwhelming variety of information sources which could be more appropriately coordinated (Recommendation 7)
- Stakeholders felt there was a need for better follow up and support and information provision after the initial diagnosis to account for the fact that the needs of patients and carers changed over time, and this was not always provided for in the current system (Recommendation 8).
**QS4. People with dementia have an assessment and an ongoing personalised care plan, agreed across health and social care that identifies a named care coordinator and addresses their individual needs.**

Service providers for people with dementia should ensure that protocols are in place in order that personalised care plans identify named care coordinators and address the individual needs of people with dementia. Therefore people can expect to receive a care plan that identifies a named care coordinator and addresses their individual needs.

In Bromley, the local integrated care pathway identifies that some people may require a social care assessment for ongoing support services. As part of this assessment may receive a personal budget to pay for their care. Family carers may ask for an assessment directly in Bromley.

Not all people with dementia in Bromley will be assessed by social care managers, only those self referring, or individuals referred by other services. Unfortunately specific data are not kept on the number of individuals with dementia that are reviewed by social care. Individuals that have an assessment carried out by LBB do not currently have a named care coordinator.

LBB care managers complete an assessment for referral to additional services, but in addition to these referrals, voluntary sector organisations that work with dementia patients carry out reviews which include looking at: health care needs; risk assessment and social background.

Many initial referrals to LBB come from the memory services. Where an assessment has already been carried out by the health care team, and the case only requires low level assessment, then the medical assessment will be used as the basis for the social care assessment with the minimal amount of additional information being gathered/discussed in order to complete it.
Age Concern’s support planning & brokerage service, floating support service and day centre all work with clients in some depth, undertaking assessments, creating individual support plans and identifying a named worker.

Once referred to Alzheimer's Society’s day care, a visit to an individual (usually in their own home) with a carer is undertaken and a personalised assessment relating to their needs for day care is performed. This is used as a live document and added to throughout the person’s journey with Alzheimer's Society and updated as required. The assessment includes physical condition, social and emotional factors that can be used to plan their personalised care here. A named key worker is appointed at the time of admission to the service and this person remains the point of contact for the duration of care.

Bromley Mind carries out an independent, full assessment of all clients who are referred. This is a single assessment that covers any or all parts of the service and therefore avoids duplication. The assessment includes basic demographic data on the client; medical conditions; medication; social history; and risk assessment. Dementia centre clients complete an additional a ‘Life Story’ page. A key worker is allocated when a client starts attending a centre and an individual support plan is drawn up using information from the initial assessment. This is added to as the key worker gets to know a client observing their functioning and preferences.

Bromley Mind also has a system whereby every client is reviewed after 3 months of attendance, 6 monthly thereafter or sooner if there is a major change in circumstances. All carers and health care professionals are invited to the reviews and if they are unable to attend then their views canvassed by phone instead. All invitees are sent a copy of the review and the support plan is updated in accordance with the outcomes.

Feedback from the listening exercise:
- Home visits are an important part of the assessment as they can provide a great deal of information about the social circumstances and general
wellbeing of the patient.
- Currently, carers assessments may be sent out by post which can result in them not being completed properly as a carer may not understand the assessment correctly. It was also felt that self-assessment under-represents need
- There are currently interface issues between services that could be improved with a clearer referral pathway
- Every person with dementia should have a named care coordinator
- Website portals and one-stop shops were not useful for a large proportion of patients and carers with dementia
- It was felt that some people are not getting the assessments they need due to the use of closed questions and if an individual has a good coping strategy then they will not be picked up
- A single assessment process would be better i.e. one that performed all of the above across the statutory, health and voluntary sectors.

Conclusions
- The integrated care pathway in Bromley sets out the social and health care plans that should be carried out for people with dementia
- Not all individuals currently have a social needs assessment, unless specifically referred for one (Recommendation 9)
- Social care assessments are not performed by a named care coordinator (i.e. one coordinator who provides continuity of care) (Recommendation 10)
- Additional assessments to the ones performed by social care managers are carried out by the voluntary sector - these are performed as the social care assessments do not provide sufficient detail for the requirements of the voluntary sector
- Stakeholders felt that assessments carried out by post (i.e. form filling and not in person) were not appropriate, and that additional information could be obtained by through person to person assessments being carried out at the case's place of residence
- Stakeholders felt that the lack of a named care coordinator was a particular issue that should be addressed
- Stakeholders felt that a single integrated assessment process across the health, social and voluntary sectors would be more appropriate to the needs of people with dementia

**Early stages of dementia**

**QS5. People with dementia, while they have capacity, have the opportunity to discuss and make decisions, together with their carer/s, about the use of:**

advance statements, advance decisions to refuse treatment, Lasting Power of Attorney, Preferred Priorities of Care.

This quality standard states that people with dementia and their carers should expect the opportunity to discuss and make decisions on the use of advance statements, advance decisions to refuse treatment, Lasting Power of Attorney and preferred priorities of care. There should be evidence of local protocols on the discussion of advance decision making.

The dementia care pathway highlights the importance of discussing arrangements for Lasting Power of Attorney and making a will and suggests that this takes place in the early course of disease during the social care assessment.

Oxleas services provide the opportunity to discuss the use of lasting power of attorney and preferred priorities of care. However, it is acknowledged that at present there is less focus on advance statements and advance decisions to refuse treatments.

Age Concern provides this service through its Support Planning & Brokerage Service and the Floating Support Service. Clients are encouraged to discuss their future care and to make plans. Age Concern support clients through this process if and when required. However, the dementia café run by Age Concern is a drop-in service for clients and their carers, and therefore does not work with individual clients on these topics specifically. Age Concern has floating support service and support planning
&brokerage service which asks clients about whether they have a Will or Lasting Power of Attorney, and will provide support to put these in place if the client wishes them to. These questions are usually asked at the beginning of the intervention with a client. At Age Concern’s Dementia Café, a series of talks and information sessions, including sessions on future planning are run.

Alzheimer’s Society's dementia advisor would be involved with the client and their carer regarding Power of Attorney / LPA / Appointeeship and information is offered so that the client and carer can chose whether this is something they need to consider.

Bromley Mind does not involve itself with any legal decision-making processes in relation to its clients. However, client choice & preferences are a priority in offering person-centred care. Bromley Mind are currently undertaking an exercise seeking clients’ preferences generally re: colours, music, food and drink, people/personalities.

Bromley Mind’s senior day care staff attend introductory training on the Mental Capacity Act and therefore understand how to undertake a basic capacity test with its clients. Bromley Mind would refer concerns to the appropriate local SSD where Care Managers are fully trained & responsible for having detailed discussions with clients and carers about advance decisions, LPA.

At Carers Bromley, during one to one meetings with carers, Carers Support Workers will discuss these choices with them and signpost on, if required.

**Feedback from the listening exercise:**

- This is a highly complex area for patients and carers to understand and a lot of help is required in navigating the process
- Information to ‘signpost’ patient and carers to the right source of help and guidance at the right time is required
- It was felt that the memory clinic was the appropriate home for provision of such
services as people more likely to be in the earlier stages of disease when seen at the clinic
- It was proposed that solicitors could be asked to attend voluntary groups to provide free advice to patients and carers on such matters
- Opportunities for discussions about taking part in research and donation of organs for research purposes should be carried out where possible

Conclusions
- At present there are opportunities to discuss and make decisions regarding Lasting Power of Attorney and Preferred Priorities of Care in both secondary and voluntary care sectors
- There is less focus on the use of advance statements, advance decisions to refuse treatment and no local protocols exist to formalise these discussions
- Stakeholders felt this was a highly complex area for people with dementia and their carers, and that much help was required in navigating such decisions
- Stakeholders felt that the memory clinic was an appropriate place for these discussions to take place as the majority of people presenting at the service were at an early enough stage of the disease to be able to engage in the process.

Middle and later stages of dementia

QS7. People with dementia who develop non-cognitive symptoms that cause them significant distress, or who develop behaviour that challenges, are offered an assessment at an early opportunity to establish generating and aggravating factors. Interventions to improve such behaviour or distress should be recorded in their care plan.

Health and social care professionals working with people with dementia who develop non-cognitive symptoms should carry out a comprehensive assessment. A behavioural and functional analysis should be conducted by health and social care professionals with specific skills, in conjunction with carers and care workers, and an
individually tailored care plan should be developed to address issues identified. This means that people with dementia who develop non-cognitive symptoms causing them significant distress, or who develop behaviour that challenges, can expect to be offered a comprehensive assessment at an early stage.

The dementia care pathway for Bromley outlines the services that people should have access to, depending on their needs during these situations, including:
- Re-ablement and domiciliary care services
- Housing related support and adaptations
- Equipment and assistive technology
- Intermediate care
- Support for family carers
- Day services, activities and social opportunities
- Peer support
- Legal and financial advice, benefits advice and advice on driving
- Support to maintain employment and volunteering
- End of life planning

Alzheimer's Society work in partnership with carers and the memory clinics to address any changes in behaviour and mood. All interventions are recorded in the patient assessment and Alzheimer's Society liaise with care managers in these circumstances. Alzheimer's Society suggests to carers different approaches to manage changing situations and works together to manage this and provide support for client and carer throughout.

Bromley Mind have staff trained to be concerned about challenging or puzzling behaviour and this would be noted on the individual's support plan. Bromley Mind's staff have had training and experience in dealing with these issues and a Dementia Skills Coach is also employed who would be consulted on individual cases if the staff are unable to resolve the problem. Bromley Mind liaise closely with the Memory Clinic and the older persons CMHTs if a client is displaying distressing behaviour. In these situations, Bromley Mind take their advice and work with their strategies.
Age Concern’s Floating Support Service and Support Planning & Brokerage Services all undertake assessments for clients. The assessments are holistic, and look at people’s emotional, physical and mental wellbeing, and what is working or not working in their lives. Once the assessment has taken place, a Support Plan is drawn up with the client, which is based on what the client would like to achieve.

**Feedback from the listening exercise:**

- There is professional education and awareness around understanding the triggers of non-cognitive symptoms. However, it was felt that this education and awareness was mainly available to those working at specialist dementia services and it was felt unlikely that people with dementia were offered an assessment at an early opportunity to establish generating and aggravating factors outside of these services. (Recommendation 14)
- It was felt that development of non-cognitive symptoms is often considered as part of the disease and alternative causes are not always investigated.
- It is important to incorporate such behaviour into ‘normal’ activities and reduce boredom, frustration, stress and to look for triggers.
- Co-ordinated care plans which are person centred and adapt to the changing needs in a person’s condition were highlighted as a critical issue.

**Conclusions**

- A range of interventions are offered to individuals who develop non-cognitive symptoms as set out in the integrated care pathway
- Stakeholders highlighted that this process was too often considered part of the disease process and therefore reversible causes were not always looked for in sufficient detail
- Stakeholders felt that this was an area that required input from secondary care services
- Stakeholders felt that co-ordinated care plans should be person centred and adapt to these changing needs as they developed
QS9. People in the later stages of dementia are assessed by primary care teams to identify and plan their palliative care needs.

As outlined at being of this health needs assessment, palliative care is not included in the scope of this report, as it is being covered by Bromley’s end of life report.(16) However, other aspects relevant to the later stages of dementia (such as advanced statements, carer support, lasting power of attorney) are dealt elsewhere within this report.

Support and interventions for carers

QS6. Carers of people with dementia are offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs.

Health and social care professionals should ensure that carers accepting an assessment of their needs receive a care plan containing a range of tailored interventions including:

- Psychological therapy including CBT
- Psycho-educational programmes
- Peer support

The local care pathway highlights the fact that family carers may ask for an assessment in their own right and this is currently provided upon request.

Currently there are a number of voluntary organisations which provide or arrange respite care including: Bromley Social Services Direct, Bromley Mind, Bromley Alzheimer’s Society, Age Concern Bromley, Carers Bromley and Bromley Mencap.

Age Concern’s Support Planning & Brokerage Service and Floating Support Service undertakes an assessment of carers at the start of an intervention which includes a client’s emotional and social needs. If needs are identified, Age Concern will discuss ways of meeting them, and this will be demonstrated on the support plan. Age
Concern will then work with the client to ensure those needs are met. Age Concern’s Day Centre also undertakes assessments with their clients and identifies emotional and social needs.

Bromley Mind:

- Offers an independent carer’s assessment when the referred client is assessed. If the offer is taken up the carer’s needs are identified and the carer is signposted to the relevant agency or group for assistance & support. (e.g. Benefits Agency; Carers Bromley)

- Offers free training to carers delivered by the Dementia Skills Coach either in groups or within the individual’s home. Bromley Mind is open to referrals for this service for carers who live in Bromley.

- Bromley Mind does not run formal carers’ groups, but does invite carers to all events at the day centres. Bromley Mind are starting to provide monthly afternoon tea for carers at each day centre for informal mutual support.

Carers Bromley staff refer carers to the Local Authority for Carers Assessments. Carers Bromley runs facilitated support groups throughout the borough, on a monthly basis. These groups have many carers in them who are caring for someone with dementia. Carers Bromley also have a monthly social group for carers (who can bring the person they care for along), former carers and friends.

**Feedback from the listening exercise:**

- The same person often performs the care assessment for the patient and carer – which may create conflicts of interest.

- Dementia is a changing disease and therefore there is a need for regular input with patients once diagnosed. One example highlighted throughout the stakeholder listening events was the fact that the memory clinic current does not provide long term follow up for patients unless they complex or if they are a Alzheimer’s patient on medications

- There is a need to clarify and promote the route to assessment and joining up health and social care assessments required
- Better communication is required on how to access assessment and support networks required for emotional support of patients and carers
- Better support is required for ex-carers
- There should be a reduction in form filling for carers and patients with dementia is required and forms should not be online only

Conclusions

- Carers of people with dementia are able to access an assessment of emotional, psychological and social needs, however, it is not always offered and in many cases must requested by the carer
- Psychological therapy including CBT is available for carers if the appropriate criteria for referral are met (Recommendation 12)
- At present there are no psycho-educational or peer support programmes for carers (Recommendation 12)
- Stakeholders felt there was an important conflict of interest to be highlighted if the assessment of patients and cares was performed by the same organisation or individual
- Stakeholders felt there was a need to clarify and promote the route to assessment and that health and social care assessments required better integration and communication (Recommendation 13)
- Stakeholders emphasised the fact that dementia is a changing disease and therefore required regular input and assessment for patients and carers after an initial diagnosis
QS10. Carers of people with dementia have access to a comprehensive range of respite/short-break services that meet the needs of both the carer and the person with dementia.

Service providers to people with dementia should ensure that information is available to health and social care staff on the range of respite/short-break services available to carers of people with dementia. Carers of people with dementia can expect to have access to a range of respite/short-break services which meet their needs.

There are several day services in Bromley, some with specialist service for dementia, some with an open door policy. There is currently a respite at home service provided by Carers Bromley, however, this involves self-financing of costs. Bromley Mind provides a sitting service that is currently free to clients but a charge is about to be introduced. Carers Bromley and Bromley Mind offer over a service for overnight stays of up to two weeks. There is a respite/residential unit which provides longer stay respites and has spare beds specifically for dementia but they are difficult to access and locate. There is extra care housing whereby people own their flat. This service is similar to sheltered housing but provides a greater level of care.

Age Concern runs a day centre called St Edwards in Mottingham, which is not a specialist day centre, however, currently around 75% of clients have short-term memory loss, but not all of them have had a diagnosis of dementia. There are places at this centre for 30 people a day. Most people attend twice a week on average. The service has never had a waiting list, and its capacity fluctuates. Different branches of Age Concern also run day services in Orpington, Penge and Bromley. The Biggin Hill Community Care Association provides a day service in Biggin Hill. There are people with dementia attending all of these centres.

Alzheimer's Society offers 135 contracted day care places each week for people with dementia in Bromley. Places are offered following assessment by Social Services to those clients who meet the current eligibility criteria which are currently “substantial or critical”. Places are also offered to self-funding clients who require them at a daily
charge. Alzheimer's Society offers some support at the drop in centre which is attended by carer and the person with dementia. Other respite services are also signposted for people with dementia and their carers.

Bromley Alzheimer’s Society runs the day service Whitegables for people with dementia.

Bromley Mind – day centres:

- Have a contract with London Borough of Bromley to provide 228 places across 3 dementia centres each week. These places are fully subscribed and there is always a waiting list. As soon as a place becomes available, day centre senior workers assess the next person on the waiting list to fill the vacancy. In addition to this, Bromley Mind always has a number of clients requesting extra days attendance. These requests have to be balanced against the waiting lists and are determined on individual circumstances.
- Bromley Mind also has capacity for privately funding clients to attend and 48 people currently attend leaving capacity for approximately 100 more.

Bromley Mind - respite at home:

- This is a combined service including: ‘sitting’; over-night respite in the client’s home; and community support for young onset dementia clients. Bromley Mind have a contract with London Borough of Bromley to provide a target of 190 hours /week for this service. On average London Borough of Bromley books about 135 hours and is therefore approaching targets. Bromley Mind still has a long waiting list particularly for the ‘sitting’ service, but cannot always provide ‘sitters’ at the times required by the carers. Over-night respite is an under-used option.

Feedback from the listening exercise:

- There needs to be a service for emergencies that patients and carers with acute problems can access
• More respite and bookable beds are required in residential homes for dementia respite
• Additional support is required for self-funders when trying to find respite as this process is currently complex and difficult to access
• Day centres should be able to provide a 7 day service, and greater flexibility is required for these services such as:
  o Providing 2 sessions a day - centre service should be longer than just pick up at 10 and drop back at 15.00
  o Having longer opening hours
  o Resolving issues around transport

Conclusions

• A range of respite/short-break services are available for carers and people with dementia in Bromley
• Respite services are offered in a variety of forms including day centres, respite at home, over-night services and residential services
• There is a high level of usage of these services and some of the day centres have a waiting list before people with dementia can be accepted
• Stakeholders felt that greater flexibility was required for respite care, as provision was not always appropriate to the needs of the carer (Recommendation 18)
• Stakeholders highlighted the need for more beds to be bookable in advance and at short notice for emergencies
• Stakeholders raised the issue that self-funders sometimes found it difficult to find appropriate services (Recommendation 19)
Costs and cost effectiveness

Key Points

- There is good evidence regarding the costs and benefits of implementing the national guidelines for dementia
- There is little evidence to demonstrate cost savings that might be achieved at the local level, although this has been reviewed across London and should be cost neutral

Across England it is estimated that the number of people with dementia will double within 30 years, and estimated costs are expected to increase from £15.9 billion in 2009 (of which around £8.2 billion are direct health and social care costs) to £34.8 billion by 2026. It is therefore vitally important that services and treatments for people with dementia are cost effective.

Several estimates have been undertaken in order to calculate the costs of dementia in the UK. The Dementia UK report estimated the annual cost of services used by people aged 65 and over with dementia in the UK for the period 2005/06 as £17 Billion.(12) This figure takes into account NHS and non-NHS costs as well as the costs associated with lost earnings by carers.

The recent report by Healthcare for London updated these figures and estimated the costs in relation to London (Table 9) although the costs associated with ‘informal care’ and self funded care home costs were excluded.(14)
<table>
<thead>
<tr>
<th></th>
<th>Mild dementia (Community)</th>
<th>Moderate dementia (Community)</th>
<th>Severe dementia (Community)</th>
<th>Dementia in care home setting</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS</strong></td>
<td>70</td>
<td>39</td>
<td>16</td>
<td>39</td>
<td>163</td>
</tr>
<tr>
<td><strong>Social service costs</strong></td>
<td>138</td>
<td>100</td>
<td>46</td>
<td>11</td>
<td>295</td>
</tr>
<tr>
<td><strong>Care home costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>386</td>
</tr>
<tr>
<td>(social service funded)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>386</td>
</tr>
<tr>
<td><strong>Care home costs</strong></td>
<td></td>
<td></td>
<td></td>
<td>190</td>
<td>190</td>
</tr>
<tr>
<td>(NHS funded)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>208</td>
<td>139</td>
<td>62</td>
<td>626</td>
<td>1,035</td>
</tr>
</tbody>
</table>

Table 9. Estimated public sector annual cost (in £ millions) of services used by people with dementia aged 65 and over in London (2009/10).

**Costs of implementing early diagnosis and management**

Implementing care pathways and the recommendations of the Dementia UK report and associated NICE clinical guidelines is associated with additional costs. This concern was highlighted at the listening event by several attendees of different backgrounds, and was a particular concern in relation to diagnosing and managing patients at an earlier stage as this would result in greater numbers of people with dementia and an even greater need for money.
The recent Healthcare for London report estimated the costs (for 2010) associated with implementing the National Dementia Strategy at £27 Million.\textsuperscript{(14)} It also estimated that the costs associated with the NICE guidelines\textsuperscript{(042)} covering Psychological Therapy and Imaging applied to London at £6.3 Million.

Table 10 estimates the costs for 2010 that would be incurred in Bromley by using the same methodology and data used in the Healthcare for London report. This analysis was performed to calculate the costs associated with implementing National Dementia Strategy locally, and it is estimated to be approximately £1,638,112 for this one year period. Further detailed analysis is required to understand where the gaps lie in Bromley’s current provision compared to these national strategies to help inform local commissioning decisions for improvement of the service.
<table>
<thead>
<tr>
<th>Estimated costs for 50,000 &gt;65s</th>
<th>NHS</th>
<th>Social Care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory assessment</td>
<td>£600,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extra support to Community Mental Health Teams</td>
<td>£460,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhancement to Social Care Services</td>
<td></td>
<td>£360,000</td>
<td></td>
</tr>
<tr>
<td>Overall cost</td>
<td>£1,060,000</td>
<td>£360,000</td>
<td>£1,420,000</td>
</tr>
<tr>
<td>Uplift to London prices</td>
<td>£1,187,200</td>
<td>£403,200</td>
<td>£1,590,400</td>
</tr>
<tr>
<td>Bromley population of &gt; 65s (2010)</td>
<td>51,500*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scaling factor</td>
<td>1.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated cost to implement in Bromley</td>
<td></td>
<td>£415,296</td>
<td>£1,638,112</td>
</tr>
</tbody>
</table>

Table 10. Cost of proposals in the National Dementia Strategy consultation document applied to Bromley.

*Source: Poppi where figures are taken from Office for National Statistics (ONS) sub national population projections by sex and quinary age. The latest sub national population projections available for England, published 27 May 2010, are based on the 2008 mid year population estimates and project forward the population from 2008 to 2033.

**Cost savings**
Implementing the National Dementia Strategy and the NICE guidelines covering Psychological Therapy and Imaging will obviously involve additional service costs,
however, there is evidence to suggest that savings can be made in other areas due to the implementation of these costs that would mitigate against this additional expenditure.

There has been no local modelling to assess the savings that may be possible, however, the national dementia strategy, and the Healthcare for London dementia services guide states that savings can be expected in the following areas:

- Early provision of support at home can decrease institutionalisation of people with dementia
- Even in complex cases, case management can reduce admission to care homes
- Older people’s mental health services can help with behavioural disturbance, hallucinations and depression in dementia, reducing the need for institutional care
- Carer support and counselling at diagnosis can reduce care home placement
- Early diagnosis and intervention improves the quality of life of people with dementia
- Early intervention has positive effects on the quality of life of family carers
- Having a co-resident carer exerts a preventative effect on entering a care home
- A brief programme of carer support and counselling at diagnosis has been demonstrated to reduce care home placement

Therefore many of the cost reductions are associated with implementation of the guidelines results from reduced use of care home facilities and admissions to secondary care. Across London it was estimated that these saving could be in the region of £5-16 Million pounds, therefore making the additional services cost neutral.
Conclusions and recommendations

Dementia is a progressive and largely irreversible syndrome that is characterised by a widespread impairment of mental function. Dementia is an important condition as it is common and complex, requiring joint working across many sectors. This health needs assessment set out to perform a review of the health issues facing people with dementia in Bromley. It is hoped that this report will result in an agreed set of priorities and resource allocation that can be developed to improve health of this population and reduce inequalities. General conclusions drawn from this report are:

- A number of national and local policies with a broad level of consensus and an evidence base for their use have been created over the last 5 years
- A local care pathway, building on the national guidelines, and created by a broad spectrum of stakeholders, has been in place since 2010
- Bromley had just under 4,000 people with dementia in 2010
- By 2030 the number of people with Dementia in Bromley is estimated to increase to 6153
- It is estimated that there are just under 500 people with severe dementia at present
- Approximately 34.9% the 4,000 estimated people with dementia in the Borough have a recorded diagnosis with their GP
- Alzheimer’s, Vascular, and mixed dementias account for the vast majority of cases of dementia in Bromley
- Hospital admission rates associated with dementia in Bromley are comparable to the rest of London

What currently works well for people with dementia in Bromley

- A good variety of training exists for staff working for people with dementia in Bromley
- Individual organisations have flexible mechanisms to ensure their staff are appropriately trained according to roles and responsibilities.
• The memory service in Bromley is generally held in high regard by users and other sectors
• The information about dementia provided to patients and carers is in a number of different and appropriate formats
• The voluntary sector carry out separate care assessments of patients and carers which look in detail at the specific needs of people with dementia
• A range of interventions are offered to individuals who develop non-cognitive symptoms as set out in the integrated care pathway
• Carers of people with dementia are able to have an assessment of emotional, psychological and social needs, however, it is not always offered and in many cases must requested by the carer
• A range of respite/short-break services are available for carers and the person with dementia in Bromley and are offered in a variety of forms including day centres, respite at home, over-night services and residential services

Recommendations for areas of improvement

A number of detailed recommendations are outlined below. The older persons partnership group have taken the strategic lead for this work to review and implementation of these recommendations.

**QS1. Appropriately trained staff**

1) Training should be focused to a greater extent on person centred care than it is at present.

2) Mechanisms for continual improvement should be put in place for care homes and respite staff. Any new dementia training should be designed with input from the mental health trust as participants at the stakeholder workshop felt this was lacking in current training programmes. In addition to this it was felt that there needed to be an increased recognition of the importance of a psychosocial, person-centred approach.
**QS2. Memory assessment services**

3) Expansion of the memory service to the levels set out in the national dementia strategy should be strongly considered as this will improve the levels of early diagnosis and in the longer term should be either cost saving or neutral.

4) The benefits of diagnosis should be more clearly communicated to those with possible undiagnosed dementia as stakeholders felt that presently this may be a barrier to undergoing an assessment for possible dementia.

5) Referral pathways to the memory clinic should be clarified for organisations other than primary care. Many organisations outside of primary care work with individuals at high risk of dementia. How these organisations can identify and refer potential cases of dementia for assessment should be clarified and would improve rates of early diagnosis.

6) Stakeholders highlighted other models of memory service clinic provision in South East London (such as Alzheimer’s Society in Croydon and MindCare in Lewisham) and urged that lessons could be learnt on how these provide cost effective services.

**QS3. Written and verbal information**

7) Many separate organisations disseminate excellent information about dementia. However, stakeholders felt there was a need for these to be better coordinated which would reduce overlap and inconsistencies that exist in the current multiple providers.

8) Information needs to be provided at different stages of dementia (e.g. mild, moderate, severe) after diagnosis. The needs of people with dementia change as the disease progresses and it was felt that currently information is mainly given at diagnosis.

**QS4. Assessment and personalised care plan**

9) Processes should be put in place to ensure that all individuals are offered a social needs assessment, rather than having to request one or be specifically referred for review.
10) It is recommended that social care assessments are performed by a named care coordinator as recommended in the quality standard as this improves continuity of care and service users and their carers felt this would improve assessments.

**QS5. Decision making**

11) People with dementia, while they have capacity, should have the opportunity to discuss the use of advance statements, advance decisions to refuse treatment and local protocols should be put in place to formalise these discussions.

**QS6. Emotional, psychological and social needs of carers**

12) The development of psychological therapy (including CBT) and peer support programmes for carers should be supported.

13) Consideration should be given to the creation of a single integrated health and social care assessment. This would improve the needs assessment for people with dementia and remove the duplication of assessments that currently exists.

**QS7. Non-cognitive symptoms and behaviour that challenges**

14) Development of non-cognitive symptoms and behaviour that challenges should not be considered part of the disease process and patients should always be explored for potential reversible causes. Protocols should be put in place to ensure this happens across all organisations providing services for people with dementia. This will ensure that more people with dementia have these needs appropriately addressed.

**QS8. Liaison services**

15) Additional work should be carried out to determine the requirement for a liaison service over and above the current informal provision as this may not be sustainable in the longer term and such a service is important for the quality of inpatient care of people with dementia.

16) A potential model for a new liaison service is available in Greenwich. This facility may improve the levels of inpatient care received by people with dementia and has been demonstrated to reduce costs associated with outcomes such as length of inpatient stay for people with dementia.
17) The design of any new service should be preceded by more detailed assessment and evaluation of requirements before such a service is scoped or implemented in Bromley.

**QS10. Respite services for carers**

18) Greater flexibility of respite care provision should be promoted as this was felt important for stakeholders.

19) Improving the access to information on respite services for individuals that are self-funders would be welcomed as this group currently finds the process difficult to navigate.
References


Appendix 1.

We would like to acknowledge the following stakeholders whose valuable contribution to this work made it possible.

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandra</td>
<td>Ajimal Sister/Ward Manager of Med 9 short stay EAU</td>
</tr>
<tr>
<td>Rob</td>
<td>Aldridge Bromley Public Health</td>
</tr>
<tr>
<td>Cllr Graham</td>
<td>Arthur Local Authority</td>
</tr>
<tr>
<td>Natalie</td>
<td>Blythe Band 5 Staff Nurse</td>
</tr>
<tr>
<td>Ellie</td>
<td>Boon Age Concern Bromley</td>
</tr>
<tr>
<td>Mandy</td>
<td>Boorman Healthcare Assistant</td>
</tr>
<tr>
<td>Shirley</td>
<td>Burrows Bromley Mind</td>
</tr>
<tr>
<td>Betty</td>
<td>Callaghan</td>
</tr>
<tr>
<td>Marilyn</td>
<td>Cook Oxleas</td>
</tr>
<tr>
<td>Ray</td>
<td>Clay</td>
</tr>
<tr>
<td>Angela</td>
<td>Clayton-Turner Older People Mental Health Partnership Group</td>
</tr>
<tr>
<td>Kevin</td>
<td>Cunningham</td>
</tr>
<tr>
<td>Pauline</td>
<td>Cunningham</td>
</tr>
<tr>
<td>Ann</td>
<td>Dalton</td>
</tr>
<tr>
<td>Sarah</td>
<td>Dowling</td>
</tr>
<tr>
<td>Christabel</td>
<td>Drakes Advocacy First</td>
</tr>
<tr>
<td>Maureen</td>
<td>Falloon Age Concern</td>
</tr>
<tr>
<td>Micheline</td>
<td>Faulkner Age Concern Bromley - Dementia Café manager</td>
</tr>
<tr>
<td>John</td>
<td>French Oxleas, Student Nurse</td>
</tr>
<tr>
<td>Martin</td>
<td>Gill Oxleas, LA, PCT</td>
</tr>
<tr>
<td>Peter</td>
<td>Grand</td>
</tr>
<tr>
<td>Margaret</td>
<td>Hales</td>
</tr>
<tr>
<td>Joy</td>
<td>Hall Chair, Older People Mental Health Partnership Group</td>
</tr>
<tr>
<td>Chris</td>
<td>Hobbs London Borough of Bromley</td>
</tr>
<tr>
<td>Jennifer</td>
<td>Hicks Bertha James Day Centre</td>
</tr>
<tr>
<td>Rebecca</td>
<td>Jarvice Bromley PCT and LBB</td>
</tr>
<tr>
<td>Jill</td>
<td>Jilani Bromley Mind</td>
</tr>
<tr>
<td>Helen</td>
<td>Jones Oxleas</td>
</tr>
<tr>
<td>Joanna</td>
<td>Kennedy</td>
</tr>
<tr>
<td>Sue</td>
<td>Kieselack Medicines Management</td>
</tr>
<tr>
<td>Nada</td>
<td>Lemic Bromley Public Health</td>
</tr>
<tr>
<td>Kay</td>
<td>Lily</td>
</tr>
<tr>
<td>Doreen</td>
<td>Maizels</td>
</tr>
<tr>
<td>Leslie</td>
<td>Marks Chair, Bromley Council on Ageing</td>
</tr>
<tr>
<td>Agnes</td>
<td>Marossy Bromley Public Health</td>
</tr>
<tr>
<td>Mary</td>
<td>Mason</td>
</tr>
<tr>
<td>------------</td>
<td>---------------</td>
</tr>
<tr>
<td>A H</td>
<td>Micklewright</td>
</tr>
<tr>
<td>Peter</td>
<td>Moore</td>
</tr>
<tr>
<td>Edward</td>
<td>Nelms</td>
</tr>
<tr>
<td>Pat</td>
<td>O’Shea</td>
</tr>
<tr>
<td>Roseline</td>
<td>Oloya</td>
</tr>
<tr>
<td>Hazel</td>
<td>Parks</td>
</tr>
<tr>
<td>Mr &amp; Mrs D</td>
<td>Patten</td>
</tr>
<tr>
<td>Melanie</td>
<td>Place</td>
</tr>
<tr>
<td>Lynne</td>
<td>Powrie</td>
</tr>
<tr>
<td>Dave</td>
<td>Prebble</td>
</tr>
<tr>
<td>Alex</td>
<td>Pringle</td>
</tr>
<tr>
<td>Carol</td>
<td>Rickell</td>
</tr>
<tr>
<td>Sally</td>
<td>Roe</td>
</tr>
<tr>
<td>Julia</td>
<td>Rollinson</td>
</tr>
<tr>
<td>Eithne</td>
<td>Rynne</td>
</tr>
<tr>
<td>Anil</td>
<td>Singh</td>
</tr>
<tr>
<td>Lynda</td>
<td>Slattery</td>
</tr>
<tr>
<td>Sarah</td>
<td>Stoner</td>
</tr>
<tr>
<td>Brenda</td>
<td>Thompson</td>
</tr>
<tr>
<td>Carolyn</td>
<td>Tillbrook</td>
</tr>
<tr>
<td>Anne</td>
<td>Waterworth</td>
</tr>
<tr>
<td>Geoff</td>
<td>Webber</td>
</tr>
<tr>
<td>Margaret</td>
<td>Whittington</td>
</tr>
<tr>
<td>Maclom</td>
<td>Wood</td>
</tr>
</tbody>
</table>