DERBY CITY COUNCIL

NHS Derby City

DERBY CITY EMERGING DEMENTIA STRATEGY

2010-2015

CONTENTS

Derby's Emerging Dementia Strategy

Introduction

This document is the product of extensive engagement with local stakeholders to identify gaps, needs, and priorities. The strategy also looks at services in line with the Department of Health's 'Transforming Community Services' programme – which aims to improve community services so they can provide modern personalised and responsive care of a consistently high standard.

1. Purpose

The overall purpose of this document is to articulate an understanding of the current and future demands on dementia services to recommend a dementia model of care and supporting commissioning intentions.

This document will identify the shared values and principles upon which we will commission and deliver dementia services.

2. Process

This document has been compiled following a review of work undertaken up to March 2010

- Local people, carers, service providers and commissioners have been involved in a priority setting process
- A needs assessment, population profile, has then been constructed
- A review of National and Local policy has been completed
- A review of Best Practice has been undertaken
- A review of Financial mapping for Older Adults
- A review of service mapping for Older Adults

Our current gaps in information are:

- A comprehensive view on Local Authority and Primary Care Trust investment
- A comprehensive view on the demand and capacity issues that face Derby

3. Next Steps

- **Share progress to date**
- **Work together to fill the gaps in information**
- **Agree a model of care**
- **Agree appropriate care pathways**
- **Work together to improve our delivery of the NDS 17 Objectives.**

4. Shared Vision, Values and Strategic Intent

The partnership document 'A Better Derby for older people 2009-2010' sets out its vision across the full breadth of service areas, from health and housing to transport issues. This document acts as a framework for all other strategies relating to older people. It can be accessed via the following link or within local libraries:

http://www.derby.gov.uk/whoiam/older_person.htm

Within NHS Derby City's 10 year strategy 'Healthy Derby' there are clear priority areas which will have a positive impact on the delivery and development of services for people with dementia – such as ensuring informed patients and public and an evidence based approach to investment decisions. The full document can be accessed as below:

http://www.derbycitypct.nhs.uk/UserFiles/Documents/AboutUs/HealthyDerby/Healthy%20Derby%20Strategy.pdf

The Transforming Community Services Programme – Enabling new patterns of provision – is also underway and Derby has identified Dementia as one of its top five priorities.

5. Developing the strategy in context

The financial resources within the Local Authority and NHS Derby City are limited – and therefore service developments will need to be shifted from within the current systems.

It is recognised that there is a need to move resources from a secondary to a primary and community focus in line with local needs.

New developments have taken place recently including a new primary care mental health initiative, a modernised day service, the Dementia Peer Support pilot, and a new home based dementia respite service is currently being commissioned. The impact of these developments is yet to be firmly established.

6. National Policy

Health and Social Care Policy Context

In February 2009, **Living Well with Dementia: the National Dementia Strategy** was released by the Department of Health. Within it, 17 objectives were identified to be taken forward at national, regional and local levels to improve the quality of dementia care.

The strategy outlines service areas and developments under the following three broad headings:

- Raising awareness and understanding
- Early diagnosis and support
- Living well with dementia

The strategy proposes that services should be improved by increasing public and professional awareness of dementia and by making sure that any health or social care worker or professional person who works with an individual who has dementia has the skills to do so. This includes knowledge of where to refer and signpost people to. Good quality early diagnosis and intervention and support, information and advice are essential components of an effective service. In order to be as responsive as possible to people's wishes as well as to be effective and sustainable in terms of cost, support and treatment should be provided as close to home as possible, including in the individual's home. People who have dementia should have the same access to intermediate care as the population as a whole.

The quality of care of people who have dementia who find themselves in institutions - general hospitals and in care homes – need to be improved by providing staff who are appropriately trained employed to care for them. People in residential or nursing care should have access to stimulation through interaction with others including staff, and through activities designed to improve their mental well-being and overall functioning.

Other policies and strategic documents nationally such as 'Our health, our care, our say' (DH, 2007) and Darzi's review set out key principles to improve services for local people.

Over the next 5 years and beyond, the drive to ensure that people whatever their need, are treated as close to their own homes as possible, will continue. People will increasingly have choice in their treatment and control over the resources, which secure these for them through self-directed care through personalised budgets and direct payments. The focus for service improvement will be based on the Darzi principles of fair, personalised, effective, and safe services. There will be a focus on prevention and promoting physical and mental health and well-being.

7. Principles and Values of Commissioning

In developing this strategy, we recognised the wider imperatives driving the development of both commissioning and services, including:

World Class Commissioning -
This is a set of standards to make sure Primary Care Trusts and Local Authorities commission quality interventions that meet the local demand, provide value for money, and are measured by their outcome for local people rather than mere activity.

A Commissioning Framework for Health and Wellbeing -
Identification of the eight steps which, when followed, provide personalised services which are flexible, integrated and responsive to individual need and choice.

Further detail regarding the national and local can be found in appendix 1 to this report.

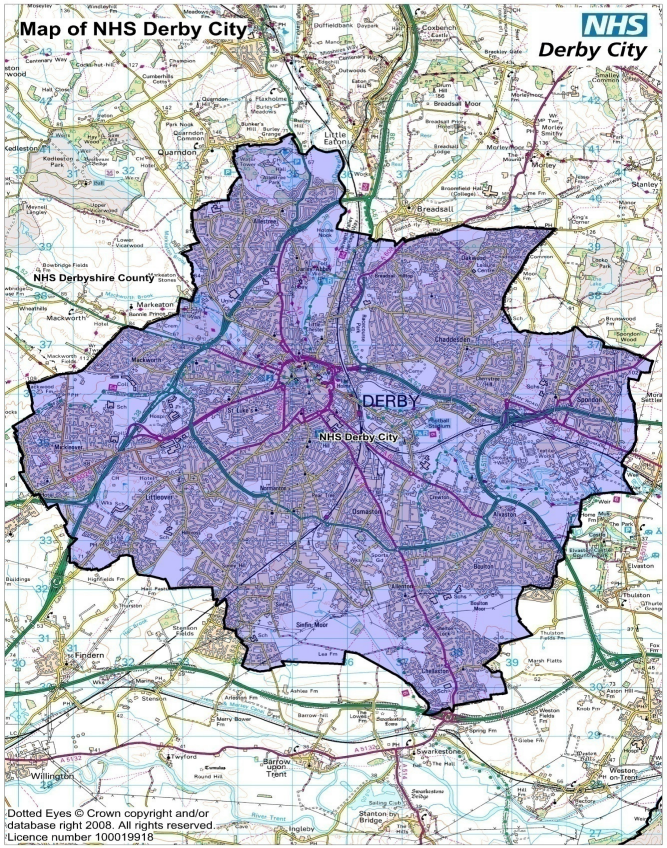
Appendix 2 contains detail of evidence based best practice

8. Current and Future need

Population Needs Analysis

DEMOGRAPHICS

The map below shows the geographical location of Derby City.



1 in 4 people may suffer from a mental health problem at some stage in their life. We know that good support from our communities and families can help to alleviate some of the worse effects, but early recognition and diagnosis is vital to ensure access to the many treatments which are now available. This chapter is presented to underline and emphasise the scale of the unmet need in this area, whether it be lack of access to information, or presentation to primary care, whilst stressing that due to population increase alone, the need for dementia services is set to rise.

Whilst the majority of NHS Derby City's registered population lives within the boundaries of Derby City Local Authority, approximately 17% of its population live in the surrounding LAD[1] 2 tier district authorities of Derbyshire County. A snapshot of registered population taken from the national Exeter[2] system gave a recent figure for NHS Derby City of 291,143 people (1st January 2009), compared to the Office for National Statistics projected resident population for Derby City of 241,000 people in 2009.

[1] LAD (Local Authority District) 2 tier authorities are those that sit within the larger LAD 1 top tier counties i.e. Amber Valley Local Authority District in Derbyshire County

[2] Also known as the NHAIS (National Health Application and Infrastructure Service), it underpins the primary care level of NHS IT; managing services, patient registration and demographic details for England, Wales and Northern Ireland

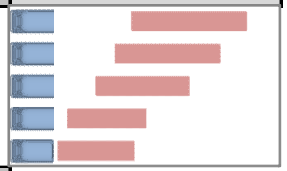
Population Estimates

The resident population estimates and projections featured in this chapter have been sourced from the Office for National Statistics and their Sub-National Population Projections Team. Population estimates are available to as lower geography as ward, while projections are available to only as low as Local Authority level. As such, projections at ward level have been achieved by applying the projected population growth by gender and age at Derby City Local Authority level, to the individual ward's population.

RESIDENT Population

FIGURE 1

Older adult population estimates ('000s and % of older adult total) by age band and gender 2009

Age Band	Males		Females		Total		Micro Chart of Total
	No.	%	No.	%	No.	%	
65-69	5	**13.1%**	5.1	**13.4%**	10.1	**26.5%**	
70-74	4.3	**11.3%**	4.7	**12.3%**	9	**23.6%**	
75-79	3.5	**9.2%**	4.2	**11.0%**	7.7	**20.2%**	
80-84	2.3	**6.0%**	3.6	**9.4%**	5.9	**15.5%**	
85+	1.9	**5.0%**	3.5	**9.2%**	5.4	**14.2%**	
Total	17	**44.6%**	21.1	**55.4%**	38.1	**100.0%**	

Source: ONS

The population estimates show that in 2009, Derby City Local Authority Area was estimated to have a total older adult[3] population of 38,100. More than fifty per cent of this population are between 65 and 74 years of age, and there are far greater numbers of females compared to males living to beyond 85 years. This is highlighted in the micro chart on Figure 1; the blue bar on which signifies male and the red signifies female proportions of the population. These distributions are in line with regional and national trends.

Population Projections

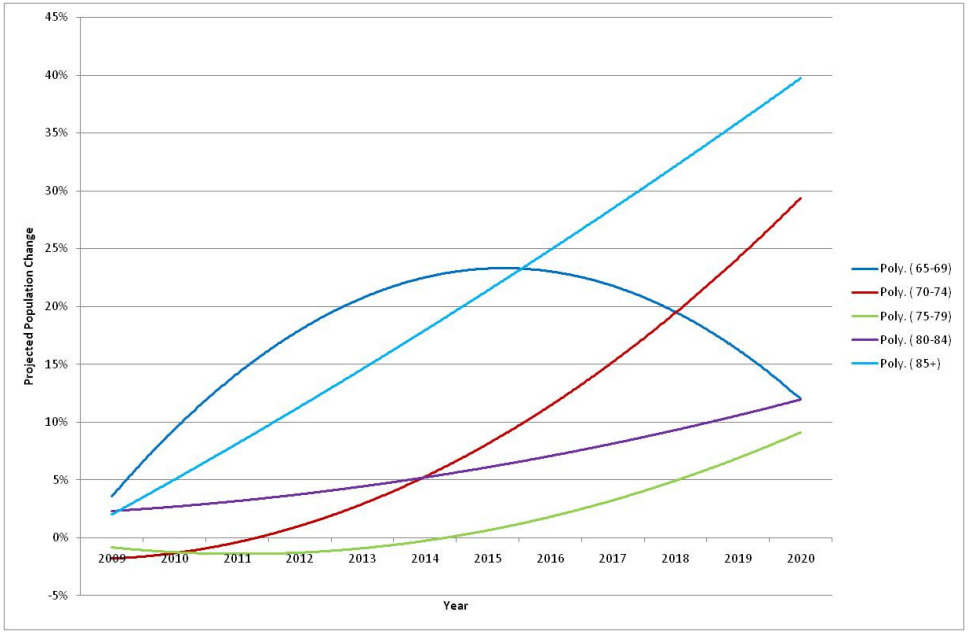
Overall, the older adult population is expected to have grown by just over 19% in Derby by 2020 from what it was in 2008, compared to 35% in the East Midlands and 28% in England.

Figure 2 demonstrates an increase in all age brackets over 65 with the exception of the 65-69 age group. Most notable is the increase in people over the age of 85. There is anticipated to be a 40% increase in numbers over 85 by 2020 (from 2008 numbers).

[3] Aged 65 years or older

FIGURE 2

Derby City resident population projections for 65+ age bands (percentage change since 2008)



Source: ONS

Ethnicity

Population by ethnic group (as % of 65+ older age band total) compared to England

Derby is an ethnically diverse city with a particularly large Asian population. This is demonstrated in Figure 3 below in that Derby has a less than average percentage of White British people and a greater than average percentage of Indian and Pakistani people, as well as Black Caribbean people, compared to the ethnic makeup of England. The largest concentration of Derby's Asian population can be found in Arboretum and Normanton Wards, as highlighted in Figure 4 below.

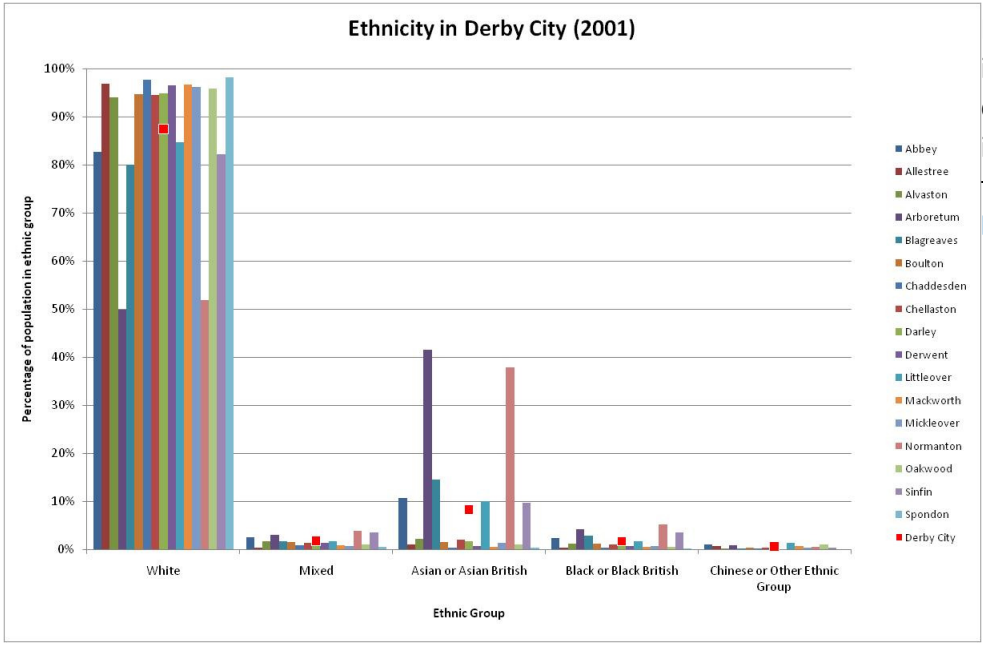
FIGURE 3

Ethnic Group	Ethnic Sub-Group	Derby City	England	Diff.
White	**British**	90.8%	93.4%	2.58%
	Irish	2.4%	2.0%	-0.45%
	Other	2.1%	1.7%	-0.37%
Mixed	**White & Black Caribbean**	0.1%	0.1%	-0.02%
	White & Black African	0.0%	0.0%	0.01%
	White & Asian	0.0%	0.1%	0.04%
	Other	0.0%	0.1%	0.06%
Asian or Asian British	**Indian**	1.7%	0.9%	-0.82%
	Pakistani	1.2%	0.4%	-0.79%
	Bangladeshi	0.0%	0.1%	0.09%
	Other	0.2%	0.2%	-0.04%
Black or Black British	**Black Caribbean**	1.2%	0.8%	-0.45%
	Black African	0.0%	0.1%	0.11%
	Other	0.0%	0.0%	0.00%
Chinese or other ethnic group	**Chinese**	0.1%	0.1%	0.01%
	Other ethnic group	0.0%	0.1%	0.05%

Source: NOMIS official labour market statistics; Census 2001

FIGURE 4

Ethnicity by Ward in Derby City (all ages) 2001

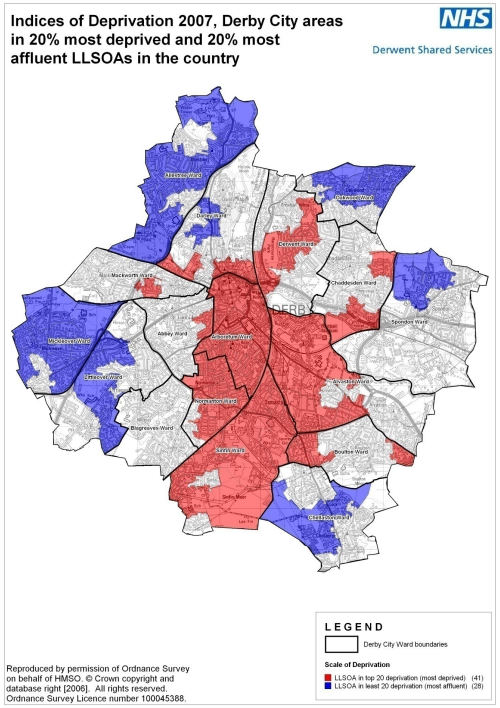


People of Southern Asian descent are more susceptible to diabetes and as a result, cardiovascular disease that is a complication. This can lead to vascular dementia. The African Caribbean population are equally at greater risk of hypertension, which can also lead to vascular dementia. As such, primary prevention should therefore focus on the wards of Arboretum and Normanton, whereas ongoing treatment, care and support should be focussed on wards with greater numbers of older people, particularly Allestree.

Deprivation

Derby City is ranked 69th most deprived of the 354 Local Authorities in England. Arboretum Ward and Normanton Ward (the most ethnically diverse wards in the city), are amongst the most deprived in the country, with half of all electoral wards in Derby City found in the top fifth most deprived in the country (see Figure 10).

FIGURE 5



Source: Department of Communities and Local Government, Indices of Deprivation 2007

People living in the most deprived wards are likely to experience a lack of access to information, recognition and ultimately, early diagnosis, in order to obtain the support and treatment they require. Peer support (dementia cafés) and carer support will need to be targeted to those wards with greatest need, with a model of care based on the community development model that is already in place in the city.

Prevalence

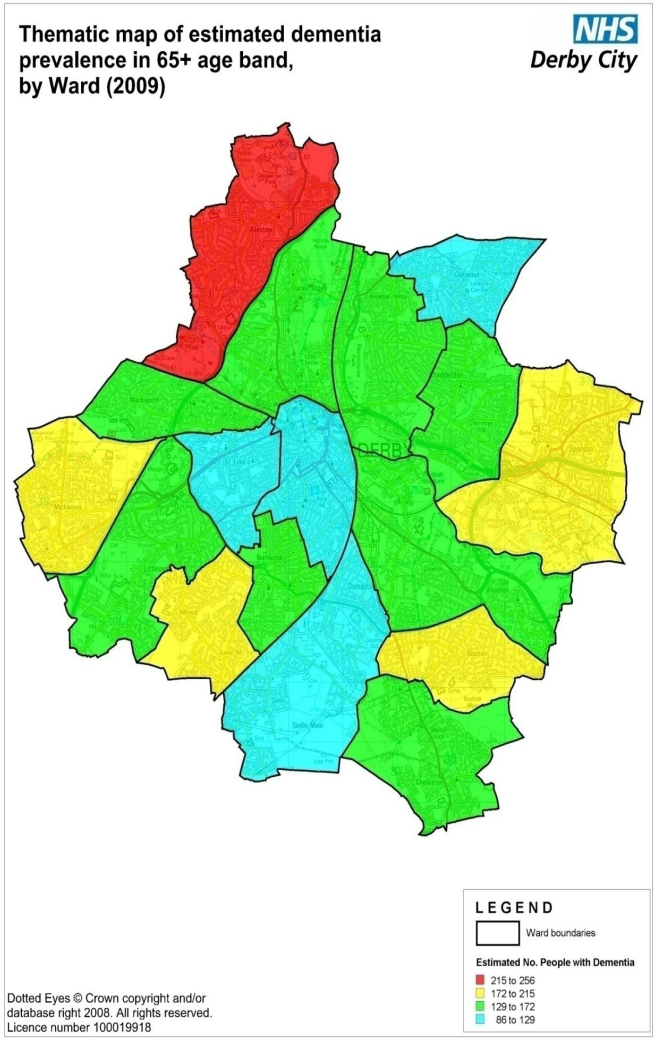
Figure 6 below was created by applying the projected mid-year 2007 estimated ward–based resident population to 2009, and applying the general dementia prevalence rate of 7.1% (Paying the Price, 2008) to that population. This highlights a hotspot of people with dementia in Allestree ward, one of the most affluent in Derby City and with a large older people population. Mickleover, Blagreaves, Boulton and Spondon wards are also expected to have a high number of older people with dementia.

This also fits broadly with what we know about access to adult social care services locally. Based on data from February 2010 the wards which access the most hours of homecare are Arboretum; Chellaston; Littleover; Mackworth and Allestree. Looking at access to all social care services the top five wards accessing these are Arboretum; Blagreaves; Mackworth; Chaddesden and Chellaston.

The prevalence rate of 7.1% used in this example gives an all age overview, by ward. The rest of this report reflects on the more detailed prevalence of dementia by gender and age in the UK, as given in the report produced and given to the Alzheimer's Society by King's College London and the London School of Economics on the prevalence and economic cost of dementia.

FIGURE 6

Thematic map of estimated general dementia prevalence in 65+ age band by ward



Whilst the general prevalence rate is commonly applied, it must be mentioned that the true prevalence of dementia varies greatly depending on the population. For instance, it is estimated that for individuals living in nursing homes, 67% will have Dementia compared to those in residential homes where it is estimated that 52% are likely to be affected. This is compared to 80% of people in elderly mental health homes. Furthermore, 60% of the older adult population are likely to develop a mental health condition whilst in a general hospital setting.

LATE ONSET DEMENTIA

The term late onset dementia is used to describe people over affected with the disease who are over the age of 65. The method used to calculate the estimated number of dementia cases has been to apply national prevalence rates to known yearly historical populations of Derby (2002 – 2009). The resulting estimates of number of people to have had dementia in previous years were then projected forward to 2015.

In the year 2015 it is estimated that there will have been a 27% increase in the number of cases of late onset dementia, from 2009.

The forecasts for Derby have been calculated by taking the registered population of NHS Derby City, and the national prevalence rates - see tables below in Figure 7. Some of the headlines include that whilst only 1.5% of males aged 65-69 are expected to have dementia, 25% of females over 85 are likely to experience dementia. Figure 8 also shows the percentage of people expected to have mild, moderate and severe dementia by age band.

FIGURE 7

Prevalence of dementia by gender and age group

Gender	65-69	70-74	75-79	80-84	85+
Males	1.5%	3.1%	5.1%	10.2%	19.7%
Females	1.0%	2.4%	6.5%	13.3%	25.2%

Source: Alzheimer's Society, Dementia UK

FIGURE 8

Percentage of people with dementia who have specified severity of dementia, by age band

Age Band	Mild	Moderate	Severe
65-69	62%	32%	6%
70-74	63%	30%	7%
75-79	57%	31%	12%
80-84	57%	32%	11%
85+	51%	33%	16%

Source: Dementia UK

EARLY ONSET DEMENTIA

Early onset dementia refers to people affected by the disease under the age of 65. The national prevalence rates for early onset dementia are shown in Figure 9 below. Figure 10 details the estimated numbers of people experiencing dementia by 2015.

FIGURE 9

Prevalence (in %) of early onset dementia by age and gender

Gender	30-34	35-39	40-44	45-49	50-54	55-59	60-64
Males	0.009	0.006	0.008	0.032	0.063	0.180	0.199
Females	0.010	0.009	0.020	0.027	0.055	0.097	0.118

Source: Dementia UK

FIGURE 10

Estimated number of cases of early onset dementia by gender, age and year

Gender	Year	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Total
Males	2009	1	1	1	3	5	14	15	41
	2015	1	1	1	4	5	15	19	47
Females	2009	1	1	2	3	4	7	9	27
	2015	1	1	3	3	5	7	11	30
Total	2009	2	2	3	6	10	22	24	68
	2015	2	2	4	7	10	22	31	77

In 2015 it is estimated that there will have been a 13% increase in cases of early onset dementia, from 2009.

Sub-types of dementia

The Dementia UK report by the Alzheimer's Society states that of all dementia cases, the prevalence is split as below:

- Alzheimer's disease: 62%
- Vascular dementia: 17%
- Mixed dementia: 10%
- Dementia with Lewy bodies: 4%
- Fronto-temporal dementia: 2%
- Parkinson's dementia: 2%
- Other dementias: 3%

This would amount to over two and a half thousand cases of Alzheimer's disease also in the registered population of Derby in 2015.

Dementia in people with Down's syndrome

It is known that people with Down's syndrome have an increased likelihood that they will be develop dementia. To calculate the number of people with dementia and Down's syndrome it is first necessary to estimate the total number of people with Down's syndrome. The estimated prevalence of Down's syndrome for the general population aged between 18 and 64 is 0.0625%[4]. The prevalence rate in people aged 65+ is 0.0036%[5]. The prevalence rates of dementia in people with Down's syndrome can therefore be seen in Figure 11 below.

FIGURE 11

Prevalence (in %) of dementia in people with Down's syndrome by age

	45-49	50-54	55-59	60+
Prevalence	8.9%	17.7%	32.1%	25.6%

Source: Coppus et al, 2006

By applying these rates to the population of Derby, it is possible to determine the likely number of people to have not only Down's syndrome, but dementia and Down's syndrome. As can be seen in Figure 12, there are likely to be a total number of 8 people in the city with dementia and Down's syndrome by 2015.

FIGURE 12

Prevalence in number of people with downs syndrome and dementia by age

		45-49	50-54	55-59	60+
2009	Total Population	16300	13600	12500	50800
	with Down's syndrome	10	9	8	9
	with Down's syndrome and Dementia	1	2	3	2
2015	Total Population	17600	16300	13600	53900
	with Down's syndrome	11	10	9	9
	with Down's syndrome and Dementia	1	2	3	2

Source: Dementia UK

As dementia in this population is presenting at an earlier age, it is imperative that diagnosis is made early to ensure an early treatment plan.

Dementia Prevalence by GP Practice

The QOF (as discussed earlier) data includes the number of patients on the dementia clinical register. All QOF data by GP Practice is publically available on the internet. Figure 13 below highlights for 2008/09 the actual dementia registers of NHS Derby City's GP Practices, and the prevalence of dementia as a percentage of the practice's total populations. As can be seen from this table, the GP surgeries recording the highest percentages of people with

[4] Based on the mean rate from two studies which put the prevalence of Down's syndrome at between 5.9 per 10,000 general population (Mantry et al) and 6.6 per 10,000 live births (NCHOD)

[5] Based on the number of people with Down's syndrome recorded on the Sheffield Learning Disability Case Register (October 2007)

dementia are Vernon St (city centre); Park Farm (Allestree) and Osmaston surgeries.

FIGURE 13

Prevalence of Dementia based on QOF clinical register and total practice

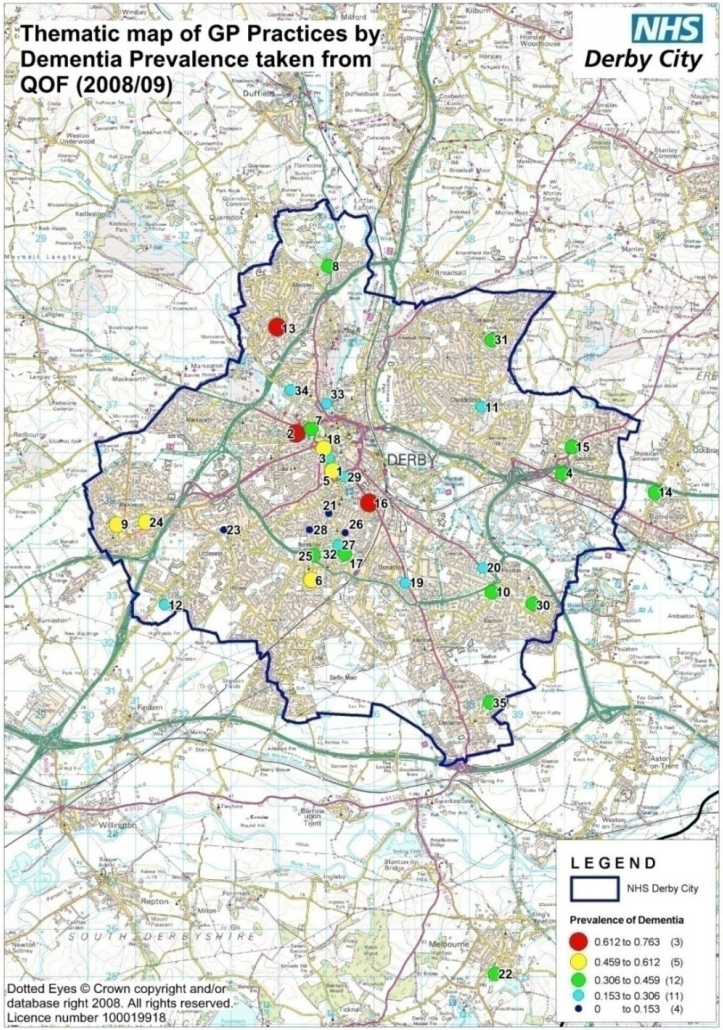
Map ID	GP Practice	No. of People on Dementia Register	No. of People on Practice List	Dementia Prevalence
1	Charnwood Surgery	20	13029	0.15%
2	Vernon Street Med. Ctr.	67	8784	0.76%
3	Wilson Street Surgery	32	14984	0.21%
4	Derwent Valley Med. Ctr.	46	12268	0.37%
5	Wellside Medical Centre	38	7863	0.48%
6	Village Surgery	57	11093	0.51%
7	Friargate Surgery	26	5777	0.45%
8	Park Lane Surgey	20	5859	0.34%
9	Mickleover Medical Centre	56	11613	0.48%
10	Alvaston Medical Centre	44	10959	0.40%
11	Park Medical Practice	67	22373	0.30%
12	Hollybrook Medical Centre	23	11585	0.20%
13	Park Farm Medical Centre	76	10573	0.72%
14	Overdale Medical Centre	36	10539	0.34%
15	Chapel Street Medical Centre	39	11583	0.34%
16	Osmaston Surgery	81	12399	0.65%
17	Lister House	60	15605	0.38%
18	Macklin Street Surgery	52	10780	0.48%
19	Ascot Medical Centre	13	8233	0.16%
20	The Newparkfield Surgery	14	6757	0.21%
21	The Dale Medical Centre	<5	5405	-
22	Melbourne Health Care Ctr.	51	13613	0.37%
24	Mickleover Surgery	29	5133	0.56%
25	Derby Lane Medical Centre	15	4106	0.37%
26	Peartree Medical Centre	5	3446	0.15%
27	Normanton Medical Centre	9	4222	0.21%
28	Clarence Road Surgery	<5	3559	-
29	Jay Bee Medical Centre	<5	1326	-
30	Hema Medical Centre	9	2642	0.34%
31	Oakwood Surgery	13	3973	0.33%
33	Derwent Medical Centre	9	3516	0.26%
34	Brook Medical Centre	9	3238	0.28%
35	Meadowfields Practice	29	7646	0.38%
32	Vidya Med Centre	<5	1573	-

The total number of people registered in Derby to have dementia on the QOF was 1,055 out of a total population of 286,054. This data suggests that for 2008/09, approximately 0.4% of Derby's registered population has dementia. This is in line with the national QOF prevalence of dementia at the same figure although is significantly lower than the number of people we would expect to actually have dementia locally. Out of the 34 GP practice serving the population of Derby, 9 had greater prevalence rates of dementia than the national average. None though, have a greater prevalence than the nationally expected prevalence of 1.1% that is documented by the Alzheimer's Society. Figure 14 presents this prevalence data as a thematic map.

Due to the variability in prevalence seen across primary care GP practices, it is likely that resources in terms of awareness raising, education, and training for primary care will be needed in order to recognise and assess the condition at the earliest opportunity.

FIGURE 14

Thematic map of GP practices by dementia prevalence



Actual vs Expected

As detailed in the previous prevalence section, the total estimated number of people with dementia in 2009 could be as many as 3243 (early onset + late onset).

If, according to the QOF, only 1,055 individuals are currently on NHS Derby City's dementia register, this means that approximately 68% of estimated dementia cases have not yet been identified.

Only when access to culturally appropriate information, resources, and improved awareness of dementia at both a population and professional level are increased, can adequate assessment, early diagnosis and support (both peer and carer) be offered, and the necessary treatment and care should this be needed.

Conclusion

The information within this section highlights that Derby's services will need to respond to:

- A growing ageing population, particularly in the 85 year+ bracket
- The anticipated rise in cases of both early onset dementia (13%) and late onset dementia (27%) by 2015
- The needs of people within the areas of notable deprivation in the city, plus areas such as Allestree with a known significant older population
- The diverse ethnic mix and the associated risk factors for people from South Asian and African Caribbean communities

- The current significant underrepresentation of people registered as having dementia according to GP records

Further detail regarding the needs assessment, prevalence and demographic issues can be found in appendix 3 to this report.

9. Market Analysis

This section will look at current and future service delivery.

It is important that future and current providers have an understanding of the skills and resources required to deliver care to meet local need in line with best practice. The local partnership will work together to achieve a common understanding to alleviate any barriers in providing personalised care.

Current feedback from stakeholders suggests:

- there is a lack of community infrastructure
- a lack of standardised access to services
- the current service profile is heavy on hospital and institutional care.

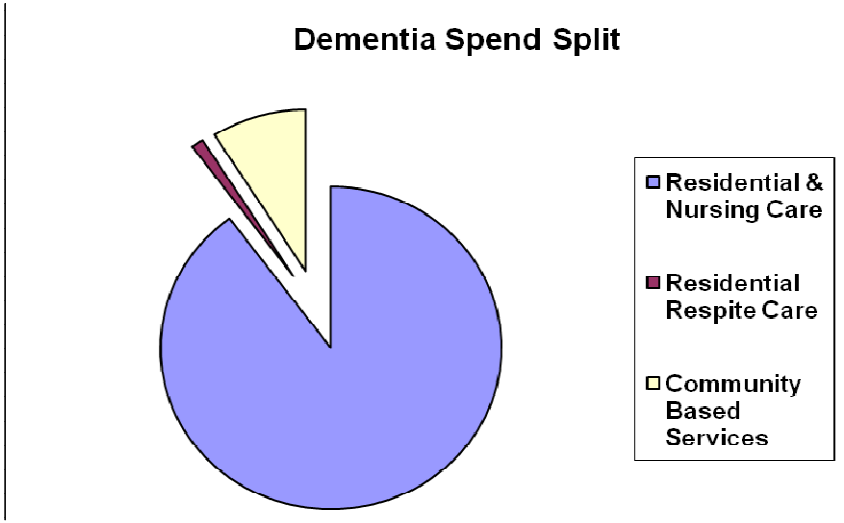
91% of NHS Derby City investment is with Derbyshire Mental Health Services Trust comprising of Inpatient Care and Older Adult Community Mental Health Team.

7% is invested in Non Statutory Service and 2% is invested within the Local Authority provider arm.[6]

A similar picture is evident with Derby City Council funding - which is also skewed towards institutional care. 90% of Adult Social Services funding for service provision goes towards residential and nursing care, whilst 9% goes towards community based services such as home care, day care or assistive technology; and the remaining 1% is spent on residential respite services.
(See figure 15)

Figure 15

Derby City Council Current Investment in service delivery



Source Derby City Council Jan 2010

[6] Source: Financial Mapping 2008/09

Table 1 on the next page will identify the Primary Care Trust 'procurement team's analysis of the market and opportunities to develop choice and competition. This highlights the underdevelopment of the services and providers at the current time. Potential for substitutions are within the inpatient services. By developing more choice within the residential care and nursing care establishments to cater for respite and continuing care this would free up expensive inpatient facilities and resources. A further area of expansion would be to re-shape memory assessment to create an **Early Diagnosis and intervention – Memory Assessment and Support service.**

This would impact on the need for more intensive support services. By intervening sooner, more people would be enabled to live independently for longer.

In taking forward the development of appropriate service delivery the existing joint (Primary Care Trust/Local Authority) provider forums will be utilised to engage providers in looking at local commissioning priorities.

For example, the local provider forums for residential and nursing care in the city have supported the Council in developing a specification for dementia specific care. The implementation of this in 2010 will result in a **fee increase** for homes meeting agreed quality standards.

Table 1 developed by NHS Derby Primary Care Trust Procurement department identifies the market characteristic, current providers who may be new providers and possible substitutions

Table 1 Market Characteristics

Market Characteristics				
Market Characteristics	**Current Providers**	**Commissioners / Consumers**	**New Entrants**	**Substitution**
Range of services covering diagnosis, in-patient and community treatment and respite care Medium economies of scale across most services Sub-regional or local geographic markets for most services	GPs and Memory Service in OACMHT, currently provide diagnosis. (But market is underdeveloped) DCHS and MHT provide most in patient and outpatient treatment DCHS and MHT's CMH teams care homes and domiciliary providers provide community based treatment and maintenance	PCT has potentially strong buying position in a fragmented market. However, some challenges in assessing quality of providers.	DCHS, MH Trust, GPs, voluntary organisations all able to enter diagnosis market Private Care Homes able to enter in patient market Community nursing /domiciliary providers able to enter community treatment Limited entry barriers for most services. Main potential challenge is access to clinicians, psychiatric nurses, compliance with regulations etc	Scope for substitution between inpatient, residential and domiciliary care Scope for early diagnosis and proactive outreach to prolong independence / avoid admission

Further detail of the Market Analysis can be found in appendix 4 to this report.

10. Financial Investment

Introduction

In previous sections we have identified how the population is changing and in the market analysis this explained where the current service investment takes place.

This section will look at the future investment requirements to make sure that local people have access to the services they need.

Table 2 on the next page identifies the combined Local Authority / Primary Care Trust investment in older adult mental health services. This will include dementia services but also includes wider services. These figures do not include the wide range of general or 'universal' services that are necessary to supporting local people with specialist needs (such as adult education or benefits advice.

Investment and Scenario Planning

Table 2 Financial Future Planning
Dementia strategy
Scenario and data input

Scenario		data input 2009	2010	2011	2012	2013	2014	2015
Total forecast demand		3,562	3,704	3,852	4,006	4,167	4,333	4,507
Current patients		1,055	1,055	1,055	1,055	1,055	1,055	1,055
Planned patients		**1,055**	**1,425**	**1,825**	**2,257**	**2,722**	**3,222**	**3,759**
Unmet demand		2,507	2,279	2,027	1,749	1,445	1,112	748
Total forecast cost of demand		8,473,969	8,812,928	9,165,445	9,532,063	9,913,345	10,309,879	10,722,274
Current cost		4,495,500	4,495,500	4,495,500	4,495,500	4,495,500	4,495,500	4,495,500
Planned cost		**4,495,500**	**5,376,793**	**5,922,179**	**6,721,119**	**7,581,692**	**8,507,549**	**9,502,538**
Unmet cost		3,978,469	3,436,135	3,243,266	2,810,944	2,331,653	1,802,330	1,219,737
Extra PCT finance needed		**0**	**577,293**	**970,679**	**2,225,619**	**3,086,192**	**4,012,049**	**5,007,038**

Table 2 above shows the current investment (£4,4995,500) and predicted current costs of dementia services (£8,473,969) as indicated by the Dementia Executive UK report financial formulas. This leaves a gap in resource of £3,978,469.

Currently Derby City would appear to be only identifying some 30% of all people with dementia. A current gap of 2,507 people is indicated.

If Derby planned to increase the identification rate of people with dementia by 10% each year, by 2015 the unmet demand would reduce to 748 people. However, the predicted costs would rise to £10, 722,274. This results in an investment shortfall of £5,007,038 over the next 5 years.
These costs could be delivered via savings from related parts of the health economy for example by putting in place the change initiatives as described, would achieve admission avoidance to the acute trust and delay admission to residential and nursing care for individuals by about 2 years. (London Commissioning Document evidence)

This would suggest that if Derby City increased the identification and delivery of services to 10% more people every year by 2015 an extra £5million pound investment would be required.

Further detail regarding the financial analysis can be found in appendix 5 to this report.

11. Stakeholder Views

A stakeholder event involving local people and carers was held on the 4th February 2009 to introduce the National Dementia Strategy and seek local opinion about priorities.

Stakeholders at the time prioritised the development of the following:

- Accessible Memory Assessment Service
- Dementia Advisors
- Clear Pathways and forms of communication
- A good neighbour scheme
- Integration of services
- A focus on community services
- Holistic assessment of need and this information being accessible to all those delivering a service

A series of five workshops took place from October 2009 to February 2010 to further understand local people's needs in detail. These events were held with stakeholders of whom 20 percent were people who used dementia services and their carers. NHS East Midlands supported these events. The workshops identified current services by pathway and the gaps in current provision. The final workshop identified stakeholder priorities.

The five top priorities as determined by the stakeholders are:

- Workforce learning and development of staff
- Integrated dementia team /care coordination
- Respite within the home and in residential care settings
- Memory assessment and support/intervention service
- Joint 5th were: Continence services; out of hours home care; and seamless community networking.

Other areas for development, were identified as:

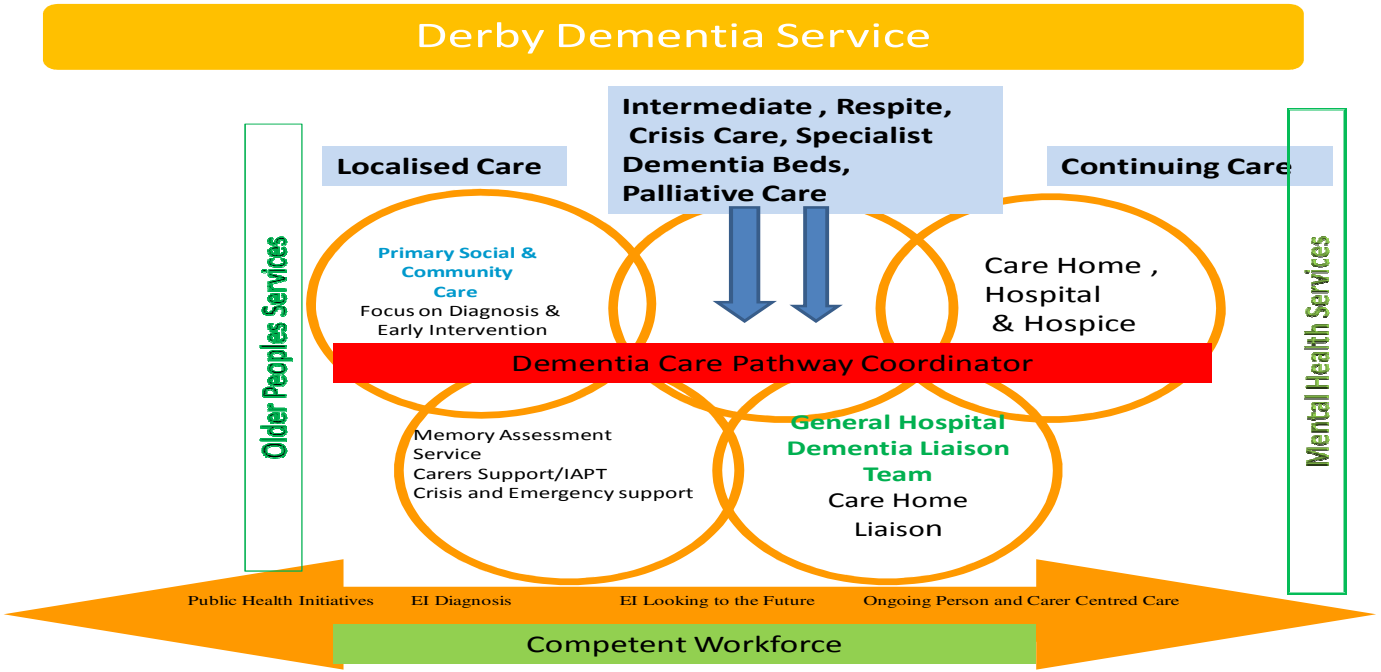
- Enhanced carer support
- Acute Care Liaison
- Home Care/ Home Care Liaison
- Treatment in General Hospitals
- Involvement in quality monitoring
- End of Life Care
- Crisis Response
- Working Age
- Residential care and supported accommodation

Further detail on Stakeholder views can be found in appendix 6 to this report.

12. Emerging Model of Care

Figure 16 below is pictorial representation of a suggested Dementia Model of Care. This figure identifies that a dementia service is bordered by both a universal older adult service and a mental health service. The dementia service will need to be able to access these facilities and staff as necessary.

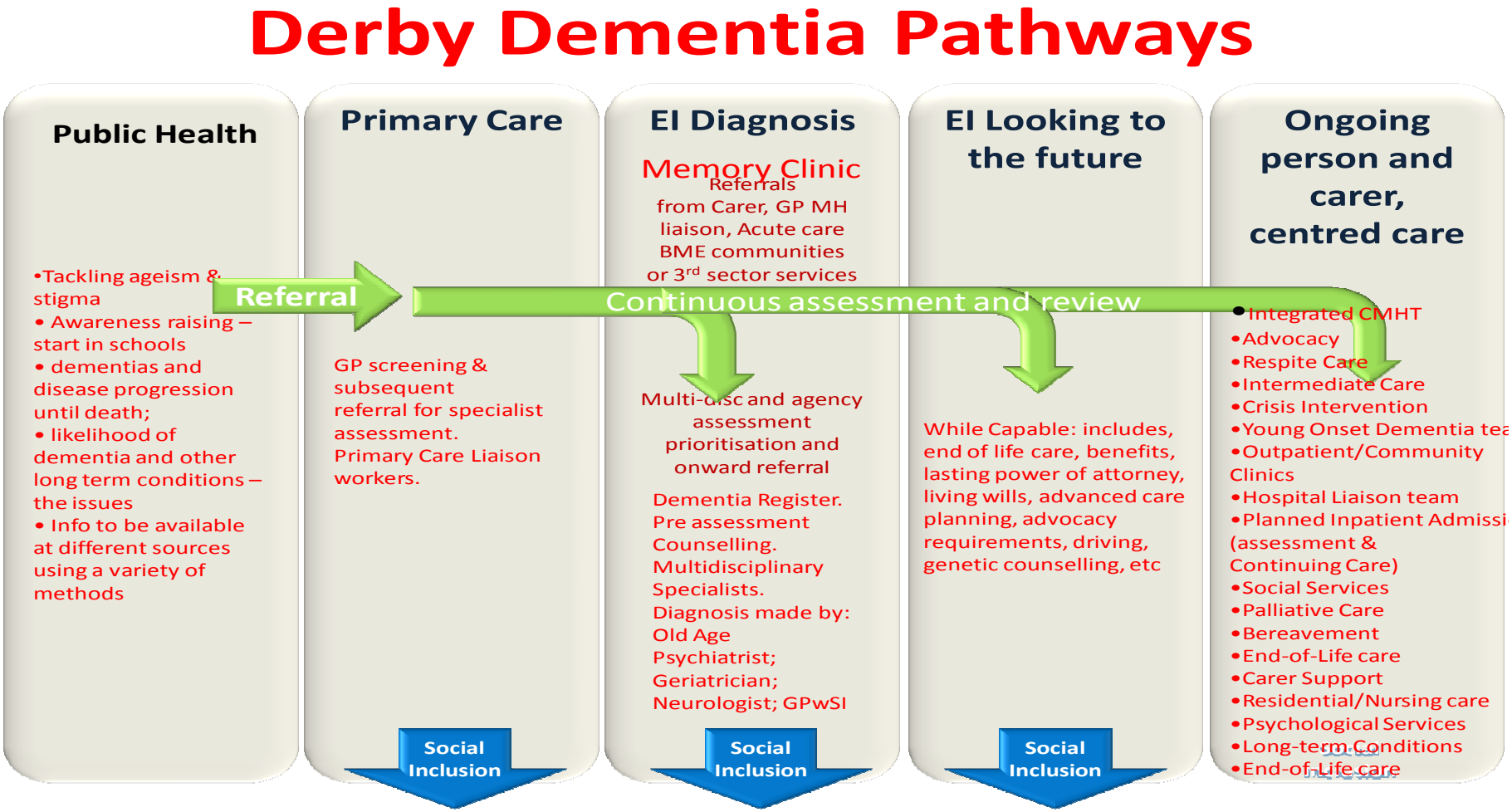
Figure 16 Emerging Model



A stepped care model underpins the whole service. Public Health, Early Intervention Diagnosis, Early Intervention Looking to the Future and Ongoing Person and Carer Centred Care are the elements of the stepped care approach. A competent workforce in turn supports this.

Figure 17 goes on to identify a high level care pathway with the memory assessment service acting as a single point of access The figure identifies the tasks and activities necessary at each part of the pathway

Figure 17 Derby Dementia Pathways



See also appendix 7

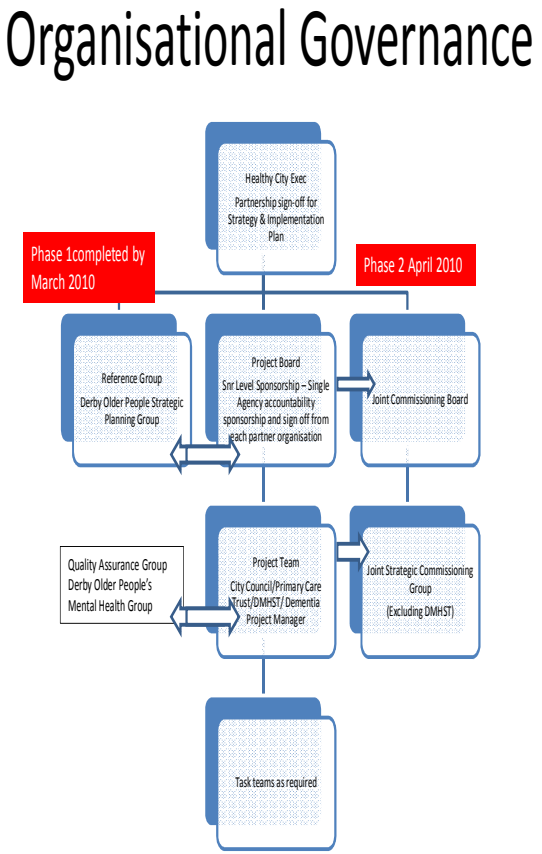
13. Governance and Monitoring Arrangements

To ensure that our local services meet people's needs the local partnership will require the following mechanisms in place.

See Organisational Governance Figure 18 on next page.

Key to the success of this strategy is the ongoing engagement from local people carers and providers. The local community for example have a central role in quality monitoring of dementia services.

Figure 18 Organisational Governance



Please also see appendix 8

14. Implementation Plan

The following implementation plan is based on the priority setting of stakeholders as described earlier, and identifies the local partnerships' next steps in taking forward this emerging strategy.

Derby Dementia Implementation Plan – March 2010

Objective	Outcome measures in NDS	Activities/ outputs agreed	Timescales for delivery	Evaluation criteria (how will outcomes be measured)	Governance arrangements	Named contact
1) Provide public information to improve awareness of dementia locally	Local people will understand the signs and symptoms of dementia, and who to go to access support and further information	Alzheimer's Society (AS) leaflet to go out to all households in Derby via 'Your Derby publication'; additional leaflets to be distributed through cafes; support groups; community events etc	Leaflet to be distributed March/ April 2010 and beyond via AS and partners	Surveys/ feedback at community events such as Liberation Day to indicate level of awareness of dementia and support available	Leaflet overseen by MH OP sub – group	Jenny Appleby
		Derby's peer support pilot to promote awareness within communities via local newsletters; events; local contacts etc	Peer support activities to commence circa May '10 until October '11	Pilot evaluation to determine level of awareness of services and support – aim for 75% of participants to feel better informed as result of project	Overseen by MH OP sub-group	Jacqui Marsh
		Local case studies/ service user/ carer stories/ examples of	To be co-ordinated during March '10	Positive features in press; local services receive appropriate	Overseen by MH OP sub-group	Jenny Appleby

Objective	Outcome measures in NDS	Activities/ outputs agreed	Timescales for delivery	Evaluation criteria (how will outcomes be measured)	Governance arrangements	Named contact
		best practice to be promoted within local press Other outputs/ activities to be agreed by project team/ project manager		queries about support on offer tbc	Overseen by MH OP sub-group	Ciara Scarff/ Karen Ray
2) Develop respite services for people with dementia and their carers within the home; within residential facilities and as holiday-style placements	People with dementia and their carers will have good access to respite that meet their needs and personal preferences. Respite will be bookable in advance and also available on an unplanned basis. Respite will be of good quality and will be delivered by staff with the appropriate skills and training.	Home Based Dementia Service to be up and running by May 2010 Residential home respite capacity to be expanded to 57 beds Dementia resource centres to be available to deliver respite from March '12 Respite within nursing care homes to be commissioned on a block booked basis (6 beds)	May 2010 September 2010 From March '11 September 2010	Number of users of the service/ hours of care delivered Positive feedback from users/ carers/ care managers	Overseen by MH OP sub-group/ Corporate and Adult Services Core Management group	Jenny Appleby/ Phil Holmes
3) Extend Assistive Technology to support	Services that help people to live in their	Development of Dementia specific	June 2010	Number of interventions; evidence of avoidance of	Via joint commissioning	Jackie Straw and Phil Holmes

Objective	Outcome measures in NDS	Activities/ outputs agreed	Timescales for delivery	Evaluation criteria (how will outcomes be measured)	Governance arrangements	Named contact
people living with dementia and their carers	own homes for longer	services Development of joint Council and NHS strategy for Assistive Technology to include dementia investment for 2011-12 onwards	October 2010	hospital and institutional care; user and carer satisfaction	arrangements for Assistive Technology	Jackie Straw and Karen Ray
4) Focus long-term residential and nursing care on meeting dementia needs	Services will work to ensure: - better care for people with dementia in care homes - clear responsibility for dementia in care homes - a clear description of how people will be cared for - visits from specialist mental health teams - better checking of care homes.	Establishment of new service specification and fee rates for Local Authority funded dementia care (residential and nursing) Establishment of new service specification and quality schedule with dementia specific measures for NHS funded nursing care Delivery of remodelled dementia resource centres	October 2010 September 2010 March 2012	Compliance of care homes with new specification against staff training and home design Incorporation of dementia needs and mental capacity within care planning Delivery of resource centres	Via Council's Adults, Health and Housing directorate Care home feedback at Consultative forum Via NHS East Midlands procurement. Care home feedback at Consultative forum Via Council's Adults, Health and Housing directorate	Phil Holmes Steph Austin Phil Holmes
5) Focus day services on meeting dementia needs	There will be a range of flexible services to support people with	Agree joint plan for reviewing and enhancing day	July 2010	Range of day services across localities and dependency levels;	Overseen by MH OP sub group	Phil Tomlinson / Phil Holmes

Objective	Outcome measures in NDS	Activities/ outputs agreed	Timescales for delivery	Evaluation criteria (how will outcomes be measured)	Governance arrangements	Named contact
	dementia living at home and their carers. Services will consider the needs and wishes of people with dementia and their carers.	opportunities Consultation with service users and carers Agree joint implementation of improved day opportunities	September 2010 November 2010	adequacy in meeting BME needs; service user and carer feedback		
6) Improve care coordination for people with dementia and their carers	People with dementia and their carers will be able to see a dementia adviser who will help them throughout their care to find the right: • information • care • support • advice	Agree joint plan for improving care coordination	July 2010	Clear pathway across health and social care services; improved carer and service user feedback	Joint governance arrangements to be confirmed	Terry Prior/ Phil Holmes
7) Informed and Effective workforce	All staff working with people with dementia and their carers will have a good understanding of dementia; they will be confident and capable of supporting people	A sub group of the Derby OPMHG has been initiated to construct a dementia training strategy to be agreed across health and social care in Derby and Derbyshire.	September 2010	To be determined based on numbers trained; numbers of people feeling confident and capable of fulfilling their roles in relation to people with dementia and their carers	Will report into OPMHG Derby and possibly Derbyshire wide strategy group	Ciara Scarff

Objective	Outcome measures in NDS	Activities/ outputs agreed	Timescales for delivery	Evaluation criteria (how will outcomes be measured)	Governance arrangements	Named contact
	with dementia and their carers All education to meet Skills for care and Nice guidance by July 2011 To ensure education and learning is embedded in practice to improve quality of dementia care	Terms of reference to be agreed for all NHS and LA training groups. Levels and scope of training to be agreed		People with dementia and their carers coproduction for education strategy		
		Components of an induction ½ or 1 day course agreed (Need to define if it can be made mandatory for all staff working in dementia care)	June 2010	tbc	As above	As above
		Complete mapping of exists education in dementia training by health and social care and a directory produced	September 2010	tbc	As above	As above
		Develop web page detailing all training and education	June 2011	tbc	As above	As above

Objective	Outcome measures in NDS	Activities/ outputs agreed	Timescales for delivery	Evaluation criteria (how will outcomes be measured)	Governance arrangements	Named contact
		Provide funds for PVI sector to access education in dementia from Derby city from the workforce grant system in Derby	April 2010	tbc	As above	As above
		Influence curriculum development	July 2011	tbc	As above	As above
8) Provide Peer Support and learning networks	New Dementia Cafés, befriending, and Support groups will be set up across Derby City People with dementia and carers will have more confidence; Improved well-being; and better access to information and support	Phased opening of 8 new Dementia Cafés and 2 new Support Groups, plus befriending services for people with dementia, and their carers	June 10 for first 2 cafés August '10 for befriending services and support groups up and running	Project evaluation to determine the level of practical & emotional support and reduced isolation – based on service user/ carer feedback, plus service access data	Overseen by MH OP sub-group	Jacqui Marsh

See also appendix 9