



Dementia Services

- Where are we now?
- What challenges do we face?
- Where do we want to be?
- What needs to change?
- Feedback from Dementia Review



Priorities – Strategic Plan

Older people / long term conditions

- 9% growth to 2015 in people 65+
- 2,250 extra older people with LTC
- 11% extra older people with respiratory problems
 - 14% increase in men 65+ living alone
- 15% increase in obese men 65+
- Small increase in BEM population 65+

Mental health (adults and older people)

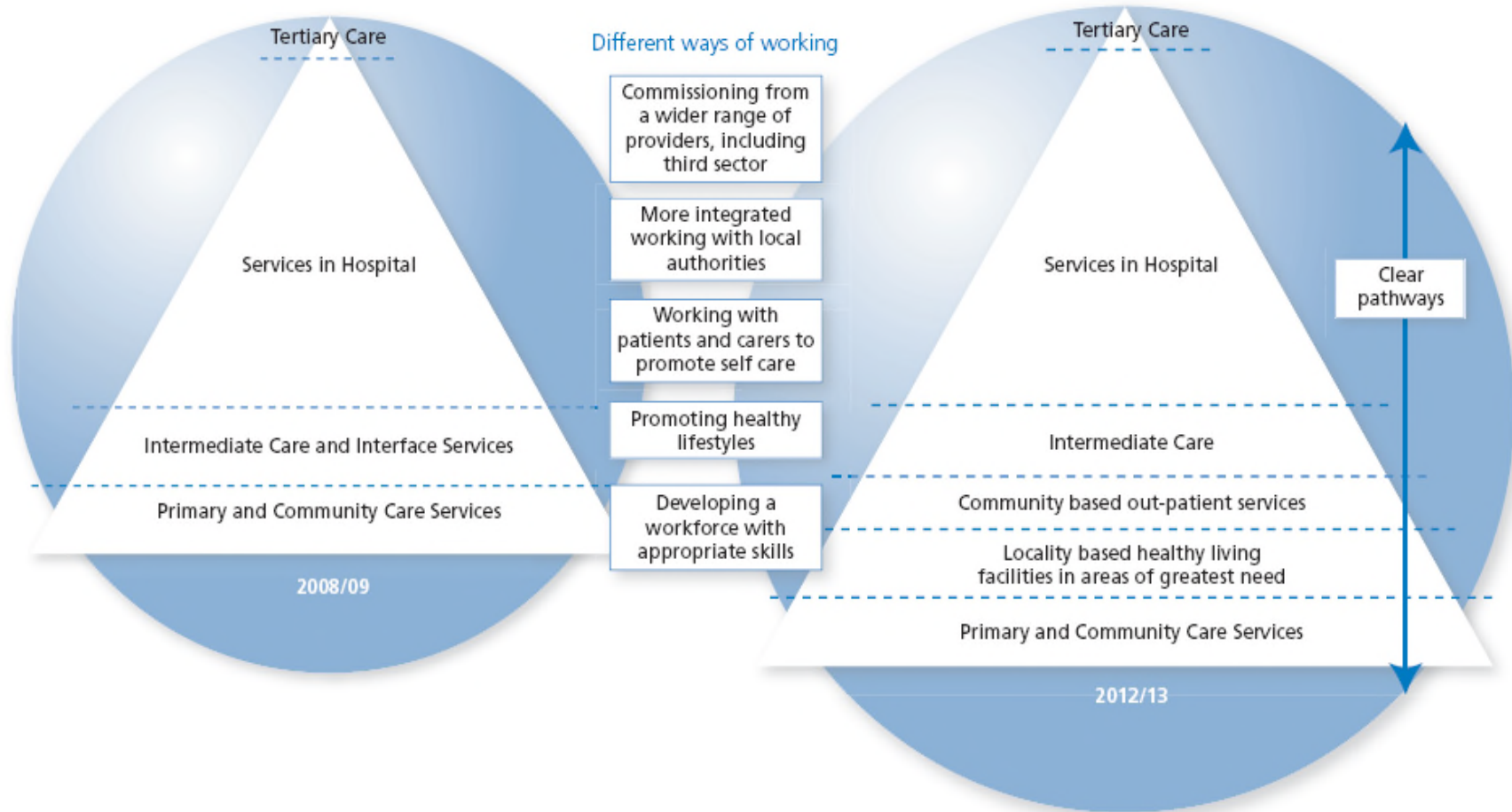
- 30,000 adults with neurotic disorder
- 8,000 people with a personality disorder
- 1,000 people with a psychotic disorder
- 7% increase in people 65+ with dementia
- link between mental health and long-term conditions
- high admission rates to secondary care

Inequalities

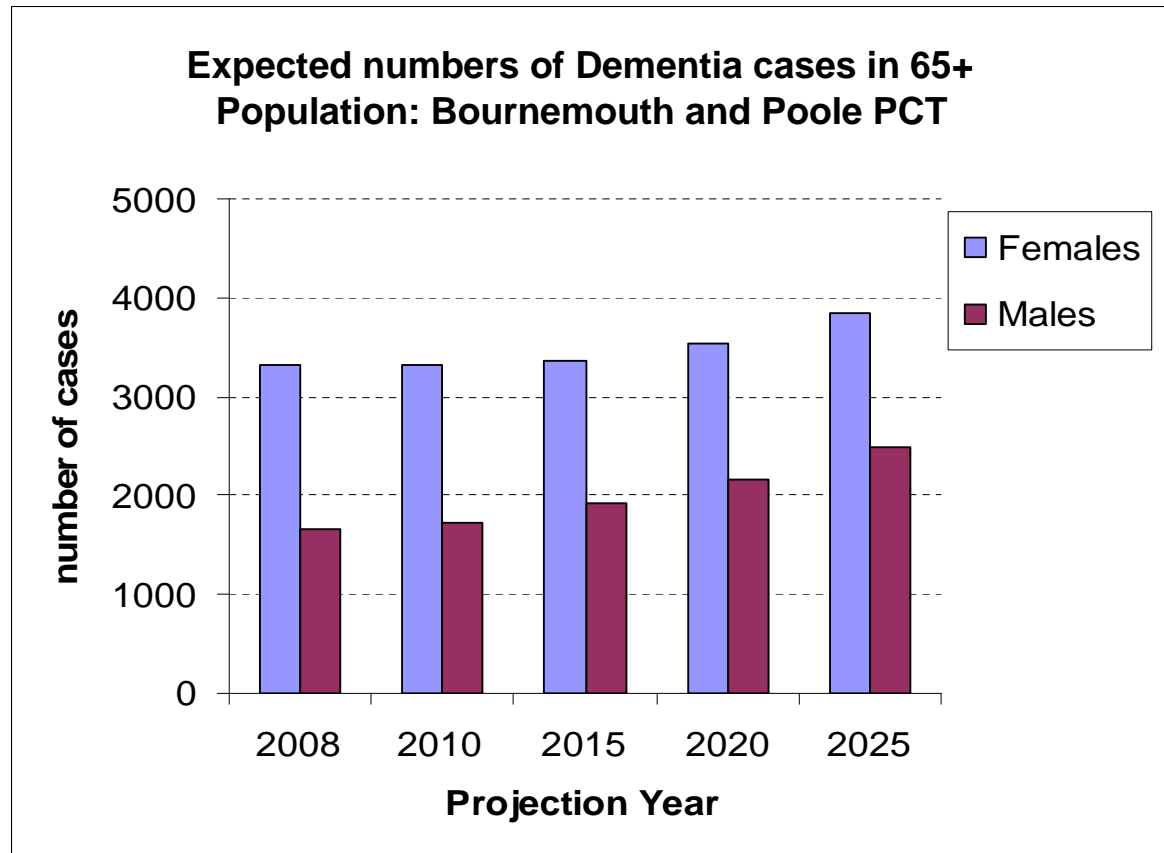
- life expectancy 'gap' of 11 years between wards
- 52% of 55-64s in council housing have LTC but 24% in privately owned
 - poorer use of health services
 - high proportion smoking and unhealthier lives in deprived communities



New Model of Service



Expected numbers of dementia cases among over 65s in Bournemouth and Poole



People with Dementia in Bournemouth and Poole 2010

- Poole;
 - 0.04% of population 18 – 64 years old of 78,900 = **32** people;
 - 8.5% of population over 65 of 29700 = 2332 people;
 - **Total of 2369 people.**
- Bournemouth:
 - 0.04% of population 18 – 64 years old of 100,800 = **40** people;
 - 8.5% of population over 65 of 31800 = 2800 people;
 - **Total of 2840 people.**
- **Combined total 5209**

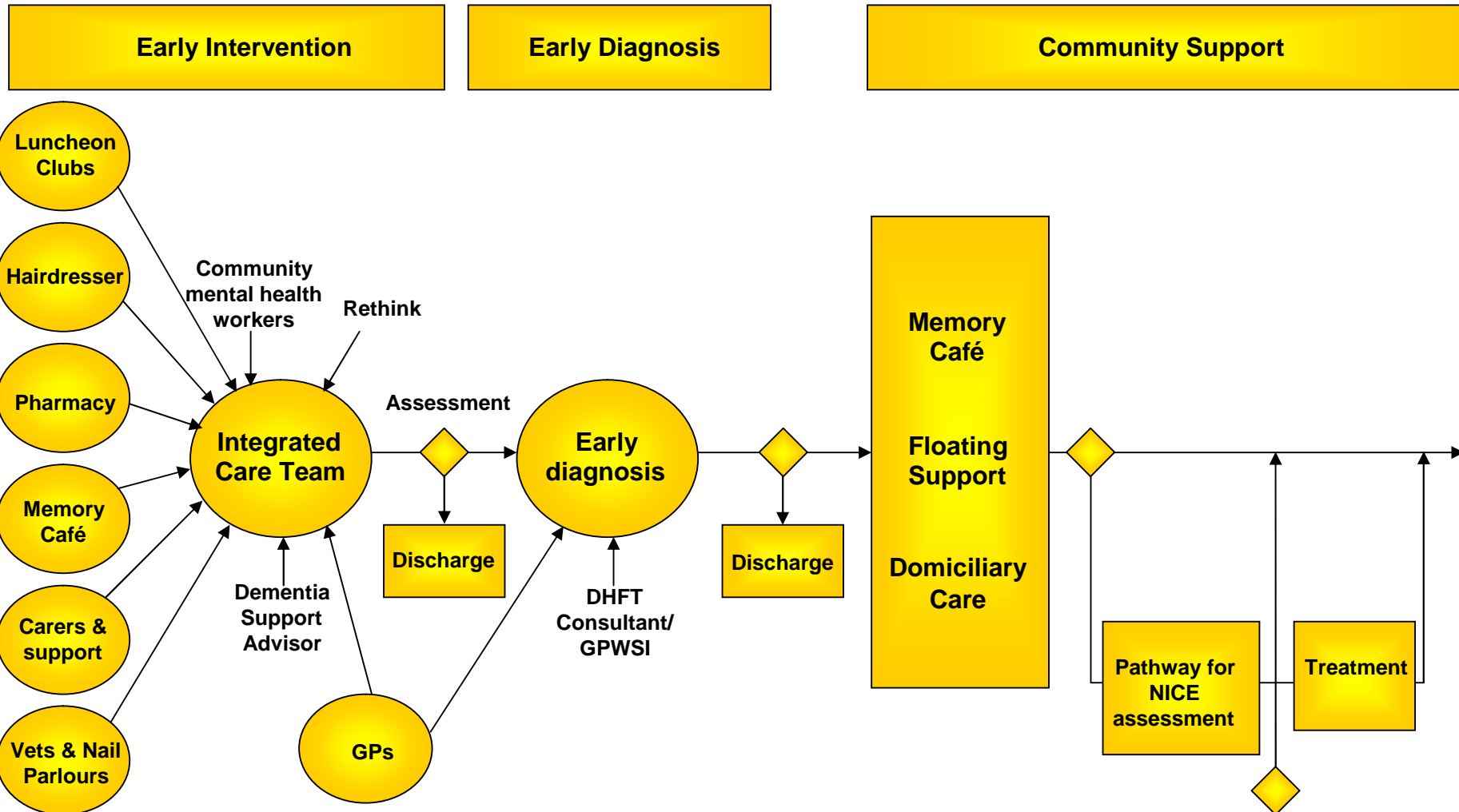


Integrated Care Pilot Overview

- The local health and Social care community have been selected by the DoH as one of only 16 Integrated care Pilots. This is one of the only pilots relating to dementia care.
- The pilot will test a new model of:
 - GP locality integrated dementia services.
 - Integrated Public and Third Sector Services.
 - Virtual integration with the community.
- The ambition is to integrate with existing health and care agencies, but to become established and known within the wider community to improve access for people with memory impairment.



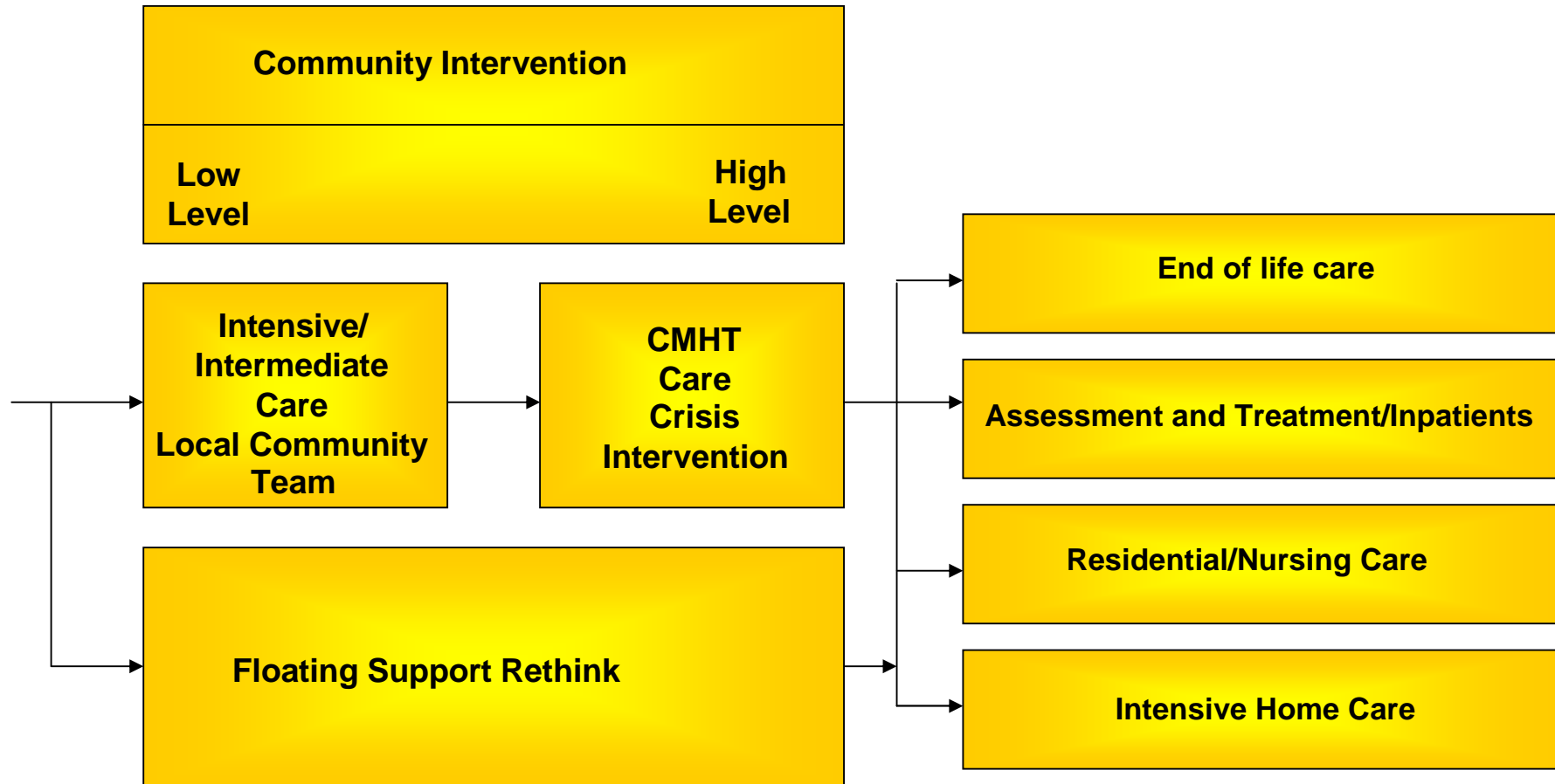
Early Stage Pathway



Pathway

Mid Stage

Late Stage



Projected Cost of Early Diagnosis & Intervention Services and Support to Older People CMHTs

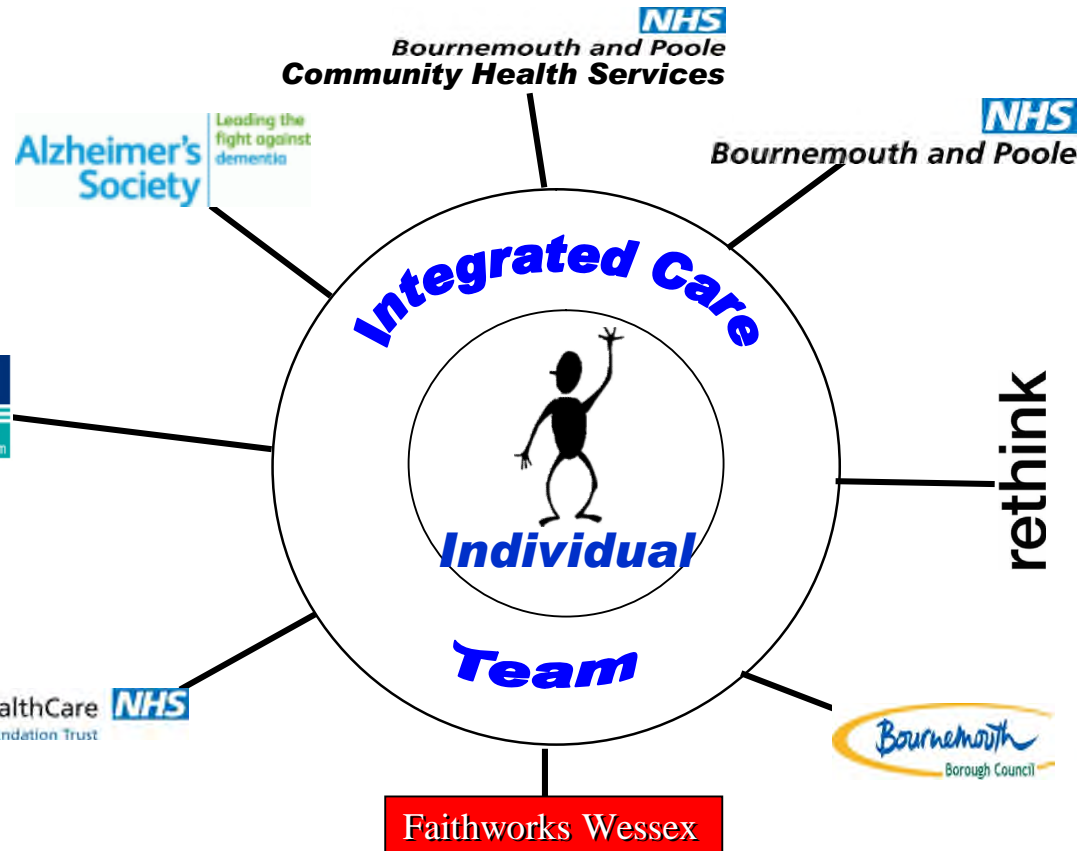
Based on Appendix 4 – “The clinical and economic case for early diagnosis and intervention services in dementia”

Year	2009		2014		2019	
Population	60,600		64,982		67,982	
	WTE	COST - £	WTE	COST - £	WTE	COST - £
Early Intervention and Diagnosis	12.12	649K	13.00	768K	13.59	883K
Older People	9.09	413K	9.75	489K	10.19	562K

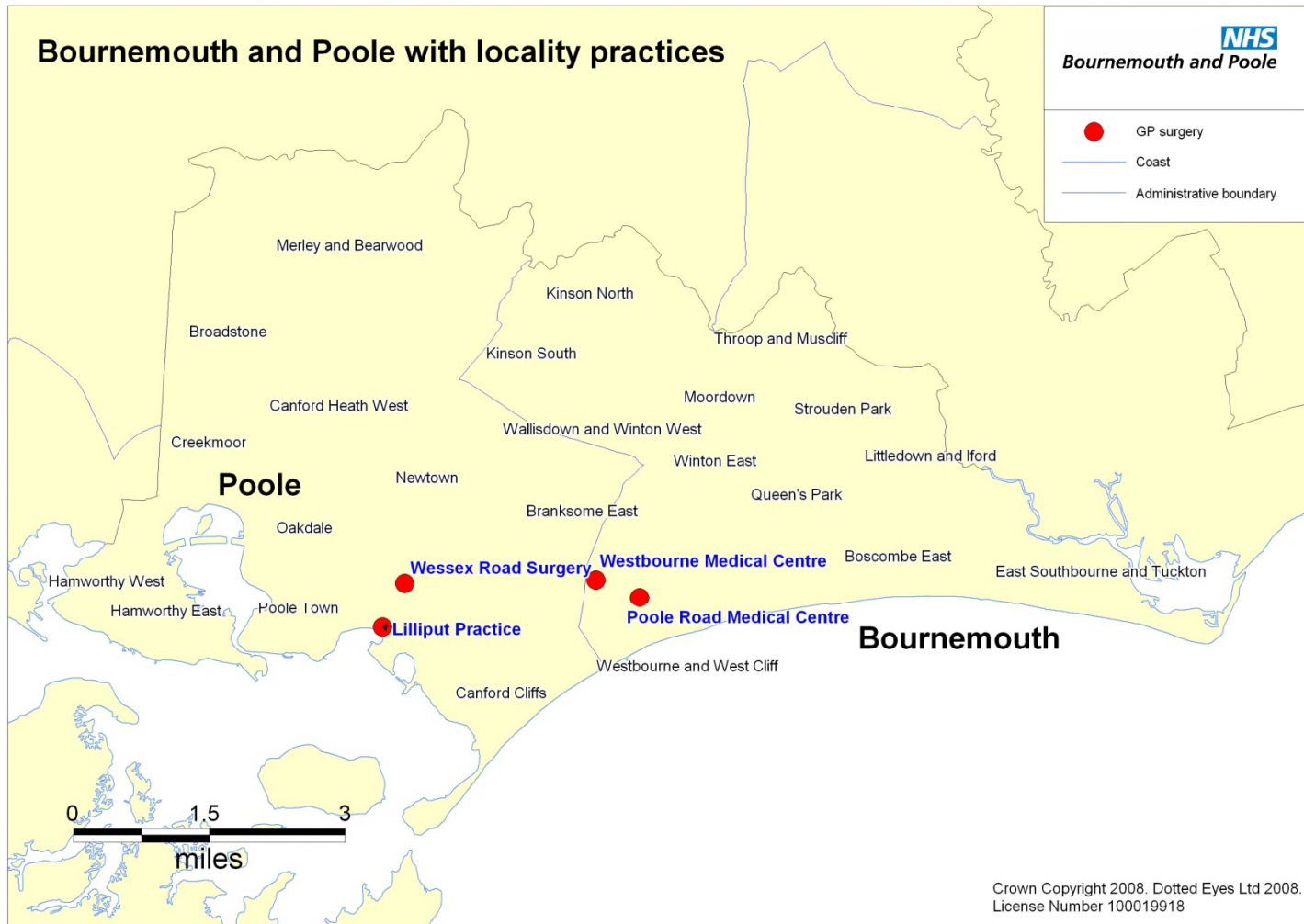
New investment 2009/10 circa £500k



What will be Integrated?



ICP Project Locality Area



Locality GP Practices Involved

Practice	Practice Population	Current Dementia Register (Estimated 40%)	Estimated No. of Patients with Dementia (i.e. 100%)
Lilliput	8547	123	308
Poole Road	7017	126	315
Wessex Road	5855	40	100
Westbourne	14353	223	558
TOTAL	35772	512	1280



Intensive Home Support Team

The objectives of the team are:

- To avoid unnecessary hospital admissions for people with memory loss.
- To provide urgent response, short interventions to support carers in crisis situations and to prevent carer breakdown situations.
- To expedite discharges from hospital for people with memory loss.
- Patients with memory loss, receive person-centred care.



Low Level Support Services

A dementia advisor will support people throughout their illness to:

- Provide advice to keep people active and well.
- To encourage the people to maintain the lifestyle, practices, and choices that they had prior to having the disease to the fullest extent possible.
- To draw up emergency plans in preparation for crisis situations.



Low Level Support Services

- Memory Cafés:
 - Signposting
 - Ongoing support
- Specialist Floating Support Service:
 - Short/long-term support
 - Team Leader integrated
- Community:
 - Church and voluntary ambassadors engaged
 - Informed and equipped
 - Signposting / support
 - Building capacity



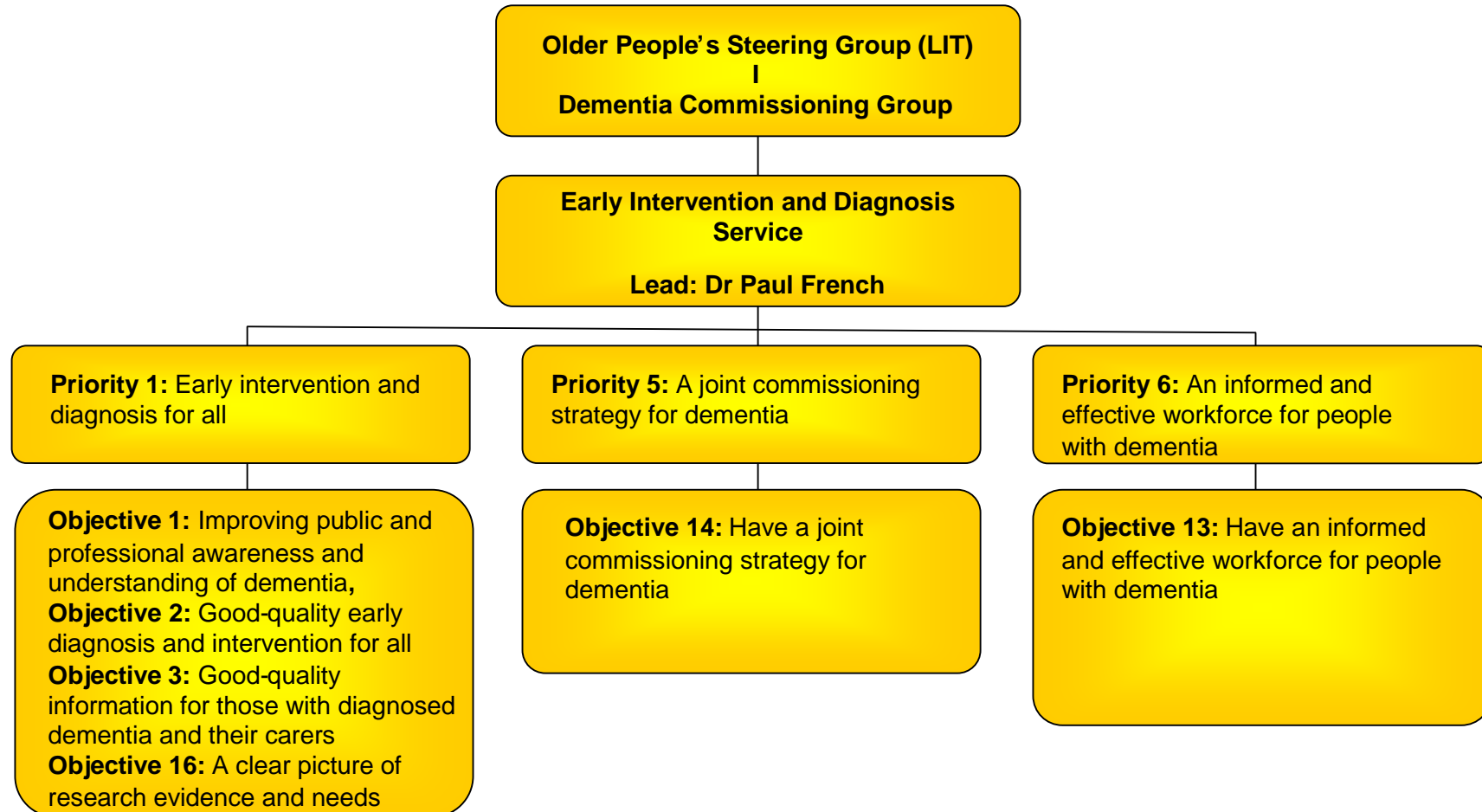
Summary - Work in Progress

- Funding model for full roll out of the Strategy
- Model for Early Diagnosis
- Link to Transforming Community Services
- Local Dementia Strategy – initial Strategy agreed, subject to ongoing work
- Workstreams
 - Early Intervention and Diagnosis
 - Crisis and Home Treatment
 - Community and Home Care
 - Residential Care
 - Care in Acute Hospitals



Local Dementia Strategy – Implementation

Workstream 1



Summary

- We have a good range of dementia services in place
- We recognise the challenge that lies ahead in implementing the strategy
- The Integrated Care Pilot is a good opportunity to test our approach to the new dementia services
- We have a robust structure in place to plan and deliver the changes



Feedback from Dementia Review



Commendations

- The jointly agreed strategy and work with statutory partners
- Relevant and prioritised workstreams within the dementia strategy
- Commitment of the whole system to working together
- Leadership of the programme
- Pulling together both the big picture and the detail
- Commitment to the integrated care pilot
- Selection of the localities and the wider community engagement approach



In particular the team commended:

- Meyrick Day Unit
- The falls service
- The colour and environment service
- Support in the community for learning disability
- Floating support and rethink
- Integration of health and social care teams
- Support in the acute setting for people with dementia
- The quality of care in care homes
- The practice development unit



Areas for Development:

- Wider engagement of users and carers
- Prioritisation between the workstreams
- Capacity and capability of workforce
- Avoiding direct discharge from hospital into care homes for people with dementia
- Develop a joint performance framework
- Improved commissioning of the third sector
- Understand the proportion of continuing healthcare spend on dementia
- Develop baseline metrics



Any Questions?

