



Response by the Association of Directors of Adult Social Services (ADASS) to 2011 inquiry of the All-Party Parliamentary Group on Dementia: How to save money in dementia care and deliver better outcomes for people with dementia?

The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in Local Authorities in England. As well as having statutory responsibilities for the commissioning and provision of social care, ADASS members often also share a number of responsibilities for housing, leisure, library, culture, arts, community services, and increasingly, Children Social Care within their Councils.

ADASS members are jointly responsible through the activities of their departments for the well-being, protection and care of their local communities and for the promotion of that well-being and protection through the use of direct services and the co-ordination of, and liaison with the NHS, voluntary agencies, private companies and other public authorities, as well as close working with the relatively newly transferred posts of Directors of Public Health, now set within Local Authorities.

ADASS members have leadership responsibilities in Local Authorities to promote local access to services and to drive partnership working to deliver better outcomes for local populations. They participate in the planning of the full range of council services and influence Health Service planning through formal and informal partnership arrangements.

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Question 1: What do you think are the best opportunities to save money but ensure quality of life for people with dementia in:

Hospitals :

- Avoiding admissions where possible both to general acute and to mental health inpatient wards, through for example work with care homes and ambulance services, or through using community based crisis services
- Shortening lengths of stay through better discharge processes.
- Access to effective services immediately after discharge such as re-ablement and assistive technology.
- Training for hospital staff on caring for people with dementia
- Better co-ordination of person centred plans while the person is in hospital
- More engagement of carers as members of the team managing the patient's condition
- Liaison from mental health services to advise hospital staff

Their own homes:

- Assistive technology
- Support that is flexible and provided by staff who understand the impact dementia can have on the person and those around them, including positive risk assessment.
- Early diagnosis so that there is more time for person centred plans to be put in place
- Carers supported fully to maintain their caring role, through timely and full access to information and through breaks in their caring role.
- Provision of consistent information and advice at the time it is needed, through simple points of contact
- Peer support for people with dementia and carers
- Access to specialist supported housing where appropriate
- Management of medications
- Access to specialist community mental health services on a 24/7 basis

Care homes:

- Using assistive technology that can maintain independence and retain existing skills
- Training for care home staff in best practice and understanding dementia and its impact on the individual.
- Having person centred plans in place
- Enabling carers and others to continue to play an active role in the support of the person
- Support from specialist mental health services and from general nursing services
- Physical design of care homes which maximise the retention of independence
- Minimising the number of moves, for example through dual registration and avoiding hospital episodes

Question 1b: What do you see as the barriers to doing these things?

- Inconsistent and fragmented advice and information for service users and carers.
- Fragmented services working in silos.
- Not having a shared approach to risk between the various professionals, carers and the individual.
- Inappropriate assumptions about what people with dementia can't do, rather than basing planning and service delivery on what they can still do
- Inadequate training.
- Lack of access to early diagnosis.
- Lack of clarity about what prevention and early intervention services are most effective.
- An over prescriptive and task based approach to care plans for people at home, rather than plans which allow for flexibility and encouraging the person to retain as much control as possible.
- Inconsistent carer support, and not treating carers as partners in the support of people with dementia.
- Lack of support to care homes in their role.
- Services for people with dementia not being mainstreamed within wider initiatives for health and social care, for example personalisation, long term conditions, access to appropriate accommodation, using telecare, improving hospital care.

Question 2: Are there any examples of services you have commissioned, provide or are aware of which in your view provide good care and support for people with dementia in a way that makes best use of resources?

ADASS have recently developed an overall framework for using resources well. This is based on six propositions aiming at providing value for service users and tax payers, as follows:

- *Prevention* “I am not forced into using health and social care earlier than I need to. I am enabled to live an active life as a citizen for as long as possible and I am supported to manage any risks.”
- *Recovery* “When I initially need health or social care, I am enabled to achieve as full a recovery as possible, and any crises are managed in a way which maximises my chances of staying at home.”
- *Continued support* “If I still need continued support, I am able to choose how this is done. I can choose from a range of services which offer value for money. The resources made available to me are kept under review.”
- *Process* “The processes to deliver these three outcomes are designed to minimise waste, which is anything that does not add value to what I need.”
- *Partnership* “The organisations that support me work together to achieve these outcomes. These organisations include health and social care, other functions in statutory bodies, and the independent sector”.
- *Contribution* “I and others who support me are expected and enabled to make a fair contribution to this support. These contributions may be financial according to my means, informal care and support from those close to me or from volunteers, or from me playing my own part in achieving these outcomes.”

A first version of this framework is on the ADASS website and is currently being populated with examples so that evidence can be spread as easily as possible. [ADASS report "how to make the best use of reducing resources"](#)

This submission brings examples together under the first three areas.

Two examples of a whole systems approach:

- The Department of Health’s team focussing on efficiency in social care (CSED) worked with all agencies in the Wirral to map the current pathway between agencies and to plan a better and more simple shared pathway. Early evaluation showed a decrease in the use of residential placements of 100, a saving of £150k on anti-psychotic drugs, and investment in assistive technology which produced recurring savings in excess of investment within 3 years.
- The Sussex Dementia Partnership involving 11 statutory health and social care agencies, the Alzheimer’s Society and SHA, led by the Sussex Partnership Trust, which is already leading to improved community services and reduced use of inpatient beds.

Prevention

- *Early diagnosis*
 - A memory assessment and support service (MASS) piloted by North Essex Partnership Foundation Trust with the Alzheimer's Society. Early evaluation showed quicker access to services.
 - A partnership approach in the Durham Dales to early diagnosis, led by primary care, with improvements already achieved in dementia care in hospitals and in community services in a rural area.

- *Information and advice*
 - Many local authority social care departments are commissioning new generic information and advice services under the overall Putting People First policy. These services have web based ways of enabling users and carers to start with their own questions and needs and find their way to solutions, but are backed up by access to advice from the voluntary or statutory sectors. Advantages include faster access to relevant information and reduce unnecessary use of staff to fulfil a pure "signposting" role.
 - Barnsley have established a care navigation system based on groups of GP practices, with early evaluation showing a reduction in contact with GPs of 50% by 50% of people, a reduction in crisis care whilst awaiting initial assessment for diagnosis, and a 20% reduction in admissions to the dementia assessment ward from 2 GP practices.

- *Peer support*
 - There are a number of dementia cafes which have now come into existence, for example in Essex, which provide a cost effective way of enabling people with dementia and carers to find mutual support.

- *Access to activities to prolong control and independence*
 - Essex council are looking to support a local organisation to offer a range of "adventures" for people with dementia, for example holidays in the UK or abroad and exploring green spaces through walking or sailing.
 - In Lancashire, Age Concern offers a flexible outreach service for people in the earlier stages of dementia which enables them to pursue new or existing interests, for example running and cycling, gardening, using technology such as SMS, and chess.

- *Raising awareness*
 - In Stockport, the EDUCATE project is enabling volunteers in the early stage of dementia to help raise awareness and educate others.

Recovery

- *Support in acute hospitals*
 - Acute hospitals in Leicestershire have audited 3 sites and put in place a programme to change staff attitudes, provide clearer guidance, and improve the environment.
 - In Darlington there is a collaborative project between mental health and acute NHS Trusts, PCT and council to change how acute care works for people with dementia. Early wins include completion of mini mental state assessments within 12 hours of admission, ward staff having access to GP dementia registers, reducing the wait for patient access to all professionals involved in treatment from 7 days to 24 hours.

- *Intermediate care*
 - Partners in the West Midlands have developed a shared specialist intermediate care service, including the use of assistive technology. An early evaluation showed savings of over £180k against an £80k investment for 37 individuals, and 57% of people at risk of being in long term nursing and residential care still being at home after a year.
 - In Harrow, the council and PCT worked together to commission intermediate care from a local nursing home, with specialist nursing input from the mental health Trust. 58% of people admitted to this service returned to their own home, with an overall 40% improvement in functional ability.

- *Other hospital discharge services*
 - In Waveney Suffolk, the county council and local NHS commissioned a flexible domiciliary support service for people with dementia at times of crisis or strain. In 18 months it worked with 110 people and avoided 46 hospital admissions and 16 residential care placements, and avoided 25 breakdowns in family care arrangements.

Long term support

- *Assistive technology*
 - In Haringey, assistive technology has been used to enable those living alone with dementia to manage their own medication, enabling this to happen for people who previously would have been thought unable to do this safely.

- *Support at home*
 - In Merton and Sutton, the South West London Mental Health Trust has worked with councils to establish the Intensive Home Treatment Team, providing a 24/7 service for people and carers living at home. Along with the Challenging Behaviour Service to nursing homes (see below) this has led to a 70% reduction in mental health bed usage.
 - In West Kent the PCT and council have worked with providers to establish a dementia crisis support service. Early evaluation showed that out of 34 people supported by the service, 10 admissions to acute hospital and 15 admissions to care home emergency beds were avoided.

- *Care homes*

- In Merton and Sutton, the mental health Trust has a challenging behaviour support service to care homes, which works alongside the intensive home treatment team to contribute to the reduction in the use of hospital beds.
 - In Gloucestershire, there has been investment in LINK workers in care homes, whereby one member of staff develops special skill and expertise and in turn lead on best practice for other staff. Outcomes include less reliance on in-reach support, reduced use of medication and reduced hospital admissions.
 - In Cornwall, there has been a county wide multi agency toolkit aimed at reducing inappropriate use of medication; where it has been rolled out there are many examples of reduced or discontinued medication.
 - In Kirkless, there has been a multi agency approach to reducing the use of anti psychotic medication in care homes; this led within 6 months to a reduction of over 60% in the number of people being prescribed this medication, and a reduction in costs from around £4.4k per month to around £1.8k.
- *Housing*
 - In south Manchester, a 10 bed specialist housing scheme for people with dementia was commissioned. Of their tenants, 53% were able to live in the unit till the end of their lives and 47% eventually had to move to nursing homes. Over 12 months 11 tenants attended A&E five times altogether (significantly less than would be expected for a group with this level of dependency).

Question 2a: Why did you decide to commission or provide this service? In particular, what evidence was it based on, or did you see something similar being done elsewhere?

As this is a summary submission for several examples, ADASS will not answer this question overall

Question 2b: Have you evaluated the service? Yes/ No. If so, please provide detail on what measures you used to evaluate the effectiveness of what you commission?

As this is a summary submission for several examples, ADASS will not answer this question overall

Question 3: Is there a joined-up approach to commissioning dementia care in your area, for example between the NHS and local authorities and other key stakeholders? Do you think there are cost savings available and/ or opportunities to improve quality of care through a joined up approach?

As this is a summary submission for several examples, ADASS will not answer this question overall

IMPORTANT

*a) The APPG on Dementia may want to hear oral evidence from some individuals. If you may also be available to give oral evidence at a session in London on 15 March 2011, please tick this box **yes***

b) In producing a report of its findings, the APPG on Dementia may want to publish some of the evidence it receives.

*Please tick this box if you are happy for your submission to be published and attributed to you **yes***

Please tick this box if you would like for your submission to be published anonymously without your name and organisation