GLOUCESTERSHIRE LMC DOCUMENT SUMMARY

Document Title: **Improving Services and Support for people with Dementia**	
Document Source: National Audit Office	Document Date: 4 July 2007
Remarks:	Date of Summary: 7 September 2007
Full Doc: http://www.nao.org.uk/publications/nao_reports/06-07/0607604.pdf Exec Summary: http://www.nao.org.uk/publications/nao_reports/06-07/0607604es.pdf	
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Bottom Line: Dementias of all sorts will rise as our population ages. More GPs will be encouraged to specialise in this area. The dottiness of old people may actually be disease-related, and with early treatment life can be made easier for them, their carers, and society at large.	

QOF already requires GPs to record and review cases of dementia. The Audit Office finding is that early recognition and treatment of dementia leads to good results and overall savings for the national economy.

'Dementia' covers a broad range of progressive, terminal organic brain diseases listed very succinctly with their progression and symptoms in the Executive Summary, first page.

Types: Alzheimer's disease (62%), Vascular dementia (30%), dementia with Lewy Bodies (4%), and fronto-temporal dementia encompassing Pick's disease (2%).

Symptoms.

- Early Stage: loss of short-term memory; confusion; lack of judgement; anxiety, agitation or distress over perceived changes and inability to manage everyday tasks.
- Middle Stage: May need reminding to do basic bodily functions; may fail to recognise people, distress, aggression and anger, perhaps from frustration; wandering off, leaving taps running and forgetting to light the gas; inappropriate behaviour; hallucinations.
- Late Stage: unable to recognise familiar objects, surroundings or people; increasingly frail leading to wheelchair or bed; finds eating and sometimes swallowing hard; incontinence; gradual loss of speech.

Key Facts.

- About 560K people have dementia in England. It accounts for 3% of all deaths, but over 4 times as many die with dementia but from other causes. Most patients have at least one co-morbidity.
- Dementia can take up to 12 years from diagnosis to death, but may be diagnosed well after it starts so it could be present for up to 20 years.

- Main risk factor is age (12.2% of people aged 82 have it) but cardiovascular factors are important and people with some learning difficulties (e.g. Downs Syndrome) may be affected earlier.
- As the population ages so there will be an increase in dementia. Currently there are no proven treatments to prevent or cure it, though symptoms can be delayed sometimes with cholinesterase inhibitors.
- The annual economic burden (at £14.3 billion a year) is more than that from stroke, heart disease and cancer combined. (Over 200K dementia patients live in care homes making up 60% of all residents.) NHS and local authorities only bear £1.17 billion and £2.13 billion of that respectively. The rest falls on families.

Recommendations of the Report.

- Primary Care Trusts, working with GPs, should benchmark their performance in diagnosing dementia against expected prevalence and set local targets for improvement, to which end they should encourage more GPs to adopt dementia as a special interest.
- Primary Care Trusts, on behalf of their health and social care communities, should use the GP registers of dementia patients to feed into their local strategic needs assessments, in planning and commissioning their diagnostic, intervention and support services for people with dementia and carers.
- The Royal College of Psychiatrists and the Royal College of GPs should take the lead (working with the British Geriatrics Society and the Association of Directors of Social Services) in developing a multi-professional protocol for diagnosis and early intervention in suspected dementia. The evidence from our work suggests this should include:
    - guidance on the skills needed to make formal diagnosis;
    - a template on the type of information to give to people with dementia and their unpaid carers, including what to expect as the disease progresses and the financial and professional support available;
    - details of the standards to apply in correspondence on referral, diagnosis and treatment, including guidance on copying this correspondence to family members/carers;
    - and the criteria for moving patients from specialist services, such as CMHTs, back to the care of the GPs.
- Where local areas do not have a Memory Service they should commission one, in line with the evidence that these services can help reduce stigma. This may be done as part of a CMHT, or through a GP with special interest, or separately, for example by geriatricians or neurologists. The Memory Service should also be explicitly responsible for raising awareness among referring clinicians of young-onset (under 65 years) dementia to improve detection in this group.
- Memory Services and others providing diagnosis for people with dementia should ensure that all appointments where diagnosis is given, provide advice and information (as per the list of items recommended by the NICE/SCIE

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guideline) and offer an opportunity to access counselling by suitably qualified and experienced staff.

- On admission of patients aged 65 or over, where there is evidence of cognitive impairment, Acute Hospital Trusts should initially provide a medical response to identify and treat any medical problems. This should then be followed up by a mental health assessment and, where indicated, testing and diagnosis of dementia. Reduced costs resulting from better management and reductions in length of stay should help Primary Care Trusts to fund the commissioning of assessment and associated community support needed from local specialist services e.g. specialist old age psychiatric liaison services, intermediate mental health care teams and CMHTs.