



House of Commons
Committee of Public Accounts

Improving Dementia Services in England— an Interim Report

Nineteenth Report of Session
2009–10

*Report, together with formal minutes, oral and
written evidence*

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The Committee of Public Accounts

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Committee staff

The current staff of the Committee is Sian Woodward (Clerk), Lori Verwaerde (Senior Committee Assistant), Pam Morris and Jane Lauder (Committee Assistants) and Alex Paterson (Media Officer).

Contacts

All correspondence should be addressed to the Clerk, Committee of Public Accounts, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 5708; the Committee’s email address is pubaccom@parliament.uk.

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Summary

Dementia, covers a range of progressive, terminal brain conditions which affect an estimated 600,000 people in England and this number is rising rapidly. People with dementia require a complex mix of health and social care with patients regularly moving across organisational boundaries. The effectiveness of care depends on co-ordination and co-operation between the NHS; social services; care homes; and the voluntary sector. Stigma and negative attitudes towards mental illness and old age further exacerbate the problem. Dementia costs £8.2 billion a year in direct health and social care costs but much of this spend is in response to crisis, in the later stages of the disease.

We first took evidence on this important subject in October 2007¹ and raised serious concerns about the status of, and approach to, this Cinderella service. The Department of Health (The Department) assured us that dementia would become a national priority and that it would be developing a National Dementia Strategy.

In February 2009 the Department launched an ambitious and comprehensive five-year National Dementia Strategy aimed at helping people to live well with dementia. The Department estimated that the Strategy would cost £1.9 billion to implement over 10 years, and that this would be funded largely through efficiency savings. National and regional leadership was put in place and initial seed funding of £150 million was allocated to Primary Care Trusts (PCTs) to assist implementation over the first two years.

However, in practice, the Department has failed to match its commitments to raise the quality and priority of dementia care with a robust approach to implementation. It has failed to ignite passion, pace and drive or to align leadership, funding, incentives and information to help deliver the Strategy. It also delayed the appointment of a national clinical director, a role that has proved very effective in developing and implementing other national strategies, until January 2010. Furthermore, improvements that we identified in 2007 as urgently needed, some of which could have been adopted straight away, have not been afforded the urgency and priority that we had been led to expect. Whilst the Department now states that improving dementia services is the greatest health and social care challenge it faces, we feel badly let down by the Department's lack of urgency. Despite stating at least 10 times at our earlier hearing that Dementia would be a national priority—it still isn't.

On the basis of an interim progress report by the Comptroller and Auditor General,² we examined the Department on: understanding and responding to the scale and urgency of dementia; driving and monitoring change in services for people with dementia; and delivering the Strategy at local level. We took evidence from witnesses from the Department of Health.

1 Committee of Public Accounts, Sixth Report of Session 2007–08, *Improving Services and Support for People with Dementia*, HC 228

2 C&AG's Report, Session 2009–10, *Improving Dementia Services in England*, HC (2009–10) 82

Conclusions and recommendations

- 1. Although the Department said dementia would be a national priority, it has not afforded it the same status as other national priorities such as cancer and stroke.** The Department should give dementia the same priority status as cancer and stroke in its key communications with the NHS including, if relevant, the next NHS operating framework. The Department should also work with Strategic Health Authorities to explore the feasibility of pooling health and social care resources in order to develop local dementia budgets; and require Strategic Health Authorities to agree with each Primary Care Trust a local dementia implementation plan, comprising costed actions and a timetable, by July 2010. The Department should establish a process for monitoring annual progress, similar to that for End of Life Care, and provide a progress report on the first two years to the Committee by October 2011.
- 2. Dementia is like cancer in the 1950s, still very much a hidden disease.** There is a need for a massive campaign to promote openness and debate on this important and challenging issue.
- 3. The Department does not know how the first £60 million of dementia funding has been spent by Primary Care Trusts.** The Department has only recently commissioned an audit of costs of dementia services which is expected to be completed in summer 2010. The Department should provide us with a copy of its audit of costs and details of how the first £60 million of funding has been spent. It should also include in the October 2011 progress report to the Committee the results of reporting from Primary Care Trusts to Strategic Health Authorities on how they spend the further £90 million of dementia funding provided for 2010–11.
- 4. The implementation of the Strategy is dependent on achieving £1.9 billion of efficiency savings by increasing care in the community and reducing reliance on care provided in care homes and acute hospitals.** The Department should write to all NHS Chief Executives setting out the good practice examples of the various ways in which it expects cost savings and improvements in care to be achieved. This should include an immediate requirement for acute hospitals to have an older people's mental health liaison team in place to ensure that unnecessary admissions are avoided and that discharge to appropriate care is as swift as possible.
- 5. Early diagnosis of dementia is crucial in providing timely and appropriate care and in preventing more costly hospital or residential care.** The Department should work with Primary Care Trusts to ensure they urgently commission good quality and effective memory services. Improvements in diagnosis and care would be further improved by including the study of dementia in undergraduate training and accredited continuing professional development for GPs and health care staff in hospitals.
- 6. There is unacceptable regional variation in access to diagnostic services for dementia and in access to dementia drugs.** The Department should build on the work of the new dementia metrics and the quality standards being developed by the

National Institute of Health and Clinical Excellence to develop a set of health and social care minimum standards for dementia which Primary Care Trusts should incorporate in their implementation plans. Strategic Health Authorities should measure progress against these standards.

7. **Local leadership is still lacking in NHS hospitals, in primary care and in the social care and care home sectors.** The Department should ensure every acute hospital has identified a senior clinical leader by 31 March 2010 and work with the new Care Homes Champion to develop dementia 'Champions' across the care home sector. The Department should also identify a similar Champion or Ambassador in the domiciliary care sector to improve providers engagement in the Strategy and improve the quality of care provided.
8. **Most people with dementia receive their day-to-day care from domiciliary carers or care home staff, who have little understanding of dementia, which therefore puts at risk the quality of care and safety of some of the most vulnerable people in society. After six years of debate and discussion, plans to introduce registration of social care staff, many of whom are without qualifications, appears to have been abandoned. As a result these staff will remain unregulated for some time to come.** As the Department has now estimated what proportion of the social care workforce is without any qualification it should require PCTs and local authorities to use their commissioning powers to drive improvements in training and qualification rates by only letting/renewing contracts with providers who have a robust approach to training, or who employ suitably trained staff.
9. **There is inappropriate and excessive prescribing of anti-psychotic drugs for people with dementia, particularly those living in care homes, which has contributed to up to 1,800 additional deaths each year.** The Department should establish as a clinical governance priority the requirement that every Primary Care Trust should set as a local performance target, the need to reduce such prescribing by two-thirds within two years.

1 Understanding and responding to the scale and urgency of dementia

1. ‘Dementia’ describes a range of progressive, terminal brain diseases, affecting an estimated 600,000 people in England. Age is the main risk factor and people with dementia need a complex mix of health and social care services. People with dementia require a complex mix of health and social care which transcends all organisational boundaries. The number of people with dementia in England is expected to double within 30 years and estimated total costs are expected to increase from £15.9 billion in 2009 to £34.8 billion by 2026.³ Most adults know someone who has dementia but the full scale and extent of the problem is poorly understood.

2. In our 2007 report we identified there were parallels between attitudes towards dementia now and cancer in the 1950s, when there were few treatments and patients were commonly not told the diagnosis for fear of distress. There are also stigmas associated with mental health and older people’s issues, which present barriers to improving awareness, understanding and openness about dementia. To date little has changed and indeed dementia is one of the very few illnesses that people rate as worse than death. Dementia is perceived as a worse illness to have than cancer, and it is the fact that people do not talk about it because of this stigma that has impeded change.⁴

3. The total estimated direct cost of dementia in 2009 was £10.1 billion (**Figure 1**), £1.93 billion of which was borne by private individuals paying for care homes, with the remaining £8.2 billion a direct cost to the NHS and social care budgets. The bulk of the direct cost related to provision of care in care homes.⁵ Over the next two years, the NHS will receive ‘flat real’ funding, that is the same level of funding received the previous year plus some extra for inflation.⁶ However demand, pay and expectations continue to rise and with recent legal rulings on eligibility for Continuing Care funding in favour of the claimants, there will be huge cost pressure on the NHS.⁷ Indeed the Department estimate that the overall cost of implementing the new National Framework for Continuing Healthcare and NHS funded Nursing Care in England in 2007 was £219 million. Significant costs pressures have also been seen with regard to local authority funding.⁸

4. The NAO’s initial report, *Improving Dementia Services in England* (July 2007), found that dementia presented a significant and urgent challenge to health and social care in terms of numbers affected and cost, but little priority had ever been attached to it. Stigma attached to older people and mental health, combined with poor quality data and lack of effective joint working across health and social care meant that services were not delivering

3 C&AG’s Report, para 1

4 Qq 104 and 124; House of Commons, Sixth Report of Session 2007–08, *Improving Services and Support for People with dementia*, HC 228

5 C&AG’s Report, para 1.4 and Figure 4

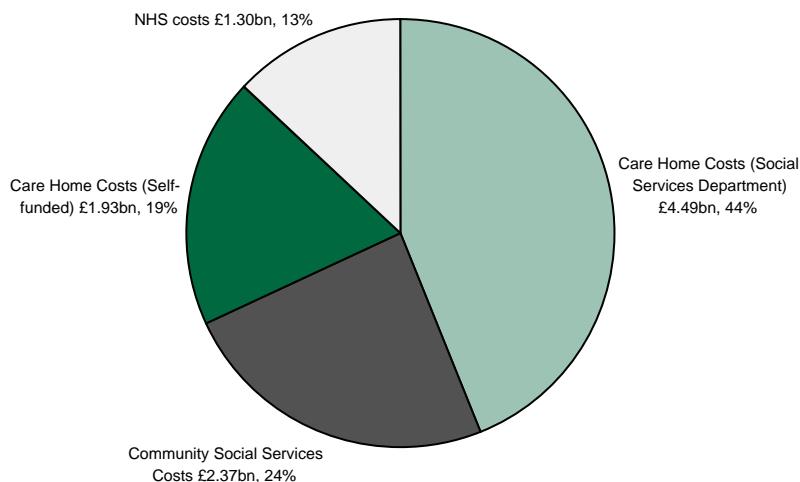
6 Qq 125 and 130

7 Qq 78, 126 and 145

8 Qq 130 and 131

value for money to the taxpayer or to people with dementia and their families. In particular, the report found that spending was late, with too few people being diagnosed or being diagnosed early enough. Early interventions that were known to be cost-effective, and which would improve quality of life, were not being made widely available. This resulted in spending at a later stage on necessarily more expensive services.⁹

Figure 1: Total estimated direct costs of dementia in 2009



Source: C&AG's report (2010), adapted from Knapp et al (2007) *Dementia UK* and the King's Fund (2008) *Paying the Price*

5. At our previous hearing in 2007, the Department announced that dementia would now be a national priority and that it would signal this to the NHS through the NHS Operating Framework. It also announced that it would develop a National Dementia Strategy.¹⁰ This five-year Strategy was launched in February 2009. The Department acknowledged that dementia was the biggest challenge it had ever faced, largely due to the complexities of joining up health and social care departments and resources.¹¹

6. However, despite agreeing in 2007 that dementia would be a national priority as important as cancer and stroke, the Department did not include it in the December 2007 Operating Framework in which stroke and cancer were listed as national 'Tier 1' indicators (**Figure 2**). Since then, two further NHS Operating Frameworks have been published but dementia has still not been included as a national priority. Rather it is mentioned as something Primary Care Trusts (PCTs) may wish to consider taking action on. One of the key outcomes of this failure to afford dementia the priority status that we were led to believe it would be given, was that progress in improving dementia services was not performance-managed by the Department or Strategic Health Authorities.¹²

7. In publishing the Strategy, the Department announced that it was allocating £150 million revenue funding to PCTs over the first two years of the Strategy to assist with

9 C&AG's Report, paras 34 and 35; Committee of Public Accounts, Sixth Report of Session 2007–08, *Improving Services and Support for People with Dementia*, HC 228, para 23

10 Qq 2, 3 and 4

11 Q 157

12 Qq 2, 4–8 and 23–29

implementation.¹³ Although the Department stated that this funding was to help PCTs implement the National Dementia Strategy, PCTs were completely free to decide how to spend it.¹⁴ It was unclear how the first year's funding of £60 million had been spent, or indeed if it had actually been spent on dementia. The Department only commenced commissioning a local audit of the costs of dementia services in each PCT in December 2009,¹⁵ and the results will not be available for several months. Each PCT was also required to complete a baseline review of services by March 2010, as set out in the revised Implementation Plan (July 2009).¹⁶ This could have been undertaken as part of the Strategy's development, but instead the initiative was launched in July 2009 and was not expected to be completed until over a year after the Strategy's launch.

Figure 2: The NHS Operating Framework: Vital Signs Indicator Set

<p>Tier 1: A small number of 'must-dos', which apply to all PCTs</p> <p>These are subject to performance management from the Department centrally. SHAs hold PCTs and NHS Trusts to account for these performance indicators and the Care Quality Commission assesses performance annually. Five Tier 1 indicators relate to cancer; two to hospital acquire infection; and one to stroke. Dementia is not mentioned.</p>
<p>Tier 2: National priorities for local delivery</p> <p>The Department considers that concerted effort on these is required across the board but allows local organisations flexibility on how they deliver. SHAs hold PCTs and NHS Trusts to account for these performance indicators and the Care Quality Commission assesses performance annually. Dementia is not mentioned.</p>
<p>Tier 3: Priorities determined and set locally</p> <p>These are a set of indicators from which PCTs can choose a small number to target local action and improvement effort. The Department does not performance manage these indicators, and the Care Quality Commission is not expected to include them in its annual assessments. SHAs need to be satisfied that PCTs have identified and are acting on a group of Tier 3 indicators. Learning disabilities has three specific Tier 3 indicators.</p> <p>There are Tier 3 indicators relating to the timeliness of social care assessments and the proportion of carers receiving a 'carer's break' or other carer's service which link to dementia care, but dementia is not mentioned specifically.</p>

Source: C&AG's Report (2010)

8. Overall, the Department had estimated that the Strategy's implementation would cost some £1.9 billion over 10 years and that this would be funded largely through efficiency savings. These could be achieved by reducing the amount of time that people with dementia spend in hospital when they no longer have a medical need to be there, or by reducing premature entry to care homes by providing better support in the community. These savings could then be re-directed to other areas, such as early diagnosis and intervention in people's own homes.¹⁷ Achieving the required £1.9 billion of efficiency savings will be a financial challenge on a scale the Department has never before

13 Qq 32 and 42

14 C&AG's Report, para 15

15 Qq 9–12, 42, 47–48 and 53; C&AG's Report, para 15

16 Qq 39–40, 76, 78, 81, 131 and 155; C&AG's Report, para 15

17 C&AG's Report, paras 7 and 8

attempted.¹⁸ It is dependent on the widespread adoption of good practice and being able to release funding from the acute sector to other health and social care settings, which has historically been very difficult to achieve.¹⁹

9. The Department explained how some prevention schemes had led to up to a 49% reduction in emergency admissions which had a considerable impact both on hospital costs and quality of care for patients.²⁰ People with dementia who were admitted to hospital could have a poor experience²¹ because they were often not seen by a specialist in dementia. There are major gaps in the provision of specialist older people's mental health services such as multi-disciplinary psychiatric liaison teams. The presence of these specialist services could create an environment conducive to earlier discharge, or perhaps even prevent admission in the first place.²² This evidence and other examples of good practice were outlined by the NAO in 2007 and could have been disseminated by the Department and adopted by PCTs much earlier.²³ Instead, the Department waited until it had developed and launched the Strategy before taking any action to disseminate good practice, resulting in a whole year being lost.²⁴

18 Qq 16, 18, and 127–128

19 Q 17; C&AG's Report, para 8

20 Q 40

21 Q 73

22 Q 82

23 C&AG's Report, Session 2006–07, *Improving Services and Support for People with Dementia*, HC (2006–07) 604, paras 4.16–4.18

24 Qq 34 and 35

2 Driving and monitoring change in services for people with dementia

10. Those leading the implementation of the Strategy had failed to ignite passion, pace and drive at the frontline. Instead, the Strategy's implementation had been process-driven and therefore had yet to actively engage the health and social care staff who actually delivered care to people with dementia.²⁵ This was demonstrated by the scepticism amongst Consultant Old Age Psychiatrists and GPs that the Strategy could be successfully implemented within five years.²⁶

11. The Department failed to appoint National Clinical Directors for dementia and older people until the eve of our hearing in January 2010. These Directors could have played a pivotal role in driving forward the Strategy, but their appointment almost a year after the Strategy's launch meant the first year of the Strategy's implementation had been wasted.²⁷

Figure 3: An effective and efficient memory service

A memory service is a service for GPs and others to refer people to if they are suspected of having dementia, for example because they have problems with failing memory or changes in behaviour or personality that may be attributable to dementia. The service is designed to generate as accurate a diagnosis as possible, as early as possible, in those with mild to moderate dementia. An effective memory service should have the capacity to work for all of the population of a PCT that might develop dementia and should do three things:

1. Make the diagnosis well;
2. Break that diagnosis well to people with dementia and their carers, and
3. Provide the immediate treatment, care and support that is needed for people with dementia and their carers.

A memory service does not have to operate out of a particular clinic setting. It can be provided in a variety of different places, including in people's own homes, and the emphasis should be on accessibility. An efficient and effective memory service should therefore be able to see approximately 20 referrals a week. A PCT with around 50,000 people over the age of 65 might typically expect to have 900–1,000 new cases of dementia a year, and should be able to commission a memory service to cover the needs of this population for between £650,000 and £1 million per year. The team to operate this level of service would comprise a multi-disciplinary team of 10 staff including health and social care professionals with a half-time consultant psychiatrist and a full-time specialist grade doctor, with nurses, psychology and the input of the local Alzheimer's Society.

Source: Qq 21 and 42–44; Evidence given by Professor Sube Banerjee

12. Early diagnosis is essential to enable people with dementia and carers to make choices about the future and to help prevent harm. However, usually only around one-third of people with dementia are formally diagnosed and late diagnosis means that the majority miss out on early intervention and timely specialist care which can enable them to live well.²⁸ Vital to enabling early diagnosis is access to memory services (**Figure 3**), which is currently inequitable.²⁹ If PCTs had spent their allocation of funding on dementia care as

25 Qq 73 and 82

26 Qq 95–98; C&AG's Report, para 2.7 and Figure 10

27 Qq 12–15 and 33–38

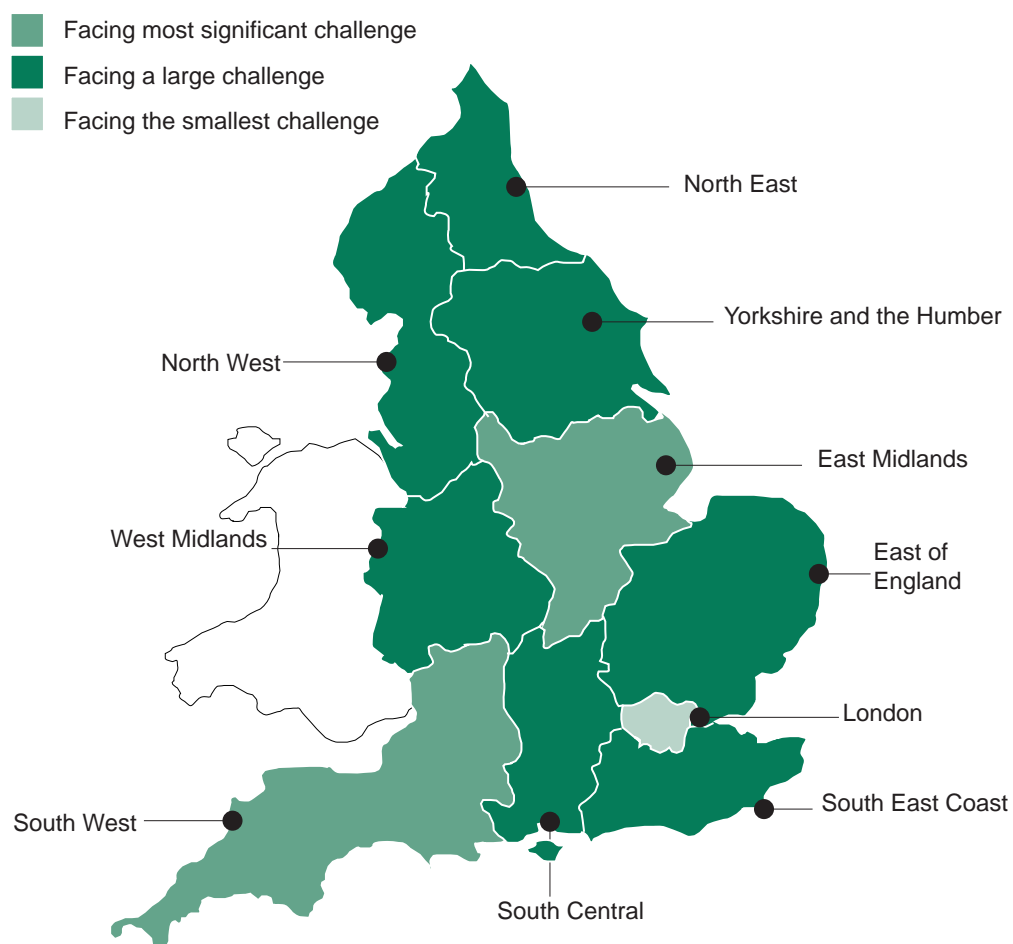
28 Qq 100, 106, 120 and 123; C&AG's Report, para 1.5

29 Q 20

intended, every PCT would have been able to afford a memory service along the lines described in **Figure 3**.³⁰

13. Having a memory service to refer patients with possible dementia to, had a positive effect on GPs' awareness of and attitudes towards the disease. This could be improved further if combined with better undergraduate and continuing professional development training.³¹ Memory services are key to improving care for people with dementia and they are crucial not just at the diagnosis stage, but throughout the disease progression for people with dementia, carers and professionals alike. Therefore, if swift progress is made on making memory services accessible for all who need it, this will help drive the entire Strategy forward.³²

Figure 4: Regional breakdown of the diagnosis gap challenge in England



Note: The 'challenge' is reflected by an index which has been calculated taking into consideration the diagnosis gap that exists at present in each region and the expected increase in future prevalence. The higher the index, the greater the challenge for the SHA to reduce the diagnosis gap in their region.

Source: C&AG's Report (2010)

30 Q 42

31 Qq 101–102 and 142

32 Qq 21, 100–102, 106, and 142–143

14. Much variation exists in terms of the diagnosis gap³³ across regions and this is exacerbated when it is considered in light of the expected increase in future prevalence, as **Figure 4** demonstrates. The regions facing the biggest challenge due to their current diagnosis gap and expected increase in prevalence were the South West and East Midlands (**Figure 3**).³⁴ There was also much regional variation in terms of service provision and drug prescription across England with the experiences of people with dementia varying on the basis of where they live.³⁵

15. Research is acknowledged as a vital component in improving dementia care, yet there was a 7% fall in dementia research funding in the year following our previous hearing in October 2007. The Department explained that its research programme was determined several years in advance and therefore it took time to influence the distribution of such funding. But in recognition of the importance of research, it held a dementia research summit in July 2009 to encourage research in the field of dementia and it expected to see plans coming forward for research with a consequent increase in funding in 2011–12 and 2012–13.³⁶

33 Diagnosis gap is the difference between the expected dementia prevalence in a given area and the actual numbers diagnosed.

34 Q 93; C&AG's Report, para 1.5 and Figure 6

35 Qq 77, 103, 109, and 111–113; C&AG's Report, para 1.6

36 Qq 71 and 72

3 Delivering the Strategy at a local level

16. Whilst national and regional leadership has been strong, local leadership for improving dementia had still to be put in place. The Department did not know how many dementia champions there were in England or where they were located³⁷ and only 21% of consultant old age psychiatrists were able to confirm that a senior clinician had taken the lead for improving dementia care in their general hospital.³⁸

17. Engagement of frontline staff within acute hospitals was particularly important since hospital stays can increase confusion in people with dementia and speed up their deterioration. Most healthcare workers came into contact with people with dementia regularly, but there was no required dementia training for generalist healthcare professionals and their awareness of the disease was poor.³⁹ A recent report by the Alzheimer's Society⁴⁰ found that by discharging people with dementia (who no longer had any medical needs) earlier from hospital, and reducing unnecessary lengths of hospital stay, the NHS could save £86 million in practice, as well as preventing the further deterioration of these patients. The Department was looking at ways to reduce unnecessary length of stay in hospitals and felt that some redesign in the system was needed with better support for people at home.⁴¹

18. Most people with dementia received much of their day-to-day care from domiciliary carers or care home staff. These staff are currently unregistered and, despite six years of discussion and planning for a new process of registration for social care staff by the General Social Care Council, all plans had been suspended and nothing had been achieved in this area.⁴² Many of the social care workforce did not have any type of training or qualification.⁴³ This general lack of training and poor level of qualifications, coupled with the absence of registration with the General Social Care Council, their professional body, meant that the quality of care and safety of the vulnerable people they looked after was being put at risk. This risk was compounded for people with dementia as the lack of understanding of this complex condition meant even lower standards of care.⁴⁴

19. Another serious issue concerned the excessive prescribing of anti-psychotic drugs for people with dementia, particularly those living in care homes. An independent review⁴⁵ commissioned by the Department, reported in November 2009 that up to 150,000 people with dementia were inappropriately prescribed anti-psychotic drugs, contrary to clinical guidelines, contributing to up to 1,800 additional deaths each year. The level of prescribing

37 Qq 79–82

38 C&AG's Report, para 2.7

39 C&AG's Report, paras 2.12 and 2.13

40 Alzheimer's Society (2009), *Counting the cost: caring for people with dementia on hospital wards*

41 Qq 74 and 75; C&AG's Report, Figure 17

42 Qq 65–70; C&AG's Report, para 2.11

43 Q 63

44 The All Party Parliamentary Group on Dementia (2009), *Prepared to care: challenging the dementia skills gap*

45 Q 54; Professor Sube Banerjee (2009), *The use of anti-psychotic medication for people with dementia: time for action*

could be reduced by two-thirds within two years but to achieve that Primary Care Trusts must acknowledge this issue as a clinical governance priority.⁴⁶

20. In July 2009, the Department appointed a Champion/Ambassador for the independent sector to improve the engagement of care homes in the Strategy and to help communicate the findings of the above anti-psychotics review to help reduce the prescribing of anti-psychotics as envisaged.⁴⁷

21. In 2007, we expressed concern at the lack of dementia training in social care, high staff turnover and vacancies. The All Party Parliamentary Group on dementia's 2009 report highlighted that these problems still hadn't been addressed. The stigma attached to dementia was reflected in the low status society gave to this work which reduced morale and motivation. Care homes told the NAO that changes in employment rules and increasing NHS pay had made recruitment and retention of care staff even more difficult.⁴⁸ The Department had commissioned Skills for Care and Skills for Health to map the training needs of the social care workforce to identify gaps. This would conclude in March 2010 and would inform the Department's workforce action plan.⁴⁹

46 Qq 57–62

47 Q 56; C&AG's Report, para 2.8

48 C&AG's Report, para 2.10

49 Q 85; C&AG's Report, para 2.14

Formal Minutes

Monday 8 March 2010

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon

Mr Ian Davidson

Nigel Griffiths

Mr Austin Mitchell

Rt Hon Don Touhig

Draft Report (*Improving Dementia Services in England—an Interim Report*), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 21 read and agreed to.

Conclusions and recommendations 1 to 9 read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Nineteenth Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Wednesday 10 March at 3.30 pm]

Witnesses

Monday 25 January 2010

Page

Sir David Nicholson KCB, Chief Executive, **Mr David Behan**, Director General—Social Care, Local Government and Care Partnerships, Department of Health, **Sir Ian Carruthers OBE**, Chief Executive, South West Strategic Health Authority, NHS, **Professor Sube Banerjee**, Section of Mental Health and Ageing and DH Senior Professional Advisor, King's College London

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List of written evidence

Department of Health

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Third Report	Financial Management in the Foreign and Commonwealth Office	HC 164
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Fifth Report	Promoting Participation with the Historic Environment	HC 189
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Nineteenth Report	Improving Dementia Services in England—an Interim Report	HC 321

Oral evidence

Taken before the Committee of Public Accounts on Monday 25 January 2010

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Angela Browning
Mr Paul Burstow

Mr David Curry
Mr Austin Mitchell
Dr John Pugh

Mr Amyas Morse, Comptroller and Auditor General, **Gabrielle Cohen**, Assistant Auditor General and **Ms Karen Taylor**, Director, National Audit Office, gave evidence.

Mr Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, gave evidence.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL IMPROVING DEMENTIA SERVICES IN ENGLAND—AN INTERIM REPORT (HC82)

Witnesses: **Sir David Nicholson KCB**, Chief Executive, **Mr David Behan**, Director General—Social Care, Local Government and Care Partnerships, Department of Health, **Sir Ian Carruthers OBE**, Chief Executive, South West Strategic Health Authority, NHS, and **Professor Sube Banerjee**, Section of Mental Health and Ageing and DH Senior Professional Advisor, King's College London, gave evidence.

Q1 Chairman: Good afternoon. Welcome to the Committee of Public Accounts, where today we are considering the Comptroller and Auditor General's Report on Improving Dementia Services in England. We welcome back to our Committee Sir David Nicholson, who is the Department of Health's Accounting Officer and Chief Executive of the National Health Service. Perhaps you would like to introduce your colleagues, Sir David.

Sir David Nicholson: Yes, we have Sir Ian Carruthers, who is the Chief Executive of the South West Strategic Health Authority, David Behan, who is Director General for Social Care, Department of Health, and Professor Sube Banerjee, who is an adviser to the Department on dementia.

Q2 Chairman: Thank you very much, Sir David. I should say that we are joined by the Speaker of the Assembly of Kosovo and nine members of the PAC in Kosovo. After this hearing I will make myself available to talk to them. We are talking about dementia services, a very important subject, Sir David. It costs the taxpayer about £8.2 billion a year but a lot of this spending is reactive. What I would like to know from you, Sir David, is that it is two and a half years since we last had this hearing. As you know, this was a subject of great interest to us. Not once, but at least ten times, Sir David, you told this Committee that it was now going to be a national priority. I asked the NAO to report back to us within a year, and here we are, two and a half years later: dementia has still not been included as a national priority. There have been three operating frameworks that you published since the hearing. Why not?

Sir David Nicholson: First of all, I think it is two years since we have met.

Q3 Chairman: All right, well let us not quibble if it has been two and a half or two years.

Sir David Nicholson: And there have been two operating frameworks published. As you know, at the last hearing the important thing for us was the development of a strategy for dementia. There had been a lot of initiatives in the past but not an overarching strategy which took in all of the complexities of this really important service. The first thing to say is that we spent quite a lot of our time getting the strategy right. No doubt we will develop that as part of the hearing, but we believe that getting that strategy right is absolutely critical. We now have a strategy which the NAO says is ambitious and comprehensive. We have a strategy that is based on evidence. There was a huge amount of work done over that period to get the evidence to see what actually works in practice; and we have a strategy which, in my view, is future-proofed against the challenges we will have in future in relation to finances in the NHS and the public sector in general. I think the strategy is in a really good place and it was really important that we took the time to get that right. We always knew that certainly for the first year or so of the strategy, and perhaps two, we were in the phase of what I think is described as gearing up and making the plans right in order to deliver what is an enormously complex service which covers primary, social and healthcare. So we have been putting all of those things in place, and no doubt, as I say, we will develop that during the hearing. We have identified in the operating framework—

Q4 Chairman: I am sorry, Sir David, this is all very interesting, but I asked you a specific question. For the sake of reference, the hearing was October 2007, so that is two years four months ago. Three frameworks have been published since then: in

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December 2007, December 2008 and December 2009. Everybody has a strategy for everything. I would be amazed if you did not have a strategy for anything. I asked you why you told us two years and four months ago that it was going to be a priority. You told us that ten times and you must have known at the time that that was not the case, or very shortly thereafter. You must have known, Sir David, why you decided that you did not want to make it a national priority. Why did you not tell us?

Sir David Nicholson: What I was trying to set out for you was the fact that it is a priority for the health and social care system.

Q5 Chairman: You are announcing today that it is a national priority?

Sir David Nicholson: It has always been a national priority for social care and the Health Service over the last period.

Q6 Chairman: It is a term of art, is it not, "national priority"? I want to peg you down on this. It is a national priority in the sense of cancer or heart disease—it is that level, is it? What are you saying?

Sir David Nicholson: It is a national priority. It is set out in the Government's document NHS 2010-2015. There is a national strategy. There is a national—

Q7 Chairman: Well, can I ask you—Sir David, I want to get this right. Karen, when you were briefing me earlier you said that there were various national priorities that were set out and then dementia was down with the others which was left to the PCT. Explain what is actually going on here, because I am now being told it is a national priority and I want to know the truth.

Ms Taylor: The operational framework sets out the Department's priorities using vital sign indicators, tier 1, tier 2, tier 3. Tier 1 is performance-managed by the Department of Health and are termed as national priorities; tier 2 are performance-managed by strategic health authorities and the Department of Health can step in and performance manage; and tier 3 are not performance-managed by strategic health authorities or the Department of Health but are up to local PCTs, and dementia—

Q8 Chairman: That is where dementia is. So it is not a national priority? I do not know why you just do not say, "Actually we cannot make everything a national priority. I am sorry, Mr Leigh; we should not have told you that it was going to be a national priority; I made a mistake; I am sorry." That would be much better, rather than pretending it is a national priority when clearly, according to the frameworks that you yourself published—and Karen has explained—it is not a national priority.

Sir David Nicholson: No, but there are two things I would say about all of that. The first thing is that the operating framework was designed to deliver the last Comprehensive Spending Review, of which dementia was not part. As part of that, the Government said—my Secretary of State said, "There will be no new national targets." Putting that through puts dementia in the place that it is. The

important thing for us, though, is to take national action, and by the evidence of what we will talk about in terms of what we have done both in terms of the national action we have taken and the local action we have set out, we believe that that indicates that dementia for us is a national and important objective.

Q9 Chairman: I do not think we are going to get any further. Let us just make progress, and other Members can come in as they want. Would you look at paragraph 3.8 on page 34. I am asking you about the first £60 million that you allocated to support implementation. You do not appear to be tracking how the £60 million is being spent. As you are not tracking it, how can you assure this Committee, Sir David, that this money is not being wasted?

Sir David Nicholson: The important thing to note—and I think I have said this to the Committee before—is that we do not earmark money or ring-fence money in that way. We give money out into PCT allocations for them to spend in line with the plans that we and they develop together. The amount of money identified in the strategy was indicative that we thought was required for that first year nationally. You cannot divide it between the number of PCTs, you cannot divide it between the number of organisations because people are in very different places. Also, it is a relatively small amount of money compared, as you say, with the £8 billion that we spend on dementia across health and social care altogether. We are putting into place a series of retrospective audits across the country to identify both how money is being spent in dementia across the totality of the amount you describe, and also that—

Q10 Chairman: So basically we have no idea whether it has gone on dementia or not.

Sir David Nicholson: They will have to account for it. Individuals—

Q11 Chairman: It is worthless—

Sir David Nicholson: No, I do not think it is worthless.

Q12 Chairman: Obviously it might well have been spent on dementia and it might not have been, and we will have no idea until this audit happens. By the way, Sir David, here we are meeting on Monday: why did you wait until Friday of last week to appoint a Tsar for Dementia—the last working day before our hearing?

Sir David Nicholson: Well—

Q13 Chairman: Was it anything to do with this hearing, by any chance?

Sir David Nicholson: The first thing is that we decided that we would want a national clinical director for both older people and dementia. We thought there was some sense in that. We went through a process of trying to identify somebody and appoint someone. We failed to get the kind of

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person that we wanted, the quality, so we went out again to advertise for the two jobs separately. It just so happened that—

Q14 Chairman: There are 365 days in the year and you just happened to appoint the Tsar on the last working day before this hearing?

Sir David Nicholson: I can absolutely assure you, it just so happened.

Q15 Chairman: Okay, I believe you. I always believe you, Sir David.

Sir David Nicholson: Thank you.

Q16 Chairman: Shall we look at this £1.9 billion in efficiency savings? Your whole strategy depends on the PCTs delivering this. Frankly, how realistic is this?

Sir David Nicholson: I think this is difficult; there is no doubt about it because when you look at the position that the NHS in general finds itself in over the next period, we are going to have to face a financial challenge like one we have never faced before in our history. Just to give you an idea, on average—

Q17 Chairman: All this, Sir David, is generalised waffle; it is not answering what I am asking. Karen, have you got any evidence that any of this extra investment is going on dementia?

Ms Taylor: The strategy identifies that savings will come four or five years down the line once there are services and support put in place to be able to reduce use of care homes; so it would not be identifiable now. It does depend on reducing the use of care homes and acute hospital beds.

Q18 Chairman: So is there any evidence that we are going to achieve this £1.9 billion in efficiency savings given that we do not have any evidence so far, Sir David?

Sir David Nicholson: That is the point I was trying to make. We have not done anything like this before. That is why we took so much time going through the arrangements to put the strategy together because we have never done it. There are signs around the country that people can do it. I was in Wakefield—and I am sure my colleagues can give examples where people are taking resources out of in-patient facilities and moving them into community-based services. I think that is well on-stream around the country as a whole. But, as I say, we have not delivered anything of this scale before. In a sense, the whole point of the first period of the strategy, which you describe as not doing very much with, is to get the plans in place, and that is what we have been doing. It is very important to get it right, and that is what people are focusing on at the moment, and what they have to do by the end of March is present us with an implementation plan, a way in which they are going to make these numbers a reality. We will obviously be in a better place when we have looked at those and considered them to measure the risk as to whether we can actually deliver it or not. That is

the nature of the strategy and the way that we are doing it. It will be the end of March before those implementation plans are finished.

Q19 Chairman: What happens to the strategy if these savings are not realised?

Sir David Nicholson: There are two or three ways. First of all, we can look to other efficiencies within the system. I do not want to go on about it, but, as you know, we are looking for efficiencies across the NHS as a whole, so there are maybe other places we can look. We have also got to look at the possibility in future that future governments may want to be more generous with their Comprehensive Spending Reviews, so we will be bidding for resources through the Comprehensive Spending Review. Those are the two bases on which we can take it forward; either get more money from the Government or provide it through efficiencies.

Q20 Chairman: Obviously, early diagnosis is absolutely essential and we have got to have equal access to memory services. Ivan Lewis, your Minister, promised us, the country, in February 2009, that there was going to be a memory clinic in every town. It is not going to happen, is it? It has now been downgraded so there will be memory services in every town, but by a memory clinic in every town we think that you are going to be going to a dedicated building where your GP will send you to be assessed in the early stages. That is not going to happen, is it?

Sir David Nicholson: I will ask Sube to speak about this, but one of the things we have been doing is identifying the elements of a memory service which leads to the outcome that you want. It may be that bricks and mortar are not what is required, so it is—

Q21 Chairman: So why were we promised a memory clinic in every town?

Sir David Nicholson: I will just ask Sube to explain to you what the memory service might look like.

Professor Banerjee: I generated many of the bits of the strategy that talk about memory services so I am very happy to fill in what might be expected of such a service. What the strategy advocates is that every PCT should commission a memory service that works for all of the population who might develop dementia. So you have in each PCT a memory service that does three things: it essentially makes the diagnosis well, then breaks that diagnosis well to people with dementia and their carers, and then provides the immediate care and support that is needed for people with dementia and carers. That service can be provided in a variety of different places. We have costed what the service might cost for an average PCT for 50,000 older people; but much of that might be delivered within people's homes rather than in particular clinic settings; so it is not clinics and bricks and mortar that matter, but it is teams of people carrying out good-quality work. If you are looking at the numbers of people you would expect those services to be looking at, they are going to be assessing in an average PCT of 50,000 people something like 900-1,000 people per year. This requires the commissioning of services to do

that. We have clear examples of PCTs where those sorts of services have been developed and are delivering for people. In terms of what “good” would look like in terms of those services, it would be the fact that they just do not deliver to the small minority of people—

Q22 Chairman: I am going to stop you now because we have to have brisk answers because other Members want to get in and I do not want to hog any more time, except to say the one thing that alarms me about what you have just said, Sir David—you talked about cuts. Does this mean that the strategy that you have alluded to is now at risk?

Sir David Nicholson: I did not say cuts at all. The NHS has been given what in the jargon I think is described is a flat real assumption to make about its resources for the next period ie, whatever we need to invest we need to find from somewhere else in the service, and that is exactly what we are planning to do; and that is what the basis of the strategy is.

Q23 Mr Bacon: Sir David, can you explain to me what a tier 1 priority is within the vital signs indicator set?

Sir David Nicholson: Yes, it is a national target and the Department sets out what it is and when it has to be delivered, and is more prescriptive about how it is delivered.

Q24 Mr Bacon: It is performance-managed by the Department?

Sir David Nicholson: It is performance-managed by the strategic health authorities.

Q25 Mr Bacon: Can you describe to me then what a tier 2 priority within the indicator is?

Sir David Nicholson: Tier 2 targets are targets that are identified nationally as being important, but it is up to PCTs to decide the timing with which they implement them, depending on local circumstances.

Mr Bacon: And it is performance-managed by the SHA again?

Sir David Nicholson: Strategic Health Authorities, yes.

Q26 Mr Bacon: What is a tier 3 priority?

Sir David Nicholson: These are important issues which it is up to individual PCTs to decide whether to take forward or not.

Q27 Mr Bacon: Is dementia mentioned in tier 1?

Sir David Nicholson: Dementia is not mentioned in any of them.

Q28 Mr Bacon: It is not?

Sir David Nicholson: No.

Q29 Mr Bacon: I was looking back at the transcript of the hearing which we had on 15 October 2007. One of the things you said was that—because we had the talk about Mike Richards and cancer and cardiac and stroke and so on.

Sir David Nicholson: Yes.

Q30 Mr Bacon: One of the things you said was: “Dementia now has its place in the sun.” That was then. “When we have looked across our priorities as a whole we have seen we are clearly making significant progress in cancer, coronary heart disease, waiting times and after the publication of the stroke strategy, stroke services”—because we have had hearings on each of those things over the years—“dementia now has its place in the sun.”

Sir David Nicholson: Yes.

Q31 Mr Bacon: Can you define for me what dementia having its place in the sun means? You say this in the present tense in October 2007, “Dementia now has its place in the sun.” What does that mean? What did it mean when you said it?

Sir David Nicholson: What it meant then and what it means now is that, first of all, there was an enormous amount of national attention on dementia—that is the first thing—and the outcome of that national attention was the development of a major strategy for dementia across health and social care, something that had never been done before.

Q32 Mr Bacon: Hang on, the strategy was not available at the time of our hearing.

Sir David Nicholson: No, no, since the hearing I am saying. You were asking what having its place in the sun meant. We put a lot of emphasis, a lot of focus and a lot of resource behind development of the strategy. As you know, a strategy that is written by a small number of pointy-headed people in Richmond House seldom has connection with the service as a whole; so it was very important for developing that strategy that we got the best international evidence and we got as much engagement with the service as we could to make it real. That is what it meant then. It also meant that the Government identified £60 million and £90 million over the last two years of the CSR to give an indication of the kind of resources that would be required to invest in dementia at a time, subsequent to the strategy, which is around planning the way in which the service will develop over the next period. That is not to say that in lots of parts of the country—and you will know this as well as I—there has been significant investment and development in dementia services, and we will be able to give examples of it, but giving it that national focus was really important.

Q33 Mr Bacon: In that case, why was appointing a national clinical director not made to happen more quickly, because we discussed this in October 2007?

Sir David Nicholson: Yes, we did.

Q34 Mr Bacon: I was concerned because of the example of Mike Richards and we discussed it specifically, and Professor Banerjee, who was here, as he was just now, was passionate on the subject—and I remember thinking, “Ah-ha, there is probably our national clinical director”; although apparently not because we have had Professor Burns since last Friday—but I asked you about this and whether you

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could get on with the appointment of a national clinical director to help drive the strategy, and indeed would it be necessary to wait until the publication of the green and white versions of this report before going ahead, and you said “no”. In fact, you said: “No, and if we are not careful we will lose a whole year if we don’t get something moving forward.”

Sir David Nicholson: Yes.

Q35 Mr Bacon: You did lose a whole year; you lost the whole of 2008, and it was June 2009, was it not, before you failed to appoint a national clinical director when you realised you needed one for old people and one for dementia and could not find somebody who could do both. Why did it take that long?

Sir David Nicholson: David will talk about that in a while. I do not think we have lost time in those circumstances. There has been a huge amount of work gone on in the service, both in developing services and taking them forward in that period. The idea that we were a kind of service sat there waiting for the appointment of a national clinical director is not the case.

Mr Behan: I am the lead official in the Department responsible for the appointment of a national clinical director, and I take full responsibility for that. As Sir David has said, we did go out and tried to combine the roles and found that was not possible. We went out and advertised again, and we are absolutely confident in the two appointments we announced last week.

Q36 Mr Bacon: Why did it take so long?

Mr Behan: Because we wanted to search and secure absolutely the right candidate. We tried to combine the roles and we found it was not possible to do that; but we have not stood still while this has been happening. We published commissioning guidance in July. We published a—

Q37 Mr Bacon: Of?

Mr Behan: July 2009.

Q38 Mr Bacon: What was going on then during 2008?

Mr Behan: We were recruiting. We published the strategy. We went through consultation. We set up external reference groups. We worked with the key stakeholders. Neil Hunt of the Alzheimer’s Society chaired the external reference group. We had a nation-wide consultation event to secure the views of people with dementia and their carers about what the essential elements should be of the dementia strategy, and that information generated the strategy, which we published in early 2009. It was one of the largest and most comprehensive consultation events. We wanted to make sure that we reflected the views of those people with dementia and their carers and the key stakeholders, in the way that we designed the strategy.

Q39 Mr Bacon: You are the Director General; you have got these deputy regional directors around the country whose job it is to influence and promote and

lead this, and they are working to you basically: how do they force the pace, if you like, when there is no local leadership in place yet?

Mr Behan: They have been working hard on both raising the profile, and in March of this year our national awareness campaign begins and we will have TV, radio and online as well as newspaper adverts to raise the profile of this. But the deputy regional directors have been leading on the baseline reviews at a local level so that each local authority and PCT by March of this year will have a joint action plan that will take forward the delivery and implementation of the National Dementia Strategy but at a local level. They have been leading to secure that local ownership, working alongside SHAs and local authorities and PCTs.

Q40 Mr Bacon: What incentive does a PCT have to take this seriously, given that it is not a tier 1 or a tier 2 or even a tier 3 priority and it is not performance-managed? What incentive does a PCT have to grasp this, to grip it and push it forward?

Mr Behan: I think there are many incentives, not least the questions you were pursuing earlier about value for money. We have published some research on Tuesday of last week on Partnerships for Older People Projects—this was University of Kent research which showed that where there are prevention schemes in place there can be a 47% reduction in overnight stays in hospitals locally. That is a powerful incentive to begin to get the quality of these services right first time. I think there are many incentives in the system. I think we need to look at the leverage that is provided by the improved commissioning strategy, the work that people have been doing to develop their local action plans to ensure that services are targeted at those people most in need. But we have also appointed an ambassador to work with the care homes sector, to drive improvements in the quality of care at a local level. The challenges are good challenges. We need to occupy a space so we do not look defensive, nor do we look complacent, but in 2009 we have seen a raft of activity designed to deliver this strategy, and that first year is largely about setting up the strategy; the second year will be about collecting the evidence for the baseline reviews, and the third and fourth years will see us pushing on to deliver this strategy on the ground.

Q41 Mr Bacon: I must move on to ask Professor Banerjee about memory services. When you said 50,000 in a typical PCT, you meant 50,000 people who might come under the ambit of care, and there would be 900 to 1,000 actual cases in a typical year. Is that what you meant?

Professor Banerjee: The best estimate for need in a particular area is the number of people over the age of 65 because dementia is associated with age, so by 50,000 people I mean 50,000 people over the age of 65. In those areas you will get 1,000 new cases of dementia a year, and the service will be there to diagnose all of them.

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Q42 Mr Bacon: The £60 million and £90 million over two years is conveniently £150 million, but we do not actually know how much of it ends up being spent on dementia and we will not know this until the audit, but £150 million for 150 PCTs is £1 million each for two years. Say a typical PCT with £1 million extra that they otherwise would not have had, had spent it on all the things you had hoped and wanted them to spend it on, what would it have gone on; what would the expenditure have looked like; what would it have bought?

Professor Banerjee: Well, for that amount of money in an average PCT you could buy a memory service with ten people running it, which is what you need for it to run—

Q43 Mr Bacon: How many consultant psychiatrists in there?

Professor Banerjee: That would be probably with half a consultant psychiatrist and a full-time associate specialist. It would be a multi-disciplinary team with both nursing and doctor and psychology time, and social care would be involved as well as the local Alzheimer's Society. It would provide the place in each PCT for expertise in dementia, and it would be a place which was readily accessible so that people, when they do become worried about their memory, can do something about it and get the diagnosis they need to—

Q44 Mr Bacon: These ten people would see roughly 20 people a week, making—

Professor Banerjee: If you get the teams working efficiently—and we have exemplars showing that can be done, and we have published data showing what we have done; we have published metrics showing how much money you might save through generating services like this; and so you would have one of these providing services for an average PCT so that everybody in the PCT gets the care they need.

Q45 Mr Burstow: Sir David, do you think it is a little misleading for announcements to be made about sums of money that are to be allocated to particular areas like dementia when, as you rightly tell us, there is no longer any ring-fencing or earmarking?

Sir David Nicholson: I do not think it is misleading. I think it gives people an order of magnitude. It is quite common when such announcements are made to make a case for the general amount that would be expected. It is based, to be frank, on the bids we will have made through the CSR in the first place.

Q46 Mr Burstow: So it is an order of magnitude.

Sir David Nicholson: Yes.

Q47 Mr Burstow: But then, when it comes to what goes on on the ground, there is absolutely no obligation or requirement upon the local organisation to spend it in that area at all?

Sir David Nicholson: In some areas we take particular action so for example in dementia we decided that the way we would encourage people to spend it was to tell them they would be audited on the use of it afterwards.

Q48 Mr Burstow: So there will be an audit?

Sir David Nicholson: Yes.

Q49 Mr Burstow: Would you also agree that it would be good if PCTs responded to enquiries by Members of Parliament about the use of such money and provided that in a timely fashion?

Sir David Nicholson: Yes, that would be sensible.

Q50 Mr Burstow: Going on from there, one of the areas that is in parallel to this is the whole area of carer strategy where similar sums of money have been allocated. To my knowledge, freedom of information requests by local charities have been unable to prise that information out of many PCTs. Do you think that is acceptable?

Sir David Nicholson: I am obviously not aware of those freedom of information requests. It would seem perfectly sensible to provide it.

Q51 Mr Burstow: Would you think it would be wrong for a primary care trust to take over three months to reply to a Member of Parliament's enquiries about how much has been spent on carers' grants?

Sir David Nicholson: I do not know about the complexities of local circumstances so I could not judge that.

Q52 Mr Burstow: Surely, at the end of the day, if the money is not earmarked, then there has to be local accountability?

Sir David Nicholson: Yes.

Q53 Mr Burstow: And that must be PCTs having to spell out how they are spending the money.

Sir David Nicholson: That is why we have said they will be audited and they will have to publish.

Q54 Mr Burstow: Can I ask you about the report that was published in November as a follow-through to the strategy around anti-psychotic prescribing. In that report there are a number of recommendations, but one of the things we understand has happened so far is that a national champion has been appointed to deal with the independent sector. What other things have been done; particularly, what communication has been had with the care home sector to make them aware now of the evidence and the need for action to reduce prescribing?

Professor Banerjee: I can certainly tell you what I did with respect to developing the report and its content. I was very pleased that the findings were accepted, and spent a long time consulting widely.

Q55 Mr Burstow: Will you forgive me, Professor Banerjee? My question was very specific: what is being done now, because the report is really good; it does spell out what needs to be done: but I want to know what is being done to communicate the recommendations of that report to the people who on the ground have to implement it.

Professor Banerjee: That is not something that I have been engaged in dealing with.

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Q56 Mr Burstow: Perhaps it is Mr Behan's responsibility and he can tell us the answer to that question.

Mr Behan: Since Professor Banerjee published the report, the Government considered and accepted the recommendations and an action plan is being developed and that is being communicated. Martin Green, who is the Chief Executive of the largest trade association for care homes, has agreed to act as an ambassador for the care home sector. He is a well-known figure within the care home sector and he is very—

Q57 Mr Burstow: That is very helpful in terms of what has been done so far. I have a follow-on that I want to ask Professor Banerjee about. In the report you said it should be possible to reduce prescribing of these anti-psychotic drugs by two-thirds.

Professor Banerjee: Yes.

Q58 Mr Burstow: Which the report does accept for some will lead to premature death. How long do you think it should take before we can see a two-thirds reduction?

Professor Banerjee: In my report I set out clearly I believe that it will be possible to reduce current prescribing to a third of current prescribing within a two-year period. That requires a considerable amount of energy and focus, and it requires local PCTs across the country to acknowledge that this must be a clinical governance priority.

Q59 Mr Burstow: Again, that is a question therefore for Mr Behan. Do PCTs acknowledge that, and what are you doing to make sure that they do acknowledge that priority?

Mr Behan: What they are doing is part of the action plan, and the recommendations were really about the audit of the workforce and about the specialist input that is required to address the recommendations from Professor Banerjee's report, and we are putting in place that action plan.

Q60 Mr Burstow: Will a two-thirds reduction be achieved in two years?

Mr Behan: The report is very measured and balanced, and you know yourself—you have done a lot of personal work in this area—we have tried to ensure that we have listened to what Professor Banerjee said about this medication being helpful to some people and equally it needs to be addressed.

Q61 Mr Burstow: So will it be done in two years?

Mr Behan: We are confident that if we have established the audit and established the baseline, we can then begin to see year-on-year improvements in the way that these—

Q62 Mr Burstow: Will that be done in two years?

Mr Behan: Yes.

Q63 Mr Burstow: Mr Behan, you said when we had this hearing a couple of years ago that 70% of the social care workforce had no qualifications and

many of them are without training. What would you say the current estimate is of the numbers without qualification?

Mr Behan: Well, we know that the numbers with NVQ level 2 have improved year on year, so it is slightly better than it was last time, but marginally so and not significantly so—

Q64 Mr Burstow: Would you let us have a note,¹ and maybe have a better figure once you have had a chance to check where we have got to? What are the levers you are using to drive that forward more quickly, given, as you have just said, that it has not progressed that much since you gave that estimate of 70%?

Mr Behan: Last year the Department published a Workforce Strategy, which was designed to demonstrate exactly how we intend to take forward the development of the social care workforce over the next period.

Q65 Mr Burstow: In the Report, on page 29, paragraph 2.11, that refers to the difficulties around social care registration and how that is going to be delayed for several years. Can you say what has caused that delay?

Mr Behan: We are looking at the approach that needs to be taken. The policy in relation to professional registration of the workforce has been reviewed following Shipman and Allitt. The nature of that professional registration we need to apply. There is a question about whether you take a post-graduate approach as there has been with GPs to largely an undergraduate—

Q66 Mr Burstow: The thing I am most interested in, with respect, are those who work in people's homes, domiciliary care workers, who are unlikely to be graduates at this stage, although that may be a long-term and excellent aspiration. The question really is when are they going to be registered with the General Social Care Council.

Mr Behan: The Government's policy is it will continue to consider that issue. We have issued a statement on that saying we are reviewing our policy and we will review a range of different options about how this can best be secured.

Q67 Mr Burstow: You are quite right that there have been a lot of statements issued. There was one in April 2005 which promised that a decision would be made about this that year, and there was no decision. There was another one in July 2005, and then in February 2008 we were told it would all go live that year; and then we were told it is going to be April 2010. Now I understand that it is not going to happen for an undefined period of time. When will domiciliary care workers be registered with the General Social Care Council, after six years?

Mr Behan: It still remains the Government's objective to secure the safety of people using care services by registering that workforce. The key issue is how best to secure the registration of that

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workforce. Arguably we need to think through in today's climate how best we can secure that, and that is what we will do.

Q68 Mr Burstow: It has taken you six years to think it through. How many more years do you think it will take before you come up with a decision?

Mr Behan: I would hope that it can be resolved as quickly as possible.

Q69 Mr Burstow: Would you care to put a timescale on that?

Mr Behan: As quickly as possible.

Q70 Mr Burstow: As quickly as possible. Will that be within the calendar year?

Mr Behan: As quickly as possible.

Q71 Mr Burstow: I wanted to ask Sir David about research. When you came to the Committee in 2007 you told us, and we have had exchanges about it already today, that dementia was a key priority for the Government. Why therefore did government investment in research in that area fall by 7% in the year after you came to the Committee?

Sir David Nicholson: One of the things about the research programme is that it is organised years in advance so it is quite difficult in those circumstances to turn something on and turn something off.

Q72 Mr Burstow: When do you think the tap will be turned on, then?

Sir David Nicholson: We had a summit of all the major research organisations and people in July. We are expecting a whole set of plans to come forward from that for research for next year, so we would expect that to increase in 2011/12/13.

Q73 Angela Browning: I apologise for being late, Chairman, but I was attending a funeral, as you know. I should declare my interest to the Committee that I am Vice President of the Alzheimer's Society. Gentlemen, from what I have heard, having come in late, is clearly the core of what we are talking about this afternoon is that you have created a strategy which has yet to be implemented, and you have missed a golden opportunity for that strategy to be included in the national operating framework first tier. I hear you now explaining to us the way you intend to work towards implementation. I would like to hear today "passion, pace and drive, in transforming dementia care", because that is what it says in the NAO Report is needed. At the moment, from what I have heard so far, we just seem to be going through the process. It is all about process. Dementia is about people but this Committee of course is also about money, so can I ask you about money? I am sure you have read the Alzheimer Society's report called *Counting the Cost*. When I look at that, and I see about people with dementia who are admitted to hospital not because they have dementia, but dementia then becomes a part of their care—we are talking about large numbers of people here—fracture of femur: very common in elderly people; total prosthetic replacement of hip joints;

urinary tract infection; and TIAs (transient ischaemic attacks). According to Alzheimer's, if you could reduce the stay in hospital for everybody who goes in and is admitted under those titles but who also has dementia, by one week and one week only, because we know that people with dementia stay in hospital a lot longer than everybody else in those conditions, you would save £86 million. What is to stop you putting that into practice now?

Sir David Nicholson: Ian Carruthers who is working on this directly in the South West will be able to give you an indication of what they are doing there. You are absolutely right about that, and indeed it was identified as part of the Government's document *NHS 2010-2015*, that dementia is one of the five long-term conditions that has the real benefit both to improve quality for our patients but also to save significant amounts of resource, which currently is wrapped up in the acute sector. We are absolutely focused on that as one of the potential benefits for the service going forward.

Q74 Angela Browning: Forgive me, Sir David, we know it is going to be a benefit, but when you say "we are focusing on", what does that mean? What are you doing? Tell us in layman's terms: what are you doing to reduce by one week the stay of everybody with dementia who goes in with a fractured hip or with a minor stroke? What are you doing?

Sir Ian Carruthers: The National Audit Office Report also includes that and it has a different figure when including falls—was my reading of it—so the figure when combined was something like 130 of the 385 you identified. What we are doing at the present time as part of the £20 billion savings—each region is looking at how it can reduce the length of stay in a number of areas, and they are putting plans together in order that they can be activated. They do need of course some re-design of the system because it is predicated on reducing the stay and obviously, people have to have support in the community and so on. In our region at the present time, because, as the Report says, we have one of the biggest challenges and diagnosis gaps, we have embarked on a process where, with the Alzheimer's Society and colleagues in social care, the DRD, with someone we took out of the job, with clinical leadership, and an assessment of every PCT where we have gone and engaged in local settings, identifying with carers, users and professionals what it is that needs to be done. We are at the point now where we are putting an action plan together, of which that will form part. We will start to look at how the services get into place in order to address that. Clearly, before you take the beds out you have to have adequate support to manage people away from home. In fact, there is a conference in the South West tomorrow on this where district general hospitals are coming together to look at an audit we have done of the Royal United Hospital, Bath, which is saying how we can help people be better cared for and managed quickly through the process, based on what happens in the district general hospitals. We are looking to do that. In fact, it will be vital for the future. It is vital and a

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key component in funding the impact assessment, and we need to go through, creating the infrastructure as well as taking the money out.

Q75 Angela Browning: We can all see why this is of benefit to patients. It saves money and it creates a substantial pot of money that we understand although not ring-fenced—you decided not to ring-fence it—theoretically could be used to implement your strategy when it comes on line.

Sir Ian Carruthers: Yes.

Q76 Angela Browning: But if that is the case, why is it that just that element of it was not rolled out as part of the operating framework?

Sir Ian Carruthers: If I could continue, I think the Committee rightly has put a lot of pressure on about the operating framework and priority, and if you look at the analysis—and we are not the only region because I have seen the briefings of all regions—every region has done a baseline review—we just happened to start first. The reason we did it is because when you look at a local determinant all our PCTs recognise in the South West this is going to be a major challenge, probably the biggest challenge we face. Therefore, we collectively decided to do that work. The point I wanted to make is that just because it is not a priority in the operating framework, it does not mean nothing has been done. I can cite lots of practical differences that have been made in the last year to people with dementia in the South West. So I can understand why you are focusing on this, but the fact is that every region is taking this forward, even though it is in the local determined category.

Q77 Angela Browning: Chairman, thank you. Obviously, I am familiar with the South West; I am a South West MP, and as far as I can gather the South West has been something of an exemplar in leading the way here, but I am concerned nationally. We do have postcode lotteries right across healthcare. Clearly, it is good for people in the South West, where we have a large retired population, but not so good for people in other areas if this is not rolled out because the concern about the failure to use the national operating framework as an opportunity is because of course there is really no local priority on the PCTs now, because they know that if it is not included they are not going to be judged on their performance in this area.

Sir David Nicholson: But they are, in a sense—

Q78 Angela Browning: Against what criteria?

Sir David Nicholson: They will be judged against a whole set of criteria as part of the work that Ian has described and we have described. Every PCT has to do a baseline assessment; they do not have a choice over whether they do it or not; they have to set out where they think they are in terms of dementia services. We have brought all of those in and David and his team and Ian have been going through them, identifying their strengths and weaknesses. Out of that discussion then comes an action plan. By the end of March every PCT has to have clear goals in

identifying how they are going to implement the arrangements for the dementia strategy in their area, so that is a very powerful mechanism for making people focus on it and take it forward. It seems to me that is a really good way of doing it. I accept that it is not in the operating framework but I think that set of plans we have is much more likely to get us success in this area, because what we have not been able to do in dementia, which is one of the issues around the others, is that there is not one measure or two or three measures that are identified by everybody as being the particular measures that you should use in these circumstances. We have been reluctant over the last two or three years to identify more national targets as part of the way we do it.

Sir Ian Carruthers: If I could add to that, the other thing is that the growth in continuing care and changes in eligibility criteria in our region is in excess of £50 million this year, and a lot of that will be to support people with dementia. Therefore, what is in the local interest is that we get services that are good for people. You have highlighted in the other areas of good practice in the Report intermediate care and some of the Leeds dementia care stuff—all of which highlight how it is possible to improve the system, spend less money, care for people better, avoid unnecessary admission, and that is not only in the public interest of the individual, but it is also in the economic interest and the well-being of the system. The incentive is to get better. I think that because times are tough, no-one can ignore that type of issue.

Q79 Angela Browning: I am very concerned about how this translates locally, right down to hospital and even ward level. How many dementia champions are now in post in hospitals?

Mr Behan: Not enough.

Q80 Angela Browning: No, no, how many? How many?

Mr Behan: I could not give you an exact figure on that, I am sorry.

Q81 Angela Browning: Since you last appeared before this Committee, have you any idea how many have been put in place?

Mr Behan: The issue is not dementia champions; it is whether there has been a lead appointed within the hospital, and that figure is changing all the time as awareness grows about the strategy, as we are doing the baseline reviews, as we are taking forward local action plans. The key role of the national clinical director is to drive this further. The Report itself that the National Audit Office published has in one of the tables a recognition by hospital-based consultants of this. It is around the 90% figure for people who are aware of the strategy. We want to drive this strategy hard, and the awareness campaign we launch in March of this year is designed to push on even further to secure that.

Q82 Angela Browning: I am sorry to be rude, but I asked a specific question for a specific answer, and I have only got two minutes left so I need to push on,

but I wonder if you would write to the Chairman.² I know that the All-Party Group for Dementia has a particular interest in this, and is seeking freedom of information requests on this very issue; so I think this Committee would like to know how many, and where they are. If you could possibly supply that to the Chairman and the Committee it would be very interesting to see just where they are and who has and who has not got one. At the end of the day, if there is no local passion, pace and drive to make some change—and that is what we are talking about—at hospital level, this is not going to happen. I would like to just ask you this: if you are aged over 65 and you are admitted to hospital, with whatever—fracture of neck of femur or all sorts of things, even onto a ward that is not a trauma ward—my understanding is that all too often if you have other issues like dementia you do not see somebody who specialises in dementia, you see the geriatrician. That is not a specialist service. It has been geriatricians, who are very good people, but who are more generalists. Why is it we have this discrimination against people over 65—and dementia can of course affect people very much younger than that—but for the over-65 population, which is where we are looking, what difference is going to be made in order to assess that patient and get them through and out of hospital, other than the geriatrician if you have not got the dementia specialist in post?

Professor Banerjee: You are absolutely right. There is a need for specialist dementia expertise in general hospitals, and general hospitals need to prioritise it for themselves because people with dementia are spread right through the whole hospital; but there is also the need for specialist old people's mental health services who are particularly skilled in the diagnosis and management of dementia. The strategy is very clear; that part of the way for delivering that in general hospitals is to generate liaison services, specialist multi-disciplinary services for the diagnosis and management of people with dementia in every general hospital. That is part of the delivery of the strategy, to identify that, along with the ownership of dementia, as part of what acute hospitals do. You are right: if those things are delivered, then you can create an environment that enables people with dementia to get out of hospital quickly, and that has quality improvements and cost improvements for people. The other trick of course is the other elements of the strategy are all there to prevent people unnecessarily entering hospital, and you want to prevent older people from getting into what can be a toxic environment; and once they are there to get them out as quickly as possible. If the strategy as a whole is taken, then it provides the framework to be able to deliver that. It is by delivering the strategy that you achieve the benefits that you have set out.

Q83 Angela Browning: Chairman, I shall be 65 next year, but I shall not be here. I hope no-one ever refers me to a geriatrician. I shall not be here because I am

retiring, but could I put on the record and have it written into the minutes of this Committee that whoever does sit round this table, that we ask the NAO to re-visit this pretty promptly so that this Committee can again look at this issue and report progress from these gentlemen—I would say 18 months maximum.

Mr Mitchell: Hear, hear.

Q84 Chairman: Is the National Audit Office happy to do that?

Mr Morse: Yes.

Q85 Chairman: Thank you, Ms Browning, for the passion, grip and drive with which you have asked your questions. I wish this was reflected in the Department. If you look at paragraph 2.14, this is the sort of bureaucratic speak of these sorts of reports. It is frankly rather stodgy and turgid. "The Department has commissioned Skills for Care and Skills for Health to map the training needs of the workforce and the training currently available across all sectors, identifying the gaps. The mapping exercise will conclude in March 2010 and make recommendations to inform the Department's workforce action plan." It is all very worthy, but where is the passion, the grip, the drive, and why have you not gripped your workforce up to now, Sir David?

Mr Behan: I think the NAO Report said that this strategy was well led at the national level and that the challenge was to drive it at the local level. I think there is passion within the Department about how to take this forward and begin to drive improvements in this. Paul Burstow's question to me was about the social care workforce. His point was whether it has moved forward from where it was the last time we were in front of the Committee. My answer was it has moved marginally through that. What we are looking for in this audit is to be absolutely clear what skills are required to respond to the increasing numbers of people with dementia and Alzheimer's and ensure that the workforce is there. Skills for Care and Skills for Health are the two sets of workforce councils that are responsible for driving the workforce strategy. They comprise mainly of employers who will take ownership of this. The strategy here—I am sorry if it reads as being dull and turgid—is an essential prerequisite to ensure that we can drive improvements and ensure that our improvement strategies are clear in terms of what we are attempting to take forward, and we can be clear that we are making progress. At the minute, as Paul Burstow's question identified, we have got a very simple measure in the social care workforce of how well qualified they are. It is largely whether they have an NVQ2 qualification or NVQ4 qualification. One of the key issues around NVQs, as I am sure some members of the Committee are aware, is whether it gives sufficient attention to the issues around dementia care and people that do not have cognition. One of the challenges as we move forward is to ensure that the curriculum adequately reflects that in much the same way as the Report has

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recommended we take action for GPs, et cetera. I am sorry it reads as dull and turgid, but I would argue that it is a very essential part of taking it forward.

Chairman: You are doing your best.

Q86 Dr Pugh: I would like to ask a quite friendly question. In my notes it says that £15.9 billion is estimated as the total cost of dementia services in 2009. I am highly suspicious of big numbers and certainly big estimates and it does strike me that in treating people with dementia you are also going to treat many people who are frail, who have complex medical needs, and who may well have other social needs that are not specifically to do with dementia. How capable are you of disaggregating a figure like that into the real costs of dementia as opposed to the costs of dealing with elderly people in troubled circumstances?

Sir David Nicholson: Which particular figure is this?

Q87 Dr Pugh: It says here that the estimated total cost of dementia care in 2009 is £15.9 billion. Do you agree with that?

Sir David Nicholson: I think it is as good an estimate as we have—it is as good as we can have. It is a highly complex area. You are absolutely right. People with dementia may have a whole series of other chronic conditions attached to them as well. It is quite difficult to disaggregate that particular bit of expenditure, as you say, but I think it is as good an estimate as we have seen.

Q88 Dr Pugh: What is the sum spent on specific medical interventions to deal with dementia as an illness?

Professor Banerjee: I can help disaggregate that because I was involved in generating the figures for the original report, the Dementia UK report. What you find is that of that £15.9 billion, at figure 5, that includes three main elements of cost. The first and the largest is that of institutional care for people with dementia, so the cost of care homes. For those individuals that is calculated on the basis of the number of people who have got dementia who are in care. Increasingly, if you do not have dementia you do not go into a care home, so actually it is the cognitive impairment from dementia and the disability that comes from that that determine if you are going into a care home. That is a fairly stable figure and that is the largest element of it and that is costed well. The NHS costs are small and those are the NHS costs that are more or less directly attributable to dementia care; so those are not about carrying out hip replacements on people with dementia. They are not even the extra time spent in hospital for people with dementia because we are not able to calculate that. They are the services directly provided for people with dementia. Those are relatively small and those are assorted throughout the course of the illness. We do not have community—

Q89 Chairman: I am going to stop you there.

Professor Banerjee: One more thing.

Chairman: You have got to try and give shorter answers; it is not fair on them.

Q90 Dr Pugh: If you would like to give the last sentence.

Professor Banerjee: The final part of it is the opportunity costs that fall to families because the immense amount done by families does need to be costed, and this was costed at minimum wage.

Q91 Dr Pugh: Okay, a useful response. You are saying NHS medical costs are relatively small. In the Report it talks about extra money being provided through the Department of Health, but paragraph 3.8 concludes by saying: “There is no extra funding for councils, no additional financial provision has been made for dementia in local government expenditure plans for 2009-2010 and 2010-2011, and there are no ring-fenced grants from the Department for dementia services.” Given what you have just said, if the situation with regard to the EMI needs—and obviously these vary from council to council because the demography are different, are not reflected adequately in councils’ spending and what councils have available to them, is it not a pretty hopeless task to deal with this problem in isolation in the Health Service?

Professor Banerjee: There is absolutely nothing hopeless about enabling people to understand whether they have dementia or not. What health services can particularly bring to the piece is to give people that vital piece of information which is that they have dementia—

Q92 Dr Pugh: Sorry to stop you—in terms of the state tackling this issue, not to look at local government funding for EMI provision is a very serious mistake, from what you said about—

Professor Banerjee: The whole of our strategy was based upon it being a joint health and social care strategy. You cannot look at dementia sensibly without looking at the social care elements as well as the healthcare elements because these are indivisible parts of people’s course of dementia in the seven or 12 years they may live with dementia. Our strategy is very specific in covering in detail the social care as well the healthcare elements.

Q93 Dr Pugh: The NAO thesis throughout their Report is that early diagnosis substantially reduces the cost of actual treatment of dementia. There is a map on page 16, which shows what is called a diagnosis gap challenge, which I suppose means in areas like the South West you are diagnosed more slowly than you would be if you were, for example, in London. Am I reading that map correctly? Right. It is obvious then that as a result of the early diagnosis in London and the later diagnosis in the South West there is differential in costs for treating dementia in those areas. In other words, is the NAO thesis correct?

Professor Banerjee: There is another element to it as well, apart from just the number diagnosed; it is also the number of people with dementia in each area. The number of people with dementia vary per population because of the different age structures across England. So there are different costs across England that are mostly attributable to the age structure of the population.

Q94 Dr Pugh: So clinicians are generally convinced despite the paucity of evidence, as it were, that the NAO are right in thinking that early diagnosis means lesser cost in the long run?

Professor Banerjee: Absolutely. There is no doubt if you accept that care homes cost as much as they do and you accept that early intervention can be critical, by reducing by 28%, that is a median of 558 days, the time that people spend in institutional care, then a very simple, small, cheap up-front investment in early intervention can have a tremendous powerful, positive effect in terms of cost; but as importantly it also results in increased quality of life for those people. We have good evidence not just from the National Audit Office but from multiple work including work we have done at the Institute of Psychiatry in King's College, London, modelling on a memory service we set up, so, yes, there is no doubt about that. Added to that are all the things that can happen in the medium term with respect to improving things in general hospitals.

Q95 Dr Pugh: So clinicians are persuaded of the overall strategy, albeit it is drawn up by pointy-headed people in Richmond House?

Professor Banerjee: I think the whole point is that it was not drawn up by pointy-headed people in Richmond House. It was drawn up by joint health and social care professionals consulting tremendously widely with the field, and it has validity because of that.

Q96 Dr Pugh: Can I refer you to page 27 and the graph at the bottom where frontline staff are asked not about strategy but how likely the strategy is to be implemented successfully. There is a huge gap there between what strategic health authority leads think is going to happen and what GPs think is going to happen. What worries me is what consultant old age psychiatrists think is going to happen.

Sir David Nicholson: I do not think we should be surprised by that.

Q97 Dr Pugh: We are not.

Sir David Nicholson: We do have quite a lot of experience in the Department about leading and managing change, and this is not surprising at this particular stage. In fact, it reinforces the reason why it is so important to embed this strategy amongst our people, because unless people get it and understand it, and want it to happen, it simply will not happen. If only it was just as easy as having a rational case at the centre and sending it out to everybody and they would implement it, we would all be in a better place, but it is not like that. If you look down here you can see those people on the front-line who have been in

dementia care for a long time who have heard all this stuff around change, and they are more difficult to shift in terms of whether they believe it will happen than those who are responsible for the implementation of it.

Q98 Dr Pugh: I think it was 15% of consultants who think they have seen the new money spent in their area, and that is a very low figure, is it not? That is elsewhere in the Report. It seems to indicate they are not just sceptical, but they have some evidence for their scepticism.

Sir David Nicholson: As I say, this was a regular pattern. If you looked at stroke; if you looked at the 18 weeks; if you looked at our attack on MRSA, you will see at the beginning of the process people in this kind of place. Part of the management of change is to persuade people and to engage them in the process to make it happen and given them the power to make it happen.

Q99 Dr Pugh: Can I ask you about memory services and memory clinics. I first thought that these were organisations that improved your memory and almost thought of enrolling myself; but I understand that they are refining a diagnosis that may originally have been made by a GP. It is a resource commitment. What study has been made of the value for money they provide?

Professor Banerjee: Lots, and that is precisely the data that was given to the National Audit Office, which they evaluated, and it is the modelling of the value for money of those services that informs the National Dementia Strategy. In terms of the quality of data, there are papers published which very clearly show the long-term savings. There are papers published that show the short-term improvements of quality of life, and, yes, they are valuable, no doubt.

Chairman: You see, it is so depressing to read here, these reports are very understated, they do not overstate things, but in 2.7 it tells us: "Few front-line staff could identify leaders who were championing dementia, and few could give examples where the profile and priority of dementia at local level had increased. Only 21% of consultant psychiatrists said a senior clinician had taken the lead for improving dementia." This is all in the Report you signed up to; it is not some politician speaking. It is very depressing when we thought we had made so much progress two and a half years ago that we are still struggling with this.

Q100 Geraldine Smith: Can I say first of all I would like to be positive because I think there are some great strides made in the National Health Service overall, but this is an area that people are becoming much more concerned about. Awareness is very important. There is not a great deal of awareness about dementia. You say that early diagnosis would make a very big difference to people and it would mean them spending much less time in a care home at the end of their life. Why is that the case? What is different about it?

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Professor Banerjee: The public actually does not understand it. We have a major problem with respect to what people understand about dementia and there are fixed false beliefs, firstly that dementia is a natural and normal part of ageing, which it is just not. It is a disease that becomes more common with age but even at the age of 80 we have only got 25% of people with dementia. The idea is there that nothing can be done about dementia, when the fact is that there is a tremendous amount that can be done to enable people to live well with dementia. But in order to have that help you need to know that you have got dementia. You need to know that you have the illness. A major problem that we have in our system is that only a third of people get diagnosed, and when they do that is late in their illness generally, at a time of crisis, when it is too late to give people help. We have a system whereby people do not ask for help because they believe it is a normal part of ageing, where help is not available because services are not set up to do that; and there is an avoidance of making the diagnosis rather than facilitation to make that diagnosis. What we also found is models that show that this can change. It can change in particular areas. The strategy's first priority, first theme, was to improve public and professional attitudes and understanding of dementia, and that is a programme of work that started with the *Worried About your Memory* campaign that we set up with the Alzheimer's Society, and that is going to go into a much larger higher gear come March time. That will deliver a national media campaign that will help people to understand that it is legitimate to be worried about your memory.

Q101 Geraldine Smith: Does the Report not say though that GPs' awareness has not improved?

Professor Banerjee: I think it is improving a little. One of the things about this is that if you ask GPs to do something impossible, which is to make a diagnosis for dementia in primary care and to subtype it, which is what you are asking them to do, they will not do it. If you ask them to do something possible, which is if you are worried about symptoms of dementia you refer people to a memory service to have a diagnosis made, then they will do that.

Q102 Geraldine Smith: So you need those memory clinics.

Professor Banerjee: You need the memory services and you also need the education, both in terms of the undergraduate curriculum for the primary care and other doctors, but also continuing professional development that improves the skill of our current medical workforce.

Q103 Geraldine Smith: The specialist support services available once a person has been diagnosed—I came across a young person, a constituent in their fifties that had been diagnosed, and they were not being offered any specialist service until their condition had deteriorated.

Professor Banerjee: There are major problems with quality of care provided for people with dementia across the country. What the strategy has done is

given us a really clear picture of the warts that we have in our system, and also given us a plan to be able to deal with that. What that requires is someone to have accurate diagnosis as early as possible, plugging into services which exist and improving social care—things that will work across diversity, including younger people dementia and older people dementia. You only do that if you prioritise dementia, and the problems that we have are symptoms of the lack of prioritisation.

Q104 Geraldine Smith: But I know, as a politician, that people talk about the Health Service and they want to know that they are not going to die of heart failure or a heart attack or cancer. The big killers are natural priorities and people are not thinking about dementia.

Professor Banerjee: Dementia is one of the very few illnesses that people, if you talk to them, will rate as worse than death. Dementia is perceived as a worse illness to have than cancer, and it is the fact that people have not talked about it. The stigma of dementia has clouded everyone's desire to be able to talk about it so that we can do things about it. I think we are starting to dispel that and I think the strategy has identified that that is a legitimate area for us to intervene in. That is why there is this campaign to try and change that.

Q105 Geraldine Smith: Do you accept, though, that there is still a long way to go between your strategy and what I see on the ground? What can I go back and tell my constituents who have relatives that might be suffering with dementia? What positive messages; what can you say has changed in the last three years; and what improvements; and where will we be in the next five years?

Professor Banerjee: Is that a question to me?

Q106 Geraldine Smith: I think all of you.

Professor Banerjee: In five years' time I would hope that there would be a national network of memory services so that everybody, when they first have problems with memory, are referred to those services, and so that people know they have dementia as early as possible so they can get on with planning their own lives and make choices for themselves, rather than those choices being made for them later on at a time of crisis. I would hope that every general hospital would see dementia as a priority and see it as a legitimate part of what they do, because if they do it well they will do the care of their patients better; their quality will be improved by improving the quality for dementia. I would hope that every social services department would have a well-developed arsenal of services for people with dementia with which you could meet people's needs, both in people's homes and also in care homes when they need to. I would hope that we would have a third sector that was providing peer group support for people with dementia and I would hope that we would have systems to support people on the whole of their trip through dementia right from diagnosis to end-of-life care, delivering quality all the way. We could do that in five years but we can only do that

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with will and with a lot of concentration in delivering this. I think the strategy, if it is delivered, will deliver that.

Mr Behan: We set out to deliver seven priorities as part of the strategy to ensure that we could be focused in the way that we move forward. The seven areas were: early diagnosis, the questions you have been asking about memory clinics; how we can improve community based services; the services that are there to support people living in the community with dementia; how we can continue to deliver and roll out the carers strategy to support people who are providing direct care to people with dementia; key challenges around general hospital care; psychiatric liaison services which exist in hospitals to ensure that exactly those people with fractured neck of femur are being assessed by a clinical specialist in psychiatry; how we can improve the quality of people's experience in care homes. We have about 240,000 people living in care homes. About 60% to 80% of those have some degree of dementia, so getting the quality of those services right.

Q107 Geraldine Smith: Do you still have the problems with the liaison between health and social care because that still feels a problem to me?

Mr Behan: We continue to insist, as Professor Banerjee has outlined, that this is a strategy that goes across health and social care.

Q108 Geraldine Smith: You can say that but what I am asking is how is it actually working?

Sir Ian Carruthers: I can talk about the South West but I know this to be the case in different parts of the country. Dementia, if you have someone in your family who has it, which I have, is the most difficult thing to deal with because not only do you see the person disappear but you also see those around them struggling to cope with something that they cannot cope with. The thing that I would actually say from my personal journey in this is the priorities are in here but we need really to systematically, at scale and pace, change some of them. The Strategy here was about two years in preparation and I think that even the Report says that it is too early to see front-line change on the ground, but it is front-line change on the ground that is actually crucial. As to where we are on health and social care, there are good examples. If you go to Torbay, where there is an integrated arrangement, you can have very fast decision-making after your assessment. Normally it takes three or four weeks; there they do it in a few days. You get very quick access. Hertfordshire, too, if you look at them as an example, they have put in an alignment of process so there is good practice between health and social care.

Q109 Geraldine Smith: Can I stop you there because what I am concerned about is Lancaster and Morecambe and the surrounding areas that I represent. I want to make sure that they have really good care. Is one of the problems that there are different standards across the country and even the

drugs that can slow down dementia, in different parts of the country people appear to have easier access. That cannot be right. That has got to change.

Sir Ian Carruthers: I cannot speak for Morecambe and your constituency but I think that there is an issue where we should have more common standards across the whole social care horizon. However, I gather that will be a subject of great debate as we head over the next few months, because people do get different things and there are different things on offer. I know from going through this that whilst people think there is a lot of community support available, when you are faced with it, it is not as great as you think, and indeed, the Report says in here that ends up with too many people prematurely being in residential care, so we need to develop those services in order to implement this Strategy.

Q110 Geraldine Smith: Can I say the most hopeful comments were the comments you made about where you would like to see things in five years' time.

Professor Banerjee: Thank you.

Q111 Geraldine Smith: If you can achieve half of that I think we will have gone a long way, but I guess it is also very expensive.

Professor Banerjee: What we want is for those changes to be in every part of the country so the variation that exists in terms of likelihood of getting a diagnosis and getting various sorts of treatment is evened out and we lose that variation so that everybody gets good-quality care.

Q112 Mr Mitchell: Can I just pursue that point about regional differences in prescribing. Sir Ian seemed to be saying we wanted uniformity, that people should have access all over the country to the same prescribing. Is that what you were saying?

Sir Ian Carruthers: What I was saying was that regardless of where we live we should have access to the same standards.

Q113 Mr Mitchell: That is not happening, is it, because at page 17 the Report says there are regional variations suggesting that people in some parts of the country who might benefit from the drugs are not receiving them. Why is that?

Sir David Nicholson: Ian is responsible for the South West and he can tell you what the position is there.

Sir Ian Carruthers: In the South West we have the big challenge because of the diagnosis gap. We have a fairly elderly growing population. The diagnosis gap is significant, as this Report says. That is where we have to go back, and if I can connect these things, and get GPs trained to identify people to come forward and receive treatment. The low use of some of the drugs is actually because we have low diagnosis because early diagnosis requires, in the main, early treatment and intervention, so what we have to work on, and others in the country, is really getting dementia diagnosed much earlier, and that is very much a staff training and particularly medical training issue, as Sube said before.

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Q114 Mr Mitchell: Can you supply us with some figures on that, in other words, the proportion of cases that is getting prescriptions over the country? It is not supplied in figure 7 on page 17 because that says it is meant to prove that people in some parts of the country who might benefit from them are not receiving them, but, in fact, what it says at the bottom is that this is a measure of “defined daily dose per diagnosed dementia patient”. In other words, people in Yorkshire and Humberside are getting bigger doses than people in the West Midlands. It does not tell us how many people are getting the doses. It just tells us the doses are bigger.

Professor Banerjee: I think this is a metric that is designed to show a good estimate of the proportion of people who would meet NICE criteria for the treatment of dementia who are being treated with drugs, and showing that it varies across the country.

Q115 Mr Mitchell: Why are they getting bigger doses in Yorkshire?

Professor Banerjee: There is more of the drug prescribed per person with dementia but there is very little prescribed per person with dementia, so what that means is that on average there are more people being initiated on these medicines in Yorkshire and the Humber than there are in the West Midlands. It is not about the dose of the medicines as such; it is about the number.

Q116 Mr Mitchell: That is not what it says it is.

Professor Banerjee: I know but that is because it is using the dose as a way into the amount of drug that is prescribed there.

Q117 Mr Mitchell: Can we have the figures in a less confusing form?

Professor Banerjee: These are National Audit Office figures.

Q118 Mr Mitchell: Of the number of people who are getting prescriptions in each area.

Professor Banerjee: There are data on that which are included in the Dementia UK report.

Q119 Mr Mitchell: Can we have them?³

Professor Banerjee: Yes, those are perfectly available.

Q120 Mr Mitchell: You were also talking about early diagnosis saving money. I do not see why that is because earlier diagnosis means earlier treatment, the treatment is expensive; I would have thought therefore earlier diagnosis leads to more expenditure.

Professor Banerjee: That is just not true.

Q121 Mr Mitchell: Good!

Professor Banerjee: Again, it is about a stereotype of dementia. If you imagine people with dementia to be people who are entirely dependent and requiring high levels of care, then that is where the cost comes,

but the reality is someone with early dementia is no different to yourself in that they would not be needing—

Q122 Mr Mitchell:—You should not say things like that to a politician!

Professor Banerjee: I am sorry, I should not have said that, but any person might have early dementia and that person will need no more care the day after they are diagnosed as having dementia than the day before. The cost of diagnosis is small because that is essentially a clinical assessment, perhaps a scan. The cost of breaking the diagnosis is small. That is the individuals, talking to the person with dementia and the carer, and the cost of care at that point is small as well.

Q123 Mr Mitchell: If early diagnosis does not lead to treatment, what is the point of early diagnosis?

Professor Banerjee: It leads to timely treatment when you need it. You will not need your home care person probably for three or four years at least, and maybe not at all if you have supported your carer, but what it does do is enable you to tell the carer what is going on so they can look out for signs early so if they start to get depressed for example, they can get treatment for that depression rather than getting so depressed they need to come into hospital, or if they start to have behavioural problems, as does happen in dementia, then you can actually look for non-pharmacological methods that would be much less harmful for an individual. Basically you prevent harm by early diagnosis and therefore prevent cost.

Q124 Mr Mitchell: I deduce from that that I shall be able to manage without a carer until at least 6 May when the election comes along, so I am very cheered by what you are saying. However, I am a bit bamboozled by what has been said because all the emphasis in the Report and in our questions has been that you are dragging your feet and that you are not taking effective action to implement the same kind of strategy that has been so successful in breast cancer and stroke. Cynically, one would assume that because the costs of this are going to be big, and figure 3 shows the increasing incidence of dementia, which means that you are embarking on a big expenditure, that you have been dragging your feet because at the moment you are trying to cut spending in the Health Service and here you are embarking on a big extra spend.

Sir David Nicholson: I do not believe that we are dragging our feet, first of all. This is probably the most complex and biggest change programme that we have ever done. This is far more complicated than delivering waiting time targets and far more complicated than delivering reductions in health care-associated infection because of the kinds of things we have been talking about: public awareness; public attitudes to dementia; the attitudes of the professions to dementia; the way in which it cuts across primary, secondary and social care; the point that only a relative small amount of expenditure is in health care that we can lever; and this issue about planned and organised care and support for people

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with dementia is less expensive than chaotic care later on when people are admitted into acute hospitals and their carers and their families break down because of it. That is a massive set of changes to make and I absolutely assure you that we are not dragging our feet. What we are trying to do is to make sure that we have plans in place and people are in the right place to make it happen. There is nothing worse than if we just implemented a series of initiatives around the country, which may sound exciting and good but do not add up to a proper service for patients because it certainly will not get the benefits that we need and that they need.

Q125 Mr Mitchell: Okay, I accept the good intentions but it is going to take more money at a time when the Health Service is going to be fairly strapped for resources. The local health service told me they are considering the prospect of cuts and what they will need to cut if they have got to reach a certain level of cuts.

Sir David Nicholson: The first thing is just to clarify this issue about cuts. The NHS has been identified over the next two years as getting what is described as “flat real”, which is the same as we got the year before plus a little bit for inflation, so the total amount of money going into the NHS is not being cut.

Q126 Mr Mitchell: Why are they all going round then thinking about 5% off?

Sir David Nicholson: But of course what happens is the NHS and our patients do not stand still. There are demographic changes going on in society. Basic demand for health care is going up in society. Patient expectations are going up in society. Pay is going up in the NHS. All of those things need to be paid for so we need to generate the savings to deliver them, but the important thing about dementia, and that is why David at the beginning talked about incentives which are so critical, is if we do nothing we will spend more. If we do nothing what will happen is all our acute hospitals will be full of people with dementia who are not being provided with the support and help and care either up-stream or to their carers and families, so to do nothing is even worse in value for money terms for the NHS.

Q127 Mr Mitchell: I hear that point strongly and I applaud you that we have got some good, strong answers today. Let me conclude with a question about efficiency savings. A lot of this is going to be paid for by efficiency savings. Efficiency savings are like a mirage in the desert. You crawl towards them and then when you get there you find it is not there; it is a mirage. A lot of this is posited, as 1.13 says, on bigger efficiency savings than you are making already and, as 1.15 says, on efficiency savings which have been very difficult to produce in the past because you have not been able to get the money out of other services.

Sir David Nicholson: I was accused of being long-winded about it earlier so I will not be long-winded again. The challenge facing us is significant and we have never done it on this scale before.

Q128 Mr Mitchell: But can you do it? Can you make efficiency savings?

Sir David Nicholson: There is small-scale evidence around that shows it works. I have been to places where they have shown by, for example, better care, better support for members of staff on orthopaedic wards to understand dementia much better, who can look after patients—because a lot of patients on orthopaedic wards have various kinds of dementia—better training and better organisation you can reduce the number of beds that you need in orthopaedics because you can get patients out quicker; better both for the patient and for the service. We have small-scale examples all around the country where that is happening. We have never done it nationally at pace and at scale and that is where the planning is so important and that is why some people might describe it as dragging our feet. I would say it is putting plans and rigour in place to make sure you have got the best chance of delivery.

Mr Mitchell: Thank you.

Q129 Mr Curry: Sir David, you have emphasised how dependent the Strategy is on an effective interface between the Health Service and social services.

Sir David Nicholson: Yes.

Q130 Mr Curry: You have said that the Health Service is going to get “flat real” financially. Local government is not, is it? If you look hard at what the funding projections for local government are, they are facing a very serious problem indeed in real-term cuts. How are they going to deliver their part of the Strategy in light of that budgetary pressure they are going to face in an area which is already very difficult?

Sir David Nicholson: I will ask David to say a bit about that but, in a sense, all of the things that you have said are correct. Undoubtedly, the whole of the public sector is going to come under pressure over the next period. That is why it is so important to us that it is a joint strategy. In some parts of the country the NHS will spend more and in other parts local government will spend more, depending on the local circumstances. The incentive for the NHS—I cannot reinforce this enough—is if local government do nothing and if the NHS does nothing, we end up with all the costs in secondary care, which is the most expensive bit of the system, so the incentive to do something is great. We are trying to create an environment where health and social care can work completely together on all this.

Q131 Mr Curry: The incentives can be there and you can try and create the environment, but it does not alter the fact that there is a budget in local government and all the fine words are not going to add anything to that budget at all. They have priorities and they are going to be challenged. Education is going to be another priority. We all know that social services is a priority. There are going to be pressures children's services, after the sequence of things that I do not need to explain, and with elderly people generally because of the ageing

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process. How can you be confident that the other half of your pantomime horse, as it were, is going to be able to keep up with you? Are you going to find the whole thing is going to be let down not because anybody is being inefficient but because we just have not got the cash?

Mr Behan: I think the imperative for health and social care to come together at a time of exactly the financial environment you have mapped out is great, because what we know is that unless they do come together and do this jointly, the danger is that costs will be passed backwards and forwards between the two systems. That is why in the base-line review we have asked people to do this review jointly and that will lead to a joint action plan. We issued earlier in the year joint guidance on commissioning, renewed guidance on intermediate care. 2009 has been a very busy year in the work that we have done on dementia, to do exactly what you are suggesting; ensuring that services are joined at the hip. There is no point in having strong primary care services if care in care homes is poor and weak. The only thing that happens is people rapidly go in and out of hospital on a revolving door.

Q132 Mr Curry: In my own county of North Yorkshire we know that care homes are groaning because the increase they have been allowed for local authority-funded people has been extremely low. Given that there is a direct relationship between the age of the population and the propensity to develop dementia, are you satisfied that the local government funding formulae therefore reflects sufficient weight on the demography of the population in order to help them cope with this sort of issue?

Mr Behan: The funding formulae are the formulae.

Q133 Mr Curry: I know. I ran it for several years!

Mr Behan: I know you are an expert about this in your own right so I am not going to do battle around funding formulae there. The key issue in relation to your own experience in North Yorkshire is they have made fantastic strides using tele-care and tele-medicine to reduce the numbers of people that are going into care homes. The thing about this is to see this across the whole system and not just look at elements of the system. Again, I come back to repeat why it is important from the Department's point of view that we continue to lead this strategy and see it as being a joint strategy across health and social care.

Q134 Mr Curry: Can we look at some actuarial assumptions. I see that on page 15 we have the cost of dementia predicted to double by 2026. We are living longer so the more we live then the more we get dementia and the more it will cost, but the earlier we can diagnose it then we might be able to reduce those costs, so we have got those things working in contrary directions. Most calculations as to what is likely to happen in the future tend to be under-estimations, do they not, on almost any subject, whether it is the use of the M25 or whatever? If the worst performed at the level of the best and if the

level of formal diagnosis improved but you then stack that against people living longer again, is the trend remorselessly upwards or is it flat real?

Mr Behan: I think the important point about the figures in the Report is that they were produced by independent commentators.

Q135 Mr Curry: I have seen that. I have noticed that.

Mr Behan: A lot of the figures which have driven our work since 2007 are based on the evidence from Professor Martin Knapp and his colleagues at LSE, which is a reputable organisation which has very high standards, so we have no reason to suspect, Mr Curry, that they are either underestimates or overestimates. Any projection that is going to 2051 always stands a risk of being too far in the distance to be reliable, but certainly what we are looking at to 2020, which is an increase in 750,000 from just over half a million today, has informed the way that we brought forward the Dementia Strategy. We think that is a reliable figure.

Professor Banerjee: I think they are reliable figures. They are more stable than you might imagine because we have very good estimates of the population prevalence of dementia. We have very good demographic projections and the calculations that we carried out included projections on increased longevity. We can be pretty sure in 20 years about the people who will get dementia because those people already will have the pathologies that will lead to dementias in their brains, so there will not be major lifestyle things that would either increase or decrease the prevalence. I think they are fairly stable as estimates of cost.

Q136 Mr Curry: Have other European countries made similar projections which would lead you to have confidence in these projections? Have they had similar sorts of outcomes?

Professor Banerjee: If you look at the French Plan Alzheimer, which was brought out just before ours, that has very similar projections across France and there has been work done by Alzheimer Europe which has generated these figures for now, for 20 years' time and for 40 years' time, and we have exactly the same thing happening across the whole of the developed world. In the developing world there has been very good work done by Alzheimer's Disease International which shows that there is even more of an issue there.

Q137 Mr Curry: Figure 5 has this little phrase "informal care costs (to families)". What are they?

Professor Banerjee: These are the opportunity costs. This is costing what families do for people with dementia. Most time and most care provided for people with dementia in their own homes is provided by families, generally by a spouse living in their own home or a family member.

Q138 Mr Curry: That is what I thought.

Professor Banerjee: So what you do is you calculate the hours of time they spend doing that and you cost it at minimum wage. That is the methodology we used.

Q139 Mr Curry: Is there a gender split in dementia? I ask the question because women tend to live longer than men so you would therefore assume that proportionately there are more women than men.

Professor Banerjee: Precisely that.

Q140 Mr Curry: Are the care needs of men and women different? Does one gender have different needs than the other gender?

Professor Banerjee: Both genders have the same sorts of needs in terms of increasing physical disability and therefore needs for activities of daily living but also psychological and behavioural problems of dementia, including dangerous behaviour, as well as wandering and those things. That happens across the genders. One of the problems that women have in particular is that male carers live less long because they die earlier, so you end up with more women living alone and therefore being looked after by children who may be distant from the home. There is a difference but it is all to do with longevity.

Q141 Mr Curry: And children may well be at work. As we know, the sociology of the family has changed so enormously over the last generation or so.

Professor Banerjee: But there are still the people who give up work in order to care for their elderly relatives.

Q142 Mr Curry: Two quick points. The diagnosis by GPs—as you know it is quite difficult to actually get to see a GP now, especially if you want an appointment for the next day because they still say you have to phone back in the morning. The idea that a patient might be their customer is still alien to large numbers of the British Medical Association, as far as I can see. How good are GPs? If you go along and say, “I’m a bit worried about dad?” You are not going to get a home visit of course because that is a thing of the past. How confident are you that the people who are at the front-line are competent to provide that early diagnosis upon which a huge amount of not just welfare of the patient but your costings ultimately depend?

Professor Banerjee: This is very important and we worked very closely with the College of General Practitioners and with others to understand that interface. As I said earlier, if you ask GPs to do something impossible, such as to diagnose early dementia and to sub-type that dementia in their surgery in seven minutes, they are not going to do it. But if you ask them to do something simple and reasonable like what they do for other illnesses, which is to be vigilant for signs that are worrisome and then refer those on to a place, to a specialist service that is specifically designed for that, you will find that GPs are entirely able to do that.

Q143 Mr Curry: But they need the family members to bring it to their attention?

Professor Banerjee: What we need to do is change the attitudes of general practitioners and others from sloughing off a request saying there is something wrong with dad, or whatever, and

changing it to saying “If you are worried about his memory then why not go to the memory service and they will sort out what is going on.”

Q144 Mr Curry: As money gets tighter we are likely to find more and more arguments about the efficacy of drugs. If you think your dad or mum or yourself might benefit then you think NICE should jolly well approve it. These are very difficult things to manage, are they not, to say to somebody, no, that is not value for money. In an illness which has so many emotions attached to it as this has, that is going to be particularly difficult. How are we going to manage that denial to patients of things which they think might help? How does the public interest take precedent over the individual interest?

Professor Banerjee: With respect to anti-dementia drugs, if you are looking in the next two to five years then what you are looking at is that it will be unlikely that there will other drugs that will come on-line that have a major impact, and the ones that are available will become generic drugs, and so their unit costs will decrease and there will be no barrier in terms of cost for individuals receiving those medications.

Chairman: I think Mr Burstow has another question.

Q145 Mr Burstow: It is a request for a note⁴ actually. Part of this has been a discussion about managing risks to delivering this strategy going forward, whether it be cost pressures or whether it be issues about training. Could you provide us with a list of the risks that you will be seeking to manage and you would expect NHS organisations to manage to deliver this Strategy on time, because I think it would be quite useful when we have the further follow-up review in 18 months’ time to see how those risks have been managed. In particular with regard to continuing care, to which Sir Ian Carruthers referred, clearly there is a huge cost pressure there, partly being driven because of the courts ruling in certain ways and also because of the new guidelines. I would assume therefore that the Department has done some modelling about this and has used economic models to come up with an estimate of what the likely cost will now be. Is there such a figure and if it is not available today can you provide us with a note that sets out the Department’s estimate of the extra costs that will arise from that?⁵

Sir David Nicholson: Yes.

Q146 Mr Bacon: Professor Banerjee said that the demographic trends were very predictable because there was something already in their brains, but I did not catch what he said.

Professor Banerjee: If you are going to develop Alzheimer’s Disease, which is the most common dementia, it is likely that the cellular changes in your brain, the cell death, very subtle changes, are happening 20 or 30 years before the actual symptoms of dementia become apparent, even the earliest symptoms of dementia. This is a neuro-degenerative disorder that is affecting your brain many years before it becomes clinically significant.

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Q147 Mr Bacon: Are there things that one can do for that preventatively like eating more seaweed or beetroot or whatever it is?

Professor Banerjee: Certainly what is true, and we have said it in the Strategy, is that what is good for your heart is good for your head.

Q148 Mr Bacon: So red wine then?

Professor Banerjee: Things that are good for your heart in terms of good exercise, good eating, not smoking, all of those things are likely to be of benefit in preventing not the Alzheimer's element of the dementia but the vascular element of dementia that is very common in later life as well. The same health messages that we have about healthy lifestyle also are likely to mean that if you do those things you also decrease the potential likelihood of some elements of dementia as well. There is a lot of work that needs to be done identifying early markers of dementia and work that needs to be done to look at the prevention of dementia. That is in the future. There is an immense amount of work that is going on at the moment in research terms.

Q149 Mr Bacon: A quick question for Mr Behan or perhaps for Sir Ian, I do not know. Figure 10 describes Strategic Health Authority Leads. Sir Ian, you are described as the SHA Dementia Lead. I take that that is within the Department of Health rather than for your own SHA?

Sir Ian Carruthers: Yes, I am a member of the National Implementation Board.

Q150 Mr Bacon: When it says SHA Dementia Lead that means you are "the", singular, it is one? Somebody is shaking their head behind you. What I really want to know is in figure 10 when it says strategic health authority leads, how many of them are there?

Mr Behan: Each SHA has a lead.

Q151 Mr Bacon: So there are ten leads?

Mr Behan: Yes.

Q152 Mr Bacon: When it calls them regional leads and then underneath it divides them between SHA leads and consultant old age psychiatrists. Are the strategic health authority leads the same people as these regional deputy directors in each case?

Mr Behan: They may be or there may not be.

Q153 Mr Bacon: But there are ten of them?

Mr Behan: Yes.

Q154 Mr Bacon: So when it says there 100% awareness among strategic health authority leads, what it means is there are ten people who should know and they all do?

Mr Behan: Yes.

Q155 Mr Bacon: Okay. I just wanted to check that.

Mr Behan: And they are a key part to driving forward the Strategy to get from the regional to the local level. They are driving forward the work that we have got on the baseline review and overseeing the delivery of action plans by March of this year.

Q156 Mr Bacon: I thought it would be quite shocking if two and a half years or two years and three months after our last hearing there were ten people who ought to know and they did not all know, so it is reassuring that they do.

Mr Behan: This is why it is really important that we are able to communicate to you that there is a lot of energy driving this forward by people who actually understand and believe in this Strategy.

Q157 Chairman: Just a quick question to the Treasury. Will you commit yourself to improving the pooling of resources across health authorities and social care units?

Mr Gallaher: I would say that in the Treasury we would always look to resource on a national basis and on the overall budget and resources we have, and we would encourage departments to pool resources and local authorities and the National Health Service where that is needed.

Mr Curry: Since it is the Committee of Public Accounts the word "resources" means "cash"; it is money we are talking about.

Q158 Chairman: I will not ask a question here but maybe we could get a note on it.⁶ On page 22 the Lincolnshire whole-system approach is quite interesting, is it not, because the study found people with dementia are most commonly in acute beds but most no longer needed to be there. If those people with dementia who did not need acute care were cared for in an alternative setting, this would save £500,000 per annum, so perhaps somebody could do me a note on that so we can put it in our Report. It might be worth flagging up. Lastly, Sir David, will you commit yourself to recommending to Ministers when they are drawing up the next Operating Framework of December 2010 that dementia should be a national priority?

Sir David Nicholson: I do not know whether when we go into the next Spending Review, given the financial circumstances in which we find ourselves, whether there will be anything that remains like an Operating Framework.

Q159 Chairman: So the answer is No?

Sir David Nicholson: What I can say is that from the Department's perspective dementia will continue to be a priority. We will continue to put the amount of effort and pace behind it to make it a reality, but this is the most complex thing that we have ever tried to deliver, certainly in my experience, of the NHS,

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covering health, social care, primary care and the position that the public finances are in also on this.
Chairman: Thank you, Sir David. It is now time to sum up. Apparently an early sign of dementia is aggressive behaviour so I am not going to give you an aggressive summing up; just to congratulate you on your knighthood, Sir David. And also to congratulate our witnesses, particularly Mr Behan,

because I always like to congratulate witnesses who show drive and vigour, particularly younger witnesses, and I hope you have a very bright future.

Q160 Mr Curry: That has finished his career!

Mr Behan: I am grateful you have called me "young", Chairman!

Chairman: Thank you very much.

Supplementary memorandum from the Department of Health

At the Public Accounts hearing on 25 January, Committee members asked for notes from the Department of Health on a number of topics. This note sets out my response to those requests.

Questions 63–64 (Mr Burstow): *Social Care Qualifications*

In 2007, the latest year for which data is available, just over 66% of care workers said they had obtained the equivalent of an NVQ level 2 or higher, while around one-third had not obtained a level 2 qualification. This compares with 2006 when fewer than 60% of care workers said they had obtained the equivalent of an NVQ level 2 or higher.

As at November 2008, there were 81,323 registered social workers in England. All registered social workers have a social work degree or equivalent professional qualification. Over 12,000 qualified social workers have a post-qualifying award of some description. There are 14,185 social work students training in England.

Questions 79–82 (Angela Browning): *Dementia Champions in Hospital*

We want to see a senior clinician identified in every general hospital to take the lead for quality improvement in dementia care with hospitals. We identified this as a priority objective in the Dementia Implementation Plan. We want to see this happening as soon as possible and would support the NAO recommendation that this happens by 31 March 2010.

Information on the number of dementia clinical leads in general hospitals, is not currently collected centrally by the Department but is an area that we are looking at as part of the audit which we are in the process of commissioning.

Question 145 (Mr Burstow): *Managing Risks*

The Department's National Dementia Strategy Implementation Programme Board has identified, and is managing, the following high-level risks for the National Dementia Strategy:

- The need to ensure that the Strategy has adequate funding in years three, four and five of the Strategy (2011–14).
- NHS & Local Authorities do not prioritise implementation of the Strategy.
- Departmental business planning does not afford sufficient resources for the central implementation team.

These risks, and mitigating actions, are regularly reviewed as part of the governance of the National Dementia Strategy Implementation Programme Board.

It is the responsibility of individual NHS Organisations to set and manage risks locally, in line with local circumstances and priorities.

Question 145 (Mr Burstow): *Costs of NHS Continuing Healthcare*

The Regulatory Impact Assessment Based which accompanied the *National Framework for NHS Continuing Healthcare and NHS funded Nursing Care in England (2007)*, estimated, based on existing data about the costs of care, the overall cost of implementing the new Framework to the NHS in the first full year as £219 million. This included an allowance for PCTs to continue paying the high band RNCC to all those receiving it, until they have chance to review the cases individually: the costs in subsequent years would therefore be projected to be lower than this.

The costs of implementation will include a cost shift from Local Authority budgets, where Social Services have previously funded individuals who may become eligible for NHS funding under the National Framework. However, any saving to LAs is likely to be minimised by general demographic and financial pressures.

Question 158 (Chairman): *Lincolnshire whole—system approach*

The National Audit Office commissioned the Balance of Care group to undertake a bed usage survey across Lincolnshire to identify alternatives to hospital for people with dementia. The central focus of the project was a survey of 863 adult inpatient case notes, which took place across Lincolnshire on 29 November 2006. The survey found that, on the day of the survey the majority of acute hospital patients with dementia (68%) did not meet criteria for needing an inpatient bed as assessed by the Appropriateness Evaluation Protocol.

Following the Balance of Care report NHS Lincolnshire has invested £1.2 million in three new dementia teams: acute hospital liaison, intermediate care in reach and community case management teams. The service has now been operational for 12 months. The key learning up to now is that:

- There is no evidence as yet that any of the services have resulted in measurable reductions in admissions or length of stay. NHS Lincolnshire plan to undertake a much more detailed evaluation in 2010–11 before they feel able to advocate a sound business case for rolling out the model as a Quality and Productivity Challenge initiative in other localities.
- Up to now the gains have been on quality and patient and carer experience.
- The acute hospital in reach service has assessed and identified 650 new individuals with dementia in a five month sampling period, representing a significant increase in detection rates (at the time of the NAO study 111 patients (13%) had a documented diagnosis of dementia).
- Mental Health assessment times have been reduced from seven days to 24 hours: a key quality indicator for the project.
- The biggest challenge identified is to improve the community based management of those people who have both dementia and other co-morbidities, as this is the group who make up the bulk of the resource usage in the acute sector.

Questions 112–119 (Mr Mitchell): *Prescribing of dementia drugs*

The table shows the number of defined daily doses (DDDs) of dementia drugs, (donepezil, galantamine, rivastigmine and memantine, these are cholinesterase inhibitors than can slow the progress of dementia), per Strategic Health Authority in England.

<i>SHA</i>	<i>Total DDDs</i>	<i>Patients with a diagnosis of dementia</i>	<i>DDDs per patient</i>
EAST MIDLANDS	2,854,515	20,089	142.1
EAST OF ENGLAND	4,307,548	25,315	170.2
LONDON	3,725,129	24,859	149.9
NORTH EAST	2,132,224	13,198	161.6
NORTH WEST	5,542,313	34,057	162.7
SOUTH CENTRAL	3,322,580	18,840	176.4
SOUTH EAST COAST	3,461,513	21,442	161.4
SOUTH WEST	3,675,320	25,920	141.8
WEST MIDLANDS	2,972,342	23,866	124.5
YORKSHIRE AND THE HUMBER	4,469,687	24,844	179.9
UNIDENTIFIED DEPUTISING SERVICES	534		
UNIDENTIFIED DOCTORS	20,788		
Grand Total	36,484,493	232,430	157.0

Source: NHS Information Centre

I trust that this information will meet with the Committee members' requests.

1 March 2010