

The National Dementia Strategy: potential costs and impacts

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Introduction

The *National Dementia Strategy* was published in early 2009. It aims to ensure that significant improvements are made to dementia services and is intended as a catalyst for change in the way that people with dementia are viewed and cared for in England (Department of Health, 2009a). Currently there are approximately 700,000 people in the UK with dementia, a figure that is expected to double in the next 30 years. Costs, however, are estimated to triple from the current £17 billion per year to over £50 billion (Knapp & Prince, 2007).

The *National Dementia Strategy* identifies three key areas for action: improving awareness, earlier diagnosis and intervention, and higher quality of care to help people with dementia live well. Greater specificity is given in the 17 objectives (see Box 1). Although the Strategy was welcomed by all stakeholders, a major concern has been the implementation costs. £150 million has been allocated to primary care trusts to support implementation in the first two years, but there have been concerns about an underestimation of the numbers of people with dementia (Age Concern), the 'hidden costs' of the workforce training implications (Santry, 2009), the difficulties of reaching people with dementia who live in care homes (www.epolitix.com), poor commitment to research (www.alzheimers.org.uk) and the need to ensure that commissioners pay a fair price to obtain good quality social care services (www.ukhca.co.uk).

As part of the Impact Assessment for the Strategy, the PSSRU was asked to help members of the Department of Health explore the literature to identify the potential costs and benefits of the objectives set out in the Consultation Document (Department of Health, 2009b). Drawing on this work, this article identifies the potential costs and impacts for five of the objectives outlined in the Strategy.

Box 1 The 17 key objectives in the National Dementia Strategy

- Improving public and professional awareness and understanding of dementia
- Good-quality early diagnosis and intervention for all
- Good-quality information for those with diagnosed dementia and their carers
- Enabling easy access to care, support and advice following diagnosis
- Development of structured peer support and learning networks
- Improved community personal support services
- Implementing the Carers' Strategy
- Improved quality of care for people with dementia in general hospitals
- Improved intermediate care for people with dementia
- Considering the potential for housing supports, housing-related services and telecare to support people with dementia and their carers,
- Living well with dementia in care homes
- Improved end-of-life care for people with dementia
- An informed and effective workforce for people with dementia
- A joint commissioning strategy for dementia
- Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers
- A clear picture of research evidence and needs
- Effective national and regional support for implementation of the Strategy

The costs of improving dementia care

Objective 1 includes delivering information campaigns to the general public, targeted groups and local populations. Such campaigns are intended to improve public and professional awareness and understanding of dementia, address stigma, and encourage appropriate help-seeking behaviour. More than three-quarters of GPs taking part in a pilot awareness campaign believed this would lead to people reporting dementia symptoms earlier (Department of Health, 2009a; Alzheimer's Society, 2008). Four fairly recent large-scale campaigns in mental health provide some indications of their likely costs and success. A public attitudes survey in Scotland following the four-year multi-media *see me* campaign showed improved rates of positive attitudes to mental health and that it reached 75 per cent of those surveyed (www.seemescotland.org). The campaign was funded at £2.8 million over four years, of which 73 per cent was direct campaign costs. Costs for the three-year DH-funded *Mind Out for Mental Health* campaign were similar at around £3.5 million. Both this and the earlier *Defeat Depression* campaign generated small but significant changes in attitudes over time. The NIHR *Shift* strategy to change media attitudes to mental health also suggests that attitudes may take a while to change; there was little impact in the first two years (www.csip.org.uk).

Objective 2 aims to provide good-quality early diagnosis and intervention for all people with dementia through access to a pathway of care delivering specialist assessment and treatment, care and support as needed by people with dementia and their carers. One such service is the Croydon Memory Service. The recent cost-effectiveness evaluation estimated the cost of providing such a service across England to be around £220 million extra per year (Banerjee & Wittenberg, 2009). If just 10 per cent of care home admissions were averted, the researchers estimate the savings by year 10 would be around £120 million in public expenditure on social care and £125 million in costs to service users and their families. A 20 per cent reduction in admissions would off-set the annual cost within six years. A relatively

small gain of between 0.01 and 0.02 QALYs per person year would render the service cost-effective in terms of positive net present value.

Objective 6 is to deliver improved community personal support services to people with dementia living at home and their carers, including specialist home care services. At the time the literature was reviewed, the 2007 *Older People's Mental Health Mapping* database was available (OPMHM; www.mhcombinedmap.org). This identified 11 teams specialising in home care support for people with dementia. On average each team had 25.7 whole time equivalent (wte) staff members (range 4 to 83.5) and was led by just under 1.0 wte manager. Teams had an average caseload of 46 (range 12 to 164); the staff to user ratio was 1:1.8.

Using data available in the 2008 *Unit Costs of Health and Social Care*, this suggests an average annual cost of about £544,000 per team. Around 270 teams would be required to provide specialist home care for 12,500 people with dementia living at home (Knapp & Prince, 2007). Home care teams that are not cited as specialist dementia teams on the OPMHM are on average slightly larger, with 39 staff and a caseload of 122. One hundred teams would be required at an average cost per team of £815,000.

Meeting **Objective 9**, to improve intermediate care for people with dementia, will also require additional resources. The Strategy suggests this improvement could be achieved through support for mainstream services or by developing specialist intermediate care for people with more advanced or complex home care needs (p55). This and previous volumes of *Unit Costs of Health and Social Care* provide a range of costs for intermediate care. For example, support provided by rapid response teams, which are intended to avert admission to hospital, may cost between £194 and £1,035 (2009, page 97) and costs for a typical episode of care based in a residential home are estimated at £2,625 (2009, page 100). A study of re-ablement services is currently underway at the PSSRU. One study of 50 services used by older people in five sites identified six typical 'intermediate care pathways' with costs (at 2002 prices) ranging between £722 for 12 days support from a rehabilitation at home service to £10,785 for a package that included 85 days in a community rehabilitation unit (Godfrey et al., 2005 and see also Kaambwa et al., 2008). Ellis and colleagues (2006) found that costs were similar for use of a joint NHS/Social Services Intermediate Care Unit and routine care for older people at around £8,500 (2000 prices).

However, specialist services for people with dementia are rare. Just over half of all services categorised as Intermediate Care on the 2007 OPMHM provided support for people with dementia alongside other people with mental health problems but only five provided a dementia-specific service (two residential and three home-based services).

Objective 13, having an informed and effective workforce for people with dementia, is central to the strategy. Once core competencies have been agreed between the Department of Health and representatives of all bodies involved, consideration will be given to the changes to curricula for pre- and post-qualification and occupational training, as well as continuing staff education.

Training and education for existing staff will be important (Department of Health, 2009a, p65-67). Training may be required in as many as 12,800 core service locations: at least 5600 nursing/care homes with places for people with dementia (www.csci.gov.uk); 270 specialist home care services (see above); around 530 older people's mental health hospital wards; and 6370 integrated mental health teams (www.combinedmap.org). An illustrative model for

training can be taken from a study in two local authority EMI homes. This comprised eight three-hour sessions including a formal talk by a psychiatrist or psychologist, small group work and feedback facilitated by a CPN, as well as homework undertaken as part of the trainees' care duties (Davison et al., 2007). There were improvements in staff management of problematic behaviour three months later, but the changes did not last to 12 months. Including preparation and travel for the course facilitators, the cost would be around £700 per course, and may need to be held twice in each location to allow all staff (25-30) to attend; total cost £1400 per location. A training programme in psychosocial intervention (PSI) for community mental health nurses (CMHNs) lasted a similar length of time (20 taught hours; Moniz-Cook et al., 2008). This small study found some impact on problem behaviours among people with dementia living at home but less than ideal adherence by the CMHNs to the treatment protocol.

Reviews of staff training have found that generally programmes increased skills and job satisfaction, reduced residents' problem behaviours and reduced staff turnover (McCabe et al., 2007; Godfrey et al., 2005). Support from management was invaluable, but shorter, low-intensity programmes were less effective. Refresher courses were likely to be needed. There are, of course, existing funds for continuing professional education, training and staff development.

Conclusion

It has been suggested that the initial £150m should be enough to help primary care trusts provide a better local framework to get proper planning started (www.epolitix.com). The Strategy notes that funding for year three onwards will be decided once the evaluation findings from the demonstrator sites have been considered. More widely, the pace of implementation will vary depending on 'local circumstances and the level and development of services' within each area (Department of Health, 2009a, p20). To this list we must add the level of finance available in the area and from the Strategy fund, the decisions local commissioners make about how to spend their scarce resources, and the costs of providing any additional supports. While the cost data presented here are unlikely to represent the true costs of delivering the objectives, in the absence of full information, they may provide some estimates of the likely resource requirements.

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