



Dear Colleagues

It is a pleasure to write again with an update on how things are developing (as I see them) in my role as your National Clinical Director for Dementia. There are three things that strike me as being particularly important at the moment.

First, work on the antipsychotic drugs. At the risk of sounding obvious, the matter of prescribing these medications is something for the whole system to own. It is not about targeting individual clinicians who prescribe them but more about getting awareness of the alternatives which may be available and raising the bar on the level of prescribing. It is, in my opinion, about making sure that everybody (GPs, carers, care homes, pharmacists, specialists) have thought about the issues around prescribing and discussed the risks and benefits of the drugs. There is a small, but significant, lobby who say the drugs should simply be banned altogether but that proposal has been rejected.

A number of people have expressed surprise about the pace which this work is beginning to gather including the Ministerial pledge of a reduction of two thirds by November of this year. For me, it is reassuring that the issue has put into sharp focus in a way not seen before and we now have the whole system beginning to get behind what is happening. The Information Centre has just completed (June 2011) the second of a three stage national audit on antipsychotic drug prescribing showing a near 20% reduction over the last two years, a figure supported by a separate MHRA report. The reduction is very encouraging.

The Call to Action was launched on 9 June 2011 (chaired superbly by Sube Banerjee). This initiative, led by the Dementia Action Alliance and the NHS Institute consists of a mobilisation of eight professional groups ranging from General Practitioners through Pharmacists, Old Age Psychiatrists, hospital doctors, commissioners, people with dementia and their carers. The aspiration of the Call for Action is that everyone with dementia who is being prescribed an anti-psychotic should have a clinical review by March 2012. In many ways this simply reflects what should be good practice in line with the NICE/SCIE Guideline. For the website, visit www.institute.nhs.uk/dementiac2a.

One of the other things we (The Department of Health and the Alzheimer's Society) have developed in relation to this is a best practice guide for the management of Behaviour and Psychological Symptoms in Dementia. This is not just another "me too" guide about what drugs to prescribe and when, but something broader that deals with prevention, ways of approaching mild to moderate symptoms. The launch date for this is 18 July.

Second, I begin to sense that we are beginning to see a change and that there is real buy in and interest from a wide variety of professionals. For example, the NHS National Clinical

Director, Sir Bruce Keogh and a small group of SHA Medical Directors (which includes Claire Lawton) have discussed issues about dementia in the General Hospital. As I have mentioned before, the estimate is that a quarter of beds in the NHS are occupied by people with dementia probably around 40% are ambulatory conditions which suggests the person may not need to be in hospital. Forty per cent of twenty five percent is ten per cent – is this the proportion of beds in the NHS occupied by people who may not need to be there and, as we know, the care they receive can sometimes be less than good.

There are super examples of where the care is improving from around the country and I have seen several first-hand. For me the encouraging thing is that I think there are signs that the issue is recognised as being of prime importance at the very top of the NHS. As I spend more time in the Department it becomes clearer to me that getting very senior buy in makes a big difference. It may be that by developing something like a screening tool or a risk assessment measure will be helpful in raising the profile of dementia in the general hospital, will result in better care and allow us to make the economic argument that caring for people in the General Hospital is cost effective.

Third, the Dementia Commissioning Pack is launched on 21 July 2011. This will reflect the Best of Practice across our five priority areas, covering the whole spectrum of dementia from early diagnosis to end of life care. This has been produced with the help of the SHAs and is being coordinated by the South West. The pack present a series of specifications, contract inserts, cases for change, costing tools, action plans and patient information booklets.

I am involved in the launch this month of two publications – one on end of life care in dementia “Difficult Conversations”(see <http://www.ncpc.org.uk/library>) following on from a successful one on chronic obstructive pulmonary disease and “*The Last taboo, A guide to dementia, sexuality, intimacy and sexual behaviour in care homes*” (see <http://www.ilcuk.org.uk/record.jsp?type=publication&ID=95>)

Finally, I am trying to get some advice and views about the issue of the Mini Mental State Examination - progress is glacial and I will write separately about this important issue when I have more news.

As always, I would be very interested in your views and feedback on any issues with which you think I could be of help.

Best wishes
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