EDITORIALS

Can we afford not to have integrated dementia services?

Nearly one million UK residents have dementia, making it the most expensive condition in health and social service providers face—£17 billion per annum is the recent Dementia UK estimate [1]. Alzheimer's disease is the third commonest cause of death, behind heart disease and cancer (both having dedicated national service frameworks, performance targets and major investment). A third of stroke patients develop dementia after 3 months. These figures represent 2007 and even if the demographics and proportions of people with dementia simply remain the same, these costs will continue to rise, especially if the current lack of co-ordination continues.

So why are there no integrated dementia services in the UK, without which it is unlikely to develop a national strategy to respond to demographic change? Medical care for people with dementia is mostly consigned to old age psychiatry services—an interesting paradox where the least resourced part of the NHS is expected to provide clinical care for its most expensive illness through a specialty not truly recognised within the rest of the European union. Elsewhere in the UK some interested geriatricians and neurologists provide diagnostic and pharmacological treatment services and (rarely) a general practitioner develops a special interest in dementia. However, it is rare to have one of these specialists who solely specialises in dementia. Instead, dementia diagnosis and management are usually part of another larger responsibility, which dilutes the attention given to them. As a result, the few who assume responsibility for delivering dementia care, along with families and social care, are gladly left to get on with it, while those around convince themselves it is too specialist for them to touch. This seems bizarre for any older person’s service, considering dementia care was always considered one of the pillars of geriatric medicine.

In the absence of a specialist clinical framework, dementia suffers well-meaning guidance from many sources: Forget Me Not [2, 3], NSF for older people [4] and Everybody’s Business [5], Dementia guideline [6]. These are all laudable compilations of carefully cited best practice and interesting research projects which have often been conducted on relatively small numbers of people, making transferability to a large local service impossibly resource-intensive. Sadly, new guidelines and recommendations usually repeat what has been said before; we still do not seem to have implemented basic suggestions first made by the Alzheimer’s Society up to 25 years ago. As such, the guidelines may receive diminished attention and can prove difficult to apply to commissioning, designing and running services on a daily basis. Why?

The basic answer is a lack of good longitudinal evidence about what actually constitutes either the trajectory of dementia syndromes, especially in terms of the patient experience, or the standards of care that a person with dementia should expect. With most research concerning pharmacological intervention or basic science’s ‘search for a cure’, we have forgotten to explore what are the essential and most cost effective service requirements. Consequently, it is very hard to make firm evidence-based recommendations about how services should be delivered. This means local services choose what they can manage to deliver from the assorted recommendations, some commissioners use lack of ‘certainty’ to pick the minimum they can get away with and postcode provision is perpetuated.

One solution to this situation is to define and create comprehensive, integrated specialist dementia services across the UK. This could have five major effects.

- First, by defining the multiple elements of dementia care provision in a locality, the real-time expenditure on the disease across a number of health, social care and voluntary organisations could be properly established, and hopefully, strategically pooled to be utilised in a more cost efficient way than current practice. Benchmarking what is already being delivered against expected prevalence estimations would allow service providers and commissioners to understand how much of the local need was actually being met. With appropriate input from people with dementia and their carers, new models of care may improve choice and access to care, for example, by using direct payments in more innovative ways.

- Second, it would capture the local enthusiasts and their expertise across current organisational boundaries, thus developing more meaningful engagement and potentially allowing them to work full time in the management of dementia; in a service defined by diagnosis and need, but no longer by age.

- Third, by creating specific and explicit standards for training of all specialist dementia clinical staff, a more expert body of professional care will arise—improving quality and reliability in the clinician-patient interaction. The situation where one specialist service passes a person with dementia to a different specialist service to deliver another aspect of dementia care, need not happen.

- As a result of this, the fourth and perhaps most important consequence will be an increase in the quantity and quality
of relevant research to establish best practice, hopefully arising as much from within the NHS as the academic sector, through its reconfigured R&D programme including the new Dementia and Neurodegenerative Diseases Research Network (DeNDRoN).

- The fifth consequence would be the emergence of an evidence base that could properly inform the commissioning process and better define the roles of primary and secondary NHS services, along with social care and the voluntary sector. This would produce sustainable and equitable services for the future.

The move to dementia services is not about major investment, rather, a strategic step to address a public health challenge. The UK has led the world in highlighting the need to provide care for people with dementia and the efforts of older people’s services, particularly, old age psychiatry, are envied and emulated in many parts of the world—including Europe. However, at the moment, these services are under pressure, with most having undergone significant resource cuts over the last 2 years, usually to support more high-profile services elsewhere in medicine. By creating integrated dementia services, the right knowledge base can be achieved to determine what the most effective choices for people with dementia in terms of efficacy, cost and investment need to be. Avoiding this step not only leaves us disarmed in the face of a major public health challenge, it also puts dementia care in danger of joining soccer and cricket as great UK inventions that the rest of the world eventually works out how to perform better than us.

Key points
- There is a need to stop providing dementia services across multiple agencies.
- This would facilitate improvements in service provision, education and research.
- Provision of integrated services would prove to be the most cost effective.

Conflicts of Interest
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Will undergraduate geriatric medicine survive?

The decline in undergraduate geriatric medicine education in United Kingdom (UK) Medical Schools [1] follows the trajectory of a progressive neurodegenerative disorder. First there is a niggling suspicion, [2] but within 2 years something is definitely amiss [3]. Over the years, the problem worsens and after 25 years a tipping point is reached [4]. The trajectory is steep and accelerating.

What is wrong?
There are fewer geriatric medicine academics [1]. The demands of the Research Assessment Exercise [5] points to where those remaining should focus their attention. Is geriatric medicine’s decline in the undergraduate curriculum inevitable?

Thanks to UK medicine we live longer, and, thanks to geriatric medicine, morbidity has been pushed later into our lifespans. The entry point to undergraduate geriatric medicine must, therefore, be the physiology of ageing [6]. Without understanding the physiological canvas on which disease is painted, students cannot understand the picture that the patient presents. Students will learn by working with older people in general but learn more by understanding