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Commissioning dementia services

Iliffe¹ makes important points about complex conditions but offers a very limited view of the possibilities for commissioning dementia services.

Any qualified provider broadens the options and there is no reason why the whole system needs to be commissioned from a single provider. In acute hospitals, services may be provided by liaison psychiatry or physicians or both. Liaison psychiatry could extend into the community² or intermediate care services. In care homes, where frailty is common, there might be an alliance of community geriatrics and old age psychiatry with the independent sector. Home treatment may include joint health and social care, memory services, and care advisors.

What is crucial is that the whole system has to be commissioned and commissioners see the whole system and bind the component parts together. This point is made in the National Institute for Health and Care Excellence dementia commissioning guide with reference to dementia clinical networks.³ Networks define a whole system where local providers are clearly identified to meet local need and operate a unified, interactive dialogue, not a care pathway that patients do not follow.

The new commissioning environment creates an exciting opportunity to think more imaginatively and this will be needed to meet the dementia challenge. This has to be more than the 'is it the GP or the specialist?' question.

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Dementia commissioning – a missed opportunity

Professor Iliffe finishes his editorial with a question,¹ but does not address a much more important issue in dementia care in this country – that although dementia is considered a public health priority by the World Health Organization,² the Department of Health's dementia commissioning pack does not prioritise dementia.

According to the Alzheimer's Society, more than half of cases of dementia continue to remain undiagnosed in the UK (www.alzheimers.org.uk). Significant resource allocation is needed to address poor diagnosis rates in the population via public mental health campaigns. This should also address the

still prevailing stigma about dementia and highlight the potential prevention strategies.

The Royal College of Psychiatrists and the Royal College of General Practitioners have tried to address this by producing the Joint Commissioning Panel for Public Mental Health (JCPMH); however, most health and well-being boards responsible for delivering the public health agenda do not have statutory representations from mental health trusts.

The Commissioning for Quality Innovation and Prevention (CQUIN) schemes for 2013–2014 have allocated resources for integrated/collaborative care in dementia but the funding is non-recurrent. The chronic underfunding of old age services to the tune of over approximately £2 billion needs to be addressed. Most consultants working in an older people's mental health service have a catchment population twice the upper limit suggested by the Royal College of Psychiatrists.³

General practitioners need to remain the focal point of coordinating dementia care and need further training in complex care rather than financial incentivisation under the Quality and Outcomes Framework.

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Author's response

In the 'quick and dirty' poll I carried out among psychiatrists in the South West, the least popular option for reconfigured services for people with dementia was the Gnosall model, described in greater detail by Susan Benbow and colleagues. This model inverts the natural world, putting the general practitioners (GPs) in charge while fostering 'interactive dialogue', and is surely an example of the more imaginative thinking that David Anderson hopes commissioners will display. Its attractiveness remains to be seen, as it is now at the point where its methods must be picked up from the 'innovator' group which created it, and used by less determined but perhaps more typical 'early adopters'. We shall see whether this happens. Since 90% of care homes are outside the public sector (even if they receive enough public funds to be inside the public domain), the second most popular option also fits David Anderson's suggestion about an 'alliance of community geriatrics and old age psychiatry with the independent sector'. This is a difficult option, because it could bring the specialist alliance into conflict with generalists over who is the clinical lead for people with dementia, with an uncertain outcome when clinical commissioning groups are heavily influenced by GPs, and are very aware of the need to reduce costs. Even more imaginative ideas about multiple providers seem to many to simply replicate the current fragmented system; curing fragmentation of provision by further fragmentation sounds counterintuitive to many, unless the whole process is to be led by consumers under a 'personalisation' agenda.