NICE National Institute for Health and Care Excellence

Putting NICE guidance into practice

Resource impact report:
Dementia: assessment, management and support for people living with dementia and their carers (NG97)

Published: June 2018

Summary

This report looks at the recommendations from NICE's guideline on Dementia: assessment, management and support for people living with dementia and their carers. This is an update of the original NICE clinical guideline (Dementia: supporting people with dementia and their carers in health and social care) which was first published in November 2006 and was last updated in September 2016.

The recommendations have been updated, but do not include any changes that have a substantial resource impact.

The uptake of the guideline reported on the NICE website shows good progress in a number of areas, however some recommendations may not have been fully implemented. They are:

- Provide people living with dementia with a single named health or social care professional who is responsible for coordinating their care (recommendation 1.3.1)
- Offer group cognitive stimulation therapy to people living with mild to moderate dementia (recommendation 1.4.2)
- Offer carers of people living with dementia psychoeducation and skills training (recommendation 1.11.1)

Dementia services are commissioned by clinical commissioning groups (CCGs) and local authorities. There are a number of providers including NHS hospital trusts, mental health trusts, community providers, private and local authority care homes, third sector organisations (such as charities), and primary care (GPs and practice nurses).

1 Introduction

1.1 The guideline offers best practice advice on dementia. It is an update of the original NICE clinical guideline (Dementia: supporting people with dementia and their carers in health and social care) which was first published in November 2006 and was last updated in September 2016.

1.2 This report discusses the resource impact of implementing our guideline on dementia: assessment, management and support for people living with dementia and their carers in England. It aims to help organisations plan for the financial implications of implementing this NICE guideline.

1.3 We encourage organisations to evaluate their own practices against the recommendations in the NICE guideline and assess costs and savings locally. Organisations can input estimates into the local resource impact template to reflect local practice and estimate the impact of implementing the guideline.

1.4 Dementia services are commissioned by clinical commissioning groups (CCGs) and local authorities. There are a number of providers including NHS hospital trusts, mental health trusts, community providers, private and local authority care homes, third sector organisations (such as charities), and primary care (GPs and practice nurses).

2 Background

2.1 The NICE Dementia guideline says that in the UK approximately 62% of dementia is due to Alzheimer's disease, 17% to cerebrovascular disease, 10% to mixed aetiologies, 4% to dementia with Lewy bodies, 2% to Parkinson's disease dementia, 2% to frontotemporal dementia and 3% to other causes.

2.2 The recorded prevalence of dementia in February 2018 was 451,731 (NHS Digital). However there may be around 850,000 people in the UK living with dementia including those without a diagnosis, with numbers set to rise to over 1 million by 2025 (Alzheimer's UK).

2.3 As the severity of dementia increases, people will need to access a number of services across health and social care.

2.4 The uptake of the original guideline reported on the NICE website shows good progress in a number of areas, however some recommendations may not have been fully implemented. These are discussed in section 3.

3 Recommendations included in the original guideline that may not have been fully implemented

3.1 **Provide people living with dementia with a single named health or social care professional who is responsible for coordinating their care (recommendation 1.3.1)**

Background

3.1.1 The original guideline recommended that care managers and care coordinators should ensure the coordinated delivery of health and social care services for people with dementia including the assignment of named health and/or social care staff to operate the care plan.

3.1.2 However feedback suggests that this recommendation has not been well implemented and there is wide variation in practice.

3.1.3 The named healthcare profession should:

- arrange an initial assessment of the person's needs, which should be face to face if possible

- provide information about available services and how to access them
- involve the person's family members or carers (as appropriate) in support and decision-making
- give special consideration to the views of people who do not have capacity to make decisions about their care, in line with the principles of the Mental Capacity Act 2005
- ensure that people are aware of their rights to and the availability of local advocacy services, and if appropriate to the immediate situation an independent mental capacity advocate
- develop a care and support plan.

Costs/savings

3.1.4 How this recommendation is implemented locally will vary depending on local pathways and the extent to which the previous guideline has been implemented. Therefore the costs and savings will need to be assessed locally.

3.1.5 The local resource impact template can be used by organisations to model any additional investment needed locally and any associated savings.

Costs

3.1.6 The key cost driver is the staff cost of appointing care coordinators. This may be achieved either using existing staff differently or appointing additional staff.

3.1.7 The cost of each additional named health or social care professional could be around £38,200 (for a band 6 nurse, mid-point plus on-costs, Agenda for Change 2017-18).

Benefits and savings

3.1.8 The recommendation is supported by health economics which looked at a Dutch study on case management (Vroomen et al. 2016). The study compared case management provided within one

care organisation, case management where care was provided by different care organisations within one region, and a group with no access to case management (control).

3.1.9 The study suggests that coordinating dementia care may result in savings to health and social care in England.

3.1.10 The potential benefits of implementing this recommendation may include:

- reduced hospital admissions
- reduced contact with healthcare professionals including GPs, psychiatrists, specialist mental health services and social workers
- delayed admission to care homes
- help to access services and support available
- improved wellbeing of carer's for people with dementia

3.1.11 Placements in a residential home are estimated to cost £28,860-£39,520 per annum depending on whether the provider is for- or not-for profit, whether it is a dementia residential home and whether the room is single or shared (PSSRU, Unit Costs of Health and Social Care 2017).

3.2 Offer group cognitive stimulation therapy to people living with mild to moderate dementia (recommendation 1.4.2)

Background

3.2.1 Cognitive stimulation therapy is recommended in both the original guideline and the update. An audit by the Memory Services National Accreditation Programme suggested that in 2014 cognitive stimulation therapy was available to people with dementia in around two-thirds of memory clinics.

3.2.2 Feedback suggests that the recommendation has still not been fully implemented meaning there could be a resource impact locally. The size of any potential costs will depend on current practice and the extent to which organisations implement the recommendation.

3.2.3 How this recommendation is implemented locally will vary depending on local pathways and the extent to which the previous guideline has been implemented. Therefore the costs and savings will need to be assessed locally

3.2.4 The local resource impact template can be used by organisations to model any additional investment needed locally based on local assumptions.

Costs

3.2.5 The key cost driver is staff time to deliver cognitive stimulation therapy.

3.2.6 Table 1 shows the staff cost per session of cognitive stimulation therapy based on the assumptions used in the health economics that support the guideline recommendation.

Table 1 Indicative staff salary cost per session

Staff used	Band 6 (e.g. OT specialist; clinical psychology trainee)	Band 4 (e.g. OT technician; clinical psychology assistant)
Hourly rate (£)[1]	43.00	28.00
Staff time – delivery (hr)	0.75	0.75
Staff time – preparation/administration (hr)	0.50	0.50
Staff time – travel (hr)	0.62	0.62
Total staff time per session	1.87	1.87
Staff salary cost per session (£)	80.41	52.36
[1] Unit costs of health and social care 2017		

Benefits

3.2.7 Cognitive stimulation therapy has been shown to improve cognition, which would be expected to then improve quality of life. This may delay admission into residential care. Placements in a residential home are estimated to cost £28,860-£39,520 per annum depending on whether the provider is for- or not-for profit, whether it is a dementia residential home and whether the room is single or shared (PSSRU, Unit Costs of Health and Social Care 2017).

3.3 Offer carers of people living with dementia a psychoeducation and skills training intervention (recommendation 1.11.1)

Background

3.3.1 A form of psychoeducation and skills training for carers is recommended in both the original guideline and the update. Feedback suggests that this recommendation has still not been fully implemented meaning there could be a resource impact locally.

3.3.2 How this recommendation is implemented locally will vary depending on local pathways and the extent to which the previous guideline has been implemented. Therefore the costs and savings will need to be assessed locally.

3.3.3 The local resource impact template can be used by organisations to model any additional investment needed locally and any associated savings.

Costs

3.3.4 This training may be delivered using existing staff or could be commissioned as a separate service. The key cost driver is either

staff time to deliver the training or the cost of procuring the training from external organisations.

3.3.5 Feedback suggests that due to the number of carers this recommendation is relevant to, this training may need to be a specifically commissioned service.

Benefits and savings

3.3.6 Evidence shows that psychoeducation and skills training reduces carer's sense of burden, depressive symptoms, anxiety and stress; and reduces the behavioural and psychological symptoms shown by the person living with dementia.

3.3.7 Psychoeducation and skills training for carers may prevent carer breakdown and may delay or avoid the need for residential care. Placements in a residential home are estimated to cost £28,860-£39,520 per annum depending on whether the provider is for- or not-for profit, whether it is a dementia residential home and whether the room is single or shared (PSSRU, Unit Costs of Health and Social Care 2017).

4 Implications for commissioners

4.1 Dementia falls under programme budgeting category 05X Mental health disorders.

4.2 Dementia care could be commissioned by either health or social care commissioners, or jointly as part of an integrated working approach.

About this resource impact report

This resource impact report accompanies the NICE guideline on Dementia: assessment, management and support for people living with dementia and their carers and should be read in conjunction with it. See terms and conditions on the NICE website.