

COMMENTARY

The National Dementia Strategy¹ highlights that dementia care and services are fragmented, poorly coordinated, and vary in quality across the UK.^{2,3} It is depressing to see that these issues had been identified several years ago,^{4,5} and also that GPs' lack of training and confidence in making a diagnosis of dementia seem, if anything, to have deteriorated since 2000.^{2,3,6} Unfortunately, the idea that making an early diagnosis of dementia could engender further fear and stigma still seems to have some currency, while current thinking and good practice both suggest that sharing the diagnosis is what people with dementia and their carers want and need.⁷ There is also strong evidence that, for many patients, secondary care is the best place in which to make a definitive diagnosis of dementia.^{1,3}

The paper by Greaves and Jolle⁸ emphasises the role of general practice, but we should probably be cautious about over-claiming for primary care. Concerns remain about the ability of general practice to provide consistent, constant, and continuous care in some settings. Poor access, lack of continuity of care, and little or no flexibility in the service are well recognised,⁹ and evidence from carers and people with dementia suggest that these are important concerns.¹

Local models of dementia diagnosis and care may not translate easily across the whole country, and we must be careful not to create fragmented care simply by promoting the role of general practice. An integrated strategy is needed, rather than further disparate approaches, which could lead to people with dementia and their carers and families continuing to receive poor care and services. Advocating an isolationist approach serves only to support the status quo and could deter NHS and social care delivery organisations from giving dementia the priority the Strategy recommends.³

There is a real danger that this is occurring, as highlighted recently in the media. It seems that, despite dementia being a national priority, there are few levers to make local authorities focus specifically on dementia, rather than on other health problems, such as cancer. Changes at local level are not taking place quickly enough and they lack leadership.³ We need to engage in the debate about how we can facilitate ways of bringing about large scale improvements. Without this, it is unlikely that the Strategy will be delivered at all, let alone within the 5-year time frame. We need less rhetoric and more 'joined up' collaborative multidisciplinary working between health and social care. Acting alone will do little to 'roll out' this much needed Dementia Strategy. We owe it to people with dementia, carers, and their families to act together and support this Strategy.

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Provenance

Commissioned; not peer reviewed

REFERENCES

1. Department of Health. *Living well with dementia: a National Dementia Strategy*. London: HMSO, 2009.
2. National Audit Office. *Improving services and support for people with dementia*. London: TSO, 2007.
3. National Audit Office. *Improving dementia services in England: an interim report*. London: TSO, 2010.
4. Beattie A, Daker-White G, Gilliard J, Means R. How can they tell? A qualitative study of the views of younger people about their dementia and dementia care services. *Health Soc Care Community* 2004; **12**: 359–368.
5. Beattie A, Daker-White G, Gilliard J, Means R. They don't quite fit the way we organise our services: results from a UK field study of marginalised groups in dementia care. *Disabil Soc* 2005; **20**: 67–80.
6. Audit Commission. *Forget me not: mental health services for older people*. London: Audit Commission, 2000.
7. Keady, J and Williams, S. Co-constructed inquiry: a new approach to generating, disseminating and discovering knowledge in qualitative research. *Quality in Ageing* 2007; **8**(2): 27–36.
8. Greaves I, Jolley D. National Dementia Strategy: well intentioned — but how well founded and how well directed? *Br J Gen Pract* 2010; **10.3399/bjgp10X483553**.
9. Campbell J. Access to primary care: advanced ... or smart? *Br J Gen Pract* 2007; **57**: 603–604.

DOI: 10.3399/bjgp10X483814

on the front line, who find themselves simultaneously the subject of criticism for supposed failings, while being expected to provide more for more people over longer periods, with no visible additional resource at their disposal. Sadly, this is being experienced thus far as a very top-down strategy. If we are to deliver optimal, flexible responses to the needs of patients and carers, we

must devolve influence to them and the frontline professionals who work with them. This encourages pride and commitment, which facilitate better use of all resources that can be tailored to individual and local needs and strengths.

CONCLUSION

The recently published National Dementia Strategy