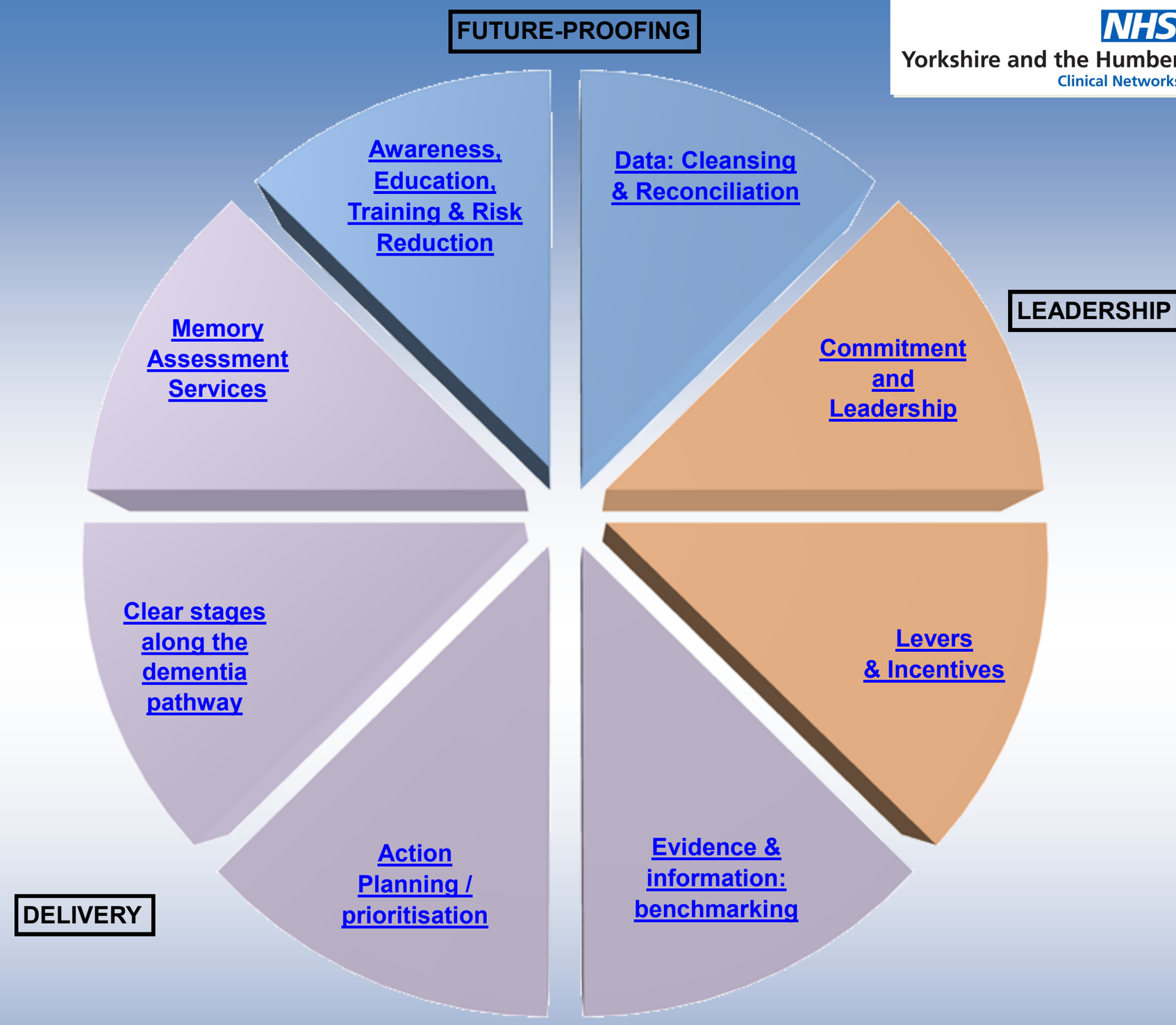
HOME

NHS
Yorkshire and the Humber
Clinical Networks

Dementia Commissioning Knowhow



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Introduction

Background

The Yorkshire and Humber Clinical Network, in collaboration with NHS England's Dementia Policy team and Intensive Support Team, has developed a tool to support commissioners of dementia services.

The resource is primarily intended to support CCGs who are endeavouring to improve dementia care services and are striving to meet the national ambitions. It will also be of interest to STPs in helping to clarify work which will add value for dementia care services.
The tool covers the dementia care pathway and advocates a systematic, standardised approach to investigating and enhancing the attributes and processes that positively impact effective commissioning of dementia care services.

Overview of the document

After working through the document, commissioners should be able to identify and develop, or enhance, the abilities and processes that need to be in place in order to successfully deliver commissioning of high quality dementia care services including:

- Strategic and leadership qualities and abilities
- Awareness of current performance
- Collaborative working with service providers
- Use of appropriate levers and incentives
- Accuracy and use of data in monitoring and reporting
- Resources to address any gaps or improvements required
- Futureproofing knowhow

Purpose

The objective of this resource is to enable CCGs to successfully deliver against key business priorities for dementia: to achieve and maintain dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia, and improve the quality of and access to post diagnostic care for people living with dementia and their carers. These are also requirements set out in the Mandate and reflected in the Prime Ministers' 2020 Challenge and the Prime Minister's Challenge on Dementia 2020: Implementation Plan.

This tool to support commissioning dementia services will help CCGs and STPs to:

- Improve the Dementia Diagnosis Rate as a continuous process.
- Assist with the refinement of local diagnosis processes and the dementia care path-way to deliver in line with the Implementation guide and resource pack for dementia care and improve outcomes for patients and carers.
- Realise the national ambition to provide consistently good quality, evidence-based dementia care and support for patients and carers.

This tool is for:

- CCG Commissioners
- STPs

This tool will be of interest to:

- Commissioners of dementia care
- CCG GP dementia leads
- STP leads
- Service providers, including health, social care, voluntary and charitable organisations

Getting Started: A whole system approach - Commitment and leadership

What is needed?	Is it being achieved?
Committed leadership, combined with a structure and system for commissioning and monitoring dementia care	**Questions to ask and address**: • How invested is system wide leadership for dementia care in your area? Is there a Dementia Strategy Board (or similar) in place? What organisations/ areas are represented on the board / group and is it appropriate? • How is leadership demonstrated? • Is there a process for making sure people living with dementia and family carers are involved as equal partners? • What are the results/ impacts/ outcomes? • How many dementia friends are there in the area? • How many dementia friendly hospitals or other organisations such as Local Dementia Action Alliances, are there?

How to improve delivery - steps to take

Establish:

1. An operational delivery or steering group that will:
    - bring together commissioners, local authorities, providers, voluntary organisations and social prescribing network representatives, local academics and public health researchers;
    - include named champions/clinical and operational leaders in each provider organisation;
    - support and promote the use of, and contribution to, local, regional and national research systems such as Join Dementia Research (JDR), to help enhance dementia services in the long term
    - aim to address dementia risk reduction;
    - refer to the RightCare programme, to help ensure that in dementia services, the right person has the right care, in the right place, at the right time, and can make the best use of available resources
    - have an agreed co-production approach involving people living with dementia and family carers in designing dementia care pathways including inpatient pathways; and
    - set out a framework delineating clear lines of reporting, responsibility & governance systems and which shows how dementia fits into or links with the other programmes of the CCG including delirium, self care, End of Life Care (EoLC), out of hospital and unplanned care.
2. Ensure commitment to a joint system-wide dementia strategy and action plan with defined reporting time frames.
3. Identify a commissioner/GP to lead dementia commissioning and a senior person in each CCG who takes responsibility for monitoring dementia care provision.
4. Encourage each GP practice to identify a dementia lead.
5. Engage with Dementia Friends and champion(s) to work with GP practices/ leads.

Resources continued on the next page, please scroll down or click here

Getting Started: A whole system approach - Commitment and leadership (continued)

Resources

7. Consider products from the NHS RightCare programme including Dementia RightCare scenarios for optimal pathways and the new mental health conditions data packs for CCGs to enable benchmarking.
8. The Department of Health publication After a diagnosis of dementia: what to expect from health and care services provides information about:
    - the support and services people living with dementia and their carers can expect to receive irrespective of their location in England
    - what really matters to people living with dementia and their carers
    - the guidance and other support that can help commissioners in their role.
9. In developing a dementia strategy, ensure it will meet the needs set out in the 'we' statements for dementia.
10. Contact organisations such as Tide and DEEP to explore possibilities for co-production.
11. Are your CCG and GP practices dementia friendly? Free Dementia Friends training is available from the Alzheimer's Society.
12. Consider the DAA Dementia Friendly Hospital Charter to help ensure hospitals are able to support people living with dementia effectively.
13. Refer to the Butterfly scheme as a good example of hospital care for people living with dementia, or Forget me not dementia training for all health and social care settings
14. Easy online training tools are available for GP practice, hospital, care home and domiciliary staff. These help staff to make every contact with someone affected by dementia an effective, positive, informed one.
15. Improve awareness of GP practice staff regarding dementia and the post diagnostic support available. Practices can order copies of the Alzheimer's Society The Dementia Guide and local helpline numbers (provided in the guide) as a standard tool.
16. The Health Education England (HEE) Dementia Training Standards Framework is designed to help organisations and individuals in health, social care or housing to ensure quality and consistency in dementia education and training.

Evidence and information: Benchmarking

What is needed?	Is it being achieved?
Complete local system-wide based mapping to inform development of specifications/ processes, service design and setting of key performance indicators for dementia care aims and strategy	**Questions to ask and address:** • What evidence substantiates and informs choices about how to plan services around patient's needs? • How is the quality of care patients receive being monitored? • How is current practice benchmarked against other CCGs and local authorities in England?

How to improve delivery - steps to take and resources

1/ Map local demographics and demand: The population currently requiring dementia care including numbers of people by age, gender, ethnicity, diagnosis and co-related illnesses. Also consider how demand will change by looking at expected changes in population demography.

2/ Map achievement of CCG IAF indicators (MyNHS). Use local data for a gap analysis and comparison with national data and key documents that outline what dementia care should look like. Key sources of data include:

I. Dementia Diagnosis Rate (monthly reporting): https://digital.nhs.uk/data-and-information/publications/statistical/recorded-dementia-diagnoses. Metrics include ***dementia diagnosis*** and ***antipsychotic prescribing, assessments and care plans***. Data is collected and organised at National, Region, Sub Region, STP, CCG and GP practice levels, and can be viewed by ***gender and ethnicity***. Source GP Practices.

II. The Dementia Assessment and Referral data collection, reports on the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours in England who have been identified as potentially having dementia, who are appropriately assessed and, where appropriate, referred on to specialist services.

III. NHS Rightcare has published new data packs for a range of mental health and dementia services for each CCG. The mental health conditions packs contain data across a range of mental health and dementia services. The packs are split into stages along a mental health pathway and enable local health economies to compare their performance with ten similar CCGs.

IV. Quality Outcomes Framework (annual reporting): https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data. Metrics include**:** percentage of ***dementia patients with a care plan review in the last 12 months***. Data is collected and organised at national, regional, sub regional, STP and CCG levels. Source: covers all General Practices in England that participating in the Quality and Outcomes Framework (QOF). Participation in QOF is voluntary, though participation rates are very high at 95.4 per cent.

V. PHE Fingertips tool (Dementia Profile): https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia Metrics: This tool provides indicators arranged into six data domains including Prevalence, Preventing well, Diagnosing well, Living well, Supporting well and Dying well. Profiles provided are based on CCG and Local Authority geographies. For specific information on local areas, benchmarking, data ranking and categories refer to the Dementia Public Health Profile and the Dementia data catalogue.

Steps to take and resources continued on the next page, please scroll down or click here

Evidence and information: Benchmarking (continued)

How to improve delivery - steps to take and resources (continued)

VI. Source: CCG and Local Authority Geographies
Public Health Outcomes Framework, particularly those indicated in the table below. The Public Health Outcomes Framework tool also enables local benchmarking and comparisons.

Preventing well domain	
2.11 Proportion of population eating 5 a day on a usual day	2.17 Recorded Diabetes
2.12 Excess weight in adults (overweight or obese)	2.22 Proportion of population 40-75 receiving an NHS Health Check
2.13 Proportion of population physically inactive	2.23 Self-reported well-being
2.14 Smoking prevalence- adults	
Living and Supporting well domains	
1.13 Older people's perception of community safety	1.18 Social isolation: percentage of adult carers who have as much social contact as they'd like
2.23 Self-reported well-being	
4.13 Health related quality of life for older people	4.11 Emergency readmission within 30 days of discharge from hospital

VII. Adult Social Care Outcomes Framework (ASCOF). Refer to the latest report for *Measures from the Adult Social Care Outcome Framework - England 2017-18: Time-series of aggregated outcome measures*, particularly:

Living and Supporting well domains	
1D Carer-reported quality of life	2B Proportion of older people (65+) who were still at home 91 days after discharge from hospital to reablement / rehabilitation services
2A Permanent admissions to residential and nursing care homes per 1000 population	

VIII. Dementia data and analysis is a guide for commissioners and health professionals which explains how to use data and analysis to support the development of dementia services.

VIII. Patient-Led Assessments of the Care Environment (PLACE). This publication provides the results of Patient-Led Assessments of the Care Environment (PLACE) Programme. It includes an experimental interactive report which allows users to explore the underlying data in a variety of ways. PLACE assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability.

Making it happen: Action planning and prioritisation

What is needed?	Is it being achieved?
To identify gaps in coverage, rate priorities and establish areas for development	**Questions to ask and address**: • Is the dementia diagnosis rate ambition being achieved? • How is everything recorded? Is it coded correctly? • What systems are being used in primary and secondary care? How is the transition to SNOMED being managed? • Is there a clear entry point to the care pathway for everyone with a diagnosis of dementia? Does it include cohorts such as those under 65 years, those with learning disabilities and those with Parkinson's and complex neurological conditions and those living in care homes (residential and nursing)? • Are systems in place to ensure person centred care and support plans are of the quality advocated in the Dementia Good Care Planning Guide; How many people with a diagnosis of dementia are being given a care plan review? • Is everyone diagnosed with dementia in your area linked to co-related areas as appropriate, for example diabetes, other long-term conditions, end of life care? How can the links be assured? • Are care homes being reviewed?

How to improve delivery - steps to take and resources

1. **Ensure that all GP practices are submitting complete and accurate data for dementia diagnoses**. Confirm that the same data items are being counted, for example by identifying the coding set that is being used locally (if there is one), using this and specific templates and asking all GP practices to use them consistently. A helpful resource has been published by Yorkshire and Humber Clinical Network in the form of a Primary Care Resources User Guide and *National Collaborating Centre for Mental Health* (*NCCMH)* has published a Dementia care plan: coding resource to support dementia care planning and the transition to SNOMED in primary care.
2. **Support primary care to use a clear framework for dementia care planning** such as the D.E.M.E.N.T.I.A framework set out in the Dementia Good Care Planning Guide (refer to pages 10 to 12).
3. **Consider innovation:** such as the DECODE Dementia system, an intelligent clinical decision support system developed by the University of Exeter Medical School to aid timely dementia diagnosis. DECODE is currently being trialed in both primary care to aid initial assessments and in Devon Partnership Trust memory clinics as a triage tool. Operational research undertaken to establish the impact of the system indicates that DECODE is likely to substantially improve Dementia Diagnosis Rates whilst substantially cutting memory clinic waiting times. Contact Dr David Llewellyn.
4. **Encourage GP practices to sign up to the Calculating Quality Reporting Service (**CQRS**)**, the approvals, reporting and payments calculation system for GP practices to boost data monitoring.
5. **Review and monitor** a) How dementia diagnosis in care homes takes place (see item 13 on page 8) and b) Referrals to memory clinics.
6. **Reconcile data**. Use for example, the dementia data quality toolkit (DQT), which incorporates system searches to generate a list of patients, who have a coded entry on the practice system that might be indicative of dementia but does not have a corresponding dementia diagnosis code that includes the patient on the QOF dementia register .

Steps to take and resources continued on the next page, please scroll down or click here

Making it happen: Action planning and prioritisation (continued)

How to improve delivery - steps to take and resources (continued)

7. **Define and embed appropriate links between primary and secondary care**. Refer to, for example, Guidance for GPs to use a Summary Care Record (SCR) to make more information available across care settings.
8. Consider incorporating social prescribing networks to enable support for people following a diagnosis of dementia and throughout the dementia care pathway.
9. **Advocate a defined dementia pathway**. Refer to NHS England's Implementation guide and resource pack for dementia care and *NCCMH*'s publication The Dementia Care Pathway – Full Implementation guide (under Dementia Care).
10. **Confirm that all people with a diagnosis of dementia are given a care plan review**. Check the data for care plan reviews in your area, use for example annual data on recorded dementia diagnoses by care plan published by NHS Digital. Confirm how post diagnostic support is tracked in your area. For examples of good practice refer to the NHS England Dementia: Good Care Planning guide and Yorkshire and Humber Clinical Network care plan templates developed, in conjunction with Airedale NHS Foundation Trust, for SystmOne and EMIS which can be found in the Primary Care Resources section of the website: http://www.yhscn.nhs.uk/mental-health-clinic/Dementia/Diagnosis.php#primarycare
11. **Check whether everyone diagnosed with dementia in your area is linked to appropriate co-related areas**. For example diabetes, other long-term conditions and end of life care. Look at how can the links be assured.
12. Review monitoring and action planning around the National Dementia Audit (NAD), which looks at the performance of general acute hospitals against criteria relating to care delivery which are known to impact people with dementia while in hospital. Reports and resources can be found on the Royal College of Psychiatrists website: https://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/thenationalauditofdementia/resources.aspx
13. **Review care homes in your area**. Refer to for example, Wessex Strategic Clinical Network, Dementia Pathway Redesign - Phase 2, End of Project Report . This project has been very successful in developing a toolkit to assist diagnosis in care homes from a GP and patient consultation process. A Dementia Strategy Group with that connects health and social care partners would also help by providing a forum for stakeholders to review performance and consider future commissioning needs. For additional information, look at the Vanguard Learning guide - high quality dementia care. Other useful resources to refer to include DeAR GP and DiADeM.
14. **Consider how best to link into local incentives and initiatives related to Dementia care**. The National CQUIN now exists in the form of the local contract. Establish what means are used to monitor the contract in your area and look at where links could be made with out of hospital initiatives, such as dementia/memory cafes and dementia friendly communities, as well as to the Vanguard work.

Data: cleansing and reconciling

What is needed?	Is it being achieved?
Routine steps and processes to action, to assist in: • Increasing Dementia Diagnosis Rates (DDR) • Improving the waiting time between referral and diagnosis and accessing appropriate care and support; • Monitoring and increasing care planning, advance care planning, and participation in research such as Join Dementia Research (JDR)	**Questions to ask and address**: • How is data quality checked? • Is data cleansed regularly? • Are the provider lists of codes in use locally, aligned with the national codes that are used in the data collection for the monthly Dementia QoF, CQRS data from GP Practices? • Are those responsible for recording diagnoses familiar with the appropriate classifications and definitions for the different types of dementia such as early onset (for people under the age of 65 years). • Are there standard working practices for information sharing between primary and secondary care around dementia diagnosis?

How to improve delivery - steps to take and resources

1. **Use the Dementia Quality Toolkit (DQT) regularly to help cleanse data**: The DQT consists of a series of reports and queries run directly on GP systems to identify patients who may have dementia, but who are not coded as such within the practice. The reports include:
   - Patients who have ever been prescribed anticholinesterase inhibitors (AChE) including donepezil, galantamine, rivastigmine, or memantine but who have no recorded coded dementia diagnosis. Further information can also be found here.
   - Patients who have a code in record that may suggest dementia and those who have previously been coded with local dementia codes i.e. this is codes that are not part of the QOF Dementia Indicator Set

   A separate report identifies patients who may be at risk of developing dementia, these searches include:
   - Patients who have ever presented with a delirium coded while in hospital or a care home setting
   - Patients aged 65 years and over and all those in care homes who have been prescribed antipsychotic medication
   - Patients who live in a care home (70% will have Dementia) - The DiADeM tool app would be recommended for use in this care setting.
2. Yorkshire and Humber Clinical Network's new Primary Care Resource User Guide walks through the process and offers technical guidance on how to import the support tools. Another example step by step guide to undertake a coding clean-up exercise is set out by Dementia Partnerships http://dementiapartnerships.com/ resource/dementia-coding-clean-up-exercise/ and http://dementiapartnerships.com/resource/guidance-on-dementia- coding/. The average time needed is approximately 5 hours per practice.
3. **Look at creating GP practice profiles if possible**. Consider the methodology developed by NHS Wakefield CCG to create a GP practice profile around Dementia Diagnosis Rates (DDR).

Steps to take and resources continued on the next page, please scroll down or click here

Data: cleansing and reconciling (continued)

How to improve delivery - steps to take and resources (continued)

4. **Check the codes** in use by local practices, against the national codes used in the monthly QOF data collection (see Dementia Care Pathway: Appendices and Helpful Resources and NHS Digital's QOF Business Rules - filter column C for Codes for Dementia). CQRS data helps GP practices to track & monitor their performance against QOF. The monthly publication of recorded dementia diagnoses is available at http://www.content.digital.nhs.uk/catalogue/PUB24036 (the Read V2 and CTV3 codes are listed in separate tabs in the workbook). Also refer to NCCMH's Dementia care plan: coding resource to support dementia care planning and the transition to SNOMED in primary care
5. **Examine secondary care data:** Develop standard working practices of information sharing between primary and secondary care, particularly around diagnosis. The Summary Care Record (SCR) would be useful here.
6. **Check the NHS England statistics on Dementia assessment and referral to the Memory Assessment Service (MAS)** from acute hospitals, now part of their standard contract.
7. **Consider 'Guidance for recording dementia care pathway benchmarks in the Mental Health Services Data Set (MHSDS) v3.0'** in Appendix D of NCCMH's publication The Dementia Care Pathway: Appendices and helpful resources.
8. **For definitions and classifications** of diseases, refer to the World Health Organisation (WHO) International statistical Classification of Diseases and related health problems (ICD-10) classification. All SNOMED codes are mapped to the ICD.
9. **Use risk management approaches and prompts when working through data.** To support clinicians who are identifying, diagnosing and providing ongoing care to patients diagnosed with dementia, Yorkshire and Humber Clinical Network have developed Dementia Reports (that includes 'At Risk' search). Please refer to the technical guidance on how to import these files to your GP practice system: SystmOne (Technical guidance), EMIS Web (Technical Guidance) in the Primary Care Resources section on the Yorkshire and Humber Clinical Network website. Look for patients with CVD, hypertension; history of TIA/stroke; diabetes; patients with neurological conditions or learning disability conditions that predispose to high levels of dementia e.g. Parkinsons, MND, Downs; the over 75's – target with a prompted query re memory concerns (Gnosall model).
10. **Consider using Health Fabric app**, an integrated, patient led care planning app including: information, medicines data and much more. For multi- agency use, families and carers, and personal management. Data links with EMIS and SystmOne. Patient version free. Practice costs: installation approx. £500; license costs up to £3.50 pp/pm.
11. **Plan targeted review and assessment visits with care homes** in your area to obtain diagnoses and enable dementia care planning and advance care planning. Confirm that care homes in your area use DiADeM. Also, check that the use of DeAR GP, a tool that aims to increase identification of possible dementia and subsequent diagnosis rates, is embedded in the processes of care homes and community settings in your area.
12. **Consider how effectively delirium coding datasets are shared between primary and secondary care**, as people diagnosed with delirium are more likely to develop dementia in the future.
13. Useful data sources:
    - Case study: Predictors of care home and hospital admissions and their costs for older people with Alzheimer's disease: findings from a large London case register
    - Care Home admissions supplementary information
    - Delayed Transfers of Care (DTOC)
    - The admitted patient care datasets contain data on the coding of delirium. Data for admissions to NHS hospitals in England are available in Hospital Admitted Patient Care Activity.

Dementia: Diagnosis Rate

What is needed?	Is it being achieved?
As a minimum, the National ambition is that two thirds of the estimated number of people with dementia should have a diagnosis	**Questions to ask and address:** • What is the dementia diagnosis rate in your area? • What is the variation between practices? Are there any outliers that need extra support? • How are GP practices in your area planning to ensure submissions of complete and accurate data by end of 2018/19? • What data sharing practices/ agreements are in place between GP practices and CCGs in your area?

How to improve delivery - steps to take and resources

1. **Check the current Dementia Diagnosis rate** for your CCG area
2. **Investigate the variation between practices** in Recorded Dementia Diagnoses by Age; Care Plans, Referrals, and Assessments at practice level in your CCG area and establish any outliers who may need extra support. Consider the methodology developed by NHS Wakefield to create a GP practice profile around Dementia Diagnosis Rates (DDR).
3. **Reconcile existing data and ensure coding is accurate and co-ordinated**. Search and review records. Refer to data cleansing and reconciling section in this resource
4. **Work with memory clinics to ensure that letters and other communications are clearly coded** and less ambiguous. Regarding coding for example, refer to the guidance document prepared for use across the North region to provide a consistent way of coding dementia and delirium in GP practices. An example letter template can be found on the Yorkshire and Humber Clinical Network website.
5. **Check that the diagnosis of dementia for people under 65 years of age (early onset) is being coded and recorded appropriately**. Are those responsible for recording diagnosis familiar with the appropriate classifications and definitions for early onset dementia? The NHS uses the World Health Organisation (WHO) International statistical Classification of Diseases and related health problems (ICD-10) classification. All SNOMED codes are mapped to the ICD.
6. **Develop or strengthen joint clinical pathways of dementia care for primary care, intermediate care hospitals and acute care** to improve diagnosis rates in hospital. Also refer to the DAA Dementia Friendly Hospital Charter to help ensure hospitals are able to support people living with dementia effectively.
7. **Ensure pathways are in place in primary and secondary care settings** to flag and refer high risk patients. Look at NICE guidelines for Dementia Diagnosis and Assessment
8. **Use DiADeM (Diagnosis of Advanced Dementia Mandate in Care Homes) and DeAR-GP (Dementia Assessment Referral to GP)** to help improve diagnosis rates in care homes.
9. **Consider using** the DECODE Dementia system to aid initial assessments in primary care and as a memory clinic triage tool in order to improve Dementia Diagnosis Rates whilst cutting memory clinic waiting times. Contact Dr David Llewellyn.
10. **Consider using** 10 steps to improving diagnosis - self-assessment framework to help enhance diagnosis.
    For everyone with a dementia diagnosis, consider using social prescribing to support their clinical pathway and enable people to keep well for longer and improve quality of life.

Memory Assessment Services

What is needed?	Is it being achieved?
Clear Service Provision and processes and priorities	**Questions to ask and address:** • Can all referrers access MAS for people with a possible diagnosis of dementia? • Can all people receiving a possible diagnosis of dementia expect to be referred to a memory assessment service? • Do the MAS offer a full range of services to aid diagnosis and initial management of dementia? • Are all care professionals, working with those with a possible diagnosis of dementia, aware of the process by which referrals can be made to the local MAS? Is the process clear? Does the process vary? If so, can it be standardised? • Are there clear pathways for the diagnosis, coding and on-going management of MCI and does the service bench mark the diagnosis internally and externally? • Are there clear pathways to diagnosis and post diagnostic support for patients with complex neurological conditions / Learning Disabilities, Young onset dementia symptoms and Stroke?

How to improve delivery - steps to take and resources

1. **Identify gaps in processes and service provision,** and rate the priorities and areas for development**.** Collate and analyse information from a variety of sources including audit, policy and research as well as local data provided by stakeholders, providers, service users and carers to identify gaps and potential solutions.
   Explore the provision of memory services in your area that make best use of workforce and resources'. Examples of different service models include
   - Enfield Memory Service
   - Stockton Memory Service
   - Geltwood House, Carlisle memory service 'virtual' clinics
   - Newcastle Memory Assessment & Management Service (MAMS)
   - Hambleton and Richmondshire memory service: assessment and diagnosis in one day.

   For three additional examples including primary care led models, also refer to Models of Dementia Assessment and Diagnosis: Indicative Cost Review. Consider training provided for post graduates and, health professionals and people who may not have a health background by the University of Birmingham. For additional information on education and training, please refer to the Awareness, Education, training and risk reduction section.

2. **Confirm that the best use is being made of NHS resources**. Check that triage processes ensure diagnosis is reached with a minimum number of appointments / steps and that the dementia pathway incorporates use scanning and ECGs only where appropriate. Yorkshire and the Humber Clinical Network's Neuro-imaging in Dementia Guidance: To Scan or not to Scan? aims to assist the streamlining of memory services pathways. The guidance addresses the questions of when neuro-imaging should be undertaken, which scan should be requested, addresses the benefits of scanning and discusses which patients a scan may not be appropriate for.

Steps to take and resources continued on the next page, please scroll down or click here

Memory Assessment Services (continued)

How to improve delivery - steps to take and resources (continued)

3. **Clarify referral processes**. Refer to NHS England's Implementation guide and resource pack for dementia care and the National Collaborating Centre for Mental Health (NCCMH)'s publication The Dementia Care Pathway – Full Implementation guidance to benchmark against and aid application of good practice.

4. **Consider implementing good practice and processes established in other areas to help reduce the diagnosis gap.** Examples of best practice include:

   - Streamlining Memory Service Pathways: guidance from the London Dementia Clinical Network
   - NICE "Dementia: support in health and social care - Quality standard [QS1] Quality statement 2: Memory assessment services - https://www.nice.org.uk/guidance/qs1/chapter/quality-statement-2-memory-assessment-services "to ensure all referrers can access memory assessment services for people with a possible diagnosis of dementia".
   - Northern England Clinical Networks best practice case studies on diagnosing well: memory services and dementia http://www.necn.nhs.uk/networks/mental-health-dementia-and-neurological-conditions-network/network-case-studies/diagnosing-well-memory-services-and-dementia/

5. **Consider the** Memory Services National Accreditation Programme to support services to help improve the quality of care they provide to service users and carers and their wider organisation and commissioners.

6. **Consider 'Guidance for recording dementia care pathway benchmarks in the Mental Health Services Data Set (MHSDS) v3.0'** in Appendix D of NCCMH's publication The Dementia Care Pathway: Appendices and helpful resources.

7. **Check that those responsible for recording diagnoses are familiar with the appropriate classifications and definitions** for the different types of dementia such as early onset (for people under the age of 65 years). The NHS uses the World Health Organisation (WHO) International statistical Classification of Diseases and related health problems (ICD-10) classification. All SNOMED codes are mapped to the ICD.

Clear definition of stages along the dementia pathway

What is needed?	Is it being achieved?
A defined step by step dementia pathway. **Clear information sharing between each stage.** **Appropriate processes to trigger each stage and ensure the right care, services and support are provided at the right time throughout the care journey.**	**Questions to ask and address:** • Are the entry and 'time points' along the dementia pathway clear? For example considerations, refer to: https://www.kcl.ac.uk/sspp/policy-institute/scwru/pubs/2015/conf/samsi28may15.pdf • Is the pathway well defined and linked to the Dementia Well Pathway? • Where are people initially identified with early symptoms of dementia? Is it at home, a care home, a nursing home, in hospital etc.? • Regarding diagnosis, who provides this? Is it GPs, old age psychiatrists, geriatricians, neurologists, clinical psychologists or memory nurses? Where is the diagnosis recorded? How is the information transferred? What systems are in place to assure this? • When are people with a diagnosis of dementia and their carers referred to support services? What signposting is in place? Is it effective? Are people receiving appropriate support? What mechanism is in place to trigger a care plan review?

How to improve delivery - steps to take and resources

1. **Ensure dementia pathways are clear.** This should include defined pathways to dementia diagnosis and post diagnostic support for patients with learning disabilities, mild cognitive impairment, early onset dementia, stroke and complex neurological conditions .For guidance on implementing a dementia care pathway refer to NHS England's Implementation Guide and Resource Pack for Dementia care and NCCMH's resource The Dementia Care Pathway: Full Implementation guidance (under Dementia).
2. **Check the data for dementia diagnosis and examine where cases are being identified** (refer to data cleansing and reconciling earlier in this document) to pinpoint where support might be needed.
3. **Confirm the systems that are in place to assure transfer of diagnosis and healthcare information between care settings**. For example the Red Bag initiative.
4. **Survey dementia support services in your area**: look at availability, usage, service user feedback to confirm accessibility and quality of services.
5. **Confirm best practice is in place for dementia care planning and mechanisms to trigger care plan reviews.** Good care planning is the gateway to good post-diagnostic support. For best practice, refer to NHS England's *Dementia: Good Care Planning* guide. It sets out the core components to be addressed in a good care plan as a minimum level for post diagnostic support (the D.E.M.E.N.T.I.A framework). Also, Yorkshire and Humber Strategic Clinical Network have developed, in conjunction with Airedale NHS Foundation Trust, care plan templates for SystmOne and EMIS which can be found in the Primary Care Resources section of the website: http://www.yhscn.nhs.uk/mental-health-clinic/Dementia/Diagnosis.php#primarycare
6. **Consider** Guidance for commissioners of dementia Services by the Joint Commissioning Panel for Mental Health: for an overview of a comprehensive dementia commissioning programme

Care home reviews

What is needed?	Is it being achieved?
Timely diagnosis of dementia for people resident in care homes. **Shared diagnosis information and advance care plans (between care settings) for each person, to enable appropriate care planning, advance care planning and post diagnostic support such as delirium prevention, as well as end of life care.**	**Questions to ask and address:** • How are dementia diagnoses made in care homes in your area? • Do you know who your care home population is? Is the place of residence coded on the GP record? Is this information linked to the patient health record? • Is there a specific code used for dementia diagnosis made in care homes which is used by all? • Are GPs and practice staff aware of the code? Do you regularly code patients as living in a care home setting? (these patients can often be hard to define in GP records) • What processes are in place in care homes to prompt steps for delirium prevention, care planning and advance care

How to improve delivery - steps to take and resources

1. **Plan targeted review and assessment visits with care homes in your area**
   - The New care models: Enhanced Health in Care Homes: Vanguard learning guide provides a wealth of information to aid implementation of high quality dementia care including resources such as *DeAR-GP User Guide*, *Dementia Assessment Referral to GP Form*, *Guide for Care Home Managers*, *Guide for Care Workers* and a *Training plan for Care Workers*.
     Co-designed by the Health Innovation Network, the Dementia Assessment Referral to GP tool (DeAR-GP) supports care workers to identify people who are showing signs of dementia and refer them to their GP or another healthcare professional for review. Once completed, DeAR-GP supports communication between care workers and GPs.
2. **Establish what systems are in place**: to ensure that people diagnosed with dementia in care homes have their diagnosis transferred onto their health record to help make sure they receive appropriate post diagnostic support.
   - Resources for care homes to use for dementia diagnosis include DiADeM.

Steps to take and resources continued on the next page, please scroll down or click here

Care home reviews (continued)

How to improve delivery - steps to take and resources (continued)

2. **Check the list of diagnosis codes** currently in use by local providers across your area and also refer to Data: cleansing and reconciling earlier in this document, to help clarify data considerations.

3. **Confirm the mechanisms in place to ensure that people diagnosed with dementia in care homes have:**

   - **A care plan:** to facilitate appropriate post diagnostic support. The Dementia: Good Care Planning Guide sets out a step by step framework (D.E.M.E.N.T.I.A) that covers the core fundamental components of a good dementia care plan.
   - **An advance care plan:** to further enable appropriate post-diagnostic support and end of life care. Guidance on considerations for initiating, assessing and checking advance care planning is set out in My future wishes: advance care planning for people with dementia in all care settings.

4. **Consider resources to enhance post diagnostic support including:**

   - Dementia environment in a care home video (Social Care Institute For Excellence (SCIE)) - highlighting simple changes to create a more dementia friendly care home
   - Coordinate My Care (CMC) to increase the use of online shared care plans within care homes.
   - Red Bag initiative (NHS Sutton CCG) to improve communication between care settings and ensure that any treatment a resident needs can be determined more effectively.
   - Care Home Pioneer Programme (Health Innovation Network), a free leadership support and professional development programme to advance skills, facilitate personal growth and enable effective management of complex everyday issues that impact on the quality of service.
   - Health Education England Training resources (Tiers 1, 2 and 3) to aid diagnosis, treatment and care of those with dementia.

Post Diagnostic Support (PDS)

What is needed?	Is it being achieved?
Mechanisms or processes in place to trigger care plan reviews and appropriate PDS (including opportunity to participate in research), to ensure that services meet patient's needs. For example, culturally-appropriate diagnosis and care (NICE)	**Questions to ask and address:** • What mechanisms are in place to trigger care plan reviews and PDS? • How is PDS being monitored in your area? Are audits being undertaken? • Is each person diagnosed with dementia being given appropriate post-diagnostic support? How many people who have been diagnosed with dementia are currently receiving post diagnostic support? • How many patients diagnosed with dementia have had a care plan review in the last 12 months? If not, why not? • How many patients are identified and assessed as having dementia and delirium within acute trusts in your area? Are they receiving appropriate referral?

How to improve delivery - steps to take

1. **Look at what post diagnostic support is available in your area**. City of Bradford Metropolitan District Council, Public Health External Development produced a report that provides a useful summary of guidance for PDS (derived from sources including NICE CG42, Quality Standards, NHS England, BMJ) set out below:
    - **From a commissioning perspective, match needs to the packages of care services for PDS**, categorised approximately as clinical, social, advocacy and opportunity to influence services, and safeguarding.
    - **Consider the provision of PDS for people with dementia** in the context of multimorbidity.
    - **Check that people with a diagnosis of dementia are given the opportunity to participate in research:** refer to Join Dementia Research (JDR) NHS toolkit for healthcare professionals http://nhs.joindementiaresearch.nihr.ac.uk/ and promote the use of, and contribution to, local, regional and national research systems, to help enhance dementia services in the long term.
    - **Review patients** who continue on treatment with AChEIs / Memantine regularly. To help prevent isolation consider social prescribing for example, https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network and https://www.socialprescribingnetwork.com/.
    - **Provide written and verbal information** to people newly diagnosed with dementia and their carers about their condition, treatment and the support options in their local area.
    - **Ensure that people diagnosed with dementia** have an assessment and an ongoing personalised care plan. Consider Yorkshire and Humber Clinical Network care plan templates developed, in conjunction with Airedale NHS Foundation Trust, for SystmOne and EMIS which can be found in the Primary Care Resources section of the website: http://www.yhscn.nhs.uk/mental-health-clinic/Dementia/Diagnosis.php#primarycare
    - **Check that carers of people with dementia are offered an assessment** of emotional, psychological and social needs and receive tailored interventions identified by a care plan. The care plan should support and enable people to live well with dementia and help them to know what to do if things start to go wrong (either for the individual or their carer). Refer to NICE guideline NG97: Dementia: assessment, management and support for people living with dementia and their carers: Recommendations, including Involving people living with dementia in decisions about their care, Care coordination and Interventions to promote cognition, independence and wellbeing

Steps to take continued on the next page, please scroll down or click here

Post Diagnostic Support (PDS) (continued)

How to improve delivery - steps to take (continued)

1. **(continued from previous page) Look at what post diagnostic support is available in your area**. City of Bradford Metropolitan District Council, Public Health Eternal Development produced a report that provides a useful summary of guidance for PDS (derived from sources including NICE CG42, Quality Standards, NHS England, BMJ) set out below:
    - **Confirm that people living with dementia are assessed by primary care** to identify and plan palliative care where possible (initiating advance care planning conversations).
    - **Ensure that people diagnosed with dementia are supported** to take part in leisure activities during their day (information provision, social prescribing).
    - **Provide training to help empower GPs and practice nurses** so that they have the same level of knowledge and confidence as those who assess patients and commence treatment.
    - **Ensure systematic follow-up is provided in the appropriate place**. It might not necessarily require a specialist hospital clinic.
    - **Confirm that robust keeping in touch mechanisms are in place** with support agencies, especially for patients with vascular dementia discharged after diagnosis where acetylcholinesterase inhibitors (AChEIs) are not prescribed to help prevent isolation. Explore social prescribing, for example consider: https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network and https://www.socialprescribingnetwork.com/.
    - **Carers of people living with dementia** should be offered an assessment of emotional, psychological and social needs and receive tailored interventions identified by a care plan
    - **Review patients face to face** at least every 6 months to evaluate for functional/cognitive change.
    - **Utilise voluntary organisations** for dementia in your area as a source of information.

2. **Check progress in post diagnostic support and person centred care**. Refer to the Progress in Personalised Care and Support Planning – self assessment tool published by the Coalition for Collaborative Care

3. **Look at Social Prescriber Networks in your area** that employ link workers who can connect people with a dementia diagnosis to community groups and enable their carers to get support from carers groups.

4. **To assist auditing, consider** the Dementia: supporting people with dementia and their carers in health and social care: NICE baseline assessment tool

5. **To ensure that patients with dementia and delirium are identified, assessed and referred** appropriately, ensure that Dementia Assessment and Referral data collection (the previous National Dementia CQUIN) is embedded and part of standard practice in acute trusts in your area.

6. **To help ensure that unnecessary hospital admissions are avoided,** consider best practice in out of hospital support for your area. Good examples can be found on Medway's Dementia Crisis Support Service webpage.

Resources continued on the next page, please scroll down or click here

Post Diagnostic Support (PDS) (continued)

Resources

7. People living with dementia are higher risk of developing delirium and being aware of how to prevent delirium, identify it promptly and treat/manage delirium are all part of providing good quality post-diagnostic support. There are various resources that can help improve awareness, assessment and management of delirium, including:
   - Why think delirium?,
   - Delirium Guidelines – Mid Yorkshire NHS Trust
   - The Knowledge Network - Think Delirium - NHS Education for Scotland
   - http://www.yhscn.nhs.uk/mental-health-clinic/Dementia/Delirium.php
   - National dementia audit recommendations for the assessment of delirium in hospital for people with dementia - NAD Spotlight Report
8. To support improvement in the quality of care and support for people with dementia and to help address variation between areas, NHS England has developed:
   - Dementia RightCare scenarios to help further the RightCare programme in ensuring that in dementia services, the right person has the right care, in the right place, at the right time, and can make the best use of available resources.
   - D.E.M.E.N.T.I.A framework set out in the Dementia: Good Care Planning guide and My future wishes advance care planning for people with dementia in all care settings to support the provision of high quality care plans and reviews, as well as addressing wishes and needs for end of life care.
   - an evidence-based treatment pathway for dementia to improve access to services, timely diagnosis and receipt of post diagnostic support.
9. NCCMH have published The Dementia Care Pathway to help support improvements in the delivery and quality of care and support, for people living with dementia and their families and carers. It accompanies and builds on the evidence-based treatment pathway for dementia published by NHS England (above) and contains key commissioning and service development considerations.
10. Greater Manchester and Eastern Cheshire Strategic Clinical Network's Evidently Better: Dementia – post diagnostic support provides commissioners with an overview of post-diagnostic support for people with dementia and their carers. It includes examples of good practice, resources to support local organisations, developing a dementia strategy, Dementia friends and Dementia Action Alliances, practical examples to stimulate local thinking and working with the not for profit and voluntary sector.
11. London Clinical Network's resource Dementia post diagnostic support planning aims to support commissioners and providers of dementia care to meet the NICE Dementia Quality Standard on Dementia QS1, which states that people with dementia should have an assessment and an ongoing personalised care plan, agreed across health and social care, that identifies a named "care coordinator" and addresses their individual needs
12. East of England Clinical Network have identified Top 10 tools for positive dementia commissioning to support commissioners in providing best practice post diagnostic support.

Levers and incentives

What is needed?	Is it being achieved?
Use incentives and levers in order to improve Dementia Care in provider organisations	**Questions to ask and address:** • How is the contract being monitored in your area? What is the evidence suggesting? • Do links into local incentives related to Dementia care exist? • Are acute trusts supported in the identification, assessment and referral of older patients with dementia and delirium? • Are GP practices in your area signed up to the Quality Outcomes Framework (QOF)? • Are there any other links that could be established? • What are the incentives around education in your area? • What are the incentives for Local Authorities in your area?

How to improve delivery - steps to take and resources

1. **Review** the local contract in your area. Check whether contracts with providers incorporate:
   - education and training for staff;
   - defined care pathways;
   - John's Campaign;
   - a separate dementia and carers strategy;
   - dementia lead clinicians;
   - defined code sets to use;
   - defined process measures in place for MAS services that align with the new 6/52 treatment ambitions**.**
2. **Check whether** GP practices in your area are signed up to QOF, a voluntary reward and incentive programme based on specific indicators. The full set of indicators (including those for dementia) can be found on the NHS Digital website.
3. **Ensure** that Dementia Assessment and Referral data collection (the previous National Dementia CQUIN) is embedded and part of standard practice in acute trusts in your area.
4. **Consider** NHS England's Dementia support offer to CCGs, to assist with improvements against the dementia indicators chosen for the CCG Improvement and Assessment Framework.

Steps to take and resources continued on the next page, please scroll down or click here

Levers and incentives

How to improve delivery - steps to take and resources

5. **Regard products from the NHS RightCare programme**, including:
    - Dementia RightCare scenarios to help ensure that in dementia services, the right person has the right care, in the right place, at the right time, and can make the best use of available resources.
    - The new mental health conditions data packs for CCGs. The data packs contain data across a range of mental health and dementia services and are split into stages along a mental health pathway and enable local health economies to compare their performance with ten similar CCGs.

Other resources include:

6. CCG Improvement and Assessment Framework aligns with NHS England's Mandate and planning guidance, with the aim of unlocking change and improvement in a number of key areas. This framework aims to enable local health systems and communities to assess their own progress from ratings published online. The indicators for dementia include diagnosis and care plan reviews.
7. The Implementation guide and resource pack for dementia care provides local services with evidence on what works in dementia care. The guide is shaped by the NHS Mandate requirement to increase the number of people being diagnosed with dementia, and starting treatment, within six weeks from referral and improve the quality of post-diagnostic treatment and support for people with dementia and their carers.

Awareness, education, training and risk reduction

What is needed?	Is it being achieved?
To ensure that the workforce is trained and skilled in the required areas of dementia care to drive system improvements across the pathway	**Questions to ask and address:** • What training is offered for GPs and practice nurses so that they have the same level of knowledge and confidence as those who assess patients and commence treatment? • What training is offered for professionals and carers working in nursing and residential care homes to enhance dementia care? • Is training offered to carers, friends or family caring for people with dementia at home?

Resources to consider

1. **Look at** Leeds Beckett University's study: What works in Dementia Education and training. The study provides:
   - a review of all published evidence about training and education in dementia for the health and social care workforce; and
   - a survey audit of staff who completed dementia training: to assess the impact on their knowledge and attitudes as well as barriers and facilitators to implementation, and case studies from a number of organisations, to investigate effective dementia training and education.

2. **Consider** the Dementia Core Skills Education and Training Framework (including tiers 1, 2 and 3). The Framework was developed in collaboration by Skills for Health and Health Education England in partnership with Skills for Care. It sets out the essential skills and knowledge necessary for the workforce supporting and caring for people living with dementia. The scope of the framework spans care offered in a variety of settings including an individual's own home, community settings, residential care homes and acute hospitals.
   Resources include:
   - Tier 1 dementia awareness training packages
   - Tier 2 Dementia Guide for Carers and Care Providers - comprehensive guide for everyone who cares for someone with dementia
   - Tier 1 Finding Patience - raising awareness of dementia in the African Caribbean community
   - Tier 2 Fred's Story - highlighting unsafe mobility for people with dementia who may leave their place of care
   - Tier 2 The Appointment - understanding the issues faced by a person with dementia when attending an appointment
   - Tier 2 Dementia Roadmap - helping primary care staff diagnose, support and signpost people with dementia

Resources to consider continued on the next page, please scroll down or click here

Awareness, education, training and risk reduction (continued)

Resources to consider (continued)

Other resources and training include:

3. Public Health England's: Health Matters - Midlife approaches to reduce dementia risk and a communication toolkit for dementia risk reduction
4. NHS Healthcheck: Dementia Health Check resources
5. For the dementia element of the NHS Health Check e-learning package https://www.healthcheck.nhs.uk/increasing-dementia-awareness-training-resource/
6. DeAR GP, a tool for care home and community settings that aims to increase identification of possible dementia and subsequent diagnosis rates.
7. Alzheimer's Society provides Online learning resources for professionals
8. The Royal College of Nursing has professional resources for nursing staff available online.
9. Royal College of General Practitioners sets out resources for clinicians on their website.
10. DAA's Dementia Friendly Hospital Charter, to help ensure hospitals are able to support people living with dementia effectively.
11. For dementia awareness training and training resources for care homes, refer to HEE /UCL Partners Breaking down the barriers
12. This is Me, a support tool to enable person centred care. First developed by the Northumberland Acute Care and Dementia Group and is supported by the Royal College of Nursing.
13. The Herbert Protocol, a national scheme which encourages carers to compile useful information which could be used in the event of a vulnerable person going missing

Dementia education and training is offered through a number of learning organisations for example:

14. https://www.e-lfh.org.uk/programmes/dementia/
15. https://bradford.ac.uk/health/dementia/training/training-courses/
16. www.mdx.ac.uk/courses/cpd/dementia-care-and-practice-graduate-certificate-postgraduate-certificate-169b719
17. https://www.worc.ac.uk/discover/dementia-education-training.html

Glossary

AChE	Anticholinesterase Inhibitors
ASCOF	Adult Social Care Outcomes Framework
CCG	Clinical Commissioning Group
CCG IAF	Clinical Commissioning Group Improvement and Assessment Framework
CMC	Co-ordinate My Care
CQRS	Calculating Quality Reporting Service
CQUIN	Commissioning for Quality and Innovation
DAA	Dementia Action Alliance
DDR	Dementia Diagnosis Rate
DeAR GP	Dementia Assessment Referral to General Practitioner
DiADeM	Diagnosing Advanced Dementia Mandate
DQT	Dementia Data Quality Toolkit
DTOC	Delayed Transfers of Care
ECG	Electrocardiogram
EMIS	EMIS Web - an electronic computer system, allows primary, secondary and community healthcare practitioners to view and contribute to a patient's electronic healthcare record
EoLC	End of Life Care
GP	General Practitioner
HEE	Health Education England
HIN	Health Innovation Network
JDR	Join Dementia Research
LA	Local Authority
MAS	Memory Assessment Service
MCI	Mild Cognitive Impairment
MHSDS	Mental Health Services Data Set
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence NICE
PDS	Post Diagnostic Support
PHE	Public Health England
PHOF	Public Health Outcomes Framework
QOF	Quality Outcomes Framework
QS	NICE Quality Standard
SCIE	Social Care Institute for Excellence
SCR	Summary Care Record
SNOMED	Systematized Nomenclature of Medicine - a structured clinical vocabulary for use in an electronic health record
STP	Sustainability and Transformation Partnerships
SystmOne	A centrally hosted clinical computer system developed by The Phoenix Partnership (TPP)