Implementing Evidence-Based Dementia Care Treatment Pathway

Wayne Goddard, Integrated Lead for Dementia, NHS Doncaster CCG and DMBC

Penny Kirk, Quality Improvement Manager, Yorkshire & Humber Clinical Networks
Background

- Improving diagnosis rates and reducing wide variance has been the national focus for dementia work in the past 3 years
- This work was also intended to act as a catalyst and a gateway for improving post diagnostic support
  BUT lack of available measures for PDS has meant a primary focus on the former
- These new standards attempt to reduce variance further…
  …AND to ensure PWD and families receive evidence-based coordinated care post diagnostically
- Align with **Achieving Better Access to Mental Health Services by 2020**
Guidance

- Publication of implementation guidance for commissioners is expected soon
- Focuses on an evidence-based treatment pathway
- NICE-recommended care should be offered at each stage - draws on existing quality statements from relevant NICE quality standards and guidelines
Evidence-based treatment pathway

The pathway is monitored using two pathway standards:

- The first recognises the need to standardise timeliness of diagnosis, and access to NICE-recommended treatment when needed (Referral to treatment).

- The second focuses on the need for ongoing access to good quality post-diagnostic support once a diagnosis has been made.
Standard 1 - Referral to treatment

• By 2020, 85% of people with suspected dementia referred to a memory service receive a diagnosis and start treatment within 6 weeks

• Clock starts when the referral is received.

• Starting treatment means:
  • the person has met with their named care coordinator AND
  • an initial care plan of NICE-recommended care for dementia has been agreed
Clock stops

Dementia assessment completed

Yes dementia
Clock stops when:
1. A diagnosis of dementia is made and given, AND
2. Person has met a named care coordinator, AND
3. A care plan of NICE-recommended care has been agreed with the person (and if appropriate carer)

Yes MCI
Clock stops when:
1. A diagnosis of MCI is made and given, AND
2. A care plan of NICE-recommended care has been agreed with the person (and if appropriate carer)

Not dementia or MCI
Clock stops when:
1. Person is informed of results, AND
2. Onward referral to appropriate service or discharge
Standard 2 - Post-diagnostic support

• **Every person** living with dementia receives ongoing, NICE-recommended, post-diagnostic support

• The person’s support needs are recorded in an initial care plan.

• This care plan is reviewed at least once within 12 months of when it is first agreed, and every 12 months thereafter, as the person’s needs dictate.

• Revisions are jointly developed and agreed with the person living with dementia (and, if applicable, their carer).
Named care coordinator

- A core part of delivering person-centred dementia care is the support of a named care coordinator
- It is not suggested that all people living with dementia will be supported by a care programme approach (CPA) care coordinator
- First point of contact
Named care coordinator

- Allocated based on personal need
- Any professional who has lead responsibility for a person’s treatment and care e.g. primary care, voluntary sector, memory service staff
- Facilitate choice, independence & person-centred care
- Signpost PWD & carers to local support services & ensure continuity of care
- Jointly develop & review the care plan at least every 12 months
- Ensure the person’s physical and mental health is monitored & they are able to access appropriate treatment if required
Care Plan

• While an initial care plan may be agreed within a memory assessment service, the follow-up review may occur in a range of primary and secondary care settings.

• Each review should ensure that the plan is still applicable to the needs of the person living with dementia and their carer

• Guidance on good dementia care planning expected from NHS England shortly
Implementation

• Local system leadership and locally-led improvement processes are key
• Close collaboration between commissioners, health & social care providers & partners, PWD & carers
• Create clear, integrated healthcare pathways
• Easy to access & monitor for the person living with dementia, their carer, & their team of health & social care professionals.
Commissioners role

Work with providers to agree:

• Service redesign plans
• Recruitment plans
• Training plans and associated costs
• A data quality improvement plan for reporting required measures
• A schedule for performance reporting
• Regularly review cases where the recommended response time has been exceeded
• Phased approach to achieving the 85% aspiration by 2020.
Data Collection

• The Mental Health Services Dataset (MHSDS) will be changed to support the implementation of the dementia care evidence-based treatment pathway.

• Providers will need to make the necessary updates to their electronic care record system to ensure clinicians are able to enter the data required to monitor performance against the evidence-based treatment pathways.
Resources expected

- Implementation guide
- Positive practice examples
- Helpful resources guide
- Workforce planning tool
- What makes a good care plan
Any questions?