SystmOne Technical Guidance

Updated February 2018
Summary

A resource to provide system support to clinicians and CCGs to:

- Data cleansing Toolkit
- Identify patients at high risk of developing dementia
- Diagnosing dementia
- Providing ongoing care to patients diagnosed with Dementia

CONTENTS

1. Introduction
2. Joining the group
2b. Leave an existing group
3. Updating your clinical tree (organisational and user tree)
4. Validating and Data Cleansing your Dementia Register
5. Reviewing the electronic patient record
6. Coding outcomes of the register validation
7. Confirmed Diagnosis and Care Planning Resources Templates
8. At Risk Reports
9. List of functionality available within this technical solution
10. Disabling System wide solution
11. CCG Guidance to Dementia Resources
1. **Introduction**

Yorkshire and Humber Strategic Clinical Network, in conjunction with Airedale NHS Foundation Trust, have been working together to provide system support to clinicians identifying, diagnosing and providing ongoing care to patients diagnosed with Dementia. This work package has been created with clinical input and is designed to support the review process to achieve the various national targets for Dementia. The codes within these templates are in line with national datasets released (where applicable) and will support manual and automatic reporting requirements.

Access to this functionality is via the use of an organisational group within SystmOne (see section 2 for further details). Amendments are made remotely and will update automatically. Please note, if you copy or amend any of this functionality you will not receive further updates. If you have suggestions for improvement or would like to raise any technical issues please email ENGLAND.YHSCN@nhs.net please note this email is not monitored every day but we will endeavour to answer queries within 7 days.

It is recommended that if your practice/service makes the decision to use this package, then the system wide functionality is disabled to ensure consistency of coding throughout your unit.

<table>
<thead>
<tr>
<th>The resource includes</th>
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<tbody>
<tr>
<td>1) A Data Quality Cleansing toolkit</td>
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<tr>
<td>2) A Data Quality resource to identify patient at high risk of developing Dementia for targeted screening assessments</td>
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<tr>
<td>3) A Suite of Clinical templates to support GP Care Planning (QOF) and aspects of care of patients living with Dementia to allow uniform coding and raise the standards of care</td>
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These resources can be used by individual practices or by CCGs to look at the needs of the CCG population.

2. **Joining the group - Yorks & Humber Clinical Networks**

A System Administrator can request to join the group by following the steps below:

1. Click on Setup and Users & Policy
2. Choose Organisation Groups
3. Double click on the Airedale NHS Foundation Trust (Trust Group) to expand the tree
4. (R) click on Yorks & Humber Clinical Networks
5. Join Group

A task will then be sent To Airedale NHS Foundation Trust to action. Once this is actioned, you will have access to DQT reports.
Units will then receive an unassigned task titled ‘Organisation Group Membership’. System Administrators can easily action this task via a right click on the appropriate task. Please see below:

2b. Leave an existing group

Units can only join 20 groups, if you are already at this limit you may need to leave one that you are already a member of.

A System Administrator can request to leave the group by following the steps below:

6. Click on Setup and Users & Policy
7. Choose Organisation Groups
8. Groups highlighted in black show the groups you are currently a member of. Select the organisation group that is no longer needed from the tree and double click to expand
9. Find the appropriate group, (R) click
10. Leave Group

3. Updating your clinical tree (organisational and user tree)

Once your unit has successfully joined the Yorks & Humber Clinical Networks Group, you will be able to access the CN Dementia - Resource Gateway template. Please follow the instructions below to add this template to your organisational clinical tree.

- Click on Setup and Users & Policy
- Select Organisation Preferences
• Click on the + to expand the Clinical Policy folder from the left hand list and select Clinical Tree Configuration
• From the clinical trees available within the middle of the screen, click on the one that has been set up specifically for your practice/service
• Click on Amend Setup directly above

Within the search box on the left hand side type ‘dementia’
• Double click to send the **CN Dementia - Resource Gateway** template to the left hand side window and re-order as appropriate using the arrows
• Now, please select any existing Dementia template(s) (on the right hand side), and click on the X to remove this from your tree. NB; this is practice discretion but is advisory to maintain consistency for data capture.
• Click OK
• Click OK

4. Validating and Data Cleansing your Dementia Register

The reports available help identify patients who already have dementia and coding may have been missed and so may require coding with a Dementia diagnosis. These reports are looking for medications or associated codes suggestive of Dementia. It is advisable that these reports are run regularly and reviewed.

You can find the Dementia Quality Toolkit Reports in Clinical Reporting, Yorks & Humber Clinical Networks, NHSE Dementia, Dementia DQT.

How to use the reports
The **WORK TO DO** reports will contain a list of patients who may have a missed dementia diagnosis. If GPs wish to review patients then you can use the read code ‘Ongoing Review (Xalpj)’ and this will remove the patients from the **WORK TO DO** reports. These patients marked with an ongoing review (awaiting/confirming diagnosis) will remain on the **MASTER LIST** until they have dementia diagnosis added to their record.

Once you have run the reports, right-click on the desired report and click Breakdown results.

You should breakdown the results by Event Date and Read code for the following reports:
Break these both down as follows:

**Patients on a dementia drug not on dementia register **WORK TO DO**

![Image of patient record]

**Patients with a code that may suggest dementia and NOT on dementia register **WORK TO DO**

![Image of patient record]

Click Refresh.

You can then see the read code/medications that have pulled patients into the reports. In order to find the entry in the patient’s record you should locate the entry in the Read Code Journal/medication view and find the corresponding consultation/entry in the New Journal.

**Adding a missed diagnosis**

If, after reviewing a patient, you decide that a diagnosis of dementia has been missed then you should backdate the diagnosis to the date of the rogue code/consultant letter etc. Blood tests should be offered inline with QOF requirements.
Referring a patient
Patients will fall off the work to do list if they have had a review, referral to memory clinic or memory clinic referral declined within the last 6 months. This will help practices maintain this list at zero. This report can then be run frequently and reviewed.

Amendments to reports are made remotely and will update automatically. Please note, if you copy or amend any of these reports, they will not be routinely updated. If you have suggestions for improvement or would like to raise any issues please email: ENGLAND.YHSCN@nhs.net please note this email is not monitored every day but we will endeavour to answer queries within 7 days.

5. Reviewing the electronic patient record

A ‘summary view’ has been created that should be useful to view data relevant to Dementia, that is already within an electronic patient record. This may not entirely remove the need for the clinician to navigate the record but should reduce the time the clinician spends reviewing if further action is required. This view is called ‘CN Query Dementia’. This view can be found within the ‘CN Dementia - Resource Gateway’ or can be accessed directly from the tree.

6. Coding outcomes of the register validation

The Dementia Quality Toolkit reports are designed for patients to be removed once an associated action has been coded into the patient’s record. To ensure your practice is using the correct CTV3 codes it is suggested that you use the latest GMS Templates.
In order for a patient to be removed from the DQT ‘Work to do’ reports they would need either of the following codes:

**Ongoing review** – useful to record that a patient is being invited in for a face to face review

**Referral to memory clinic/declined** – this will remove patients for a period of 6 months Dementia

**DEM Cluster** – Diagnosis codes within this cluster will remove the patient from the work to do list

**Memory recall normal** – This code will remove the patient from the work to do reports for a period of 12 months

7. Confirmed diagnosis and Care Planning Resources Templates

There are now templates available to support clinicians once a patient has a confirmed Dementia diagnosis, these includes Advance Care Planning, Mental Capacity Act, Carers Assessment templates. We are also working on a Dementia Care plan and Dementia review template. These templates can be accessed via the ‘CN Dementia - Resource Gateway’ template.

NB: The Care Plans provided are intended to support the CN Dementia - Annual Care Plan (QOF) template, and not the light version.

8. At Risk Reports

There is now a suite of reports that look for ‘at risk’ indicators. These can be run separately, for instance only for patients with Delirium or you may choose to prioritise the patients with multiple risk factors. These reports can be broken down by readcode to identify why they are in the report. This resource can be used on an individual practice level or by a CCG to look at case finding across the CCG footprint (as long as the correct data sharing agreements are in place between the CCG and GP practices).

Once you have identified your patients please use the ‘Dementia – Making a Diagnosis’ template to code any referrals, normal memory tests or if they are under ongoing review. These codes will then remove the patients from the At Risk reports for a period of 6 months, unless they receive a diagnosis of Dementia in which case they will be removed from the reports indefinitely.
9. List of functionality available within this technical solution

Templates

All templates below are available through the main ‘CN Dementia - Resource Gateway’

- CN Dementia - Resource Gateway

Supporting Diagnosis

- CN DiADeM
- CN Dementia - Making a dementia diagnosis
- CN Dementia - GP COG
- CN Dementia - 6 CIT

Care planning templates

- CN Advance Care Planning
- CN Antipsychotics in Older People
- CN Dementia - Annual Care Plan (QOF)
- CN Dementia - Annual Care Plan (QOF) Light
- CN Dementia - Care Plan (acute)
- CN Dementia - Global Deterioration Scale
- CN Dementia - Staging Tool
- CN Malnutrition Universal Screening Tool (MUST)
- CN Mental Capacity and Decision Making
- CN Safeguarding Adults

Carer’s templates

- CN Dementia - Carers Health Check

Delirium templates

- CN Think Delirium

Care plans

Two care plans have been created, Clinician copy and a Patient copy. These Care Plans gather data from the Annual Dementia Reviews and other Long Term condition Reviews to create documents aimed at improving either communication with other professionals or as record of process for the patient. The patient held care plans has been tested and approved by several patient groups as being Dementia Friendly. These are used to help the GP as well as the patient with any useful information. Please note that these screen shots are taken from a test patient.

![Clinician Care Plan](Click to generate a care plan for printing)

![Patient/Carer Care Plan](Click to generate a care plan for printing)
Clinician Care Plan

Dementia Care Plan Record – Clinician Copy

Patient Name: Jane Smith
Date of Birth: 01/01/1950

PATIENT DEMOGRAPHICS

Gender: Female
Ethnicity: Caucasian

CARE PLAN DETAILS

Care Plan Review Date: 01/01/2023

MEDICATION REVIEW

Current Medications:
- Tramadol 50mg OROS 24hr
- Donepezil 5mg

PHYSICAL ASSESSMENTS

Height: 160cm
Weight: 65kg
BMI: 25

SOCIAL CIRCUMSTANCES & ACTIVITIES OF EVERYDAY LIVING

Activities Include:
- Eating
- Dressing
- toileting
- Personal hygiene
- Performing daily activities

ADVANCED CARE PLANNING INFORMATION

Advance Directive: None
Designated Health Care Proxy: None
Advance Directive for Nutrition and Hydration (DNAR): No

Patient Care Plan

Dementia Care Plan – Patient/Care Copy

Patient Name: Jane Smith
Date of Birth: 01/01/1950

CONTACT DETAILS

Carer Name: John Smith
Contact No: 0123456789

USEFUL CONTACTS

Gp of Clinician: Dr Jane Smith
Professional Coordinator of Care: John Smith

Support Services in place:
- Memory Cafe
- Respite Care
- Family Support Group

Mental Health Key Worker: John Smith
Community Nursing: Jane Smith

WHAT WE NEED TO DO TOGETHER

Cognitive Stimulation
Medication Review

ADDITIONAL PLANNING DECISIONS

Advance Directive (DNAR): No
Advance Directive for Nutrition and Hydration (DNAR): No
Advance Directive for Comfort Measures (DNAR): No

WE ARE THE PEOPLE WHO WILL HELP TO MAKE THOSE ACTIONS HAPPEN

Key Executive: John Smith
Key Contact: Jane Smith

MY IMMUNISATIONS

Flu, Pneumococcal, Shingles

NEXT REVIEW DATE

11/01/2024
Reports

Reports are broken down into the following categories (please note the location from the screenshot below):

- Dementia Quality Toolkit (DQT)
- Useful Reports
- At Risk of Dementia

Views – A summary of data collected

Views can either be accessed through the main template or added to organisational trees depending on practice preference. Views include:

- CN Advance Care Planning
- CN Risk of Dementia (will show the condition the patient has which has included them within the ‘at risk’ report)
- CN Query Dementia (includes information within the record that may be useful, particularly when reviewing the DQT work to do list)
- CN Medication View

Status Alerts

Status alerts will automatically be activated upon approval of the group membership. Status alerts include:

- CN - ACP in Place – this is represented as a red star in the patient demographic box. Users can click on this to launch the CN Dementia - Advance Care Planning template, which also provides a view of the existing information recorded within the record.
- CN - Patient with Dementia - this is represented as a head in the patient demographic box. Users can click on this to launch the CN Dementia - Resource Gateway template
10. Disabling System wide solution

If your service/practice decides to use the functionality created by the Dementia Clinical Network, it is advised that the SystmOne template and status alert is deactivated. This will ensure continuity of data entry.

Status alerts are deactivated as follows:

- Setup
- Data Output
- Patient Status Alerts, Untick ‘enabled’

11. CCG guidance to Dementia Resources

It is possible for Trust Reporting Units to join the Dementia Resource Group. The main advantages of this are the DQT or At Risk reports can be run across the CCG and broken down by Practice. This will allow CCGs to gain an understanding of Dementia stats throughout the local patch, helping to inform future planning and support.

Trust units can join the group by following the instructions provided in section 1. Reports can be accessed and run as they would within practice units (see section 8). To obtain data at practice level reports should be broken down by Registered Practice, see screenshot.

NB: Locally agreed data sharing agreements are the responsibility of individual practices & CCGs. The Dementia Resource package provides functionality to obtain this provided local configuration to pull this data is already in place.

Benefits for CCGs:
• Increase local registers & prevalence
• The reports provided have been refined over time and provide optimal results, with very little wasted time
• Defining at risk populations for targeted case finding
• Measured outcomes by using the complete suite of templates you can easily measure outcomes such as ongoing reviews, referrals or Diagnosis of Dementia

If you have any queries contact ENGLAND.YHSCN@nhs.net please note this email is not monitored every day but we will endeavour to answer queries within 7 day.