Y&H Dementia GP Clinical Leads Meeting 6\textsuperscript{th} September 2017

WELCOME

"High Quality Care for All, Now and for Future Generations"

www.england.nhs.uk
Agenda for CCG GP Dementia Leads meeting

6th September, 2 – 4.30pm, Hatfeild Hall, Wakefield

- DiADeM app launch - Colin Sloane/Sara Humphrey 2.00
  - DiADeM primary care template
- Updated primary care resources - Sara Humphrey/Paula Woodrow 2.30
  - DQT
  - At risk searches
  - QOF annual review template
- New primary care resources Sara Humphrey/Paula Woodrow 2.40
  - Delirium template
  - Care plan reports
- Discussion - ALL 3.00
  - Feedback on resources
  - how do we support roll out and implementation in practice
- Links to frailty work – Sarah De Biase 3.30
- AOB 4.00
DiADeM app launch

Colin Sloane/Sara Humphrey
Diagnosing Advanced Dementia Mandate in a Care Home setting
DiADeM App
Dr Sara Humphrey & Colin Sloane
What is DiADeM?

*DiADeM is a tool for diagnosing of advanced dementia in people who live in care homes.*

- Supports primary care clinicians to make a diagnosis
- Reduces the need to attend formal clinics
- Increases the likelihood of receiving good post diagnosis care
Why Choose a Care Home Setting?

• Reports suggest that 70% and 80% of care home residents have dementia & that many do not have a formal diagnosis.

• Often residents with advanced dementia &/or frailty, are denied a diagnosis due to difficulty attending a memory service clinic even though formal referral to memory services is rarely desirable & often distressing.

• A Diagnosis enables access to appropriate support, care planning & in some cases, treatment & gives the opportunity for the patient with dementia to share their preferences for future care with family & carers.
A diagnosis of dementia can be made with a high degree of certainty if all five criteria listed below are met:

1. **Functional Impairment**
   - The person is no longer fully independent in relation to basic activities of daily living, washing, dressing, feeding and attending to own continence needs. The requirement of prompting or supervision of staff constitutes a loss of full independence.

2. **Cognitive Impairment – 6 CIT assessment**
   - **Question** | **Scoring** | **Score achieved**
   - 1. What year is it? | Correct – 0 points, incorrect – 4 points
   - 2. What month is it? | Correct – 0 points, incorrect – 3 points
   - 3. Give an address please to remember with 5 components e.g. John, Smith, 42, High St, Wakefield
   - 4. About what time is it (within 1 hour) | Correct – 0 points; incorrect – 3 points
   - 5. Count backwards from 20-1 | No errors – 0 points; 1 error – 2 points; more than 1 error – 4 points
   - 6. Say the months of the year in reverse | No errors – 0 points; 1 error – 2 points; more than 1 error – 4 points
   - 7. Repeat address phase | No errors – 0 points; score 2 points for every component wrong e.g. 3 errors, 6 points
   - **TOTAL SCORE**

   6 CIT scores: 7 and below normal; 8 and above indicate impairment.
   - **Assessment tools other than 6 CIT can be used. If used does score indicate impairment?**

3. **Corroborating History**
   - History of gradual cognitive decline (typically for the last few years) is confirmed by care staff, relatives and medical records. Staff/relatives confirm that in their opinion the patient consistently demonstrates both functional and cognitive impairment.

4. **Investigations**
   - Dementia screening bloods are normal (where clinically appropriate and patient consents to bloods). If patient lacks capacity to consent to bloods, a best interest decision must be made and documented accordingly.
   - NB: If intracranial pathology (e.g. subdural haematoma, cerebral tumour) is suspected, referral for a brain scan may be appropriate. Otherwise where dementia is advanced, differential diagnosis is unlikely to affect patient management & a brain scan is unnecessary.

5. **Exclusion Criteria**
   - There is no acute underlying cause to explain confusion i.e. demmin (acute confusional state) has been excluded.
   - Mood disorder or psychosis is also excluded.

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*1. Guidance for Commissioners of Dementia Services*, published by The Joint Commissioning Panel for Mental Health states patients who present with advanced symptoms of dementia can be diagnosed and managed by primary care with or without OMHI. [Help www.gpmsi.info](http://www.gpmsi.info)

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**Where a diagnosis of dementia is confirmed, a copy of the completed DiADeM tool should be saved into the patient’s clinical record as evidence for the diagnosis.**
Paper v’s Electronic

Now on SystmOne and EMIS Web
Paper v’s Electronic
what's the difference?
DiADeM App will give you:

- Instant access to the tool no need to download and print.
- Automatic calculation which eliminate potential user error.
- Access to two cognitive impairment tests (6CIT or GP COG) enabling clinical choice to meet individual patient needs.
- DiADeM SNOMED read code has been created to enable practices to record that the diagnosis of dementia was made using the DiADeM tool for clinical audit.

- A report summarising the findings and outcome of the test which is sent securely to the registered report recipient to be actioned appropriately.

- Advice on next steps to take e.g. adding the patient to the GP Dementia register if it is a positive diagnosis using the relevant CTv3/Read/SNOMED codes.
DiADeM Report

<table>
<thead>
<tr>
<th>Date of Test:</th>
<th>9/1/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time of Test:</td>
<td>1:13 PM</td>
</tr>
<tr>
<td>Interviewer Name:</td>
<td>Colin Sloane</td>
</tr>
<tr>
<td>Patient's Name:</td>
<td>Test P2</td>
</tr>
<tr>
<td>Patient's Date of Birth:</td>
<td>25/12/1963</td>
</tr>
<tr>
<td>Informant Name:</td>
<td>iPhone Teller</td>
</tr>
<tr>
<td>Location Name:</td>
<td>Iphone6</td>
</tr>
<tr>
<td>Location Type:</td>
<td>(code - XaImT) SystemOne (code - 13FK) EMIS Web</td>
</tr>
<tr>
<td>Consent Obtained From:</td>
<td>Patient's close relative</td>
</tr>
<tr>
<td>1 Functional Impairment:</td>
<td>TRUE</td>
</tr>
<tr>
<td>2 Cognitive Impairment:</td>
<td>TRUE</td>
</tr>
<tr>
<td>3 Corroborating History:</td>
<td>TRUE</td>
</tr>
<tr>
<td>4 Investigations:</td>
<td>TRUE</td>
</tr>
<tr>
<td>Blood Results Available?:</td>
<td>Blood Tests Not Appropriate (code - XaZ0g) SystemOne (code - 41M..) EMIS Web</td>
</tr>
<tr>
<td>Intracranial Pathology Suspected?:</td>
<td>No</td>
</tr>
<tr>
<td>5 Exclusion Criteria:</td>
<td>TRUE</td>
</tr>
</tbody>
</table>

Diagnosis of Dementia Indicated

Please add this patient to the GP Register using the code(s) taken from the North Guidance on Dementia and Delirium Coding document published July 2014. Or using the regionally, locally agreed codes in your area please also consider adding other codes highlighted in the report which help to indicate location of patient and blood test declined.

Diagnosing Advanced Dementia Mandate Tool (observable entity): SNOMED CT
ID:10773610000000106

Ensure that planned follow-up and next steps are recorded in the patient's health record including any onward referrals where appropriate. Ensure that arrangements are made with the patient and carer (where applicable) to jointly review the care plan.

How to Access DiADeM

REGISTER & DOWNLOAD

Registering with DiADeM

There are various roles in the DIADeM project:

- At a care home or nursing home - GPs or nurse clinicians make use of the DIADeM app to interview patients and then upload the result to a secure server
- At a General Practice - GPs, practice managers or other members of staff receive emails containing a patient's DIADeM Report for internal processing
- Interested organisations (such as The Alzheimer's Society) can view a 'dashboard' of project statistics and contribute to the direction of the project
- People who prefer to use the original paper-based DIADeM tool

With this in mind there are various ways people can register with Diadem:

- Register as a Clinician Undertaking DIADeM Assessments
- Register as a DIADeM Recipient
- Register as both a Clinician Undertaking DIADeM Assessments and Recipient of DIADeM Reports
- Register as a DIADeM Partner Organisation
- Register to download a PDF of the original paper-based DIADeM tool

Once registered you will receive an email with a link to download the application.
Registration Screen

DiADeM - Diagnosing Advanced Dementia Mandate
DiADeM Web Service

Register as a Clinician Undertaking DiADeM Assessments

This form is for those wishing to create DiADeM reports (by using the DiADeM app) and not wishing to receive DiADeM reports (at GP Surgeries etc). Your options are to:

By registering here you will be able to log in on the DiADeM app (please ask if you don’t know how to get the DiADeM app) and carry out DiADeM assessments. For more on being a ‘Clinician Undertaking DiADeM Assessments’ please click here.

Please complete all fields with an asterisk beside them.

First Name: [Text Box]

Last Name: [Text Box]

Organisation: [Text Box]

Email: [Text Box]

Password: [Text Box]

Confirm Password: [Text Box]

I agree with The Apperta Foundation Privacy & Cookie Policy

Register

Back
Out and about promoting DiADeM
Edinburgh Live Code Conference
EHI Live in Birmingham
Dementia diagnosis rates

- YH doing well but still potential to improve
- Dear GP + DiADeM + Primary Care Resources
- ALL can help to achieve improvement

**Dementia Diagnosis CCG Rates at end of Jul 17**

- 72% = current Y&H average
- 66.7% = national ambition

Diagnosis rate shown is number of patients on QOF dementia registers as a percentage of estimated dementia prevalence by CCG (for ages 65+ only)
Dementia diagnosis rates

Clinical Network will support Improvements in those areas below the National Average

| Dementia Diagnosis Rates aged 65+ as a Percentage of Dementia Prevalence Estimates Showing Change Relative to Previous Month 2017/18 |
|---|---|---|---|---|
| CCG/Area | Apr-17 | May-17 | Jun-17 | Jul-17 |
| England | 67.9% | 67.8% | 68.0% | 68.0% |
| North of England (Region) | 73.1% | 72.9% | 73.1% | 73.2% |
| Yorkshire & Humber | 71.3% | 71.6% | 71.9% | 72.0% |
| Humber, Coast and Vale (STP) | 64.9% | 64.9% | 65.2% | 65.1% |
| South Yorkshire and Bassetlaw (STP) | 77.2% | 77.3% | 77.9% | 77.9% |
| West Yorkshire (STP) | 73.4% | 73.4% | 73.4% | 73.5% |
| NHS Airedale, Wharfedale and Craven | 78.7% | 78.5% | 78.2% | 78.2% |
| NHS Barnsley | 70.6% | 71.6% | 72.1% | 72.3% |
| NHS Bassetlaw | 79.9% | 79.3% | 79.8% | 80.2% |
| NHS Bradford Districts | 81.6% | 82.0% | 81.9% | 82.0% |
| NHS Calderdale | 66.7% | 66.1% | 66.2% | 65.7% |
| NHS Leeds North | 69.4% | 69.8% | 69.6% | 70.3% |
| NHS Bradford City | 81.0% | 80.3% | 81.4% | 81.8% |
| NHS Doncaster | 74.3% | 74.7% | 75.3% | 75.2% |
| NHS East Riding of Yorkshire | 65.2% | 65.1% | 65.1% | 64.9% |
| NHS Greater Huddersfield | 70.3% | 69.9% | 70.6% | 70.5% |
| NHS Leeds West | 72.8% | 72.5% | 72.5% | 73.6% |
| NHS Hambleton, Richmondshire & Wh | 60.9% | 61.0% | 61.4% | 61.5% |
| NHS Harrogate and Rural District | 78.3% | 78.3% | 77.6% | 77.8% |
| NHS Hull | 76.8% | 77.1% | 76.6% | 75.8% |
| NHS Leeds South and East | 78.8% | 80.3% | 80.3% | 80.3% |
| NHS North East Lincolnshire | 70.9% | 70.3% | 71.2% | 71.9% |
| NHS North Kirklees | 70.0% | 69.7% | 70.4% | 69.7% |
| NHS North Lincolnshire | 61.6% | 62.6% | 63.8% | 63.7% |
| NHS Rotherham | 79.9% | 79.7% | 80.9% | 81.3% |
| NHSScarborough and Ryedale | 59.0% | 59.0% | 58.7% | 58.8% |
| NHS Sheffield | 79.8% | 79.7% | 80.0% | 79.8% |
| NHS Vale of York | 58.4% | 58.3% | 58.7% | 59.0% |
| NHS Wakefield | 66.1% | 65.9% | 66.2% | 66.2% |

Dementia diagnosis STP rates July 2017

Clinical Network will support Improvements in those areas below the National Average
Thank You for Listening

If you would like support from the Clinical Network with DiADeM/Dear GP/Primary Care resources

Please feel free to contact

colinsloane@nhs.net
Updated primary care resources and
New primary care resources
Sara Humphrey/Paula Woodrow
CCG IAF Framework

Dementia – Dementia indicator banding

<table>
<thead>
<tr>
<th>Category</th>
<th>Diagnosis rate</th>
<th>Care plan reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>76.7 – 100%</td>
<td>79.5 – 100%</td>
</tr>
<tr>
<td>2</td>
<td>66.7 – 76.6%</td>
<td>77.6 – 79.4%</td>
</tr>
<tr>
<td>3</td>
<td>56.7 – 66.6%</td>
<td>75.7 – 77.5%</td>
</tr>
<tr>
<td>4</td>
<td>0 – 56.6%</td>
<td>0 – 75.6%</td>
</tr>
</tbody>
</table>

Data from the Well Pathway will be used as contextual information
Patients in England with a record of dementia diagnosis on their clinical record, June 2017

Introduction
The Department of Health (DH), on behalf of Secretary of State and NHS England (NHSE), have directed NHS Digital to establish a data collection in order to receive specific dementia diagnosis data to support the Prime Minister's Dementia Challenge. When NHS Digital received such a direction we issue a Data Provision Notice to the appropriate providers of the required data.

We collect and publish data about people with dementia at each GP practice so that the NHS (GP's and commissioners) can make informed choices about how to plan their services around their patient needs.

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Table 1: Cleared prevalence of recorded dementia by age group and gender, England, June 2017
Table 2: Three years of recorded dementia prevalence, England, 2006/07 to 2012/13
Table 3. Recorded diagnosis of dementia by ethnic group, England, June 2017
Table 4. Recorded dementia assessments and care plans, England, June 2017
Table 5. National coverage of GPSS dementia sessions, England, June 2017

Read V2 codes
CTG codes
Ethnic groups

Notes:

Contact details
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Email: enquiries@nhsdigital.nhs.uk
Press enquiries should be made to Media Relations Manager: Telephone: 0300 303 3685

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Table 4: Recorded dementia assessments and care plans, England, June 2017

<table>
<thead>
<tr>
<th>Assessments for dementia at a GP practice</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record of receiving an assessment</td>
<td>181,152</td>
</tr>
<tr>
<td>Recorded as being 'at risk of dementia' and declined an assessment</td>
<td>20,338</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Memory assessments and clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record of an initial memory assessment</td>
</tr>
<tr>
<td>Record of declining an initial memory assessment</td>
</tr>
<tr>
<td>Record of a referral to a memory clinic</td>
</tr>
<tr>
<td>Record of declining a referral to a memory clinic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care plans and reviews by a GP practice within the 12 month period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record of receiving a dementia care plan or dementia care plan review</td>
</tr>
<tr>
<td>Record of declining a dementia care plan or declining a dementia care plan review</td>
</tr>
</tbody>
</table>

Source: NHS Digital
Patients in England with a record of dementia diagnosis on their clinical record, 2016-17

Supporting data

Publication date: 14th July 2017
Link to publication: http://digital.nhs.uk/publication/dl1617

Contents
To access data tables, select the table headings or tabs.
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Table 1: Time series of recorded dementia diagnoses, England, 2010-17

Table 2: Observed and expected prevalence of recorded dementia, by age group and gender, England, March 2017

Table 3: Age-standardised annual rate of emergency hospital admissions for patients with a diagnosis of dementia per 1,000 patients with a dementia diagnosis on their GP record, by CCG of responsibility

Table 4: Recorded dementia prevalence by age and co-morbidity of Down syndrome and/or learning disabilities, from a sample of GP practices in England, 2016-17

ICD10 Codes
Read U1 codes
CTV3 codes

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www.england.nhs.uk
Implementation guide and resource pack for dementia care

3.11 A core component of person-centred dementia care is the support of a named coordinator of care and the presence of a flexible, up-to-date care plan. This person should be allocated based on personal need, and may come from various settings, for example primary care, the voluntary sector or memory assessment services.

Named coordinator of care: key role

- Facilitate choice, independence and person-centred care, including, where appropriate, seeking informed decision-making and valid consent through use of advance directives and the Mental Capacity Act 2005
- Signpost people with dementia and their carers to local support services and to ensure continuity of care
- Jointly develop and review the care plan with the person and their carer, at least every 12 months, to ensure that it is still applicable and effective
- Ensure the person’s physical and mental health is monitored and that they can access appropriate treatment

3.2 NHS Operational Planning and Contracting Guidance 2017-18 sets an expectation in providing dementia care 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.
Recorded Dementia Diagnoses: 2016-17

At 31 March 2017:

422,000 people aged 65 and over in England have a recorded dementia diagnosis. This is an increase from 414,000 in March 2016.

This represents 1 in 23 people aged 65+ registered with a GP.

98 per cent of GP practices in England are represented within these data.

1 in 5 women aged 90 or over have a recorded dementia diagnosis, the highest prevalence for any group.

The number of people with a recorded dementia diagnosis is different to estimates from other research. The chart below compares the number of people thought to have dementia with the number of people diagnosed with dementia.

Comparison of recorded dementia prevalence (solid bars) and estimated prevalence from CFAS II1 (unfilled bars)

Confidence intervals are displayed in orange for the CFAS II study to show the range in which we can be 95 per cent certain that the true dementia prevalence lies.

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Recorded Dementia Diagnoses in Primary and Secondary Care

Age standardised annual rate of emergency hospital admissions for unique patients with a diagnosis of dementia per 1,000 patients with a dementia diagnosis on their GP record.

In 2016-17, there were 207,797 unique patients aged 65 and over admitted to hospital in an emergency with a diagnosis of dementia (provisional data).

In England, the rate of emergency hospital admissions for patients aged 65+ with a diagnosis of dementia is 492 per 1,000 patients with a dementia diagnosis on their GP record. When standardised by age this rate varies by CCG, from 235 in NHS Windsor, Ascot & Maidenhead to 620 in NHS Solihull.

Variation in admission rates between CCGs could be caused by a number of reasons. Higher rates of admission may mean that there are low diagnosis rates of dementia in Primary Care resulting in a lower than expected denominator. Conversely lower rates of admission in some areas may result from efforts to improve the diagnosis and recording of dementia by GP practices.

To view the full underlying data for recorded dementia diagnoses please visit: http://content.digital.nhs.uk/gfddementia
For more information on secondary care please see: http://content.digital.nhs.uk/hestdata

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Dementia in Patients with Learning Disabilities

Dementia prevalence by age and comorbidity of Down syndrome and/or learning disabilities, 2015-16

Data were recently collected from over half of GP practices in England to identify potential differences in the health and care of people with learning disabilities compared to the rest of the population.

Dementia is more common in people with learning disabilities, particularly for individuals with Down syndrome who appear to develop dementia at younger ages.

This chart shows the earlier presentation and higher rates of dementia in people with Down syndrome. This is less clear in patients aged 75 and over as less people with Down syndrome survive to this age.

To view the full underlying data please visit: http://www.content.digital.nhs.uk/catalogue/PUB23781

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DiADeM
Diagnosing Advanced Dementia Mandate
(for care home settings)

www.england.nhs.uk

Link to website
DeAR–GP, developed by the Health Innovation Network and supported by Alzheimer’s Society, is a simple paper based case-finding tool which has been designed for use by care workers to identify people who are showing signs of dementia. DeAR–GP acts as a communication between care workers and health professionals.
Dementia Quality Toolkit (DQT)

• Updated DQT Access them [HERE]
• Automated system search which is easily uploaded by the practice
• Available across Yorks & Humber for GP practices using SystmOne and EMIS Web
• Other system searches due shortly
• Technical guidance
• [Frequently Asked Questions]
NEW ‘At Risk Toolkit ‘ to support case finding’

at-risk’ patients are:

• Aged >60 with CVD, stroke, peripheral vascular disease or DM
• Aged > 40 with Down’s syndrome;
• Aged >50 with learning disabilities;
• long-term neurological conditions which have a known neurodegenerative element, for example, Parkinson’s disease.
• Living in a care home
• Previous Delirium
• Female > 90 yrs old
Updated Resources Gateway

### DEMENTIA RESOURCES

- [CN Dementia - Making a dementia diagnosis](#)

#### GOF

- **Dementia v36 2017/2018**
  - SystmOne standard template
  - To support the GOF criteria

- **CN Dementia - Annual Care Plan (QOF)**
  - To support the QOF criteria

- **CN Dementia - Annual Care Plan (QOF) Light**
  - To support the QOF criteria. This version of the GOF review contains less readcodes and is more the text driven

- **Clinician Care Plan**
  - Click to generate a care plan for printing

#### ADDITIONAL SUPPORTING TEMPLATES

- **CN Advance Care Planning**
- **CN Mental Capacity and Decision Making**
- **CN Dementia - Carers Health Check**
- **CN Think Deimium**
- **CN DDoM**
  - [Making a dementia diagnosis in care home papers](#)

[www.england.nhs.uk](http://www.england.nhs.uk)
Making a Diagnosis of Dementia

Using all the codes used to monitor primary care referrals
Care Planning Outputs

For Professionals

Patient Name: Abigail Mrs
Today's Date: 25 Jul 2017

NHS Number:
Date of Birth: 21 Jul 1977
Gender: Female
Language: Main spoken language English

Current Home Address:
Florence Nightingale House
Airedale General Hospital
Skipton Road, Skipton
Keighley
West Yorkshire
BD20 6TD

Home Tel: 01535 292732
Mobile Tel: 07803 721097

CARERS DETAILS

Carer: Barry Smith
Contact No: 1235656565

Next of Kin: Sally Smith
Contact No: 01254789854

GP PRACTICE DETAILS

Practice:
The Health Centre,
Holme Lane,
Cross Hills,
Keighley BD20 7LG

Practice Tel. No: 01535 637900
Practice Fax No: 01535 632187

Diagnosis Date: Drug Compliance Checked: 11 Jul 2017
Medication Review Done: 11 Jul 2017

RISKS

Level of mood: Bored
Driving status: Does not drive a car
Behaviours that challenge: Verbal aggression

PHYSICAL HEALTH ISSUES

Mobility: Mobile in home, Fully mobile, Mobile outside with aid, Needs walking aid in home
Falls: At risk of falls, Multidisciplinary team falls assessment done
Continence: Continent, Urinary incontinence, Double incontinence
Nutritional status: Poor nutrition
Hydration Adequate: Hydration Adequate

GP ACTIONS

REFERRALS

GP Name: GP/Clinician
30 Jan 2015, Referral to physiotherapist
12 Jul 2017, Referral to Social Services
10 Apr 2015, Referral to service
16 Apr 2016, Referral to service

WHAT REVIEWS HAVE WE DONE TOGETHER
Care Planning Outputs
For People Living with Dementia and their Carers

Patient Name: Mrs Abigail Vanderquack-Test
NHS Number: 123456
Date of Birth: 21 Jul 1977
Gender: Female
Language: English

CONTACT DETAILS
Carer: Barry Smith
Contact No: 1234567890

Next of Kin: Sally Smith
Contact No: 0123456789

USEFUL CONTACTS
GP: GP/Clinician
GP Tel. No: 0123456789

Coordinator of Care: Name/Role/Contact No.

THIS IS THE SUPPORT I ALREADY HAVE IN PLACE
Support services in place: Meals on wheels, Attending day centre
Under care of team: Social Care, Occupational therapy
Mental Health key workers: Seen in memory clinic, Under care of mental health team
Community Nursing: Under care of dietitian

WHAT REVIEWS HAVE WE DONE TOGETHER
Medication reviews done: 11 Jul 2017
Dementia annual review date:

THESE ARE THE ACTIONS MY DOCTOR IS GOING TO TAKE AND WHY
Support services in place: Meals on wheels, 27 Jul 2017
Referral made to:

THESE ARE THE ACTIONS I'M GOING TO TAKE
Identifying personal goals: To try and get out more., 27 Jul 2017
Social circumstances: Staying, 27 Jul 2017
Activities of everyday life: Sees family on regular basis, 27 Jul 2017

MY ADVANCED PLANNING DECISIONS
Review of dementia advance care plan, 27 Jul 2017

OTHER USEFUL INFORMATION
Useful links to website

NEXT REVIEW OF THIS CARE PLAN IS DUE
Free text here

www.england.nhs.uk
Planned new developments

• Development of a single page template for assessment of potential Dementia in a patient with LD

• Development of a quality assurance product for CCGs to assess the quality of Dementia Care Planning – along the lines of the 9 Care Processes for Diabetes
Discussion - ALL

Feedback on resources

How do we support roll out and implementation in practice
Links to frailty work
Sarah De Biase
Supporting Routing Frailty Identification in Primary Care

Sarah De Biase
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The electronic Frailty Index (eFI)

- International guidelines recommend **routine frailty identification**

- Currently available tools require additional resource and may be inaccurate

- The eFI has been developed and externally validated using **routine primary care data**

Clegg et al Age & Ageing (2016)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Development cohort (n = 207,814)</th>
<th>Internal validation cohort (n = 207,720)</th>
<th>External validation cohort (n = 516,007)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>75.0 (7.2)</td>
<td>75.0 (7.3)</td>
<td>75.0 (7.3)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>45%</td>
<td>45%</td>
<td>44%</td>
</tr>
<tr>
<td>Female</td>
<td>55%</td>
<td>55%</td>
<td>56%</td>
</tr>
<tr>
<td>FI score: mean (SD)</td>
<td>0.14 (0.09)</td>
<td>0.14 (0.09)</td>
<td>0.15 (0.10)</td>
</tr>
<tr>
<td>Males: mean (SD)</td>
<td>0.13 (0.09)</td>
<td>0.13 (0.09)</td>
<td>0.14 (0.10)</td>
</tr>
<tr>
<td>Females: mean (SD)</td>
<td>0.15 (0.10)</td>
<td>0.15 (0.10)</td>
<td>0.16 (0.10)</td>
</tr>
<tr>
<td>FI score 99th centile</td>
<td>0.49</td>
<td>0.49</td>
<td>0.42</td>
</tr>
<tr>
<td>Frailty category</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fit</td>
<td>50%</td>
<td>50%</td>
<td>43%</td>
</tr>
<tr>
<td>Mild</td>
<td>35%</td>
<td>35%</td>
<td>37%</td>
</tr>
<tr>
<td>Moderate</td>
<td>12%</td>
<td>12%</td>
<td>16%</td>
</tr>
<tr>
<td>Severe</td>
<td>3%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Number of comorbidities</td>
<td>2.1 (1.2)</td>
<td>2.2 (1.1)</td>
<td>2.3 (1.3)</td>
</tr>
<tr>
<td>Number of medications</td>
<td>8 (8.0)</td>
<td>8 (8.1)</td>
<td>9 (6.8)</td>
</tr>
</tbody>
</table>
| Townsend quintile (social deprivation)
  1 (least deprived)             | 28%                              | 28%                                    | 27%                                    |
  2                               | 18%                              | 18%                                    | 24%                                    |
  3                               | 23%                              | 23%                                    | 20%                                    |
  4                               | 16%                              | 16%                                    | 16%                                    |
  5                               | 15%                              | 15%                                    | 11%                                    |

All values are mean (SD) unless otherwise stated. Comorbidities defined using Health Survey for England definition (cardiovascular disease; diabetes; cancer; chronic lung disease; asthma; arthritis; osteoporosis; Parkinson's disease; any emotional, nervous or psychiatric disease).

a FI, frailty index.
a FI scores of 0–0.12 = fit; >0.12–0.24 = mild frailty; >0.24–0.36 = moderate frailty; >0.36 = severe frailty.
b 2% missing data on social deprivation in external validation cohort.
## Adverse Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Mild frailty (HR, 95% CI)</th>
<th>Moderate frailty (HR, 95% CI)</th>
<th>Severe frailty (HR, 95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 yr care home admission</td>
<td>2.00 (1.68 to 2.39)</td>
<td>2.70 (2.41 to 3.04)</td>
<td>5.94 (4.61 to 7.64)</td>
</tr>
<tr>
<td>3 yr care home admission</td>
<td>1.52 (1.37 to 1.69)</td>
<td>2.70 (2.41 to 3.04)</td>
<td>3.42 (2.84 to 4.12)</td>
</tr>
<tr>
<td>5 yr care home admission</td>
<td>1.56 (1.43 to 1.70)</td>
<td>2.34 (2.10 to 2.61)</td>
<td>3.00 (2.42 to 3.70)</td>
</tr>
<tr>
<td>1 yr hospitalisation</td>
<td>1.85 (1.81 to 1.88)</td>
<td>2.96 (2.90 to 3.02)</td>
<td>4.62 (4.50 to 4.74)</td>
</tr>
<tr>
<td>3 yr hospitalisation</td>
<td>1.71 (1.69 to 1.73)</td>
<td>2.54 (2.51 to 2.58)</td>
<td>3.64 (3.57 to 3.70)</td>
</tr>
<tr>
<td>5 yr hospitalisation</td>
<td>1.63 (1.61 to 1.64)</td>
<td>2.43 (2.40 to 2.46)</td>
<td>3.59 (3.54 to 3.65)</td>
</tr>
<tr>
<td>1 yr mortality</td>
<td>1.91 (1.78 to 2.04)</td>
<td>3.39 (3.15 to 3.65)</td>
<td>5.23 (4.73 to 5.79)</td>
</tr>
<tr>
<td>3 yr mortality</td>
<td>1.74 (1.68 to 1.81)</td>
<td>3.02 (2.90 to 3.14)</td>
<td>4.56 (4.29 to 4.84)</td>
</tr>
<tr>
<td>5 yr mortality</td>
<td>1.66 (1.62 to 1.71)</td>
<td>2.73 (2.64 to 2.81)</td>
<td>3.88 (3.68 to 4.09)</td>
</tr>
</tbody>
</table>
% of population with each individual eFl score:

- FIT: 50%
- MILD: 35%
- MOD: 12%
- SEV: 3%

Frailty Index - Gamma Distribution
eFI Engagement

http://www.improvementacademy.org/improving-quality/efi-engagement.html
Practicalities of eFI Implementation

- **eFI** identifies patients at risk of/likely to have frailty: **does not diagnose frailty**

- **Draws clinicians in to those who require further assessment to enable frailty diagnosis** i.e. using principles of CGA/holistic assessment

- **Clinical oversight paramount**
  - False positives/negatives and/or clinical disagreement with patient eFI scores
  
  *e.g. 75 year old man with 3 LTC highly independent eFI > 84yo female residing in care home with end stage dementia*

- **What care approach would be best for the individual?**
  - LTC/guideline specific mx
  - or holistic assessment & individualised care & supporting planning

- **Other frailty screening tools available e.g. Clinical Frailty Scale**
  - Supports frailty diagnosis & severity grading
  - Supports opportunistic case finding
  i.e. by other health & care professionals within & beyond primary care

- **Data quality & eFI reliability**
  - Ensure GP informed of service use/deficits identified
  - Appropriate to reach a consensus locally as to which deficits are less well coded & set about selecting codes to use to improve coding

- **Limitations within EHRs in terms of application**
  - EMIS population report/SystmOne patient report
  - Not in other modules of EHR systems i.e. no trust wide reporting (unless local soln.)
Identify Risk of Frailty: What next?

Evidence for:
- Individualised multifaceted & MDT assessment
- Care and Support Planning
- Case management
- Medication review
- Supported self management
- Multicomponent exercise interventions
- Advance Care Planning

Evidence Briefing
Improving outcomes for residents of care homes

Effectiveness Matters
May 2017

Recognising and managing frailty in primary care

- Frailty is a distinct health state where a minor event can trigger major changes in health from which the patient may fail to return to their previous level of health
- Simple tests that have been recommended by NICE for frailty in primary care are gait speed, self-reported health status and the PRISMA 7 questionnaire
- Exercise programmes, particularly high intensity interventions, may improve gait, balance and strength and have positive effects on fitness
- Medication review forms part of the holistic medical review of people with frailty
- Supported self-management can improve health outcomes. However, the value of case management is still to be proven
- Discussion about end-of-life care is important to most older people, but is often neglected

Commissioners of care providers' services advised:
- Support the delivery of Comprehensive Geriatric Assessment (CGA)
- Ensure broad remit of health and social care in a sliding scale of frailty and to ensure they are consistently available
- Ensure services specialisms include interventions such as falls prevention
- Ensure services are available and coordinated in worst to end of life care

Evidence Briefing, improving outcomes for residents of care homes

Evidence Briefing, improving outcomes for residents of care homes

Effectiveness Matters
Reducing harm from polypharmacy in older people

- Polypharmacy is common among older people, it can increase the risk of adverse drug effects and mortality, can lead to hospitalisation, severe disability as well as reduce compliance and adherence
- Positive (but inconsistent) effects of deprescribing interventions have been observed
- Patient and practitioner decisions about stopping medications are influenced by social influences, expected consequences, and factors such as consultation length
- Practitioners said they knew little of patients' knowledge and skills, plus beliefs about the capabilities of patients could influence their decisions
- Patients said their emotions, treatment goals, and willingness to experiment could also influence their decisions
- A multilocal, person-centred coordinated care approach, as advocated in NICE clinical guidelines and by the ‘House of Care model, should underpin efforts to reduce harm from polypharmacy in older people

Evidence Briefing, improving outcomes for residents of care homes

Evidence Briefing, improving outcomes for residents of care homes

Evidence Briefing, improving outcomes for residents of care homes
NICE 56: Multimorbidity Clinical Assessment & Management

NICE 56: Multimorbidity Clinical Assessment & Management recommends assessing frailty in patients with multimorbidity (in primary care and community settings):

- Informal assessment of gait speed (e.g. time taken to walk from waiting room)
- Formal assessment of gait speed (more than 5s to walk 4m indicating frailty)
- PRISMA 7
- Self-reported health status (e.g. ‘how would you rate your health status on a scale from 0 to 10?’)

The eFI is also recommended for identifying people with multimorbidity who are at risk of unplanned hospital or care home admission.
Frailty Contract & Dementia QOF:

- No direct/explicit contractual linkage between Frailty Contract requirements and the Dementia QOF requirements – but aligned (not least because cognitive deficits contribute to the eFI model)

- Once NHSE obtain the frailty contractual data extract they will explore whether and how the conditions map and interact (expect to be a year or so away)
Opportunity exists to do more ...
National eFI implementation...

- **Micro**: GPs using it to understand frailty prevalence within GP practice population
  e.g. Home Based (frailty) Assessments

- **Meso**: GP federations/CCGs using it to identify specific frailty cohort(s) to offer targeted intervention
  e.g. Care of Frail Elderly Schemes

- **Macro**: Whole Systems/STPs using eFI alongside other data sets to give rich picture of population need which includes frailty & develop new models of care
  - e.g. North West London Whole Systems Care for > 65 year olds
Patient identified with Mild/Moderate/Severe Frailty using eFI Assessment by Practice Nurse with additional training using a mCGA Template

Social Services and Third Sector

Medicines reconciliation using SystmOne STOPP tool by GP or Pharmacist

Secondary Care-

Community Services-

NHS Hambleton, Richmond & Whitby CCG: Home Based Frailty Assessment (mCGA)
Frailty Risk - Frailty Diagnosis Post Assessment
Drs Lane and Quakers Lane

- Mild Control: 23
- Moderate Control: 52
- Severe Control: 16
- Mild Intervention: 14
- Moderate Intervention: 27
- Severe Intervention: 9

Frailty Diagnosed
No Frailty Diagnosed
House bound patients being seen at home

More considered approach to medications reconciliation

Increased identification of Frailty, Falls, AF and Dementia

More detailed assessment & referral onto the appropriate services

Not sure if the patients understand they are being cared for in a different way – but they like seeing the nurses and appreciate things being sorted

Need a protocol for on-going management of these patients

Nurses doing assessments which they didn’t do previously – depression, cognitive assessments etc.

Interventions for managing early frailty are not in place in the wider system

It seems to be identifying significant unmet need

Identified the need to streamline how we [GPs] refer need a single point of access
What is the Mild Frailty Offer?

Modifiable risk factors:
- Alcohol excess
- Cognitive impairment
- Falls
- Functional impairment
- Hearing problems
- Mood problems
- Nutritional compromise
- Physical inactivity
- Polypharmacy
- Smoking
- Social isolation and loneliness
- Vision problems

North Durham CCG: Care of Frail Elderly Scheme

Main elements of scheme:
1. Identification of frail patients and maintenance of a ‘disease register’ of frail patients.
2. Regular assessment of these frail patients (at least annually)
3. Creation a care plan for frail patients

Identification of Frail Patients:
• Clinicians’ knowledge of their practice population
• Identification following presentation (to primary or secondary care) with a ‘frailty syndrome’ e.g. delirium, fall
• eFI

Key assessment areas (BGS Fit for Frailty):
• Dementia
• Depression
• Nutrition
• Polypharmacy
• Falls risk
• Continence
• Vision and hearing
• Mobility and inactivity
• Alcohol and smoking
• Social isolation and loneliness

Built a SystmOne eFI pt level report - calculates an eFI for every patient on the practice list
Leeds Intelligence Hub
Identifying Care Management Cohorts

Top 2% (CPM)

Top 2% (eFI)

Top 2% (Count LTCs)

1,668 (25.7%)

1,154 (17.8%)

1,461 (22.5%)

643 (9.9%)

575 (8.9%)

818 (12.6%)

175 (2.7%)
Leeds Integrated Dashboard:
Patients with 7 or more deficits (eFI > 0.19)
Leeds City Wide eFI Implementation

Using the eFI to stratify their populations according to need:

- **Healthy adults**
- **At risk** – asthma, smokers, obese, excess drinking (target for PH interventions)
- **Single LTC** – conditions from a single domain (i.e. if you had 3 cardiovascular conditions this would still be classed as one condition as could still be managed in same pathway)
- **Multiple LTCs** – conditions from 2 or more domains.
- **Frail** – using the eFI but they exclude the deficits related to long-term conditions so this group have impaired functional ability. The theory is care model for this group needs to be community based (even more so that multiple LTCs)
West London CCG  Whole Systems Model of Care  on one page

1. Shared Care Plan for health & social needs - SystmOne
2. Tier 0: Over 65s mostly healthy
3. Tier 1: Over 65s with well managed LTCs
4. Tier 2: Over 65s at risk, under monitoring
5. Tier 3: Over 65s with complex needs

- Users empowered for self-care
- Health & Social Care Assistants (HSCAs)
- Case Managers (CMs)
- Community Independence Service (CIS)
- Tailored increase in resources for primary care for over 65s e.g., longer appointments, enhanced workforce, enhanced IT

- Named GP with clinical responsibility
- Supported by Hub Admin & IT SystmOne WSIC Module
- Supports 20+ practices
- Staff/Teams – A Service Culture of Integration: moving towards a single organisation
- Financial Integration: capitated budgets, aligned financial incentives
- Systems and Operational Integration: integrated IT and robust legal and governance arrangements
eFI in the NWL WSIC Dashboards

- EFI will appear on the ‘Patient Summary’ screen
- Will be categorised into three categories - Mild, Moderate & Severe
- LTCs contributing to eFI score listed
- Other outcomes include days at home; days in contract with other services e.g. A&E etc.
Connected Yorkshire: linked data supporting care pathway redesign

Frailty theme portfolio:

• Improved intervention targeting & population level/CCG Frailty risk stratification e.g. Health Foundation funded Supported Self Care & Safer Prescribing projects

• Investigate the health economic impact of frailty - understand the impact of frailty, measured by eFl, on the utilisation and the costs of primary and secondary healthcare

• CLEARPATH (Uni Leeds): Big data visualisation and care pathway mapping to identify treatment burden, inefficiencies and gaps in service provision

• Other projects to improve care for people living with frailty e.g. Dementia & Frailty: improving access to advance care planning/palliative care
Dementia & Frailty: improving access to advance care planning +/- palliative care

Results:

• Age remains a key determinant of mortality within dementia with frailty population

• Very difficult to clinically determine/identify accurately people in ‘general population’ who are in last year of life

• Suggestion is need for more upstream ACP i.e. last 2 years of life

• Prioritise initially based those with Dementia, Frailty and older age i.e. offer ACP to people >95 years; & those with dementia, severe frailty starting with oldest age groups first as more likely to be in last 2 years of life
Alongside clinically led decision making
(alternative approaches to contemplate...)

• Offer ACP on basis of frailty category transition or rapid changes in eFl score
  e.g. Health Improvement Scotland using severe frailty eFl scores but looking each month for those with the biggest changes in score to target for palliative, anticipatory and EOLC planning
  - approach would need reports to be triggered within EHR/primary care dashboard to flag up those with changing eFl scores

• Sub-stratify within severe frailty category i.e. if resources restricted
i.e. consider dementia & frailty population and/or:
  ❖ Dementia severity
  ❖ Intensity of hospital admissions
  ❖ Increased dependency
  ❖ Weight loss
  ❖ Changes in nutritional support requirements
  - approach requires more population level analysis
eFI Next Steps

• **Optimise eFI within EHRs:** SystmOne eFI patient level protocol; EMIS population level report; primary care dashboard provider eFI replication e.g. DR Foster, RAIDR

• **Role of eFI in Secondary Care:**
  - **Cross –validation of eFI with HoW-CGA Frailty Index** (derived from HES) with Nuffield Trust; Acute Frailty Network collaboration
  - **Aim:** to identify which evidence based frailty screening approach is best to use in which setting

• **eFI revalidaiton: optimise credibility/face validity of the tool**
  - University of Leeds & University of Manchester research collaboration
  - Will include mood deficits/mental health deficits
  - Analysis will consider frailty in context of **co-morbidities/clusters of ‘deficits’** and reversible versus chronic ‘deficits’
  - **Time constraints for deficits**
Summary:

eFI Supporting the NHS England 5YFV

- Helping to case find those at risk of frailty (+/- other LTCs) i.e. breaking down barriers to support people with multiple health conditions

- Support practices/CCGs & communities to choose effective new models of care options which integrate out of hospital care, primary care & other community based providers

- Supporting people living with mild frailty i.e. self care offer

- Facilitating partnership working e.g. across STPs, with VCS

- Optimisation of digital systems to support high quality care
Thank you

Any questions?
Contact Details

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Future Events

• The National Frailty Conference 28th September 2017- 9.30am to 3.45pm at Cloth Hall Court, Leeds City Centre LS1 2HT.

• Digital Showcase event - Friday 29 September 2017 09:30-12:30 South Yorkshire and Bassetlaw ACS Doncaster Keepmoat Stadium, Stadium Way, Doncaster, DN4 5JW

• Loneliness in Older People – 16th November, all day event – save the date

  Hatfield Hall at Normanton Golf Club, Aberford Road, Stanley, Wakefield, WF3 4JP