## Dementia (DEM)

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### DEM – rationale for inclusion of indicator set

Dementia is a syndrome characterised by an insidious but ultimately catastrophic progressive global deterioration in intellectual function and is a main cause of late-life disability. The prevalence of dementia increases with age and is estimated to be approximately 20 per cent at the age of 80\(^96\). The annual incidence of vascular dementia is 1.2/100\(^97\) overall person years at risk and is the same in all age groups. Alzheimers disease accounts for 50–75 per cent of cases of dementia.

The annual incidence of dementia of the Alzheimers type rises to 34.3/100 person years at risk in the 90 year age group; the prevalence is higher in women than in men due to the longer lifespan of women. Other types of dementia such as Lewy Body dementia and fronto-temporal dementia are relatively rare but can be very distressing. In a third of cases, dementia is associated with other psychiatric symptoms (depressive disorder, adjustment disorder, generalised anxiety disorder, alcohol related problems). A complaint of subjective memory impairment is an indicator of dementia especially where there is altered functioning in terms of activities of daily living.

### DEM indicator 001

The contractor establishes and maintains a register of patients diagnosed with dementia


DEM 001.1 Rationale

It is expected that the diagnosis will largely be recorded following patients being referred to secondary care with suspected dementia or as an additional diagnosis when a patient is seen in secondary care. However it is also important to include patients where it is inappropriate or not possible to refer to a secondary care provider for a diagnosis and where the GP has made a diagnosis based on their clinical judgement and knowledge of the patient.

DEM 001.2 Reporting and verification

See indicator wording for requirement criteria.

DEM indicator 004

The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months

DEM 004.1 Rationale

Where a patient does not already have a care plan or an advanced care plan in place, it is expected that the practice will develop a care plan.

The face-to-face care plan or advanced care plan review focuses on support needs of the patient and their carer. In particular the review should address the following key issues:

- an appropriate physical, mental health and social review for the patient,
- a record of the patients’ wishes for the future,
- communication and co-ordination arrangements with secondary care (if applicable),
- identification of the patients’ carer(s); and

1. obtain appropriate permissions to authorise the practice to speak directly to the nominated carer(s) and provide details of support services available to the patient and their family, if applicable, the carer’s needs for information commensurate with the stage of the illness and his or her and the patient’s health and social care needs,
2. as appropriate, the carer should be included in the care plan or advanced care plan discussions,
3. if applicable, the impact of caring on the care-giver,
4. offer the carer a health check\(^\text{98}\) to address any physical and mental health impacts, including signposting to any other relevant services to support their health and wellbeing.

An enhanced service (ES) for facilitating timely diagnosis and support for people with dementia\(^\text{99}\) runs in parallel to the QOF indicators. The ES requires practices to

\(^{98}\) Where the carer is registered at a different practice, the patients practice should inform the patient’s carer that they can seek advice from their own practice.

provide advanced care planning in line with the patient’s wishes and increase the health and wellbeing support offered to carers of patients with dementia.

Patients diagnosed with dementia are expected to be offered annual face-to-face appointments specifically to review their diagnosis and/or their care plan or advanced care plan. The practice will agree with the patient and their carer, what is to be covered in the review and the duration of the consultation - where appropriate, extended consultations may take up to 30 minutes\textsuperscript{100}. Ideally the first such appointment would be within six months of diagnosis.

A series of well-designed cohort and case control studies have demonstrated that patients with Alzheimer-type dementia do not complain of common physical symptoms, but experience them to the same degree as the general population. Patient assessments therefore include the assessment of any behavioural changes caused by:

- concurrent physical conditions (e.g. joint pain or inter-current infections)
- new appearance of features intrinsic to the disorder (e.g. wandering) and delusions or hallucinations due to the dementia or as a result of caring behaviour (e.g. being dressed by a carer).

Depression could also be considered as it is more common in patients with dementia than those without\textsuperscript{101}.

Patients and carers are to be given relevant information about the diagnosis and sources of help and support (bearing in mind issues of confidentiality). Evidence suggests that healthcare professionals can improve satisfaction for carers by acknowledging and dealing with their distress and providing more information on dementia\textsuperscript{102}. As the illness progresses, needs may change and the review may focus more on issues such as respite care.

There is good evidence from well-designed cohort studies and case control studies of the benefit of healthcare professionals asking about the impact of caring for a person with dementia and the effect this has on the caregiver. It is important to remember that male carers are less likely to complain spontaneously and that the impact of caring is dependent not on the severity of the cognitive impairment but on the presentation of the dementia, for example, on factors such as behaviour and affect. If the carer is not registered at the practice, but the GP is concerned about issues raised in the consultation, then with appropriate permissions they can contact the carer’s own GP for further support and treatment.

As the illness progresses and more agencies are involved, the review could additionally focus on assessing the communication between health and social care and non-statutory sectors as appropriate, to ensure that potentially complex needs are addressed. Communication and referral issues highlighted in the review need to be followed up as part of the review process.

\textsuperscript{100} The practice should agree with the patient the most suitable length of this for this appointment, this could be provided as two 15 minute appointments if this is more appropriate for the patient.

\textsuperscript{101} Burt et al. Psychol Bull 1995; 117: 285-305

\textsuperscript{102} Eccles et al. BMJ 1998; 317: 802-808
Further information


NICE Quality Standard 1: Dementia. https://www.nice.org.uk/guidance/qs1


DEM 004.2 Reporting and verification

See indicator wording for requirement criteria.

Verification – Commissioners may require randomly selecting a number of patient records of patients in which the review has been recorded as taking place to confirm that the four key issues are recorded as having been addressed, if applicable.

DEM indicator 005 (based on NICE 2010 menu ID: NM09)

The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 12 months before or 6 months after entering on to the register

DEM 005.1 Rationale

There is no universal consensus on the appropriate diagnostic tests to be undertaken in those with suspected dementia. However, a review of 14 guidelines and consensus statements found considerable similarity in recommendations\textsuperscript{103}. The main reason for undertaking investigations in a patient with suspected dementia is to exclude a potentially reversible or modifying cause for the dementia and to help exclude other diagnoses (e.g. delirium). Reversible or modifying causes include

metabolic and endocrine abnormalities (e.g. vitamin B12 and folate deficiency, hypothyroidism, diabetes and disorders of calcium metabolism).

The NICE clinical guideline on dementia\textsuperscript{104} states that a basic dementia screen is performed at the time of presentation, usually within primary care. It includes:

- routine haematology
- biochemistry tests (including electrolytes, calcium, glucose, and renal and liver function)
- thyroid function tests
- serum vitamin B12 and folate levels.

**DEM 005.2 Reporting and verification**

See indicator wording for requirement criteria.

For the purpose of this indicator, if a test for HbA1c has been carried out within the timeframe permitted by this indicator, then a test for glucose would not be required. All tests are required to be carried out (with the exception of glucose in the above scenario) to meet the requirements of this indicator. Where the test is declined by the patient, then the patient may be exception reported.

This indicator only applies to patients with a new diagnosis of dementia in the QOF year. However the workload has the potential to span more than one QOF year. Therefore the Business Rules cover 30 months to capture patients whose care could span more than one QOF year e.g. 12 months before or six months after a new diagnosis is recorded.

This indicator only applies to patients with a new diagnosis of dementia in the QOF year. However, the workload has the potential to span more than one year. The Business Rules will look at a 30 month period of which 18 months is for the diagnosis of dementia (this includes six months for those patients diagnosed in the last six months of the previous year) and the additional 12 months accounts for the 12 months preceding diagnosis for the tests.

\textsuperscript{104} NICE CG42. Dementia. Supporting people with dementia and their carers in health and social care. 2006. \url{www.nice.org.uk.CG42}