Implementing the Dementia Care Evidence Based Treatment Pathway

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Dementia facts

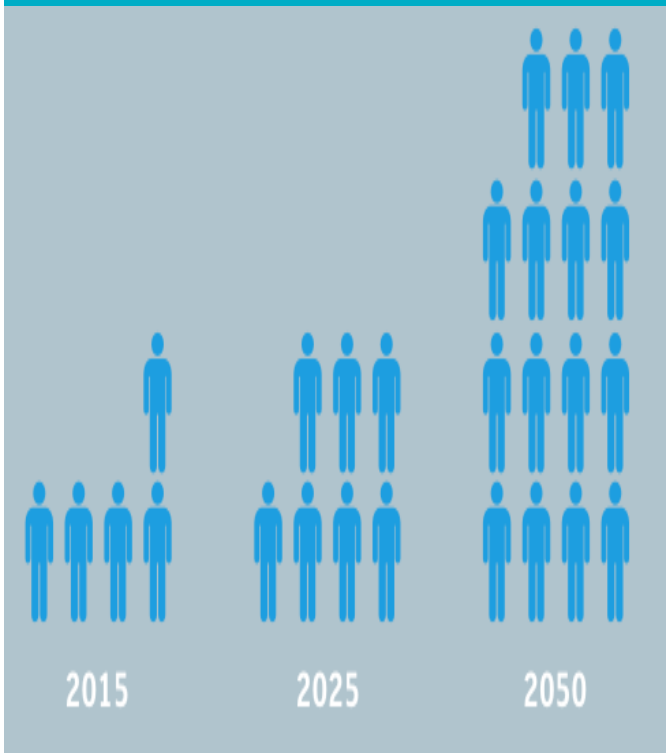
£26 billion - financial cost of dementia per annum.

60,000 deaths each year are directly attributable to dementia

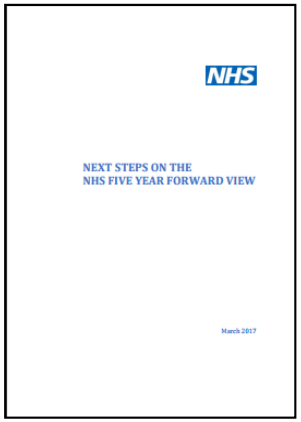
42,000 younger people with dementia

700,000 people with dementia

The number of people with dementia is forecast to increase to 1,142,677 by 2025



Policy drivers



CQC and the British Geriatrics Society have shown that many people with dementia living in care homes are not getting their health needs regularly assessed and met. One consequence is avoidable admissions to hospital.

Continue to maintain focus on diagnosis and post-diagnostic support for people with dementia and their carers.

NHS Mandate 2017-18

NHS England

Overall 2020 goals:

- Deliver the actions as outlined in the Challenge on Dementia 2020 Implementation Plan

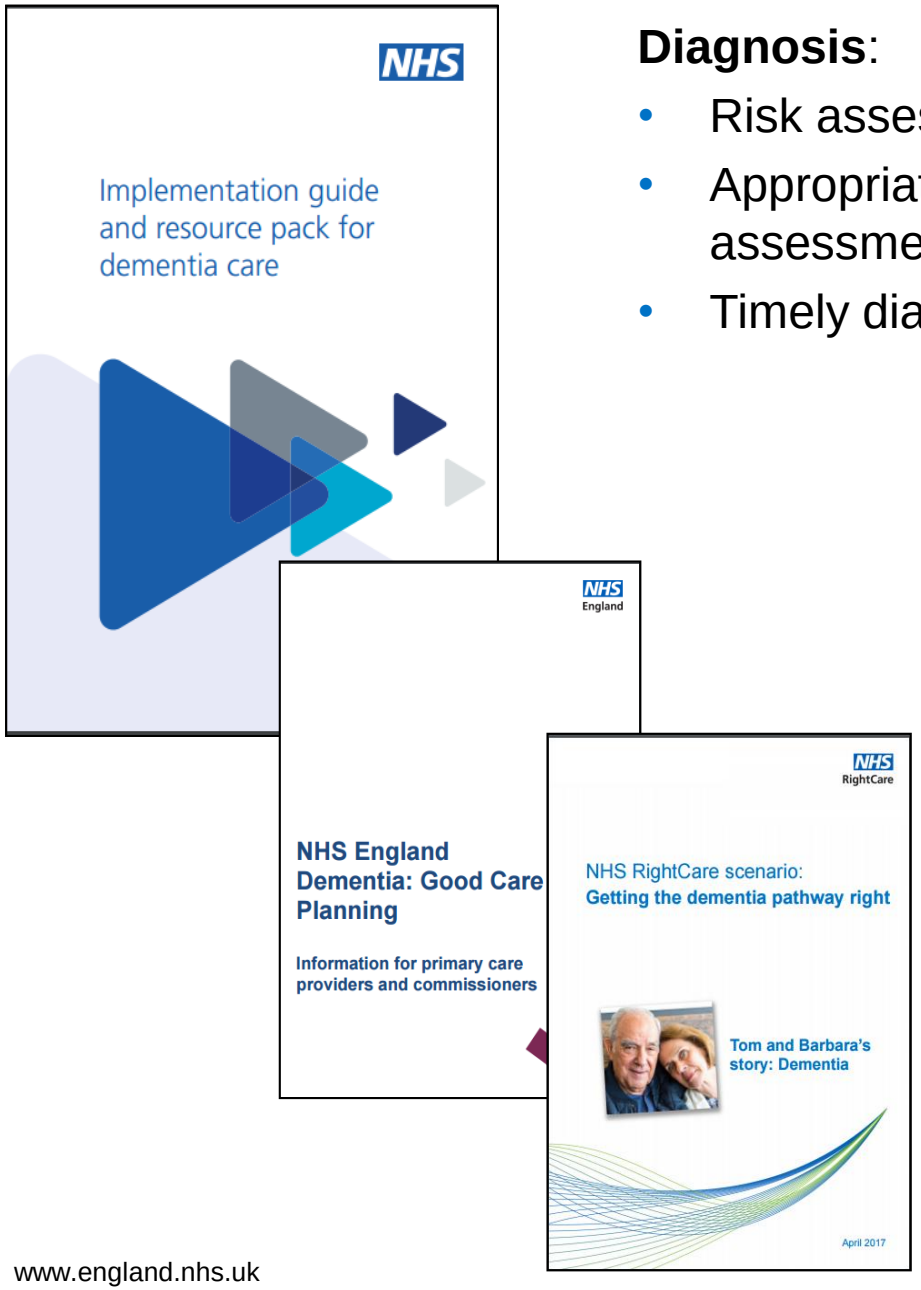
2017-18 deliverables:

- Maintain a minimum of two thirds diagnosis rates for people with dementia.
- Continue to develop an evidence based framework for a national treatment and care pathway and agree an affordable implementation plan for the 2020 Dementia Challenge, including to improve the quality of post-diagnosis treatment and support

NHS Planning Guidance 2017-19

- 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.

NHS England



Diagnosis:

- Risk assessment
- Appropriate referrals to memory assessment clinics
- Timely diagnosis

Post-diagnostic support core components:

- the support of a named coordinator of care; and
- the presence of a flexible, up-to-date care plan

NICE recommended care

NHS England

People with suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia

People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local areas

People with dementia are enabled, with the involvement of their carers, to access services that help maintain their physical and mental health and wellbeing

People with dementia have an assessment and an on-going personalised care plan, agreed across health and social care, that identifies a named coordinator of care and addresses their individual needs

People with dementia, with the involvement of their carers, have choice and control in decisions affecting their care and support

People with dementia receive care from staff appropriately trained in dementia care

NHS ENGLAND TRANSFORMATION FRAMEWORK – THE WELL PATHWAY FOR DEMENTIA

PREVENTING WELL

Risk of people developing dementia is minimised

"I was given information about reducing my personal risk of getting dementia"

STANDARDS:

- Prevention[1]
- Risk Reduction[5]
- Health Information[4]
- Supporting research[5]

DIAGNOSING WELL

Timely accurate diagnosis, care plan, and review within first year

"I was diagnosed in a timely way"

"I am able to make decisions and know what to do to help myself and who else can help"

STANDARDS:

- Diagnosis[1][5]
- Memory Assessment[1][2]
- Concerns Discussed[3]
- Investigation [4]
- Provide Information[4]
- Integrated & Advanced Care Planning [1][2][3][5]

SUPPORTING WELL

Access to safe high quality health & social care for people with dementia and carers

"I am treated with dignity & respect"

"I get treatment and support, which are best for my dementia and my life"

STANDARDS:

- Choice[2][3][4], BPSD[6][2]
- Liaison[2], Advocates[3]
- Housing [3]
- Hospital Treatments[4]
- Technology[5]
- Health & Social Services [5]
- Hard to Reach Groups[3][5]

LIVING WELL

People with dementia can live normally in safe and accepting communities

"I know that those around me and looking after me are supported"

"I feel included as part of society"

STANDARDS:

- Integrated Services[1][3][5]
- Supporting Carers[2][4][5]
- Carers Respite[2],
- Co-ordinated Care[1][5]
- Promote independence[1][4]
- Relationships[3], Leisure[3]
- Safe Communities[3][5]

DYING WELL

People living with dementia die with dignity in the place of their choosing

"I am confident my end of life wishes will be respected"

"I can expect a good death"

STANDARDS:

- Palliative care and pain[1][2]
- End of Life[4]
- Preferred Place of Death[5]

References: (1) NICE Guideline. (2) NICE Quality Standard 2010. (3) NICE Quality Standard 2013. (4) NICE Pathway. (5) Organisation for Economic Co-operation and Development (OECD) Dementia Pathway. (6) BPSD – Behavioural and Psychological Symptoms of dementia.

RESEARCHING WELL

- Research and innovation through patient and carer involvement, monitoring best-practice and using new technologies to influence change.
- Building a co-ordinated research strategy, utilising Academic & Health Science Networks, the research and pharmaceutical industries.

INTEGRATING WELL

- Work with Association of Directors of Adult Social Services, Local Government Association, Alzheimer's Society, Department of Health and Public Health England on co-commissioning strategies to provide an integrated service ensuring a seamless and integrated approach to the provision of care.

COMMISSIONING WELL

- Develop person-centred commissioning guidance based on NICE guidelines, standards, and outcomes based evidence and best-practice.
- Agree minimum standard service specifications for agreed interventions, set business plans, mandate and map and allocate resources.

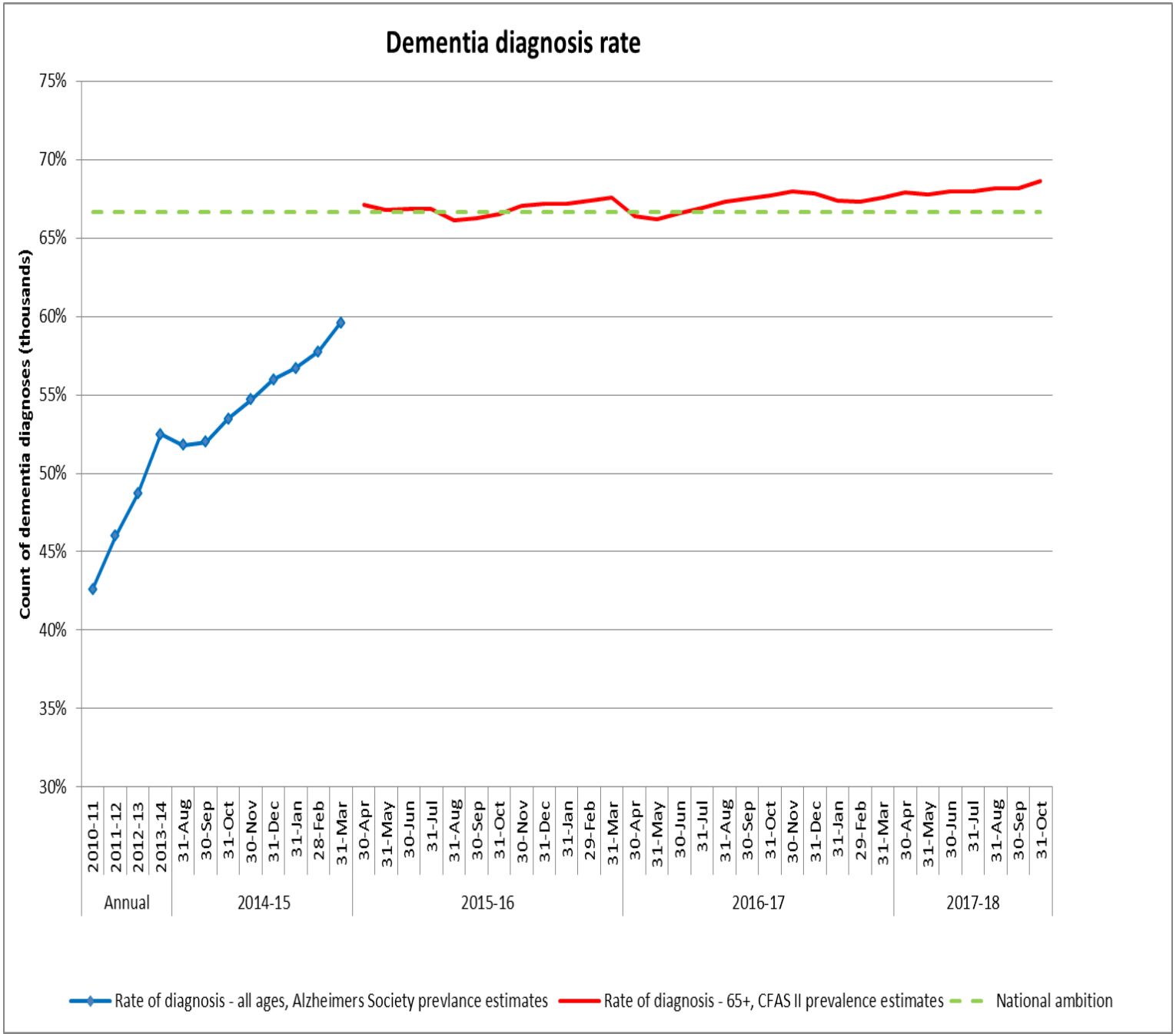
TRAINING WELL

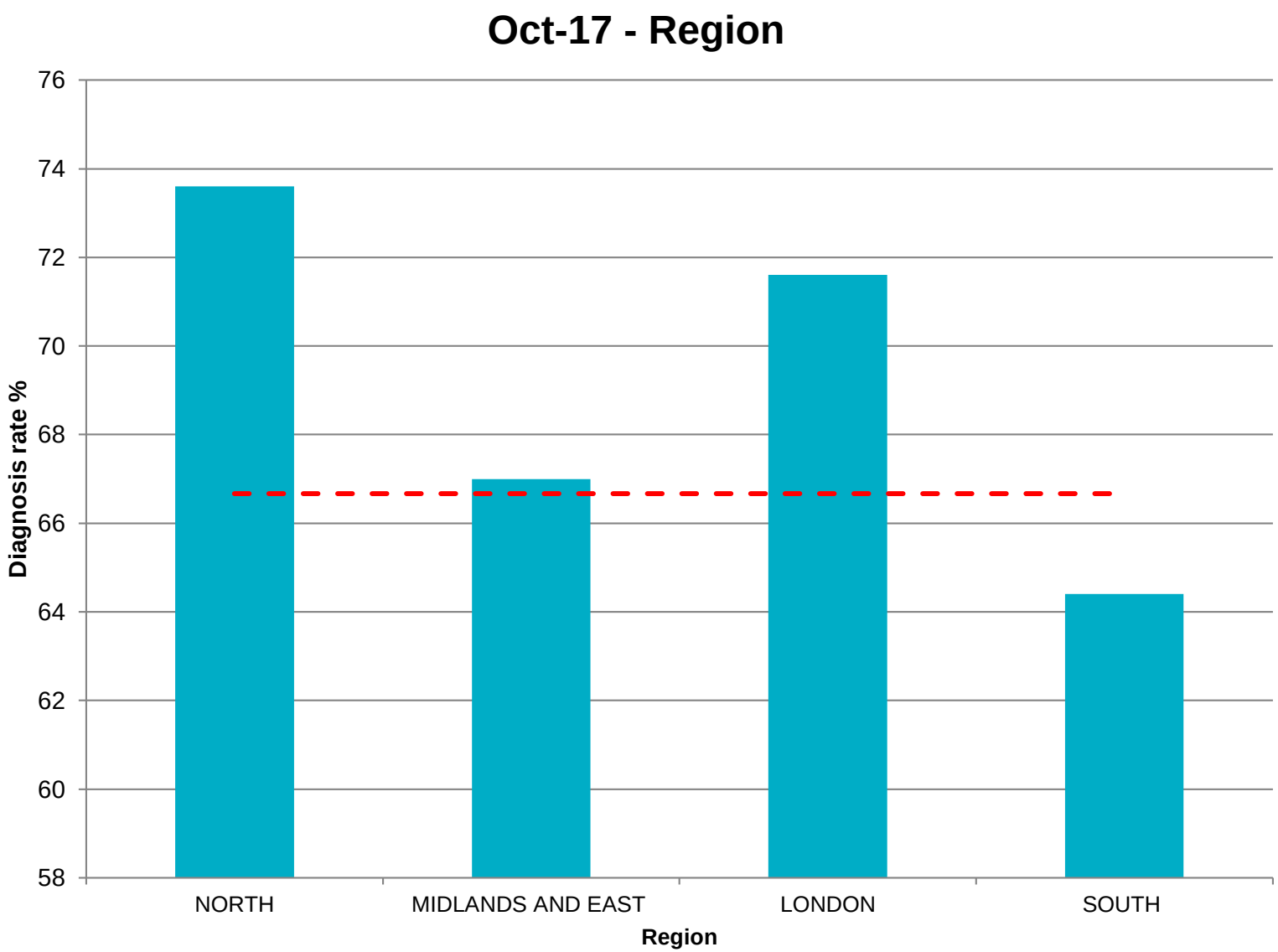
- Develop a training programme for all staff that work with people with dementia, whether in hospital, General Practice, care home or in the community.
- Develop training and awareness across communities and the wider public using Dementia Friends, Dementia Friendly Hospitals/Communities/Homes.

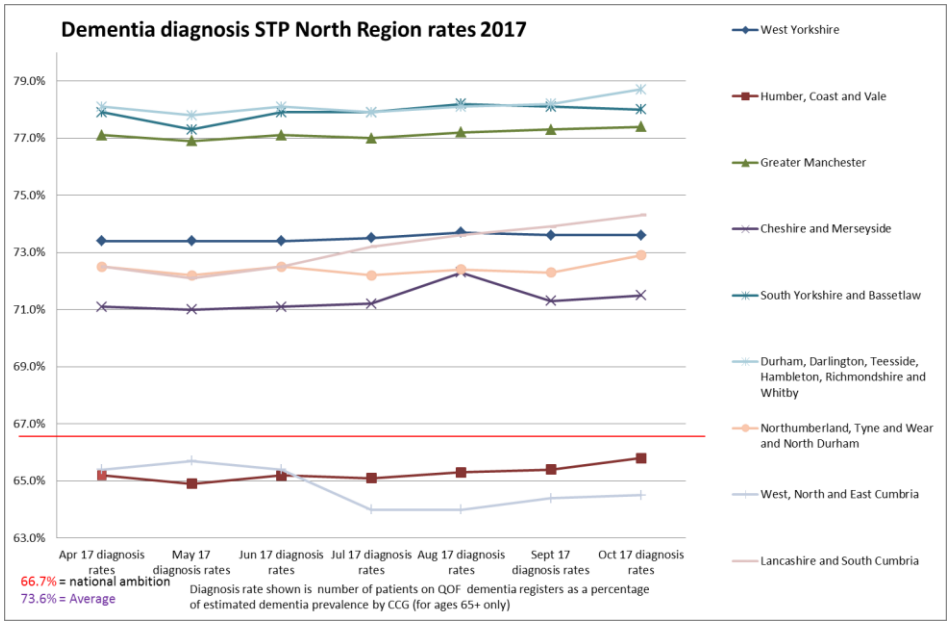
MONITORING WELL

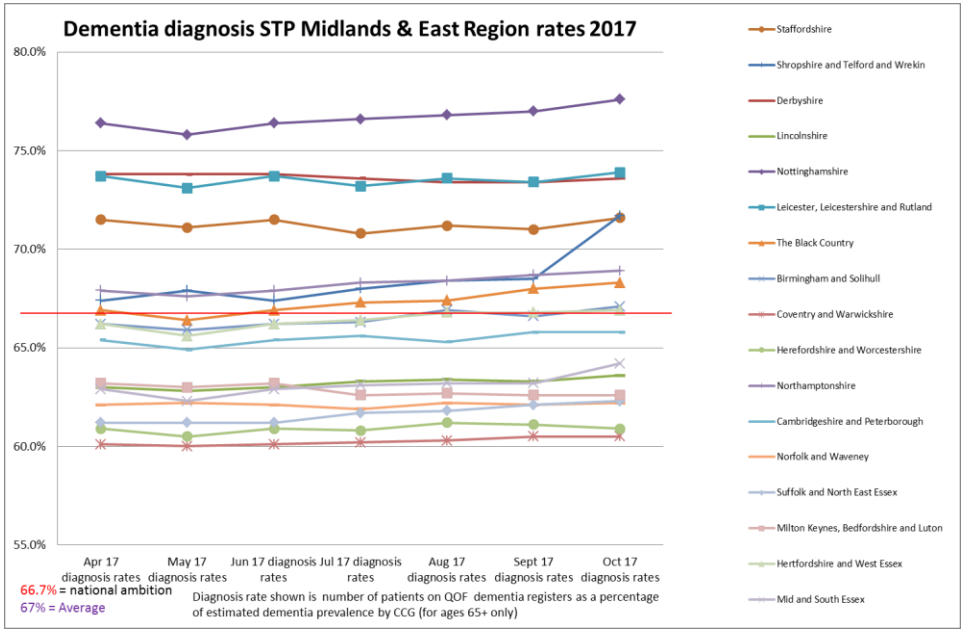
- Develop metrics to set & achieve a national standard for Dementia services, identifying data sources and set 'profiled' ambitions for each.
- Use the Intensive Support Team to provide 'deep-dive' support and assistance for Commissioners to reduce variance and improve transformation.

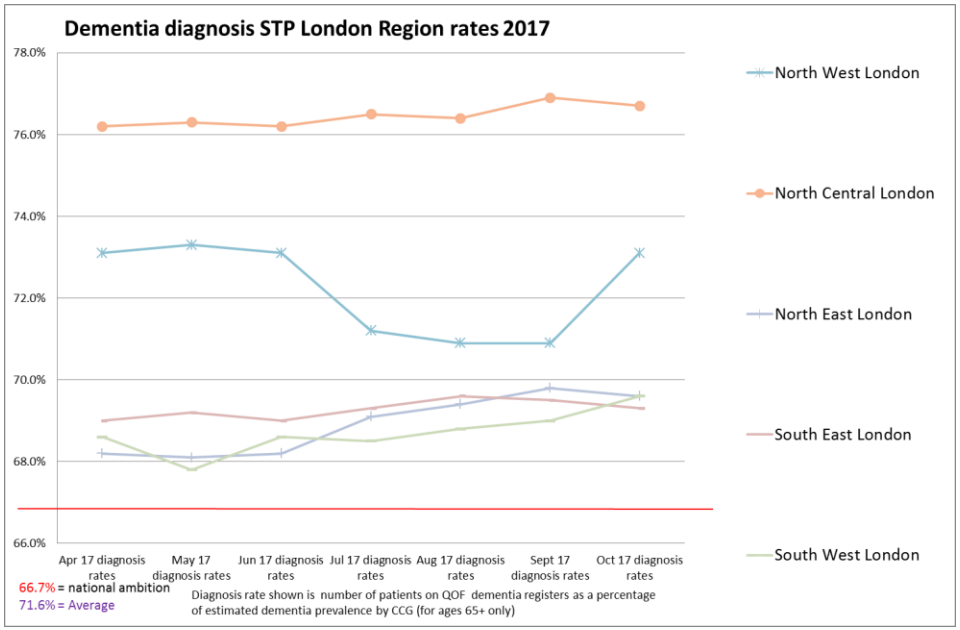
NHS England

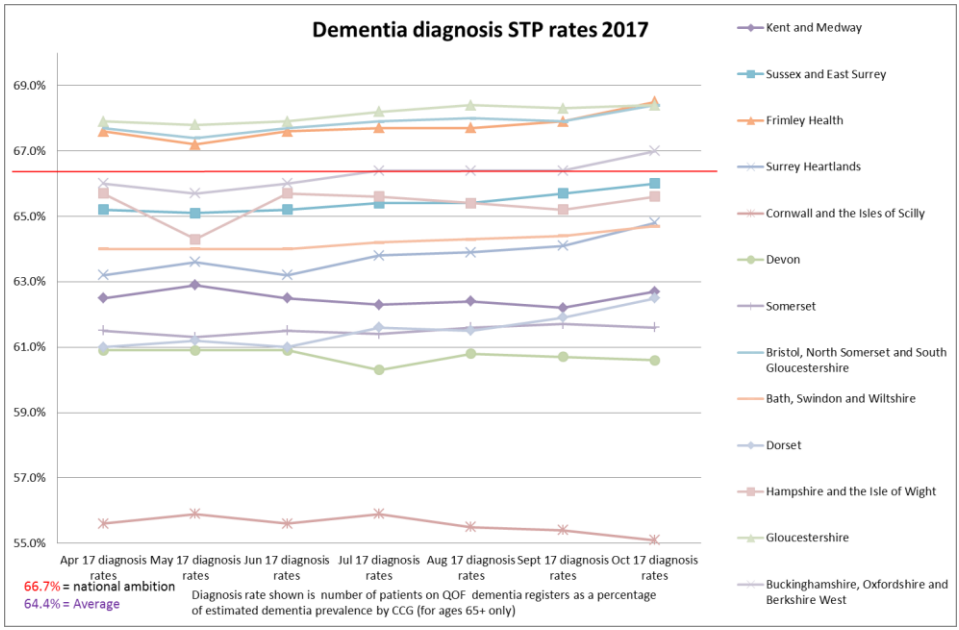

Dementia diagnosis rate
Count of dementia diagnoses (thousands)
75%
70%
65%
60%
55%
50%
45%
40%
35%
30%
2010-11
2011-12
2012-13
2013-14
31-Aug
30-Sep
31-Oct
30-Nov
31-Dec
31-Jan
28-Feb
31-Mar
30-Apr
31-May
30-Jun
31-Jul
31-Aug
30-Sep
31-Oct
30-Nov
31-Dec
31-Jan
29-Feb
31-Mar
30-Apr
31-May
30-Jun
31-Jul
31-Aug
30-Sep
31-Oct
30-Nov
31-Dec
31-Jan
29-Feb
31-Mar
30-Apr
31-May
30-Jun
31-Jul
31-Aug
30-Sep
31-Oct
Annual
2014-15
2015-16
2016-17
2017-18
Rate of diagnosis - all ages, Alzheimers Society prevlance estimates
Rate of diagnosis - 65+, CFAS II prevalence estimates
National ambition


Oct-17 - Region
76
74
72
70
68
66
64
62
60
58
Diagnosis rate %
NORTH
MIDLANDS AND EAST
LONDON
SOUTH
Region

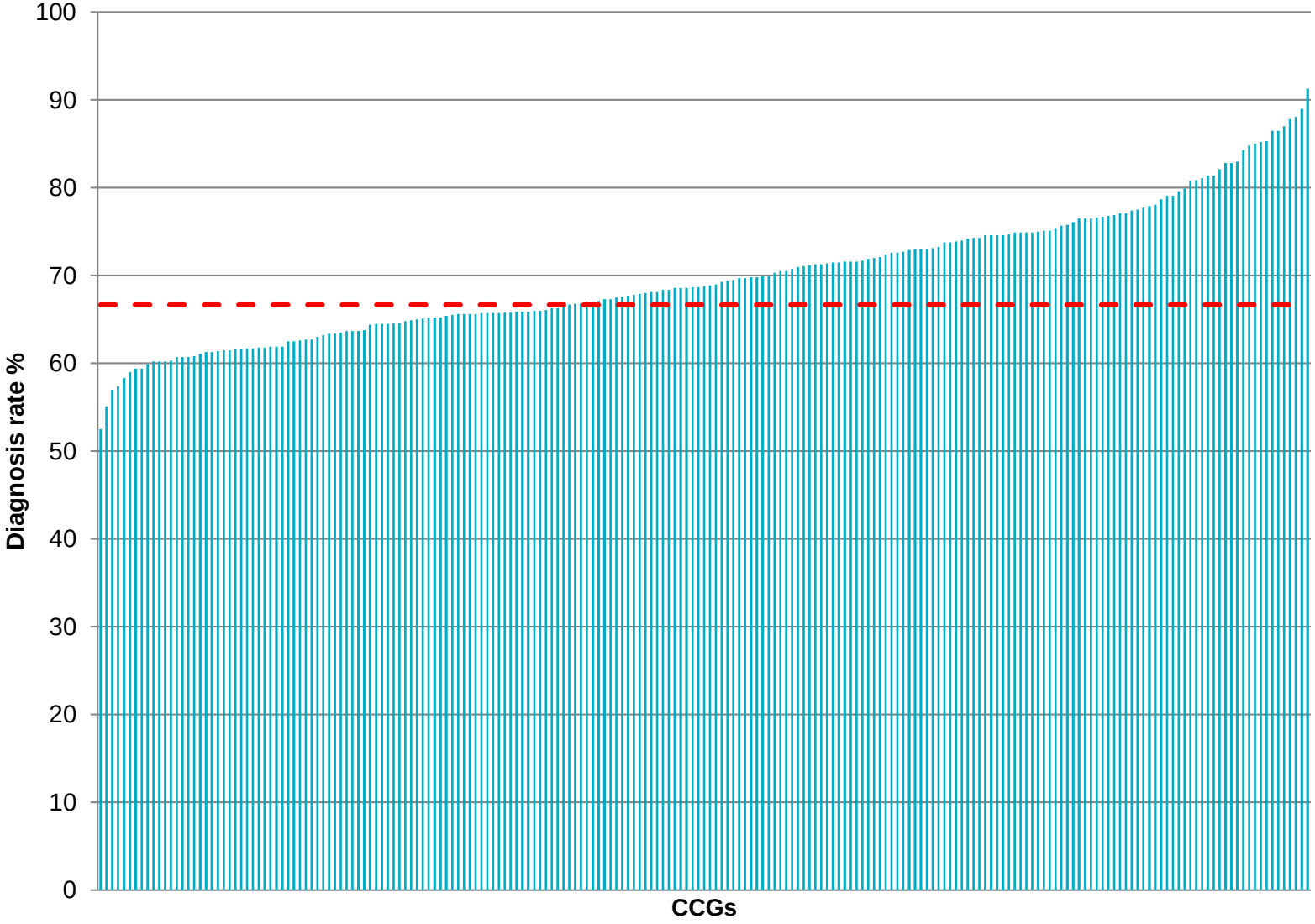

Dementia diagnosis STP North Region rates 2017
79.0%
77.0%
75.0%
73.0%
71.0%
69.0%
67.0%
65.0%
63.0%
Apr 17 diagnosis rates
May 17 diagnosis rates
Jun 17 diagnosis rates
Jul 17 diagnosis rates
Aug 17 diagnosis rates
Sept 17 diagnosis rates
Oct 17 diagnosis rates
West Yorkshire
Humber, Coast and Vale
Greater Manchester
Cheshire and Merseyside
South Yorkshire and Bassetlaw
Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby
Northumberland, Tyne and Wear and North Durham
West, North and East Cumbria
Lancashire and South Cumbria
66.7% = national ambition
73.6% = Average
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 STP Midlands & East Region rates 2017
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
Apr 17 diagnosis rates
May 17 diagnosis rates
Jun 17 diagnosis rates
Jul 17 diagnosis rates
Aug 17 diagnosis rates
Sept 17 diagnosis rates
Oct 17 diagnosis rates
Staffordshire
Shropshire and Telford and Wrekin
Derbyshire
Lincolnshire
Nottinghamshire
Leicester, Leicestershire and Rutland
The Black Country
Birmingham and Solihull
Coventry and Warwickshire
Herefordshire and Worcestershire
Northamptonshire
Cambridgeshire and Peterborough
Norfolk and Waveney
Suffolk and North East Essex
Milton Keynes, Bedfordshire and Luton
Hertfordshire and West Essex
Mid and South Essex
66.7% = national ambition
67% = Average
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 STP London Region rates 2017
78.0%
76.0%
74.0%
72.0%
70.0%
68.0%
66.0%
Apr 17 diagnosis rates
May 17 diagnosis rates
Jun 17 diagnosis rates
Jul 17 diagnosis rates
Aug 17 diagnosis rates
Sept 17 diagnosis rates
Oct 17 diagnosis rates
North West London
North Central London
North East London
South East London
South West London
66.7% = national ambition
71.6% = Average
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 STP rates 2017
69.0%
67.0%
65.0%
63.0%
61.0%
59.0%
57.0%
55.0%
Apr 17 diagnosis rates
May 17 diagnosis rates
Jun 17 diagnosis rates
Jul 17 diagnosis rates
Aug 17 diagnosis rates
Sept 17 diagnosis rates
Oct 17 diagnosis rates
Kent and Medway
Sussex and East Surrey
Frimley Health
Surrey Heartlands
Cornwall and the Isles of Scilly
Devon
Somerset
Bristol, North Somerset and South Gloucestershire
Bath, Swindon and Wiltshire
Dorset
Hampshire and the Isle of Wight
Gloucestershire
Buckinghamshire, Oxfordshire and Berkshire West
66.7% = national ambition
64.4% = Average
Diagnosis rate shown is number of patients on QOF dementia registers as a percentage of estimated dementia prevalence by CCG (for ages 65+ only)

Oct 2017 - CCG



Diagnosis

NHS England

Increase the number of people being diagnosed with dementia, and starting treatment, within six weeks from referral

What we've done:

- Achieved and maintained national ambition
- Inclusion in CCG IAF
- Reduced number of CCGs more than 10 percentage points below ambition
- Provided IST to CCGs most in need
- Ethnicity data

What we're doing now:

- Continue to address diagnosis rates at sub-national level
- Monitoring RTT

Monthly data

Ethnic group	Number	Proportion (%)
Asian or Asian British	10,471	2.3
Black or African or Caribbean or Black British	14	0.0
Mixed or multiple ethnic groups	1,941	0.4
White	103,964	22.9
Other ethnic group	1,974	0.4
Not defined	335,695	73.9

_	Number of Patients
Assessments for dementia at a GP practice	
Recorded of receiving an assessment	245,324
Recorded as being ‘at risk of dementia’ and declined an assessment	26,640
Memory assessments and clinics	
Record of an initial memory assessment	76,126
Record of declining an initial memory assessment	2,823
Record of a referral to a memory clinic	21,877
Record of declining a referral to a memory clinic	2,388
Care plans and reviews by a GP practice within a 12 month period	
Record of receiving a dementia care plan or dementia care plan review	286,077
Record of declining a dementia care plan or declining a dementia care plan review	1,491

Referral to treatment time

NHS England

- SNOMED codes
- MHSDS
- Long-guide and helpful resources pack
- New metrics:
  - Of the patients with dementia not discharged back to primary care:
    - the number of referrals accepted by memory assessment service in each month
    - the number diagnosed with dementia/MCI/nothing each month
    - the average number of days between referral being sent and accepted at MAS
  - Of those diagnosed with dementia:
    - the average number of days between referral being accepted and first assessment
    - the average number of days between first assessment and diagnosis being recorded
    - the average number of days between diagnosis being recorded and treatment starting
    - the average number of days between referral being accepted and treatment starting
    - the number of newly diagnosed patients who start treatment in each month
    - the number of newly diagnosed patients discharged back to primary care without treatment starting

Post-diagnostic support

NHS England

Improve the quality of post-diagnostic treatment and support for people with dementia and their carers

What we've done:

- Care plan in CCG IAF
- Published good care planning guidance
- Anti-psychotics prescribing data

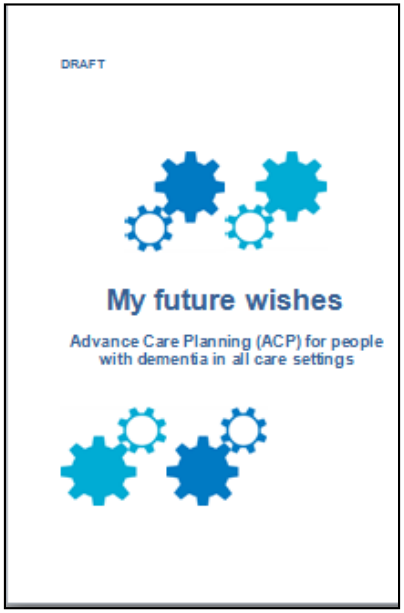
What we're doing now:

- Publishing advanced care planning sign-posting document
- Operationalising the good care planning guidance template
- STP pilot
- Experience measure

Dementia care planning

- Incorporation of the dementia good care planning template on to GP IT systems.
- Establish a nationally agreed set of codes for Dementia Care planning.
- Ensure a standardised approach, consistency and eliminate repetition.
- Incorporates the core components which constitute the minimum information that should be included in dementia care planning.
- Transition to SNOMED in primary care 2018.

Advanced care planning


DRAFT

My future wishes

Advance Care Planning (ACP) for people with dementia in all care settings

- Advance care planning is the basis for delivering person-centred end of life care that accords with the wishes of the individual in the event that they have lost mental capacity.
- We are now developing a resource to support ACP and the intention is to ensure that it will be valuable in all settings including care homes.
- The aim is to help ensure:
  - ACP conversations are introduced as early as possible.
  - A person has maximised choice/control over their treatment.
  - All care staff are responsible for embedding ACP

STP initiative

Component	Description
Identification of dementia	Recognising dementia facilitates care by understanding symptoms, allows advance care planning to take place and can reduce inappropriate hospital admission. Tools are available which can achieve this effortlessly with minimal fuss (eg DeAR-GP or the prize winning DiaDem).
Dementia Care Mapping	This is a simple technique which has been well established in care home and emphasises the need for person centred care. It reduces outpatient attendances and challenging behaviours in residents but evidence of overall cost effectiveness is awaited. However, it is cheap and likely to be cost effective. The dementia academy in Hull has demonstrated the feasibility of the approach).
Old Age Mental Health teams	These are key in providing support to care homes not only for individual clinical advice around dementia and rapid response to but also for general learning and support, yet their availability is scanty. Their effect in reducing hospital admissions has been clearly demonstrated but the cost is estimated to be half that of traditional care with a reduction of 50% in hospital admissions.
Medication Review	While reductions in antipsychotics have been nationally demonstrated, their continued use needs monitored. Prescription of certain drugs can be an indicator of an upcoming crisis
Advance care plans	Consequent on the diagnosis of dementia will be a discussion about end of life care

Other areas to explore and test	
Care home to hospital transition – the Red Bag	This has been established as a communication tool and may also have the added consequence of reducing hospital admissions.
Home to care home transition – the Green light	A new idea where ambulances when called in an emergency (a blue light) take a person with dementia to a care home
Dementia Advisors	New evidence shows that the provision of dementia advisors keeps people in the community and the estimates are for every £1 spent, £4 are saved.

Support offer 1/2

NHS England

The dementia support offer recognises that CCGs will have varying levels of need for support and provides two levels, which can run concurrently.

Level 1 – general advice available to all CCG

This level mainly continues the support already available to CCGs e.g.

- Publication of the monthly dementia diagnosis rates alongside CCG specific reports and benchmarking
- Working through the Clinical Networks (CN) and Academic Health Science Networks (AHSN) to ensure direct support is provided to CCGs at a local level through monthly WebEx and annual CN and AHSN meeting
- Working with regions to deliver the new Operating Model by using local intelligence and data to support commissioners and providers to deliver the efficient and effective dementia services
- Publication of other dementia metrics along the well pathway on the PHE dementia Fingertips profile
- A catalogue of best practice examples is available from England.domainteam@nhs.net
- Publication of Commissioning for Value RightCare Packs for Dementia and costed RightCare Dementia Care Pathway Scenarios to support commissioners to achieve value for money https://www.england.nhs.uk/publication/getting-the-dementia-pathway-right/

Support offer 2/2

NHS England

- Publication of the new dementia pathway to support commissioners and providers to improve access to dementia services. https://www.england.nhs.uk/mental-health/dementia/implementation-guide-and-resource-pack-for-dementia-care/

- Publication of guide to support implementation of care planning template into GP systems to ensure providers are aware of requirements and supported to make any system changes necessary to meet them https://www.england.nhs.uk/wp-content/uploads/2017/02/dementia-good-care-planning.pdf

- And, the Alzheimer's Society offers face to face meetings with a senior Alzheimer's Society official to provide information, advice and support to help review how local services can best meet local need. This can be arranged via Raj Kapoor, Head of External Training and Consultancy at Alzheimer's Society via email at Raj.Kapoor@alzheimers.org.uk

Level 2 – targeted support available to those CCGs that need to make an improvement

The support offered at this level is in addition to the support offered in level 1 and includes:

- A sustainability assessment tool which CCGs can use to identify key areas that need to be hardwired into systems and processes for on-going identification of dementia. This tool will be available from England.domainteam@nhs.net in Q4 2017/18.
- Advice to individual CCGs provided by the national clinical director for dementia or other senior representatives

- System collaboration, including buddying arrangements

NHS England

Questions?

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