

Dementia Workstream

Joint QIPP and JIP initiative
across health and social care

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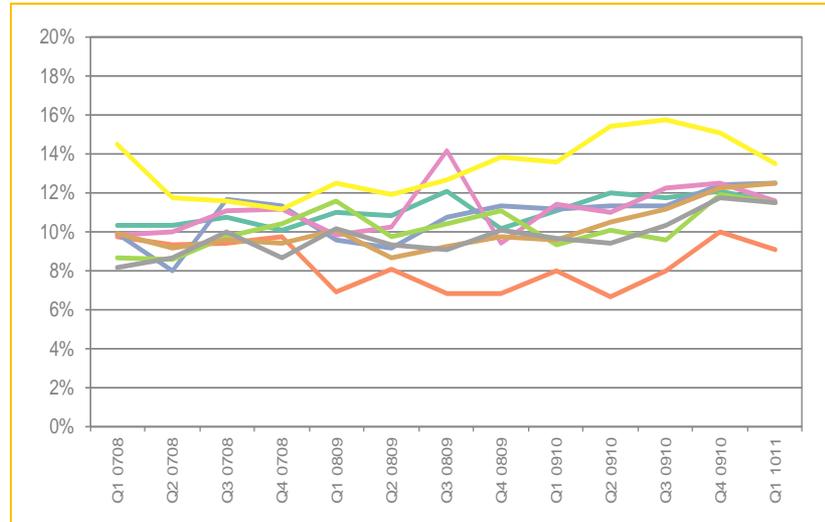
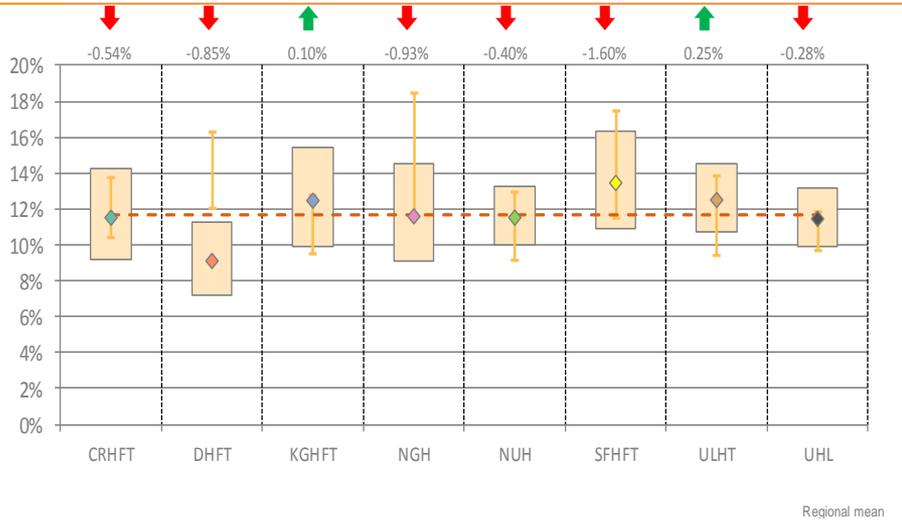
Case for change



- East Midlands alongside the South West faces the most significant challenge in England. In 2010 there were 52,836 people living with dementia in the East Midlands rising to 82,155 in 2025 (55% increase). Direct costs to the NHS and social care will treble as a result by 2030.
- Diagnosis is a gateway to appropriate care: Only 37% of people with dementia are currently diagnosed in the East Midlands and services for dementia are acknowledged to be underdeveloped in all sectors (community, specialist MH, care homes, and acute hospitals).
- As a result too few people access appropriate prevention, early intervention and intermediate care and too many people with dementia are admitted to high cost services in hospitals and residential care (up to 1/3 of people in acute beds and 2/3 of people living in care homes have dementia).
- Investing in diagnosis, early intervention and improving quality of dementia care should release savings through reduced admissions to hospitals and care homes (e.g. £6 million per DGH, 1 year delay in admission to a care home). Savings realised will need to be reinvested to deliver quality services in line with rising need.

Variation & Opportunity

Proportion of Dementia Coding in >65 Emergency Admissions (Q1 1011)



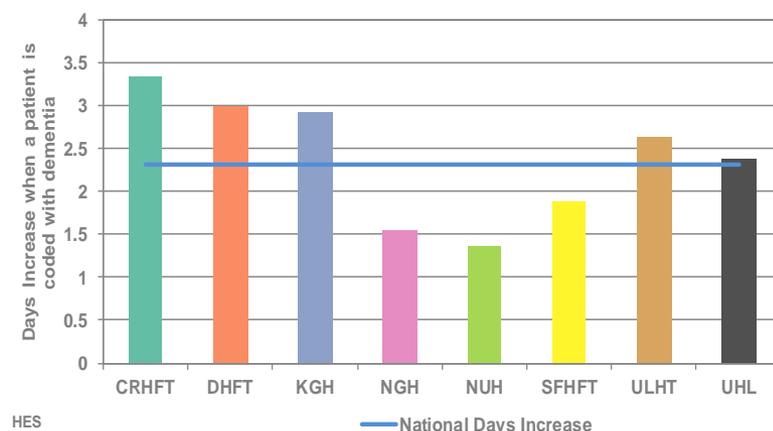
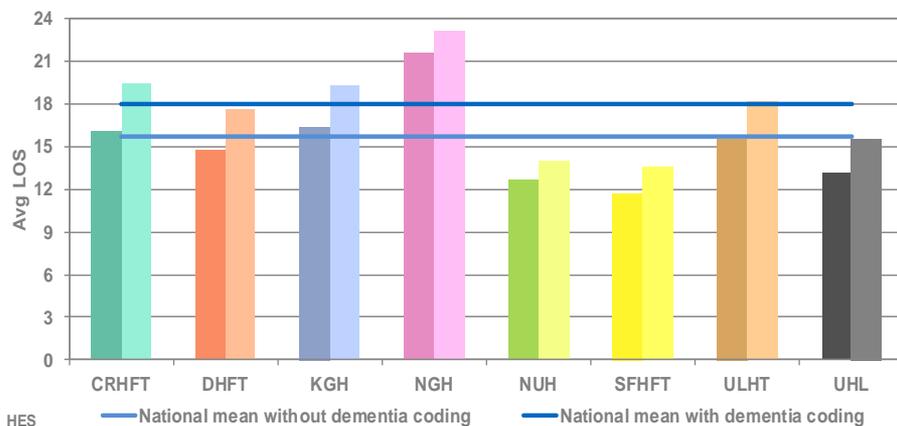
Provider	FY 0708	FY 0809	Q1 0910	Q2 0910	Q3 0910	Q4 0910	FY 0910	Q1 1011
CRHFT	10.37%	11.02%	11.08%	12.00%	11.75%	12.06%	11.73%	11.52%
DHFT	9.55%	7.15%	7.94%	6.62%	7.98%	9.96%	8.20%	9.11%
KGHFT	10.28%	10.21%	11.12%	11.33%	11.34%	12.37%	11.56%	12.47%
NGH	10.51%	10.93%	11.38%	11.01%	12.20%	12.52%	11.80%	11.59%
NUH	9.36%	10.68%	9.30%	10.08%	9.55%	11.92%	10.23%	11.52%
SFHFT	12.28%	12.73%	13.60%	15.37%	15.75%	15.05%	14.94%	13.45%
ULHT	9.50%	9.42%	9.60%	10.45%	11.13%	12.25%	10.84%	12.50%
UHL	8.87%	9.66%	9.69%	9.44%	10.31%	11.73%	10.31%	11.45%
East Midlands	9.85%	10.04%	10.16%	10.49%	10.91%	12.10%	10.93%	11.66%
National			11.65%	11.80%	12.48%	12.99%	12.24%	12.94%

Narrative:

There is variation in the coding of dementia in emergency admissions for the >65 across the region. The regional average is slightly below that seen nationally but has been improving in the last 3 years from 9.85% to 11.66%. Three trusts in the region are coding patients above the national average whilst DHFT are the only trust significantly below national and their peer group. The low percentages could be because the coding of dementia is not relevant to the admission. However early diagnosis in an acute setting will have an impact on the care and experience a patient receives.

Variation & Opportunity

LoS for the Top 3 Dementia Coded Primary Diagnosis (UTI, Pneumonia and #NOF) in >65 emergency admissions (FY 0910)



Provider	Total number of patients	No. of patients with a dementia coding	Avg LoS without dementia coding	Avg LoS with dementia coding
CRHFT	1495	408	16.05	19.38
DHFT	2443	576	14.68	17.67
KGHFT	1489	356	16.34	19.26
NGH	1101	303	21.61	23.16
NUH	3299	1007	12.62	13.98
SFHFT	1753	504	11.68	13.56
ULHT	2982	723	15.51	18.15
UHL	3765	880	13.20	15.57
East Midlands	18327	4757	15.21	17.59
National	228312	59644	15.71	18.03

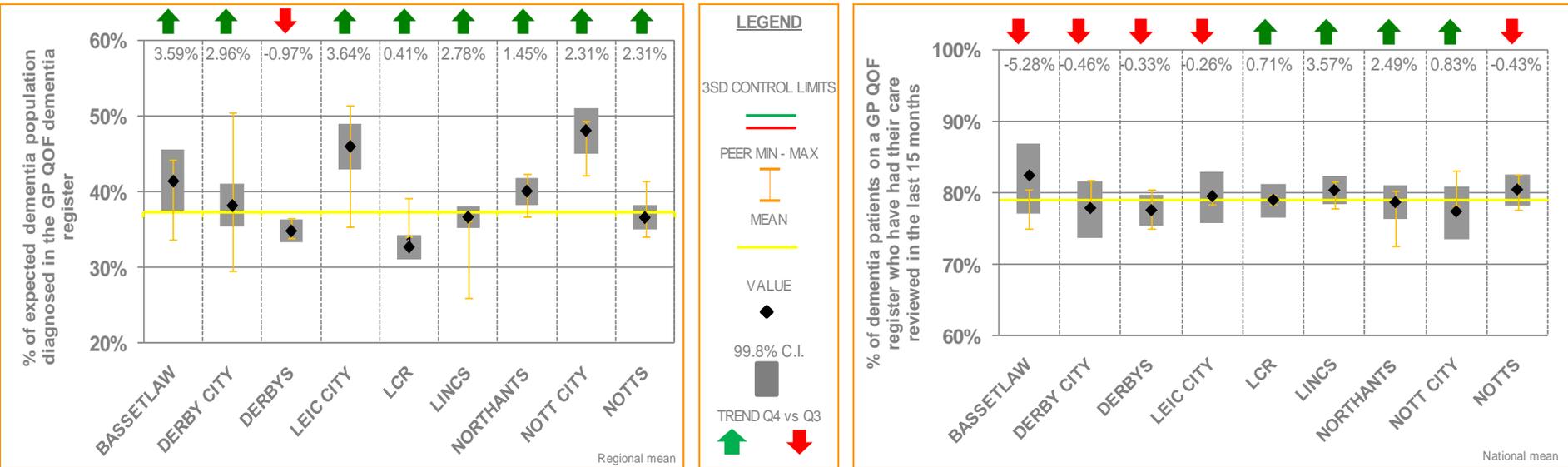
Narrative:

When comparing LoS for patients with and without dementia coding when they are admitted for UTI's, Pneumonia and #NOF most trusts are operating around the national averages. NGH have a significantly longer LoS in both scenarios which may require further investigation. NUH have a 1.36 day difference between the two cohorts of patients which could indicate good practice that could be shared across the region

Variation & Opportunity



QOF Indicators (2009/10)



Narrative:

All trusts within the region, with the exception of Derbyshire County, have seen an improvement in the diagnosis of dementia over expected prevalence in the last year. However with this in mind there is still wide variation between the trusts, 15.41% between the highest and lowest in the region. Looking at the peer analysis nearly all trusts are within their peer ranges, Lincolnshire are above their maximum peer range whilst LCR are below their minimum peer range.

There is less variation between the trusts in the care review measure. Bassetlaw have seen more of their dementia patients for a care review in the last year even with the largest decrease from the previous year. Derby City are below their peer minimum peer range for care reviews of their dementia patients.



Products achieved



The NHS East Midlands QIP/JIP workstream has:

Product	Status	Attachment
1. EMPHO East Midlands Dementia Profile, Mapping and analysis of current services, PDF in all localities (excludes Derbyshire) and action plans	complete	
2. Systems Dynamic modelling tool to support commissioning of dementia services (can be accessed by other regions also)	complete	
3. Case study service specifications for memory services	In progress	
4. Funded commissioning support across health and social care (Local Dementia Programme Leads)	Complete, report in progress	
5. Case study basic dementia training in care homes (all local authorities participating in project)	In progress	
6. Integrated workforce plans for dementia (excludes Lincolnshire)	In progress	
7. Acute hospital dementia coding guidance	In progress	
8. Acute hospital resource pack	In progress	
9. Accessible standards – Dementia charter	In progress	
10. Updated prescribing guidelines for use of anti psychotics, audit methodology, and behavioural management guidelines	In progress	
11. Social Care Metrics grid	In progress	
12. East Midlands compendium of good practice	complete	

Case study / good examples



Derbyshire County Council (working with NHS Derbyshire) opened the first of 8 planned community care centres in Staveley in 2010. The centre provides services to people with dementia. The centre aims to provide good quality person centred support and integrated community services that prevents individuals (or their carers) reaching crisis, needing hospital admission or anti psychotic medication. The centre offers residential beds, intermediate care beds, open access community facilities, and day opportunities. The centre is used by social care, health and the voluntary sector and the local community. The site is adjacent to a school thus providing opportunity for intergenerational work. A new memory assessment service provided by the mental health trust operates from the centre. The local authority will be evaluating outcomes of implementing the new model of care.

GPs in Gnosal Staffordshire have led the redesign of memory assessment services based on a pilot in primary care. For a list size of 7199 in 2006 (predicted prevalence dementia 60) rising to 8000 in 2009 savings identified against mental health and acute hospital admissions of £400,000 per year. Diagnosis rates have increased from 6 in 2006 to 38 in 2009 and it is expected that 80% of people will receive a diagnosis by 2013/14. Time from initial contact to diagnosis was 3 years in 2006 and was reduced to 4 weeks and in 2009. Only 2 people diagnosed with dementia were admitted to a hospital or care home in 2009. As a result of the pilot new care pathways and service specifications have been designed and the service has been re-tendered. The successful provider supporting GPs to deliver the new model is MAC UK Neurosciences.

Healthcare for London has produced a Dementia Services Guide that includes integrated care pathways, general hospital care pathways, and commissioning specifications for memory services.
www.healthcareforlondon.nhs.uk/assets/Mental-health/HealthcareforLondon_Dementia-services-guide.pdf



Securing the benefits



Securing the benefits

	Provider	Commissioner
Memory Assessment Redesign	Implement and optimal care pathway in line with NICE guidance for dementia that <ul style="list-style-type: none"> •maximises opportunity to increase capacity •Includes suite of evidenced based diagnostic tools •Includes evidence based protocols •Includes follow-up using the most cost effective system for 6 month review System in primary care to link QoF recording and diagnosis in provider organisations	Agree current activity and cost baseline for memory services and secure PBR clustering in order to differentiate dementia patients Develop outcome focused service specifications Develop a strategy to increase capacity in line with increasing prevalence rates e.g. through re-tender Agree system to ensure diagnosis is translated to QOF register
Improved quality in Acute care	Appoint a lead clinician, implement a dementia care pathway and protocols, compliance with NICE and RCP standards, analyse data on LoS and dementia versus non dementia patients. Use coding guidance for dementia to improve standardisation of coding	Understand acute sector costs and activity for dementia, % dementia patients versus non dementia, Los and relevant costs with and without complications. Benchmark between providers Compliance with Quality indicators: Optimal LoS, NICE Standards, RCP Organisation of Services Standards Ensure access to liaison and intermediate care/ reablement
Reduction in anti psychotics prescribed to people with dementia	Prescribers comply with prescribing guidelines Implement guidelines for managing challenging behaviour Mental health trust were contracted provide in-reach into care homes	Audit (use of low dose anti psychotics) Adopt prescribing guidelines Plan to reinvest savings into training and psychological interventions to manage challenging behaviour
Improved quality dementia care in care home	Identify dementia champion, implement a rolling training plan, Implement person centred planning including life story work Implement guidelines for managing challenging behaviour	Local authority commissioners specify quality standards for dementia in line with NICE standards (awareness training, person centred planning, management of challenging behaviour. leadership)



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Challenges



- The need for health and social care organisations to save money.
- Work stream focuses on improving quality & outcomes
- Initial costs required to maximise benefits (invest now, save in future)
- Need to implement all recommendations to maximise potential
- Benefits are not instant –takes time
- Costs and benefits do not fall equally across health and social care
- Obtaining credible data for measurable quality benefits and metrics, and to show variance
- Exposure to those with influence that have competing other priorities
- The rapidly increasing demand over coming years with anticipated doubling in need by 2030.

Summary & questions



To summarise:

- Early diagnosis and intervention reduces use of expensive hospital and care home services.
Agree baseline with MH Trusts scope capacity to redesign CMHTs and identify capacity to deliver new service specification for memory services and early intervention as part of SLA. Include dementia in reablement plans.
- Improved quality of care in nursing and care homes can help to reduce use of anti-psychotics and reduce admissions to hospital
Agreeing model to support nursing and care homes to improve dementia awareness and to manage challenging behaviour. E.g. access to NHS training monies/ modules and in-reach support from CMHTs
- Implementation of acute hospital Trust RCP guidance will reduce LoS
Ensure acute trust trusts Implement coding guidance and RCP quality standards
- Reduce use of anti psychotics by 2/3
Audit use of low dose anti psychotics and implement prescribing guidelines alongside improving access to specialist in-reach and training in the management of challenging behaviour in nursing and care homes

Questions to ask:

- Is there something you need between now and the end of March 2011?
- How can we sustain momentum post March 2011?
- What other information do you need?
- What will convince you to implement these objectives?