# Dementia Diagnosis Ambition—Learning from East of England CCGs

NHS
East of England
Strategic Clinical Networks

## Awareness

◊ Increased awareness with a Community Mobilisation Steering Group—raising profile of benefits of early diagnosis with a range of stakeholders to spread the word within the community to increase people coming forward

◊ With a range of stakeholders including Adult Social Care, MH Trust, Alzheimer's Society, District General Hospital and the general public during Dementia Awareness Week (DAW) (18th –24th May 2015)

## Communication

◊ Monthly system wide newsletter—two of which have been dedicated to dementia

◊ Monthly communication to practices outlining the CCG position and gap to diagnosis ambition

◊ Reminders to practices of the available tools (including Dementia Quality Toolkit and SUS Data)

◊ Regular communication with primary care

◊ Pack of useful information sent to practices (including Dementia Revealed, Brief Pragmatic Resource for GPs and a laminated guide to all dementia services in the area including post diagnostic support

## Care Homes

◊ Validation Scheme—Scoping of patients in care homes, diagnosis by trained dementia nurse, validation of diagnosis by clinician and updating practice register

◊ Care Home Enhanced Service

◊ Care home, memory clinic and associated third sector pathway

◊ GP diagnosis in care homes within their area

## Education / Training

◊ Dementia workshops through time to learn events with GPs

◊ Dementia talks at Local Clinical Group Meetings

◊ Talks to GPs from Dr Sunil Gupta on the benefits of early diagnosis

◊ Community dementia nurse training via Anglia Ruskin University to support severe diagnosis in memory clinics and care homes

◊ Dementia training for clinical and non clinical staff across the CCG

## Incentives/ Monitoring/ New Models

◊ Dementia Enhanced Service

◊ Care Home Enhanced Service

◊ Contract KPI with MH provider for 95% RTT within 6 weeks

◊ Close and consistent monitoring by the CCG

◊ Shared care protocol to support the diagnosis in primary care

◊ Computer system prompts for at risk patients

◊ Triangulate the list of patients with the LD provider and cross reference to QOF register

## Leadership

◊ Mental Health Clinical Lead drive and determination

◊ CCG board commitment

◊ Clinical leadership and engagement from CCG reinforcing the importance of timely diagnosis and the benefits for patients and carers

◊ Wider stakeholder support via the local health and social care economy and networks i.e. Dementia Strategy Group.

◊ Dedicated project worked within CCG to coordinate the approach

## Memory Assessment Service

◊ Commissioned increased capacity to ensure timely response to referrals

◊ Commissioned additional support from Alzheimer's Society in MAS clinics and GPs

◊ Focus on MAS redesign to improve variation in access and performance

◊ Partnership working and challenge with MH provider to ensure effective performance of MAS

## Targeted Support

◊ To facilitate the practices in updating their records and embedding robust processes

◊ For those practices without capacity to do the harmonisation work it was done by the CCGs Medicines Management Technicians and the records were reviewed by the practice.

◊ To a small group of practices with the greatest gap and lowest diagnosis rate—offering bespoke on site support from a dedicated clinician

◊ Providing support and advice direct to practices

◊ GP associate visited every practice to discuss the benefits and issues around dementia diagnosis