Dementia practice incentive scheme

Improving dementia awareness and appropriate early diagnosis

Agreement between NHS Bristol and insert Practice name

Background

It is estimated that there are about 560,000 people living with dementia in England, and because it is an age-related condition, this number is likely to increase to over 750,000 by 2020. Historically, dementia has suffered from poor awareness and understanding, combined with the stigmas attached to both mental illness and old age. Fear and ignorance of the disease are barriers to people approaching their GP about suspected dementia. Additionally a web forum and a GP survey conducted by the National Audit Office suggests that among GPs there is a perception that little can be done for dementia and that diagnosing and addressing the condition is not a high priority.

There is now plenty of evidence that making diagnosis earlier rather than later is valued by patients and their carers, and is cost effective. An early diagnosis can delay or prevent admission to a care home and improves quality of life for both patients and carers.[1,2,3] Improved accessed to support, is an opportunity to plan for the future and enables increased access to medicines that can improve the person's wellbeing.

Only about a third of people with dementia ever receive a formal diagnosis. Unfortunately the UK's performance on diagnosis is in the bottom third in Europe, below almost all northern and western European nations. Also the average reported time to diagnose the disease in the UK is up to twice as long as in some countries. Without diagnosis, no interventions or services can be offered.

The Quality and Outcomes Framework (QoF)

Dementia is already recognised in a modest way within the QoF, with practices receiving payments related to the size of their register and for performing a patient review. Here is a reminder of the main points of the dementia domain of the QoF, including the new DEM3 indicator:

Dementia (DEM) indicator 1

The practice can produce a register of patients diagnosed with dementia.

Rationale

A register is a pre-requisite for the organisation of good primary care for a particular patient group. There is little evidence to support screening for dementia and it is expected that the diagnosis will largely be recorded from correspondence when patients are 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 2

The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months.

Expectation

The face to face review should focus on support needs of the patient and their carer. In particular the review should address four key issues:

i. An appropriate physical and mental health review for the patient.

ii. 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.

iii. If applicable, the impact of caring on the care-giver.

iv. Communication and co-ordination arrangements with secondary care (if applicable).

DEM 4

The percentage of patients with a new diagnosis of dementia recorded between 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 6 months before or after entering on to the register.

Dementia Incentive Scheme - Aims

Through supplementing the QoF, the aims of this small incentive scheme are to raise the profile of dementia within Bristol GP practices, and to improve the diagnosis rates of dementia so that practice registers better reflect the true dementia prevalence. The incentive scheme is part of a broader programme to improve care for people with symptoms of dementia.

The Scheme – payment

We recognise there are factors beyond the control of practices that affect whether people with cognitive or behavioural symptoms present to their GP. However, within Bristol, dementia registers range from over 100% of expected prevalence to less than 10%, suggesting that there are things that can be done to improve the accuracy of their dementia registers (see attached). For example, patients who have dementia might in fact be coded as having a similar diagnosis such as confusion, memory problems or cognitive impairment. These patients could be then be reviewed and coded appropriately. Additionally, symptomatic patients might be opportunistically identified, investigated, diagnosed and coded.

Although dementia features in the QoF, NHS Bristol has identified a small extra sum to award practices in return for some additional effort in ensuring all appropriate people have a proper diagnosis coded in their record. Approximately five thousand pounds is available across Bristol to facilitate this. The payment for practices will be in proportion to the size of the practice list and will be shared between the practices that sign up for it.

By 1st November 2011 the commissioner, will advise practices of the amount to be awarded. Practices will be required to send an invoice to the commissioner for the appropriate amount for payment by 1st December 2011.

The Scheme – requirements

In order to be eligible for the incentive scheme and receive payment, the practice lead must:

1. a) Discuss the attached outline protocol within the practice team and then adapt it to produce a practice protocol relevant to the needs of the practice

   b) Conduct an appropriate audit of the practice dementia register *before and after* implementing the protocol

   c) Send through a copy of the implemented protocol and a very short summary detailing the audit steps and results.

   This will attract 70% of the incentive monies.

2. Achieve a practice prevalence that is at least 60% of the expected prevalence. **This will attract the remaining 30% of the incentive scheme monies.**

Practices will need to return the agreement to sign up to the incentive scheme by 1st June 2011.

Practice protocols and the associated audit will need to be received by NHS Bristol by 1st October 2011. Part 1 and Part 2 of the payment will be made on the basis of practice prevalence on 1st October 2011.

Parties to the agreement

1. The 'Provider' is.
2. The 'Commissioner' is Emma Moody

Terms of the agreement

3. This Incentive scheme will run until October 1st 2011.
4. Practices wishing to withdraw from this incentive scheme will need to do so in writing.
5. NHS Bristol may terminate this agreement by giving one month written notice to the Provider.
6. In the event of disagreement or dispute, NHS Bristol and the practice will use best endeavours to resolve the dispute without recourse to formal arbitration. If unsuccessful, the matter will be determined in accordance with the normal contractual dispute resolution procedure.
7. It is the contractor's responsibility to prove they have delivered the service.
8. Should there be insufficient sign up, NHS Bristol reserve the right to cancel the scheme.

References

1. Knapp et al. (2007) *Dementia UK: Report to the Alzheimer's Society*, Kings College London and London School of Economics and Political Science.

2. Banerjee S, Wittenberg R. Clinical and cost effectiveness of services for early diagnosis and intervention in dementia. International Journal of Geriatric Psychiatry. Volume 24, Issue 7, pages 748–754, July 2009

3. Report by the Comptroller and Auditor General. Improving Dementia Services in England – an Interim Report. HC 82 Session 2009–201014 January 2010

Practice sign up

Dementia incentive scheme 1st May 2011 – 30th September 2011

I confirm that this Practice wishes to sign up to the Dementia incentive scheme

Practice Name:

Practice Code:

Practice Signatory:

Individual Name:

Position:

Date:

E-mail address:

The NHS Bristol contact for this Agreement is, Emma Moody, Tel: (0117) 984 1512, E-mail: emma.moody@bristol.nhs.uk

Please note for contractual reasons we do require a signed hard copy of this page of the enhanced services agreement. Please sign and return to Emma Moody (details below) by 30th May 2011:

Emma Moody
Commissioning Manager for Older People
NHS Bristol
Marlborough Street
South Plaza
Bristol
BS1 3NX

Tel: (0117) 984 1512
Fax: (0117) 900 2690
e-mail: emma.moody@bristol.nhs.uk

Outline dementia diagnosis protocol[1]

Objectives

- Appropriate early recognition and diagnosis of signs/symptoms of possible dementia
- Achieve an accurate and complete register of patients with dementia using appropriate QoF recognised codes
- Enable GPs to code a patient with a diagnosis of dementia in clear-cut cases or following referral to a specialist memory clinic

History from patient and carer – include:

- Any history of confusion
- Reason for presentation and duration of problems
- Daily functioning and specific problems
- Rule out or treat depression (memory loss is a common presenting symptom of depression in the elderly)
- Identify any dangerous behaviour
- How does the carer perceive the problem and how are they coping?
- Establish whether the person has the capacity to make decisions about their care
- Review medication

Examination

- Exclude acute confusional state
- We recommend using the Mini-COG (1st choice) or GPCOG as both are quick and well validated in primary care. However, GPs should continue to use other tools if they feel comfortable with them. See: http://www.cks.nhs.uk/home
- PHQ-9 if applicable

Investigations

- U&Es, LFTs, TFTs, FBC, random glucose, calcium, B12, Folate
- Consider MSU if acute confusion and others such as CXR or ECG if relevant
- CT head (either via specialist or direct access)

Consider referral

- Memory clinic – esp. if cholinesterase inhibitors may be indicated or diagnosis unclear
- Community Nurse for Older People
- Community Matron
- Health visitor for older people
- Community Mental Health Team for patients at risk or need complex care needs
- Day hospital for complex physical needs.
- Social services/Care direct
- Alzheimer's Society http://alzheimers.org.uk/site/custom_scripts/branch.php?branch=true&branchCode=14519

Coding

See the full list of acceptable codes attached, but suggest using:

"Uncomplicated Senile Dementia"	E000
"Alzheimer's disease unspecified"	Eu00z
"Multi-infarct dem'"	Eu011
"Alzheim' disease"	F110
"Lewy body dementia"	F116

[1] This outline protocol provides only basic information and it is recommended that it is supplemented with more detail from the NICE dementia guideline and other sources together with practice-specific information to make a workable document created and owned by the wider practice team.

Mini-Cog Assessment Instrument

1. To administer the Mini-Cog Assessment Instrument

Explain to the person that they should listen carefully to and remember three unrelated words. The three words are then spoken to them, and the person is asked to repeat the words.

Ask the person to mark, on a circle, the hours of a clock then draw the minute and hour hands to show 11:10.

Ask the person to repeat again the three words that they were given at the start.

2. To interpret the Mini-Cog Assessment Instrument

Give 1 point for each word the person correctly remembers after the clock drawing test. Consider the clock drawing test to be normal if all numbers are present in the correct sequence and position, and the hands display the requested time.

- Interpret a score of zero as suggestive of dementia.
- Interpret scores of 1 or 2 with *abnormal* clock drawing test as suggestive of dementia.
- Interpret scores of 1 or 2 with *normal* clock drawing test as a negative screen for dementia.
- Interpret a score of 3 as a negative screen for dementia.

Identifying patients who may have dementia but are not recorded on the register

- Screen care home population to identify individuals who may have dementia and are not on the QoF register
- Cross-check register with suggestions from members of the community team
- Review the learning disability register. Learning disability masks the early signs of dementia and virtually all people with Down's syndrome develop the plaques and tangles in the brain associated with Alzheimer's disease
- Review the Parkinsons disease register. Almost everybody with PD will eventually suffer from a degree of dementia.
- Actively ask patients or their carers about their memory within the consultation if you or your reception team suspect any cognitive impairment, and then follow it up
- Consider older patients with hospital admissions, falls and UTIs
- Review elderly people with a diagnosis of depression – it could be early dementia
- Search for people on cholinesterase inhibitors and no dementia diagnosis
- Review people with other cognitive impairment or confusion codes. See the full list attached for a full audit, but those most commonly used are:

2232	O/E - mentally confused
2232.11	O/E - confused
2841	Confused
2841.11	Confusion
E030.00	Acute confusional state
E030.11	Delirium - acute organic
1B1A.00	Memory loss - amnesia
1B1A.11	Amnesia symptom
1B1A.12	Memory loss symptom
1B1A.13	Memory disturbance

QoF acceptable dementia register codes:

Eu02.%
E00..%
Eu01.%
E02y1
E012.%
Eu00.%
E041.
Eu041
F110. – F112.
F116.

Full list of codes that may hide potential dementia patients

Memory-based

Readcode	Description
1B1A.00	Memory loss - amnesia
1B1A.11	Amnesia symptom
1B1A.12	Memory loss symptom
1B1A.13	Memory disturbance
1B1A000	Temporary loss of memory
1B1Y.00	Poor visual sequential memory
1B1a.00	Poor auditory sequential memory
28G..00	Forgetful
8BIk.00	Patient forgets to take medication
E2A1000	Mild memory disturbance
E2A1100	Organic memory impairment
R00z011	[D]Memory deficit
Z7CA100	Isolated memory skills
Z7CE400	Memory disturbance (& amnesia (& symptom))
Z7CE411	Amnesia symptom
Z7CE412	Memory loss symptom
Z7CE413	Memory loss - amnesia
Z7CE414	Memory disturbance
Z7CE415	Loss of memory
Z7CE500	Forgetful
Z7CE600	Amnesia
Z7CE611	Memory loss
Z7CE612	Memory gone
Z7CE613	Dysmnesia
Z7CE614	Memory loss - amnesia
Z7CE615	Loss of memory
Z7CE616	LOM - Loss of memory
Z7CEA00	Impairment of registration
Z7CEA11	Impairment of working memory
Z7CEA12	Impairment of immediate recall
Z7CEA13	Impairment of primary memory
Z7CEB00	Amnesia for remote events
Z7CEB11	Loss of memory for remote events
Z7CEB12	Poor memory for remote events
Z7CEC00	Amnesia for recent events
Z7CEC11	Loss of memory for recent events
Z7CEC12	No memory for recent events
Z7CED00	Amnesia for day to day facts
Z7CEE00	Amnesia for important personal information
Z7CEF00	Temporary loss of memory

Z7CEG00	Transient memory loss
Z7CEH00	Memory impairment
Z7CEH11	Memory dysfunction
Z7CEH12	Memory deficit
Z7CEH13	Bad memory
Z7CEH14	Memory problem
Z7CEH15	Poor memory
Z7CEI00	Mixes past with present
Z7CEJ00	Memory lapses
Z7CEK00	Minor memory lapses
Z7CEL00	Mild memory disturbance
Z7CEM00	Distortion of memory
Z7CEN00	Confabulation
Z7CEN11	Invents experiences to compensate for loss of memory
Z7CEO00	Momentary confabulation
Z7CEP00	Fantastical confabulation
Z7CF800	Poor short-term memory
Z7CF811	Short-term memory loss
Z7CFF00	Forgets what was going to do
Z7CFG00	Forgets what was going to say
Z7CFH00	Forgets recent activities
Z7CFI00	Forgets what has just done
Z7CFJ00	Forgets what has just said
Z7CFK00	Forgets what has just read
Z7CFL00	Forgets what has just seen
Z7CFM00	Forgets what has just heard
Z7CFO00	Poor long-term memory
Z7CFO11	Long-term memory loss
Z7CFw00	Memory aided by use of diary
Z7CFx00	Memory aided by use of labels
Z7CFz00	Memory aided by use of lists

Confusion-based

Readcode	Description
2232	O/E - Mentally confused
2232.11	O/E - confused
2841	Confused
2841.11	Confusion
E030.00	Acute confusional state
E030.11	Delirium - acute organic
E030.12	Toxic confusional state
E030100	Acute confusional state, of infective origin
E030200	Acute confusional state, of endocrine origin
E030300	Acute confusional state, of metabolic origin
E030400	Acute confusional state, of cerebrovascular origin
E030z00	Acute confusional state NOS
E031.00	Subacute confusional state
E031.11	Delirium - subacute organic
E031000	Subacute confusional state, post traumatic
E031100	Subacute confusional state, of infective origin
E031200	Subacute confusional state, of endocrine origin
E031300	Subacute confusional state, of metabolic origin
E031400	Subacute confusional state, of cerebrovascular origin
E031z00	Subacute confusional state NOS
E042.00	Chronic confusional state
E132.00	Reactive confusion
Eu04.00	[X]Delirium, not induced by alcohol+other psychoactive

	substance
Eu04.11	[X]Acute / subacute brain syndrome
Eu04.12	[X]Acute / subacute confusional state, nonalcoholic
Eu04.13	[X]Acute / subacute infective psychosis
Eu04.14	[X]Acute / subacute organic reaction
Eu04.15	[X]Acute / subacute psycho-organic reaction
Eu04y00	[X]Other delirium
Eu04y11	[X]Delirium of mixed origin
Eu04z00	[X]Delirium, unspecified
Eu44y13	[X]Psychogenic confusion
R009.00	[D]Confusion
R009.11	[D] Senile confusion
R009000	[D]Toxic confusional state
R00zX00	[D]Disorientation, unspecified
Ryu5700	[X]Disorientation, unspecified
Z7CC300	Disorientated
Z7CC311	Orientation confused
Z7CC312	Orientation poor
Z7CC400	Disorientated in time
Z7CC500	Disorientated in place
Z7CC600	Disorientation for person
Z7CC611	Disorientated in person