NHS Cornwall and Isles of Scilly:
Future plans to accelerate dementia diagnosis and time frames:
2012/13

Item	Summary	Expected Outcomes	Timescale
Care Home Dementia Conference	A conference delivered by Dementia Care Matters- 100 care home owners and managers and Directors and Service Improvement teams attended from the Local Authority and PCT.	To raise the profile of dementia in the county and to engage with top level staff in care homes to ensure collaboration with the Dementia Link Workers ensuring a commitment towards person centeredness, proactive detection and diagnosis of dementia care. Increased dementia detection and diagnosis.	Completed
GP training	Consultant Psychiatrist and Clinical Dementia Lead to visit each GP practice to lead education and training on the ethics of early diagnosis, local services and current and future commissioning plans. New primary care pathways, e learning and educational tools around diagnosis and end of life care. Reminder mouse mats distributed with read code reminders, links to the GP portal web site and service directory information Primary care engagement event May 2011 STAR medications in Dementia Training June 2011 GP Dementia Portal site to be launched July 2011 Visits to GP Locality Groups by Commissioner,	GPs will feel more competent and confident to diagnose. GPs will feel more confident in local services and have an improved whole systems approach. Increased dementia detection and diagnosis.	January 11- Dec 12

	Clinical Lead from PCT and Secondary Care Service Lead Summer 2012		
Community Dementia Link Worker Programme	Led by Clinical Dementia Lead in conjunction with support from specialist clinical teams; countywide sustainable peer support and educational network. This will include the provision of a Dementia Resource Toolkit, e learning, face to face teaching and quarterly support forums. 60 individuals from hospital wards and community teams have been identified as Dementia Link Workers.	Community staff in all wards and community teams will have a greater awareness and understanding of dementia and the importance of detection, identification and diagnosis. Staff will be informed and empowered to initiate and support the process of diagnosis within their locality teams. Increased dementia detection and diagnosis.	Ongoing
Care Home Dementia Link Worker Programme	Led by Clinical Dementia Lead in conjunction with support from specialist clinical teams; countywide sustainable peer support and educational network within care homes. This will include the provision of a Dementia Resource Toolkit, e learning, face to face teaching and quarterly Dementia Provider Forums. 30-40 individuals from care homes have been identified as Dementia Link Workers. Launch of AMP toolkit: (Assess Monitor Prevent) to support care home staff to identify and understand physical health needs that may impact adversely on symptoms of dementia.	Community staff in care homes will have a greater awareness and understanding of dementia and the importance of detection, identification and diagnosis. Staff will be informed and empowered to initiate and support the process of diagnosis within their locality teams. Increased dementia detection and diagnosis.	Ongoing
Community Dementia Liaison Nurses: targeted care home intervention	Targeting of Community Dementia Liaison Service (Cornwall Partnership Foundation Trust) to provide in reach support to all community hospitals and care homes with dementia registered beds across the county.	Dementia Liaison Nurses will be detecting those in care homes without a formal dementia diagnosis and the staff will work closely with	Ongoing

	Focussed work from 2012: -ongoing reconciliation of all community team dementia registers with GP QOF registers -completion of annual health checks for those individuals in care homes -embed toolkits: AMP (Assess Monitor Prevent)- detection, management of physical health needs and STAR (Stop Think Assess Review) multi-agency training and toolkits to reduce prescribing of anti-psychotic medications -embed Dementia End of Life pathway Care Homes to be targeted 12/13: East Locality and top 20 highest admitting care homes	primary care and the Memory Assessment service to Increased dementia detection and diagnosis. Increased percentage of annual health checks in care homes being completed. Reduce un-scheduled admissions Increase capacity and competency in care homes Improve communication across primary/secondary care and between care homes	
Specialist Psychiatric Liaison services with Acute Hospital	Developing current specification psychiatric liaison service to develop specialist input to Acute Hospital Trust. Clinical Lead to deliver management and clinical support across the Community Dementia Liaison service and the Acute Hospital Trust. The role includes assessment, diagnosis and management recommendations within acute hospital Support implementation of National CQUIN and multi-disciplinary training Development of RAID model (Rapid Assessment Interface Discharge)	Increased detection and early management within the acute hospital setting. Facilitating timely discharge through working closely with all community services. Supporting the development of education programmes through Dementia Action group Develop a clear pathway between acute and community	Ongoing
Implementing, sustaining and embedding new Primary Care Practitioner Service	Workshops with Mental Health Provider, Cornwall Partnership Foundation Trust to establish service re-design. New pathways, training packages, service interface designed to support new service. Commissioner-Provider joint meetings to locality	Improve primary-secondary care interface and communication. Increase rates of primary care detection and diagnosis of	Recruitment Aug-Sept 12. Service operational

	commissioning groups to ensure sign up to service and involvement in model design and implementation.	dementia. Improve consistency and quality of continuous post diagnostic care Increased capacity and competency at primary care	Dec-Jan-13
Trial of new models of practice based dementia care: 1. Memory nurse dedicated to one GP practice 2. Memory support worker dedicated to one GP practice 3. Mental health provider specialist dementia staff based in primary care across four practises	1. One practice with an expected prevalence of 80 people with dementia has a part time memory nurse who takes responsibility for the full holistic care of all individuals with dementia. This post includes case finding. 2. Memory support worker who supports the individuals with low level interventions and holistic model of care and community signposting and re-integration. This post includes case finding. 3. Development of practice based practitioners from mental health provider within GP practices and local community hospitals. Local Consultant Psychiatrist input to both and the development of locally based Memory Assessments and treatment interventions	Continued learning alongside the Newquay ICP to ensure the most relevant dementia care model based around GP practices. This will increase the numbers of people on QOF registers, will raise the profile of dementia care in primary care and will improve the individual's experience. Develop skills within primary care setting and confidence in managing individual's needs. Will respond to the needs of the local population Create a pull from Community hospitals using case management model	Evaluation completed
Quarterly audits of diagnosis rates per GP practice and Memory Assessment Service	Quarterly reports of expected and actual diagnosis rates and completion of annual health checks per practice sent to each practice and locality managers with RAG rating.	This process will raise the profile of dementia diagnosis for GPs and will provide some countywide comparative data to	Ongoing each quarter

	Letters included with revised recommended read code letter and tips for diagnosis/reconciling registers etc. Locality visits by commissioner to up-date on local services/ developments etc	ensure some gentle competitiveness. It will support the increase of QOF diagnosis and use of the memory assessment service.	
Continued dissemination of key messages and new services to engage with public and professionals around de-stigmatisation	Bi-monthly Dementia Newsletter disseminated to a wide range of colleagues in the statutory, independent and voluntary market. Regular up-dates and up to date service information on local NHS and Council web sites including a new NHS self care web site. Monthly positive press releases. Radio interviews and 'phone ins' on a quarterly basis. Quarterly provider forums. Regular reporting slots at Older People's Forums, Joint Older People's Partnership Boards, Overview and Scrutiny Committee meetings. Ongoing professional training as outlined above. Poster campaign in 100 local buses for 3 months promoting a positive message about aphasia and signposting people to help. New Dementia Help line. Dissemination of refreshed Dementia Directory of Services leaflet Annual community pharmacy awareness raising campaign	By decreasing public and professional stigmatisation and lack of understanding of dementia people can be encouraged to seek help earlier and to detect signs and symptoms in themselves, their friends, their neighbours and patients. As dementia is mainstreamed and becomes 'everybody's business' people will become more informed and confident to seek help and ensure that more people are diagnosed earlier. Increased dementia detection and diagnosis.	Ongoing
Expansion of more community interventions: • Cognitive Stimulation	Increased community activities to ensure people are given choices of intervention to participate in to increase and enhance their sense of well being and independence. GPs have informed us that they have difficulties diagnosing people unless they feel there	GPs will have more confidence in feeling content to diagnose the knowledge that there are community support options to sign people in to.	Ongoing

Therapy • Activity group for younger people with dementia • Arts for Health Creativity in Care project/Reading Allowed groups • Peer led network: memory cafes • Books on Prescription planned	are community activities that will support people with dementia and their carers. Regular dissemination on locality basis of opportunities.	Increased dementia detection and diagnosis. People living with dementia and their carers have more choice to engage in community activities and well being enhanced.	
Comprehensive and specialist MAS	Countywide specialist Memory assessment Service provided by community mental health provider which comprises multi disciplinary team assessments in 22 locations across the county. It has open access and individuals can self refer. It offers a comprehensive specialist assessment, ensuring an accurate diagnosis and pre and post diagnostic counselling. The service has been fully operational since January 2010 and its performance is being measured on a monthly basis. MAS Audit completed May 2011 and Peer Review completed Feb-12. Action Plan developed and shared with Dementia Steering Group Caradon MAS accredited as 'excellent' by MSNAP and to be used as benchmark for other Quarterly GP QOF reports circulated to locality	Increased numbers of people will receive their diagnosis of dementia in an appropriate way whilst under going a standardised process for comprehensive assessment and diagnosis. The assessment service includes strong elements of supportive 'breaking of diagnosis' and of offering individualised information and advice packs. Increased dementia detection and diagnosis. Closer working relationships between Primary care and secondary care with dedicated	Ongoing

	clinics. Development of move towards in-reach support to primary care. Monthly activity reports received at Contract Review Meetings.	Memory practitioners from secondary care linking with specifies surgeries increasing confidence in diagnosing and supporting management of individuals post diagnosis.	
Overview of progress by Dementia Programme Steering Group	Maintains an overview of the progress of implementing local work streams. Involves commissioners, providers and patient user representatives. Trajectory set for expected monthly increases in dementia diagnosis to monitor performance against.	Bi-monthly monitoring of diagnosis rates and completion of annual health checks and performance and development of services and new initiatives within a whole system context.	Bi-monthly
STAR (Stop Think Assess and Review) Medications in Dementia Campaign	A multi-agency educational package supporting detection of people with dementia and a medications review to ensure appropriate prescribing of anti-psychotic medications. Joint GP/Pharmacy care home medication review visits including up-dating of QOF Dementia Registers.	Increased dementia awareness. Increased consideration of person-centred care. Increased dementia detection and diagnosis.	September and ongoing
QIPP programmes	Dementia QIPP prescriptions feed into both the Long Term Conditions and Mental Health QIPP group.	Increased dementia awareness. Increased profile of dementia care. Increased understanding of importance of whole system approach to dementia care. Increased dementia detection and diagnosis.	Ongoing
Implementing National Diagnosis CQUIN	Re-design of Maxims system to capture data. Support ward Dementia Link Workers to undertake	Improved detection and diagnosis at secondary care	Ongoing

	audits at ward level Review data sharing relationship between GPs and secondary care. Training of staff to understand pathway for CQUINs and to establish processes to build in to admissions clerking in proforma.	level. Improved understanding and awareness of dementia in hospital. Improved communication of presence of confirmed diagnosis across the hospital and to GPs.	

Brief Overview: Improving Diagnosis of Dementia

Interventions
Monitoring, Performance, Contracts
Quarterly audit: rates of diagnosis of both primary and secondary care by practice
Monthly monitoring and reporting of Dementia QOF registers
Monthly monitoring and reporting of QOF health checks
Quarterly RAG rating of GP practices diagnosis rate and dissemination to all practices
Monthly monitoring of secondary care memory assessment activity
Monitoring QMAS data
Trajectory used to reach 50% diagnosis by Mar-2013
Development and implementation of KPIs with secondary care linked to outcomes: present for all dementia service lines: acute and community liaison, memory assessment services, community mental health services.
Audits completed and/or in place: review of case list of Community Matrons to cross reference with GP QOF registers, MAS audit, community nurse liaison audit.
Activity collected on a monthly basis from secondary care
Incentives

CQUINs set for Diagnosis in Hospital, staff training, Rapid Assessment Interface Discharge model and implementation of primary care facing anticipatory case management service.
Needs Assessment, Capacity Planning
JSNA, capacity planning and widespread consultation informed CIOS original Dementia Commissioning Plan. This years JSNA is being produced and joint capacity planning and refresh of local Dementia Strategy is completed with PCT and the Council.
Community Matrons use risk stratification tool PARR (Predicting and Reducing Re-admission) to Hospital. Plans in place for secondary care to utilise.
Plans to use Commissioning Toolkit in place.
Commissioning specification, pathways
MAS specification refreshed, up-dated and implemented.
New dementia specifications created in partnership with secondary care including new outcome measures
New pathways and guidelines created for acute hospital, GPs for dementia and MCI
Case finding
Case finding in care homes and in some GP practices with memory support workers and improved identification of people with dementia in acute hospital- use of dementia stickers
Engagement with GPs, Practices
GP referring protocol, guidelines, toolkits
GP training, education, engagement sessions
GP portal development
Training, Education and Awareness Raising
Training needs analyses completed: of Dementia Link Workers, of health and social care staff, of care home staff

Re-designed training pathways across the sector: e learning, classroom, dementia link worker programme in care homes/community teams/community hospitals and acute trust
Awareness raising initiatives for the public (posters, media, bus campaign, community pharmacy campaign) and professionals (conferences, newsletters)
Information packs/ Directory of Service leaflet for people with dementia and carers
Information DVDs eg on memory cafes on the web, You tube, dedicated web pages for dementia on Council and PCT pages
Services-New ways of working
Expansion of countywide dementia liaison service in all dementia registered care homes
Countywide network of memory cafes, cognitive stimulation therapy groups
Joint GP/pharmacy medications reviews in care homes
Practice based memory nurses and memory support workers
Specialist MAS
Integrated health and social care teams launched: Early Intervention Service
Supportive carer information sessions
Adult placements for people with dementia
Completion of integrated care pilot
Leadership
Some practice GP Leads
PCT Clinical Lead
Acute Trust dementia lead
Clinical lead in MAS and information in secondary care
Dementia metrics reported to PCT Board and Acute Trust Board
Non Exec and Exec Directors as Dementia Leads
Council/PCT Joint Dementia Programme Manager