

Committee Date: 13 June 2012

Agenda Item No: 11

**Dementia Care in Stockport in 2012/13**

<b>Summary:</b>	This paper outlines the actions regarding the allocated recurrent dementia care monies (£250K) and provides a brief update on the developments in dementia care in Stockport since our local strategy was launched.
<b>Link to Annual Business Plan:</b>	Proposed actions link to the SCCG's Clear and Credible Strategic Plan (supporting objective Long term conditions & Older people with complex needs)
<b>Action Required:</b>	To endorse: <ul style="list-style-type: none"> <li>implementing GP LES to improve outcomes on identification, diagnosis and support for patients with dementia and their carers in primary care</li> <li>increasing capacity for Pennine Care Dementia Treatment Clinic to support locality based working</li> </ul> To note developments in dementia care in Stockport as part of local dementia strategy.
<b>Potential Conflict of Interests</b>	GP members should be aware of conflicts of loyalty and potential conflicts of pecuniary interest in considering the GP LES.
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<b>Committees / Groups Consulted:</b>	This paper has been developed in partnership with Pennine Care Mental Health Foundation Trust

**Compliance Checklist:**

Documentation		Statutory and Local Policy Requirement	
All sections above completed	✓	Change in Financial Spend: Finance Section below completed	to follow
Page numbers	✓	Service Changes: Public Consultation Completed and Reported in Document	✓ as part of dementia strategy
Paragraph numbers in place	✓	Service Changes: Approved Equality Impact Assessment Included as Appendix	
2 Page Executive summary in place (Docs 6 pages or more in length)	✓	Patient Level Data Impacted: Privacy Impact Assessment included as Appendix	N/A
All text single space Arial 12. Headings Arial Bold 12 or above, no underlining	✓	Change in Service Supplier: Procurement & Tendering Rationale approved and Included	N/A
		Any form of change: Risk Assessment Completed and included	N/A
		Any impact on staff: Consultation and EIA undertaken and demonstrable in document	N/A

## Contents

<b>1</b>	<b>Executive Summary</b>	<b>Page</b>	<b>2</b>
<b>2</b>	<b>Plans regarding dementia care 12/13</b>	<b>Page</b>	<b>3</b>
<b>3</b>	<b>Appendix 1: Draft GP LES 12/13 – including shared care protocol</b>	<b>Page</b>	<b>13</b>
<b>4</b>	<b>Appendix 2: Overview of actions undertaken as part of the Dementia Strategy Implementation Plan</b>	<b>Page</b>	<b>25</b>

### 1. Executive Summary

1.1 Improving dementia care has been a national, regional and local priority since the national dementia strategy was published in 2009 followed by our local strategy in 2010.

1.2 Through local engagement and an equality impact assessment, the SCCG has recognised the need for investments in dementia care in Stockport to support the implementation of a shared care protocol between primary care and secondary care and to ensure that capacity will meet current and future demand.

1.3 This paper presents a Local Enhanced Service for GPs to assist GP practices to put the right structures and training in place to implement a local dementia shared care protocol in primary care.

1.4 This document also recommends the implementation of 2 wte dementia specialist link nurses, extra hours for the neuropsychologist and 0.5 wte OT to ensure the dementia assessment and treatment clinic will meet current and future demand. In addition, it is suggested to appoint a dementia support worker (Alzheimer's society) who will work alongside GPs to provide post-diagnostic information, advice and support to patients and their carers. This post will first be piloted with money that has been allocated to Stockport for post-diagnostic dementia support. When successful the post will become recurrent and funded through the SCCG's allocated dementia care monies.

1.5 The additional capacity for dementia care, together with the roll out of the GP LES, will contribute to the implementation of a locality model for dementia care. Central in this locality model are the close links between primary care, the 4 dementia specialist link nurses from Pennine Care Mental Health Foundation Trust and the Alzheimer's Society's post-diagnostic support worker. It is envisaged that this model will contribute to integrated and seamless care for people with dementia and their carers in the community from diagnosis till end of life.

1.6 The document finishes with a brief overview of achievements in dementia care since the launch of the local dementia strategy.

## Investments & expenditure summary:

SOURCE OF FUNDING	R/NR	2012/2013	2013/2014	2014/2015
Recurrent investment dementia care from 12/13 onwards	R	250,000	250,000	250,000
DH Health & Social Care post-diagnostic support allocation *	NR	28,500	28,500	
Greater Manchester End of Life Demonstrator site project	NR	15,400		
<b>Total</b>		<b>293,900</b>	<b>278,500</b>	<b>250,000</b>
<b>EXPENDITURE OUTLINE</b>				
		<b>2012/2013</b>	<b>2013/2014</b>	<b>2014/2015</b>
GP LES 12/13 - one off payment 52 practices	NR	52,000		
GP LES 12/13 - review payments - max of 2044 reviews	NR	61,320		
GP LES 13/14 - vascular dementia and reviews	NR		80,000	
GP dementia care in primary care investments	NR			60,000
Training including development of training DVD & lead GP meetings	NR	10,000	5,000	
Patient Information Packages & directory of services website	NR	7,500	3,000	500
Supervision Dementia support worker, development of vascular dementia toolkit, development 'move-on' support group ****	NR	10,000		
Dementia End of Life Demonstrator project (GM Cluster)	NR	15,400		
Optional: personalised care pilot in care homes	NR	30,000		
<b>Sub-total Non-recurrent</b>		<b>186,220</b>	<b>88,000</b>	<b>60,500</b>
2 wte Pennine Care dementia link nurses (band 6 and band 7) **	R	62,500	93,750	93,750
Pennine Care neuro psychologist ***	R	10,780	32,340	32,340
Pennine Care occupational therapist (0.5 band 6)	R		20,850	20,850
0.8 wte Support worker Alzheimer's Society for GP practices ****	R	23,520	35,250	35,250
<b>Sub-total recurrent</b>		<b>96,800</b>	<b>182,190</b>	<b>182,190</b>
<b>TOTAL EXPENDITURE</b>		<b>283,020</b>	<b>270,190</b>	<b>242,690</b>

R = recurrent  
NR = non-recurrent

\* part of the budget will be rolled over to 13/14

\*\* 8 months in 12/13; 12 months in 13/14 & 14/15

\*\*\* 8 months in 12/13 for 7.5 hrs a week; 12 months in 13/14 & 14/15 for 15 hrs a week

\*\*\*\* paid through Health and Social care post diagnostic funds from 1 August 2012 until 1 December 2013

## SCCG briefing paper Dementia Care 12/13 - May 2012 v2.0

### 1. Aim

1.1 This paper aims to provide an update for the board on the developments regarding dementia care in Stockport and to explain the plans for the allocated recurrent dementia care monies (£250K) from 12/13 onwards as part of the implementation of Stockport's Joint Commissioning Strategy for Dementia Care.

### 2. Local dementia strategy

2.1 In July 2010 we launched our local joint dementia strategy, signed off by NHS Stockport and Stockport Metropolitan Borough Council. This strategy was developed through a multi-agency approach including involvement from service users and carers.

#### *Rationale*

- Dementia is the loss - usually gradual - of mental abilities such as thinking, remembering, and reasoning. The most common dementia symptoms include loss of memory, confusion and changes in personality, mood and behaviour.
- Dementia usually affects older people and becomes more common with age. About 6 in 100 of those over the age of 65 will develop some degree of dementia, increasing to about 20 in 100 of those over the age of 85.
- Although most of the people who develop dementia are over the age of 60, it's important to remember that dementia is not a normal part of growing older, and that most of the older people never will develop dementia.
- Given the aging nature of Stockport's population we can expect the numbers of people with dementia to rise.
- The updated JSNA analysis showed that Stockport GP practices have currently 1844 people with dementia registered (local QOF data, April 2012).
- The King's Fund and London School for Economics, on behalf of Alzheimer's Society, suggest that there are around 3,794 people in Stockport with the condition, including around 100 people with young onset dementia (report 2011).
- This means that currently only 49% of the people with dementia are registered on the GP dementia register (national average is 40%).
- Early diagnosis and interventions can deliver better outcomes for people with dementia and their carers, and save money.

2.2 Stockport's local dementia strategy supports the 4 key quality outcomes set by the Department of Health:

- good-quality early diagnosis and intervention for all;
- improved quality of care in general hospitals;
- living well with dementia in care homes; and
- reduced use of antipsychotic medication (reduction with two thirds).

2.3 Our local strategy also has plans included for improved carers' support, raising dementia awareness and tackling discrimination and stigma related to dementia, implementing quality end of life care for people with dementia, increased access to telecare solutions to support people remaining their

independence at home and the implementation of tailored services specifically focussing on the needs of people with young onset dementia, people with dementia and learning disabilities and people with dementia and Parkinson's disease. In appendix 3 a brief overview is presented on the actions undertaken so far.

### **3. Important role to play for primary care in dementia care**

3.1 For the majority of people, the first opportunity for individuals or their families to raise concerns about changes in memory or behaviour is within primary care. In the majority of cases, this is triggered through a discussion for example with General Practitioners, Practice Nurses, District Nurses, Care workers and Social Workers. Supported by national and local awareness raising campaigns, people are encouraged to express their concerns at an early stage. However, this is also at a stage that making a diagnosis could be more challenging.

3.2 GPs have a crucial role in ensuring that early concerns are detected and responded to, and not misattributed to the symptoms of old age, and that the needs of younger people with dementia are addressed.

3.3 The GP-practice does not only play a key role in the diagnostic process, the practice also has an important role to play in following the person with dementia and their carers through the different stages of dementia to ensure all support is available for the patient's ongoing management of health and well-being.

Dementia is a medical disorder and should be managed like any other serious long-term illness, including regular monitoring, conducting health checks (for the person with dementia and their carers), ensuring people with dementia attend screening programs, advising on preventive actions and contingency planning and signposting people to local information, advice & support services.

3.4 The local strategy appreciates that GP-practices can't deliver dementia care in isolation. The strategy therefore builds on good local practice to support people with dementia and their carers all the way through alongside the care provided by their GP-practice. Good local examples of existing quality services are the highly valued training for informal carers delivered by Stockport Dementia Care Training, the variety of peer support networks (dementia cafes, singing group, walk & talk groups) developed by the Alzheimer's Society and Age UK Stockport, the variety of telecare opportunities that is available, trained personal assistants commissioned through personal budgets, staff at hospital wards trained in delivering care to people with dementia, the implementation of a young onset support worker's post, the reviewed and redesigned day services and carers' break facilities (Age UK Stockport and ISKK) and the support offered by Signpost for Carers. All examples that Stockport offers some very good services delivered through partnership working between primary care, secondary care, social care and third sector organisations which assist people with dementia and their carers to live healthily and well in the community by making the best use of limited resources.

## 4. Shared Care Protocol: GPs and Secondary Care

4.1 A shared care protocol has been developed to clarify the role of primary and secondary care in assessment, diagnosis, medication (initiation, maintenance and decision making around discontinuation of medication), follow on care and end of life care.

4.2 New for most GP practices will be conducting medication reviews for patients stable on dementia medication. This proposed way of working meets NICE guidance as long as it is part of a shared care protocol and structures are in place for fast track referrals back to Pennine Care in case of any doubts, side effects or deterioration for which the GPs require specialist input from secondary care.

4.3 It is envisaged that yearly about 150 Stockport patients will be stable on dementia drugs and fit for discharge to GP practices for medication reviews as part of this shared care protocol. This part of the pathway has caused some concerns with the LMC especially regarding the extra workload this may cause. However, several GP practices have already adopted the draft shared protocol and feel confident in managing medication reviews in primary care.

4.4 The current situation is that GP practices differ in the level of dementia care provision which could lead to inequalities in care across the borough. Therefore a GP LES has been developed as an incentive for a more structural implementation of the protocol to ensure that all GP practices will agree to work towards the shared care pathway from July 2012 onwards. This will ensure that every dementia patient will receive the same level of care across Stockport and it will also free up capacity in secondary care to enable Pennine Care to concentrate on the more complex and specialist patients and improve the delivery of more complex dementia care in the community and in care homes.

## 5. GP LES 12/13 Dementia Care

### Background

5.1 The LMC has expressed their concerns about the increase of workload for GPs regarding dementia care and therefore was not willing to agree to the implementation of the Shared Care Protocol without allocation of extra resources. The implementation of the shared care protocol is however crucial in ensuring expensive secondary care services can be used for the people with the most complex needs and to prevent waiting times for assessment at Pennine Care's dementia assessment clinic. It also fits in with the SCCG's strategy to focus on care primarily being delivered in the community.

5.2 Pennine Care recently invested in a dementia specialist nurse visiting GP practices to discuss the draft shared care protocol and to provide training regarding dementia care tailored to the practice needs. Findings of this pilot project were that some practices already support the draft Shared Care

Protocol and provide thorough dementia reviews in their practice. Others felt less confident in providing dementia care in their practice, especially regarding reviews of patients with dementia being on dementia medication.

5.3 It is felt that through a LES, GP practices will become better equipped to accommodate the primary care part of the Shared Care Protocol. With a contribution towards training, guidance on conducting reviews, and the access to a Dementia Specialist Link Nurse for every locality, it is envisaged that every practice will be able to implement the dementia care pathway as outlined in the shared care protocol and will be able to effectively manage patient with dementia and their carers in primary care.

5.4 Another aspect of the Shared Care Protocol is the recognition that GPs can diagnose patients in primary care. For not all patients a referral to secondary care is necessary to confirm the dementia diagnosis. However, at them moment Adult Social Care not always accepts referrals for social care support from GPs when Pennine Care has not confirmed the dementia diagnosis first. Arrangements will be made with Adult Social Care to ensure that besides Pennine care also GPs can directly refer dementia patients for social care services.

5.5 The GP LES has 2 components:

- £1000 one off payment to attend training, to identify a lead GP, to have an annual meeting with the Locality Dementia Link Nurse, to ensure structures are in place for conducting dementia reviews following shared care protocol
- contribution of £30 for every annual dementia review of patients on the GP dementia register and all newly diagnosed and/or discharged patients from secondary care – following the local guidelines and demonstrating review through the practice’s electronic health record.

→ Maximum calculated spend on GP LES 12/13:	<b>£ 113,320</b>
52 practices x £1000,-	£ 52,000
Review of 1844 patients currently on register x £30,-	£ 55,320
Review of est. 200 newly diagnosed patients in 12/13 x £30,-	£ 6,000

### **Considerations regarding the implementation of the LES**

5.6 The first idea was to focus the LES only on dementia patients on medication and financially support the medication reviews for this cohort of patients (about 350 patients have been identified by Pennine Care as already been discharged or currently being stable and suitable for discharge). However, there is more and more evidence that the risks of dementia drugs are low, and with the drugs coming off licence, an annual review should be sufficient (instead of a more time-consuming 6 monthly review). It is currently also under review whether there is a need for people to stop their medication or that they can continue with taking their medication for as long as they think they benefit from them. Besides that, it is felt that people diagnosed with Alzheimer’s Disease already get more support than people diagnosed with other types of dementia.

It was therefore felt that a general contribution to the workload of GPs in the form of a financial incentive – in addition to the QOF payments – for conducting annual dementia reviews to all patients registered on the dementia

practice register (either being on dementia medication or not) would be a better investment to improve the quality of care for all dementia patients and would ensure that all Stockport dementia patients receive the same level of support on their 'dementia journey'.

### **Possible risks:**

\* Practices do not agree with the shared care protocol and therefore do not sign up for the LES which means that patients are unnecessarily treated in secondary care instead of in primary care

→ risk stratification:

- It is envisaged that the implementation of the shared protocol through a LES will give practices many benefits. Part of the LES is having access to a dementia specialist link nurse who can offer training 'on the job' to GPs who do not feel comfortable to implement the shared care protocol, especially regarding conducting medication reviews. The LES also gives GP access to a post-diagnostic support worker from the Alzheimer's Society who can assist GPs with their information and advice role.
- GP practices / localities could decide to pool review budgets and recruit a practice nurse to do the reviews for them.
- A neighbouring GP practice could conduct the dementia reviews for the practice, however this means that patients might have to travel and particularly regarding patients with vascular dementia, other vascular disease management opportunities might be missed.
- Increased capacity for specialist dementia link nurse to conduct the reviews (this is not the preferred option as this will mean that secondary care will still be involved in reviewing stable patients who could be supported in primary care).

\* Practices decide to only do the bare minimum regarding the QOF 15-monthly reviews and claim the extra £ 30,- for these reviews without changing practice and without following the review guidelines including medication review and anti-psychotic review.

→ risk stratification:

- The practice will at least have to sign up for the shared care protocol and will have to annually review discharged patients from the dementia treatment clinic to be entitled to receive their one off payment of £1,000. The practice will also have to demonstrate that they have followed the LES guidance for the dementia reviews through presenting readcode summaries via their electronic health records. Not used payments could be allocated to the Alzheimer's Society and the dementia link nurse so that they can run alternative services to ensure that patients in these GP areas do not miss out on local support.

\* GP practices decide to review every patient known with dementia above and beyond the number of patients identified on their dementia register. This could have an impact on allocated LES' budget.

→ risk stratification:

Identifying more people with dementia would be a positive development.

However, we only have funding available to cover for reviews for the number of patients already being on the register. The LES payment will therefore be limited to the current number of registered patients. Practices can however decide to use this budget to pro-actively identify and review other patients known to have dementia but not being registered yet. The practices are free to use the LES money flexibly and spend it on conducting reviews regarding newly diagnosed and patients not being on the register yet. Their QOF payments could then be used for conducting the 15-month reviews for the patients already being on the dementia register.

It is recognised that practices can claim money twice for conducting 1 review but especially this first year, the shared care protocol and new local review guidelines will also impact on staff's work load and that is what we want to acknowledge in the first dementia LES. It focuses on getting it right for the patients already being identified and supports GP practices in putting structures in place to manage patients with dementia and their carers well in primary care. It is envisaged to focus a LES in 13/14 on for example increasing the number of patients on the registers to match the national prevalence figures and/or targeting health interventions for patients with vascular dementia.

## **6. Investment for Pennine Care**

6.1 Beside the focus on primary care and the shift from secondary care to the community care, it was also part of the dementia strategy to 1) increase the capacity in secondary care to ensure the dementia assessment and treatment clinic will be able to meet current and future demand and to 2) implement a locality based dementia care provision through partnership working between primary care, secondary care and the Alzheimer's Society.

6.2 We locally need sufficient secondary care capacity for Pennine Care Mental Health Foundation Trust to be able to provide training for GPs and practice nurses, to meet demand for assessments, to support GPs with delivering dementia care in their practice, the support GPs with reviewing patients on anti-psychotic drugs and to provide care for people presenting with challenging behaviour. Also, more support for care homes is necessary to ensure quality dementia care through personalised care plans. And finally, the extra capacity will support the locality model that currently is in development regarding long term conditions and older people with complex needs (including dementia patients).

6.3 It is therefore suggested to use part of the recurrent dementia monies for:

- recruiting 2 dementia specialist link nurses (band 6&7) to be able to allocate a link nurse to every SCCG locality (this will increase the current capacity of 2.6 fte dementia nurses to 4.6 fte link nurses – to cover all 4 localities including a training, management & innovation function within their role)

- extra neuropsychology capacity to meet demand for the more complex secondary care assessments
- extra OT capacity to support patient to live well with dementia in the community.

→ Spend 12/13: - implementation by August 2012 (8 months)      **£ 73,280**  
 2 fte specialist dementia link nurses (band 6 & 7)      Total cost      £ 62,500  
 Additional 7.5hrs a week neuro-psychologist      Total cost      £ 10,780  
 (The neuro-psychologist post will be increased with another 7.5 hrs a week from 13/14 onwards & 0.5 wte OT will be put in place by April 2013)

## **7. Alzheimer's Society Support Worker**

7.1 The Department of Health allocated £ 57K to Stockport for post-diagnostic support in 2011. The money had to be transferred to the local authority via an agreement under section 256. NHS Stockport and SMBC have agreed to spend this budget on:

- support worker (Alzheimer's society) to provide post diagnostic information and advice via clinics in GP practices, time limited group sessions and information events, 1-1 sessions to develop care & contingency plans
- supervision for the support worker via Pennine Care
- development of information material to encourage healthy lifestyle actions for people with vascular dementia
- pilot to test out the running of a 'move on' group for ex-carers.

A service specification and contract has been developed and the support worker will hopefully be in post at the end of August 2012 for 16 months. The support worker will work alongside the specialist dementia link nurses and the GP practices.

7.2 When the evaluation of this post is positive and the support worker has proven to add value to the dementia care pathway in primary care, it is envisaged to continue the funding for the support worker through the SCCG's dementia care budget.

## **8. Other developments**

8.1 Regarding 2012/13:

In addition to the above proposed spending of the allocated dementia care monies on the LES and additional capacity for Pennine Care / Alzheimer's Society it is suggested to also spend part of the budget on:

- providing training, network meetings for the GP lead per participating practice and to develop a training dvd with instructions how to conduct a

dementia review (→ £10K). Training provision in primary care will continue in 13/14 (→ £ 5K).

- developing local information packages that can be handed out to all newly diagnosed patients and their carers. We already have an online directory of services but patients told us they would prefer to also receive key information on paper. The directory of services is currently a [link](#) to a document on the PCT's website. To improve access it would be helpful to create a separate web-link to the directory of services e.g. 'dementia-stockport.org.uk'. (→ £7.5K)
- optional: depending on the outcome of a pilot Pennine Care is currently running regarding improving dementia care in care homes (6 months till October 2012), it is envisaged to either support continuation of this pilot or support care homes with personalised care planning through a life story project. Life story work is an important ingredient for personalised care. The idea is to create a small team of life story / reminiscence volunteers. These volunteers will receive training in life story work and could assist care homes / community run groups in developing life story books with people with dementia. This group of volunteers could be managed by either the Alzheimer's Society or Age UK Stockport.

In addition Stockport has also been awarded £ 15K to become a dementia demonstrator site for the Greater Manchester Cluster. Stockport will pilot a project for patients admitted to NHS Stockport Foundation Trust to improve the identification of patients with dementia in the end stage of their life and to ensure appropriate community follow up.

Finally several CQUINs for the hospital, community services and Pennine Care have been developed to further work in partnership on improving several aspects of dementia care in Stockport.

## 9. Action plan

9.1 To implement the different work streams as described above the following actions are planned - just broad summary -:

Actions	Ready by
GP LES	
- sign off plan & put in right format	June 2012
- roll out in GP practices including readcode for health record	June-July 2012
- roll out training programme	Ongoing Aug 2012 – March 2014
- 2 GP lead network meetings	October + February each year
- monitoring of LES performance	6 monthly
- communication Adult Social Care	June 2012
Dementia Specialist Link Nurses	
- job description / service spec	June 2012
- recruitment	Aug / Sept 2012 in post
Alzheimer's Society Support Worker	August 2012 in post
Neuro-psychologist	
- extension of current contract	Augustus 2012
Information package newly diagnosed	August 2012

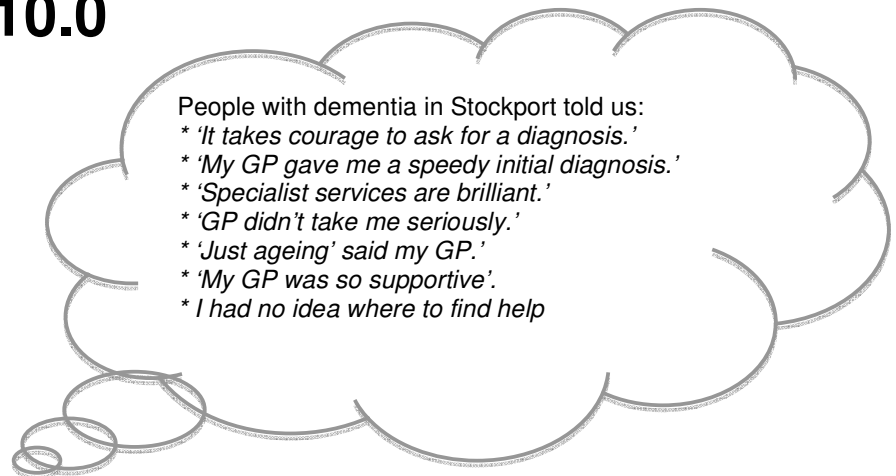
patients & carers	
Launch Directory of services Website	November 2012
Pilot care homes - evaluation - follow up	October 2012 November 2012
End of Life demonstrator site	August 2012 person in post

**Service Specification  
for a Local Enhanced Service:  
'Recognition and Management of Dementia Patients  
and their carers in General Practices in Stockport'**

**GP LES Dementia Care  
Stockport**

**2012-2013**

**Draft v10.0**



Our ambition: every patient will have timely access to a memory assessment and he/she and their carers will get the right emotional and medical support and signposting to services in the community following their diagnosis.

<b>Service</b>	<b>LES Dementia Care in GP-practice</b>
<b>SCCP sponsor</b>	Dr. C. Briggs
<b>Commissioner Lead</b>	Dr. N. Hussain, GP MH Lead Nicole Alkemade, Older People's Joint Commissioning Manager
<b>Period</b>	12 months in 2012-2013

## 1. Summary

This service specification includes:

- a local shared care pathway, including partnership working with Pennine Care Mental Health foundation Trust - Old Age Psychiatry - regarding diagnosis, initiation and maintenance of dementia drugs & complex dementia care in primary and secondary care
- guidance to ensure all dementia patients and their carers in Stockport will receive the same level of dementia care from their GP practice
- right mix primary care and specialist care in providing dementia care in Stockport
- payments and other assistance available for GP practices to support the implementation of quality dementia care in primary care in 12/13.

The LES is for the financial year 12/13 and is especially meant to contribute towards the GPs workload with the implementation of the new dementia shared care protocol (appendix 2).

Depending on the success of this LES, a follow up for 13/14 will be considered focussing on other aspects of dementia care as part of the shared care protocol (e.g. more specific care for people with vascular dementia).

## 2. Rationale

GPs have a crucial role in ensuring that early concerns about memory problems are detected and responded to, and not misattributed to the symptoms of old age and also that the early signs of young onset dementia (people under 65) are addressed.

Following national and local awareness raising campaigns, people are encouraged to express concerns about their memory at an earlier stage to ensure people get the right support as early as possible. It is envisaged that this will increase the demand on GP practices. It is also recognised that assessing people and making a dementia diagnosis at an earlier stage could be more challenging.

The GP-practice does not only play a key role in the diagnostic process, the practice also has an important role to play in following the person with dementia and their carers through the different stages of dementia to ensure all support is available for the patient's ongoing management of health and well-being.

Dementia is a medical disorder and should be managed like any other serious long-term illness, including regular monitoring, conducting health checks (for the person with dementia and their carers), ensuring people with dementia

attend screening programs, advising on preventive actions, advanced decision making and contingency planning, and signposting people to local information, advice & support services.

The local strategy appreciates that GP-practices can't deliver dementia care in isolation. The strategy therefore builds on good local practice to support people with dementia and their carers all the way through alongside the care provided by their GP-practice. Good local examples of existing quality services are the highly valued training for informal carers delivered by Stockport Dementia Care Training, the variety of peer support networks (dementia cafes, singing group, walk & talk groups) being developed by the Alzheimer's Society and Age UK Stockport in the last years, the variety of telecare opportunities that is available, trained personal assistants commissioned through personal budgets, staff at hospital wards trained in delivering care to people with dementia, the implementation of a young onset support worker's post, the reviewed and redesigned day services and carers' break facilities and the support offered by Signpost for Carers.

Stockport offers some very good examples of partnership working between primary care, secondary care, social care and third sector organisations to assist people with dementia and their carers in living healthily and well in the community making the best use of limited resources. It is crucial that GP practices are aware of these to be able to signpost the person with dementia and their carers timely to the right services.

With respect to dementia care a specific shared care pathway has been developed to describe partnership working between GPs and Secondary Mental Health Care (Pennine Care Mental Health Foundation Trust). One crucial aspect of this pathway is the guidance regarding the initiation and maintenance of dementia drugs and decision making around discontinuation of medication. The tasks and responsibilities for both care providers have been captured in a shared care protocol (see appendix 2). Some GP practices already deliver care according to this protocol, others not yet. This LES is meant to support all GP practices in Stockport to implement the shared care protocol and to ensure every dementia patient will receive the same level of support regarding assessment, diagnoses and follow up care regardless which GP practice they are registered.

### **3. Aims of the local enhanced service for dementia care in Stockport's GP practices**

This GP Local Enhanced Service for Dementia Care in 12/13 aims to:

- Increase the early recognition and diagnosis of dementia through opportunistic screening (asking patients if they have problems with their memory affecting their daily life when they for example attend a flu clinic) and work towards the estimated prevalence for their practice on their dementia register;
- Provide a recall and review system for people who have been transferred back into primary care after being initiated and stabilised on Anti Cholinesterase (ACIs) according to the local shared care protocol (appendix 2);

- Provide a review process for people with dementia who are on low dose anti-psychotic medication and to reduce practice prescribing rates;
- Contribute towards the reduction of the waiting time for a memory assessment in secondary care, by implementing the shared care protocol in the GP practices. This will enable secondary care resources to focus on the most complex cases;
- Provide care closer to home and reduce the number of stable patients being managed in secondary care;
- Provide a holistic package of care to enable more people with dementia and their carers to be managed in primary care where appropriate,
- Enhance physical care and health promotion advice for all patients and carers for people with dementia, especially regarding vascular dementia.
- Ensure dementia patients and their carers receive the same level of dementia care among all GP practices in Stockport;

#### **4. Components of the LES**

##### **4A) Adopting the Shared Care Model including the management of people stable on dementia medication (acetyl-cholinesterase / memantine)**

- To undertake investigations/screening as indicated in Appendix 1 and investigate any abnormalities to exclude potentially treatable causes prior to referral to Pennine Care's Memory Assessment Service.
- To undertake opportunistic screening especially regarding high risk groups (people with learning disabilities, people who have had a stroke or have a neurological condition such as Parkinson's disease)
- To record the discharge letter received from Pennine Care's Memory Assessment Service and act upon guidance mentioned in the letter.
- To review every diagnosed dementia patient at least once a year (Alzheimer patients and other dementia patients) following the annual review template in appendix 1.
- To have a system in place to ensure all patients on Anti Cholinesterase (ACIs) / memantine treatment are reviewed regularly - at least once a year -and people with dementia using anti-psychotics once in the three months.
- To continue the prescribing of AChE inhibitor / memantine treatment and adjust the dose as advised by the Memory Assessment Service and in line with NICE clinical guidelines.
- To notify Pennine Care's GP Locality link dementia nurse of any adverse drug reactions, deterioration in condition or any other clinical concerns regarding the patient's health that can not be managed in primary care.

Payment of £30,- per review (payment for one review per patient per year) - whether the patient is on dementia drug treatment or not. This is in addition to the normal QOF payments GP practices receive for conducting a 15-monthly review.

Measurement through read code.

Payment is only for patients already being on the practice Dementia register (DEM 1 – QOF – results of year 2011/2012) and the patients newly diagnosed by the practice or discharged from Pennine Care to the practice in 2012/2013.

#### **4C) Dementia friendly practice management**

##### **4C.1 Up to date dementia register & carers register**

- working towards up to date dementia registers: ensure all patients with dementia are registered on the practice dementia register and their carers on the carers' register.
- coding and administration system in place to follow up discharge letters from hospital and secondary care (including guidance regarding anti-psychotics reviews).
- opportunistic screening to identify patients with dementia in an early stage (especially high-risk patients – people with learning disability, having had a stroke or having a neurological condition such as Parkinson's Disease).

##### **4C.2 GP Practice Dementia Lead**

- every practice has identified at least one GP dementia lead for the practice and preferably a dementia lead practice nurse too
- the practice dementia GP lead will at least attend one of the two network meetings per year
- the GP dementia lead will cascade any information e.g. dementia newsletter and updates of directory of services to colleagues in the practice.

##### **4C.3 Annual visit**

- agree to an annual visit at a practice meeting from the Pennine Care's link specialist dementia nurse and the Alzheimer's Society support worker
- identify any training needs for the practice and discuss with link nurse how best to act up on these.

##### **4C.4 Information provision at time of diagnosis**

- ensure that all people with dementia and their carers will be provided with written information regarding information, advice and support services – the practice will receive an example information pack.

One off payment of £ 1,000,- for each practice which is able to demonstrate meeting the indicators mentioned above under 4C).

## **5. Benefit of LES for GP practice**

GP practices signed up for the LES will be entitled to receive:

- An annual visit from Pennine Care's Link Specialist Dementia Nurse to discuss:
  - shared working following the shared care protocol
  - training needs of practice staff and to develop tailored training plan to meet these needs
  - guidance on review and monitoring of dementia patients in the practice
  - access to carers services and signposting to local services
  - vascular dementia
- Access to up to date directory of services
- Free training based on identified training needs
- Fast track referral option back to Dementia Specialist Link Nurse for advice and further assessment if necessary
- Dementia leads' network meetings (once in the 6 months) to share good practice.
- Readcode for review template.

## **6. Payments**

The LES will be paid on achievement of the following outcomes:

One off payment of £ 1,000:

Practice needs to ensure clinical and administration processes are in place to identify people with dementia, staff has followed training, the practice has identified a GP dementia lead, the practice has signed up for the shared care protocol, and a meeting has taken place with the link dementia specialist nurse and a support worker from the Alzheimer's Society.

and/or

A payment of £30,- will be made for every conducted annual review of:

- patients with dementia  
(up to maximum number of reviews based on total of identified patients on dementia register 11/12 and newly diagnosed by the practice in 12/13)
- patients discharged to the practice under the Shared Care Protocol
- evidenced through use of read code template as part of practice's electronic health record.

(Please note: this is in addition to the payments the practice already receives for DEM 2 QOF activities.)

**Appendix 1: Annual Review Template**

**Guidance notes / prompts when undertaking a review of a patient with a diagnosis of dementia**

Ensure that your practice has a system in place for recalling patients at least 12 monthly for a review.

When a patient is recalled for a review, capture and record any changes in his/her presentation.

Pro-actively follow up DNAs, especially regarding people living alone.

**Assessment of cognition, mood and behaviour and function needs to be considered.**

**Questions to be asked of patient and carer. (May need to arrange to have a separate word with carer if seems unable to speak frankly in presence of relative.)**

**Global**

- How have things been over the last 12 months?
- Have there been any notable changes?

**Cognition**

**Ask about deterioration in memory, communication, orientation, recognition e.g.:**

- Has there been any significant change in your memory since the last assessment? In what way?
- Have there been more difficulties with communication e.g. finding the right word, understanding, reading or writing? How bad?
- Do you have significant difficulties in finding your way around – any episodes of getting lost?
- Any more difficulties in recognising people or objects?

**Mood and Behaviour**

**Ask about change in behaviour, depressed mood, hallucinations and delusions e.g.:**

- Do you ever feel / does your relative ever seem depressed / low in mood?

- Have you / has the relative lost interest in things normally enjoyed?
- Have you / has the relative had any unusual experiences e.g. hearing /seeing things that are not there? Feeling worried / suspicious that something is going on?

**For carer where appropriate:** Has there been any change in your relative's behaviour that you found more difficult to manage, e.g. irritability, aggression (verbal or physical), agitation, wandering, disinhibition, self neglect, incontinence?

- Are you / does the relative sleep well?
- Are you / is the relative eating well?

**→ If suspecting depression: – GP review and intervention e.g. psychological therapy / Antidepressants**

**→ If psychotic symptoms/ behavioural change – consider underlying cause – follow guidelines for managing challenging behaviour**

## **Function**

**Ask about decline in day to day functioning e.g.:**

- Have you noticed any significant changes in your / your relative's ability to do things on a day to day basis e.g. cooking, self care (washing/dressing), managing medication, managing money?
- Are you / is your relative still driving and do you have any concerns about their driving? (Ensure DVLA are aware of diagnosis). (May need to ask relative separately).

## **Medication**

### **Cholinesterase Inhibitors**

**Ask about:**

- Compliance with medication
- Any new side effects from the tablets ie weight loss?

### **ACTION**

- If stable continue medication at current dose.
- If there is a significant deterioration in cognition and/or function consider whether a trial off medication is required / appropriate.
- If only mild deterioration consider trial off at next review should deterioration continue.
- Follow titration advice for trial off.

If you need further advice discuss with the Primary Care Link Nurse from Dementia Treatment Service

### **Antipsychotics**

Ask if the person is on an antipsychotic and if so ask:

- How long for?
- What for?
- Has it helped
- Has this been reviewed? Has an attempt to reduce it / stop it been made?
- When is next review? If not, ensure review date is planned with GP (once in 3 months).

### **Quality of Life issues**

**Ask about:**

- Involvement in any social activities?
- Awareness/involvement with the Alzheimer's Society?
- Is there a package of care? Are you happy with it?
- As a carer, are you happy with the support you receive? Encourage Carers to have regular breaks / arrange support.
- Is the carer registered on carers register?
- Is any additional support required eg from Social Services, Age UK, Sign Post for Carers?
- Is contingency planning in place / needed (e.g. when carer gets ill)?

### **Other topics that might be useful when conducting a dementia review**

### **Local support**

Some suggestions for local support you could provide when you invite your patients for a review:

- Alzheimer's Society: for information and advice regarding all issues related to dementia (all dementias – not only Alzheimer's disease), and the society offers a variety of peer support
- Age UK Stockport: peer-support, one-to-one support, carers support, home after hospital, sitting service if people have a health appointment. Age Concern also offers a well check service which supports people in finding the right solutions for their needs
- Signpost for Carers: carers support, benefits, training
- Dementia Training for Informal Carers: Stockport Dementia Care Training – provides by informal carers highly valued training in dementia care
- Council's Contact Centre for social care support: not all services are means tested. No secondary care diagnosis needed, diagnosis from GP should be sufficient

→ please encourage people to attend a peer support group, it keeps people social active, it is beneficial to share information with others, it can give the carer a break and the vast majority of people find peer support a 'life saver'.

#### **Tips and advice to support living well in the community:**

- Telecare devices: flood detector, fire alarm, door detector, fall prevention – a social worker or the Alzheimer's Society can assist people in finding the right devices and the council runs a telecare demonstration unit which people can visit
- Many people will benefit of making a life story book together with their carer. Besides that it is a nice activity to do together, the information can also be very helpful to caregivers and other staff dealing with the person with dementia.
- The Council / Age UK Stockport can support the patient with exploring housing adaptations and different housing options.

#### **Other health care services**

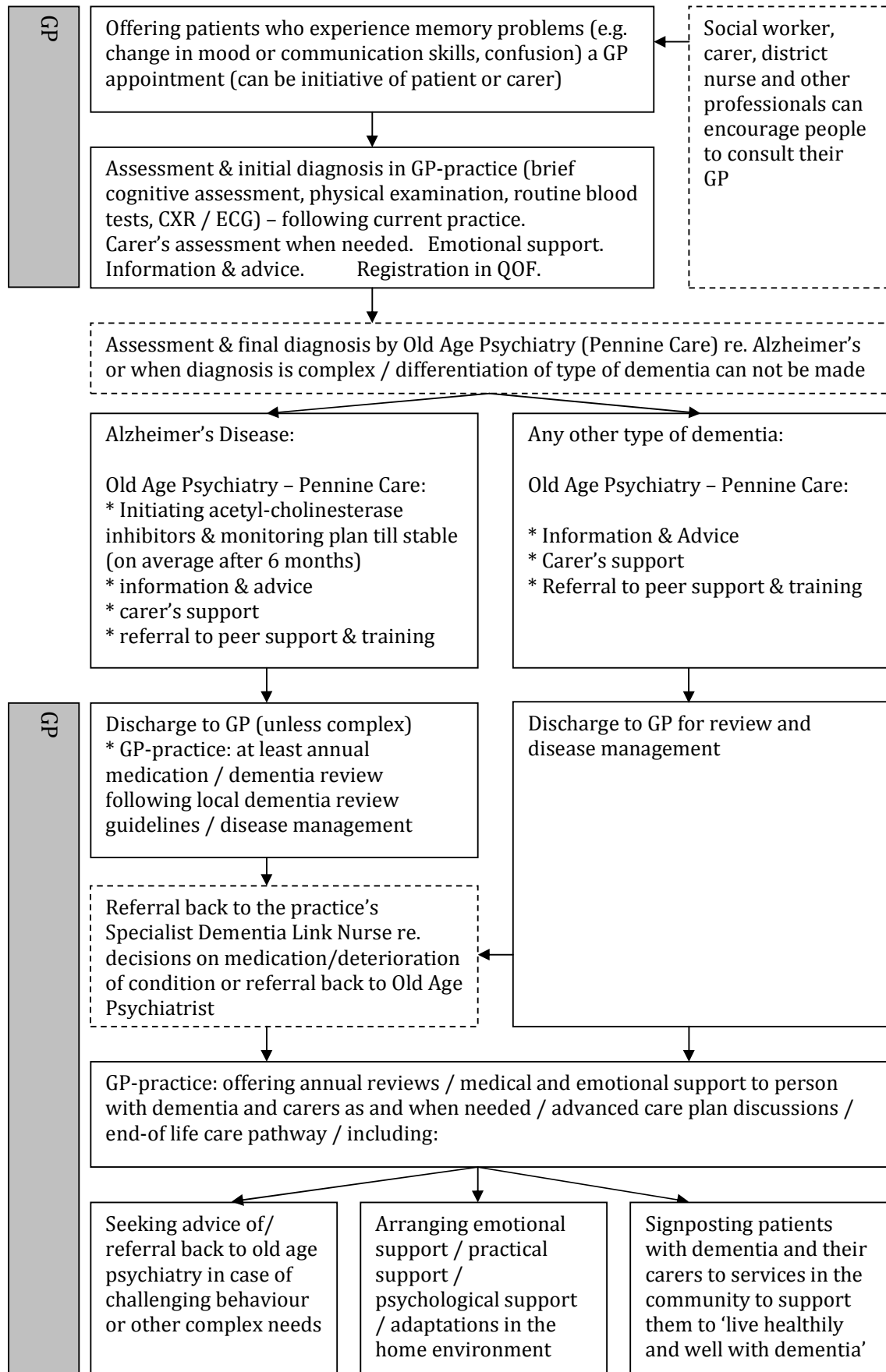
- Ensure that if the person needs to go to hospital for other medical treatment, a dementia diagnosis is clearly stated in the referral letter and patient with dementia / carer has filled in a 'this is me leaflet' to support their care provided in hospital (Alzheimer's Society can help with this)
- Ensure the person with dementia and their carers are involved in any end of life advance care planning – including hand-over documents for the GP OOH-service, when appropriate

#### **Healthy life style**

- Check healthy eating, physical activity (Alzheimer's Society and Age UK Stockport run highly valued walking peer support groups)
- Check vaccinations / screening uptake
- Check sensory impairments
- Check sleep patterns
- Assess falls risk
- Assess for any triggers to behavioural problems over past 12 months and what helped resolve the problems (drug or environmental). Liaise with carer to promote preventative strategies (e.g. preventing urine infections)

#### **Advanced care planning**

- Advice people to take advanced decisions / arrange power of attorney / end of life advanced care planning.



**DEMENTIA LES Agreement August 2012 - August 2013**

**Fax to: 0161 426 XXXX ..... Deadline: 15 July 2012**

**I accept the following requirements (please indicate  which parts of the LES your practice signs up to)**

**A. Dementia reviews**  
*£ 30,- for every conducted annual review under shared care protocol*

1. Accepting working according Dementia Shared Care Protocol (appendix 2)
2. Reviewing patients (with or without dementia medication) on the practice register 11/12, newly diagnosed patients in 12/13 and/or patients referred back to GP from Pennine Care following shared care protocol. Reviews are conducted according to the guidelines (appendix 1 of the LES 12/13) and this is evidenced through readcode / case notes in electronic health record.

And/or

**B. Dementia care implemented in GP practice**  
*£1000,- one off support to put structures in place to deliver quality dementia care in GP practice -*

3. System in place for registering newly diagnosed patients (including type of dementia) and conducting regular dementia reviews & anti-psychotic reviews
4. Opportunistic screening to ensure dementia register becomes a better reflection of national prevalence figures.
5. System in place to register carers for patients with dementia on carers' register.
6. Identified dementia lead for the practice (at least one lead GP and preferably a lead practice nurse too):  

<u>Lead GP</u>	<u>Lead practice nurse</u>
Name GP:	Practice Nurse:
Email address:	Email address:
7. Accommodated an annual visit from Pennine Care's specialist link dementia nurse and Alzheimer's Society support worker to meet the practice team
8. System in place to ensure patients newly diagnosed will receive written information material
9. Training needs identified. GP Lead (and lead practice nurse where identified) will attend at least one of the two dementia network meetings.

Signed by GP:

Date:

GP name (Block capitals):

GP practice name:

Appendix 2: Overview actions Local Dementia Strategy

Stockport Clinical Commissioning Group

<b>Awareness raising</b>	<b>Early diagnosis</b>	<b>Living well with dementia</b>	<b>Moderate - Severe Dementia</b>	<b>End of Life</b>
Annual Dementia awareness week / information bus	Identification pathways in community and hospital (CQUINs – GP LES *)		Day-services review and redesign (Age UK – ISSK)	Demonstrator project (Palliative care team)
Project to prevent financial abuse	GP liaison dementia nurse (Pennine Care)	Personalised budgets (SMBC) Personalised care plan pilot (Borough Care)		
BME awareness raising	Hospital action plan: training, environment, diagnosing, nutrition, reminiscence			
Dementia champions network	Implementation MH liaison service hospital / RAID model			
Vascular dementia toolkit *	Delirium task & finish group	Peer support networks including EDUCATE (Age UK, Alzheimer’s Society)		‘Move on’ network for ex-carers (Alzheimer’s Soc.) *
Post-diagnostic Support worker (Alzheimer’s Society)*				
Young onset dementia worker and virtual team (Pennine Care) Pennine Care Dementia assessment and treatment clinic *				
Anti-psychotic target */ GP audit / Pennine Care audit / guideline development				
Directory of Service */ Care Knowledge – dementia channel / dementia newsletter				
Stockport Dementia Care Training (Pennine Care & SMBC)				
Carers support: advice, guidance, peer support, carer breaks, sitting service (Signpost for Carers, Age UK, Care Scheme, Oasis)				
		Stockport Life story network		
Vascular dementia healthy life style promotion *		Telecare (SMBC)		

\*) supported through SCCG dementia monies

## Overview of initiatives related to the Local Dementia Strategy

Since the launch of the Local Dementia Strategy the following developments have been taken place - in addition to the normal dementia care that already was provided in Stockport-:

### 2010 / 2011

- We implemented a local network of **Dementia Champions** – currently 30 champions (people with dementia, LINK, staff and volunteers from Health and Social Care, third sector, domiciliary care and care homes). The group meets every quarter to exchange good practice, identify gaps and develop new initiatives to raise awareness and improve dementia care in Stockport. The group has links with several national dementia support groups.
- We were successful in becoming a **national dementia demonstrator** pilot site in 2009. We locally tested three different **peer support** options. 1) User-led networks run by Age UK, 2) EDUCATE – a peer support network of people with dementia educating others about their condition and 3) a virtual peer support network. Age UK implemented six user-led peer support networks linked to an activity, like walking, signing, and creative activities. Also some groups met each other for a pub lunch. When the pilot finished, Age UK managed to sustain 4 of the groups as part of their ‘Stepping out’ work stream. The only concession they had to make was to open up the group to other people. The staff is however still trained in dementia care skills and ensures that people with dementia will continue to benefit from the network activities as much as every other participant. The EDUCATE group is doing really well. At the moment we have about 20 EDUCATErs who are frequently booked to contribute to meetings, training events, and other activities related to dementia care. The group has 4 volunteers supporting the running of the group and accompanying the EDUCATErs when they have to present. The facilitation of the group has been sustained through Stockport Dementia Care Training. The virtual peer support project as such has not been continued but the project gave people more confidence in the use of the computer, some participants are now able to Skype with relatives abroad and the group still meets up once in the month for a pub meal.
- a small working group has been installed to yearly organise activities during the national **dementia awareness** week, e.g. visiting several location in the borough (e.g. supermarkets) with an information bus and inform the public about dementia and our local services.
- through **pathway mapping** Alzheimer’s Society, Age UK, Signpost for Carers and Pennine Care improved their pathways to ensure best use of current resources and to avoid duplication.

- on the Council's '**Care Knowledge**' website a special dementia channel has been developed with information on dementia and links to documents, websites and services.
- in partnership with the Council's communication department a dementia **newsletter** has been developed and a new edition has been published at least twice a year.
- SMBC and Pennine Care fund together '**Stockport Dementia Care Training**'. In the past 10 years Stockport Dementia Care Training has provided many training sessions to staff working in health and social care (including district nurses, podiatrists and dieticians), care home staff and the service has contributed to many other training events. Stockport Dementia Care Training also provides the highly valued training for informal carers. Not only gives this training carers an insight in how best to support the person with dementia they are caring for, the training also offers people peer support opportunities. The training on offer is constantly in development to follow the trends in dementia care (e.g. life story work is now included in the training).
- Pennine care was able to pilot and sustain a small service to support patients with **young onset dementia**. Mainstream services are less suitable for younger people with dementia. With help of the 'young onset dementia support worker' patients are encouraged to stay active and continue their hobbies and activities for as long as possible.
- A small task & finish group developed materials to prompt professionals to 'think **delirium**' when people present with confusion. Guidance was also developed for domiciliary care agencies to recognise delirium and how best to care for people with a delirium

## 2011 / 2012

- With help from a volunteer from the Alzheimer's Society a **directory of services** was developed and will regularly be updated. This online document contains information for people diagnosed with dementia, their carers and professionals. It also includes local information to signpost people to the support services available in Stockport.
- A specialist dementia nurse from Pennine Care has worked together with GP practices to support the development of the shared care pathway, to **liaise with primary care** and provide training to support GPs in managing patients with dementia in the community.
- A 2-year health & social care project has been implemented by Pennine Care to support the discharge planning and transition back to the community for older people with mental health problems, including dementia, delirium and depression (**Older People Mental Health Liaison Service** – funded through DH Health & Social Care monies)

- The SMC's care home pharmacist conducted an **audit on anti-psychotic** drugs prescribed to patients with dementia. As a result of this, local guidance has been developed including supportive information materials for professionals and carers on how to deal with behaviour that challenges.
- A GP master class on mental health and several other local **events** were organised to inform and train professionals in the community on various aspects of dementia care.
- The Council has developed a **demonstration unit for telecare** equipment. This unit is open to people with dementia and their carers and to professionals to get information about the different telecare solutions available and how they work.
- A **hospital steering group** has been implemented to oversee dementia care improvements in the FT including CQUIN objectives.

#### **Recent initiatives 12/13:**

- We recently were successful in securing money for a Greater Manchester Cluster demonstrator site project regarding **dementia and end of life**. In August 2012 a specialist dementia nurse will come in post to support hospital staff with identifying people with dementia in the end stage of their life and ensuring a pathway into the community (palliative care register). This will hopefully not only improve the quality of care for these end of life patients but will also encourage advanced decision making and preventing unnecessary hospital admissions
- The DH-money allocated money to support people newly diagnosed with dementia. A service specification has been developed to recruit a support worker for 16 months who will assist patients newly diagnosed in primary care. The **post-diagnostic support worker** can develop a support plan for people with dementia and their carers and encourage them to have a contingency plan in place. The support worker will also liaise with BME groups and will organise information sessions specifically for people with Vascular Dementia.
- As we noticed that some organisations are starting to work with life story work, we installed a **local life story network** to exchange good practice and to guarantee quality standards regarding the use of this method.
- 7 National and Regional Dementia **CQUINs** 12/13 were agreed regarding Mental Health Care, Hospital Care and Community Care and are currently being implemented.

**Other initiatives in preparation (in addition to a GP LES and recruiting Dementia Specialist Link Nurses):**

- development of a time limited **peer support group for ex-carers** with the aim to train them as volunteers to assist others who are caring for people with dementia.
- improving support for people with Vascular Dementia to encourage them to adopt healthier lifestyles where appropriate – development of **vascular dementia health toolkit**.
- piloting a peer support group focusing on **cognitive stimulation** for people who worry about their memory but for whom a dementia can not (yet) be diagnosed.
- development of a **dashboard** to be able to monitor progress in a more quantitative way including the CQUIN achievements.
- the specialist dementia link nurses will support the new to implement integrated **health and social care core teams** which focus on people with long term conditions who are at high risk of hospital admissions (SCCG's part of clear and credible plan).