10 key steps to improving diagnosis, and diagnosis pathways
The Dementia Prevalence Calculator, Guidance and Resource Pack have been produced jointly by the NHS Commissioning Board and NHS South of England.

2nd edition, January 2013
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10. Review prescribing  
   Appropriate prescribing of anti-dementia drugs  
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References
Introduction

**NHS Mandate**
(Department of Health, 2012)
The Government’s goal is that the diagnosis, treatment and care of people with dementia in England should be among the best in Europe.

**NHS Commissioning Board’s objective**
to make measurable progress towards achieving this by March 2015, in particular ensuring timely diagnosis and the best available treatment for everyone who needs it, including support for their carers.

The NHS Commissioning Board will
- work with CCGs, driving significant improvements in diagnosis of dementia, and capturing this in a national ambition for diagnosis rates built up from local plans.
- publish the expected level of diagnosis across the country through to March 2015;
- work with CCGs to support local proposals for making the best treatment available across the country.

This Resource Pack sets out key steps for Commissioners, and key steps for General Practices to improve the diagnosis of dementia, and the diagnosis pathway. These steps focus on,
- understanding your local prevalence of dementia, and the local diagnosis rate;
- considering where and how improvements in diagnosis might be achieved, focusing on improving,
  - awareness and recognition
  - access to memory assessment and diagnosis
  - access to the right information, at the right time
  - and improving the experience for people seeking help with memory problems.

Using the Resource Pack
The ‘Key Steps’ offer a systemic approach to improve the quality of services for people seeking help with memory problems.

Each step is accompanied by links to a range of resources to support local implementation, and examples of positive practice. Click on the title of the resource / example to download it.

**Why is diagnosis important?**
Most people want a diagnosis, many to help them plan for the future. An earlier diagnosis can lead to,
- a better quality of life for both the person with dementia, and carer
- the right support for carers/families, at the right time
- a reduction in the risk of misdiagnosis and inappropriate management
- delaying a move to a care home, enabling people to remain in their own home, for longer

Note: positive practice has been identified in order to enable commissioners and general practices to accelerate improvement. This does not reflect an endorsement by NHS Commissioning Board of any products, goods or services.
ensuring people have access to services and medication that will enable them to live well, for longer

• planning for future care and support needs, including, end of life care.

Dementia Prevalence Calculator
The Dementia Prevalence Calculator enables General Practices and Commissioners to,

• take account of prevalence among patients in local care homes, and in the community;

• review estimated local prevalence in relation to numbers of patients on a Practice’s dementia register, and estimate a Practice’s ‘diagnosis gap’;

• consider prevalence by age group, and by severity;

• plan, and take action to improve local diagnosis rates using a range of mechanisms, including improving coding, case finding, targeted screening, and education to improve recognition, assessment, and diagnosis;

• use the tool and data as a means of:

- informing the demand for services, and the supply of services;

- reviewing and redesigning diagnosis pathways;

- benchmarking progress to improve diagnosis rates.
10 key steps
to improving diagnosis, and diagnosis pathways

The ‘10 Key Steps for improving dementia diagnosis and the diagnosis pathway’ (page 7) identifies interventions which can be applied at different points, and at different levels within health and care systems.

Principles critical to the success of this approach are embedded in each Key Step.

These principles include:

- **leadership, and capacity** to deliver diagnosis improvement plan, including resources, are established at the outset
- **a strategic, planned approach** is taken jointly with key stakeholders, including people living with dementia
- **action, is based on an understanding of the baseline**, and what is needed;
- **the introduction of ‘catalysts’, ‘accelerators’ and ‘enablers’** to drive change and improvement;
- **actions are within systems and across systems**, and initiated in parallel where this will have a positive effect
- **brief cycles of change** are used in order to maintain momentum
- **interdependencies** are mapped, anticipated and reviewed regularly
- **action is sustained** over time, ensuring continuity where system change may otherwise be destabilising
- **change and improvement are tracked, measured**, and inform next steps.

(Schneider, K., 2012)
10 key steps to improving diagnosis, and diagnosis pathways

Key Steps for Clinical Commissioning Groups

1. Understand demand
2. Improve access to memory assessment
3. Build capacity and support in the community
4. Drive improvement; monitor and review
5. Ensure transparency about delivery and standards
6. Educate; promote

Key Steps for Primary Care

7. Recognise - screen; assess; refer
8. Find cases
9. Coding
10. Review prescribing
10 Key Steps

1. Understand demand
   - True prevalence, incidence, diagnosis rates, forecast
   - Supply vs demand for services

2. Improve access to memory assessment
   - Local strategic leadership
   - Appropriate treatment, care and support post-diagnosis
   - Recognition and support in primary
   - Carers’ support
   - A fit for purpose workforce
   - Timely, accessible information

3. Build capacity and support in the community

4. Drive improvement; monitor and review
   - Incentives
   - Quality improvement
   - Performance management
   - Citizen, community, corporate and system leadership
   - Data, information; intelligence

5. Ensure transparency about delivery and standards

6. Educate; promote
   - Knowledge, skills and capacity
   - Recognition and support

7. Recognise - screen, assess; refer
   - Patients with co-morbid conditions and/or complex needs
   - Proactive, responsive primary care services

8. Find cases
   - The ‘diagnosis gap’; the true local prevalence vs. numbers with a diagnosis of dementia

9. Coding
   - Appropriate prescribing of antipsychotics
   - Accurate coding and recording on GP QOF Dementia Register

10. Review prescribing
    - Appropriate prescribing of anti-dementia drugs
1. Understand demand

✓ what are the local needs – today, and what is the forecast?
✓ what is the ‘supply gap’?
✓ what is people’s experience?
✓ what needs to improve?

**DRIVER:** True prevalence, incidence, diagnosis rates, forecast

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<td>Review current diagnosis rate(s) at General Practice, and/or CCG level.</td>
<td><strong>Dementia Prevalence Calculator</strong></td>
<td><strong>NHS Cornwall and Isles of Scilly</strong> <a href="#">Accelerating Dementia Diagnosis 2012 - action plan</a></td>
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<tr>
<td>With stakeholders, consider • variation and range • factors that may be affecting the capture and recording of dementia diagnosis; • methods and options for improving rates of diagnosis: consider the domains covered within the ‘10 Key Steps’ (page 7).</td>
<td></td>
<td><strong>NHS Cornwall and Isles of Scilly</strong> Diagnosis audit template</td>
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Review diagnosis rates
Consider factors that may be affecting the capture and recording of dementia diagnosis
1. Understand demand

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| Map and review current diagnosis pathway(s), activity and contracts in order to establish  
  • estimated true prevalence  
  • actual and projected demand v. supply  
  • the quality of service response;  
  • improvement priorities  
  • deliverables and associated outcomes  
  • actions to deliver improvement  
  • leadership and time frame  
  • governance, monitoring and review of delivery | Map of Medicine (2011)  
Map of Medicine for Dementia assessment  
Map of Medicine (2011)  
Map of Medicine for Dementia management  
Dementia Diagnosis Improvement Plan Template  
Dementia Partnerships (2012) New Models of Care for Dementia  
Department of Health (2010) Quality outcomes for people with dementia: building on the work of the national dementia strategy  
NICE (2010) Dementia Quality Standards | Dementia Partnerships Peer Review of Memory Assessment Services in the South West  
NHS Dorset, Bournemouth and Poole Early Intervention and Diagnosis – Local Delivery Action Plan 2012-13  
NHS Bristol - Dementia Care Pathway  
NHS Cornwall and Isles of Scilly Accelerating Dementia Diagnosis 2012 - action plan – Dementia Leadership Groups; comprehensive and specialist Memory Assessment Service. |

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| Review outcomes for people using diagnosis and post-diagnosis pathway(s);  
  • listen to the experience of people seeking help with memory problems  
  • involve people living with dementia in the (re)design of local pathway(s). | Department of Health (2010) Quality outcomes for people with dementia: building on the work of the national dementia strategy  
NICE (2010) Dementia Quality Standards  
Dementia Partnerships (2012) New Models of Care for Dementia  
South West Dementia Partnership (2011) Involving People Living with Dementia | Involving People Living with Dementia The Alzheimers Society, in partnership with people living with dementia, has designed and tested ways of engaging with people with dementia better to inform service improvement, commissioning, and leadership. |
2. Improve access to memory assessment

- what resources are in place currently?
- what are the ‘unmet needs’?
- could services be designed to be more effective, and more efficient?

**DRIVER:** Supply vs demand for services

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<td>With stakeholders, • model demand and supply for specialist assessments, specialist memory services; and for post-diagnosis support in the community • identify outcomes and quality standards</td>
<td>Department of Health (2011) Dementia Commissioning Pack</td>
<td>How different localities have used the Dementia Prevalence Calculator NHS Cornwall and Isles of Scilly Accelerating Dementia Diagnosis 2012 - action plan</td>
</tr>
<tr>
<td>Set trajectories for improvement in diagnosis rates. Estimate the number of specialist memory assessments which will convert to diagnosis of dementia.</td>
<td>Dementia Prevalence Calculator</td>
<td></td>
</tr>
<tr>
<td>Establish cost benefits and options for service delivery</td>
<td>Department of Health (2011) Dementia Commissioning Pack Memory assessment service cost / benefit tool</td>
<td>NHS Dorset, Bournemouth and Poole Early Intervention and Diagnosis – Local Delivery Action Plan 2012-13</td>
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## 2. Improve access to memory assessment

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| Produce memory service specifications to include required increase in rates of diagnosis and standards of delivery. This may include:  
- diagnosis pathways within primary care (for example, for people presenting with at a later stage of dementia, i.e. with moderate-severe dementias)  
- diagnosis pathways via specialist memory services (for example, for people presenting with possible mild dementias, early onset dementia; complex presentations) | Department of Health (2011) Dementia Commissioning Pack  
Service specification for dementia: memory service for early diagnosis and intervention  
NICE (To be published in 2013) Commissioning care for people with dementia  
NICE (2011) NICE Dementia Quality Standards  
South West Dementia Partnership (2011) Guidance and Standards for Diagnosing Dementia | Bristol CCG is aiming to move towards a nurse-led chronic disease model. Dementia-specialist nurses from the secondary care memory assessment service are now based in primary care, supporting GPs as they regain skills in managing dementia.  
Gnosall memory assessment service offers memory assessment in primary care, with expert support from a specialist memory service.  
Lostwithiel General Practice, Cornwall – has introduced a nurse led memory assessment service to support detection, diagnosis, and post-diagnosis care and support.  
NHS Cornwall and Isles of Scilly Accelerating Dementia Diagnosis 2012 - action plan commissioning a mixed model of primary and specialist memory services. |
| Commission specialist memory services sufficient to meet projected increase in demand. | | |
| Incorporate requirements for memory assessment services into annual contract(s), including activity and quality standards. | Payment by Results for Mental Health, Clusters 18-21 | NHS North Somerset Dementia Pathway and Payment by Results illustrates care packages for people living with dementia. |
| Introduce a set of standard Read codes to specialist memory services and ensure these are utilised in discharge. | South West Dementia Network (2012) Dementia Diagnosis Coding Audit Tool | |
3. Build capacity and support in the community

- what do people with dementia, and their carers/families need, to live well?
- how can the needs of people living with dementia be better understood, and 'mainstreamed'?
- what are the commissioning opportunities?
- what is the role of the GP and primary health care team?

**DRIVER:** Local strategic leadership

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<td>Engage with local authority public health, and Health and Wellbeing Boards to review prevalence of dementia and trajectories for increase. Consider implications of this changing profile, over time. Undertake a needs assessment for the current and future population with dementia.</td>
<td><strong>Dementia Prevalence Calculator</strong></td>
<td><strong>NHS Dorset, Bournemouth and Poole</strong> Early Intervention and Diagnosis – Local Delivery Action Plan 2012-13</td>
</tr>
<tr>
<td>Ensure that the needs of vulnerable older adults are reflected in local planning strategies (supported housing; transport; health; social care, residential and nursing care; carers' strategies; carers' services).</td>
<td>NHS London (2011) Dementia Needs Assessment</td>
<td><strong>NHS Gloucestershire</strong> Dementia Strategy</td>
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3. Build capacity and support in the community

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| Promote dementia friendly communities to tackle stigma, raise awareness, and promote opportunities for people living with dementia to live well. | **Prime Minister’s challenge on dementia**  
**Dementia Action Alliance** | **Hampshire** has secured non-recurring funding from NHS South of England Dementia Challenge Fund to **establish sustainable dementia friendly communities**. This is a county-wide project submitted by the five Clinical Commissioning Groups in Hampshire, and their local partners. The project will deliver:  
• groups of empowered people with dementia and their carers who will have a voice and role in developing services and support that enable them to “live well” with dementia;  
• an engaged community enthusiastic about and supportive of people with dementia that promotes inclusivity in its universal services such as leisure centres, opticians, shops, restaurants, hairdressers etc;  
• a Dementia Action Alliance for Hampshire.  
• piloting of Dementia Friendly/ Memory Aware High Street schemes;  
• identification of Community Dementia Champions and the establishment of a sustainable network of champions.  
For more information about dementia friendly communities, go to [www.dementiapartnerships.org.uk/communities](http://www.dementiapartnerships.org.uk/communities) |
3. Build capacity and support in the community

**DRIVER:** Appropriate treatment, care and support post-diagnosis

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| With stakeholders, review local strategies and care pathway(s) to identify range of support required at different stages and steps, and inform local strategies. For example,  
- targeted screening for dementia  
- information and guidance  
- GP/Primary Care liaison and support  
- education and training for carers  
- flexible respite  
- support and care at home, including night sitting  
- case management/key working  
- advocacy  
- telephone contact 24/7  
- specialist advice and interventions  
- dementia care in hospital (acute and community hospitals)  
- workforce development | Dementia Partnerships (2012) [New Models of Care for Dementia](#)  
SCIE (2011) [Windows of Opportunity](#)  
Department of Health (2011) [Dementia Commissioning Pack](#)  
South West Dementia Partnership (2011) [South West Hospital Standards in Dementia Care](#)  
South West Dementia Partnership (2011) [South West Hospital Standards in Dementia Care self assessment template](#)  
Healthcare at Home (2011) [Understanding Out of Hospital Dementia Care](#)  
Dementia Partnerships [Dementia Workforce Portal](#) | NHS Bristol [Dementia Care Pathway](#) – primary-care led diagnosis pathway.  
Dementia support workers [An evaluation of dementia support worker roles](#) (Dementia Partnerships, 2012) New roles and ways of working in the community  
Dementia Partnerships [Dementia Care in Hospital: Building on Strengths. A compendium of positive practice](#)  
NHS Cornwall and Isles of Scilly [Accelerating Dementia Diagnosis 2012 - action plan](#) – community dementia link worker programme; care home dementia link worker programme; community dementia liaison nurses. Introduction of new Primary Care Practitioner Service to improve rates of primary care detection and diagnosis of dementia, post-diagnosis care and support; capacity and competency. |
3. Build capacity and support in the community

**DRIVER:** Recognition and support in primary care

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<td>Ensure effective training is in place for GPs and primary health care teams to ensure they have the competences required to recognise memory problems; undertake a basic dementia screen; make a diagnosis of dementia (moderate-severe stage); and refer to specialist memory assessment services where indicated.</td>
<td>NICE Clinical Guideline (2006) <em>Dementia – Supporting people with dementia and their carers in health and social care. CG42</em>&lt;br&gt;South West Dementia Partnership (2011) <em>Guidance and Standards for Diagnosing Dementia</em>&lt;br&gt;Dementia Partnerships <em>Dementia Workforce Portal</em>&lt;br&gt;Social Care Institute for Excellence <em>Dementia Gateway</em>&lt;br&gt;Royal College of General Practitioners (2011) <em>Care of people with dementia in primary care</em>&lt;br&gt;Royal College of General Practitioners (2011) <em>Diagnosis and early intervention in primary care</em>&lt;br&gt;Royal College of Psychiatrists <em>Alzheimer’s and dementia resources</em>&lt;br&gt;South West Dementia Partnership (2012) <em>Dementia Care in Primary Care Toolkit</em>&lt;br&gt;NHS Gloucestershire’s <em>Dementia Strategy - primary care engagement</em> includes GP leadership for dementia; extensive training across sectors and providers; awareness raising activities; annual countywide Summit; carers education; working with pharmacy advisers; and development of the QOF framework to improve the quality of dementia registers and recording, working with Primary Care Managers to include dementia and carers’ issues in QOF practice visits&lt;br&gt;NHS Somerset <em>Dementia Strategy</em> aims to provide a framework to implement improved, responsive and quality services for people with dementia and their carers across Somerset and improve health related outcomes. See also <em>Somerset Dementia Action Plan 2012</em>.&lt;br&gt;NHS Devon <em>Dementia Diagnosis Action Plan 2011-12</em> - GP clinical lead for dementia appointed 2010. GP education programme completed for 107 practices, local memory assessment pathway, and local Map of Medicine.</td>
<td>NHS Gloucestershire’s <em>Dementia Strategy - primary care engagement</em> includes GP leadership for dementia; extensive training across sectors and providers; awareness raising activities; annual countywide Summit; carers education; working with pharmacy advisers; and development of the QOF framework to improve the quality of dementia registers and recording, working with Primary Care Managers to include dementia and carers’ issues in QOF practice visits&lt;br&gt;NHS Somerset <em>Dementia Strategy</em> aims to provide a framework to implement improved, responsive and quality services for people with dementia and their carers across Somerset and improve health related outcomes. See also <em>Somerset Dementia Action Plan 2012</em>.&lt;br&gt;NHS Devon <em>Dementia Diagnosis Action Plan 2011-12</em> - GP clinical lead for dementia appointed 2010. GP education programme completed for 107 practices, local memory assessment pathway, and local Map of Medicine.</td>
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## 3. Build capacity and support in the community

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<td>Work with primary care commissioners to ensure that standards of care and support are in place in primary care for people who have a diagnosis of dementia, and their carers/families – both for those living at home, or in care homes.</td>
<td>NHS Cornwall and Isles of Scilly, with SW Peninsula Deanery have funded one STR4 GP trainee to work with local general practices to develop understanding about, treatment and care for people living with dementia.</td>
<td><strong>Severn Deanery</strong> has recruited 5 GP Dementia Fellows to work with local practices to develop understanding about, treatment and care for people living with dementia. <strong>EVIDEM Project</strong> – Professor Steve Iliffe and colleagues reviewed studies of interventions to improve GPs’ performance in the early detection and management of dementia. Interventions proved more successful when tailored to the learning needs of the GPs and developed with them. (Iliffe, S., 2011).</td>
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<td>Work with general practices to ensure that the case management role of the general practitioner is recognised and effective.</td>
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<td>Facilitate the identification of learning and development needs within general practice, and support local improvement plans.</td>
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<td>Promote awareness and understanding of the role health and social care, and the voluntary and community sector, and independent in supporting people living with dementia in the community, and in care homes.</td>
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## 3. Build capacity and support in the community

**DRIVER:** Carers’ support

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<td>Ensure carers have timely access to carers’ assessments, flexible</td>
<td>Rotarians Easing Problems of Dementia (2010) <a href="#">Dementia Carers’ Pathways Devon</a></td>
<td>Torbay pilot project (2012) offered enhanced health and wellbeing checks to 6 practices. The report, Early Identification of People with Dementia and their Carers in Torbay, recommends that all carers of newly diagnosed patients with dementia should be offered an enhanced health check at the time of diagnosis.</td>
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<tr>
<td>respite, carer’s breaks, education, single point of contact 24/7.</td>
<td>South West Dementia Partnership (2011) <a href="#">Dementia Information Pack for Primary Care</a></td>
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<tr>
<td>Ensure carers are signposted to social care to access Carers’ Assessments (Carers Recognition and Support Act, date)</td>
<td>Department of Health (2012) <a href="#">The operating framework for the NHS in England 2012/13</a></td>
<td></td>
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<tr>
<td>Capture feedback and outcomes from carers of people living with dementia, in order to establish quality of experience and standards of care. Use this information to inform local service improvement and (re) design.</td>
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<td>Ensure carers receive regular health checks, and engage with health promotion opportunities.</td>
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**DRIVER:** A skilled, compassionate workforce

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<td>Consider range of relevant service contracts, and build in to contracts standards for staff competence in working with people living with dementia</td>
<td>NICE (2006) Clinical Guideline Dementia – Supporting people with dementia and their carers in health and social care, CG42</td>
<td>Dementia Training and Education Strategy for Gloucestershire A dementia training programme which is open to all Health and Social Care staff in Gloucestershire including those in the Voluntary and Independent sector, and those who are caring for a person with dementia. <a href="http://www.gloucestershire.gov.uk/dementiatraining">www.gloucestershire.gov.uk/dementiatraining</a></td>
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<td>South West Dementia Partnership (2011) <a href="#">Dementia Workforce Commissioning Guidance</a></td>
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<td>South West Dementia Partnership (2011) <a href="#">Dementia Competency Framework</a></td>
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## 3. Build capacity and support in the community

**DRIVER:** Timely, accessible information

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<td>Ensure patients and carers/families have access to a range of information about memory problems, and dementia. Build this requirement into contracts, making use of a range of media and ensuring that that information meets people’s changing needs.</td>
<td>South West Dementia Partnership (2011) <a href="#">Dementia Information Pack for Primary Care</a></td>
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<td>South West Dementia Partnership (2011) <a href="#">Dementia Information Pack for Hospitals</a></td>
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<td>The University of Sheffield (2012) <a href="#">Sheffield dementia information pack</a></td>
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A gateway to diagnosis

GPs and primary health care teams are often the first port of call for people worried about their memory, and are a gateway to early diagnosis and interventions.
4. Drive improvement; monitor and review

✔️ what levers can be used to drive quality, innovation, prevention, productivity, and performance?

**DRIVER:** Incentives

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<tr>
<td>Introduce incentives to promote focused action to improve recognition, screening, and access to diagnosis in primary and secondary care, community services, and local communities (LES, DES, CQUINs).</td>
<td>Department of Health (2012) <em>Quality and Outcomes Framework for 2012/13</em></td>
<td>Torbay Care Trust <a href="#">Local Enhanced Scheme 2011-12</a> - the programme has helped practices to use examination of their patient register to identify patients with confusion or memory problems who might be in the early stages of dementia and/or whose condition may have deteriorated. Without the pilot these patients could have been 'missed' until a crisis occurred. Significant numbers of carers of people with dementia or memory problems not previously 'known' to the practice were identified and offered support.</td>
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<td>Department of Health (2012) <em>NHS Outcomes Framework 2012/13</em></td>
<td>NHS Bristol <a href="#">Dementia Incentive Scheme</a> over 50% of practices signed up and from those practices, nearly 250 people were identified as having dementia and added to the registers. The biggest improvement was 37 people in one practice (2012-13).</td>
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<td>Department of Health (2012) <em>NHS Outcomes Framework 2013/14</em></td>
<td>Stockport Clinical Commissioning Group <a href="#">Local Enhanced Scheme 2012-13</a> offers examples of partnership working between primary care, secondary care, social care and third sector organisations, to assist people with dementia and their carers/family in living healthily and well in the community.</td>
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### 4. Drive improvement; monitor and review

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<tr>
<td>Ensure care pathways, systems, information and training are in place to support local implementation of national dementia CQUIN.</td>
<td>Department of Health (2012) <a href="#">CQUINs 2012-13</a></td>
<td>University Hospitals Bristol NHS Foundation Trust has taken a <a href="#">systemic approach to introducing the national dementia CQUIN</a>.</td>
</tr>
<tr>
<td>With local stakeholders, track progress, address challenges. Monitor referrals to memory assessment services in order to measure impact and outcomes.</td>
<td></td>
<td>Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust – dementia CQUIN methodology.</td>
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Enable and support stakeholders to access pump priming monies to support local innovation, and implementation of innovations in dementia in order to accelerate change and improvement.

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## 4. Drive improvement; monitor and review

**DRIVER:** Quality improvement

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<tr>
<td>Work with pharmacists, primary, community, and secondary care providers to improve prescribing of (a) anti-dementia drugs; and (b) antipsychotics</td>
<td>NICE (2011) <em>Technology Appraisal (TA217) Alzheimer's disease - donepezil, galantamine, rivastigmine and memantine</em>&lt;br&gt;The Institute of Psychiatry, King’s College London (2009) <em>The use of antipsychotic medication for people with dementia: Time for action</em>&lt;br&gt;NHS Institute for Innovation and Improvement (2011) <em>The Right Prescription: a call to action on the use of antipsychotic drugs for people with dementia</em></td>
<td><strong>NHS Cornwall and Isles of Scilly</strong> Accelerating Dementia Diagnosis 2012 - uses the ‘<em>Stop, Think, Assess and Review (STAR) tool</em> to support medications review and ensure appropriate prescribing of antipsychotic medications. Joint GP/Pharmacy care home medication review visits including updating of QOF dementia registers. <strong>Resources and audit tools:</strong> Department of Health (2011) <em>Commissioning Pack resources: Reduce inappropriate prescribing of antipsychotics</em></td>
</tr>
<tr>
<td>Design, facilitate and promote engagement with general practices and primary health care teams to develop, implement and review general practice dementia care improvement plans. Link this to education and training initiatives and opportunities (Key Step 6, below)</td>
<td>GP Dementia Diagnosis Improvement Plan Template&lt;br&gt;South West Dementia Partnership (2012) <em>Dementia Care in Primary Care Toolkit</em></td>
<td><strong>NHS Gloucestershire’s</strong> Dementia Strategy - primary care engagement includes development of the QOF framework to improve the quality of dementia registers and recording, working with Primary Care Managers to include dementia and carers’ issues in QOF practice visits. <strong>NHS Somerset</strong> Dementia Action Plan - following GP Quality Outcome Framework visits during 2011-12, assessors suggested that GP practices could improve case finding by reviewing patients in care homes to consider whether referral to memory clinic or diagnosis of dementia is appropriate/ previously without codes. <strong>NHS London</strong> - quality outcomes tool for general practice provides bundles of outcome indicators for general practices to promote transparency, manage performance, and identify opportunities for improvement: <a href="http://www.myhealth.london.nhs.uk">www.myhealth.london.nhs.uk</a></td>
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4. Drive improvement; monitor and review

**Performance management**

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<tr>
<td>Monitor delivery of local diagnosis improvement trajectories at General Practice, and/or CCG level. With stakeholders, consider: • variation and range • factors affecting the capture and recording of dementia diagnosis • action to close gaps.</td>
<td>CCG Dementia Diagnosis Improvement Plan Template</td>
<td>NHS Cornwall and Isles of Scilly <em>Accelerating Dementia Diagnosis 2012 - action plan</em> quarterly audits of diagnosis rates per general practices and Memory Assessment Service; benchmarking; locality visits by commissioner to update on local services/developments.</td>
</tr>
<tr>
<td>Set trajectories/ambitions, driving improvement via General Practice Contract, quality schedule, training plans.</td>
<td>NHS Cornwall &amp; Isles of Scilly (2011) <em>QOF DEM1, DEM2 audit template</em>.</td>
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**Quality improvement**

Work with pharmacists, primary, community, and secondary care providers to improve prescribing of anti-dementia drugs and antipsychotics.
5. Ensure transparency about delivery and standards

✓ how shall we ensure accountability, and to whom?

**DRIVER:** Citizen, community, corporate and system leadership

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<tr>
<td>Identify, and bring together key stakeholders to review standards of access, delivery, the experience of people living with dementia and their carers/families.</td>
<td>Dementia Partnerships (2012) Dementia Diagnosis Improvement Plan Template</td>
<td>NHS Cornwall and Isles of Scilly Accelerating Dementia Diagnosis 2012 - action plan</td>
</tr>
<tr>
<td>Develop a local action plan for improving diagnosis rates, and the diagnosis pathway.</td>
<td>South West Dementia Partnership (2011) Involving People Living with Dementia</td>
<td>NHS Gloucestershire Dementia Strategy</td>
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**DRIVER:** Data, information; intelligence

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<td></td>
<td>Dementia Prevalence Calculator</td>
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</table>
6. Educate; promote

✓ what is the ‘diagnosis gap’ in my practice?
✓ what are the needs of people living with dementia, on my practice list?
✓ what do our patients’ experience tell us? what do our staff tell us?
✓ how can we improve their experience, and achieve better outcomes?
✓ do patients and carers/families have access to the right information and support, at the right time?

**DRIVER:** True prevalence for GP patient registered list

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</table>
| Estimate true prevalence and calculate local diagnosis rate:  
• estimated prevalence of dementia in the community,  
• estimated prevalence of dementia in local care homes. | Dementia Prevalence Calculator | NHS Cornwall and Isles of Scilly [Accelerating Dementia Diagnosis 2012](#) has used the tool to identify General Practice outliers and offer targeted support to improve diagnosis rates |
| Promote and support dementia friendly communities. | | |

**DRIVER:** Diagnosis rate for GP registered patient list

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<tbody>
<tr>
<td>Use true local prevalence as a baseline in order to establish ‘diagnosis gap’ and local trajectories for improvement.</td>
<td>Dementia Prevalence Calculator</td>
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</tbody>
</table>
| Estimate:  
• local diagnosis rate  
• local ‘diagnosis gap’ in the community, and among patients living in care homes  
• patients with co-morbidities  
• potential needs of carers/families | | |
### 6. Educate; promote

**DRIVER:** Knowledge, skills and capacity

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<tr>
<td>Listen to the voices of people living with dementia.</td>
<td>South West Dementia Partnership (2011) <a href="http://www.scie.org.uk/publications/dementia/">Involving People Living with Dementia</a></td>
<td><a href="http://www.scie.org.uk/publications/dementia">Involving People Living with Dementia</a> The Alzheimers Society, in partnership with people living with dementia, has designed and tested ways of engaging with people with dementia better to inform service improvement, commissioning, and leadership.</td>
</tr>
<tr>
<td>Review learning needs, and build in to General Practice team development plans training and education in dementia recognition, assessment, and care.</td>
<td>Dementia Partnerships <a href="http://www.scie.org.uk/publications/dementia/">Dementia Workforce Portal</a> SCIE open dementia e-learning programme South West Dementia Partnership (2012) <a href="http://www.scie.org.uk/publications/dementia/">Dementia Care in Primary Care Toolkit</a></td>
<td><a href="http://www.scie.org.uk/publications/dementia">NHS Gloucestershire</a> training programme and resources for GPs primary health care teams can be found on the <a href="http://www.scie.org.uk/publications/dementia">Dementia Workforce Portal</a>.</td>
</tr>
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</table>
## 6. Educate; promote

**DRIVER:** Recognition and support

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| Ensure patients and carers/families have access to a range of information about memory problems, and dementia | South West Dementia Partnership (2011) [Dementia Information Pack for Primary Care](#) | **South West Dementia Partnership Information Packs** - an information pack and templates for (a) primary care and (b) hospitals, for local adoption and adaption.  
  
The University of Sheffield (2012) [Sheffield dementia information pack](#) |
| Promote and support dementia friendly communities. | [Prime Minister’s challenge on dementia](#) | **Hampshire** has secured non-recurring funding from NHS South of England Dementia Challenge Fund to [establish sustainable dementia friendly communities](#).  
The county-wide project will empower people with dementia and their carers to have a voice and role in developing services and support that enable them to “live well” with dementia. It will also pilot Dementia Friendly / Memory Aware High Street schemes, supporting identification of Community Dementia Champions and the establishment of a sustainable network of champions.  
For more information about dementia friendly communities, go to [www.dementiapartnerships.org.uk/communities](http://www.dementiapartnerships.org.uk/communities). | [Dementia Action Alliance](#) |
7. Recognise - screen; assess; refer

✓ how can we improve recognition of memory problems?
✓ how can we improve diagnosis of dementia?
✓ how can we improve the management of our patients' care?

**DRIVER:** Proactive, responsive primary care services

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| Introduce targeted screening for key groups, e.g.  
  - frail elderly people, including older carers  
  - people with long term conditions,  
  - patients in care homes  
  - patients with cardiovascular disease  
  - patients with Huntingdon’s Disease or Parkinson’s disease  
  - older adults with depression  
  - adults with learning disabilities  
  - patients presenting with memory problems, or mild cognitive impairment  
Initiate targeted screening via,  
  - annual checks for over-65s  
  - over-75 health checks  
  - ‘flu clinics  
  - reviews of clinic registers | South West Dementia Partnership (2012)  
Dementia Care in Primary Care Toolkit  
NICE Clinical Guideline  
Dementia – Supporting people with dementia and their carers in health and social care, CG42  
NICE (To be published in 2013) Commissioning care for people with dementia | NHS Bristol Dementia Incentive Scheme has included indicative screening and review of disease registers in its dementia incentive scheme.  
**Torbay Care Trust** - trialed an enhanced health and wellbeing check for carers of people living with dementia.  
NHS Bristol Dementia Incentive Scheme has included review of coding used for people with Mild Cognitive Impairment (MCI); and health checks for people with MCI in its scheme.  
Alzheimer’s Society (2011)  
Mild cognitive impairment Factsheet 470  
NICE (To be published in 2013) Commissioning care for people with dementia  
Alzheimer’s Society (2011)  
Mild cognitive impairment Factsheet 470  
**NHS Bristol Dementia Incentive Scheme** has included review of coding used for people with Mild Cognitive Impairment (MCI); and health checks for people with MCI in its scheme.

Review annually patients who have presented with Mild Cognitive Impairment (Eu057).  
Maintain a register of people with suspected dementia or mild cognitive impairment. Review regularly within primary care, or via referral for a specialist memory assessment.
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| Run a real time audit with Primary Health Care Team to check, and follow up on cases involving or patients presenting with  
  • falls  
  • possible carer strain  
  • older patients failing to attend appointments  
  • older patients failing to collect, or take dispensed medications  
  • patients in community hospitals  
  • patients in care homes presenting with confusion, depression, problems thinking, reasoning, struggling to follow up conversations, forgetfulness, other changes in mood and cognition  
  • problems with self care. | | Gloucestershire – engagement with local Black and minority ethnic groups has led to better understanding of the needs of people with memory problems, and living with dementia. Cultural differences have informed the work of dementia liaison nurses, and local training and education. Information about dementia and local services has been translated into different languages [www.dementiawebgloucestershire.org.uk](http://www.dementiawebgloucestershire.org.uk). |
| Consider the needs of patients from Black and minority ethnic groups, where cultural differences may affect the timeliness of presentation. | | |
8. Find cases

**DRIVER:** The ‘diagnosis gap’; the true local prevalence vs. numbers with a diagnosis of dementia

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<tbody>
<tr>
<td>Establish general practice's 'diagnosis gap' and local trajectories for improvement (see 6).</td>
<td><strong>Dementia Prevalence Calculator</strong>&lt;br&gt;NHS Employers and British Medical Association (2011) <em>Quality Outcomes Framework for Dementia 2012-13</em> (QOF DEM1, DEM2, DEM3)</td>
<td>NHS Dorset, Bournemouth and Poole <em>Early Intervention and Diagnosis – Local Delivery Action Plan 2012-13</em></td>
</tr>
<tr>
<td>Review patient lists: vulnerable older patients in the community, and in care homes. Where dementia is moderate to severe (i.e. established dementia) • check whether a diagnosis has been recorded on the General Practice dementia register; • record a diagnosis where indicated</td>
<td>South West Dementia Network (2012) <em>Dementia Diagnosis Coding Audit Tool</em>&lt;br&gt;NHS Cornwall and Isles of Scilly <em>Stop, Think, Assess and Review (STAR) tool</em></td>
<td>NHS Cornwall and Isles of Scilly <em>Accelerating Dementia Diagnosis 2012</em> - uses the ‘Stop, Think, Assess and Review (STAR) tool to support medications review and ensure appropriate prescribing of antipsychotic medications. Joint GP/Pharmacy care home medication review visits including updating of QOF dementia registers.</td>
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**DRIVER:** Patients with co-morbid conditions and/or complex needs

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<tr>
<td>Review patients with co-morbid conditions:&lt;br&gt; • Cardiovascular disease and stroke&lt;br&gt; • Huntington’s Disease&lt;br&gt; • Parkinson’s Disease&lt;br&gt; • older adults with depression&lt;br&gt; • adults with Down’s Syndrome</td>
<td>South West Dementia Partnership (2012) <em>Dementia Care in Primary Care Toolkit</em></td>
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</table>
9. Coding

✓ is our practice’s coding of dementia robust?
✓ are we getting the right in information back from memory services?
✓ how can we use our dementia register better to support our patients with dementia, and their carers/families?

**DRIVER:** Accurate coding and recording on GP QOF Dementia Register

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<tr>
<td>Introduce a set of standard Read codes for routine use in the General Practice to be applied for cases of established dementia (moderate to severe).</td>
<td>South West Dementia Network (2012) Dementia Diagnosis Coding Audit Tool</td>
<td>NHS London Guidance on Dementia Coding – recommends a set of four codes to reconcile READ codes with ICD10.</td>
</tr>
<tr>
<td>Audit and reconcile referrals to memory services, and General Practice dementia register (QOF DEM1) to ensure that • outcome of referrals are recorded accurately; • Read codes and ICD10 codes are reconciled.</td>
<td>NHS London Guidance on Dementia Coding – recommends a set of four codes to reconcile READ codes with ICD10.</td>
<td>NHS London Guidance on Dementia Coding – recommends a set of four codes to reconcile READ codes with ICD10.</td>
</tr>
<tr>
<td>Review records of patients with the following codes: • IB1A memory loss symptom • IB1A0 temporary loss of memory • Eu057 mild cognitive disorder</td>
<td>NICE (2006) Clinical Guideline Dementia – Supporting people with dementia and their carers in health and social care. CG42</td>
<td>NICE (To be published in 2013) Commissioning care for people with dementia</td>
</tr>
</tbody>
</table>
9. Coding

Review/recall patients where absence of a code, the code, or the patient’s presentation indicates that a review would be appropriate.

Consider also the needs of carers:
- health and wellbeing; health checks
- health promotion and prevention
- education, information needs
- local networks / groups for support
- need for signposting / referral for carers’ assessment and care plan.


Torbay project – Early Identification of People with Dementia and Their Carers recommends consistent coding, and review of patients with Mild Cognitive Impairment (3.2).

Coding

Introduce a set of standard Read codes for routine use in the General Practice to be applied for cases of established dementia (moderate to severe).
# 10. Review prescribing

**DRIVER:** Appropriate prescribing of anti-dementia drugs

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| Audit prescribing of acetylcholinesterase inhibitors. Check for:  
• adherence to NICE guidance  
South Staffordshire and Shropshire NHS Foundation Trust audited compliance with NICE Technology Appraisal 111 |

**DRIVER:** Appropriate prescribing of antipsychotics

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| Audit prescribing of antipsychotics of adults. Check for:  
• adherence to NICE guidance  
• outliers, where action is needed  
• diagnosis captured on GP dementia register (QOF DEM1) | The Institute of Psychiatry, King’s College London (2009) *The use of antipsychotic medication for people with dementia: Time for action*  
NHS Institute for Innovation and Improvement (2011) *The Right Prescription: a call to action on the use of antipsychotic drugs for people with dementia*  
Alzheimer’s Society (2011) *Reducing the use of antipsychotic drugs. A guide to the treatment and care of behavioural and psychological symptoms of dementia*  
Oxleas NHS Foundation Trust (2010) *Antipsychotic initiation and review clinician decision support tool* | NHS London audit tool and guidance - reduction of antipsychotic prescribing  
NHS Cornwall and Isles of Scilly Accelerating Dementia Diagnosis 2012 - uses the ‘Stop, Think, Assess and Review (STAR)’ tool to support medications review and ensure appropriate prescribing of antipsychotic medications. Joint GP/Pharmacy care home medication review visits including updating of QOF dementia registers.  
## 10. Review prescribing

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<tr>
<td>Review regularly general practice patients living in care homes who have been prescribed antipsychotics.</td>
<td></td>
<td>Psychotropic medicine management for people in care homes with dementia This guidance aims to support the safe management of psychotropic medicines in Norfolk care homes particularly when given to residents to assist in managing their psychological agitation.</td>
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<tr>
<td>Consider training needs of care home staff in the management of behavioural symptoms.</td>
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<tr>
<td>Engage with care home management and pharmacy leads to address this, where appropriate.</td>
<td>NHS Institute for Innovation and Improvement (2011) <em>The Right Prescription: a call to action on the use of antipsychotic drugs for people with dementia</em></td>
<td></td>
</tr>
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Review prescribing

Work with pharmacists, primary, community, and secondary care providers to improve prescribing of anti-dementia drugs and antipsychotics
References


Berkshire Healthcare NHS Foundation Trust – prescribing protocol

Bristol Clinical Commissioning Group nurse-led chronic disease model.


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Dementia web Gloucestershire Gloucestershire – engagement with local Black and minority ethnic groups


Department of Health (2011) **Commissioning Pack resources: Reduce inappropriate prescribing of antipsychotics**

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Map of Medicine (2011) [Map of Medicine for Dementia management](#). Map of Medicine, London.


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NHS Bristol [Dementia Incentive Scheme](#)

NHS Commissioning Board and NHS South of England (2012) [Dementia Prevalence Calculator](#)

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NHS Cornwall & Isles of Scilly (2011) [QOF DEM1, DEM2 audit template](#).

NHS Cornwall and Isles of Scilly (2011) [Stop, Think, Assess and Review (STAR) tool](#)

NHS Devon [Dementia Diagnosis Action Plan 2011-12](#)

NHS Dorset, Bournemouth and Poole [Early Intervention and Diagnosis – Local Delivery Action Plan 2012-13](#)

NHS Gloucestershire Dementia Strategy

NHS Institute for Innovation and Improvement (2012) National Dementia CQUIN and Call 2 Action

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NHS London (2011) Audit tool and guidance - reduction of antipsychotic prescribing

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NHS North Somerset Dementia Pathway and Payment by Results

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Royal College of General Practitioners (2011) Essential knowledge updates - dementia.
RCGP, London.

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South West Dementia Partnership (2012) Dementia Workforce Portal


South West Dementia Partnership (2012) Improving dementia care in primary care: 10 key steps for General Practice

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South West Dementia Partnership (2011) Dementia Competency Framework.

South West Dementia Partnership (2011) Dementia Information Pack for Hospitals
South West Dementia Partnership (2011) Dementia Information Pack for Primary Care

South West Dementia Partnership (2011) Dementia Workforce Commissioning Guidance


South West Dementia Partnership (2011) Involving People Living with Dementia

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South West Dementia Partnership (2011) South West Hospital Standards in Dementia Care self assessment template

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University Hospitals Bristol NHS Foundation Trust systemic approach to introducing the national dementia CQUIN.

University of Sheffield (2012) Sheffield dementia information pack