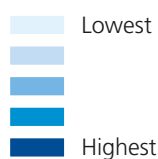**MENTAL HEALTH DISORDERS**

Map 45: Percentage of people who are recorded in GP registers of severe mental illness (SMI) by CCG

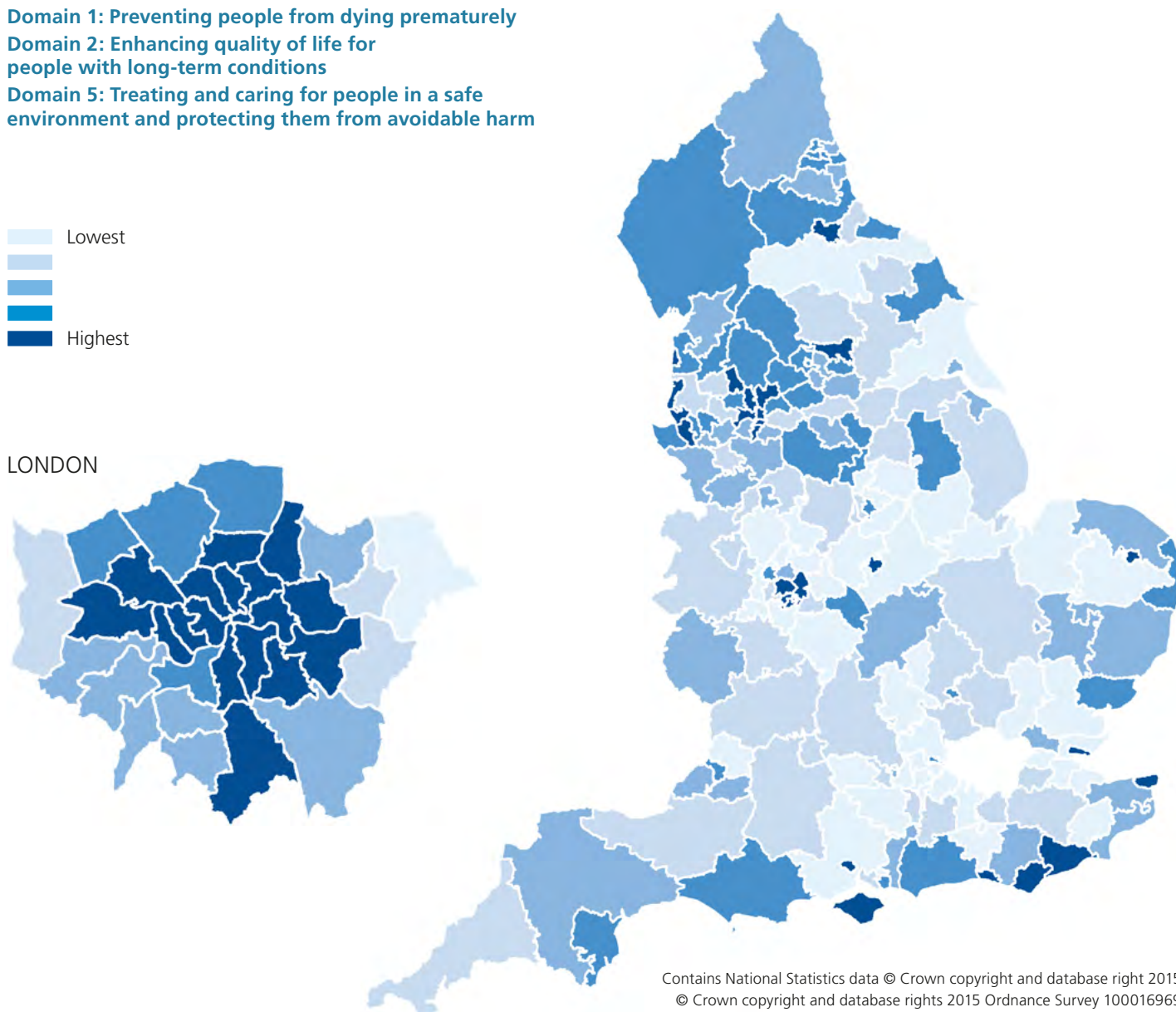2013/14

Domain 1: Preventing people from dying prematurely
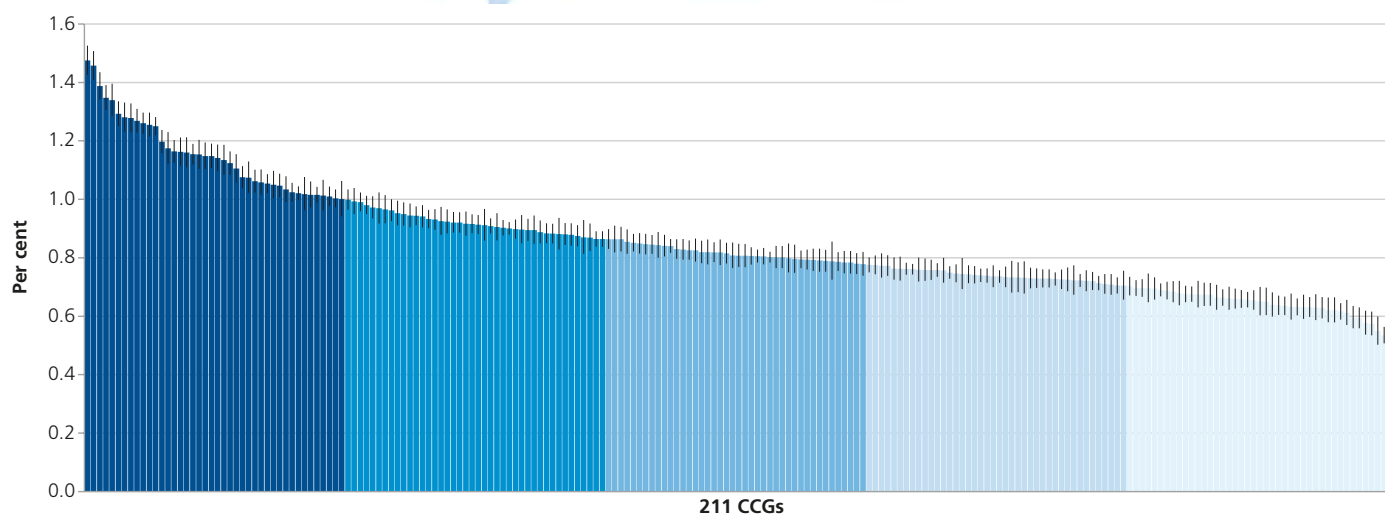**Domain 2: Enhancing quality of life for**
people with long-term conditions
Domain 5: Treating and caring for people in a safe
environment and protecting them from avoidable harm

Lowest

Highest

LONDON

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211 CCGs

Context

If not treated early, psychosis can cause morbidity with substantial and enduring distress and disability. People with psychosis, however, often do not receive, when needed, evidence-based assessments and treatment interventions from which they would benefit. The consequence of a lack of, or inappropriate, treatment can mean substantially worse physical and mental health and social outcomes, including a reduced ability to secure and retain stable accommodation and employment. Currently, the life-expectancy of people with severe mental illness (SMI) is 15–20 years shorter than that for the general population.[1]

Rates of psychosis, or other severe mental disorders, vary by locality. The planning of treatment and support for existing or new cases requires knowledge and awareness of estimates of the number of people with psychosis in the local population. Accurate estimates of the prevalence of SMI at a local level, however, do not exist. The Quality and Outcomes Framework (QOF) SMI register is often presented as a basis for quantifying numbers of people with SMI, but it reflects only the level of identification of SMI in primary care as a proportion of people on GP registers:

› diagnosed with schizophrenia;

› diagnosed with bipolar disorder;

› diagnosed with other psychoses;

› on lithium therapy.

The register is a cumulative count of all identified cases, which, over time, will approach a primary care-based lifetime prevalence.

In England, 0.86% of the population (483,933 people) registered with a GP are included on the SMI register.

Magnitude of variation

For CCGs in England, the percentage of people who are recorded in GP registers of SMI ranged from 0.5% to 1.5% (3.0-fold variation). When the seven CCGs with the highest percentages and the seven CCGs with the lowest percentages are excluded, the range is 0.6–1.3%, and the variation is 2.1-fold.

One reason for the degree of variation observed is differences in the characteristics and contexts of local populations, including the level of deprivation in different localities – a higher proportion of people in more-deprived areas are recorded as having an SMI when compared with people in less-deprived areas.

Other reasons for variation include differences in:

› actual prevalence of people with SMI, for example, there are higher rates of SMI in urban areas when compared with rural areas;

› the rates at which SMI is detected, diagnosed and treated;

› extent of provision of pro-active outreach and enhanced services models in primary care.

Given that psychosis presents most often in adolescence and young adulthood, there may also be differences in awareness, and access to mental health expertise, among parents, schools, other educational bodies, and wider youth agencies across the country.

Options for action

Commissioners need to specify that service providers design and plan services for people with SMI according to need. As these prevalence estimates are limited and need to be interpreted with caution (the QOF SMI register provides only a measure of primary care detection), it is advisable for those responsible for planning local services to draw upon, for further validation, several other measures indicating level of need, such as:

› estimates of incidence;

› rates of people with care coordination in secondary care ('Care Programme Approach'; CPA[2]);

› rates of people with psychosis engaged with different types of secondary care community mental health teams;

› admission rates to hospital, unplanned and elective;

› rates of detention under the Mental Health Act 1983 (as amended by the Mental Health Act 2007).

Commissioners and service providers then need to review estimates of the number of cases and of new cases of SMI in relation to current service provision, and adjust provision accordingly. After triangulation of the data, service planners need to review local SMI registers.

Some GP practices are using pro-active outreach methods: engaging people with SMI, working closely with families and carers, and third sector outreach services, and making special arrangements for the homeless and mobile populations. In areas with high levels of need, some CCGs have introduced enhanced services, with whole-team training in mental health and the development of additional practice nurse expertise in the assessment and treatment of the common physical co-morbidities in psychosis.

RESOURCES

› Mental Health Dementia Neurology Intelligence Network (MHDNIN) Prevalence and service measures.
http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness

› PsyMaptic. Online prediction tool for healthcare planners, commissioners and other key stakeholders requiring accurate, reliable data on the expected incidence of psychotic disorder.
http://www.psymaptic.org/

› London Strategic Clinical network (2014) A commissioner's guide to primary care mental health. Strengthening mental health commissioning in primary care: Learning from experience.
http://www.slcsn.nhs.uk/scn/mental-health/london-mh-scn-primary-care-commiss-072014.pdf

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1   Royal College of Psychiatrists (2013) Whole-person care: from rhetoric to reality - Achieving parity between mental and physical health.
http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/op/op88.aspx

2   The CPA is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs.
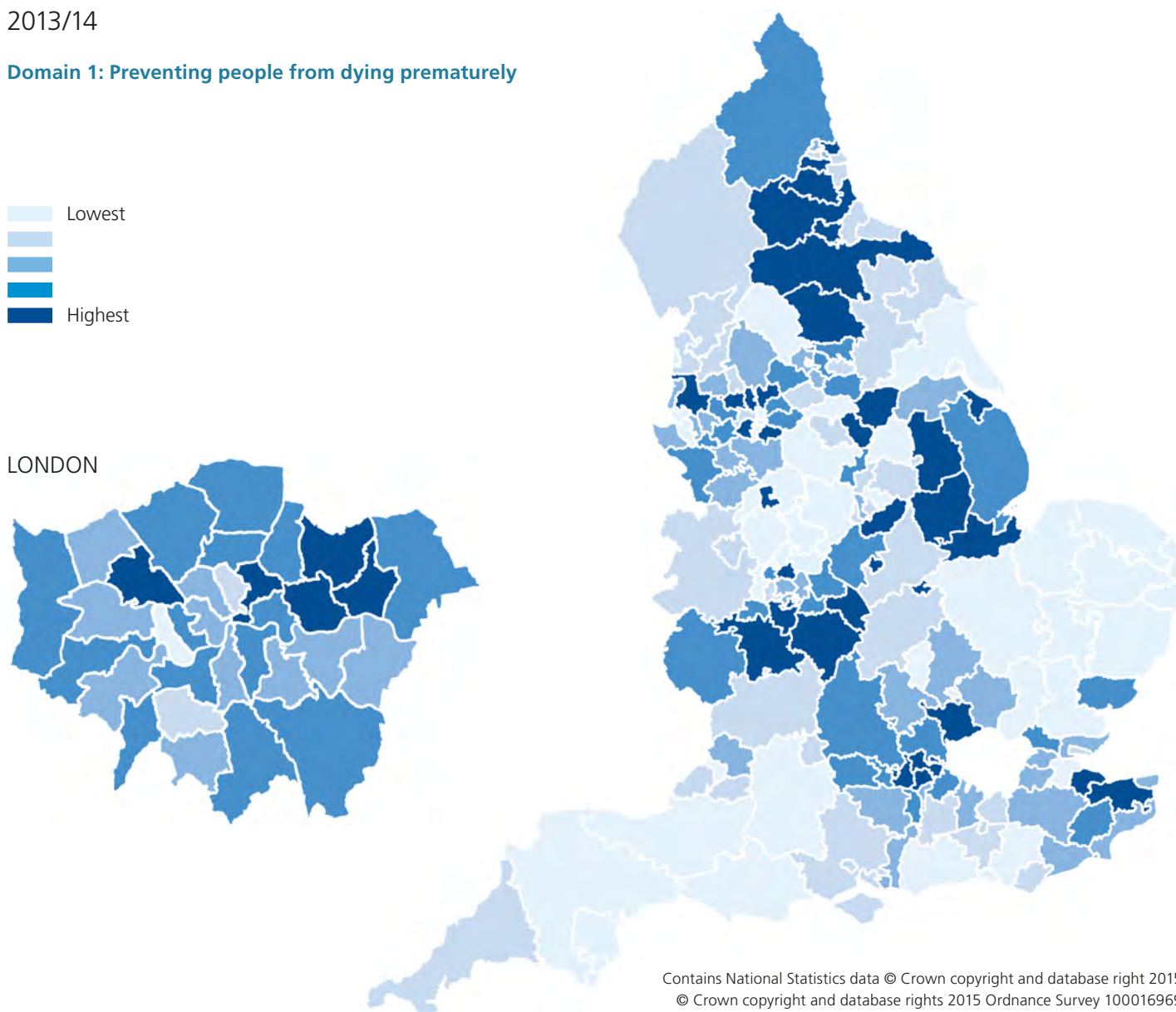
MENTAL HEALTH DISORDERS

Map 46: Mean percentage achievement score for physical health checks on people with severe mental illness (SMI) recorded in GP SMI registers by CCG

2013/14

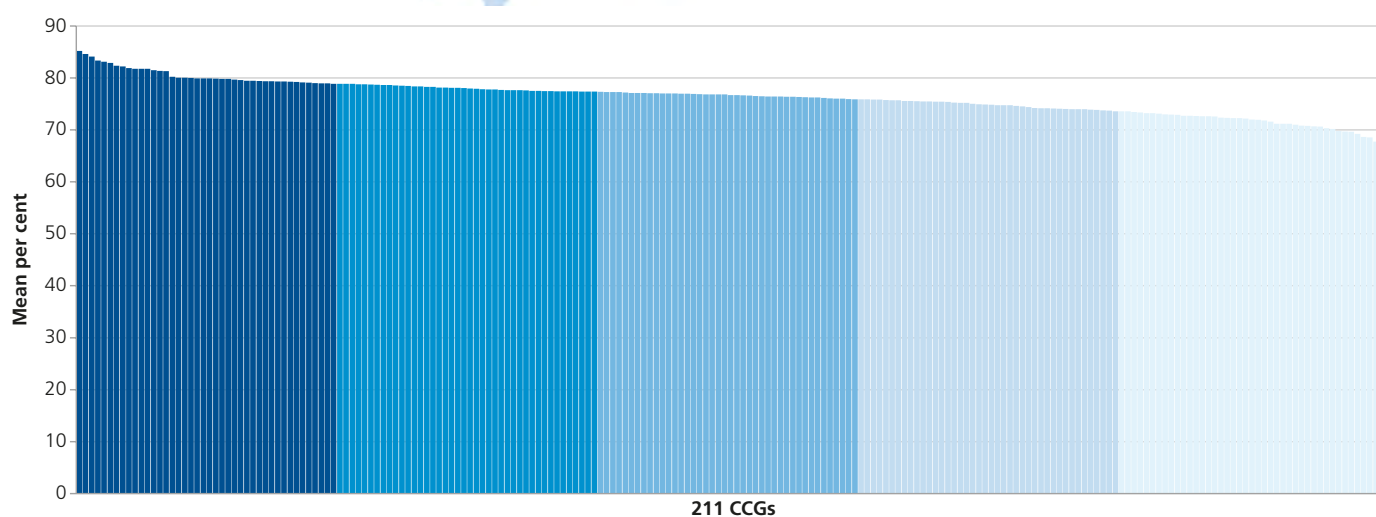**Domain 1: Preventing people from dying prematurely**
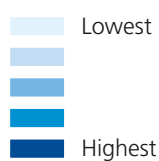
Lowest

Highest

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Mean per cent

211 CCGs

Context

People with severe mental illness (SMI) are at increased risk of poor physical health, and their life-expectancy is reduced by an average of 15–20 years mainly due to preventable physical illness.[1] Healthcare professionals need to understand the physical health risks for people with SMI, investigate any physical symptoms and signs, and provide appropriate treatment, including expert support to establish and maintain a healthy lifestyle (e.g. physical activity and diet), and reduce associated health risk behaviours, such as smoking.

Annual physical health checks in people with SMI provide an opportunity to detect physical conditions and health risk behaviours, and to offer appropriate interventions. In England, the overall average provision of physical health checks for people on the SMI register is 76%.[1] For 2013/14, there was an increase of 4.5% in average provision of physical health checks in people with SMI when compared with 2012/13, which could relate to changes in exception-reporting (see Map 47, pages 138–140).

In 2013/14, the SMI physical health check comprised six individual components appropriate to a person's age and sex, which also related to the cardio-metabolic risks associated with SMI, linked to the effects of medication, and the difficulties people with SMI have of maintaining a healthy lifestyle (see Table 46.1).

Table 46.1: Components of the physical health check for people with SMI, and their completion rates in 2013/14[2]

Component	Completion rate
Alcohol consumption	79.0%
Body mass index (BMI)	78.8%
Blood pressure	82.9%
Cervical screening (women aged 25–64 years)	72.3%
Cholesterol (people aged ≥40 years)	68.0%
Blood glucose (people aged ≥40 years)	74.9%

This indicator has been calculated as the average of the six components of the physical health check. Each component is weighted equally, i.e. those for the full population (e.g. BMI) contribute equally to those for subgroups of the population (e.g. cervical screening for women with SMI aged 25–64 years). The indicator excludes people on the SMI register recorded as "exempt"[3].

Magnitude of variation

For CCGs in England, the mean percentage achievement score for physical health checks on people with SMI recorded in GP SMI registers ranged from 62.2% to 85.2% (1.4-fold variation). When the seven CCGs with the highest mean percentage achievement scores and the seven CCGs with the lowest mean percentage achievement scores are excluded, the range is 69.8–82.2%, and the variation is 1.2-fold.

The degree of variation observed does not appear to be associated with levels of deprivation. Possible reasons for unwarranted variation include differences in:

› accessibility of primary care for people with SMI, including pro-active outreach;

› the model of primary care mental health used locally.

Options for action

To improve the health of people with SMI, commissioners need to specify that service providers and planners:

› assess, using practice-level data, what proportion receive (i) annual physical health checks, and (ii) effective interventions for physical conditions and health risk behaviours;

› improve coverage of annual physical health checks;

› respond appropriately and flexibly when health check results indicate intervention;

› assess the outcomes of interventions for physical conditions and health risk behaviours;

› improve outcomes of interventions for physical conditions and health risk behaviours;

› use a clinical decision template to support guided clinical assessment (see "Case-study resource").

Although this indicator is a summary measure, service providers need to assess each component of the health check to identify whether specific components could be improved.

Primary care service providers need to consider:

› pro-active engagement of people with SMI, including support to understand physical health risks, flexibility in booking appointments, third sector outreach support, support to carers, and appropriately framed reminders to attend;

› implementation of responsive care initiatives, including enhanced SMI service models for high-impact conditions, developing practice nurse capacity and capability, continuing professional development, and the use of clinical decision support templates (see "Case-study resource").

CASE-STUDY RESOURCE

› NHS Improving Quality. Living Longer Lives Case Study. Physical healthcare of patients with severe mental illness. A template for physical healthcare in Bradford: a collaboration between specialist mental health and primary care. June 2014. http://www.nhsiq.nhs.uk/media/2484208/bradford_mental_illness_-_final_updated.pdf

RESOURCES

› Mental Health, Dementia and Neurology Intelligence Network (MHDNIN) Severe Mental Illness Profiling tool. http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness

› Joint Commissioning Panel for Mental Health. Commissioning Tools: For people with severe mental illness. http://www.jcpmh.info/commissioning-tools/cases-for-change/physical-health-care/severe-mental-illness/

› Rethink Mental Illness. Health professionals – Physical health resources. See CQUIN Toolkit. http://www.rethink.org/about-us/health-professionals/physical-health-resources

› Hardy S. Physical Health Checks for people with Severe Mental Illness: a primary care guide. University of East Anglia and NHS Northampton. http://physicalsmi.webeden.co.uk

› BMJ Learning for Nurses (2015) Contains two UCL Partners modules: Medication for mental health problems in primary care: a guide for practice nurses – part one and part two. http://learning.bmj.com/learning/info/CME-CPD-for-nurses.html?gclid=COCC-p2lw8UCFQLItAodL3YA_Q

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1 Royal College of Psychiatrists (2013) *Whole-person care: from rhetoric to reality - Achieving parity between mental and physical health.* http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/op/op88.aspx

2 As of 2014/15, in the Quality and Outcomes Framework (QOF), the measurement of BMI, and cholesterol, and blood glucose levels are no longer included in the physical health check for people on the SMI register.

3 According to QOF protocols, people with SMI who have been contacted but have not agreed to be placed on the register can be listed as "exempt", and reported as "exceptions".
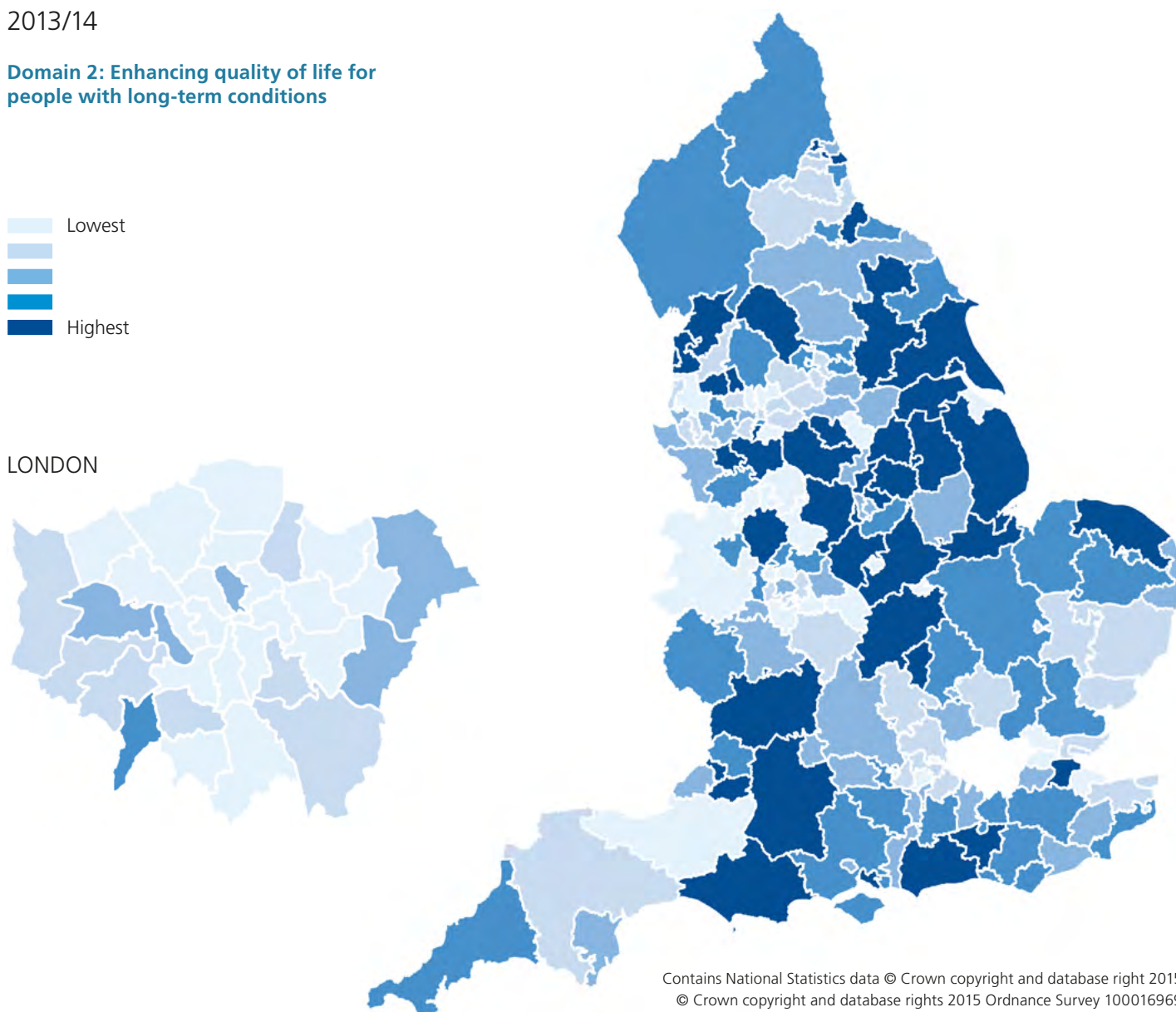
MENTAL HEALTH DISORDERS

Map 47: Percentage of people with severe mental illness (SMI) recorded in GP SMI registers who were excepted from the calculation of QOF achievement scores by CCG

2013/14

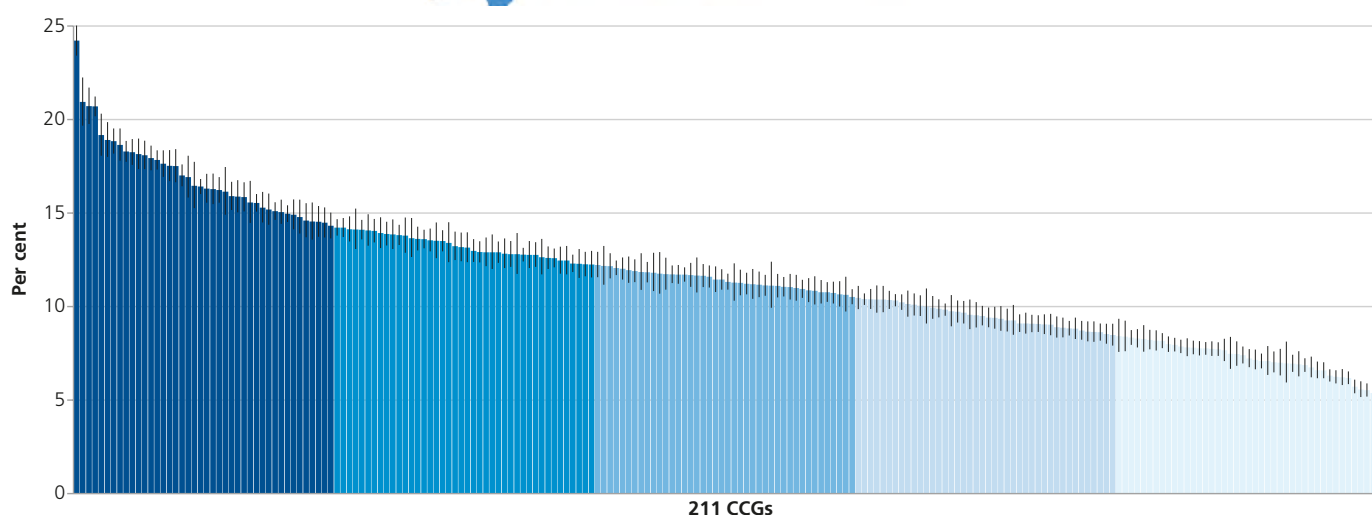**Domain 2: Enhancing quality of life for people with long-term conditions**
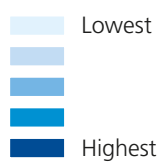
Lowest

Highest

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211 CCGs

Context

People with severe mental illness (SMI) have a life-expectancy 15–20 years less than that of the general population.[1] The frequency of physical health checks, and implementation of appropriate evidence-based interventions to address physical health conditions and associated health-risk behaviours, in primary care can reduce this premature mortality. Variation in the provision and quality of physical healthcare for some people with SMI is of serious concern given their level of premature mortality.

In 2013/14, there were 11 indicators in the Quality and Outcomes Framework (QOF) relating to specific measures and diagnostic tests for the assessment of the physical health of people with SMI.[2] Under the QOF scheme, GPs are rewarded for achieving an agreed level of population coverage for each indicator. In calculating coverage, practices are allowed to except defined people from the target population to avoid being penalised for factors beyond the GPs' control. For each QOF indicator, three measures are reported annually:

› percentage including exceptions;

› exception rate;

› percentage excluding exceptions.

Exceptions relate to people on disease registers who would ordinarily be included in the denominator for the relevant QOF indicators but are not because they meet at least one of the stated exception criteria. For instance, the SMI register includes people who are "in remission" (i.e. who have no record of antipsychotic medication, inpatient or secondary or community care mental health follow-up within the last five years), yet they are excluded from the denominator.

In 2013/14, the average exception rate across all relevant QOF indicators was 4.1%. The largest proportion of exceptions was in mental health at 14.4%; exceptions for SMI were 11.4%, a decrease when compared with 15.5% in 2012/13[3].

Where exceptions are applied, many of the people with SMI most in need may be excluded from physical health checks as a consequence. This indicator highlights the effectiveness of education, outreach to and engagement of vulnerable groups, and whether this group of people are receiving the support from primary care services that they need.

Magnitude of variation

For CCGs in England, the percentage of people with SMI recorded in GP SMI registers who were excepted from the calculation of QOF achievement scores ranged from 4.9% to 24.2% (4.9-fold variation). When the seven CCGs with the highest percentages and the seven CCGs with the lowest percentages are excluded, the range is 6.2–18.6%, and the variation is 3.0-fold.

In 2013/14, of all CCGs in England, 34 (one in six) had exception rates higher than 15%. The exception rate was 8.13% in the London region, 11.94% in the Midlands and East region, 12.17% in the North region, and 12.83% in the South region.

Exception rates are not related to the level of deprivation. Possible reasons for unwarranted variation include differences in:

› availability of appropriate primary care services for people with SMI;

› accessibility of primary care services for people with SMI.

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1   Royal College of Psychiatrists (2013) Whole-person care: from rhetoric to reality - Achieving parity between mental and physical health.
    http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/op/op88.aspx

2   For QOF 2014/15, the diagnostic indicators were deleted.

3   Changes were made to the QOF indicators for 2013/14, e.g. a decrease in the time-period over which measurements were taken from 15 to 12 months, which may have had an impact on exception-reporting.

Options for action

Commissioners and service providers in localities with high exception rates need to review practice-level data to ascertain whether some primary care services are experiencing difficulties supporting people with SMI. It is possible to identify which practices in a CCG have high exception rates; practices where rates are low can share learning with practices where rates are higher.

Service providers need to review whether people with SMI:

> have a comprehensive care plan, including support to attend physical health checks;

> receive interventions to address physical health conditions and health risk behaviours, focusing on cardio-metabolic health monitoring.

Commissioners need to specify that service providers implement initiatives to increase the number of people on the SMI register, such as local secondary mental health services taking a leadership role to ensure full cooperation is achieved. This would help to facilitate the performance of physical health checks and minimisation of the exception rate. This may involve:

> targeted local needs assessment to determine gaps in the provision of health checks or physical health interventions for people with SMI;

> quarterly reconciliation of people being treated in secondary care under the Care Programme Approach (CPA)[4] and people on the QOF register;

> skilled assistance in ensuring checks are acceptable to and accepted by service users in primary care settings or at the individual's residence;

> improved collaboration and coordination between primary care and secondary mental healthcare services in support of the physical health of people with SMI, potentially including different models of integrated care;

> establishment of enhanced primary care services for people with SMI;

> workforce undergraduate and continuing professional development in mental health.

Primary care service providers need to consider pro-active and supportive methods of engaging with people with SMI to encourage uptake of physical health checks, including:

> help for people to understand the importance of and need for health checks;

> flexibility when booking appointments;

> providing third sector or family outreach services;

> appropriate framing of reminders to attend;

> utilising wider community resources, such as community leaders, cultural communities, and community pharmacists.

For people with psychosis or schizophrenia, commissioners need to specify that secondary mental health services follow NICE guidelines (CG178; see "Resources") and take responsibility for people's physical health within the first year of treatment. After this time-period, commissioners need to specify that the responsibility moves to primary care. Commissioners and all service providers must be clear about who has responsibility for an individual's physical health during the course of treatment and care for SMI. This can be assisted by routine use of the NHS Number, which enables all treating clinicians to access the Summary Care Record. This record indicates the range of health needs, assessments, test results, medication, and monitoring arrangements for an individual.

RESOURCES

> Mental Health Dementia Neurology Intelligence Network (MHDNIN) Severe Mental Illness Profiling tool. http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness

> NICE. Psychosis and schizophrenia in adults: treatment and management. NICE guidelines [CG178]. February 2014. https://www.nice.org.uk/guidance/cg178

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4   CPA is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs.
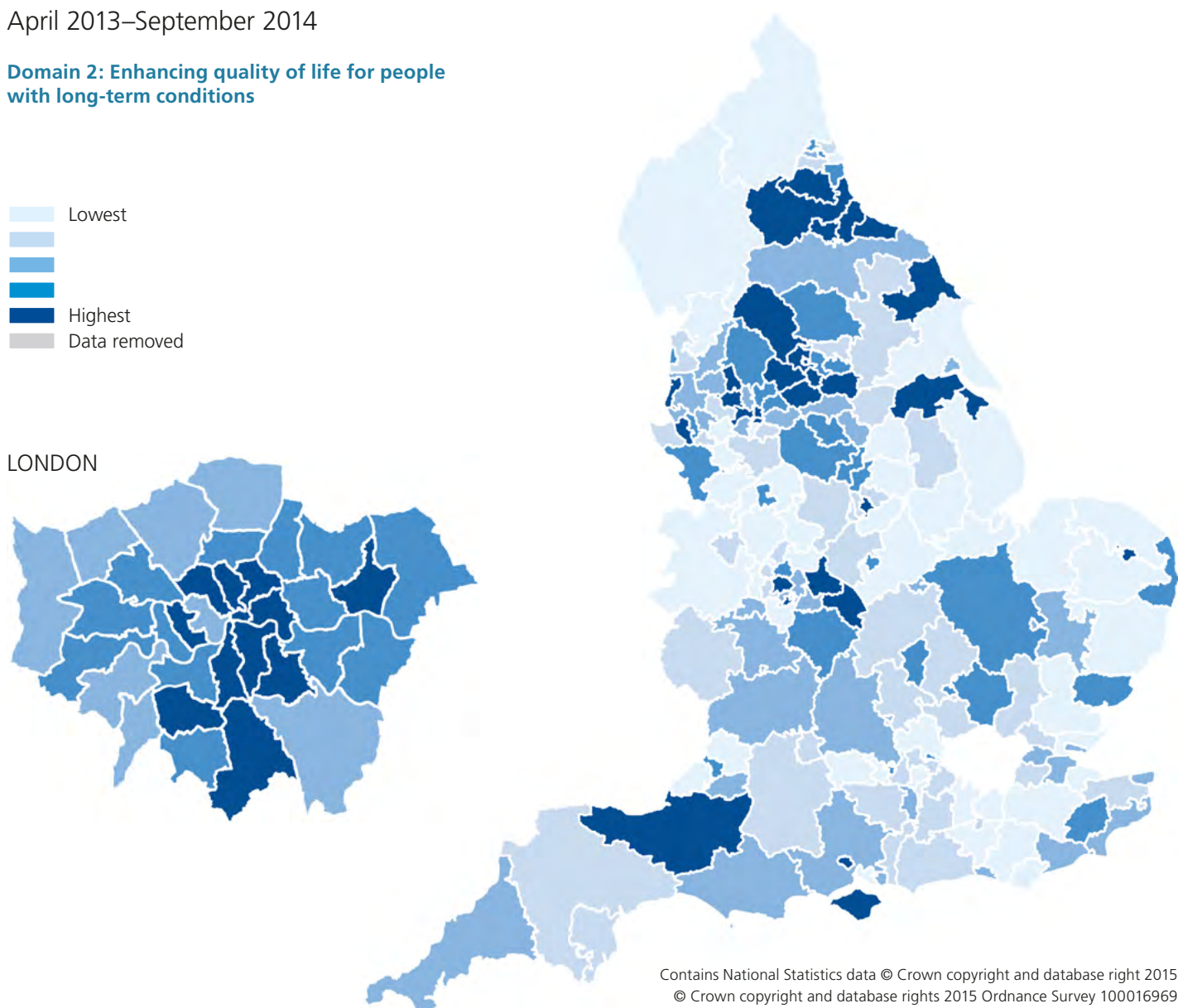
MENTAL HEALTH DISORDERS

Map 48: Rate of new cases of psychosis in people aged 18 years and over who received early intervention in psychosis (EIP) services per population by CCG
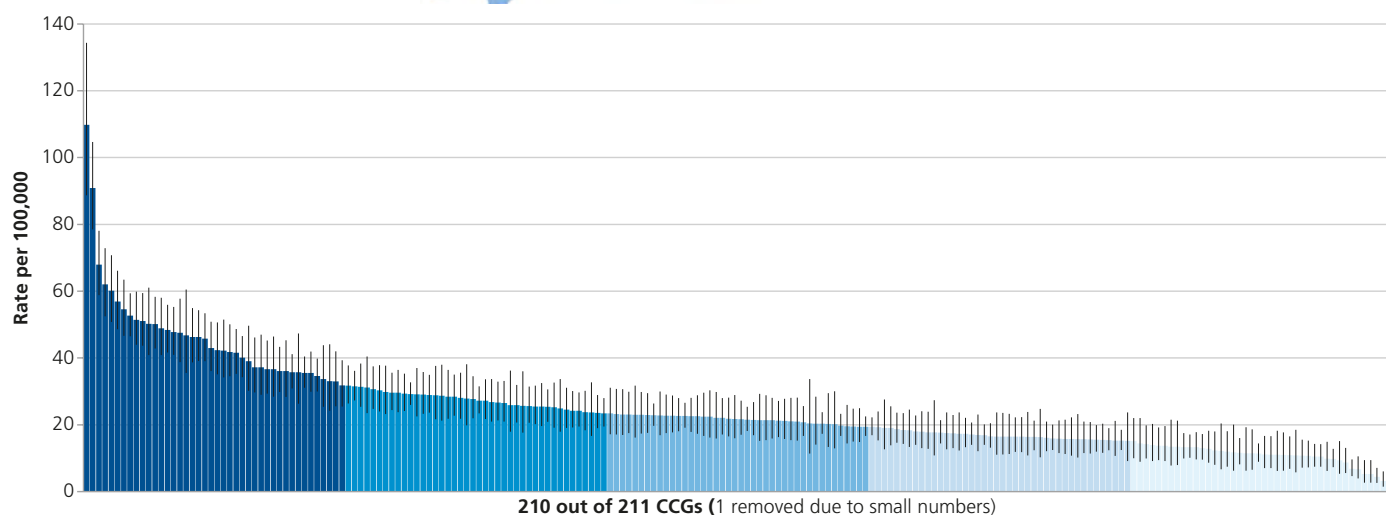
April 2013–September 2014

Domain 2: Enhancing quality of life for people with long-term conditions
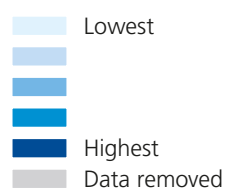
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210 out of 211 CCGs (1 removed due to small numbers)

Rate per 100,000

Context

According to NICE, when compared with standard care, effective care by early intervention in psychosis (EIP) teams can reduce the duration and severity of a first episode of psychosis, and help improve people's social functioning and outcomes (CG178; see "Resources"). In effect, EIP can prevent an episode of psychosis developing into a long-term condition. Furthermore, economic analysis highlights that when compared with standard care treatment by EIP services saves £15 net for each £1 spent.[1] The proportion of people with first-onset psychosis accessing EIP services can be estimated by comparing access rates with predicted incidence rates, using an online tool such as PsyMaptic[2].

From April 2016, the new access standard for EIP is for more than 50% of people experiencing a first episode of psychosis to be treated with a NICE-approved care package within two weeks of referral from any source into secondary mental health services.[3] The introduction of this standard includes the development of new indicators for the Mental Health and Learning Disability Minimum Data Set (MHLDMDS). It will apply to people of all ages, whereas at present EIP is typically understood to be available to people under the age of 35 years. Apart from increasing access to EIP services, it is also important to reduce the delay between the onset of a first episode of psychosis and referral, measured as duration of untreated psychosis (DUP),[4] and submitted a part of the MHLDMDS.

At present, we have limited understanding of the timeliness of access to NICE-concordant services for people experiencing a first episode of psychosis; this indicator is based on quarterly aggregate returns, and not patient-level data and services. Despite limitations, the available data in reported access to services can act as a baseline to inform understanding and service development, and assist services to improve data quality and ensure that calculations of the local prevalence of psychosis are understood.

There were 15,527 new cases of psychosis served by EIP services during the 18-month period April 2013 to September 2014. In England, the annual rate is 24.4 new cases seen per 100,000 adult population.

Magnitude of variation

For CCGs in England, the rate of new cases of psychosis in people aged 18 years and over who received EIP services ranged from 3.1 to 110 per 100,000 population (35.2-fold variation).[5] When the seven CCGs with the highest rates and the seven CCGs with the lowest rates are excluded, the range is 8.7–53 per 100,000 population, and the variation is 6.0-fold.

One reason for the degree of variation observed is differences in levels of underlying need among local populations: socio-economic deprivation and population age-structure are factors related to the incidence of psychosis. The majority of the 46 CCGs with rates significantly higher than the England average are in more deprived areas. Other demographic factors include differences in the proportion of people in the population who are mobile, in transition, or homeless.

Despite these demographic differences, the variation across CCGs merits further investigation. Possible reasons for unwarranted variation include differences in:

› local area Institution Investment Portfolios, including whether an area has youth offender and adult bail and residential hostels, residential rehabilitation care homes, supported accommodation, prisons, and specialist forensic and other units;

› age thresholds for EIP services;

› availability and capacity of EIP services;

› prevalence of drug-induced psychoses in different localities, such as skunk cannabis and alcohol;

› drivers for local EIP services to accept people as part of their caseload who do not meet access criteria (e.g. people with learning disability without psychosis).

There may also be errors in coding, and the reporting of, data.

Options for action

Commissioners need to specify that service providers work towards achieving NICE quality statement 1 within NICE QS80 (see "Resources"), using the NHS England guidance published to support implementation of quality statement 1 (see "Resources").

Commissioners and service providers need to review:

› the coverage of EIP services by comparing numbers of people supported with the predicted incidence of psychosis, QOF data on severe mental illness, admissions for SMI, and numbers of people managed using the care programme approach[6] (CPA) in relation to local demography;

› the way in which EIP services fit into wider service planning, and whether EIP services are being used inappropriately to supplement gaps in provision for other groups of people in need;

› the way in which "at-risk" groups , e.g. people with moderate-to-severe common mental health problems, can be supported to prevent possible onset of psychosis, including people currently experiencing a "clinical high-risk state".

The Mental Health, Dementia and Neurology Intelligence Network (MHDNIN) will facilitate the routine presentation of data to commissioners and service providers with the aims of improving data completeness and accuracy, and of using robust data to help improve services.

RESOURCES

› MHDNIN. Severe Mental Illness Profiling tool. http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness

› NICE. Psychosis and schizophrenia in adults: treatment and management. NICE Guidelines [CG178]. February 2014. http://www.nice.org.uk/guidance/cg178

› NICE. Psychosis and schizophrenia in adults. NICE quality standard QS80. February 2015. http://www.nice.org.uk/guidance/qs80

› Quality statement 1: Referral to early intervention in psychosis services. http://www.nice.org.uk/guidance/qs80/chapter/Quality-statement-1-Referral-to-early-intervention-in-psychosis-services

› NHS England. Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16. February 2015. http://www.england.nhs.uk/wp-content/uploads/2015/02/mh-access-wait-time-guid.pdf

1   Knapp M et al (2014) Investing in recovery: making the business case for effective interventions for people with schizophrenia and psychosis. PSSRU, The London School of Economics and Political Science, and Centre for Mental Health, London, UK. http://eprints.lse.ac.uk/56773/

2   http://www.psymaptic.com

3   NHS England (2015) Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16. 12 February 2015. http://www.england.nhs.uk/wp-content/uploads/2015/02/mh-access-wait-time-guid.pdf

4   http://mentalhealthpartnerships.com/resource/duration-of-untreated-psychosis-dup-measurement/

5   Data from one CCG have been removed due to small numbers.

6   The CPA is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs.
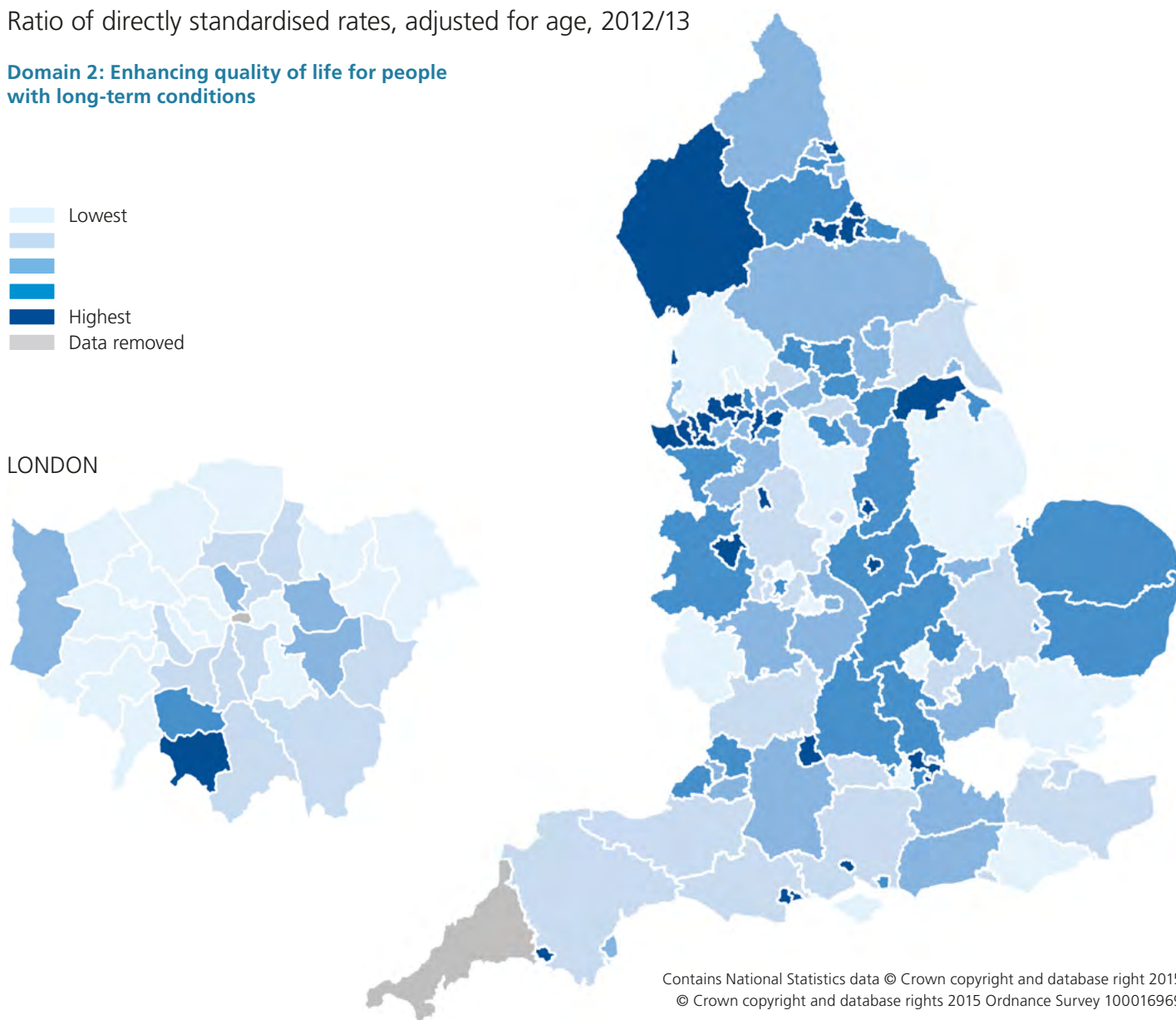
MENTAL HEALTH DISORDERS

Map 49: Standardised mortality ratio (SMR) in people aged 18–74 years in contact with mental health services by upper-tier local authority

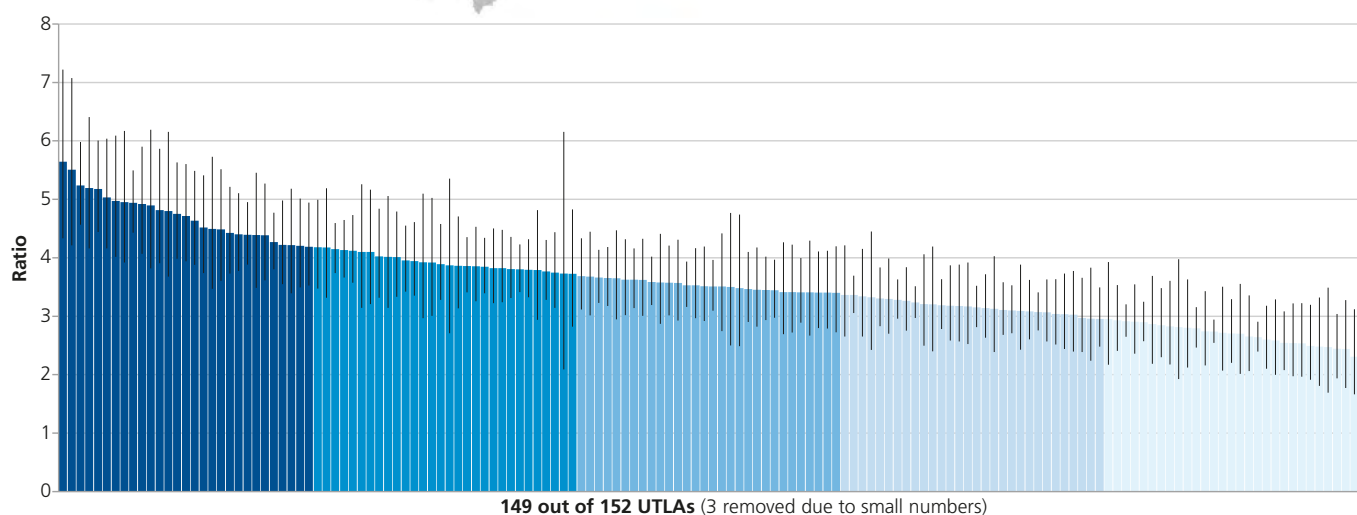Ratio of directly standardised rates, adjusted for age, 2012/13

Domain 2: Enhancing quality of life for people with long-term conditions
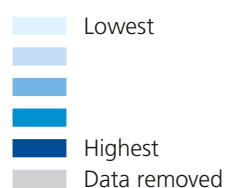
Lowest

Highest
Data removed

LONDON

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149 out of 152 UTLAs (3 removed due to small numbers)

Context

People with a mental illness die on average 15–20 years younger than the rest of the population, primarily due to poor physical health.[1] In all local authorities in England where people are in contact with mental health services, people with mental health problems die earlier than the general population.

In England in 2012/13, the mortality rate among adults aged 18–74 years in contact with mental health services (in the last three years) was 3.47 times greater than that among the general population of the same age. This ratio has been gradually increasing since 2009/10, when the ratio was 3.27.

Reducing premature death in people with severe mental illness (SMI) requires an understanding of the causes of those deaths; typically the primary cause is preventable physical illness. For people in contact with mental health services, the major causes of excess mortality, including liver disease and respiratory disease, are shown in Figure 49.1. Mental health-related causes, such as suicide, account for about one-third excess premature deaths.

Opportunities to intervene to improve mental and physical health outcomes include:

> health awareness and educational programmes;

> the provision of integrated intensive community treatment services;

> pro-active engagement of people with SMI to attend annual physical health checks – in the National Audit of Schizophrenia, only 29% of people with SMI in specialist community services were accessing physical health checks[2].

When patients are admitted to mental health inpatient care, there is a greater opportunity to ensure that integrated physical and mental healthcare is provided, and also coaching for healthy lifestyles and smoking cessation; CQUIN data for 2014/15 indicate that this

is much needed because there appears to be highly variable levels of monitoring in these inpatient settings.[3]

The data for this indicator:

> are specific to people in contact with secondary care services;

> do not include people wholly under primary care services for mental healthcare;

> do not include people with mental health problems who have not been in contact with specialist services.

All people in contact with specialist services are counted; it is not possible to define accurately those people with particular diagnoses, such as psychosis, schizophrenia or bipolar disorder.

Magnitude of variation

For upper-tier local authorities (UTLAs) in England, the standardised mortality ratio (SMR) in people aged 18–74 years in contact with mental health services ranged from 1.39 to 5.64 (4.0-fold variation).[4] When the five UTLAs with the highest SMRs and the five UTLAs with the lowest SMRs are excluded, the range is 2.48–5.03, and the variation is 2.0-fold.

One reason for the degree of variation observed is differences in the level of deprivation among different localities in the country. Excess mortality is higher in the most-deprived areas.

Other reasons for variation are likely to relate to differences in local healthcare practices, including the extent:

> to which primary care services pro-actively engage people with SMI to attend annual physical health checks;

> of follow-up to ensure healthcare interventions are provided, including those addressing health risk behaviours.

1   Royal College of Psychiatrists (2013) Whole-person care: from rhetoric to reality - Achieving parity between mental and physical health.
    http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/op/op88.aspx
2   National Audit of Schizophrenia Project Team. Report of the National Audit of Schizophrenia (NAS) 2012.HQIP and the Royal College of Psychiatrists.
    http://www.hqip.org.uk/assets/NCAPOP-Library/NCAPOP-2012-13/Schizophrenia-National-Audit-Report-pub-2012.pdf
3   http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/cquin.aspx
4   Data for three UTLAs have been removed due to small numbers.

Options for action

Commissioners and services providers need to review the physical and mental health causes of premature mortality in people who are in contact with primary care, drug and alcohol and secondary care mental health services in their locality. Commissioners need to specify that service providers assess:
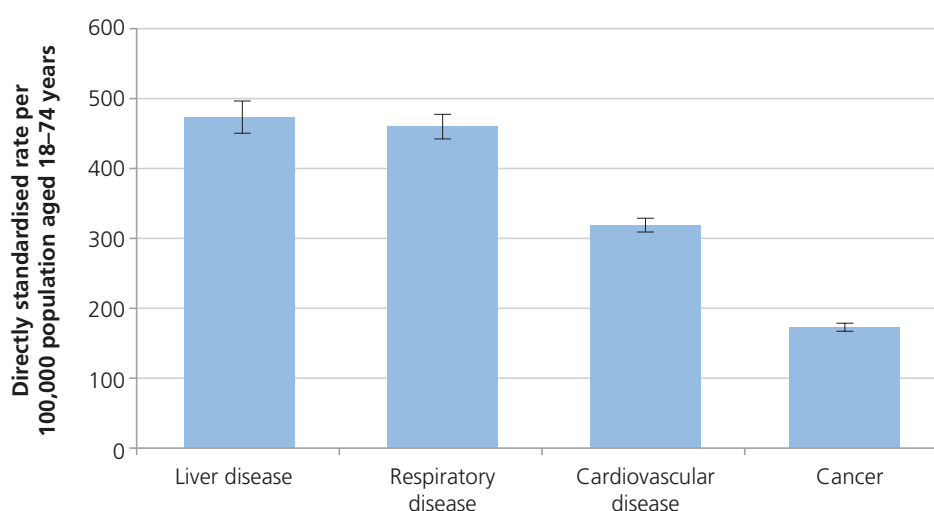
› existing pathways for early intervention to ensure people with SMI gain integrated physical and mental health treatment and support at initial presentation;

› the effectiveness of any mental health interventions provided to ensure they are evidence-based, systematically deployed in a timely manner, and appropriate to a person's need;

› the occurrence of physical health side-effects as a result of metal health medications, such as weight gain and diabetes;

› education about the adverse effects of using drugs or alcohol to reduce the level of distress from illness;

› routine assessment of the side-effects of medication (e.g. using the Glasgow Antipsychotic Side-effect Scale, GASS[5]);

› the appropriate use of medication for people in contact with mental health services to avoid excessive dosages or polypharmacy;

› the level of provision of physical health checks in people with SMI to ensure they occur at least annually;

› the need for enhanced primary care mental health services in localities with a higher prevalence of SMI;

› the provision of support to facilitate a healthy lifestyle for people with SMI;

› the provision of targeted support to reduce health risk behaviours, such as smoking, drug use, and alcohol use;

› the potential for "diagnostic over-shadowing" (the failure to investigate physical health fully because of mental health problems);

› the availability of suicide prevention training and programmes in primary care and specialist mental health services.

RESOURCES

› Mental Health Dementia Neurology Intelligence Network (MHDNIN) Severe Mental Illness Profiling tool. http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness

› Health and Social Care Information Centre (HSCIC) Causes of excess mortality in adults with SMI.[6] http://www.hscic.gov.uk/catalogue/PUB10347/ment-heal-bull-mhmds-anua-retu-2011-12-bulletin.pdf

Figure 49.1: Cause of excess mortality in people in with SMI (2012/13)

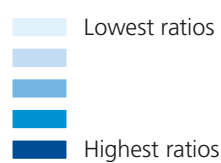5 GASS. http://mentalhealthpartnerships.com/resource/glasgow-antipsychotic-side-effect-scale/
6 This document provides additional data but is based on an older time-series.
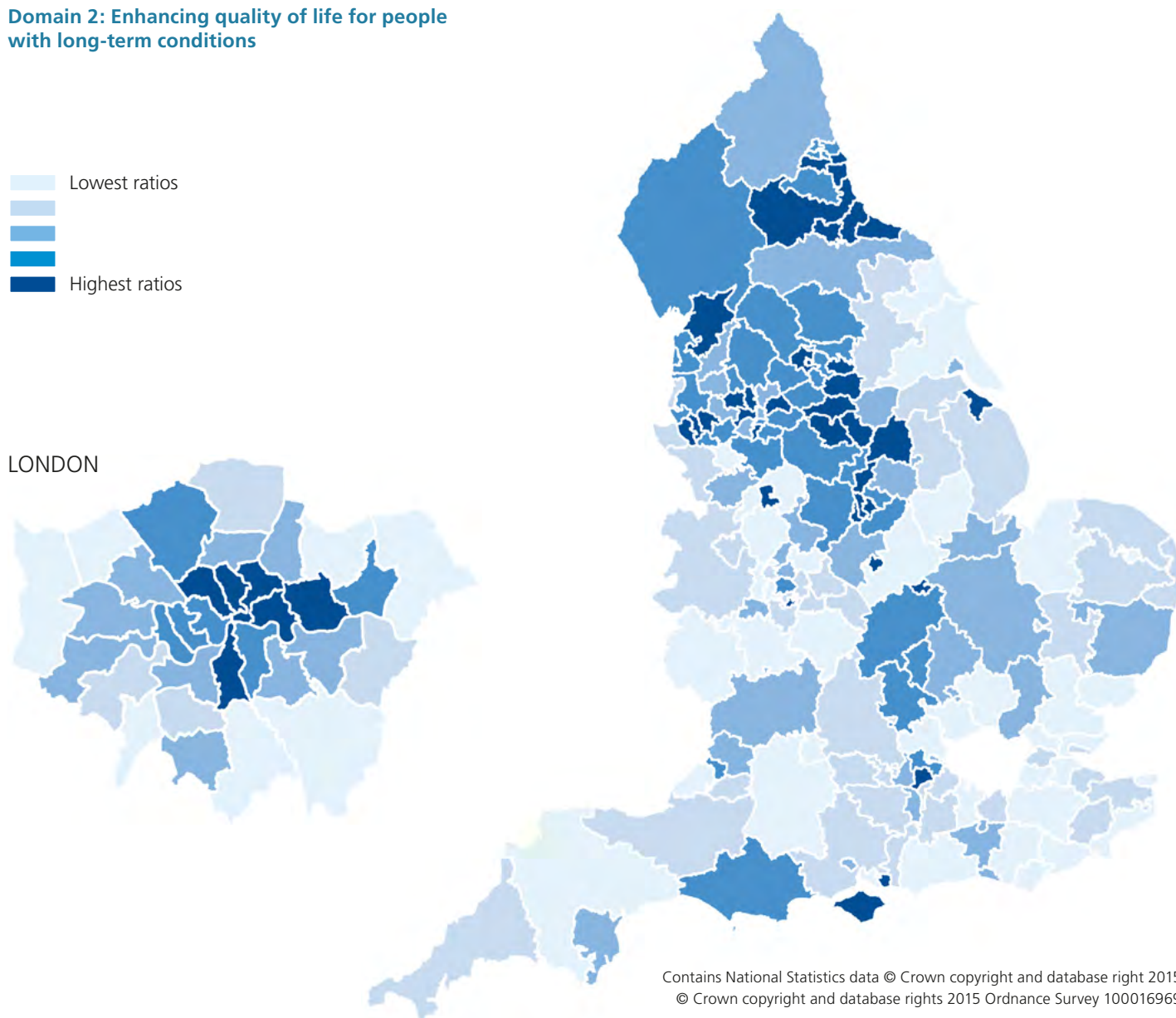
MENTAL HEALTH DISORDERS

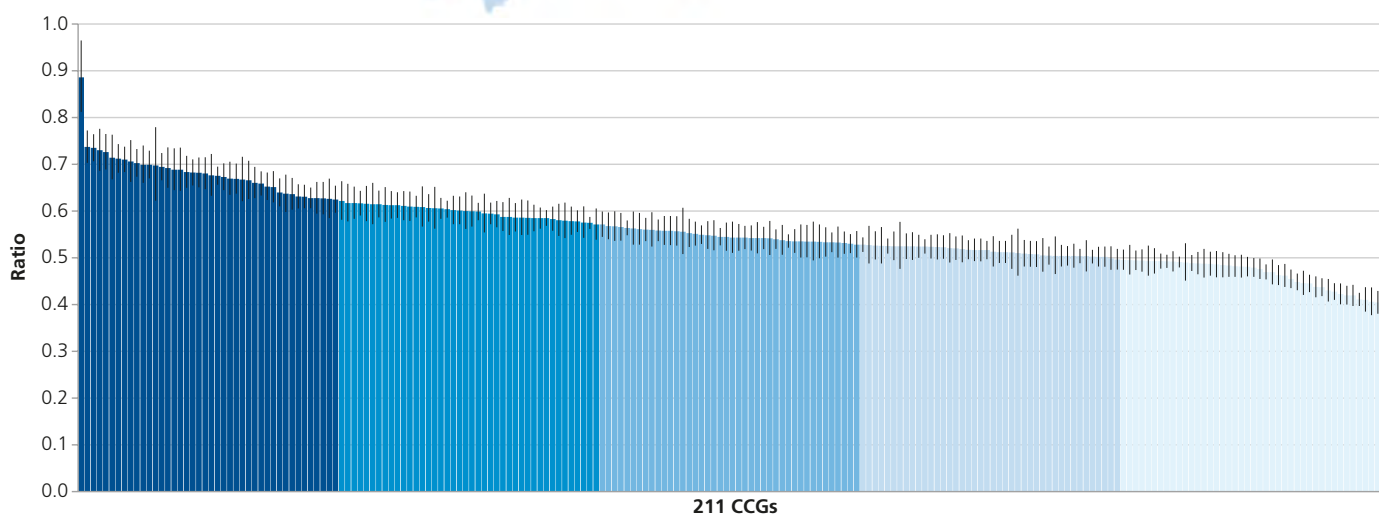# Map 50: Ratio of reported to expected prevalence of dementia by CCG

October 2014

Domain 2: Enhancing quality of life for people with long-term conditions

Lowest ratios

Highest ratios

LONDON

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211 CCGs

Context

Dementia is a syndrome, a group of related symptoms associated with increased age, in which there is a decline in brain function, especially of the memory. There are four main types:

› Alzheimer's disease, the most common;

› vascular dementia, commonly due to a stroke or a series of transient ischaemic attacks;

› Lewy body dementia;

› fronto-temporal dementia, much rarer, usually occurring in people aged under 65 years.

Sometimes, a person may have more than one type, e.g. Alzheimer's disease and vascular dementia.

Dementia is one of the most feared illnesses for people over the age of 50 years because there is no cure and symptoms deteriorate over time. As treatments are available that can improve the quality of life for people with dementia, "timely" diagnosis is important, and can confer psychological as well as practical financial benefits.

The Delphi consensus facilitated by the Alzheimer's Society in 2014 suggests there are 850,000 people in the UK with dementia.[1] In the Cognitive Function and Ageing Study (CFAS), based on empirical surveys, a lower estimate of 670,000 people were expected to have dementia in the UK in 2011.[2] NHS England estimated that the dementia diagnosis rate for England was 61.6% by March 2015.[3]

For this indicator, the number of people on GP Quality Outcomes Framework (QOF) registers is the numerator; the estimated number of people in a locality with dementia is the denominator.

Magnitude of variation

For CCGs in England, the ratio of reported to expected prevalence of dementia ranged from 0.40 to 0.89 (2.2-fold variation). When the seven CCGs with the highest ratios and the seven CCGs with the lowest ratios are excluded, the range is 0.42–0.71, and the variation is 1.7-fold.

One reason for the degree of variation observed is differences in the demography of local populations, including:

› ethnic composition, especially as there are cultural issues associated with a diagnosis of dementia;

› age structure – localities that have a higher proportion of younger people, such as CCGs with universities or colleges within their boundaries, will have a lower prevalence, and CCGs with a large number of nursing and residential care homes within their boundaries will have a higher prevalence.

Possible reasons for unwarranted variation include differences in:

› level of awareness of the symptoms of dementia, and the importance of diagnosis, in primary care;

› access to memory assessment services;

› secondary care systems to identify and refer people with dementia;

› access to mental health, primary care or community geriatric input in residential and nursing care homes.

Options for action

Commissioners need:

› to review regularly diagnosis rates for dementia in the local population using material developed by NHS England (see "Resources");

› to review level of access to memory assessment services, and commission services in line with the estimated prevalence of dementia locally;

› to commission an appropriate level of post-diagnostic support for people with dementia according to NICE commissioning guidance and NHS England Enhanced Service Specification (see "Resources").

CCGs, GPs and other approved stakeholder organisations can use the Dementia Prevalence Calculator (see "Resources") to gain an understanding of the estimated prevalence in the local population and among people living in local care homes.

1   Alzheimer's Society. Dementia UK: Update. 2nd edition. November 2014.
    http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2323
2   Matthews FE, Arthur A, Barnes LE et al on behalf of the Medical Research Council Cognitive Function and Ageing Collaboration. A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II. *Lancet* 2013; 382: 1405-1412.
3   HSCIC. Quality Outcomes Framework (QOF), Recorded Dementia Diagnoses, April 2014-March 2015. April 2015.
    http://www.hscic.gov.uk/article/2021/Website-Search?productid=17760&q=+Quality+Outcomes+Framework+%28QOF%29%2c+Recorded+Dementia+Diagnoses%2c+Publication+Date+17+April+2015&sort=Relevance&size=10&page=1&area=both#top

GPs need to consider:

› referring people presenting with memory problems to memory assessment services;

› the possibility of dementia in people with the following vascular risk factors – high blood pressure, obesity, atrial fibrillation, raised cholesterol levels, diabetes, and excessive alcohol use.

Healthcare professionals, particularly clinicians, need to raise awareness among individuals and in local populations of the benefits of diagnosing dementia, especially of the support available after receiving a diagnosis.

Primary care providers need to ensure that GPs are offered skills development in the early identification and diagnosis of dementia.
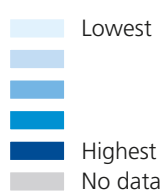
RESOURCES

› All-Party Parliamentary Group on Dementia. Unlocking Diagnosis: The key to improving the lives of people with dementia. July 2012. http://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=873

› Barrett E, Burns A. Dementia Revealed. What Primary Care Needs To Know. A Primer for General Practice. July 2014. NHS England and Hardwick CCG with the support of the Department of Health and the Royal College of General Practitioners. http://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf

› Alzheimer's Society. Dementia UK: Update. 2nd edition. November 2014. http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2323

› NHS England. Enhanced Service Specification. Facilitating timely diagnosis and support for people with dementia 2015/16. March 2015. http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/03/facilitate-tmly-diag-dementia.pdf

› NICE. Support for commissioning dementia care. NICE commissioning guides [CMG48]. April 2013. https://www.nice.org.uk/guidance/cmg48

› NICE. Dementia: Supporting people with dementia and their carers in health and social care. NICE guidelines [CG42]. June 2006. https://www.nice.org.uk/guidance/cg42

› NICE Centre for Clinical Practice – Surveillance Programme. Recommendation for Guidance Executive: CG42 Dementia – Supporting people with dementia and their carers in health and social care. May 2015. https://www.nice.org.uk/proxy/?sourceUrl=http%3a%2f%2fwww.nice.org.uk%2fnicemedia%2flive%2f10998%2f71780%2f71780.pdf

› NICE Centre for Clinical Practice – Surveillance Programme. Recommendation for Guidance Executive: CG42 Dementia – Supporting people with dementia and their carers in health and social care. May 2015. https://www.nice.org.uk/proxy/?sourceUrl=http%3a%2f%2fwww.nice.org.uk%2fnicemedia%2flive%2f10998%2f71780%2f71780.pdf

› NICE. Dementia quality standard. NICE quality standard [QS1]. June 2010. https://www.nice.org.uk/guidance/qs1

› NICE Pathways. Dementia overview. Revised and updated 2014-15. http://pathways.nice.org.uk/pathways/dementia

› Dementia Partnerships. Dementia Prevalence Calculator. http://dementiapartnerships.com/diagnosis/dementia-prevalence-calculator/

› http://dementiapartnerships.com/wp-content/uploads/sites/2/DPC-introduction-v4.pdf
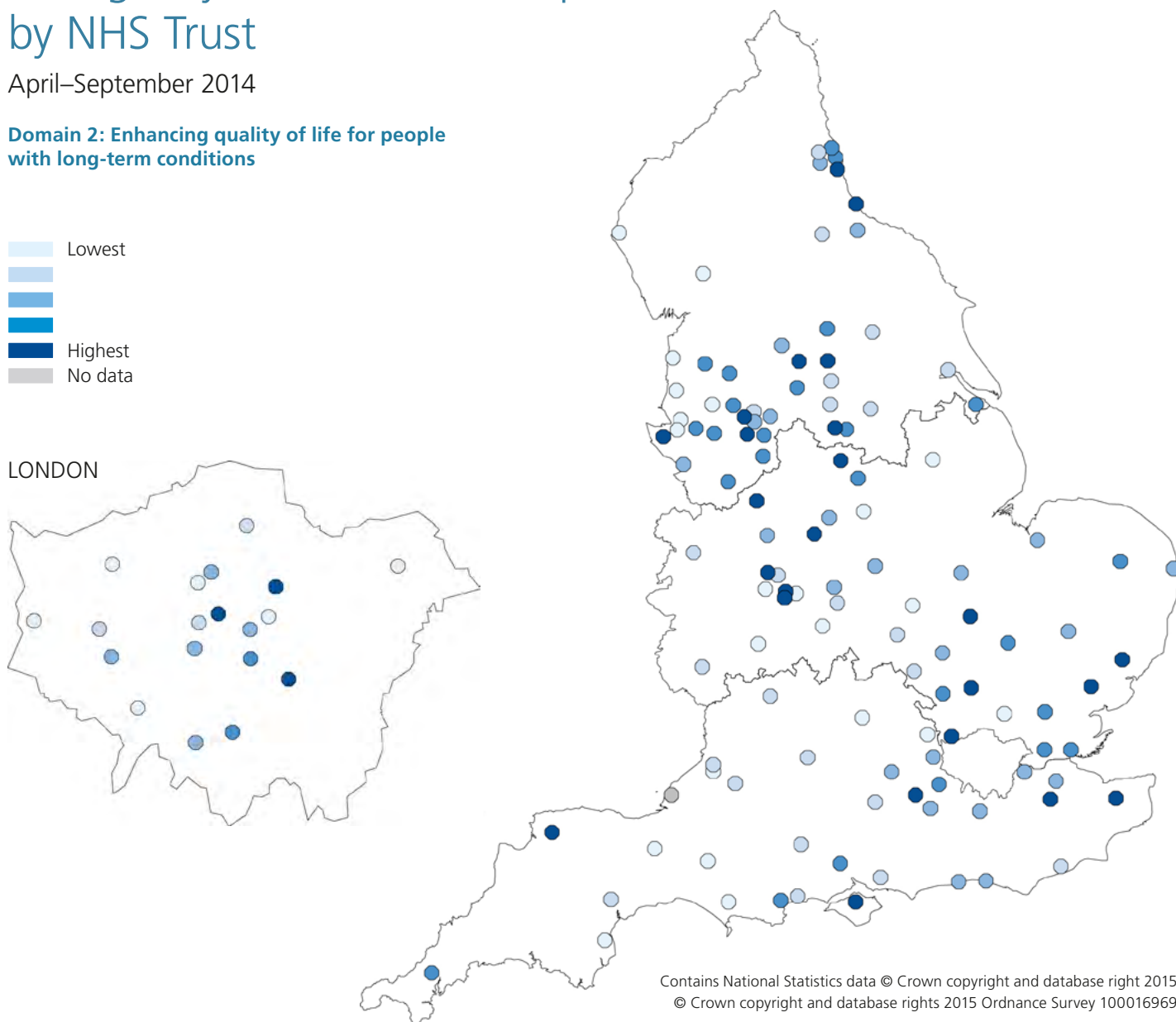
MENTAL HEALTH DISORDERS

Map 51: Percentage of people aged 75 years and over to whom dementia case-finding was applied following emergency admission to hospital for more than 72 hours by NHS Trust
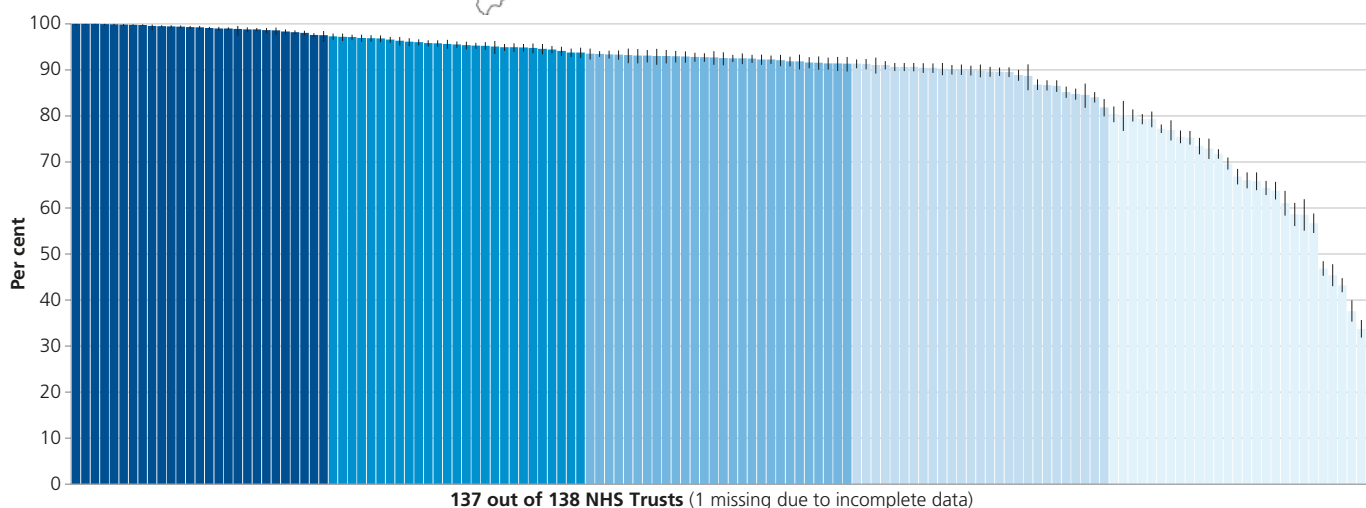
April–September 2014

Domain 2: Enhancing quality of life for people with long-term conditions

Lowest

Highest
No data

LONDON

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Per cent

100
90
80
70
60
50
40
30
20
10
0

137 out of 138 NHS Trusts (1 missing due to incomplete data)

Context

As the population ages, people admitted to hospital tend to be older, and dementia increases in prevalence with age. The findings of observational studies suggest that one in four admissions to general hospital is a person with co-morbid dementia, although dementia is rarely the primary reason for hospital admission. Co-morbid dementia can be poorly identified, and many people in hospital with co-morbid dementia have never received a diagnosis. In addition, delirium (confusional states) is often seen in people with dementia, and dementia itself is a risk factor for delirium.

During 2013 and 2014, in a thematic review of the care of people living with dementia as they moved between care homes and hospital, the Care Quality Commission (CQC) found aspects of variable or poor care in:

› 56% of hospitals regarding how a person's needs were assessed;

› 22% of hospitals regarding the arrangements for how organisations shared information as people moved between them;

› 61% of hospitals regarding people or their families or carers not being involved in decisions about their care or how they spend their time;

› 42% of hospitals regarding how the care met people's physical and mental health, and social and emotional needs;

› 56% of hospitals regarding staff's understanding and knowledge of dementia care;

› 28% of hospitals regarding the way hospitals monitored the quality of dementia care.[1]

People with dementia experience a longer length of stay than that for other patients, and worse symptoms after being in hospital.[2]

As hospital admissions can adversely affect the health of people with dementia, it is important:

› to identify inpatients with co-morbid dementia, which is as yet undiagnosed;

› to improve the quality of care and support for all inpatients with dementia who are in hospital for whatever reason, especially as they have complex needs.

In the NICE dementia quality standard (see "Resources"), Quality Statement 8 suggests that:

"People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older people's mental health."

The data for these three indicators on dementia assessment and referral are from NHS England Commissioning for Quality and Innovation (CQUIN) for NHS Trusts. From 2015/16, the CQUIN will be extended to community service providers, and the indicators will be reported on a new basis.[3]

Magnitude of variation

Map 51: Dementia case-finding after emergency admission

For NHS Trusts in England, the percentage of people aged 75 years and over to whom dementia case-finding was applied following emergency admission to hospital for more than 72 hours ranged from 21.7% to 100% (4.6-fold).[4] When the five NHS Trusts with the highest percentages and the five NHS Trusts with the lowest percentages are excluded, the range is 46.8–99.9%, and the variation is 2.1-fold.

Map 52: Appropriate assessment of people with possible dementia

For NHS Trusts in England, the percentage of people aged 75 years and over identified as potentially having dementia who were appropriately assessed following emergency admission to hospital for more than 72 hours ranged from 18.8% to 100.0% (5.3-fold variation).[4] When the five NHS Trusts with the highest percentages and the five NHS Trusts with the lowest percentages are excluded, the range is 38.6–100.0%, and the variation is 2.6-fold.

1   Care Quality Commission. Cracks in the Pathway. People's experiences of dementia care as they move between care homes and hospitals. October 2014. http://www.cqc.org.uk/sites/default/files/20141009_cracks_in_the_pathway_final_0.pdf

2   Alzheimer's Society. Counting the cost. Caring for people with dementia on hospital wards. 2009. http://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=356

3   CQUIN Guidance 2015/16. http://www.england.nhs.uk/nhs-standard-contract/15-16/

4   Data from one NHS Trust are missing.
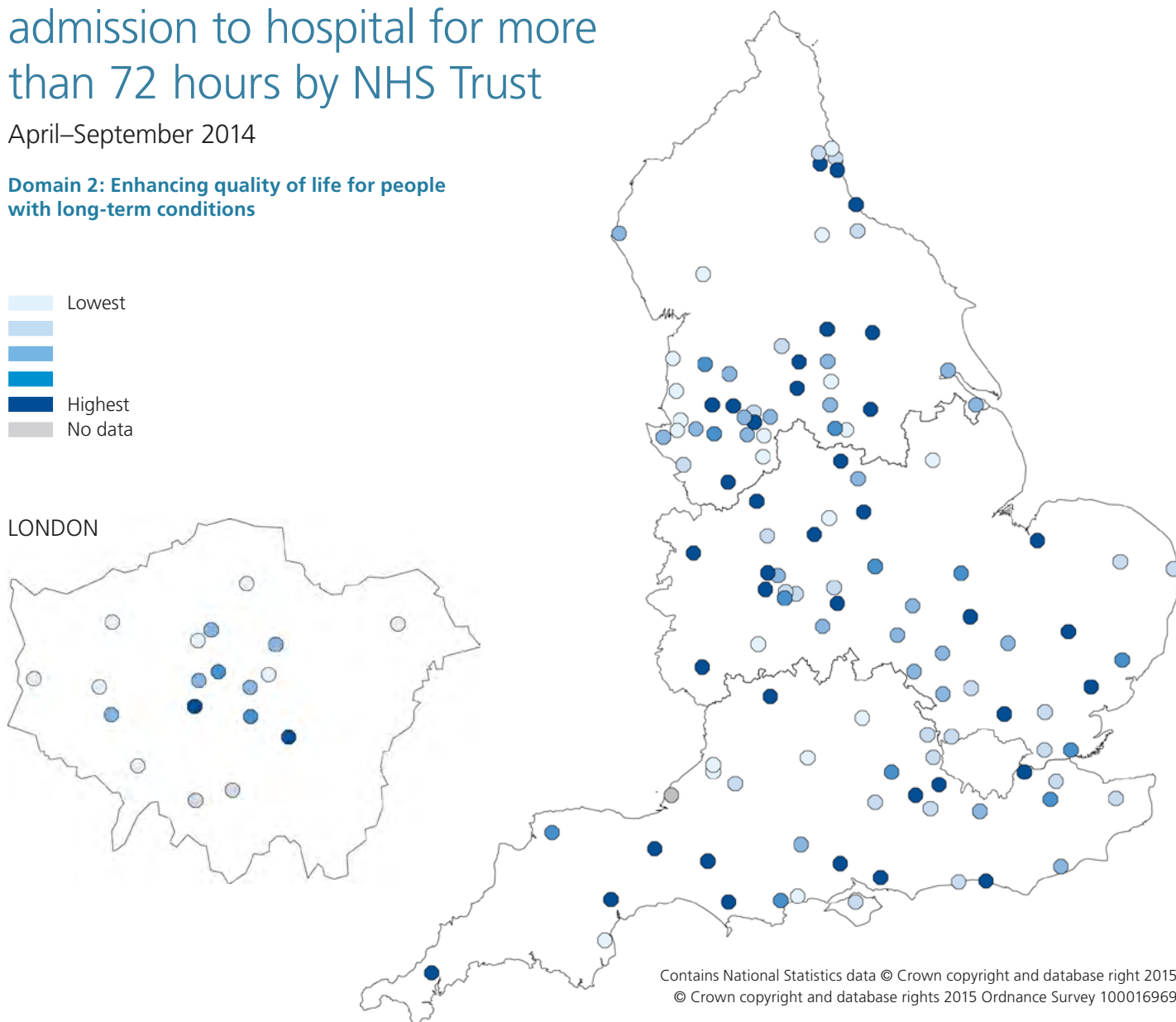
MENTAL HEALTH DISORDERS

Map 52: Percentage of people aged 75 years and over identified as potentially having dementia who were appropriately assessed following emergency admission to hospital for more than 72 hours by NHS Trust
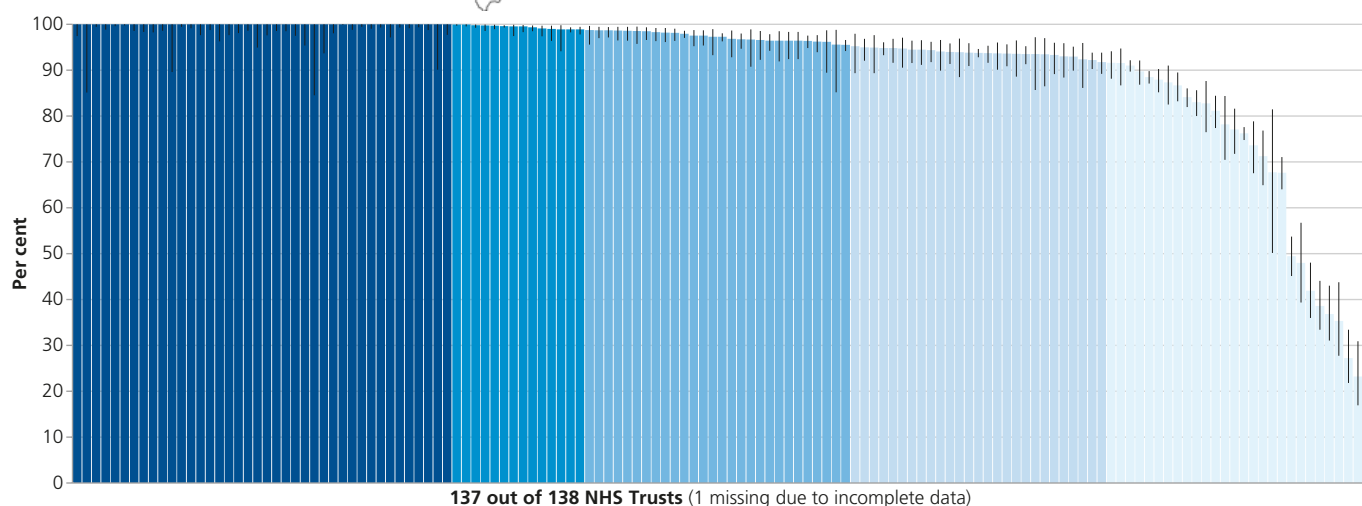
April–September 2014

Domain 2: Enhancing quality of life for people with long-term conditions

Lowest

Highest
No data
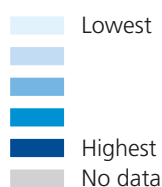
LONDON

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137 out of 138 NHS Trusts (1 missing due to incomplete data)

MENTAL HEALTH DISORDERS

Map 53: Percentage of people aged 75 years and over identified as potentially having dementia and appropriately assessed following emergency admission to hospital for more than 72 hours who were referred to specialist services by NHS Trust

April–September 2014

Domain 2: Enhancing quality of life for people with long-term conditions

Lowest

Highest
No data

LONDON

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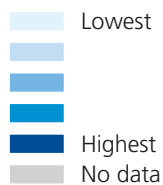© Crown copyright and database rights 2015 Ordnance Survey 100016969

137 out of 138 NHS Trusts (1 missing due to incomplete data)

Per cent

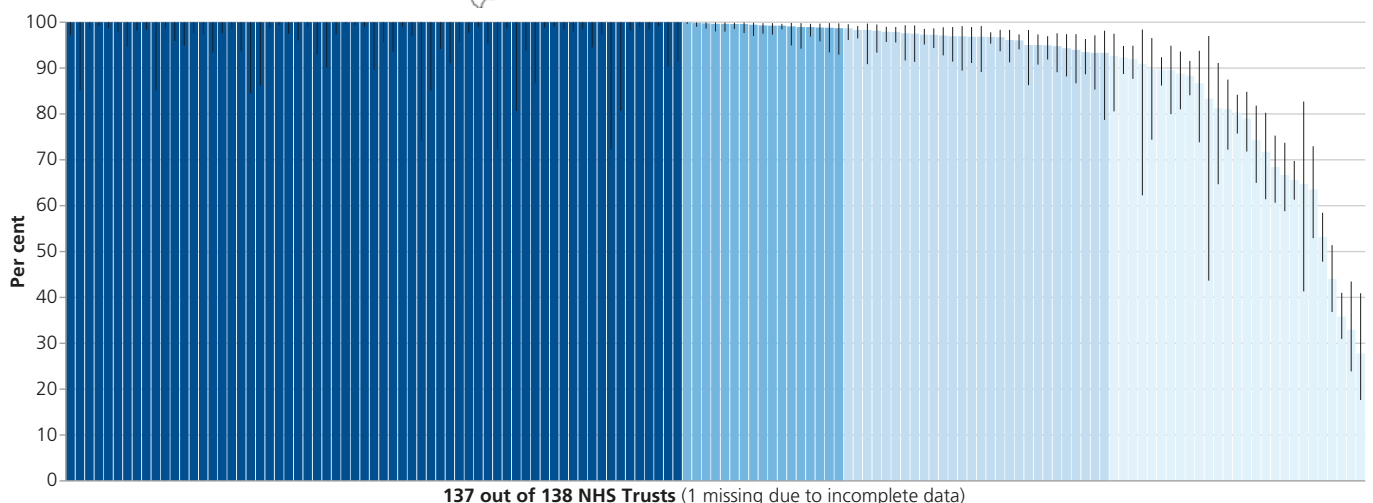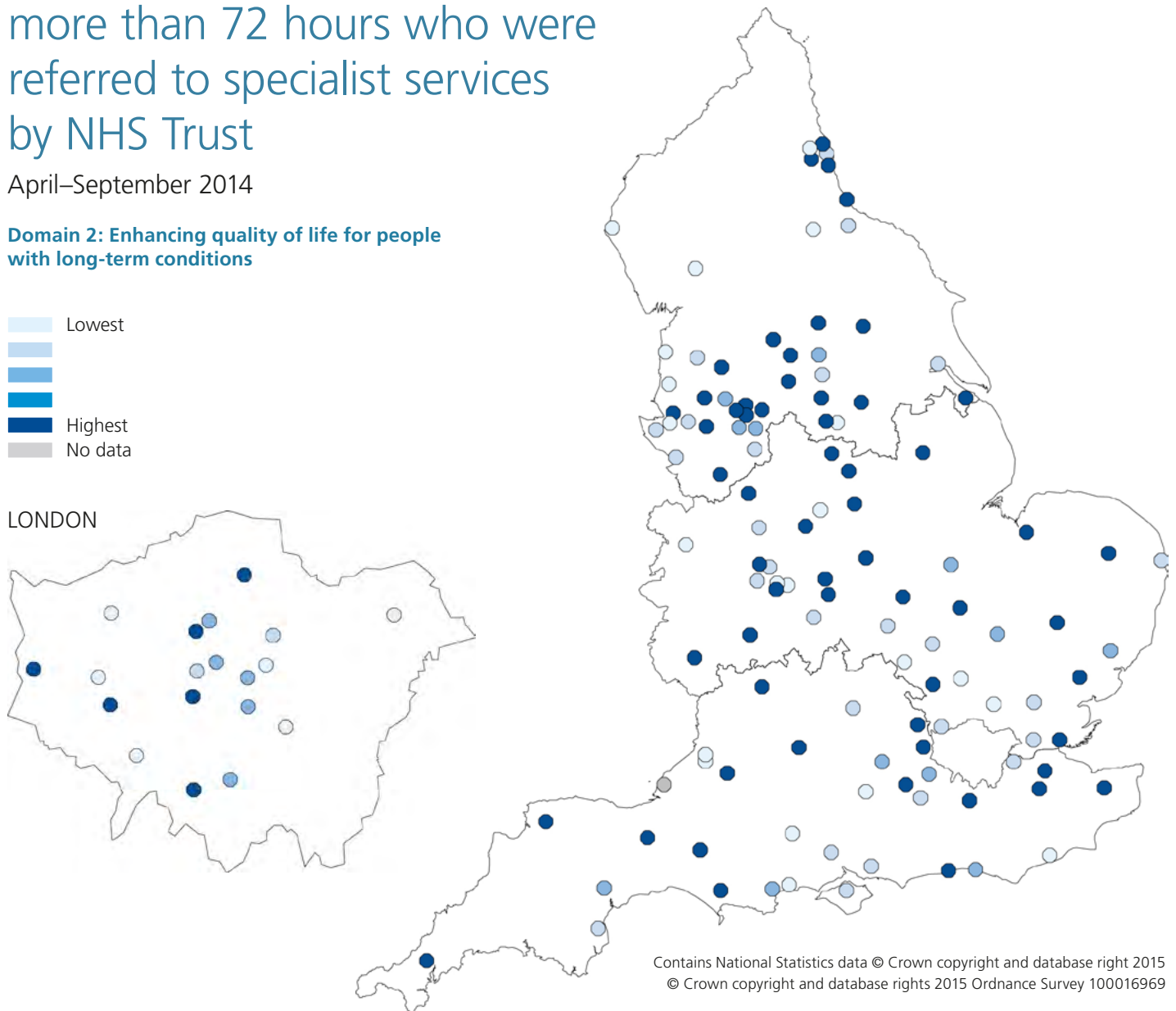## Map 53: Referrals to specialist services

For NHS Trusts in England, the percentage of people aged 75 years and over identified as potentially having dementia and appropriately assessed following emergency admission to hospital for more than 72 hours who were referred to specialist services ranged from 27.8% to 100.0% (3.6-fold variation).[4] When the five NHS Trusts with the highest percentages and the five NHS Trusts with the lowest percentages are excluded, the range is 63.5–100.0%, and the variation is 1.6-fold.

Possible reasons for unwarranted variation in these three indicators may include differences in:

› local dementia diagnosis rates;

› awareness of and education about dementia among healthcare professionals in hospitals;

› identification of dementia as a possible co-morbidity in secondary care in the absence of a diagnosis;

› access to liaison and specialist services.

Options for action

Commissioners need to specify that secondary care service providers:

› are alert to the potential for undiagnosed dementia and/or delirium as a co-morbidity in older people admitted to hospital;

› develop protocols for dementia case-finding and referral to appropriate services;

› increase staff awareness and knowledge of existing hospital dementia plans;

› deliver good-quality dementia care by trained staff which is patient-centred, and includes specific protocols for nutrition, hydration, end-of-life care, and discharge planning.

Commissioners in conjunction with secondary service care providers can review the effect of incentivising the identification and diagnosis of dementia in hospitals.
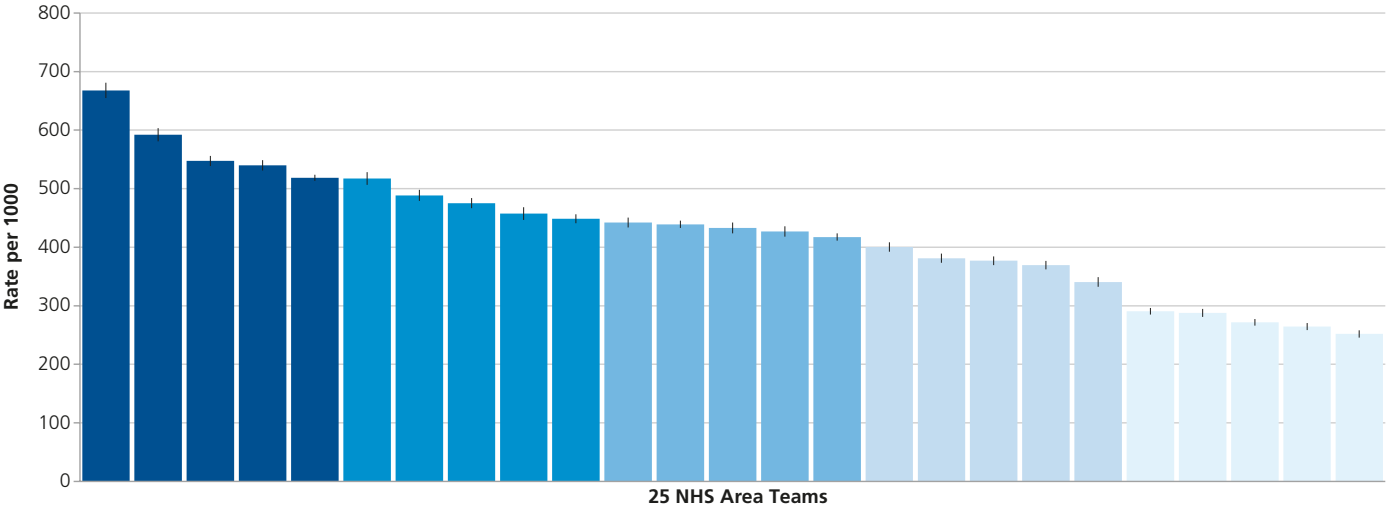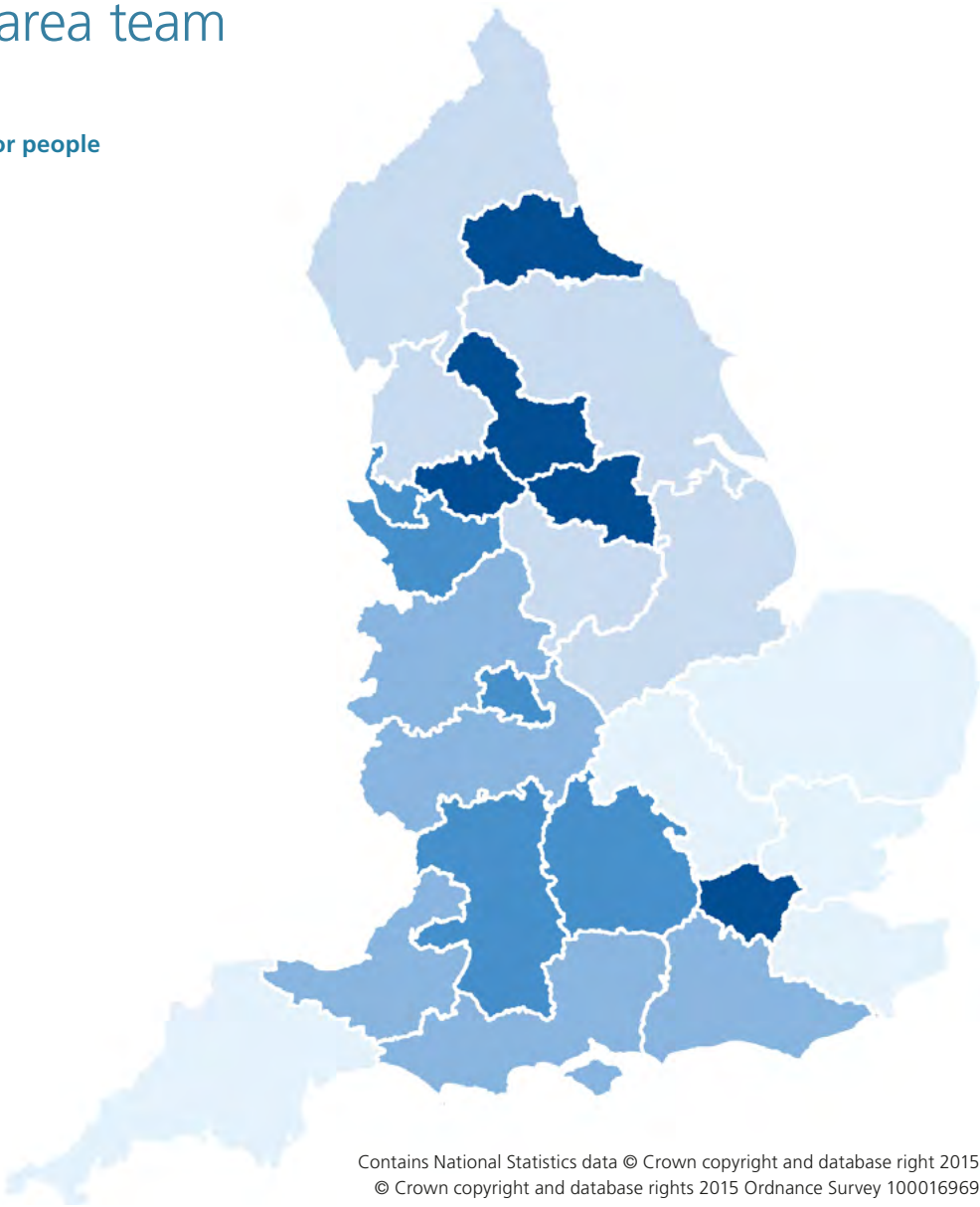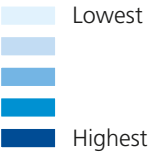
RESOURCES

› All-Party Parliamentary Group on Dementia. Unlocking Diagnosis: The key to improving the lives of people with dementia. July 2012. http://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=873

› Alzheimer's Society. Dementia UK: Update. 2nd edition. November 2014. http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2323

› Royal College of Psychiatrists (2013) National Audit of Dementia Care in General Hospitals 2012-13: Second Round Audit Report and Update. Editors: Young J, Hood C, Gandesha A, Souza R. HQIP. http://www.hqip.org.uk/assets/NCAPOP-Library/NCAPOP-2013-14/NAD-NATIONAL-REPORT-12-June-2013.pdf

› NHS Confederation (2010) Acute Awareness: Improving hospital care for people with dementia. http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Dementia_report_Acute_awareness.pdf

› National Audit Office. Improving services and support for people with dementia. HC 604 Session 2006-2007. July 2007. http://www.nao.org.uk/report/improving-services-and-support-for-people-with-dementia/

› NICE. Support for commissioning dementia care. NICE commissioning guides [CMG48]. April 2013. https://www.nice.org.uk/guidance/cmg48

› NICE. Dementia: Supporting people with dementia and their carers in health and social care. NICE guidelines [CG42]. June 2006. https://www.nice.org.uk/guidance/cg42

› NICE Centre for Clinical Practice – Surveillance Programme. Recommendation for Guidance Executive: CG42 Dementia – Supporting people with dementia and their carers in health and social care. May 2015. https://www.nice.org.uk/proxy/?sourceUrl=http%3a%2f%2fwww.nice.org.uk%2fnicemedia%2flive%2f10998%2f71780%2f71780.pdf

› NICE. Dementia quality standard. NICE quality standard [QS1]. June 2010. https://www.nice.org.uk/guidance/qs1

› NICE Pathways. Dementia overview. http://pathways.nice.org.uk/pathways/dementia

MENTAL HEALTH DISORDERS

Map 54: Rate of claims by GPs for an enhanced service (ES) offer of assessment for dementia to at-risk patients on practice registered lists per estimated population with dementia by NHS area team

2013/14

Domain 2: Enhancing quality of life for people with long-term conditions

Lowest

Highest

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25 NHS Area Teams

Context

Four new enhanced services developed by NHS England were introduced as part of the general medical services (GMS) contract in 2013/14, one of which was "Facilitating timely diagnosis and support for people with dementia". An enhanced service (ES) is more specialised than the essential or additional services provided by GMS to all patients. The ES for people with dementia was designed to reward GP practices for undertaking a pro-active approach to the assessment of at-risk patients who may be showing the early signs of dementia. The ES was undertaken through an initial enquiry followed by a specific test, and intended to support improvement in the prompt diagnosis of patients with dementia such that they were brought into the care pathway earlier.

The original coverage of at-risk groups was people:

› over 60 years with cardiovascular disease;

› over 60 years with long-term neurological conditions;

› over 50 years with learning disability.

At the time of writing, the ES for dementia in primary care is in its third year (see "Resources" for 2015/16 ES Specification). The coverage of at-risk groups has been expanded to include people:

› over 60 years who have risk factors for vascular disease;

› over 40 years with Down's syndrome;

› over 60 years with chronic obstructive pulmonary disease (COPD).

Any person, however, can be included as part of the ES if it is thought to be clinically appropriate.

The outcomes of the ES should be:

› a referral for further assessment;

› provision of an assessment of needs;

› instigation of appropriate treatment.

The emphasis in the ES for 2015/16 is on care planning, and the need to provide high-quality support for carers.

Magnitude of variation

For NHS area teams in England, the rate of claims by GPs for an ES offer of assessment for dementia to at-risk patients on practice registered lists ranged from 251.9 to 667.8 per 1000 estimated population with dementia (2.7-fold variation).

Possible reasons for the degree of variation observed include differences in:

› the prevalence of, and/or risk factors for, dementia in local populations;

› the confidence of GPs to ask patients about the symptoms of dementia;

› access to specialist services.

Options for action

Commissioners need to identify ways to fund earlier intervention and community care for people with dementia, including joint working with GP practices, secondary care providers, social services and other community partners:

› to improve the early identification of people with dementia;

› to ensure effective care planning, including robust advance care planning, for people with dementia;

› to develop and implement a person-centred dementia care pathway;

› to implement the use of a summary care record (SCR) and/or local electronic health record (EHR) to support continuity of care for people with dementia;

› to establish professional collaboration among service providers involved in the care of people with dementia, including the provision of specialist support for community-based services;

› to maintain people with dementia in their usual place of residence;

› to develop appropriate and effective ways to involve patients and carers;

› to provide support, in particular the provision of health checks, to carers of people with dementia;

› to include dementia awareness training as part of the organisational training strategy;

Service providers in residential care or nursing homes need to increase awareness and understanding of end-of-life care for people with dementia.

RESOURCES

› Barrett E, Burns A. Dementia Revealed. What Primary Care Needs To Know. A Primer for General Practice. July 2014. NHS England and Hardwick CCG with the support of the Department of Health and the Royal College of General Practitioners. http://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf

› Alzheimer's Society. Dementia UK: Update. 2nd edition. November 2014. http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2323

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› Royal College of General Practitioners. Dementia Toolbox webpage. http://www.rcgp.org.uk/clinical-and-research/clinical-resources/dementia.aspx

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› NICE. Dementia: Supporting people with dementia and their carers in health and social care. NICE guidelines [CG42]. June 2006. https://www.nice.org.uk/guidance/cg42

› NICE. Dementia quality standard. NICE quality standard [QS1]. June 2010. https://www.nice.org.uk/guidance/qs1

› NICE Centre for Clinical Practice – Surveillance Programme. Recommendation for Guidance Executive: CG42 Dementia – Supporting people with dementia and their carers in health and social care. May 2015. https://www.nice.org.uk/proxy/?sourceUrl=http%3a%2f%2fwww.nice.org.uk%2fnicemedia%2flive%2f10998%2f71780%2f71780.pdf

› NICE Pathways. Dementia overview. http://pathways.nice.org.uk/pathways/dementia
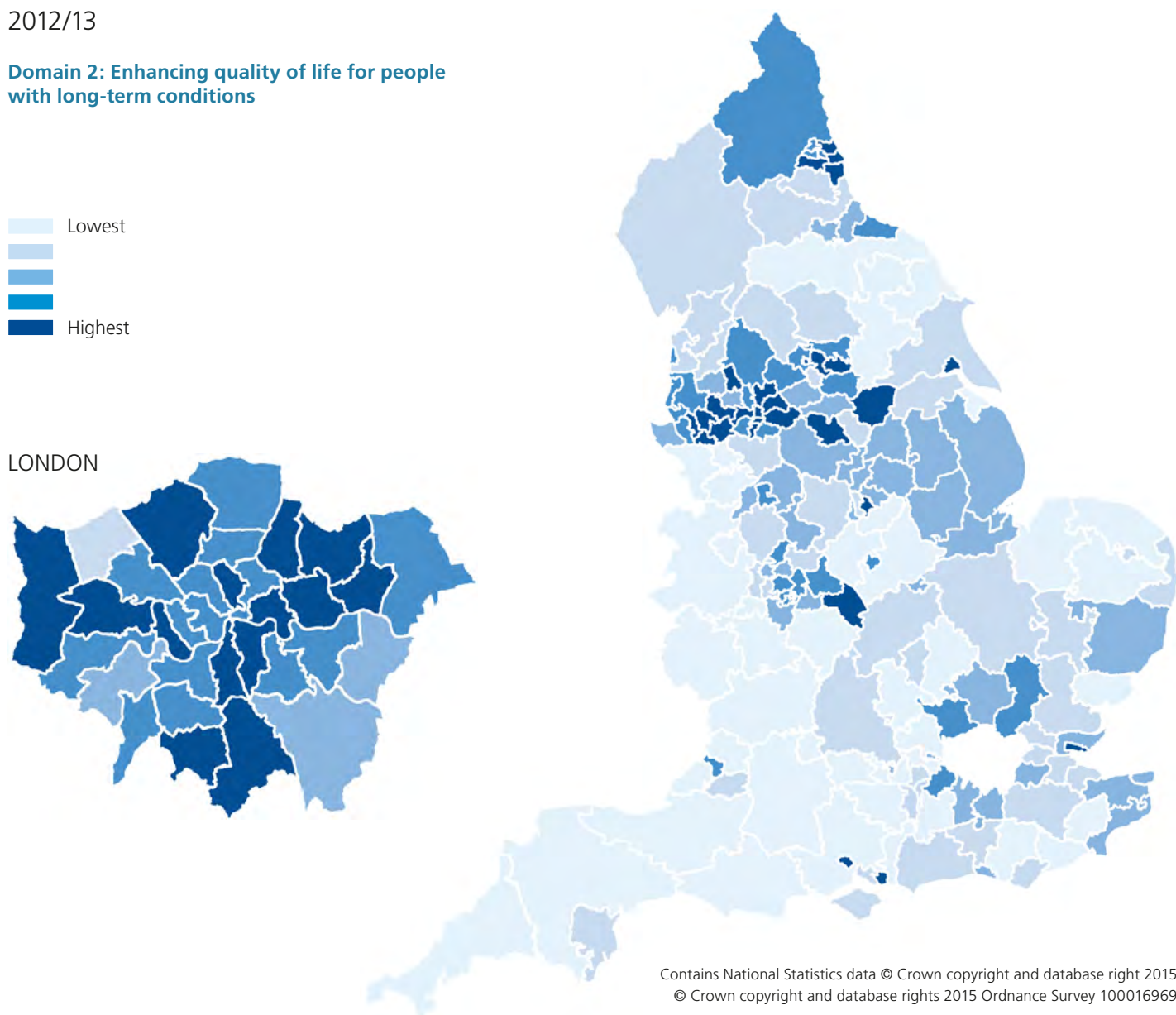
MENTAL HEALTH DISORDERS

Map 55: Rate of emergency admissions to hospital of people with dementia aged 65 years and over per population by CCG
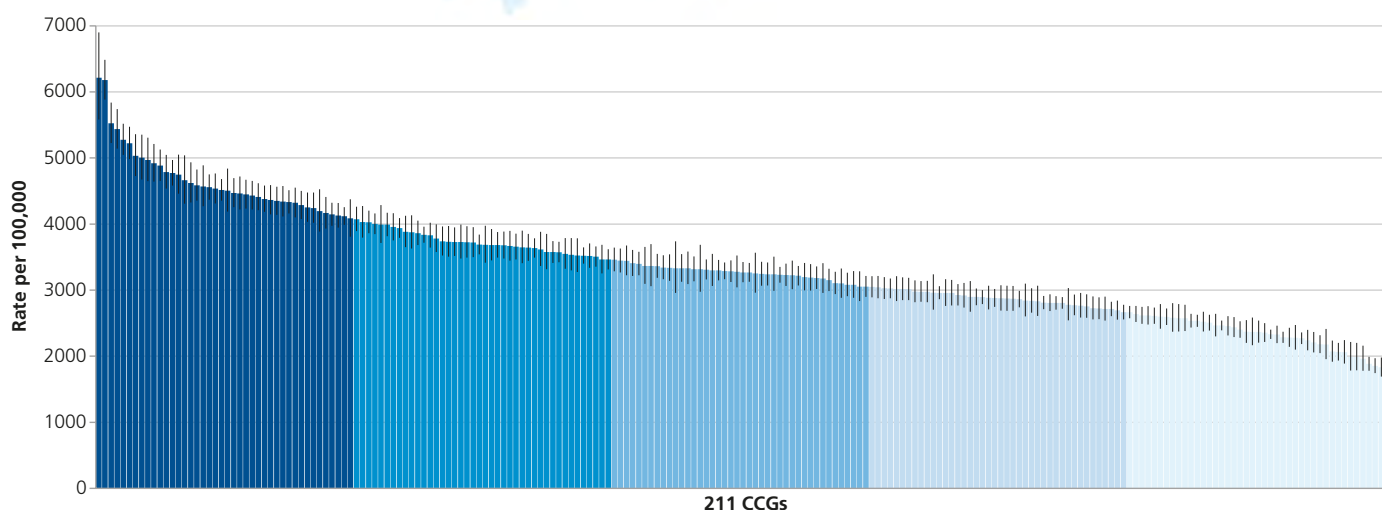
2012/13

Domain 2: Enhancing quality of life for people with long-term conditions

Lowest

Highest

LONDON

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Rate per 100,000

211 CCGs

Context

People with dementia have complex needs, and in later stages can have high levels of dependency and morbidity. It has been estimated that 40% of people over the age of 65 years in hospital beds are living with dementia.[1]

People with dementia are usually admitted to hospital for a reason other than dementia: a fall (14%), a broken or fractured hip or hip replacement (12%), urine infection (9%), a chest infection (7%), and a stroke or minor stroke (7%).[2] In a report from the South Central region, citing 2010 and 2011 data, the most frequently admitted acute conditions for people with dementia (in order of most frequent to least frequent) were: urinary tract infection, pneumonia, chronic renal failure, fractured neck of femur, syncope, superficial injury, acute bronchitis, acute cerebrovascular disease, non-specific chest pain, and other psychoses.[3]

During 2013 and 2014, in a thematic review of the care of people living with dementia as they moved between care homes and hospital, the Care Quality Commission (CQC) found aspects of variable or poor care in:

> 56% of hospitals regarding how a person's needs were assessed;

> 22% of hospitals regarding the arrangements for how organisations shared information as people moved between them;

> 61% of hospitals regarding people or their families or carers not being involved in decisions about their care or how they spend their time;

> 42% of hospitals regarding how the care met people's physical and mental health, and social and emotional needs;

> 56% of hospitals regarding staff's understanding and knowledge of dementia care;

> 28% of hospitals regarding the way hospitals monitored the quality of dementia care.[1]

People with dementia experience a longer length of stay than that for other patients, and worse symptoms after being in hospital.[2]

Magnitude of variation

For CCGs in England, the rate of emergency admissions to hospital of people with dementia aged 65 years and over ranged from 1730 to 6217 per 100,000 population (3.6-fold variation). When the seven CCGs with the highest rates and the seven CCGs with the lowest rates are excluded, the range is 2061–5004 per 100,000 population, and the variation is 2.4-fold.

Possible reasons for the degree of variation observed include differences in:

> the prevalence of dementia in local populations;

> reporting of dementia as a co-morbidity;

> coding of dementia as a secondary diagnosis.

Possible reasons for unwarranted variation include differences in:

> rates of diagnosis in primary care;

> identification of co-morbid dementia when patients are admitted to hospital for another reason;

> access to specialist services for diagnosis and management;

> access to early intervention and community care models.

Options for action

To reduce emergency admissions to hospital for people with dementia, commissioners and all relevant service providers, including local authorities and the third or voluntary sector, need to work together:

> to review and benchmark HES data;

> to review care pathways and identify areas for redesign;

> to improve the early identification of people with dementia;

> to ensure effective care planning, including robust advance care planning, for people with dementia;

1   Care Quality Commission. Cracks in the Pathway. People's experiences of dementia care as they move between care homes and hospitals. October 2014. http://www.cqc.org.uk/sites/default/files/20141009_cracks_in_the_pathway_final_0.pdf

2   Alzheimer's Society. Counting the cost. Caring for people with dementia on hospital wards. 2009. http://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=356

3   Dementia Action Alliance and NHS Institute for Innovation and Improvement (not dated) The Right Care: creating dementia friendly hospitals. Dementia Care in Acute Hospitals. A Report from the Dementia Action Alliance South Central Region. http://www.dementiaaction.org.uk/assets/0000/1757/CHKS_South_Central_Region_Report.pdf

> to implement the use of a summary care record (SCR) and/or local electronic health record (EHR) to support continuity of care for people with dementia;

> to establish professional collaboration among service providers involved in the care of people with dementia, including the provision of specialist support for community-based services;

> to maintain people with dementia in their usual place of residence;

> to use any emergency admission to hospital of a person with dementia as a stimulus and opportunity for feedback from secondary care providers to those in primary care, such as GPs, to ensure a care plan is in place, and that it needs to be shared, and updated whenever a significant event occurs.

Commissioners need to identify ways to fund earlier intervention and community care for people with dementia, including joint working with social services and other community partners. Options such as housing telecare and support for carers may enable people with dementia to stay at home.

To improve the care of people with dementia in hospital, commissioners need to specify that secondary care providers:

> improve the early identification of people with dementia, and implement effective care planning;

> develop and implement a person-centred dementia care pathway;

> develop screening procedures for malnutrition when patients are admitted, and ensure meals fit the dietary needs of patients;

> have a policy or guideline to ensure that patients with cognitive impairment or dementia are assessed for delirium at presentation;

> develop a procedure for multidisciplinary assessment that includes mental assessment;

> provide an environment that is easier to navigate for cognitively impaired patients, including a social area, signage, and easy-to-read information;

> develop a protocol governing the use of interventions for patients with behavioural or psychological symptoms of dementia;

> provide access to liaison psychiatry services from a specialist mental health team and to an older people's service, both during the day and out of hours;

> develop appropriate and effective ways to involve patients and carers;

> regularly review hospital discharge policy and procedures relating to patients with dementia, and audit re-admissions;

> improve coding of secondary dementia and the quality of data available;

> establish procedures to ensure information important to future care is supplied at the point of discharge, including an appropriate care plan, and discussions about discharge are held with both patients and their carers;

> include dementia awareness training as part of the organisational training strategy;

> raise awareness of advance care planning for people with dementia.

Service providers also need to identify learning and positive practice from among peers that have demographically similar populations.

Ambulance crews can play a role not only in the identification of people with dementia so that an appropriate care package can be developed on admission, but also in the identification of people with dementia who require dementia-appropriate community services and crews can initiate the links to those services.

Service providers in residential care or nursing homes need to increase awareness and understanding of end-of-life care for people with dementia.

RESOURCES

> Care Quality Commission. Cracks in the Pathway. People's experiences of dementia care as they move between care homes and hospitals. October 2014. http://www.cqc.org.uk/sites/default/files/20141009_cracks_in_the_pathway_final_0.pdf

> Alzheimer's Society. Counting the cost. Caring for people with dementia on hospital wards. 2009. http://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=356

> Alzheimer's Society. Dementia UK: Update. 2nd edition. November 2014. http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2323

> Royal College of Psychiatrists (2013) National Audit of Dementia Care in General Hospitals 2012-13: Second Round Audit Report and Update. Editors: Young J, Hood C, Gandesha A, Souza R. HQIP. http://www.hqip.org.uk/assets/NCAPOP-Library/NCAPOP-2013-14/NAD-NATIONAL-REPORT-12-June-2013.pdf

> NHS Confederation (2010) Acute Awareness: Improving hospital care for people with dementia. http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Dementia_report_Acute_awareness.pdf