Dementia Action Alliance

Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks

Yorkshire and the Humber Clinical Networks

Dementia Quality Improvement Awards 2016 Across the Pennines

Yorkshire and Humber CN, Greater Manchester, Lancashire & South Cumbria SCN and DAA Dementia Quality Improvement Awards

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1 Foreword

Dr Oliver Corrado
Joint Clinical Lead for the Dementia Y&H Clinical Networks

Dr Amanda Thornton
Clinical Director

"Welcome to the 'Across the Pennines' Quality Improvement Award for Dementia!

This year's Yorkshire and Humber Clinical Network for Dementia QI Award was held in partnership with the Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network and the two respective regional branches of the Dementia Action Alliance making this a truly 'Across the Pennines' event.

This is the third year we have ran the awards ceremony but with the joining of the two Strategic Clinical Network areas this made the judging process of applications incredibly hard due to the wide area and diversity of these applications.

Abstract submissions were invited from health professionals in both regions, and once again there was a very large entry making adjuration difficult. The range and diversity of projects was incredible, projects encompassed all care settings, including memory services, general hospitals and the community.

Five groups were invited to present their projects at the final held on Friday 13th May 2016 at Horizon Leeds Conference Centre in Leeds. The standard of presentation was so high that the panel of judges had a very difficult job determining the winner and as a result decided to award a joint winner prize to the 'Home from Home' application from NAViGO presented by Janice Smith and Tracy Abbott. The other winner was, 'Developing and evaluating a regional 18F (fluorine)-FDG (2-fluoro-D-deoxy-glucose) positron emission tomography/computed tomography (PET/CT) brain imaging service for patients with difficult to diagnose dementia' from Leeds Teaching Hospitals NHS Trust, Bradford and District Care Foundation Trust and Tees, Esk and Wear Valley NHS Foundation Trust presented by Dr Fahmid Chowdhury and Dr Chirag Patel Congratulations to the winners.

With the growing success of these awards, next year's ambition is for these to become the *Northern* Dementia Quality Improvement Awards. We look forward to ongoing success of this Clinical Network led opportunity.

2 The Quality Improvement Awards

Healthcare professionals within Yorkshire & the Humber and Greater Manchester, Lancashire and South Cumbria were invited to enter their dementia-related quality improvement project for the 3rd Dementia Quality Improvement Award 'Across the Pennines'. This award is sponsored by the Regional Dementia Action Alliance in conjunction with the Yorkshire and Humber Clinical Network and Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network for Dementia.

2.1 Quality Improvement Project Criteria

In order to be eligible for consideration the quality improvement project:

- Must have been undertaken (at least in part) between 1st August 2015 and 30th April 2016

- Must have been undertaken by a healthcare professional (or professionals) working in Yorkshire and Humber and Greater Manchester, Lancashire and South Cumbria. Projects could be undertaken by professionals from different disciplines working together.

2.2 Entries

Applicants were encouraged to submit an abstract of no more than 600 words in total.

2.3 Judging Process

Abstracts were judged by a multi-disciplinary panel of professionals and lay people with an interest in dementia using a standardised process. The authors of the abstracts judged to be the best five were invited to give a presentation of their project on the afternoon of Friday 13th May at Horizon, Leeds.

The winner, runner up and finalists are detailed in section 3, 4 and 5.

The semi-finalists are detailed in section 6.

All other abstracts for Yorkshire & the Humber and Greater Manchester, Lancashire and South Cumbria are detailed in section 7.

3 Joint Winners

3.1 Home from Home

3.1.1 Applicants

Janice Smith, Senior Operational Manager – Older People's Services

Tracy Abbott, Clinical Team Leader

NAViGO Health and Social Care CIC

3.1.2 Authors

NAViGO Home from Home team – Thirty people

3.1.3 What was the problem your improvement project aimed to address?

'Home from Home', a totally new concept, combines physical/mental health/social care needs for older people with confusion/delirium of ANY known cause through an integrated in-reach/out-reach care team offering care and treatment as an alternative model to acute hospital care.

Project Drivers:

- Assisting service users to maintain independence
- Reducing admissions to care homes
- Reducing long hospital stays (e.g. 'bed blocking')
- Reducing A&E presentations + resultant cost savings

3.1.4 What was done, when and where did it take place?

The project, which began fully in June 2015, supports 30 people at any time. It is a partnership between NAViGO and Northern Lincolnshire and Goole NHS Foundation Trust. People with dementia and their carers have had involvement from the start in, for example:

- completing audits to demonstrate service need
- environment
- design
- staff recruitment interviews
- involvement in staff training
- conference presentations

The new project has:-

- Brought back to life a dis-used hospital ward the general hospital in Grimsby N E Lincolnshire
- Bespoke environment - 15 hospital-based, 24hr medically covered beds but also provides intensive support in the community via 15 beds located in people's own homes accessed either immediately or following discharge from in-patient facility
- In-patient v community care options decided upon assessment
- Combines mental health/physical health/Therapy/Adult Social Care
- Individual en-suite rooms
- Safe garden area
- Offers dignified palliative care

- Was 6 month proof of concept now 2 year pilot (Transformational Framework)
- Referrals come via in-patient wards

3.1.5 What was achieved?

In general terms the project has achieved the following improvements to dementia care:

- Offers a more appropriate treatment setting to medical wards
- Reduces 'delayed discharge' statistics
- Reduces A&E presentations
- Reduces inappropriate use of sedation
- Improved parity of esteem between physical/mental health care
- Offers quality/efficient/effective/consistent and safer patient care/treatment protocols
- Provides a structured referral/crisis response
- Better transitional planning
- Joint working with health/other partners
- A safe/effective discharge process which includes the integration of social care
- Single en-suite accommodation and the ability for carers/family members to stay and be part of the care/reducing anxiety/assisting recovery
- Integration of adult social care into model has expedited discharge
- Environment design – dementia friendly/space to walk/space to maintain activities of daily living

3.1.6 Ideas tested which were successful

- A single en-suite accommodation and the ability for carers/family members to stay and be part of the care
- Integration of adult social care into model has expedited discharge
- Environment design – dementia friendly, space to walk, space to maintain activities of daily living

3.1.7 Ideas tested which were unsuccessful

Nothing was unsuccessful per se but initial resistance to change from physical colleagues, given that Mental Health service running acute physical care is not the norm. Success of pilot has helped change to be embedded.

3.1.8 How has this improvement project helped people with dementia and family carers?

By:-

- Reduced length of often upsetting hospital stays
- Offers improved community care/rehabilitation pathway
- Maintenance of independence, reducing institutional care requirements
- Improving dignity of care and patient/carer experience
- Offering REAL choice around end of life care
- Helping maintenance of good mental health (often exacerbated by treatment within an inappropriate environment)

Care Act 2015:

- Full, inclusive assessments
- Easier passage between services
- Better information/advice towards making informed care/support choices

- Openness/transparency (duty of candour)
- Wellbeing – physical, mental and emotional (cared for & Carer)

during the project	project still on-going
over a year	204 in-patient referrals + 164 Community Referrals since April 2015

3.1.9 How has this improvement benefitted your organisation and staff?

- Improved communication skills/integration with our physical health colleagues
- Improved training/skill set of general medical staff around Dementia, delirium and confusion, providing a 'specifically' skilled workforce
- Improved our CQC reviews/Friends/Family test results
- Improved productivity in-patient care/elective bed spaces
- Reduction in non-elective admissions
- Provides a service 'we would be happy for our families to use' (as per NAViGO ethos)

3.1.10 How has this improvement helped to raise awareness of dementia?

Launch of the new service has prompted very positive local/national press and awareness has been raised through inclusion in national award nominations. Most importantly the feedback from service users has been exceptional and they are spreading the word within the local community.

3.1.11 How will this work continue to have impact in the future?

We see this replicable project as having a nationwide impact. Our learning from implementation will assist others in setting up similar services. This being the case, we will use our very stringent monitoring measures in order to facilitate quality evidence disseminating our findings effectively nationwide.

3.2 Developing and evaluating a regional 18F (fluorine)-FDG (2-fluoro-D-deoxy-glucose) positron emission tomography/computed tomography (PET/CT) brain imaging service for patients with difficult to diagnose dementia

3.2.1 Applicants

Dr Fahmid Chowdhury, Consultant Radiologist

Dr Chirag Patel, Consultant Radiologist

Leeds Teaching Hospitals NHS Trust

Dr Anilkuma Pillai, Consultant Psychiatrist for the Elderly

Dr Gregor Russell, Consultant Psychiatrist for the Elderly

Bradford and District Care Foundation Trust

Dr Tolulope Olusoga, Consultant Psychiatrist for the Elderly

Tees, Esk and Wear Valley NHS Foundation Trust

3.2.2 Authors

Mr Haroon Motara, Mrs Karen Askew, Dr Andrew Scarsbrook, Dr Stuart Jamieson, Dr Suman Ahmed, Dr Nicholas Brindle

3.2.3 What was the problem your improvement project aimed to address?

It is well recognised that the diagnosis of dementia can be challenging in some individuals, especially in the early stages of the disease, in younger patients (<65 years), in those with atypical presentations, and in patients with substantial psychological overlay. The first new guidance for Alzheimer's Disease (AD) diagnosis since 1984 emphasized that functional neuroimaging with [18F]-2-fluoro-2-deoxy-D-glucose (FDG) positron emission tomography/computed tomography (PET/CT) can be used as a pathophysiological biomarker of AD by depicting reduced glucose uptake in the brain. We recognised that the lack of a brain PET/CT service for dementia in Yorkshire and Humber needed to be addressed and set out to collaboratively develop and subsequently evaluate this new service.

3.2.4 What was done, when and where did it take place?

In August 2012, an initial scoping exercise was performed to evaluate the demand for, and feasibility of, a dedicated brain PET/CT service by consulting staff within the Nuclear Medicine and PET/CT department at the Leeds Teaching Hospitals NHS Trust, and key clinical stakeholders regionally. This was followed by presentation of a mini-business case to the specialist commissioners for PET/CT services at NHSE in October 2012, which was approved. After the formulation of a departmental protocol for these scans and a new clinic-radiological pathway for patients with difficult-to-diagnose dementia, the service was commenced in January 2013. An audit of the service was undertaken in January 2016.

3.2.5 What was achieved?

A brain FDG PET/CT service for difficult-to-diagnose dementia patients was developed at the Leeds Teaching Hospitals for patients from across the entire region. 136 patients were scanned between June 2013 and June 2015, and these cases underwent a questionnaire-based audit of the clinical users of the service in 2016, achieving a return of 72%. With a mean patient follow-up of 471 days, FDG PET/CT was shown to have an impact on patient management in 81%, adding confidence to the pre-test diagnosis in 43%, changing the pre-test diagnosis in 35%, reducing the need for further investigations in 42%, and resulting in a change in therapy in 32%. There was substantial correlation between the PET/CT diagnosis and final clinical diagnosis with a correlation (k) coefficient of 0.78 ($p < 0.0001$). The accuracy of FDG PET/CT in diagnosis of AD was 94%, with a sensitivity of 87% and a specificity of 97%.

3.2.6 Ideas tested which were successful

A collaborative approach involving multiple clinical disciplines across the Yorkshire and Humber region proved successful in setting up, delivering and auditing this important new service for patients with difficult-to-diagnose dementia in our region. A typical comment from the clinical users of this service included: "Being suspected to be developing dementia, especially at a young age, must be a devastating experience. The alternative to FDG-PET may be a lengthy period of follow up with repeated cognitive testing to see if progressive deterioration is setting in. This must be deeply disturbing for patients, and casts blight over their lives. The added clarity that FDG-PET gives, allowing greater reassurance that it does

not appear to be a neurodegenerative disorder, or if necessary confirming it is but allowing the patient to then access support, treatment and relevant services earlier, is of great value".

3.2.7 Ideas tested which were unsuccessful

FDG PET/CT scanning does not have perfect accuracy for neurodegenerative dementia, as shown in our audit (e.g. sensitivity of 87% for AD). We have as yet not been able to secure commissioning support for the provision of the more sensitive PET technique for AD, which involves amyloid plaque PET radiotracers that are now available for clinical use in the UK.

3.2.8 How has this improvement project helped people with dementia and family carers?

For patients with difficult-to-diagnose dementia, who have no clear diagnosis after expert clinical assessment and negative CT/MRI, the availability of FDG PET/CT brain imaging has helped to reach a timely diagnosis either by confirming the presence of a neurodegenerative dementia and sub-typing the condition (e.g. AD vs. fronto-temporal dementia) or by making a diagnosis of neurodegenerative dementia unlikely in the case of a normal PET scan.

during the project	136 patients underwent brain FDG PET/CT during the project period of June 2013-June 2015.
over a year	Approximately 100 patients with an uncertain diagnosis of dementia are now referred to the brain PET/CT service in Leeds per year.

3.2.9 How has this improvement benefitted your organisation and staff?

The development of the brain PET/CT service for dementia patients has allowed us to increase the skill set and knowledge of our multidisciplinary staff in this important area of practice, and acted as an impetus to diversify our PET/CT work in other non-oncological areas, e.g. infection and inflammation.

3.2.10 How has this improvement helped to raise awareness of dementia?

The details of this project have been disseminated widely. There have been presentations locally about this service, delivered to multiple groups (neurology, radiology, and care of the elderly in the Leeds Teaching Hospitals NHS Trust, psychiatry for the elderly in Bradford and District Trust, and a broader audience at the Dementia 2013 conference in Leeds). The audit results have been presented at the European Congress of Radiology (ECR) in Vienna in March 2016, and are due for presentation at the British Nuclear Medicine Society (BNMS) in Birmingham in April 2016. We have also submitted a paper based on this work to Clinical Radiology, the UK's leading imaging journal, which is currently under consideration for peer-reviewed publication.

3.2.11 How will this work continue to have impact in the future?

The brain FDG PET/CT service for difficult-to-diagnose dementia patients is now firmly established at the Leeds Teaching Hospitals NHS Trust and is available to patients from across the region. Based on the audit of this service, we are putting in place a recommended algorithm for the use of functional imaging in these patients, with a clearly defined role for amyloid PET imaging, which will be presented to the specialist commissioners at NHSE to revisit the funding of amyloid PET scans in a highly selected subset of these patients. We also hope that a future collaborative study will attempt to capture the patient experience, and evaluate the benefits of timely diagnosis, or reassurance, from the patients' perspective.

4 Runner-Up

4.1 Lewy Body Information and Support Group (6 Monthly) & Lewy Body Support Group (3 Monthly)

4.1.1 Applicants

Jenny Day, Dementia Specialist Nurse

Pennine Care NHS Foundation Trust

Maria Curphy, Parkinson's Specialist Nurse

NHS Stockport NHS Foundation Trust

4.1.2 Authors

Staff from memory service and EDUCATE (Early Dementia Users Co-operative Aiming to Educate)

4.1.3 What was the problem your improvement project aimed to address?

Current support offered is often focused on Alzheimer's or Vascular dementia conditions. Lewy Body presents very differently and is often more complex and challenging.

Feedback from relatives was the need for specific Lewy Body information and support.

4.1.4 What was done, when and where did it take place?

Effective clinical links were made with specialist Parkinson's nurse who also identified similar concerns regarding this group of patients.

Joint working initiated the development of an information session regarding Lewy Body Dementia. Feedback from attendees identified the need of a support group. This resulted in the formation of a regular group for education and peer support around this condition.

A range of speakers have contributed including attendance from third sector e.g. Alzheimer's Society, Signpost and Age UK.

The success of this group has been due to the passion and enthusiasm of two nurses working together in a skilful and effective manner which has impacted on day to day clinical practices.

To the best of our knowledge this is the first group of its kind in the country. It is fully supported by our CCG and our commissioner attended the first session

It has highlighted Lewy Body as a dementia in its own right. By working alongside the Parkinson's specialist nurse, patients have accessed this group at a timely opportunity.

The first meeting was in 2013 and continues to date.

The group takes place within a Memory clinic setting

4.1.5 What was achieved?

The group highlights living well with Lewy Body but recognises the huge complexities involved. Staff are willing to address difficulties and arranging issues which improve the person with dementia and their family carers.

The number of attendees has increased at each group.

This project has significantly impacted on people's lives. The feedback has been extremely positive and encouraging.

4.1.6 Ideas tested which were successful

- Development of support groups for specific types of dementia
- Partnership working between Memory service and Parkinson's service has been dynamic
- Empowerment and better coping through peer support

4.1.7 Ideas tested which were unsuccessful

N/A

4.1.8 How has this improvement project helped people with dementia and family carers?

People report feeling less isolated and more knowledgeable to cope with the condition.
Improved awareness from professionals for the challenges of living with this condition.
Better individual support for people and their carers.

during the project	Estimated number of people helped: 61
over a year	

4.1.9 How has this improvement benefitted your organisation and staff?

Informed partnership working across health settings,

Consultants are using the facilitators as a resource

Education to other health professionals as a result of the lessons learnt from the group

4.1.10 How has this improvement helped to raise awareness of dementia?

Improved understanding of the specifics of this dementia type and the impact this has on the person with dementia and the carers. Learning has been shared through training for primary care and care home staff.
Opportunity for students to attend the group and learn from lived experiences.

4.1.11 How will this work continue to have impact in the future?

The information group and the Support group have become part of a recurrent offer from the Memory Service. Future aspirations are to include music and art as therapeutical interventions.

5 Finalists

5.1 Making Space, Dementia Space Team and Dementia Associates

5.1.1 Applicants

Kathryn Penrith, Consultant Admiral Nurse

Rachel Yates, Dementia Development Coordinator

Making Space

5.1.2 What was the problem your improvement project aimed to address?

The Making Space, dementia Space team was created in October 2014.Its aim, to support people with dementia and their carers, to raise the quality of service being delivered across the organisation and share good practice with other partners and external agencies.

As a national UK organisation supporting 100's of people living with dementia and their families. As a small team of three, we could not reach them all to deliver the quality care needed so; following feedback from staff we created a role which staff could apply for. The project involved training up 15 people across the organisations from all levels to become a dementia associate. The additional training was:

- Dementia Care mapping from Bradford University (basic)
- http://www.bradford.ac.uk/health/dementia/dementia-care-mapping/

- Best Practice in dementia Care from Sterling University (Train the trainer)
- http://dementia.stir.ac.uk/education/flagship-courses/best-practice-learning-programme

- Helping yourself to wellbeing-Public Health Bury (Train the trainer)
- http://www.bury.gov.uk/CHttpHandler.ashx?id=16831&p=0

- After the completion of the above courses, the associates then cascaded the knowledge and arranged sessions to deliver the course to their staff and volunteers.

5.1.3 What was done, when and where did it take place?

The accredited train the trainer packages took place April 2015-Febuary 2016 and the training sessions have taken place in:

Oldham (Community)
Manchester (Hospital)
Kirklees (Community)
North Yorkshire (Community)
Doncaster (Dementia Day care)
Darlington (Extra care)
St Helen's (Residential)

People living with dementia and their carers have been involved in the development and consultation of these projects and with the set-up of four local DEEP groups in Making Space, we aim to build on this and have plans in place for the DEEP groups to contribute to Making Spaces `Making Change' group. This group of service users meet up every two

months to have their voice, opinions and ideas heard on new developments and organisational policies and procedures.

5.1.4 What was achieved?

From this project, the associates have been empowered to become involved in further projects of Making Space and have worked alongside the central team to develop:

• Bury dementia Friendly GP's
• Dementia Law Clinics in partnership with the University of Manchester
• Development of DEEP (Dementia Engagement and Empowerment).
• Development of the dementia training packages (SPACE Training) which is being run from each step Blackley and open to all everyone. This has lead on to developing micro dementia training sessions (45 mins) and activity training.
• Development of dementia cafes and groups i.e. Contour Housing (Bolton, Middleton, Manchester and Preston) and CIC Each step
• Developed guidance for young people to understand dementia- Intergenerational work
• Development of an organisational dementia email group- sharing of good practice.

5.1.5 Ideas tested which were successful

Making Space aims to learn from any project and look upon pilot projects as a learning experience. All of the above projects have been successful though we learn from the little things that didn't go so well and aim to improve them with the development of the projects.

5.1.6 Ideas tested which were unsuccessful

As above.

5.1.7 How has this improvement project helped people with dementia and family carers?

This has been very hard to estimate as this project has reached more people than just our staff, people with dementia/carers. It has reached other organisations and the wider communities.

We do however estimate that this project has reached over 1000 people.

during the project	More than 1000 people
over a year	

5.1.8 How has this improvement benefitted your organisation and staff?

1. Raised further awareness of dementia
2. Empowered and developed staff knowledge and skills.
3. Engaged, enthusiastic workforce.
4. Training and development for people with dementia within the community to take an active role in services.
5. Reduce stigma.
6. Raise awareness of what people with dementia really want.
7. Influenced policy makers and commissioning.
8. Empower people living with dementia to have a voice and be heard- see positive change in their communities.
9. Increase wellbeing for those with dementia (identity, occupation, comfort, inclusion, attachment) Enriched model (Kitwood, 1997).

10. Reduce health inequalities.
11. Increase confidence and self-esteem.
12. Increased knowledge on feeling emotional, mentally and physical wellbeing of everyone.
13. Shared good practice with others.
14. Built up trusting partnerships with other organisations.

5.1.9 How has this improvement helped to raise awareness of dementia?

The education, training and ongoing support which the dementia associates have received and implemented has made a real difference to them Individually, the people they support and work with in their service and their communities which will continue to have a lasting effect.

5.1.10 How will this work continue to have impact in the future?

We have reviewed our dementia strategy in line with the PM vision 2020, NICE guidelines, and the OECD framework for Dementia and the Dementia I-statements. An action plan is in place to develop further associates across the organisations with different levels of skills and competencies.

5.2 Improving Care pathways for people with cognitive impairment and their carers in Kirklees

5.2.1 Applicants

Dr Subha Thiyagesh, Clinical Leaf and Consultant Psychiatrist

South West Yorkshire NHS Foundation Trust

Dr Andrew Cameron, GP Board Member and Clinical Lead for Mental Health

North Kirklees CCG

5.2.2 Authors

Dr Maria Wybrew, Julia Orlinski, Natalie Ackroyd

5.2.3 What was the problem your improvement project aimed to address?

There was no clear pathway for referral of patients, with suspected cognitive impairment and for their carers to secondary mental health trust and for third sector.

It had previously been challenging to successfully bring clinicians from primary and secondary care together to produce genuinely clinically-led change.

There has been sustained increase in referral rates to the memory service, including ongoing management of diagnosed patients. This led to monitoring of non-complex patients in the secondary care leading to reduced access to new referrals and lengthy assessment times.

A diagnosis of dementia is usually made in memory service. However, there are circumstances where referral to the memory service is not always necessary or desirable. For example, patients may present in a care home with advanced cognitive impairment, or might decline referral. These patients would still benefit from a formal diagnosis, in terms of accessing on-going support and care planning.

There was no clear support mechanism in place to aid general practitioners to confirm diagnosis in such circumstances.

We aimed to improve access for community and primary care clinicians to enable patients with cognitive impairment and carers to get care and support in a timely manner and by the right people throughout their care journey.

5.2.4 What was done, when and where did it take place?

Commitment was secured from both secondary and primary care clinicians. Management support was allocated. Meetings were held regularly. Challenges affecting all parts of the system were openly discussed; objectives were agreed and worked through.

Clear care pathways were developed taking into account the different routes of referrals, the various types of dementia and cognitive impairment presentations, where medication may not be prescribed etc.,

A pathway was also established following workshops with third sector that had the view of the service users and carers and were aware of the ongoing issues with access and support in the system.

A clear diagnostic and support guidance was put together for GPs to help confirm diagnosis of advanced cognitive impairment / dementia in community, especially in care homes to improve quality of care and get the right access for such patients.

These pathways and support guidance have now been presented in Yorkshire and Humber strategic clinical network meetings and the guidance has been collated and merged with a Yorkshire-wide guidance and app for primary clinicians.

The above workshops and discussions took place between October 2014 and summer 2015.

The pathways were agreed across North Kirklees and Greater Huddersfield.

5.2.5 What was achieved?

A single agreed pathway across primary, secondary and third sector to enable a seamless pathway.
This has now paved the way for further improvement and innovation in the way we would like to provide services closer to home.

The guidance has been collated into a resource pack that has been circulated to all practices. This includes the new pathways, contact details for all local dementia services, guidance around common challenges faced by primary care clinicians, links to the regionally developed clinical system templates and to national guidance.

5.2.6 Ideas tested which were successful

Primary care screening of treatable causes of memory impairment now embedded.

After some initial resistance, there has been a gradual increased uptake of requesting CT scans in primary care at the point of referral. This is now being recognised as a positive step in improving the patient journey, rather than imposed additional workload on an already over-stretched primary care system.

Consideration of doing ECG.

Discharge of non-complex patients following diagnosis and titration of medication back to primary care following review and with a res.

GPs more confident in making a diagnosis of dementia in cases of advanced dementia especially in care homes.

5.2.7 Ideas tested which were unsuccessful

Requesting of CT scans not yet embedded in primary care way of working.

Process of discharging non-complex patients from the service meant re-deploying clinicians away from the diagnostic service for a period of time. This resulted in a significant temporary reduction in capacity, leading to an initial increase in waiting times.

It has proved difficult to obtain the necessary IT support to achieve our aim of localising the regionally-developed clinical system templates to include links to our resource pack.

5.2.8 How has this improvement project helped people with dementia and family carers?

The changes and the pathways has enabled closer working with third sector and supporting better the post diagnostic aspect of the pathway which is equally, if not more important than the diagnostic process.

There is a clearer understanding that can be shared as to what can be expected from the point of referral to point of discharge.

Memory service has become more responsive and access is getting quicker with the appropriate care being delivered rather than 'routine' care at secondary care level. This will be helpful in keeping with the increasing demand and limited resource that is found in any health economy.

during the project	discharged over 1600 non-complex patients back to primary care
over a year	around 1890 referrals; around 129 referrals per quarter (from the last available data) to the commissioned third sector for post diagnostic support

5.2.9 How has this improvement benefitted your organisation and staff?

- Better care for patients and carers
- Better working relationship and engagement with primary care, secondary care and third sector and CCG
- More efficient and high quality care delivered overall in the Kirklees district

5.2.10 How has this improvement helped to raise awareness of dementia?

We publicised this widely by presenting this to third sector such as making Space, GP PPI meetings, CCG quality board to enable wider dissemination of information to GPs so that referrals can be appropriately made. The process has been a collaborative one across the two local CCG's and the Memory Service provider. Clinicians have taken the lead from the outset, with a working group of local GP's and a consultant psychiatrist meeting together regularly, supported by CCG and mental health trust management colleagues.

Sharing with the wider clinical community is vital. Recognising the different ways primary care colleague's access information, the resources produced have been disseminated

through a variety of means. An information 'pack' has been emailed to every practice and has been uploaded to each CCG's intranet site. The proposals have been presented and debated at large CCG protected time events, with GP's nurses and practice support staff in attendance, and at smaller 'cluster' meetings. The respective CCG lead GPs are also available to support individual practices.

5.2.11 How will this work continue to have impact in the future?

- Links to the pathways and guidance will be imbedded within clinical system templates
- Establishment of ‘One stop shop’ community clinics – discussions ongoing

6 Semi Finalists

6.1 Clinical Audit of Antipsychotic Medication in Care Homes with Dementia Patients

6.1.1 Applicants

Dr Suman Ahmed, Consultant Psychiatrist

Tanya Bahrouni, Community Mental Health Nurse

Tees, Esk and Wear Valley NHS Foundation Trust believing

6.1.2 Authors

Dr Helen Singateh – Amanda Jameson Allen, Clinical Lead

6.1.3 What was the problem your improvement project aimed to address?

Aim

- Review of use of antipsychotic medication for those with a diagnosis of dementia and
- Living in care homes
- Living well with dementia in care homes (objective of the National Dementia Strategy)
- Report by all party Parliamentary Group on Dementia entitled “Always a Last Resort” which identified problems with over-prescribing of antipsychotics and recommended local and national audit of this
- The Right Prescription - A call to action on the use of antipsychotic drugs for people with dementia.

6.1.4 What was done, when and where did it take place?

NICE have introduced a guideline document in response to a report by the All-Party Parliamentary Group on Dementia entitled ‘Always a last resort’ (9.1). The report found that Over-prescribing of antipsychotics in care homes is a problem, and recommended local and National audit of the use of antipsychotics for people with dementia in care homes.

The Care Home Liaison Team wrote to the GPs and Care Homes explaining the purpose of The review and to invite them and the patient’s relatives to the medication review.

A multi-professional Review was conducted in 20 Care Homes with patients/relatives. Commenced Audit in 2015 and re-audited in January 2016.

6.1.5 What was achieved?

4. What was achieved?
Patient received a more holistic and person-centred approach to their care and treatment

24 patients discontinued from Antipsychotic medication 18%

Criterion	% target achieved	
Documented evidence that any of the following non-pharmacological interventions were tried before and since medication was prescribed	**2014**	**2015**
Engagement in social/personal activities	18 (60%)	25 (83.3%)
Changes to staff approach	11 (37%)	23 (76.7%)
Changes to environment	12 (40%)	20 (66.7%)
Watchful waiting/monitoring	16 (53%)	30 (100%)

Criterion	% target achieved	
Was the person offered an assessment at an early opportunity:	**2014**	**2015**
Yes	20 (67%)	30 (100%)

Criterion	% target achieved	
	2014	**2015**
Has a tailored care plan	19 (63%)	30 (100%)
If yes, does the care plan address the behaviour that challenges?	6 (20%)	25 (83.3%)

Patient received a more holistic and person-centred approach to their care and treatment
24 patients discontinued from Antipsychotic medication 18%.

6.1.6 Ideas tested which were successful

Utilising less restrictive options before antipsychotic medication. Educating and supporting care home staff and carers.

6.1.7 Ideas tested which were unsuccessful

Relatives /carers invited to attend the Medication review appeared to be minimal attendance for some care homes.

6.1.8 How has this improvement project helped people with dementia and family carers?

The Team have also developed (Behavioural Psychological Symptoms of Dementia (BPSDs) Management protocol for the care homes. The Care Home Liaison team attended 18 MDT sessions lasting 3 hours on each occasion.

during the project	72
over a year	83

6.1.9 How has this improvement benefitted your organisation and staff?

- Identifying that there is a need for improvement such as requiring ECG.
- Staff has enhanced their skills re initial screening and non-pharmacological approach in BPSD management.

6.1.10 How has this improvement helped to raise awareness of dementia?

Educating Care Home staff and relatives in appropriate ways of managing BPSDs, rather than the Pharmacological model.

6.1.11 How will this work continue to have impact in the future?

Effective reviewing Managing BPSDs.

6.2 New Medical Unit for Dementia Patients "Oasis Unit" at Rochdale Infirmary

6.2.1 Applicants

Kathryn Saunderson, Commissioning Project Manager

Jeanette Leach, Integration Programme Manager (HMR CCG/RBC Adult Care)

NHS Heywood, Middleton and Rochdale CCG

6.2.2 What was the problem your improvement project aimed to address?

The Oasis Unit was borne when HMR CCG Clinical Lead was faced with an elderly lady wandering confused within the hospital site. This led to a review of dementia services whereby it became apparent that a standard hospital ward is not the ideal environment for this cohort of patients.
We know on average, people with dementia spend nearly four times as long in hospital following a fall and the resulting frailty from a fall and an extended stay in hospital.
The new unit provides an assessment and diagnostic service for patients (over the age of 18 years). Meeting the needs of patients with dementia who present with an acute medical problem which requires treatment or diagnosis, caring for them in a safe and suitable environment with enhanced nursing care to support these vulnerable patients.

6.2.3 What was done, when and where did it take place?

In 2012 a business case was developed to design a five bed facility within the borough. The Oasis Unit opened in 2014 which is a unique clinical resource for the management of Dementia in the most clinically appropriate setting and offers patients who present or who are referred to the hospital with a safe and suitable purpose-built environment to support recovery and access to nursing and mental health staff. This unit is believed to be the first of its kind in a hospital setting in England.

6.2.4 What was achieved?

The Unit is made up of 5 single rooms, 2 bathrooms a lounge dining area and kitchenette facility. It sits alongside the Clinical Assessment Unit (CAU, 48 hour locally commissioned unit) and runs in conjunction with it. The unit is supported by medical staff from the CAU, is accessible 24 hours a day, and the average length of stay is 7.5 days compared with the national length of stay in a similar acute unit of 13.25 days.

6.2.5 Ideas tested which were successful

The unit uses pop-up reminiscence pods called 'RemPods'. These are portable scenes with full-size images and background sounds of settings such as pubs, beaches and gardens. The pods work by turning a care space into a therapeutic, calming environment. Family carers have expressed how positive the experience has been and suggested we adopt this approach within the care home/residential setting.

6.2.6 Ideas tested which were unsuccessful

None to date.

6.2.7 How has this improvement project helped people with dementia and family carers?

This project is a fantastic example of partnership working. The older peoples RAID team works within the acute site to offer psychiatry liaison services to provide more support to adult patients presenting with Mental Health problems. Post discharge these RAID nurses follow up the work in the community to ensure continuity of care.

during the project	20 admissions per month
over a year	approx. 240 patients referred

6.2.8 How has this improvement benefitted your organisation and staff?

HMR has a dedicated commissioned unit that we can seek assurance through reporting and monitoring from the provider and that the patients are at the heart of the care delivered. HMR CCG is one of the GM devolution localities and this model has been an exemplar model.

6.2.9 How has this improvement helped to raise awareness of dementia?

There is constant dementia awareness rising throughout the Borough and we have a strong third/voluntary sector that champions this.

We have recently commissioned the Life Story Network to complete an engagement project on hearing the stories / lived experiences of 'people' affected by dementia and their carers

The new model not only builds on the concept of 'system leaders':
• We have committed to embedding a 'social model' of dementia care / support (rather than the prevailing medical model).
• We are actively engaging with local communities and proactively using the third sector to build the local infrastructure.

6.2.10 How will this work continue to have impact in the future?

In February 2016, HMR CCG approved the expansion of the Oasis Unit from 5 beds to 10 beds; this provided a return on investment of more than 150% whilst securing excellent clinical outcomes provided in the existing unit to a wider cohort of patients.

6.3 Rethink Physical Health Monitoring for People with Dementia and Memory Problems

6.3.1 Applicants

Julie Henworth, Deputy Manager

Wendy Smith, Support Worker

Adele Preston, Assistant Practitioner

Gary Raffaelli, Support Worker

Kit Askew, Support Worker

Lancashire Care NHS Foundation Trust

6.3.2 Authors

Melanie Forrest Team Manager and Michelle Forsyth previous Assistant Practitioner

6.3.3 What was the problem your improvement project aimed to address?

Lack of attention to the physical health needs for people with dementia within community mental health.

6.3.4 What was done, when and where did it take place?

- A tool used elsewhere within Lancashire Care was identified that could support our service users (SU's) with their physical health needs.
- SU's and carers provided initial feedback about how helpful this was in identifying actions needed like when to contact their GP, dentist or optician.
- With consent every SU at home now sees support staff. Basic health checks undertaken include lifestyle questions, blood pressure, weight, and height and waist measurements. Appropriate advice given.
- Results from the assessments are reviewed by qualified staff and provide baseline information.
- The SU's GP is contacted with concerns; onward referrals are made e.g. dieticians.
- Staff support the SU with actions identified, for example making/attending appointments
- Results are recorded on the SU's record
-

6.3.5 What was achieved?

This tool supports the team to develop a holistic overview of our SU's. Improved understanding of the SU's lifestyle assists in patient centred care planning.

In February 2016 actions prompted by Rethink assessments included;

- 10 SU's completed Rethink
- Two SU's were identified with blood pressure problems, GPs alerted on the same day. One had medication altered, one monitored before being admitted
- Two SU's identified with problems with nutritional intake and subsequently referred to the dietician
- Two SU's attended day care as part of Dignity Day

- Staff identified problems with medication concordance and/or stockpiling, working with SU's and GP's to improve medication management
- Physical health needs discussion led to identifying social/ occupational routines/needs that the team supported with.

6.3.6 Ideas tested which were successful

- Support workers are always the same sex as the SU due to the intimate nature of some of the questions. SU's responded well to this and are able to speak openly one to one.
- Staff encourages family/carers to participate the SU's consent. This allows family/carers to increase awareness of the SU's needs and respond with support more readily.

6.3.7 Ideas tested which were unsuccessful

Originally Rethink assessments were part of the initial assessment process. On review it was recognised more flexibility was needed. The approach was adapted so that assessments are completed when appropriate for the SU. Some need time to develop rapport with the team before answering personal and intimate questions.

6.3.8 How has this improvement project helped people with dementia and family carers?

Our SU's are helped to identify physical health concerns and access further investigations/ treatment. The assessment helps staff identify SU's who would benefit from increased occupation. They could then support SU's with this.

Family participation prompts their awareness of SU's needs and to support them. Being part of the process, seeing staffs interactions with SU's and how they respond improves families understanding of how dementia affects their relative and approaches to use.

The process encourages SU's to think about their own health and can be an empowering experience.

during the project	During the project – August 2015 to March 2016 – 61 clients
over a year	Over a year – approximately 120 clients

6.3.9 How has this improvement benefitted your organisation and staff?

Rethink assessments support SU's holistically. This reduces re-referrals.
Support staff's role in this work allows the team to function more efficiently, as it frees up qualified staff's time.

6.3.10 How has this improvement helped to raise awareness of dementia?

Involving families/ care agencies raises their awareness and understanding of dementia. It allows them to see what support are available and beneficial approaches to use.
Involving families/carers helps understanding that physical health remains an important consideration with their relative, and not to assume dementia is the cause of any deterioration.

6.3.11 How will this work continue to have impact in the future?

Rethink assessments has clearly evident benefits, the team will continue to use it with all clients who consent.

Further developments planned include;

- Providing written details of action plans to the SU and/or family to prompt them
- Reviewing the assessment for potential improvements, e.g. it doesn't currently ask about hearing problems.

6.4 Memory Matters

6.4.1 Applicants

Lyndsay Wheatcroft, Senior Caseworker

Anne Aspden, Caseworker

Hyndburn Homewise Society Ltd

6.4.2 What was the problem your improvement project aimed to address?

Support for people living at home with dementia and their carers.

6.4.3 What was done, when and where did it take place?

Home visits across East Lancashire to clients and their carers to assess their needs and putting solutions in place e.g. fitting signs and pictures to help them identify places, providing memo minders reminding them not to do or to do certain things, referrals to organisations who can help (OTs, Social Services, Alzheimers Society, Carers Link).

6.4.4 What was achieved?

Over two hundred home assessments have been carried out which have improved the independence for the person living with dementia, reduced falls and hospital admission and alleviated the need for full time residential care.
Carers have now good support networks in place and have respite has been given. This has reduced their levels of stress and has had a positive impact of their health and wellbeing.

6.4.5 Ideas tested which were successful

- Nightlights have helped with orientation and prevented falls
- Memo Minders have stopped people from wandering and prevented accidents
- Daily living aids prescribed from Occupational Therapy have improved health and wellbeing e.g. people can now bathe safely following installation of bath lifts, people can mobilise upstairs safely due to second banister rail, etc.
- Signage around the home has helped with orientation and increased independence
- Assistive Technology for falls sensor, automatic pill dispenser etc. has given the carer peace of mind and reduced hospital admission and need for medical intervention.

6.4.6 Ideas tested which were unsuccessful

- Memo Minders have proved confusing in certain instances and have had to be removed
- Assistive Technology can be problematic when first installed for the person wearing the pendant
- Nightlights can also cause confusion in some cases

6.4.7 How has this improvement project helped people with dementia and family carers?

The Project has improved the independence of people who live with dementia. It has enabled them to live in a safe and more user friendly environment.
The Project has ensured that carers have relevant support and respite in place, through referring directly through to Carerslink, Age UK, Alzheimer's Society, Social Services etc. on their behalf and then monitoring to ensure the networks of support that have been put in place are working.

during the project	206
over a year	206

6.4.8 How has this improvement benefitted your organisation and staff?

Staff is all dementia friends and is aware that making small changes to the living environment can make huge differences. The Project has enabled other Organisations to refer into us for assessments for their clients knowing that every aspect of what is needed for both the person living with dementia and their carer is addressed.

6.4.9 How has this improvement helped to raise awareness of dementia?

The Project has attended many events throughout East Lancashire promoting the benefits of the service. The Senior Caseworker has given presentations to professionals/non-professionals in order to ensure that as many people can access the project as possible; this has impacted on the amount of referrals it now receives through word of mouth, friend of a friend etc.

6.4.10 How will this work continue to have impact in the future?

People with dementia and their carers greatly value living in their own homes. Ensuring that it is a safe and user friendly environment and carers have sufficient support in place prevents early admission to residential care or unnecessary hospital admission.

6.5 Dementia Local Improvement Scheme

6.5.1 Applicants

Denise Woodburn

Dr Rakesh Sharma, Clinical Lead for Mental Health

East Lancashire CCG

6.5.2 Authors

Contributors include all the GP Practices in East Lancashire and the East Lancashire Memory Assessment Service at Lancashire Care Foundation Trust.

6.5.3 What was the problem your improvement project aimed to address?

In April 2014 across East Lancashire diagnosis rates for Dementia were approximately 50% of what was expected.

6.5.4 What was done, when and where did it take place?

Practices were incentivised to:

- Add new patients identified are added accurately to the practice register and that we maintain data quality.
- Take a pro-active approach to delivering enhanced support to people with dementia and their carers, through standardised review processes and systematic follow up following diagnosis
- Identify carers of people with Dementia
- follow the local dementia shared care pathway – Dementia Drugs (regarding medication monitoring)
- To support all newly diagnosed patients and their carers (where applicable) by ensuring that there is a follow up meeting within 3 months with the Primary care team following a diagnosis decision

6.5.5 What was achieved?

Across East Lancashire the proportion of expected patients with a diagnosis of dementia rose to 67% by April 2015 and has been maintained at this level throughout 2015/16.
In up to December 2015/16, over 1500 Enhanced Dementia reviews took place across East Lancashire, with over 200 Mental Health Medication reviews in people with Dementia.
More patients have had appropriate timely access to the Memory Assessment Service than in previous years. More carers have had support from medical services and cares services across East Lancashire.

6.5.6 Ideas tested which were successful

Ideas alongside the LIS included;
Local drop in clinics for the Memory Assessment Service, so people could go and talked to a Memory Specialist without a referral.
In practice searches to identify people at high risk of dementia but who hadn't seen a GP in a significant length of time, who were contacted for an assessment/chat.
Clinical Record searches to identify people who had had a diagnosis of dementia in another service, but this has not been recorded on their clinical record, and thus weren't given the appropriate support and clinical reviews.
Work is on-going in care homes to diagnose dementia patients by Memory Assessment Services outreach.

6.5.7 Ideas tested which were unsuccessful

The iPad application CAMCOG was trialled within the memory assessment service, by the GP Community Matrons in Hyndburn and in community venues, but was found to be too complicated for the patients of East Lancs.

6.5.8 How has this improvement project helped people with dementia and family carers?

This project has ensured that patients are diagnosed earlier in the disease and that this is effectively recorded on their clinical record so that they have access to appropriate support mechanisms and services.

during the project	4-5k
over a year	1.5k

6.5.9 How has this improvement benefitted your organisation and staff?

Patients being diagnosed effectively and having better access to services has improved quality of care, and relieved pressure on the system by ensuring secondary prevention takes place.

6.5.10 How has this improvement helped to raise awareness of dementia?

An increased recorded prevalence ensures awareness is raised across the board.

6.5.11 How will this work continue to have impact in the future?

Patients being diagnosed effectively and having better access to services has improved quality of care, and relieved pressure on the system by ensuring secondary prevention takes place.

6.6 Redesign and Implementation of a New Cognitive Impairment Pathway in Bury CCG – with GPs assessing, diagnosing and managing patients without referral to the Memory Assessment Service

6.6.1 Applicants

Dr Jeff Schryer, GP

Nigget Saleem, Clinical Lead for Dementia

Bury CCG

6.6.2 What was the problem your improvement project aimed to address?

The main aim was to implement a clinically integrated pathway where care for people with 'non-complex' dementia is part of the mainstream work undertaken by practices, in partnership with various other services provided by the statutory and voluntary sectors. Care would be delivered closer to home, mirroring the management of other long term conditions. The need to provide earlier social and community support for people with suspected or diagnosed cognitive impairment lies at the forefront of this redesign.

The underlying problem being addressed was the need to stem the recent increase in referrals to the Memory Assessment Service (MAS), whilst maintaining the focus on increasing diagnosis rates. MAS Consultants would support and mentor practices in their new roles and continue to deliver services for patients with 'complex' dementia.

6.6.3 What was done, when and where did it take place?

- Redesigned the cognitive impairment pathway
- Arranged direct access to diagnostic scans
- Developed a clinical template.

- Proposals were discussed with the CCG's Patient and Cabinet
- All 33 practices nominated a Dementia Clinical Lead (DCL) who participated in a tailored education programme
- Communications programme commenced (ongoing).

During 2015/16:

- The new pathway was implemented
- DCL education continued and MOCA training was arranged for Practice Nurses/HCAs/GPs
- MAS Consultant Psychiatrists supported and mentored DCLs
- Progress was monitored and evaluated and recommendations made for future developments
- More than 20 practices participated in 'Dementia Friendly Practice' Learning Time Initiatives (LTIs).

6.6.4 What was achieved?

- By December 2015 at least 20 of 33 practices were assessing, diagnosing and managing 'non-complex' cognitive impairment without referral to MAS and at least 16 had cascaded education in house.

- Diagnosis rates increased from 58.6% in March 2014 to 77.8% in March 2015 and third highest in GM at 89.3% of over 65s in February 2016.

- Year on year, the number of referrals to MAS reduced by 42%; time to diagnose dementia by MAS reduced by 52%.

6.6.5 Ideas tested which were successful

- Pathway has worked well and DCLs want it to continue
- Patients/relatives appear receptive, generally preferring familiar people/venues.

6.6.6 Ideas tested which were unsuccessful

Nothing unsuccessful but challenges include:

- Time – length of appointments/repeat appointments plus need for some home visits
- In some practices staffing issues delayed implementation/cascading processes internally.

6.6.7 How has this improvement project helped people with dementia and family carers?

- Timelier response from clinicians
- More holistic care provided, in community setting.

during the project	In eleven months 22 different practices had referred 161 patients for diagnostic scans; in 10 months 80 newly diagnosed patients had been referred to Dementia Advisers.
over a year	Estimate c175, expected to increase to 200+ as implementation becomes further embedded.

6.6.8 How has this improvement benefitted your organisation and staff?

- Practices have gained new skills and confidence
- An example of successfully moving care into the community.

6.6.9 How has this improvement helped to raise awareness of dementia?

- New patient information leaflets written and published
- Accompanying 'Dementia Friendly Practice' LTI raised awareness amongst all practice staff including administrators.

6.6.10 How will this work continue to have impact in the future?

Plans include:

- Local Commissioned Service pilot for 2016/17
- Commissioning further education packages for practice staff
- Quality assurance and evaluation of model of care.

Linking with:

- GM Standards and Care Plans
- Third sector organisations on delivery of post-diagnostic dementia care/support
- Bury Council and developments on making Bury a 'Dementia Friendly' town.

7 All Other Applications (Yorkshire & the Humber)

7.1 Dementia and Delirium (Behaviours, Symptoms & Integrated Person – Centred Care

7.1.1 Applicants

Carol Egars, Care Home Liaison Nurse

Krystal Hemingway, Service Manager

Bradford District Care Foundation Trust

7.1.2 Authors

Sue MacPherson Care Home Liaison BCaN CMHT for Older People, Sue Proom Care Home Liaison AireWharfe CMHT For Older People, Donna Wachniuk Care Home Liaison AireWharfe CMHT for Older People, Dave Lacy Care Home Liaison S&W CMHT for Older People, Cynthia O'Neil Care Home Liaison Craven CMHT for Older People, Kelly Wood Delirium Practitioner, Chris North Dementia Lead BDCFT, Clifton Springthorpe Business Manager

7.1.3 What was the problem your improvement project aimed to address?

Large percentage of inappropriate Admissions to hospital from care homes due to delirium/challenging behaviour in dementia.

7.1.4 What was done, when and where did it take place?

Care Homes with a large percentage of inappropriate hospital admissions were offered training packages to enhance their understanding of dementia and delirium. Each care home

was offered a tailored made training package to enhance the staffs understanding of challenging behaviour focussing on how to identify challenging behaviour, hot to recognise delirium .Reasons for the behaviours and utilising a person centred approach how to tailor a package of care to reduce this behaviour. Care home liaison staff also visited the homes to review all residents and identify those most at risk of developing challenging behaviour .Those residents identified were given a personalised plan of care for the home to follow and these care plans were shared electronically with the GP. The identified residents were also reviewed by care home liaison staff at regular intervals.

7.1.5 What was achieved?

An increase in knowledge and understanding by care staff of how to care for individuals within their home, confidence for the care home staff to manage behaviours and not feel the need to dial 999 and exacerbate the situation by removing the person from their home and send them to a busy and disorientating A& E department. An easy to follow behavioural plan to implement as a first course of action. Links and relationships with care homes.

7.1.6 Ideas tested which were successful

- Tailored educational programmes
- Increased understanding of dementia and delirium
- Behavioural plans
- Sharing of plans from a Rio clinical record system to a system one clinical record

7.1.7 Ideas tested which were unsuccessful

Refusal of one care home to engage with the training package but did engage with behavioural plans, felt that their own in-house training pack was sufficient and couldn't understand that they had been identified due to high admissions to hospital.

7.1.8 How has this improvement project helped people with dementia and family carers?

Project has assisted to enhance care delivery to people identified to have a dementia in care homes. Reduced upset due to reduced admissions to acute hospital.
Improved understanding of communication through behaviours by the care home staff, that behaviours have meaning to the individual. Ensured person centred care plans for each individual.

during the project	91
over a year	91

7.1.9 How has this improvement benefitted your organisation and staff?

- Increased knowledge of role of care home liaison staff leading more appropriate referrals
- Opportunity to try something new
- Improved relationships with care homes.

7.1.10 How has this improvement helped to raise awareness of dementia?

Through the education packages this has helped to raise awareness of dementia and dementia care within care home setting. Improved understanding that behaviours are a form of communication for people with dementia.

7.1.11 How will this work continue to have impact in the future?

Hopefully through the education of staff this will continue to have long standing positive impact on the delivery of care to residents with dementia. Potential for 'mop up sessions' as staff turnover.
Potential to identify new homes and work with them.

7.2 Hearts and Minds

7.2.1 Applicants

Rachel Thompson, Practice Manager

Rockwell and Rose Practice

HOTS, Health on the Streets Programme

Bradford Council

7.2.2 Authors

Health on the Streets Team (Sue Hodgson and Pauline Bland) now decommissioned, Helen Hirst – CO of Bradford Districts CCG, Dr Sara Humphrey – Lead GP for BDCCG in Dementia, Dr Elizabeth Milwain – Memory Tree Group in Bradford, West Yorkshire, Stephen Hugh – Falls Team (Physiotherapist)

Stalls: Lifeline Piccadilly alcohol, Falls Team, Age Concern, Medicines management team for BDCCG, BRASS smoking cessation, Thorpe Edge Community Project, Carers Resource, Alzheimer's Society, Ability Matters, Disability Advice service, Continence service.

7.2.3 What was the problem your improvement project aimed to address?

- Reduce Fears
- Promote & Attend Dementia screening
- Key message - commence planning early with your loved ones
- To break down barriers, particularly surrounding the stigmatism and improve general education/ awareness of Dementia

7.2.4 What was done, when and where did it take place?

My practice organised a large health promotion event at Inspire Business Park, Newlands Way, Eccleshill Bradford, BD10 0JE on Thursday 2nd June 2015. (See link to report above). This event was open to anyone (regardless of their registered practice) and included lunch, transport, free health checks, entertainer (singalong and dancing) and many stalls (freebies and goody bags).
This event was for Education, Information, Socialisation and Recreation. The event focussed on two significant chronic diseases ; Dementia (morning session) and Healthy Hearts (afternoon session); specifically chosen to support the clinical objectives of Bradford District Clinical Commissioning Group and Bradford Council Public Health Team for 2015 - 2016. This was a joint venture with local community groups, voluntary sectors and other neighbouring surgeries which attracted 70 members of the public. We arranged for speakers from local voluntary sector and also Specialised GPs to talk to patients regarding all aspects of Dementia identification.

7.2.5 What was achieved?

- This was an excellent example of integrated health and social care with primary, community and voluntary sector working together
- The event attracted above 70 members of the public from the BD10 and BD2 area from 6 difference practices
- Positive Feedback
- Dementia Education

7.2.6 Ideas tested which were successful

Opportunistic Dementia Screening – 6 cit score

7.2.7 Ideas tested which were unsuccessful

Nothing

7.2.8 How has this improvement project helped people with dementia and family carers?

Raise awareness and in particular reduce fears. We encouraged early screening and sign-posted patients to services that could help them. E.g. Alzheimer's cafe, memory tree group, Age Concern, carers support and particularly Relate who have a service to help when a patient's personality has disappeared. .

We also introduced the concept of self-care booklets and advanced care plans to help dementia sufferers and their families.

during the project	70 patients and their carers attended
over a year	we estimate those who attended will have shared the information with relatives , friends and carers alike so approximately 100

7.2.9 How has this improvement benefitted your organisation and staff?

Because we integrated and engaged with various "bodies" both; NHS and voluntary sector, we are recognised as a Dementia Friendly practice, putting patients at the heart of our business. We want patients to have the very best experience of primary care and this event was an excellent example of good patient engagement. It was attended by Helen Hirst – Chief Officer of Bradford Districts CCG

7.2.10 How has this improvement helped to raise awareness of dementia?

Local Bradford Newspaper came to photograph the team and also promoted the event through an article. The practice produced a report which is enclosed and also designed our own patient newsletter which broadcast the event and prompted patients to attend in the first place.

Attracting good specialised speakers was extremely important and we thank Dr Sara Humphrey and Dr Elizabeth Milwain for their services.

We have notices up and regularly refer patients to local services and also hand out the Dementia self-care booklets to anyone with Dementia.

7.2.11 How will this work continue to have impact in the future?

This is an ongoing piece of work for our practice. General practices are ideally place to promote Dementia awareness and recognition. Some aspect of this work features regularly in patient group meetings. We are about to submit the Dementia Friendly toolkit and our own bespoke action plan to become a recognised Dementia Friendly organisation in the near future. We are having whole team training for this.

7.3 Diagnosing and Treating Dementia at Home

7.3.1 Applicants

Dr Jeremy Seymour, Consultant in Old Age Psychiatry

David Wagg, Community Services Manager

Rotherham, Doncaster & South Humber NHS Foundation Trust

7.3.2 Authors

Dr John Bottomley, Clinical Director, Elizabeth Lawley, Admin Team Leader

7.3.3 What was the problem your improvement project aimed to address?

The central Memory Clinic in Doncaster was inaccessible for some patients with dementia, from both “geographical” and “I don’t want to attend” perspectives. Did Not Attend (DNA) rates were being highlighted by users and carers/commissioners. The limited literature available would suggest that people with dementia and their carers prefer home assessment and treatment. It presents undue anxieties and enables a more person centred approach to patient care delivery.

7.3.4 What was done, when and where did it take place?

The Doncaster Memory Clinic served a population of 46,000 over 65s, had run for over a decade and had full accreditation with MSNAP (Memory Service National Accreditation Programme). In summer 2014 the Clinic was disbanded and the staff relocated into the four localities community mental health teams.
In line with this new service development the existing dementia pathway was modified such that now all patient assessments, treatments and follow ups are performed in patients’ own homes using standardised protocols and a multi-disciplinary approach. These changes were initiated in summer 2014 and the transition was completed September 2015.

7.3.5 What was achieved?

Home based assessment, diagnosis and treatment by trained staff using standardised protocols agreed with Primary Care and Commissioners.
Reduction in DNA rates and an increase in patient satisfaction levels regarding this new way of working evidenced through the return of 85 complimentary “Your Opinion Counts” forms about the service and zero complaints during the pilot period.

7.3.6 Ideas tested which were successful

People with dementia and carers preferred being seen in their own homes. A more inclusive service with fewer people refusing to access it; a service closer to patients’ own homes and due to a reduction in DNA rates this enabled more patients to be seen.

7.3.7 Ideas tested which were unsuccessful

More travelling time for staff, incurring a cost in staff time and travelling expenses.

7.3.8 How has this improvement project helped people with dementia and family carers?

For people with dementia the message is: we are supporting you at home, we do not wish to institutionalise you.
For carers: less time off work and travel time taking relatives to the Memory Clinic.
For both: greater continuity of care with same member of staff usually assessing, feeding back the diagnosis and following through. A more multi-disciplinary and holistic approach to care, using resources of the whole CMHT including Psychology, Occupational Therapy and Social Work, leading to improved problem solving and care for patients within the service.

during the project	The period audited is June 2014 – May 2015: 640 initial contacts plus 2745 follow up contacts (some of which may include telephone contacts).
over a year	Similar numbers with slightly increased follow up contacts are projected for June 2015 - May 2016.

7.3.9 How has this improvement benefitted your organisation and staff?

People with dementia and their carers are more relaxed in their own home such that we are more likely to get a more accurate assessment of cognitive function and activities of daily living. The service has seen an increase in performance efficiency and response to referral rates, access to specialist services and reduced patient transitions. The service development is consistent with national policy e.g. NHS England report “Models of Dementia Assessment and Diagnosis: Indicative Cost Review (2015)”.

7.3.10 How has this improvement helped to raise awareness of dementia?

Firstly through improved interface and communication with primary care and our partnership working with other agencies. Secondly, internally within the Trust the specific needs and risks of dementia care have been highlighted at Trust Board and the Trust users and carers forum.

7.3.11 How will this work continue to have impact in the future?

We hope that the benefits of supporting large numbers of people at home with dementia keep family networks together longer, promote health patient outcome/satisfaction levels and ultimately delay admission into hospital or care home settings. The risk is that high workloads in the CMHT will build up over time, which we will monitor and manage in collaboration with supportive commissioners.

7.4 Aggression, older people and care workers

7.4.1 Applicants

Chelsea Doughty, Quality Improvement Fellow

Rob Kersh, Consultant Geriatrician

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

7.4.2 What was the problem your improvement project aimed to address?

Incidents of 'aggressive & violent' behaviour on the wards, often leading to the use of antipsychotics medications and longer length of stay.

7.4.3 What was done, when and where did it take place?

Incidents of 'violent and aggressive' behaviour were measured via the Datix reporting system, a new training course developed with our neighbouring mental health trust.

7.4.4 What was achieved?

Nursing staff felt more equipped with diversion, distraction and de-escalation as well as more technical skills such as methods of physical restraint and self-defence. Incident reporting of incidents has been monitored.

7.4.5 Ideas tested which were successful

Staff training has helped equip staff with new techniques. Also discussing/ debriefing has been introduced to help staff discuss difficult situations and share ways to best manage patients.

7.4.6 How has this improvement benefitted your organisation and staff?

Staff feel more able to deal with challenging behaviours and wellbeing/ moral of staff had increased.

7.4.7 How has this improvement helped to raise awareness of dementia?

Staff more aware of challenges that can arise with patients with dementia, but aware that this is a time of high levels of stress for patients, relatives or carers and staff.

7.4.8 How will this work continue to have impact in the future?

We plan to roll-out the training across the organisation to front line staff. This will continue to increase and improve awareness of dementia, help staff with new techniques of managing these patients and promote ways staff can improve morale and wellbeing.

7.5 Can we reduce the readmissions of people with Dementia?

7.5.1 Applicants

Dr Claire Scampion, ST4 Geriatrics

Huddersfield and Calderdale NHS Foundation Trust

Dr Ayisha Eltilib, GP ST2

Leeds Teaching Hospitals NHS Foundation Trust

7.5.2 Authors

Dr Oliver Corrado, Consultant Geriatrician, Leeds Teaching Hospitals Trust, Dr Niall Cahill, Trust Grade SHO, Leeds Teaching Hospitals Trust, Rachel Robinson, Informatics Officer, Leeds Teaching Hospitals Trust

7.5.3 What was the problem your improvement project aimed to address?

Aimed to identify what health and social factors lead to people with dementia being readmitted to hospital. To determine whether there are strategies to improve future care and avoid unnecessary admissions.

7.5.4 What was done, when and where did it take place?

Retrospective case note audit of patients >65 years old with an ICD code of dementia re-admitted to Leeds Teaching Hospitals Trust four or more times in the year following an initial admission in 2013.

7.5.5 What was achieved?

We had expected that readmissions in people with dementia would be for primarily social reasons. We showed, however that this is not the case. Most admissions were for health reasons reflecting the often complex medical needs of patients with dementia. These were, however, often 'soft' readmissions e.g. fall or minor infection that might have been manageable in the community.

We also showed that there was little involvement of hospital or community mental health team when patients with dementia are repeatedly re-admitted to hospital.

We identified that carer's needs were rarely assessed.

7.5.6 Ideas tested which were successful

We have fed back our results to Leeds Teaching Hospitals Trust and Yorkshire and Humber Dementia Clinical Leads and Commissioners Forum and there is ongoing work to develop strategies to try and prevent unnecessary admissions.

7.5.7 Ideas tested which were unsuccessful

Ongoing work into developing strategies with no formal results as yet.

7.5.8 How has this improvement project helped people with dementia and family carers?

Identified a need for better communication between acute hospitals and mental health teams (community and liaison) when patients with dementia are admitted to provide better continuity of care for this vulnerable group.

7.5.9 How has this improvement benefitted your organisation and staff?

Aim to develop strategies to try and reduce the readmission rates of patients with dementia.

7.5.10 How will this work continue to have impact in the future?

Health problems are the primary reason for readmission in people with dementia. These are often 'soft' admissions. This should be considered when developing unplanned admission strategies in primary care. Work is ongoing to develop and implement strategies to better support people with dementia in the community to try and reduce readmission rates.

7.6 Memory Support Worker (MSW) Team

7.6.1 Applicants

Lynn Welsh, Memory Support Team Manager

Leeds & York Partnership NHS Foundation Trust

Michael White, Operations Manager, West Yorkshire

Alzheimer's Society

7.6.2 What was the problem your improvement project aimed to address?

- Local evaluation indicated that there was an inconsistency in the Leeds citywide post diagnostic support process
- Lack of a "joined up" pathway for service users across health, social care and voluntary services. Inadequate liaison/communication processes between services
- Services users wanted to have one named person to be their named contact for their Dementia journey
- Potential service users lack of knowledge of what is available for them to access to enable social inclusion

7.6.3 What was done, when and where did it take place?

- Initial discussions/thoughts about the service/teams were initiated at the citywide Leeds Dementia Board which included members from Health, Social Care, Commissioners, GPs and primary practice

- The Leeds Dementia redesign group were tasked to draft the proposed model and operationalise the team once the funding had been secured (Better Care Fund). The redesign group had service users/carers representation from a member of Leeds Involving People who was a member of the group and consulted with service users/carers on such items as the title of the role etc.

- The 13 MSW posts were created in line with the Integrated Neighbourhood Teams (INTs) model that was/is being rolled out across the across the city. (one support worker per team)

- There was a joint recruitment process between LYPFT and the Alzheimer's Society and all posts were recruited into

- A comprehensive two week induction was formulated and implemented including subjects such as psychological perspectives about dementia, symptoms/presentations of delirium and guest speakers such as a solicitor talking about lasting power of attorney and people with a diagnosis of dementia and their carers telling their stories

- The MSW's made contact with the cluster of GP surgeries attached to their INT's

- The MSW's introduced themselves to the coordinators and volunteers within their local Neighbourhood Network Schemes and community organisations

- The contact details of the MSW's were provided to all concerned for referral purposes and a MSW poster was circulated to all relevant venues across the city

7.6.4 What was achieved?

- The MSW role is embedded within the teams with referrals being generated in all areas.
- The team have been able to collectively "shape" the role/post and continue to inform the development of the service
- The team is established as an integral part of the newly established Leeds Dementia Pathway

7.6.5 Ideas tested which were successful

- Having a worker in each of the Integrated Neighbourhood Teams
- Establishing regular links with all of the Health/Social and 3rd Sector
- Direct links/supervision agreements with the Dementia/Mental Health Community Liaison Practitioner team

7.6.6 Ideas tested which were unsuccessful

Nothing to date

7.6.7 How has this improvement project helped people with dementia and family carers?

- MSW's are a named point of contact to support the person with dementia, their family and friends
- People with symptoms indicating possible dementia and their family / friends have been supported to overcome barriers to memory assessment and diagnosis (e.g. attending appointments, denial of symptoms)
- The MSW enables social inclusion, through support in attending activities and signposting

during the project	Since November 2015 = 392
over a year	N/A

7.6.8 How has this improvement benefitted your organisation and staff?

- Liaison and partnership working
- Enabled the established Leeds Memory Service to transfer services users back to the GP to do routine monitoring of dementia medication with the MSW as named point of contact
- For the capacity that has been released for the Memory Services team to concentrate on a more comprehensive post diagnostic support /interventions model inclusive of psycho social interventions

7.6.9 How has this improvement helped to raise awareness of dementia?

- Through promotion from the Alzheimer's Society e.g. website, social media, helpline, networking and in various venues across the city
- Through MSW presence in the 3rd sector organisations
- Through MSW having direct face to face contact with staff in Primary Care & LCH

7.6.10 How will this work continue to have impact in the future?

- Through extensive networking across the city by the MSW team to promote an understanding of dementia

- Working in partnership with Primary care and secondary mental health will ensure a more efficient and qualitative package of care
- Facilitation of a potentially quicker response to new or previously worked with services

7.7 Patients into People

7.7.1 Applicants

Caroline Bird, F1 Doctor

Saadia Aslam, CT1 Doctor

Doncaster and Bassetlaw NHS Foundation Trust

7.7.2 Authors

Dr Rod Kersh (Care of the Elderly Consultant)

7.7.3 What was the problem your improvement project aimed to address?

“This is me” was being used on the Care of the Elderly (COTE) wards in Doncaster Royal Infirmary for patients with known diagnoses of Dementia. Many patients on these wards have cognitive impairment and probable dementia; however this diagnosis may not be made till follow up in an outpatient memory clinic. Therefore, it is likely that we are not using "This is Me" on all patients with dementia due to a lack of a diagnosis in the first place. We believe that “This is me” helps the staff to better understand and know their patients, which aids to improve the quality of care delivered and inpatient experience. It makes patients into people.

7.7.4 What was done, when and where did it take place?

Members of the multidisciplinary team on the COTE wards were approached to complete a questionnaire to assess their baseline knowledge of the patients (the questions were based on the content of "This is Me"). This information was collected over a two week period, which was then collated and analysed.

“This is Me” was then placed in all patients notes, we have decided to start using the new edition that has been designed by Dr Kersh and Helen Anderson.

In order to raise awareness posters have been placed in the staff room to remind staff that all “This is Me” booklets need to completed, it has been incorporated into the ward newsletter, it has been added to the nursing staff handover checklist and the ward clerk has agreed to place them in front of all patients notes as they arrive on to the ward.

7.7.5 What was achieved?

All patients on COTE wards now have a "This is Me" at use in their notes regardless of a Dementia diagnosis. The project has helped families to be involved in the patient's care, through completing "This is Me" for their relative which in turn allows staff to know their patients better. We feel that this helps to improve patient care and inpatient experience.

7.7.6 Ideas tested which were successful

Introduction of “This is me” for all patients

7.7.7 Ideas tested which were unsuccessful

In the reality of the NHS the pressures on the staff mean that there is not always time available both for filling out and reading "This is Me". Staff understandably have to prioritise clinical management of the patient.

7.7.8 How has this improvement project helped people with dementia and family carers?

"This is Me" helps support the patient who is unable to communicate the information for them. It helps staff care for the patient as they would have wished for and their family/carer are an appropriate person to help them express that now. It also highlights the patient's care needs to staff members. Through this project we are able to extend these benefits to patients without a formal diagnosis of dementia making “This is Me” a common tool on COTE wards in Doncaster Royal Infirmary.

during the project	32 Patients (number of inpatients)
over a year	711 patients (inpatients)

7.7.9 How has this improvement benefitted your organisation and staff?

Staff feel that they know their patients better as people as they know facts about their life, interests and achievements, rather than as an unwell frail patient. It has allowed for conversations to be tailored to the patient's interests and therefore help engage them in socialising. It helps avoid topics or actions the patients are known to find distressing. It has improved the patient experience that in turn improves staff experience of looking after that patient.

7.7.10 How has this improvement helped to raise awareness of dementia?

Staff have an improved awareness and understanding of communication difficulties that Dementia patients suffer from and “This is Me” has led to the bridging of this communication barrier and led to a better understanding of each individual as a whole. It has also increased awareness of the patients with underlying cognitive impairment that may require similar attention despite the fact that a d diagnosis of dementia is not in place.

7.7.11 How will this work continue to have impact in the future?

We believe that each patient that arrives on to the COTE wards in Doncaster Royal Infirmary should have a “This is Me” that will help to improve the inpatient experience for all patients. We plan on saving each individual “This is Me” in their medical notes so that it can be re-used on further admissions.

7.8 Younger Person’s Dementia Advisor

7.8.1 Applicants

Kayleigh Haynes, Dementia Advisor

Alzheimer’s Society

7.8.2 Authors

Anna Machalica (Alzheimer’s Society), Dr Kirsty Harkness, Dr Daniel Blackburn, Dr Aijaz Khan

7.8.3 What was the problem your improvement project aimed to address?

A gap in Sheffield was identified in the provision for services for younger individuals with a diagnosis of dementia, their families, and carer's. Newly diagnosed younger people with dementia are not yet ready to access the care services provided by the Society but need practical and emotional support to help understand and come to terms with their diagnosis.

7.8.4 What was done, when and where did it take place?

The DA role was implemented from September 2015 working from the Alzheimer's Society office in Sheffield and being based two days a week in clinic with the neurology consultants Dr Harkness and Dr Khan at the Royal Hallamshire Hospital in Sheffield.

7.8.5 What was achieved?

The DA was meeting with new and existing patients on a weekly basis through the memory clinic at the RHH, giving information, advice, support and follow up after the clinic appointments. The DA was then able to make contact with patients and offer further support and advice around matters such as benefits, financial matters, support for the individual and their families, peer support groups, carer peer support group, activities in the local communities, liaison with social services, G.P's, and other professionals.

7.8.6 Ideas tested which were successful

Working alongside the neurology consultant at the RHH has been very successful in meeting new and existing patients with a diagnosis of dementia and informing them of the services we offer in Sheffield as well as offering valuable support to the consultants around what is available, who else to involve and follow up with patients. Referrals have been made for other NHS services, support groups, and carer liaison services through the DA.

7.8.7 Ideas tested which were unsuccessful

To date no ideas or interventions tested have been unsuccessful to my knowledge.

7.8.8 How has this improvement project helped people with dementia and family carers?

It has provided a dedicated worker that can offer information, advice, emotional support, sign posting for individuals affected by a diagnosis of young onset dementia and their families. We have been able to support individuals to engage in therapeutic activity, peer support groups, community activities, patient involvement forums and research studies. We are providing persons centred key worker service to any individual and their families through their diagnosis and support needs.

during the project	85 in 6 months (approximately)
over a year	200+ (approximately over the full year)

7.8.9 How has this improvement benefitted your organisation and staff?

It has added to the already well established younger person services we have at the Alzheimer's society in Sheffield. It has filled a gap that the services we provide could not have filled due to not having a bespoke younger person's dementia adviser working in conjunction with the Hallamshire. We are receiving more referrals to support younger individuals with a diagnosis and their families and by having a dedicated worker we are able

to support more individuals and hopefully support individuals to live well with their diagnosis, live independently for longer, avoid the need for additional NHS services and spending and be a part of their community for longer.

7.8.10 How has this improvement helped to raise awareness of dementia?

Part of the Dementia Adviser role has been to contact other NHS and private organisations to inform them of the services we offer in Sheffield for individual with young onset dementia and how we can work better together. A part of the DA project involved working collaboratively to create a new dementia pathway for the NHS for Sheffield for younger individuals diagnosed with dementia. This is an on-going piece of work.

7.8.11 How will this work continue to have impact in the future?

The current project is only funded by the Sheffield Clinical Commissioning Group until August 2016 but we are currently seeking additional funding from various avenues to keep the project going. The DA project has raised a lot of interest from the head of younger person's service development within the Alzheimer's Society with their plans to make this an exemplar project and model the DA role with the aim of improving services available to younger individuals across the UK.

7.9 3Ds Triple Screening Tool for Delirium, Dementia and Depression

7.9.1 Applicants

Chris North, Dementia Lead

Dr Gregor Russell, Old Age Psychiatrist

Bradford District Care NHS Foundation Trust

7.9.2 Authors

Andrea Allanach (Ward Sister, Westwood Park Community Hospital), Dr Jo Ostler (Old Age Psychiatrist, Bradford District Care NHS Foundation Trust), Danielle Woods (Dementia Lead Nurse, Bradford Teaching Hospitals NHS Foundation Trust)

7.9.3 What was the problem your improvement project aimed to address?

Under identification / diagnostic overshadowing of the 3 most common mental health conditions for older people admitted to general / acute hospitals.

7.9.4 What was done, when and where did it take place?

Creation, testing, revision and implementation of the tool in two community hospital settings. Education and support of general nurses within staff teams by mental health practitioners. Revisions based on staff experience, skills and knowledge questionnaires.

7.9.5 What was achieved?

Marked change in staff culture towards contacting family members to gather detailed history of current presentation and issues / needs arising.

7.9.6 Ideas tested which were successful

Improved levels of identification of both possible dementia and depression.

7.9.7 Ideas tested which were unsuccessful

Improvement in numbers of patients sign-posted to Memory Clinic for diagnostic testing.

7.9.8 How has this improvement project helped people with dementia and family carers?

Greater awareness of and confidence in caring for older people with dementia and greater levels of engagement with family carers.

during the project	121 over 7 month period that project ran for
over a year	207 (Extrapolated from the project figures)

7.9.9 How has this improvement benefitted your organisation and staff?

- Improved joint working and decision making between acute hospital staff and mental health practitioners.
- Better awareness of links between delirium, dementia and depression by acute hospital staff.

7.9.10 How has this improvement helped to raise awareness of dementia?

Tool guides general nursing staff to gain detailed history from family carers, helping build up picture of need within patients with possible dementia. Also helps to develop skills in cognitive testing to assist with identification through inclusion of Mini-Cog scale.

7.9.11 How will this work continue to have impact in the future?

Aim is to further revise tool for further roll-out across both local elderly medicine network and wider regional dementia networks, to be implemented in a variety of hospital settings where people with possible dementia may be admitted.

7.10 A Masterclass in Dementia, person centred care and quality improvement for medical students

7.10.1 Applicants

Rob Kersh, Consultant

Doncaster and Bassetlaw NHS Foundation Trust

Sara Page, CT1

Sheffield Teaching Hospitals NHS Foundation Trust

7.10.2 What was the problem your improvement project aimed to address?

Teaching on dementia and person-centred care in the medical undergraduate curriculum is limited. There is also limited opportunity to interact with positive role models for person centred care. Medical students may not feel empowered to engage with patient care and take part in quality improvement, despite their valuable role in observing patient care over a number of sites.

7.10.3 What was done, when and where did it take place?

Medical students attended a masterclass which consisted of 5 interactive group sessions that aimed to educated students about dementia with a focus on person centred care. The sessions were held in a seminar room in the University of Sheffield Medical School. Throughout the sessions, the students were taught about dementia and patient centred care through informal discussion and video.

7.10.4 What was achieved?

The students were able to increase their knowledge about dementia. Through real life examples of excellence in dementia care, they were able to develop an understanding of a holistic approach to disease management and how quality improvement affects patients. Students were encouraged to consider patients' journeys during their clinical attachments and think of ideas for their own quality improvement projects.

7.10.5 Ideas tested which were successful

Students were enthusiastic about person centred care and were able to think of many potential quality improvement projects. They began to consider a person centred approach to care.

7.10.6 Ideas tested which were unsuccessful

There are challenges in supporting the students to undergo their quality improvement projects. Particularly, due to short rotations, the students felt that they were not part of a team. These challenged have meant that none of the students underwent a quality improvement project by the end of the masterclass, but efforts to support them are still ongoing.

7.10.7 How has this improvement project helped people with dementia and family carers?

Medical students are tomorrow's doctors - the current system to support doctors in understanding dementia, how to support and care for patients with both dementia and delirium requires postgraduate study - we feel this should begin at medical school and be for as broad an audience as possible.

during the project	7
over a year	How many patients with dementia will a junior doctor see in a year? 100's? 1000's?

7.10.8 How has this improvement benefitted your organisation and staff?

This project has shown that we are committed to teaching, training and development of staff understanding of dementia for all tiers, no matter their position in the organisation.

7.10.9 How has this improvement helped to raise awareness of dementia?

It has brought the importance of dementia to a new generation, it has demonstrated the centrality of dementia and person centred care to understanding 21st Century Medicine.

7.10.10 How will this work continue to have impact in the future?

The doctors of tomorrow will maintain their good practice and induct others into understanding the meaning and significance of dementia to our patients and our society.

8 All Other Applications (Greater Manchester, Lancashire & South Cumbria)

8.1 Post-diagnostic support for people with dementia: how can we help?

8.1.1 Applicants

Julie Patel, Clinical Psychologist

Lancashire Care NHS Foundation Trust

Lesley Tiffen, Commissioning Manager

NHS Fylde and Wyre CCG

8.1.2 Authors

Service users and carers who kindly recorded their 'stories', Dr Kath Greenwood, GP and MH Lead, Jayne Marshall, Service Manager Fylde Coast older people's community MH service, Alan Orchard, Public Health Co-ordinator, Lancashire County Council, Dr Mark Worthington, Consultant Psychiatrist, Dr Ian Leonard, Consultant Psychiatrist, Michele Scott, Manager, Care and Repair and Lead for Dementia Action Alliance work, Fylde and Wyre Community Forum, Ann Marsh, Manager, Alzheimer's Society, Rebecca Rose-Hewitt, AgeUK, Margaret Hall, N-compass – advocacy and support for people with dementia and their carers, Will Roberts, Commissioning Team, Fylde and Wyre CCG

8.1.3 What was the problem your improvement project aimed to address?

To improve knowledge about post-diagnostic support available to people with dementia and their carers.

8.1.4 What was done, when and where did it take place?

For several years, Fylde and Wyre have held partnership group meetings - known as the 'EBIT'. It focuses on working together to improve services for people with dementia. We have recently been working on 'Post-diagnostic support'. This involved compiling information about support services. Often, individual services are knowledgeable about their own area, but people with dementia frequently find it difficult to navigate the 'range' of services available. We believed that one of the barriers to GPs and others making referrals to Memory Assessment Services for early diagnosis is the erroneous belief that 'not much can be done'.

The EBIT pulled information together from multiple services to gain a 'whole' picture of the needs of people with dementia and the 'range' of services that can be tapped into.

The LCC Public Health service, which inputs to the EBIT, worked with people at the early stages of dementia (and carers) to record personal stories about experiences of receiving a diagnosis and 'living' with dementia. They kindly gave permission for these to be used for educational purposes/ service development. We used 3 examples from the stories during an education event organised by our CCG with GPs and staff in Primary Care.

8.1.5 What was achieved?

- Multiple agencies and groups worked together with a shared agenda to support people with dementia
- Promoted 'Dementia Friends Awareness' across all our respective agencies. Several members of the group provided 'Dementia Friends' training across Fylde and Wyre.
- Pulled together information on post-diagnostic support available across agencies, for Fylde and Wyre
- Our CCG organised a large educational event on 24th Feb 2016. We presented information about sources of help available. This was attended by around 100 front-line Primary Care staff and partner agencies. Speakers included our locality GP MH lead, Consultant Psychiatrists from Lancashire Care Trust (LCFT)'s Memory Service, Care and Repair, Alzheimer's Society, N-Compass, AgeUK, and Public Health (who presented the voices and stories of people with dementia).. Michelle Scott, one of the presenters, raised awareness about the wider community initiatives for 'Dementia Friends' and 'Dementia Friendly' communities
- A range of 'market stalls' were available at the event providing information about the support different agencies can provide. This included a stall with LCFT's research team, providing information about projects and encouraging Primary Care services to offer people with dementia the opportunity to be involved in research if they so wish.

8.1.6 Ideas tested which were successful

- Working together in partnership - achieved so much more than any one agency could have done alone
- The 'dementia stories' at the CCG educational event were a fantastic way of trying to understand the issues from the perspective of people living with dementia
- We received feedback that the CCG educational event has encouraged GPs in making early referrals to the memory service
- We have been able to promote awareness of wider community initiatives to staff in Primary Care settings.

8.1.7 Ideas tested which were unsuccessful

- We would have liked to have more time at the Education/Workshop event – time was limited - were keen to do more
- We initially considered several models - we considered the '5 pillars model of support' but then moved to using the 'WELL' model to map out services as this was more straightforward.

8.1.8 How has this improvement project helped people with dementia and family carers?

- Enabled people with dementia to 'tell their stories' and share their experiences in a positive manner
- Information 'to hand' about services providing local post-diagnostic support - have disseminated this
- Promoted 'early diagnosis' to enable people to be involved in early decision-making about their care and wishes

Estimated number of people helped:

a) During the project –many 'Dementia awareness' sessions delivered over the last year: EBIT group has worked hard on information-provision - difficult to estimate exact numbers

b) Over a year – several hundred people (perhaps more via 'Dementia Friendly Communities')

during the project	many 'Dementia awareness' sessions delivered over the last year: EBIT group has worked hard on information-provision - difficult to estimate exact numbers
over a year	several hundred people (perhaps more via 'Dementia Friendly Communities')

8.1.9 How has this improvement benefitted your organisation and staff?

- LCFT produced an information leaflet for Primary Care about Memory Services and community services available
- 'Working together' has been fantastic – positive relations between agencies, improved knowledge
- Primary Care staff better informed about 'pathways' to LCFT and other services
- Positive feedback about the CCG event received.

8.1.10 How has this improvement helped to raise awareness of dementia?

- Better information available across agencies
- Promotion of DAA and Dementia Friends
- Ways of involving people with dementia promoted (e.g. via research opportunities)
- Please see 7 above

8.1.11 How will this work continue to have impact in the future?

- Early diagnosis of dementia
- Improved information available
- EBIT partnership group continuing
- Linking with Wyre and Fylde Community Forum - Dementia Friendly Communities

8.2 'Dementia Care – Registered Nurse'

8.2.1 Applicants

Sarah Monks, Lead Dementia Specialist Nurse

The University Hospital of South Manchester NHS Foundation Trust

8.2.2 Authors

Annette Weatherly, Deputy Chief Nurse, University Hospital South Manchester.

8.2.3 What was the problem your improvement project aimed to address?

Whilst there is a global commitment for action against dementia (G8 Summit, 2013), there remains an inequality within the standards of hospital care received by those living with Dementia across England (Fix Dementia Care, 2015).
UHSM is proud to have developed a unique initiative, addressing inequality in dementia care, whilst redefining the future of nursing within acute trusts.

8.2.4 What was done, when and where did it take place?

UHSM has introduced the new 'Dementia Care Registered Nurse' (DCRN) programme. This is an 18 month programme offering work based training to develop a clinical skill set, support and clinical supervision to support the development of future Dementia Care leaders. Working closely with The University of Manchester, UHSM also ensured the DCRN's programme included accredited Person Centred Dementia Care dementia modules, developing a theoretical underpinning that can be implemented in to practice.
The DCRN works collaboratively across professional and organizational boundaries to provide a holistic and comprehensive assessment of patient needs and ensure appropriate admission, with timely and safe discharge.
The initiative offered 40 DCRN positions within the first intake and envisages that these nurses will work across the organisation, developing and implementing best practice and person centred care across South Manchester.

8.2.5 Ideas tested which were unsuccessful

Initially it had been presumed that the roles would only be required within the complex wards. However in consultation with staff, people with dementia and their carers, it had been apparent that all areas would like a DCRN in post. Following this the number of DCRN nurses to be recruited had been raised to 40.

8.2.6 How has this improvement project helped people with dementia and family carers?

This project enables all areas across the trust to access a dementia care registered nurse, enabling greater assessment, support and individualised care for people with a dementia and their carers. This has enabled improvements in care via access
The Initiative had been developed through the engagement of people living with Dementia and their carers. Development of the project had been highlighted within the carer and patient engagement group. The development of the role remains a focus for the carer and patient engagement group as nurses become embedded in their role and opportunity to improve dementia care arises.

during the project	Continuous project
over a year	Over a year- All emergency treatment and admissions for those with a dementia diagnosis and suspected dementia and there carers over the year.

8.2.7 How has this improvement benefitted your organisation and staff?

This initiative has enabled the trust (staff, patents, carers and community organisations) to work towards a centre of excellence for Dementia Care and show how UHSM are being proactive and remain committed to improving the lives of people with Dementia and their carers. These roles enable quick access to support and training and help achieve the local and national dementia strategy.

8.2.8 How has this improvement helped to raise awareness of dementia?

Throughout all areas of the hospital awareness has increased due the presence of the roles and their impact in practice. The Trust has arranged Launch events, learning events that have included all those entering the hospital and engaging in services within the community.

8.2.9 How will this work continue to have impact in the future?

We believe that through promotion of the initiative, other Trusts will begin to adopt the same programme. We believe this scheme has the potential to evidence how the North West is making leaps in Dementia Care. This initiative will improve the care for people with Dementia and their Carers, having beneficial impact on health and wellbeing outcomes for all involved.

8.3 Integration of the Dementia service with integrated care communities in South Cumbria

8.3.1 Applicants

Dr Sam Jebur, GP Dementia Lead

NHS Cumbria CCG

Deborah Parker, Operations Manager

Alzheimer's Society

8.3.2 Authors

This work was actively supported by the mental health care of the elderly team, Cumbria Foundation Trust.

8.3.3 What was the problem your improvement project aimed to address?

Inadequate level of understanding of Dementia by the general population, the lack of diagnostic skills by the primary care, and the consequential waste of resources caused through post diagnostic support sitting outside of an integrated pathway that starts with the person and their GP.
We found that professionals were working independently and the community as a resource is being left untapped and effectively disempowered to support the dementia care or use the available resources appropriately.

8.3.4 What was done, when and where did it take place?

Dr Jebur was looking for an opportunity to implement the Dementia integration project she had devised for the locality (see attached project). At the same time Alzheimer's society had been working on ways to provide a Dementia Advise and Support service across Cumbria so that every person diagnosed with dementia would have meaningful care following their diagnosis, which supports them and those around them. In February 2015 funding was made available to pilot in one area.
The two joined forces and in June 2015 agreed the two initiatives were part of the same solution. It was also agreed that we must embrace all stakeholders not least community.

In Date Dr Jebur convened the first steering group, including GPs , Psychiatrists, CPN, acute trust representatives, 3rd sector, Alzheimer's society and Furness carers, the hospice, age uk, carer's representative, we invited Cumbria county council who sent a care home manager to represent, we had managed to link with Barrow council and the health and wellbeing board.

We have a representative from local businesses as well. We had a discussion on how to start, what to do, who will do it, and when?, we agreed to work jointly and support each other,

we called for a steering group meetings only when we feel we have an issue that need the whole group decision and we need to move on, but each member of the team (organisation) was able to communicate directly with any other member of the group as needed.

Please see below details of the project.
CCG MENTAL HEALTH LEADERSHIP PROJECT
Integration of Dementia service with Primary care communities/ Furness Locality
Introduction
The dementia service integration with the primary care communities is part of the wider redesign of the primary care in the locality; we will be working on different work streams simultaneously to achieve this integration.
Project Aim
The main aim of the redesign is to implement a clinically integrated dementia pathway where care for people with non-complex dementia is part of the mainstream work undertaken by practices (as part of the newly developed Furness Primary Care Communities) in partnership with various other services provided by statutory and voluntary sectors. Care is therefore delivered closer to home, mirroring the management of other long-term conditions.
Locality context
Cumbria CCG has 6 CCG localities, Furness is one of them.
There had been recent changes in the way GP practices work and few smaller practices had merged with other practices as it was felt that the demand had increased to the extent that these practices will not cope with it.
We are in a process of finding new ways of working where the practices will be working collaboratively and sharing the community services through 4 “Primary Care Communities”

Background
Dementia can have considerable impact on the quality of life of people with the condition, as well as on their families and other carers.
As successive generations survive longer due to reduced mortality rates associated with other conditions, they may face a rising lifetime risk of dementia onset. A major challenge in this context is how to provide high-quality treatment and support to these individuals in ways that are therapeutic to and valued by them and their family carers, but at a cost considered by society to be affordable.

Definition
ICD10 F00-F09
Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgment. Consciousness is not clouded. Impairments of cognitive function are commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation.

DEMENTIA – STATISTICS
• At the current estimated rate of prevalence, there will be 850,000 people with dementia in the UK in 2015.
• The total number of people with dementia in the UK is forecast to increase to over 1 million by 2025 and over 2 million by 2051.
The costs of dementia in the UK
The overall economic impact of dementia in the UK is £26.3 billion, working out at an average annual cost of £32,250 per person.
‘Good’ and ‘bad’ costs
The ‘good costs’ are associated with care and support delivered in response to assessed needs and in cognizance of expressed preferences, while the ‘bad costs’ are those economic

impacts associated with failure to do just that, i.e. failure to identify or respond appropriately to needs and preferences (such as crisis admissions to hospital, unnecessarily long periods of inpatient stay, unnecessarily early admissions to care homes).

Mortality

· Dementia is now one of the top five underlying causes of death and one in three people who die after the age of 65 have dementia.

Hospital care

· An estimated 25 percent of hospital beds are occupied by people with dementia.

· People admitted to hospital who also have dementia stay in hospital for longer, are more likely to be readmitted and more likely to die than patients without dementia who are admitted for the same reason.

Care homes and care at home

· An estimated one-third of people with dementia live in residential care and two thirds live at home.

· People with dementia living in a care home are more likely to go into hospital with avoidable conditions (such as urinary infections, dehydration and pressure sores) than similar people without dementia.

END OF LIFE CARE

End of life care needs remain somewhat neglected, and over-investigation and inappropriate interventions remain a costly exercise for both patients and the health and social care economy.

Advance Care Planning (ACP) is one mechanism by which individuals' wishes and preferences may be better respected, especially in end of life care where the loss of decision making ability is common.

Rationale for the Project

National policy drives

1. The Prime Minister's Challenge on Dementia 2020 (Department of Health, 2015).

2. The Dementia UK update / Alzheimer's Society 2014

3. NICE Guideline 2014

General Practice and Primary Care

Dementia QOF.

Dementia DES, improving diagnosis rate, and post diagnosis support.

Department of Health (2015b) Primary Medical Services Directions 2015

"(g) a Dementia Scheme, the underlying purpose of which is to encourage and support primary medical services contractors to proactively offer assessment to patients at risk of dementia and to continually improve the quality and effectiveness of care provided to patients with dementia; and (h) an Avoiding Unplanned Admissions and Proactive Case Management Scheme for the purpose of providing a high quality service to patients that will help avoid their unnecessary or unplanned admission to hospital and keep them living healthily and independently in the community."

Secondary care

Increased pressure on both acute hospital (A&E, unplanned and planned care) and Mental Health /Older adult mental health.

The need of the Community

Listening to the patients and the carer's voice.
Due to increase public awareness about dementia, there had been increased demand on the service to improve dementia care.

Local Context

Why this project is important for our locality?

· Because the primary care clinicians are best placed to know the patient as a person and know the families (in our locality for many generations).
· GP have wide medical experiences that can deal with Dementia as part of complex multiple pathologies and deal with polypharmacy.
· As the locality CCG is in the process of developing the primary care communities which would mean GPs are clusters into 4 clusters to work together, we felt that this will be the right time to configure the Dementia service around the 4 clusters.
· GPs are managing chronic diseases like renal failure, respiratory failure, heart failure & Diabetes. Dementia is a brain failure and can be managed by GPs.

THE PROJECT OBJECTIVE

To achieve The Integration of Dementia service with Primary care communities/ Furness Locality, and Improve the quality of the care, working on the different parts of the care cycle simultaneously as we will need to use the resources (particularly the manpower) efficiently.
Action Plan
PART 1
· To develop GPs clinical skills in early diagnosis and management of straightforward cases of Dementia.
· Each Primary care community will have a Dementia Lead GP/Clinician
· Will use a pathway similar to Bury Dementia pathway redesign project, as I was actively involved in setting up the GPs training curriculum(please see attachment enclosed).
· Will arrange 3-4 training workshops for the GPs leads as 1st step and 6 monthly peers review workshops to share information and knowledge.
· The educational program include details of the learning needs of the primary care clinicians and does include online support material.
· The locality CCG will take responsibility in organising and paying the cost.
· We had agreed with our psychiatrists colleagues to deliver the training.

PART 2

Directly working with Older adults Psychiatrists to bring the memory clinic service to primary care, by linking to each of the four primary care communities running service from GP premises and have direct access to GP IT system and discuss directly with GPs (CPN will be part of the GP team).
This would free time of the more specialised secondary care service to look after more complex cases and support GPs with management as needed.

PART 3

The Care Homes

Improvement, by training dedicated GP/GPs to develop higher skills of dealing with both mental Health/Dementia and physical health of older people. This will be achieved partly as the result of achieving part 1, but might need further links with the local geriatric service.

PART 4

Post Diagnosis Support, closer working with the Dementia Advisor, Dementia support worker (particularly for the care homes), working with STINT team, social services, home carers....etc.

PART 5

Supporting the voluntary organisations in delivering the dementia friends' information session to the wider community and helping in getting the support of the local business.

What have we done so far?

· We had developed a wide membership of stakeholders (Primary care, CCG, Secondary care clinicians (Mental Health), social service, 3rd sector (Alzheimer's society) and St. Marys Hospice) to discuss the proposal.
· Alzheimer society had already employed a "Dementia Advisor" to work with our pilot and just funded 14h/week for a Dementia support worker who is starting working in Millom (one of the primary care communities, where the Pilot had already started).
· We had started delivering Dementia friend's information sessions and had approached a lot of local organisations and local businesses to join to become Dementia Friends.'
· Alzheimer Society will work on developing the Dementia alliance and health professionals will be active partners in that.
· The care home work is already ongoing in Millom and had proven very successful.

What would be Difficult?

· As this is a time of reconfiguration of CCG work and BCT (better care together). I expect some resistance from some of GP colleagues to take the training.
· As secondary care colleagues are currently quite stretched and we have a serious recruitment problem, we anticipate difficulty in gaining continuous support and engagement.
· The CCG management team is working on resources identification and cost implication.
· We have to be clear about the time schedule as a project like this can be difficult to achieve in a short time, I would expect a 2years implementation period with 6 monthly reviews.

Some thoughts on how to overcome difficulties:

· Try to link the project to other reconfiguration projects the CCG is taking (that is developing the 4 primary care communities)
· Taking the training and signing to the project should be an optional commitment to take on, as forcing people to do it would have a negative impact.
· Using some of our audit outcomes to persuade stakeholders that this will be a very good project, not only to improve the quality of care for our patients with Dementia, but it will decrease GPs workload and use resources efficiently.

· By training more of the Dementia friends in the community we raise the community awareness. This means that the service delivered by the GPs need to improve to meet the community expectation.

· The locality CCG should try to look for some initial resources to support the project but we do see the huge potential of saving in the near future if correctly implemented.

Outcome measures

· Percentage increase in documented diagnosis of dementia.
· Documented increase in MMSE and assessment.
· Documented evidence of thorough medication review.
· Patients and carers feedback.
· Documented changes in referral behaviour.
· GP s and primary care feedback.
· Secondary care and other professionals involved in in the pilot feedback.
· Audits of significant events analysis, both positive and negative.
· Case studies and assessment

References

1. Dementia UK: Update Second edition
Publication date November 2014
http://www.alzheimers.org.uk/dementiauk

2. Prime Minister's challenge on dementia 2020
February 2015
www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-20

3. QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS 2012
http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf

4. Department of Health (2015b) Primary Medical Services Directions 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417192/pms-des-directions-2015.pdf

8.3.5 What was achieved?

So far, we had delivered 4 training workshops for the GPs/ nurses, with 4 parallel workshops for the practice staff , about Dementia, care and post diagnosis support, ,the sessions are delivered and supported by, Dr Jebur, a Psychiatrists, a member of Alzheimer's society, a CPN. We had also a geriatrician to work with us on frailty as part of Dementia and to think about the physical aspects of management of a person as a whole, including the polypharmacy, and multiple pathologies. We had invited a lawyer and "experts" to talk about the legal issues.

On the community front we were able to host a Dementia Champions training day which has ensured that we have sufficient local champions to meet the growing demand for dementia friends sessions and the facilitator is the right person for the audience given we are now working with clinicians, whole businesses (e.g. Tesco) and public services to name but three. We are actively involved in developing the Dementia friendly community and had linked with businesses. We had delivered 5, 2hours training workshops to the whole of the police services in Furness to educate them about Dementia and how to communicate with a person with dementia. We also used these sessions to try to agree a better way of communication between the different agencies.

Dr Jebur had delivered dementia friend's sessions to the acute hospital doctors, and the locality GPs, so far reached around 200 doctors, and the feedback was excellent.

We had developed excellent relationship with the local hospice and in a process of looking at if we can do things to improve the care, including arranged meeting to discuss the medical management.

8.3.6 Ideas tested which were successful

We will evaluate the project after we finish the 1st Phase (Furness GPs training).

8.3.7 Ideas tested which were unsuccessful

As above.

during the project	The diagnosis rate has improved. The dementia advisor/support worker managed to reach more people. We don't have the full figures for the outcome yet.
over a year	No completed figures yet.

8.3.8 How has this improvement benefitted your organisation and staff?

We hope that GP s will be able to improve the diagnosis, will have more support on the post diagnosis management.

Alzheimer's staff are now working effectively side by side with peers in related organisations e.g. Dementia Adviser / support worker with partnership trust nurses and GP support staff, local managers working with team leaders, and onward to the more senior ranks with a shared desire to make this work. The joint working is not stifled by hierarchy within the steering group all members are equal and all have a part and a voice (see diversity of membership).

8.3.9 How has this improvement helped to raise awareness of dementia?

We are working on the dementia friendly community, worked with police, identified the need to work with the paramedics, the council and others.
We have also succeeded in raising awareness in areas assumed aware and therefore difficult to reach. We include here clinicians some of whom have felt safe enough to admit the lack of knowledge and embraced the opportunity to address this.

8.3.10 How will this work continue to have impact in the future?

We intend to run regular Peer support group for the GPs to discuss patient's cases and learn from each other and expert professionals.
We are starting the 2nd stage of rolling out the project to South Lakes GPs, and then we hope we will have the agreement to implement Cumbria wide.
Continuing to grow the dementia friend's movement in Barrow and south lakes that is already becoming self-sustaining. Connecting with and becoming members of the emerging Dementia Action Alliances in the Furness and South Lakes footprint.

8.4 Admiral Nurses: Preparing families for end of life in Dementia

8.4.1 Applicants

Stephanie Ragdale, Admiral Nurse

Manchester Mental Health & Social Care Trust

8.4.2 Authors

Tracey Fletcher, Admiral Nurse Clinical Lead, Jackie Wike, Gillian Graham and Caroline Clifton, Admiral Nurses, Helen Green, Admiral Nurse, Paula Smith, Zoe Scowcroft & Leah Rickards, Admiral Nurse Practitioners, Debbie Westacott and Deborah Hutchinson, Admiral Nurses, Pam Kehoe, Admiral Nurse/ Lead Nurse for Dementia, Susan Ashcroft-Simpson, Admiral Nurse Service Manager, Kath Penrith, Consultant Admiral Nurse.

8.4.3 What was the problem your improvement project aimed to address?

The North West Admiral Nurse practice development team wished to encourage other Admiral Nurses to produce literature evidencing the Admiral Nurses vital role in the end of life care aspect of palliative care. This was with the goal in mind of building the body of evidence for Admiral Nursing.

8.4.4 What was done, when and where did it take place?

The Admiral Nurses used Practice Development opportunities to collaborate & review current practice and policy around end of life care. We met once a month over the course of a year. This gave an opportunity for all nurses to bring a range of experience from different backgrounds to share experiences and current knowledge.

8.4.5 What was achieved?

This work contributed to the development of individual competency frameworks and supported Admiral Nurses with less experience. It enhanced nurses' experience and confidence in working around the issue of end of life care. The end product was a video highlighting the work that Admiral Nurses do and calling other Admiral Nurses to action.

8.4.6 How has this improvement project helped people with dementia and family carers?

We have been unable to measure this however we are hopeful that this work has and will impact positively on Admiral Nurse's ability to support individuals and families caring for someone with dementia at the end of their life.

8.4.7 How has this improvement benefitted your organisation and staff?

Admiral Nurses within the Northwest practice development group have benefitted from developing their individual competency frameworks and the opportunity to reflect on the work that we do.

8.4.8 How has this improvement helped to raise awareness of dementia?

This project has highlighted the importance of good end of life care within dementia care.

8.4.9 How will this work continue to have impact in the future?

Currently approximately 70 Admiral Nurses have been able to watch the video with a view that this will be rolled out to all Admiral Nurses and then potentially the general public.

8.5 Before I Forgot

8.5.1 Applicants

Vivienne Trott, End Of Life Facilitator

Trinity Hospice

Peter Brooks, Dementia Care Homes Officer

Blackpool Council

8.5.2 What was the problem your improvement project aimed to address?

For people living with dementia to have an improved quality of life through effective personal centre planning.

8.5.3 What was done, when and where did it take place?

Specific needs led training and reviews of training across Blackpool and the Fylde coast.
A community with a dementia friendly approach to its members and visitors.
Before I forget
As part of its commitment to improving local dementia care for patients, a number of Blackpool services including NHS England, Blackpool Council, key charities and local providers such as the Trinity Hospice, this has specifically included a focus on improving end of life care for dementia patients... As a result Trinity Hospice has now become dementia friendly in its environment and its approach to meet the needs of patients and their families.

As part of this process, Trinity Hospice's End of Life Care Facilitator (EoLC) has trained as a Dementia Friend Champion, which now enables Dementia Friends Information sessions to be held at the hospice for all staff and volunteers. This helps to increase awareness and understanding of dementia and the reasons why the hospice interior has changed to be better equipped to meet the needs of a patient or family member who maybe living with dementia.

The effectiveness of this approach has enabled staff to make changes within their own job role/practice. The training has also highlighted increased anxiety which reflects the raised awareness of training needs which the hospice is working to address.

All staff are also now linking more closely with care homes and domiciliary care services commissioned by Blackpool Council.
In line with objective 11 of the National Dementia Strategy, the Council has appointed a Dementia Care Homes Officer to deliver dementia awareness training. In addition to working with Trinity Hospice, the officer is also working extensively with local residential and care homes.

A dedicated training programme, titled 'Let's Respect', has been developed within the Council to ensure that training will meet the National Institute for Health and Care Excellence along with the Joint Commissioning Pathways initiative 'Living Well With Dementia'. In addition its approach on research carried out through its membership of the Institute of Dementia at Salford University.
This approach to the training means that learners are able to use the information in practice as well as evidence for NVQ and QCF training.
A key feature of the training is that Care Home Managers are able to use the Let's Respect resource as an induction and supervision tool for their own staff- thus ensuring that training is sustained consistently.

The training programme offers both half day and fuller five week courses.

8.5.4 What was achieved?

The training provided has already brought a number of key benefits to residential dementia care locally including:

- Increasing the choice of homes locally able to provide dementia care.
- Reinforces clear responsibility of Management responsibility for dementia care within
- services.
- Improving the qualifications and capability of local care home workforce.
- Enabling tailoring of support to care homes and services.

Since the launch of the Let's Respect initiative, 71 care homes locally have taken part in training, with over 800 staff trained. A further 15 care homes will receive additional training in 2016 to raise the number of their staff completing the course to above 80 per cent, whilst other care homes will have new staff engaging in training.
In addition 95% of the homes that has participate in the training have made changes to their services in some way, this shows the success of the training and the impact on the lives of residents, their families and staff providing support. Key changes include:

- Care home owners are investing in becoming more dementia friendly and adopting ideas presented in training, such as the introduction of dementia friendly dining rooms, equipment, dementia friendly lounges, hallways and communal areas that reflect the individual needs of residents.
- Bedrooms are becoming more personalised, reflecting tastes, interests and life stories of residents.
- Scrapbooks, memory boxes and computer assisted technology is being introduced as a way of developing life story work and enabling families to be involved in the care of a loved one.
- Residents are becoming more involved in "work" based activities that reflect their interests and experiences.

8.5.5 How has this improvement project helped people with dementia and family carers?

Families, friends carers are working together to provide an improved quality of life for people with dementia, that reflects and supports the needs of everyone in the circle of care.

during the project	800+ Care homes staff trained that support 1,300 people with dementia
over a year	100 Domiciliary care staff trained that support approx. 100 people with dementia Community facility staff and volunteers trained i.e. library staff, museum staff and care volunteers

8.5.6 How will this work continue to have impact in the future?

The care and public services community have a foundation to build and develop services to meet the individual needs of people with dementia to live well. Key activities already planned for 2016 include the following:
A "Dancing with Dementia" event will take place as part of Dementia awareness week at the Blackpool Tower Ballroom.

- Contribution to learning for Social Workers via presentations to Social Work Students at Salford University.
- Training of Library staff to enable them to provide support to people with dementia.

- Training of Museum staff to enable them to provide support to people with dementia.
- Provision of development advice and information to Library and Museum management.

8.6 Admiral

8.6.1 Applicants

Pam Kehoe, Admiral Nurse

Tameside General Hospital

8.6.2 What was the problem your improvement project aimed to address?

Following a complaint by the relative of a patient living with dementia, the Trust acknowledged the gap in care provision of specialist support, education and advice for patients living with dementia and their families during their acute inpatient hospital experience.

8.6.3 What was done, when and where did it take place?

The Trust was keen to take action to enhance the well-being of both patients living with dementia and their loved ones and ensure the gaps identified in the service delivered by the Trust were fully addressed. The Carer who raised the gap in provision was an integral part in in the establishment of the service.
The Key Aims were discussed in the Dementia Steering Group which were to:
Focus on the needs of the family carer, including psychological support for carers to understand thoughts, feelings and behaviours and to adapt to the changing situation.
Use a range of specialist interventions and group work helping people live well with dementia, developing skills to improve communication and maintaining relationships.

Provide an invaluable source of contact and support at particular points of difficulty in the dementia journey, including diagnosis, condition progression, or when tough decisions need to be made such as moving a family member into residential care
Help families cope with feelings of loss and bereavement as the condition progresses.
Provide advice on referrals to other appropriate services and liaise with other healthcare professionals on behalf of the family.
An action/ implementation plan was developed to launch the Service involving:

Conversion of the existing Dementia Nurse post to Admiral Nurse/Dementia Lead post, utilising the job description based upon the local requirements in line with the specific requirements of Dementia UK.
Operational Policy development supported by Dementia UK, in line with local requirements and adaptable to allow for sustainability and growth.
Establishment of a Strategy Group including partner organisations and carers.
Development/ delivery of awareness and training

Development/ delivery of promotional events and actions
Engagement with local community organisations to work collaboratively and inclusively with the service.

8.6.4 What was achieved?

Just some of the positive changes include:

- 1:1 support for family carers –312 families have had 1:1Admiral nursing support in the last year, provided by one nurse

- The Forget me Not programme within the wards Our Forever Friendship Café – providing that vital “hub” support
- The Story box sessions have proved an outstanding success, enabling staff to see the person behind the diagnosis of Dementia.
- Dementia Champions have been established in all clinical areas. Establishing John’s Campaign in the hospital, supporting carers to be with their loved ones whilst they are in hospital at a time that suits them.
- We have 44 regular dining companions, a further 59 in the process of being trained.
- Twiddle muffs /Twiddle boards have been provided by our local community
- We are introducing a staff Admiral Nurse clinic – I am stopped daily for advice by our staff about their own loved ones – they are carers too and may need vital Support and Advice.

8.6.5 Ideas tested which were successful

See point 4

8.6.6 Ideas tested which were unsuccessful

- Financial constraints identified have required the innovative sourcing of funding to support and develop the service.
- Establishing collaborative working with multi agencies and teams - overcome by encouraging inclusion and informing throughout development of the service and enabling the service to grow in an inclusive and community focused way.

8.6.7 How has this improvement project helped people with dementia and family carers?

Feedback/evaluation identified key findings in a number of areas:

- Patients say they have welcomed being seen as much more than a diagnosis of dementia, or worse, a bed number - they are now seen as unique individuals, with thoughts, beliefs and emotions
- Patients feel more supported by those experts who know them best – their loved ones
- They have benefitted from an increased focus on PSI rather than experiencing a task directed medical model approach with the focus on medication.
- Carers say that they feel more supported, informed and heard
- They are happy that they can continue in their caring role – where they choose to, and recognise that they can be actively involved in their loved ones care from the very point of admission to discharge and beyond.
- They say that they feel able to help influence the development of meaningful care for their loved ones.

during the project	a) During the project 312 patients/carers received 1:1 support, Education and Advice 236 attended the Forever Friendship Café.
over a year	The service is under one year old

8.6.8 How has this improvement benefitted your organisation and staff?

- We have provided bespoke dementia awareness training to all our staff often that traditionally would have been excluded including the Estates dept., Catering, Security, Porters and domestic staff as well as clinical staff.1112 staff have received dementia awareness training which focusses on the experience of dementia.

- Staff say they feel more confident in supporting their patients living with dementia in a meaningful way.

8.6.9 How has this improvement helped to raise awareness of dementia?

Feedback from patients, Carers and staff indicates that they feel a real sense of contributing to making our hospital more Dementia and Carer friendly.

8.6.10 How will this work continue to have impact in the future?

- Continue to focus on supporting a connected, skilled and committed community within the Hospital.
- Recognising our achievements, Dementia UK, the Charity that supports Admiral Nurses have asked us to Support other interested Acute Hospital Trusts to replicate our service, a real honour.

9 Conclusion

The award has attracted considerable interest which is reflected by the incredibly high standard and increasing number of submissions each year.

The intention is to build on the success of these awards by extending involvement and engagement to the other two CNs in North England.

The CN's are well placed to manage the dementia quality improvement awards. The QI awards provide an opportunity to share local intelligence and innovative practice in place across the northern region. Due to the volume of interest moving forward, the awards will be opened up and will seek applications from social care and the 3rd sector, as well as mapped to the 'Dementia Well' pathway (NHS England 2016) in keeping with national strategy and objectives.