Dementia Quality Improvement Awards 2015
Yorkshire and Humber SCN and DAA Dementia Quality Improvement Awards

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1 Foreword

Dr Oliver Corrado
Joint Clinical Lead for the Dementia SCN

Simon Wallace
Project Manager
Dementia Action Alliance Yorkshire & Humber

“Welcome to the Yorkshire and Humber Quality Improvement Awards for Dementia!

This award is organised in partnership by the Yorkshire and the Humber Strategic Clinical Network for Dementia and regional branch of the Dementia Action Alliance.

This is the second year we have run the awards but it is the first time we have invited project submissions from all health professions in the region and not just the medical profession.

The award has attracted considerable interest which has been reflected by the incredibly high standard of submissions we have received this year.

The projects demonstrate the considerable passion and commitment colleagues have for providing high quality care for people with dementia and their carers in the region.

The range and diversity of projects has been incredible, surpassing our expectations. Projects encompass all care settings, including memory services, general hospitals and the community. The standard has been very high and the panel had an extremely difficult job judging the abstracts and in particular arriving at a shortlist of 5 to give an oral presentation at today’s event.

This booklet brings together all of the abstracts submitted. Please do take a few minutes to read through them and use your refreshment breaks to browse the posters and speak to the authors. The 5 short-listed projects will give their presentations at a workshop this morning, with the winner reprising their presentation after lunch.

We sincerely hope you enjoy today’s event, and hope that it will inspire you to improve the services you provide for people with dementia and perhaps enter a project for next year’s award.”
2 The Quality Improvement Awards

Healthcare professionals within Yorkshire & the Humber were invited to enter their dementia-related quality improvement project for the 2nd Yorkshire & Humber Dementia Quality Improvement Award. This award is sponsored by the Regional Dementia Action Alliance in conjunction with the Yorkshire and Humber 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 2014 and 30th April 2015
- Must have been undertaken by a healthcare professional (or professionals) working in Yorkshire and Humber. 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 400 words in total should before by Monday 11th May 2015.

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 have been invited to give a presentation of their project on the afternoon of Thursday 25th June 2015.

The finalists are detailed in section 3.

All other abstracts are detailed in section 4.

All are listed in alphabetical order by first author’s surname.
3 Finalists

3.1 Intergenerational Cognitive Stimulation Therapy Project

3.1.1 Authors
Beardsley, M. Team Leader
Tramsen, C. Occupational Therapist

Rotherham Doncaster and South Humber NHS Foundation Trust
Memory Therapy Services & Our Lady’s Primary School Armthorpe
Speciality Dementia Cognitive Stimulation Therapy

Base: Forest Gate Day Hospital plus community settings

3.1.2 Introduction
Our service offers cognitive stimulation therapy (CST) to patients who have a diagnosis of dementia. This is a treatment recommended by NICE guidelines and outcome measures show that it is extremely beneficial to patients. Children from the local primary school are involved with the group on a weekly basis. The aim of the project is to educate the children, reduce stigma, raise self-esteem in patients and promote social inclusion for both patients and children.

3.1.3 Methods
We built strong relationships with the teachers and the children prior to the commencement of the CST group. Staff visited the school to educate children about dementia and answer any concerns about meeting the patients.

3.1.4 The Project
The project involves well prepared topics and tasks of the 14 week Cognitive Stimulation Therapy (CST) programme, which patients and children embark upon in a group setting or in a “buddy-up” system in smaller numbers. Staffs provide support to both patients and children at all times and monitor individual progress throughout the programme.

3.1.5 Results
The results of this project are invaluable as patients and children benefit from each other’s company, approach, experience and knowledge so much, that they do not want to miss out on any session! The children often update the elderly patients on the general on-goings in their lives in regards of e.g. latest technologies, current school life and events in the local community, favourite things and hobbies in accordance with the prepared topic or within the actual task. In return patients can compare their own memories and experiences to all this information, and tell the children, what things were like when they were young.

3.1.6 Conclusion
The project is benefiting both patients and children. Communication skills and confidence of both patients and children have developed throughout the duration of the programme. The atmosphere is inclusive, calm, creative, nurturing and fun. Feedback from patients show the whole experience of CST is enhanced by the presence of the children. The children involved in the project have recently presented at a local Dementia conference and impressed everyone attending with their knowledge and understanding of Dementia. We would recommend that other providers engage in this method.

3.2 Hospital Dementia Support Services

3.2.1 Authors

Faxon-Wastnage, V. Dementia Nurse Specialist, Barnsley Hospital NHS Foundation Trust
Simmons, A. Alzheimer’s Society

3.2.2 Introduction

The hospital dementia support service is a partnership project between Barnsley Hospital NHS Foundation Trust and Alzheimer’s Society. We have been working together over six months with an aim to provide support, guidance and information to people living with dementia, their families and carers who find themselves as patients across the different departments.
In continuing to develop new ways to bring people together, share experiences and support each other, the latest addition to our work is the Hospital Dementia Support Services.

3.2.3 Method

The project was initially funded for three months. Our initial aim was to support people with dementia and their carers whilst an in-patient in hospital.
We are delighted to share with you that further funding has been secured for a twelve month project that will be formally reviewed in April 2016.

The project has steadily developed with the initial focus changing and adapting in accordance with patient and carer feedback. Although we do still support people with dementia and their carers during a stay in hospital, the project has grown, with key focus and drive around planned admissions and out-patient appointments.
We offer to support the person with dementia and their carer from out-patient appointment, admittance into hospital through to discharge. We help to create a person centred supportive plan which identifies individual needs so that we can work together with our patients, their carers, hospital teams and ward staff to ensure that a visit to hospital is as positive as it can be.

We explain the butterfly Scheme and how it can be of benefit, provide information of hospital processes and support people with dementia and their carer to ask questions that are important to them. We signpost to services within the community, ensuring that we are working together.
3.2.4 Results
We have supported more than 30 people living with dementia and their carers through a variety of hospital admissions. As this service is relatively new we are beginning to see the numbers of people contacting us for support increasing (see table 1).

3.2.5 Conclusions and Recommendations
Our patient and carer feedback is positive. Increasing numbers of people are using our service. Improved communication between patient, carer and hospital staff. Improved patient and carer experience. Raise awareness of dementia trust wide. We hope that this will continue to be a success and expand further.

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Case Study 1
Referral received from Community DSW. Mrs A had an appointment for pre assessment for Cataracts removal. Rang Mrs A’s Daughter, arranged to meet Mrs A and her daughter in outpatients area. Mrs A was taken into see nurse immediately, they spent time reassuring Mrs A and her daughters, the outcome of the appointment was that Mrs A would not be able to sit still long enough to have the operation with local anaesthetic and a general anaesthetic would be the best option. Mrs A’s daughter’s queried overnight stay in hospital, I spoke to Specialist Dementia Nurse who confirmed with pre assessment department that it is possible to do the operation by general anaesthetic and be discharged the same day. Dementia Specialist Nurse requested pre assessment team to enrol Mrs A onto Butterfly Scheme. Dementia Specialist Nurse liaised with Pre Assessment team prior to Mrs A admittance. Mrs A was put early on the list. Concerns raised that Mrs A may get agitated, which would in turn upset Mr A and again make Mrs A more agitated, which would potentially put the operation at risk of being abandoned. If Mrs A had to wait around, would not be happy sat in bed for long periods, again resulting in agitation. Mrs A may not understand about operation staff would need to spend time explaining and coaxing for Mrs A cooperation. Mr A is also elderly and this is traumatic for him, preparing for admission and worrying about the consequences, Mr A needs must also be considered. Hospital environment could be unsettling not knowing where she was, may need explanations and reassurance. Prior to Mrs A being admitted Dementia Specialist Nurse liaised with ward staff so that Mr A could stay at the hospital during Mrs A’s operation. Mrs A was enrolled onto Butterfly Scheme. The DSW met with Mr & Mrs A on the ward prior to Mrs A’s operation and spent time chatting with both of them, offering reassurance and responding to any questions that Mr A had about the process. The questions were raised with nursing staff and clarified for Mr A. Meanwhile Dementia Specialist Nurse spoke with staff regarding Mrs A’s specialist needs during her stay on the ward. During this contact the DSW noted that Mr A needed an appointment with Audiology, As arranged the DSW accompanied Mr A to his appointment in audiology and in doing so was able to ensure Mr A’s appointment was immediate and timely so as to return to the ward in time for the return of his wife from her operation. Mrs A had arrived back to ward, she was happy, Mr A was relaxed, staff were very happy with Mrs A’s recovery, so much so at 2:30pm they made a call for Mr and Mrs A’s daughter to collect them.

Feedback: Everybody was wonderful. The support was excellent. I can’t improve on this service, never had a service like this in my life. I was cared for, my wife was cared for, feels as if life’s worth living. I can’t thank you enough. I would love to have your support again.
3.3 Older Peoples Mental Health (OPMH) Liaison Service – improving outcomes by improving diagnostic rates

3.3.1 Author
Goddard, W. Integrated Lead for Dementia, Doncaster CCG and Doncaster Metropolitan Borough Council

3.3.2 Introduction
The Older People Mental Health Liaison team in Doncaster has three functions; acute liaison, Care Home liaison and primary care liaison.

I am nominating this team for a number of reasons:
1. Despite being a commissioned and contracted service they have worked and delivered up and above what they are specified to do...they have definitely gone the extra mile.
2. Shown innovation and the ability to “self-start”
3. Worked outside the silo spanning business divisions.
4. Promoted the values of partnership working and integration
5. Made a real difference to people with dementia, their families and care homes.

The team developed a full screening and education process to assist Doncaster moving from a diagnostic rate of 51% to 63% in 1 year.

3.3.3 Methods
The Care Home Liaison Advanced Nurse Practitioner worked in partnership with the Primary Care Liaison Nurse and local care homes to develop methods of;
- Capturing dementia data across the system
- Comparing that data with the dementia registers and acute MH data.
- Analysing the data to produce a work plan
- Delivered that work plan in a timely and professional manner to produce effective results.

3.3.4 Results
The ultimate measure was the increase in Doncaster’s diagnostic rate however outcomes, experience and satisfaction have improved across the system including:
- Large percentage of patients were not on the GP dementia register. Many had received a diagnosis years previously.
- Over 560 residents were screened, 224 were on the dementia register and 120 additional diagnoses were added.
- As a result of screening and case finding, care plans resulting in improved objectives such as Capacity assessments, EOL and Advanced Wishes.
- Medication reviews took place with many residents having medication titrated, or even stopped.
- Some patients were on AChEIs prompting OPMH liaison review with MH pharmacist.
• Additional elements have now been added to the care home training plan and staff induction plans.
• Families have been involved making this a truly partnership and engaged approach.

3.3.5 Conclusions
The work can be judged on two levels, process and results:
• Process: Well planned, delivered and managed involving and engaging with system wide stakeholders for the benefit of the resident, their family and care home staff.
• Results: Doncaster’s dementia prevalence was weighted for a number of factors but the large number of residential beds was a key factor. Working with care homes in a focused and structured way has assisted in an annual 12% increase in Doncaster diagnostic rate.

3.4 The Effect of Ambient Lighting in Elderly Care Wards on the Behavioural and Psychological Symptoms of Dementia: a Staff and Carer Survey

3.4.1 Authors
Stapley, S. CMT2, Grimsby
Reece, S. National Medical Director’s Clinical Fellow
Battersby, D. Apollo Lighting
Harman, D. Consultant Geriatrician

Hull Royal Infirmary

3.4.2 Introduction
The behavioural and psychological symptoms of dementia (BPSD) are common \[^1\] and the use of anti-psychotic medication to control BPSD are related to significant morbidity and mortality \[^2\]. Therefore non-pharmacological control of BPSD should be preferable.

In Hull Royal Infirmary we have redecorated and added ambient lighting to one of our single-occupancy cubicles to offer non-pharmacological control of BPSD. We have assessed the efficacy of this using a survey for the nursing staff and the patients' visitors.

3.4.3 Method
We renovated the room to provide varying lighting conditions over the daytime to mimic the colour temperature and intensity of daylight. We have also installed a colour-changing wall comprising of an LED tape mounted with variable colours managed by a separate control panel.

To assess for objective change in the patients symptoms we developed two surveys, one for the nursing staff and one for the patients' visitors. Patients were selected if
they had been nursed in a normal bed and moved into that cubical during the admission. There was no exclusion criteria. We only collected responses from the visitors if the patient had a diagnosis of dementia.

3.4.4 Results

We received a total of 16 responses from the nurses; 7 patients had a formal dementia diagnosis and 4 were being treated as delirium. When the room was used by patients with dementia their behavioural symptoms were either 'much better' (71%) or 'slightly better' (29%). The agitation was better at night in most patients (86%) and the patient’s mood was better in all of the responses. When used for patients with delirium there was mostly no change in behavioural symptoms (80%), there was no change in any of the patients’ agitation, and most patients (75%) had no change in their mood. None of the nurses surveyed felt the symptoms became worse in the ambient room.

We also received 6 surveys from the patients’ family and friends. 3 felt there was a big improvement in BPSD and one felt that the symptoms were slightly worse. 5 of the 6 respondents would rather their friend or relative was nursed in such a room.

3.4.5 Conclusion

The results of this pilot study are promising when the cubical had been used for patients with dementia, although these were not reflected in patients with delirium. There are definitely compelling reasons for expanding the programme and for further detailed research into the use of ambient cubicles to help with BPSD.

Fig. 1 Change in behaviour as reported by nurses


3.5 Shared Follow up of People on Medication for Alzheimer’s disease

3.5.1 Authors
Sweeney, R. GP, Governing Body Member, NHS Harrogate and Rural District Clinical Commissioning Group

Olusoga, T. Consultant Psychiatrist, Senior Clinical Director MHSOP, Tees, Esk and Wear Valleys NHS Foundation Trust

3.5.2 Introduction
Harrogate and Rural District CCG is a small, mixed urban/rural CCG with relatively low deprivation and a high proportion of elderly people. We have an estimated 2738 people with dementia (1.7% of the population) and a diagnosis rate of 63.4% (January 2015). Tees, Esk and Wear Valley Foundation Trust have a Memory Clinic that, in 2013, was providing twice yearly follow up for all people on medication for Alzheimer’s disease, as recommended by NICE. There was significant pressure on the Memory Clinic causing inevitable capacity problems.

The GP Quality and Outcome Framework rewards practices each year for an annual review of all people on their practice dementia register but there is no clarity around the purpose and content of this review.

A Shared Care follow up arrangement was introduced for people who were attending the Memory Clinic for twice yearly review because they were on medication for Alzheimer’s disease. Reviews alternate between the Memory Clinic and GP, so halving the number of appointments needed at the Memory Clinic while giving GPs no additional clinical work, as they are already providing an annual review for these people.

3.5.3 Methods
1. Public Consultation – in previous consultation events there had been broad support for care closer to home and more involvement of the GP practice in dementia care. A further meeting to specifically discuss the Shared follow up also indicated popular approval
2. GP consultation – GPs met to discuss QOF QP (reducing referrals) ideas. All suggestions were taken forward to a meeting of practice representatives and the Shared Follow up received unanimous support
3. Area Team – Area Team supported the idea, even though it did not actually reduce referrals, but generated capacity for the inevitably increasing prevalence of dementia
4. CCG/TEWV – developed GP guidelines, clear communication between Practices and Memory Clinic and Practice training was offered

3.5.4 Results
1. 780 appointments were released in the Memory Clinic, giving capacity for new or complex problems with minimal recurrent investment
2. A protocol was developed for GPs, making their annual review valuable for both the patient and the service (figure1)
3. Better communication and integration between Primary and Secondary Care
4. More convenient care for patients, closer to home

3.5.5 Figure1

Shared Care Reviews of People who are on Medication for Dementia

1. Patient attends their routine review in Secondary Care

2. Patient/Carer are informed that their next review in 6 months will be with their GP and they should contact their GP practice (in the month review is due) to book an appointment

3. Memory Clinic sends letter (as they do now) to GP, including prominently displayed GP action needed, with advice when the next review is due, that the patient has been asked to book an appointment for this review and that it is the practice responsibility to ensure this review happens

4. GP practice has a system in place to ensure that the patient is reviewed at the right time, and is contacted if no appointment is made

5. GP practice reviews the patient 6 months after the Memory Clinic review, ensuring the following information is gathered
   a. Any significant worsening of behaviour?
   b. Any significant worsening of memory?
   c. Any significant deterioration in activities of daily living or living environment?
   d. Any significant concerns from carer feedback? (including medication side effects)

6. If the answer to a, and any one of b, c, or d is positive advice should be sought from the Memory Clinic (Tel: 01423 556001, Rebecca Ferris Lead nurse) to see if Specialist Review is needed. The same contact details can be used for advice about any other concerns

7. If the patient’s condition is stable the GP informs them that they will receive an appointment from the Memory Clinic in 6 months time for their next review, and will be seen in 1 year for review by the GP

8. At the end of each month the GP practice sends a list of all patients who they have reviewed to the memory clinic (plus a list of patients due review who have not been reviewed, with an indication if this is due to delay or failure to review, with the reason if the review is not going to happen)

3.5.6 Conclusions

This project has moved follow up closer to home, enhanced the role of GPs in Dementia Care and freed capacity in the Memory Clinic, for a small investment to support the administrative costs in running a call/recall system in Primary Care.
4 Other applications

4.1 Improving dementia service - A quality improvement initiative

4.1.1 Authors

Bangar, S. ST 6 in Old Age Psychiatry
Olusoga, T. Consultant Psychiatrist

Memory Service, Tees Esk and Wear Valleys NHS Foundation Trust, Alexander House, Ash Tree Road, Knaresborough HG5 0UB

4.1.2 Introduction:

Dementia is a very common illness, but there is a significant delay in identification and diagnosis. In fact, 52% people do not receive a formal diagnosis. Everyone with dementia has a ‘Right to Know’. However, recently there has been an improvement in diagnosis with just 48% people getting diagnosed. Ideally, all patients with dementia should receive a diagnosis. On the regional basis, this varies between 51%-71%. In Harrogate, at the end of January, this was 63.4%. The waiting time for a specialist assessment from the GP referral is variable. At the national level, there are regional variations from 2 weeks to over 6 months. Our trust standards are 28 days.

4.1.3 Methods

We carried out a survey to study the impact of the Shared Care Protocol and implementation of the Dementia Care Pathway in our Memory Service with the aim of identifying the waiting time since the referral from the GP until initial assessment. We also gathered data on the diagnosed dementia patients whose diagnosis was recorded on our electronic database. This information was collected from the ‘Diagnosis Information’ section.

The data was collected for a period of 3 months from 1st January 2015 until 31st March 2015. All the patients referred were included.

4.1.4 Results

As depicted in the table, majority of our patients were assessed, in keeping with recent national audit data of 5.2 weeks. The 8 patients who were not seen because 5 died and 3 had moved out of area. For the remaining 13 patients, appointments have been made. Regarding the diagnosis, in excess of 85% patients had the diagnosis recorded on our system.

4.1.5 Table 1: Summary of result

<table>
<thead>
<tr>
<th>Patients referred (153)</th>
<th>Total assessed 132 (86.27%)</th>
<th>Not seen 8 (6.06%)</th>
<th>Awaiting 13 (9.84%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessed within 6 weeks</td>
<td>104 (78.78%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-8 weeks</td>
<td>25 (18.94%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than 8 weeks</td>
<td>3 (2.28%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.1.6 Conclusion/ Recommendation
This initial survey has already shown a positive outcome of the movement of work from secondary care to the primary care allowing more timely initial assessment and diagnosis. The improvement in quality of care offered to patient is reflected in our 100% positive patient feedback on the NHS Friends & Family Test.

4.1.7 References
1. Alzheimer’s society website: Right to know
2. HSCIC, Dementia Diagnosis Rate, Jan 2015
4. The National Dementia Strategy
5. Dementia Care Pathway and Shared Care Protocol, TEWV

4.2 THINK DELIRIUM: Delirium screening and management on the AMU

4.2.1 Authors:
Bell, Fred
Hicken, Lucy

StRs Geriatric Medicine, Calderdale and Huddersfield NHS Trust

4.2.2 Introduction
The aim of the THINK DELIRIUM project is to improve the identification and management of delirium in Calderdale and Huddersfield NHS Trust, through development of a screening tool and an individualised care plan for each elderly patient with delirium.

4.2.3 Method
We initially conducted a baseline audit in August-September 2014 to establish detection rates of delirium on the acute medical unit (AMU) in Calderdale Royal Hospital. Following this, we went on to develop a simple, user-friendly screening tool, based on a CAM assessment, to be used on all elderly admissions to AMU. We also created a new delirium care plan, incorporating an investigation plan and ongoing individualised management plan to be completed by all members of the MDT. We are currently trialling this in a QUIP cycle, using feedback from the AMU medical and nursing teams, delirium link nurses, psychiatric and geriatric teams to improve the tools, with a view to implementation across the Trust.

4.2.4 Results
The baseline audit data identified a problem with identification of delirium on the AMU, showing a detection rate of 16%, below that of the expected rate (approximately 40%) based on NICE/BGS guidelines. Of those cases identified, management was frequently inconsistent. The lack of a structured care plan
demonstrated that in up to 40% of cases we had collected but failed to act on contributing factors. Our initial pilot trials of a screening tool and care plan received strong positive feedback from the MDT team and early results indicate an improvement in awareness of delirium and a more structured approach to assessment. Our second cycle QUIP is in process and we anticipate this will demonstrate a significant improvement of recognition and management of delirium.

4.2.5 Conclusion

The THINK DELIRIUM project aims to bring a sustainable, long-term improvement to the recognition and management of delirium in Calderdale and Huddersfield NHS trust. The project promotes individualised care and emphasises an MDT approach, with a structured care plan giving guidance on investigation and management as well as consolidating multiple sources of information e.g. test results, collateral history, into one easily accessible place, improving safety and quality of care. Going forward, we aim to integrate screening for delirium into the routine clerking process of AMU, leading to lasting change. We believe this project has the potential to be implemented in other Trusts in its current format.

4.3 Organisational response to improving Dementia screening

4.3.1 Authors

Bowman, Neil, Head of Business Delivery
Ruckledge, Anita, Lead Nurse for Dementia

Mid Yorkshire NHS Trust (based Pinderfields)

4.3.2 Introduction

Mid Yorkshire NHS Trust undertakes dementia screening of all patients who are acutely admitted to the hospital within 72 hrs of admission. The screening of these patients is undertaken by a Nurse led dementia screening team supported by Healthcare assistants.

In Q2 2014 the performance of the Trust was 73.6% of patients who were acutely admitted to the Trust and over age 75 were asked the Dementia screening case finding question. This performance resulted in the Trust not achieving the standards of care for these patients or attaining the CQUIN relating to Dementia screening. As a result of this a team was established involving an Improvement manager, Dementia screening team, Performance team and Administrators. The brief for this team was to address the system failures in the Dementia screening process and improve levels of screening and subsequent patient care.

The measures put in place and the actions of this group have resulted in a significant improvement in the numbers of patients screened to 99.9% of patients meeting the screening criteria and improved the care that Dementia patients receive.
4.3.3 Improvement methodology
The improvement diagnostic taken by the team was structured around a practical approach to understanding the current system this involved:
- Data analysis of performance
- Review of information and methods for measuring performance
- Walkthroughs of the dementia screening
- Observation of Data input and admin processes
The output of the diagnostic phase was a workshop involving the MDT to identify opportunities to redesign the failing screening process.

4.3.4 Solutions identified
- Implementation of an IT system linked to the Trusts PAS to identify patients requiring screening in real time.
- Visual communication tool to alert clinicians to a diagnosis of Dementia and the suggested treatment plan

4.3.5 Benefits
- Increased numbers of patients screened significantly so that 99.9% of patients are screened.
- Reduced the numbers of nursing hours required for the screening process by 20, these hours were redirected into Dementia education and training
- Attainment of the Dementia CQUIN
- Visual communication tool for doctors to improve the quality of discharge letters and onward patient management.

4.3.6 Results
Improvement intervention began at the end of Q1.

Table Dementia screening performance against key metrics

<table>
<thead>
<tr>
<th>CQUIN Indicator</th>
<th>Target</th>
<th>Q1 14/15</th>
<th>Q2 14/15</th>
<th>Q3 14/15</th>
<th>O2 14/15</th>
<th>O3 14/15</th>
<th>O4 14/15</th>
<th>O1 15/16</th>
<th>O2 15/16</th>
<th>O3 15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients aged ≥75 yrs admitted as an emergency identified as having known diagnosis of dementia, or clinical diagnosis of delirium, or who have been asked the dementia case finding question.</td>
<td>≥90.0%</td>
<td>32.0%</td>
<td>29.0%</td>
<td>87.2%</td>
<td>73.6%</td>
<td>73.6%</td>
<td>96.6%</td>
<td>98.9%</td>
<td>99.9%</td>
<td>100%</td>
</tr>
<tr>
<td>% of above patients with clinical diagnosis of delirium or who answered positively on the dementia case finding question who have had a diagnostic assessment, including investigations</td>
<td>≥90.0%</td>
<td>36.2%</td>
<td>94.9%</td>
<td>54.3%</td>
<td>60.6%</td>
<td>58.7%</td>
<td>100%</td>
<td>100%</td>
<td>99.5%</td>
<td>100%</td>
</tr>
<tr>
<td>% of above patients who underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive, referred for further diagnostic advice</td>
<td>≥90.0%</td>
<td>0.0%</td>
<td>94.9%</td>
<td>83.3%</td>
<td>81.0%</td>
<td>91.5%</td>
<td>99.5%</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.3.7 Conclusions
This project demonstrated that an MDT with a clear brief could make a transformational change in performance and improve patient care, whilst making optimal use of the resource available.
4.4 Title of Project Self Care – Living Well with Dementia

4.4.1 Authors
Butler, T. Self Care and Prevention Programme Manager, City of Bradford Metropolitan District Council
Humphrey, S. Clinical Lead

4.4.2 Introduction
The Self Care & Prevention Programme works across Bradford & district and Bradford City, Districts and Airedale Wharfedale & Craven CCGs. There is a committed, dedicated Board and multi-agency partnership that supports the shaping/delivery of the programme. Dementia was identified as a strategic priority, and also as part of Direct Enhanced service (DES) priority for GPs.

It was agreed amongst partners, that a dementia Self Care pack be developed, aimed at people with dementia. Designed to be printed by clinicians from SystmOne, via practice websites, given to patients at diagnosis/reviews and used as hard copy/electronic format, at various events. The pack includes a range of relevant information and support, making it useful for not only those with dementia, but for a range of stakeholders including carers, families, friends and also as a tool, useful for professionals to refer to, across health, social care and third sector.

4.4.3 Methods
A multi-agency partnership approach, led by a third sector partner, worked with partners to produce an accessible, informative pack, modelled on the RNIB booklet, Living well with Diabetes.

The Alzheimer's Society Bradford gave peer support and determined areas for improvement. They held focus groups for people with dementia and their carers. This approach facilitated development of a resource that was targeted, accessible, a tool that had 'practical real world' use.

4.4.4 Results
• Pack sits on SystmOne/key websites – Bradford Council, Public Health, three CCG's, local practices and third sector.
• Used as clinical resource by health, social care and third sector
• Pack was showcased in ‘Evidently Better NHS England North’ - subsequent requests from other authorities to use the pack as a template
• Pack has been downloaded 128 times from the Bradford Council website
• The Dementia Strategy Group, “Strongly endorse the dementia Self Care publication and value it as a tool, for its accessibility and as a useful resource, to support people with dementia, within Bradford and District.”

4.4.5 Conclusions/Recommendations
The value of creating a Dementia Self Care pack was initially queried, regarding potential duplication. However, this was identified as a resource that worked well and was felt that it did not duplicate existing tools. By bringing partners together, to co-
design, shape and develop the pack, ensured an accessible and informative publication.

4.5 Positive Steps Carer’s Education Course

4.5.1 Authors
Burns, M. Admiral Nurse in Kirklees
Pickup, K. Admiral Nurse in Kirklees

4.5.2 Introduction
The Positive Steps Carer’s Education Course has been run in Kirklees since January 2013. It was developed to meet the educational needs of carers of people living with dementia in Kirklees.

In September 2014 the course underwent a process of quality improvement following feedback received earlier that year. There was a long waiting list for places on the course and people were unable to attend the course when they needed it the most.

4.5.3 Methods
Feedback was received from carers who had previously attended the course; focusing on things that they had learned and implemented in their caring role. Also there was some room for improvement with helping to reduce behaviours that they find challenging.

We used this information to develop a new course which was more focused on the key issues identified by the carers. The course covers:

- What is Dementia?
- Challenges of Caring
- Life Story Work
- Looking after Ourselves
- Planning for the Future

In addition to this there are ask the expert sessions which are question and answer sessions with professionals and experienced carers. The carers are identified from the Admiral Nurse caseloads as people who are/were able to cope well with the demands of caring for someone with dementia and are able to present to the group. We then developed a pathway to identify what support carers would need following the end of the course and signpost them to the service that would best meet their needs.

We also developed the resource pack that was given to carers and the improved the quality of the market place (an event where local services from health, social services and voluntary sectors come together to offer support to carers).

4.5.4 Results
Evaluation is ongoing for this project and will be collated at the end of 2015. There are some objective measures observed such as:

- Reduced waiting list; now 10 weeks
- Increased the number of courses run and carers attending the course
- Made more cost effective by reducing the number of sessions, using junior nurses and carers to facilitate the course

4.5.5 Conclusions/Recommendations

The course provides much needed education and support for carers of people living with dementia, at the time they need it. Previous evaluation has shown that skills learned have been useful 6 months down the line and, in some cases, prevented a carer crisis.

4.6 Creation of a Transferable Portrait of a Life Profile

4.6.1 Authors
Carter, S. Transformation Programme Manager
Holroyd, L. Care Homes Liaison Team Member/POAL Clinical Advisor

South West Yorkshire Partnership NHS Foundation Trust

4.6.2 Introduction

Information about an individual's past history can impact on the care given today (e.g. understanding life routines/behaviours, such as knowing that the individual was a shift worker, would enable appropriate adjustment to care planning). Whilst our staff are gathering vital information regarding past memories and history about the service user in their care, there was no mechanism via which to share with others in the care partnership. For example when an individual needed to visit an acute hospital, transferred into a care home, or is supported with care at home.

4.6.3 Methods

Project group explored ways of incorporating evidence gathered through life story interventions into care plans and discharge packs to:

- aide portability of service user information
- reduce the stressful impact of transference of care
- improve communication and collaboration between care partners, families and the individual living with a diagnosis of dementia
- encourage involvement in care planning and record keeping by junior healthcare staff e.g. HCA

The group explored and trialled both paper and electronic methods of data transfer across assessment, inpatient, and community settings during Nov-Mar 2015.
4.6.4 Results

All participants preferred the electronic method. The following diagram illustrates the benefits stated by the participants:

In April 2015, the Trust commissioned a full roll out of the POAL electronic profile to be used throughout the patient’s journey from initial assessment on entry to services, through the stages of care/care partnerships, onto discharge.

4.6.5 Conclusions/Recommendations

Participants have stated that they have gained understanding in the importance of ‘seeing the person first’, building confidence to communicate and support individuals living with dementia through the application of life story information in the provision of day to day care.

Several positive outcomes for service users such as improved engagement, reduced behaviours that challenge, and more meaningful care planning, were reported following implementation of POAL one page profile.

Findings from the project indicate that past memories/life stories gathered, recorded and subsequently used in care does indeed support behavioural change, improved outcomes and leads to a better more person-centred experience for service users.

Further research is recommended, involving care homes and acute partners, to see if the improved portability of life story information about an individual has any positive
impact on the person-centred care they have been able to provide following the transference of that individual into their care.

4.7 Can we influence frequent readmissions of people with dementia to hospital?

4.7.1 Authors
Eltilib, A. Core Medical Trainee, Niall Cahill, Trust Grade Doctor
Scampion, C. Registrar
Robinson, R. Information Manager
Corrado, O. J. Consultant Physician, Leeds Teaching Hospitals NHS Trust

4.7.2 Introduction
People with dementia often have other co-morbid medical problems (in Leeds 90% have at least 1 other long term condition) and they are frequently admitted to hospital. The purpose of this study was to identify the health and social factors which led to people with dementia being readmitted to hospital and determine whether there may be strategies which might improve their future care and avoid unnecessary admission in future.

4.7.3 Methods
We undertook a retrospective case note audit of all those patients aged over 65 who had an ICD Code of Dementia and 4 or more emergency readmissions (within 30 days) to Leeds Teaching Hospitals (LTHT) in the year following an initial admission in 2013. We chose 4 admissions or more to provide a reasonable but manageable representative sample. We devised an audit tool to identify whether primarily social or health factors (or both) had led to each admission and identify what agencies were involved in their care.

4.7.4 Results
72 patients with dementia were readmitted 4 or more times in the 365 days following their initial admission. 38 were female and their ages ranged from 66 – 101 years (mean 83). Of the notes audited to date health reasons predominate over social factors as a reason for admission, there was little involvement of the hospital’s Mental Health Liaison Team and little collaboration with Community Health Teams about patient’s management and support.

4.7.5 Conclusions/Recommendations
We had expected patients with dementia to be readmitted for principally social reasons but this is not the case. Our audit emphasises that people with dementia often have associated medical problems and these are often the principal reason for admission. This should be born in mind when devising ‘unplanned admission strategies’ in primary care. Our study has also shown that links between acute hospitals and mental health teams (community and liaison) could and should be much stronger in the management of this vulnerable client group.
4.8 The Side by Side Memory Project

4.8.1 Author
Fry, J.

Location of Project: Kirklees, various local communities
Started: June 2014 - ongoing

4.8.2 Approach
The Side by Side Memory Project developed from a growing concern for the number of people with early to middle stage dementia living independently in local communities for whom there is little ongoing support. These people are experiencing isolation, loneliness, anxiety and despondency during this period of the illness and although there is no need at this stage for formal intervention the emotional impact is severe. Dr. Nisreen Booyah, a former medical director of SWYPT described these years as the ‘wilderness years’.

The Project sets up small support groups in local areas with local volunteers. Three groups have been established so far and a fourth is in the pipeline. The activities are planned in consultation with the group members and include singing, poetry reading, storytelling, reminiscence, craft, role play, armchair movement, music, current affairs, quizzes and word games, and occasional outings. The main aim is to enhance wellbeing, and also to maintain social and communication skills. Some group members have described the experience as ‘giving me back my life’. The groups meet weekly and group numbers do not exceed nine people in each. We provide transport where needed, and one group stays all day and enjoys a hot midday meal. Many of our members live alone with carers at a distance. In circumstances where a group member lives with or near a partner or carer we provide a break for the carer and are able to offer them advice, a listening ear, and we can refer them on to other appropriate means of support.

We are monitored by an experienced management group and have all the relevant policies in place. Support and training are provided for volunteers, one of whom recently commented that her involvement made her feel ‘valued and worthwhile’. We regularly invite informal feedback from our members and below are some of their comments.

“It makes me glad to be alive”
“It stops putting us in the category of lost memory people; I feel normal again”
“It is one day in the week when I know I can express myself properly”
“It gives me confidence and makes me feel safe”

Our vision is to provide a place where people who are living with this illness can feel loved, safe, understood and accepted, where they can be themselves and, above all, find hope.
4.9 Developing the role of Dementia & Mental Health Liaison Practitioner within the Integrated Neighbourhood Teams.

4.9.1 Authors
Jubb, J. Occupational Therapist (West/North West Leeds)
Walker, S. Occupational Therapist (East/North East Leeds)
Irvine, A. Registered Mental Health Nurse (South/South East Leeds)

4.9.2 Introduction
The purpose of the project has been to provide a liaison service to primary and community care services, to facilitate the development of the teams, to meet complex needs arising from dementia linked to physical health long-term conditions and acute illness.

The roles were intended to:
Build upon Leeds and York Partnership Foundation Trust (LYPFT) long-standing provision of liaison services in acute hospitals and care homes
Form part of a strategic approach, bringing specialist clinical knowledge and skills and embedding the bio-psychosocial approach to person centred care.

4.9.3 Methods
Over the last 15 months 3 Practitioners have been based within the 13 Neighbourhood Integrated Health and Social Care Teams, with the principal role to:
• Develop practice through co-working;
• Attend and contribute to the neighbourhood case management meetings.
• Deliver training
• Act as a bridge between locality services and secondary mental health care teams.
• To share and develop expertise across NHS, social care, independent and voluntary sector.

4.9.4 Results
The project has been evaluated by measurements including: staff evaluation of improved confidence and capability; staff/service user/carer feedback regarding input; records of involvement in casework; case studies and outcomes; feedback from training facilitated.

Over the course of 12 months a total of 441 clinical involvements have been recorded and the presence of the roles has highlighted the following themes:

• Dementia/Mental health needs are considered equally.
• Optimising health, well-being and recovery.
• Champions for personhood.
• Maintaining independence & positively managing risk.
• Prevention of unnecessary hospital admissions and appropriate use of secondary mental health services.
• Embedding new ways of working into practice.
4.9.5 Conclusions/Recommendations:
Following successful evaluation, 3 substantive posts have been funded. There is recognition that there is a need for increased resource to be extended to: enable capacity to support GP’s and other associated professionals; and allow for more in depth work with service users.

By being a visible and integrated part of the team, the roles have ensured that dementia and mental health needs have been considered at the earliest point. There has been an enhanced understanding of how to best meet individual needs and utilise other services and organisations effectively.

4.10 The Getting Along© programme

4.10.1 Authors
Murphy, D. Freelance collaborator and volunteer with CMHT. York. Associate. Innovations in Dementia.

4.10.2 Introduction
I have lost count of the times I have gone in to people’s houses and found them questioning the validity of decades of marriage because neither understood the impact of the dementia upon the relationship. There is still little attention to their interdependence or to the importance of relationships within families at this critical peri-diagnostic period.

4.10.3 Aims of the Getting Along programme
- equip couples/families to live better with the presence of dementia in their midst;
- enable professionals to recognise and respond to both sides of the caregiving relationship;

4.10.4 Methods
With lottery funding secured as an associate of Innovations in Dementia, I ‘recruited’ 4 couples from local CMHT in York under criteria of a recent diagnosis and observed tensions within the relationship,

I conducted 4 semi-structured interviews with each couple. Interviews included both partners together and took place in their own homes. A summary letter was sent to each couple between sessions as a re-cap.

4.10.5 Results
‘To equip couples to live better with the presence of dementia’ – “Well, you’ve ticked that box!” Mr A.

Participants revealed how key needs around time of diagnosis aren’t currently met.
‘Most services are just social, they don’t help you back at home where you spend most of your time’

The local consultant reported that Mr and Mrs A were ‘visibly more relaxed’ since the programme; referrals increased and the programme was soon oversubscribed as interest grew amongst the CMHT.

‘I would say real shouting matches have virtually gone now thanks to the Getting Along conversations.’ Mr A.

4.10.6 Conclusions/ recommendations

People want and need to talk. Getting Along® can provide a framework to broach what can sometimes be sensitive issues.

‘Why didn’t people tell us all this at the start? Everyone should have this’ was a consistent call. It highlights a need for a new practical approach around the time of diagnosis.

With so many unanswered questions and unattended antagonisms within the relationship in that peri-diagnostic period, Getting Along can be implemented as a programme and as a broader service approach from first contact with services. Thus providing immediate practical support to keep pace with the drive for increased and earlier diagnostic rates.

Getting Along can enhance the contact we already have with families and, with a consistent approach across the board, the front line response can ever closer match the agenda of those at the heart of services

4.11 Audit of the time to treatment following referral in patients diagnosed with Dementia

4.11.1 Authors

Narayana, U. ST5 Old Age psychiatry
Patel, M. CT1
Burn, W. Consultant Old Age Psychiatrist (Leeds and York partnership foundation trust)

4.11.2 Aims and Hypotheses

The objective of the audit was to evaluate the time taken from referral to treatment in patients diagnosed with Dementia. We aimed to identify the proportion who were treated within 18 weeks as set out in the Royal College manifesto.

4.11.3 Background

The NHS constitution states that no-one should wait longer than 18 weeks to receive treatment for a health problem, if the treatment has been recommended by NICE
guidelines, or the patient’s doctor. The NICE guidance for dementia also states that memory assessment should offer a ‘responsive service to aid early identification’.

4.11.4 Methods
All paper and electronic records of 50 patients were reviewed retrospectively using a piloted data collection tool which gathered information on date and reason for referral, the date of first consultation, diagnosis of dementia, details of CT scan requests and the time of treatment.

4.11.5 Results
- 88% of patients had a CT scan requested. The average waiting time for a scan and a diagnostic appointment was 30 days and 27 days respectively.
- Out of the 39 diagnosed with Dementia, 79% (n=31) commenced treatment for dementia within 18 weeks of referral and for the remaining 21% (n=8) the reasons for the delay were variable
  - One patient chose to wait; one was delayed in the referral process and another due to rearrangement of appointments.
  - 3 patients missed CT scan appointments.
  - 2 were delayed due to changeover of doctors.

4.11.6 Conclusions
The results reflect 79% compliance with the standards which could be explained by an efficient administration team and high attendance rates as patients are contacted before an appointment.

Actions taken include:
- Set reminders to check requests and results of investigations.
- If a CT scan has been missed, a doctor to contact the patient and re-request scans.
- A new system for effective handover of patients during changeover of doctors.

4.12 Using a Visual Memory Assessment Tool

4.12.1 Authors
Purves, A
Mashinter, K

Specialist Occupational Therapists, Memory Services, Huddersfield

4.12.2 Introduction
The Visual Memory Assessment Tool (V-MAT) is an exciting innovative tool that potentially could transform the diagnostic experience for people with anything from Mild Cognitive Impairment to Dementia. The idea was inspired by a need to support a cultural/equitable experience for people with dementia who struggle with the current
traditional assessment process due to cultural sensitivity/language barriers, expressive/receptive dysphasia and hearing impairment Often these individuals receive a service that is ineffective, time consuming and anxiety provoking. V-MAT is an assessment process that is accessible resulting in a more accurate Patient Reported Outcome Measure and offers a more accurate cognitive assessment. Often patients are unable to be assessed using traditional assessment methods causing the assessment to be abandoned or misconstrued, leaving patients, carers and clinicians in limbo. This is supported by the fact that Professor Alys Young and her team at the University of Manchester is investigating the experiences of deaf people with dementia and their barriers to receiving an accurate diagnosis of dementia (Alzheimer's Society 2011 1990).

4.12.3 Method/Results
A small study using qualitative outcomes measures highlighted carers reporting that they had gained increased insight into the actual functioning and intellectual abilities of their loved one. “I feel terrible because we have been talking over her all this time as we presumed she did not understand when clearly she could”. Using the traditional assessment has often caused the assessment process to breakdown, using the V-MAT has shown to enable better communication to take place. (Dementia Care Mapping outcome measure Brooker 2009).

4.12.4 Conclusion
Currently there is no assessment tool to capture the cognitive ability of those who have a visual, hearing or speech impairment (due to neurological changes). This is a national challenge for the (NHS) with all age groups. In Testing V-MAT, there is the potential for scaling up and application to a wider and more diverse population. As an innovation V-MAT has significant potential for widespread use, APP development in several languages and can reduce interpretation needs and the possibility of skewed results. The V-MAT can be implemented at pace in the drive for Quality and Outcomes with relative ease.

To date V-MAT has won the Medipex NHS 2012 award and has just been nominated for the Advancing Health Care Awards 2015. We are so grateful to everyone who has the supported V-MAT and for those it will serve in the future.

4.13 Meri Yaadain Dementia Outreach Support Service

4.13.1 Author
Rauf, A. Team Manager, Bradford Metropolitan District Council

4.13.2 Introduction
Meri Yaadain Dementia Outreach Support Service (MYDOSS) was initially set up to work with South Asian families but it now covers all BME communities. It has had national recognition through it being able to support the setting up on initiatives in other cities – Leeds, Oldham, Tower Hamlets, Newcastle, Wolverhampton and more. MYDOSS staffs raise awareness of Dementia amongst BME communities so as to
be able to have meaningful engagement and support to these communities as a whole as well as to the person with Dementia and their carer(s).

4.13.3 Methods

We run community roadshows and ad hoc radio programmes to raise awareness and then follow these up with home visits and one to one support. This support includes information and guidance on a number of issues. We also look at supporting individuals to get a diagnosis which requires advocacy. We set up a website and created some information leaflets in community languages. But we now feel that Dementia is becoming a recognisable term amongst the BME communities – who do not have a name for it in the five main South Asian languages. MYDOSS have delivered training sessions and has been involved in supporting other organisations as well as speaking at conferences to share good practice.

4.13.4 Results

The result of our work has been incredible. We have moved community organisations to think about the concept of Dementia and start using the term itself as the name for the condition. We have had many carers approach us directly by picking up information about the work of the team as well as getting referrals from GPs, Social Workers, the hospital, relatives and community groups. The success has been the growth of our expertise and knowledge to be shared across the country. MYDOSS itself has expanded now to offer ‘Care Navigation’, which looks at promoting people to access low level support needs within their communities. These service users do not have to have dementia diagnosed or necessarily show symptoms – but is part of the preventative agenda and supporting families or individuals to help themselves.

4.13.5 Conclusions/Recommendations:

We have developed expertise in BME Dementia related issues.
We have already been sharing good practice.
We have expanded our work to include more communities.
We have been involved in supporting other agencies and local hospitals in the planning of Dementia related work – including supporting Dementia Friendly Communities work.

4.14 Working to become Dementia Friendly 2014/15

4.14.1 Author

Sharp, C Head of Leadership & Learning, Yorkshire Ambulance Service

4.14.2 Method

In December 2013 YAS became the first ambulance Trust in the country to receive the ‘Working to Become Dementia Friendly’ recognition from the Dementia Action Alliance (DAA). Throughout 2014/15 YAS has proudly displayed the ‘forget-me-not logo on all our front line vehicles. In recognition of the Trusts commitment to ‘Working to become Dementia Friendly a number of work streams have been instigated throughout 2014/15, as follows:
4.14.3 Dementia Awareness Training

All new frontline employees will now undertake Dementia Awareness Training as part of a package that is focused on the patient experience. The Alzheimer’s society’s ‘Dementia Friends’ training has since been integrated into the delivery our Dementia Training. For existing staff, we have created a bespoke distance learning resource for staff alongside a full range of online learning. This distance learning pack has been specifically designed for frontline staff.

4.14.4 Dementia Friendly Design – New Ambulances

YAS became the first NHS ambulance service in the country to procure new ambulances with a dementia-friendly specification. In April 2014, a fleet of 33 new vehicles arrived at the service with a dementia-friendly design.

4.14.5 Dementia Friendly - Patient Reception Centre (Leeds General Infirmary Pilot)

Using the Kings Fund Environment Assessment Tool for Dementia Friendly design in Hospitals an assessment was made on the LGI Patient Reception Centre with a view to making the environment more dementia friendly. Following the assessment in November 14, a number of changes were made in the following month to improve the environment, these included:

- New artworks
- Additional planting
- Larger clock with day and date
- Photographs to encourage reminiscence from ‘Pictures to Share’
- Access to a range of games and books
- Safety and conveyance notices.

4.14.6 Results

- A total of 2430 staff have received Dementia Awareness training since July 2013 from the blended learning approach detailed above
- All YAS Ambulances are now procured with a Dementia Friendly design, this has been extended nationally by the supplier.
- Reports indicate that this resource has been successfully used by staff and in one case visibly reduced the stress and agitation of a patient in the care of the PTS Team.

4.14.7 Next steps

Pledge now in place for National Dementia Awareness week to:

- Roll out Dementia Friendly PRC’s YAS wide
- Roll out Reminiscence resource for all non-emergency ambulances

Train all staff by April 2017
4.14.8 Dementia Friendly Ambulances

4.14.9 Dementia Friendly PRC - LGI before and after

4.14.10 Dementia Reminiscence Resource
4.15 Let’s Change Dementia Care – A Home within a Hospital

4.15.1 Authors
Smith, J. Senior Operations Manager, Older People’s Service
Nwokedi, F. Clinical Team Lead, Older People’s Service
NAViGO Health and Social Care CIC

4.15.2 Introduction
Multi-award winning, NAViGO Health and Social Care CIC (http://navigocare.co.uk/) provides a whole mental health service for the NHS in N E Lincolnshire.

As a not-for-profit organisation, our membership (uniquely made up of staff/service users/carers/local community all with equal voting rights) decides how any annual surplus is spent to improve/increase services.

In 2014, our Older People’s Team won the right to develop an innovative project plan (with major input from service users/carers/staff) to refurbish Konar Suite, our Dementia care in-patient facility. Little investment previously had led to a clinical environment with a lonely unwelcoming feel/no separate private areas/no bath etc.

4.15.3 Methods
Internal environmental changes made, separating Functional/Organic areas to meet all our client group’s needs are:-

Dementia:
- Installing a sensory bathroom
- An interactive traditional memory-retaining street scene
- Different coloured bedroom front doors; multiple cue concepts reduces confusion.
- 3 flat-lets able to accommodate carers during care, strengthening family ties
- Colour contrast/individually/uniquely decorated bedrooms
- Specialist acoustic-softening flooring softening acoustics (less echo/more homely feel)
- Chairs with contrasting cushions/piping promote depth recognition/enhancing independence.
- Wardrobes with safe glass in external doors to allow visibility of clothing/lessening confusion

Functional:
- Specialised Functional Area with a separate lounge/open kitchen encouraging independence.
- A new wheelchair-accessible garden area.
- Bariatric toilet facility.
- Conservatory café encouraging visitors to spend more time at the unit.
- Separate spaces allow SU/carers more privacy/dignity.
Social Inclusion:
- Garden area with potting sheds/raised/beds/comfortable seating areas.
- A large log cabin ‘mock social club’ encouraging safe participation in ‘normalised’ activities shared with families/carers.
- Dementia Engagement Worker, responsible for:-
  - Community Engagements Projects
  - Volunteer recruitment
  - Raising awareness of Dementia
  - Creating more integrated care pathways locally

Safety/Local Contribution:
- Assistive technology/Patient safety alarm system allowing environmentally-based positive risk taking.
- Energy efficient LED/sensor lighting.
- ‘A’ rated efficient appliances
- Re-cycled general waste
- Thermostat setting dependent on occupation
- Locally sourced food suppliers

4.15.4 Results
Positive Impact:
- Improvement in the Friends/Family test since the environment update.
- Patient Reported Experience Measures (PREMS)/Patient Reported Outcome Measures (PROMS) positive feedback, borne out by testimonials received.
- Service Users are assisted to maintain their independence whilst in a care setting.
- More positive interaction/reduction in violence/aggression as people retain their sense of identity/feelings of self-worth.
See the facilities here:


4.15.5 Conclusions/Recommendations:
Creating an outstanding environment for Service Users, based on research undertaken, that careful design of physical/social environments lifts positivity enhancing quality of life; we have turned a hospital setting into a home ‘providing services we would be happy for our families to use’.

4.16 Hospital Dementia Carer Support Service

4.16.1 Authors
Sweeney, F. Dementia Carer Support. Leeds Teaching Hospitals Trust (LTHT).

4.16.2 Introduction
Carers’ consultations identified three main areas of required action for carers of patients with dementia within LTHT:
• Better identification of dementia carers and assessment of their needs.
• Increased carer involvement in patient care and hospital services.
• Improvement in availability and access to dementia carer support services.
In order to improve outcomes for carers within LTHT, a Dementia Carer Support Service was established in partnership with Carers Leeds.

4.16.3 Methods

• Identification of carers and assessment of needs.
  o Increased by raising awareness with hospital staff around carer issues.
  o The Carer Support Worker (CSW) assesses each individual carer referred to the service to determine and meet their needs.

• Increased carer involvement.
  o CSW regularly gains feedback from carers about their experiences at LTHT which is shared with relevant people, e.g. LTHT Dementia Strategy Group.
  o Carers are more included in the patient’s care, e.g. the CSW acts as an advocate for carers in Care Planning Meetings.

• Improved access to carer support services.
  o Carers who access the service receive one-to-one, personalised support. A weekly drop-in session has been established in the Carer and Family Enquiry
  o Room, the service’s information and resource room at St James’ Hospital. Information leaflets and posters about the service are available across the hospital sites.

4.16.4 Results
• Identification of carers and assessment of needs.
  o Over 200 carers supported within 18 months.
- 100% using service to access information and/or advice, particularly around hospital specific issues
- Referrals from over 40 hospital wards across 3 hospital sites, demonstrating increasing awareness of carers of patients with dementia.

- Increased carer involvement
  - Feedback collected used to demonstrate the need for carers to be more involved in patient care
  - 50% of carers supported to share their views with health and social care professionals during discharge planning.

- Access to dementia carer support services
  - 90% of supported carers given information about/referred on to further support services in the community, e.g. dementia carer training.

4.16.5 Conclusions/ Recommendations

The Hospital Dementia Carer Support Service has supported dementia carers at LTHT by providing carers with access to support, meeting their needs, and promoting their involvement. The partnership working with the third sector has enabled positive outcomes for carers both in the hospital setting and in the community.

4.17 The Good Old Days: Locala Community Partnerships

Reminiscence Work

4.17.1 Authors

Sykes, E. Registered Mental Health Nurse, Locala Community Partnerships
Williams, J. Sun Woodhouse, Fartown, Huddersfield
Sorby, S. Quality Manager, Locala Community Partnerships

4.17.2 Introduction

The aim of this project was to improve the lives of individuals living with Dementia in care homes, through sporting reminiscence.

A multidisciplinary Care Home Support Team was commissioned by Greater Huddersfield CCG in 2014. This team included a Mental Health Nurse who had attended training on sporting reminiscence. Initial involvement in the care homes identified a gap in opportunities for reminiscence work to improve Mental Health and cognition of residents with Dementia as supported by a wealth of literature and networks, for example Sporting Memories Network. This was the inspiration & passion for the author to embark on this project which commenced in December 2014.

4.17.3 Methods

- An integrated approach was taken, led by the author, involving a care home, local authority and local Dementia Action Alliance colleagues.
• Reminiscence therapy principles were shared and incorporated in to holistic assessments. Residents where asked what they would like to “be involved with” or “have another go at”.
• Armed with resident’s wishes, local football and rugby clubs were contacted to support sporting reminiscence activity.
• Tickets have been sought from local football and rugby clubs and were allocated to residents and their relative/carer

4.17.4 Results
To date, 15 different residents have attended home matches with the following patient and carer feedback.

4.17.5 Conclusions/Recommendations
Although only conducted on a small cohort of patients, this project has demonstrated the individual benefit to those patients engaged to date.

This success of this project has resulted in continued growth of sport reminiscence across more Care Homes within our geographical patch. It has also been a catalyst for further reminiscence work. The team are currently advertising for volunteers to become befrienders; musicians, artists or singers to volunteer to work with local care homes; people with animals to support pet therapy and have also contacted a local charity who specialise in animal assisted therapy. Further partnership working with Local Authority has resulted in tea dances within the local care home community.
5  The Final

On the 25th June finalists will present their abstract as part of the Ahead of the Game in the Dementia event at Elland Road Football Stadium, Leeds. The session will be chaired by Dr Oliver Corrado and judged by a panel of 5 people.

5.1  Panel members

Panel members include:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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</thead>
<tbody>
<tr>
<td>Simon Wallace</td>
<td>Project Manager, YH Dementia Action Alliance</td>
</tr>
<tr>
<td>Danielle Woods</td>
<td>Lead Nurse for Dementia, Bradford Teaching Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>Dr Paul Twomey</td>
<td>Joint Medical Director, Yorkshire and Humber, NHS England (North)</td>
</tr>
<tr>
<td>Beryl Oates</td>
<td>Family Carer</td>
</tr>
<tr>
<td>Tony Oates</td>
<td>Person Living with Dementia</td>
</tr>
</tbody>
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6  Next steps

The Yorkshire and Humber Strategic Clinical Network for Dementia in conjunction with the Regional Dementia Action Alliance plan to launch the next round of the Quality Improvement Awards towards the end of 2015.

Details will be provided on the SCN website and via the monthly bulletin