Improving the Whole Patient Pathway

Chairs: Wayne Goddard, Integrated Lead for Dementia, NHS Doncaster CCG and DMBC
Dr Wendy Burn, Consultant Old Age Psychiatrist
Leeds & York Partnership NHS FT
Yorkshire and Humber Dementia Strategic Clinical Network

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Consultant Psychiatrist – MHSOP, Kendray Hospital, Barnsley

Mr Andrew Stones
Nurse Consultant

25th June 2015
Over view

• National Dementia CQUIN and the “gap”
• Barnsley Memory Services
  • Configuration
  • Core business
  • Hospital Liaison Pathways
  • Some numbers!!
• Closing the dementia “CQUIN gap”
  • Our experience!
National CQUIN
Dementia & Delirium

Part 1 (find, assess, investigate, refer, inform (FAIRI))

• The proportion of patients aged 75 years and over to whom case finding is applied following an episode of emergency, unplanned care to either hospital or community services;
• The proportion of those identified as potentially having dementia or delirium who are appropriately assessed;
• The proportion of those identified, assessed and referred for further diagnostic advice in line with local pathways agreed with commissioners, who have a written care plan on discharge which is shared with the patient’s GP.

Part 2 Staff Training
Part 3 Supporting Carers
Where is the CQUIN gap?

- Find
- Assess
- Investigate
- Refer
- Inform

GP → Memory Team

GAP
Where is the CQUIN gap?

- Find
- Assess
- Investigate
- Refer
- Inform

GP → Memory Team
Act of balance!

**Advantages**
- Capture all the cases identified through CQUIN
- Sooner diagnosis
- Improved diagnostic rates
- Address antipsychotic prescribing

**Disadvantages**
- Resource implications
- Demand and capacity
- False positives
- Breach of KPIs
“Hub and Spoke” model

Memory Service Hub

- Inpatient wards
- Third sector

Primary care

MVH

BDGH

Care Homes
NICE Quality Standard (QS1 June 2010)

Quality statement 1: Appropriately trained staff
Quality statement 2: Memory assessment services
Quality statement 3: Written and verbal information
Quality statement 4: Assessment and personalised care plan
Quality statement 5: Decision making
Quality statement 6: Emotional, psychological and social needs of carers
Quality statement 7: Non-cognitive symptoms and behaviour that challenges
Quality statement 8: Liaison services
Quality statement 9: Palliative care needs
Quality statement 10: Respite services for carers

Core business

Memory assessment and Diagnostic services
Living well with Dementia
Managing challenging behaviours
Dying well with Dementia

With all of us in mind
Staffing

• Medical Support
  • 2 WTE Consultants
  • 1 WTE Specialty doctors
  • 1 WTE higher trainee

• Nursing
  • Band 8b – 1WTE
  • Band 7 – 2 WTE
  • Band 6 – 8 WTE
  • Band 5 – 6.2 WTE
  • Band 3 – 5 WTE

• OT – 1WTE
• Psychology – 2.4 WTE
• Admin – 9 WTE
Liaison Pathway - 1

AMT assessment carried out on admission at BNFHT for patients 75+.

Scores 8+ assessment complete. No further action.

Scores 7 or below, further investigations are required.

Refer to Dementia Nurse Specialist (A.R.U)

Referrals through Dementia Liaison Nurse

Known to Dementia Service

Challenging Behaviours

No Diagnosis
**Liaison Pathway - 2**

<table>
<thead>
<tr>
<th>Known to Dementia Service</th>
<th>Challenging behaviours/BPSDs</th>
<th>No Diagnosis</th>
</tr>
</thead>
</table>
| • Check if in Dementia Register, verify diagnosis, treatment etc  
• Update RiO on current status  
• Need for Dementia Advisor  
• Need to be reviewed in NMP  
• Review antipsychotics (if appropriate)  
• Refer to Antipsychotic Clinic | • Liaise with respective ward staff  
• Offer advice on antipsychotic prescribing  
• Liaise with medics if appropriate | • Check if a referral has already been made by GP/other professionals  
• If still inpatient – Carry out cognitive assessment if appropriate  
• Collate all the results of investigations for diagnosis (if appropriate)  
• If not, carry out initial assessment at home following discharge  
• Redirect the referral to appropriate team for initial assessment  
• If discharged to intermediate care – Follow CQUIN/ write to GP/ re refer at more appropriate time.  
• If discharged to MVH – Continue with appropriate support. |
“Hub and Spoke” model

- Memory Service Hub
  - Primary care
  - Inpatient wards
  - Third sector
  - Care Homes

- MVH
- BDGH
MPDF in action

Assessment
• History
• Investigations
• Cognitive tests

Enabler

MPDF

Diagnosis
• Non medical delivery

Management
• Medical
• Psychosocial
• OT

Other interventions
• Challenging behaviours
• Antipsychotic review
• PPC
• End of life

Catalyst

Patient Choice

South West Yorkshire Partnership NHS Foundation Trust

With all of us in mind
Some numbers!

From 01/03/2015 to 06/05/2015

- Total number of referrals received from BDGH – 230
- Patients know to our service – 106
- Not known – 124
  - Deaths: 10
  - Refused assessment: 7
  - Out of area: 6
  - Not eligible for assessment: 21
  - Known to Functional Mental Health Team: 8
- Patients eligible and undergoing further assessment: 72
- Expected diagnostic rate: 60-70% (Data not available currently)
Some numbers!

Patients known to service

- Known to service: 106, 46%
- Not known to service: 124, 54%
Patients not known to Service

Spread of numbers

- Undergoing further assessments: 72, 58%
- Deaths: 21, 17%
- Refused assessment: 7, 6%
- Out of area: 6, 5%
- Not eligible for assessments: 10, 8%
- Others: 8, 6%
Diagnosis in acute hospitals by Geriatricians

**Cons**
- Level of expertise and access to additional resources
- May not be right environment for diagnosis
- Missing out on robust memory services pathways
- Issues with initiation and titration
- Lack of timely post diagnostic support
- Lack of access to other support systems locally

**Pros**
- Quicker diagnosis
- Better patient experience
- Avoiding duplication of work
- Better opportunities for medicines reconciliation/optimisation
- Easy access to further investigations
Thank you
Innovative Solutions in Liaison Psychiatry

Dr. S.M. Dasari
Hospital Mental Health Team
Who Are We?

The Team is based close to Hull Royal Infirmary and consists of:

• Team lead (x1 band 7)
• Mental health nurses (x8 band 6, x1 band 5)
• Social workers (x2 band 5)
• Psychiatrists
• Support workers
• We operate 7 days a week from 8am to 10pm
What We Do

• We are an ageless service

• We seek to support individuals attending the hospital who are experiencing mental health problems or those who present with DSH.

• We attend all wards, not simply A&E departments and this includes both Hull Royal Infirmary and Castle Hill Hospital

• We also accept referrals from Minor Injuries Units across the Hull & East Riding area

• Examples of our referrals include issues such as delirium, depression, self harm, dementia, suicidal ideation & general psychiatric liaison concerns. This is not an exhaustive list and we accept many other referrals or queries for a whole range of mental health related concerns
Our Area

Key Facts

• Hull & East Riding covers a combined area of 2,479km²

Estimated Population:
• Hull – 264,000
• East Riding – 326,000
Hospitals
(our sources of referrals)

• Hull Royal Infirmary (HRI)
• 709 beds
• A&E Department dealing with an estimated 120,000 patients per year
• £8 million investment into A&E currently underway
• Castle Hill Hospital (CHH)

• 610 beds

• Location for the majority of the Trust's elective activity

• The hospital houses the award winning Queen's Centre for Oncology and Haematology
Hospital Mental Health Team

- Perinatal
- Self Harm
- Acute Mental Illness
- Older People
- General Liaison

Single Point of Contact For All Referrals

Tel: (01482) 226226

7 Days a week
8am – 10pm
Team Leader (Band 7)
• 6 x full time Band 6
• 1 x full time Band 5
• 1 x part time Band 6

• 8am – 10pm, 7 days per week
• Self-harm
• Suicide (including suicidal ideation)
• Acute mental illness
• Includes under 18s
Older Adult Liaison Team

Team Leader shared with Adult Liaison

- 0.6 Consultant Psychiatrist
- 3 x full time Band 6
- 1 x full time Band 5

- 8am-6pm, 5 days per week
- Acute mental illness
- Dementia
- Delirium
- Depression
- Self-harm
- Suicide (including suicidal ideation)
<table>
<thead>
<tr>
<th>General Liaison</th>
<th>Learning Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 1 x Consultant Psychiatrist</td>
<td>• 1 x Band 7</td>
</tr>
<tr>
<td>• 1 x SPR</td>
<td></td>
</tr>
<tr>
<td>• Liaison therapists</td>
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</tbody>
</table>
Other Services

• Perinatal Liaison Team

• Huntington's Team

• Chronic Fatigue Service
## Referral Figures (last 6 months)

<table>
<thead>
<tr>
<th></th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Totals</th>
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<tbody>
<tr>
<td><strong>Under 18</strong></td>
<td>24</td>
<td>21</td>
<td>14</td>
<td>18</td>
<td>22</td>
<td>32</td>
<td>131</td>
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<tr>
<td><strong>18-64</strong></td>
<td>189</td>
<td>212</td>
<td>171</td>
<td>200</td>
<td>177</td>
<td>180</td>
<td>1129</td>
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<tr>
<td><strong>Over 65</strong></td>
<td>72</td>
<td>40</td>
<td>73</td>
<td>75</td>
<td>80</td>
<td>61</td>
<td>401</td>
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<tr>
<td><strong>General Liaison</strong></td>
<td>35</td>
<td>28</td>
<td>28</td>
<td>20</td>
<td>31</td>
<td>29</td>
<td>171</td>
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<tr>
<td><strong>Learning Disability</strong></td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>4</td>
<td>12</td>
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<tr>
<td><strong>DNW</strong></td>
<td>46</td>
<td>42</td>
<td>42</td>
<td>57</td>
<td>31</td>
<td>42</td>
<td>260</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>366</td>
<td>344</td>
<td>329</td>
<td>376</td>
<td>341</td>
<td>348</td>
<td>2104</td>
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</tbody>
</table>
Referral Outcomes

- The majority of referrals can be dealt with ‘in house’ with no further action/cost to Mental Health Services
- Crisis Teams can be utilised appropriately for either home treatment, or to gate-keep inpatient admissions

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Resolution &amp; Home Treatment Teams (working age adult)</td>
<td>188</td>
</tr>
<tr>
<td>Older People’s Home Intensive Treatment Teams</td>
<td>56</td>
</tr>
<tr>
<td>Child &amp; Adolescent Mental Health Services</td>
<td>41</td>
</tr>
<tr>
<td>Adult Community Mental Health Teams (psychosis &amp; non-psychosis)</td>
<td>40</td>
</tr>
<tr>
<td>Older Adult Community Mental Health Teams</td>
<td>84</td>
</tr>
<tr>
<td>Community Alcohol Teams</td>
<td>17</td>
</tr>
<tr>
<td>Single Point of Access (counselling services)</td>
<td>93</td>
</tr>
<tr>
<td>Discharge to GP/Other</td>
<td>2,278</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2,797</td>
</tr>
</tbody>
</table>
Delirium Clinic

- Consultant in post since June 2014. Clinic started in October.
- No. of patients seen - 70 since October 2014
- Types of patients: All Patients seen at HRI/CHH by nursing staff or myself with a diagnosis of Delirium
  - 15 Diagnosed with Dementia
  - 6 patients accepted treatment (ACHEI)
- Follow up by GP
Our Future

• 24 hour service
• Permanent base in A&E
• Enhanced training packages for HEY.
• Care home liaison
Any Questions?
A whole system commissioning approach for dementia

In Walsall
Encourage positive risk taking

Do not tick boxes

Speak to People!

Outcome focused services

Integration & partnership working

Person centred not service centred

Note to self:

Do not sail with the prevailing wind!

Age inclusive and Age appropriate

Maximise Social capital & assistive technology
Commissioning Challenges

- Providing equitable services
- MH service transformation and redesign
- A greater shift to outcomes
- Establishing and maintaining a dementia friendly community
- Increasing the dementia diagnosis rate
- Post diagnostic support
- Long term support including carers
- Preventing crises to reduce the number of acute hospital and care home admissions
- Planning for the future / End of life care
Older people’s mental health transformation

- Retain specialist functional and dementia service
- Increase transition age to 75 years
- 7 day working for community teams
- Develop an intensive support team
- Align to five integrated locality teams with D/Ns and S/Ws
- New post of Primary Care Co-ordinator role for localities
- Increase the number of older people accessing talking therapies
- Review of wards, day hospital and Memory Assessment Service
Acute hospital care

- Dementia steering group
- Action plan
- Integrated dementia pathway
- CQUIN
- Critical friend audit
- Older people’s mental health liaison team
- Dementia Support Workers: Acute hospital care
- Dementia friendly hospital work: environment, RCN, activity, technology, restaurants & staff training
Patients and staff celebrate the opening of Ward 29 at Walsall Manor Hospital.
Dementia Friendly Communities

- Second year of locally developed programme
- Do first, praise and credit later!
- NHS and council approved certificate presented by the Mayor of Walsall

Use the support of the media to increase awareness and maximise the Dementia Friendly Communities programme to increase sign-up…

Kite mark certificates awarded by the Mayor
More ready for award and several others currently in the programme

dementia friendly Walsall
Surgeries, shops, libraries, banks, cafés, pharmacies, day care, hairdressers
Activity & Technology

- Rempods
- Reminiscence boxes
- iPads with dementia apps chosen by users and carers
- MyLife digital reminiscence
- Activity materials
- Assistive technology
Personal Assistants - Dementia

- One for each locality, one for working age dementia
- Support everyone post diagnosis for 12 weeks
- Free service
- Information, advice, support & signposting
- Self help, planning for the future & ‘This is me’
Dementia Support Worker: Care home support & end of life

- Offer to audit every care home using ‘Care Fit for VIPS’
- Audit will produce action plan
- DSWs will receive training in EoL from a hospice and palliative care team
- Introduce Namaste Care Programme
- Introduce use of Abbey pain scale across Walsall
Dementia Support Worker: Screening & support

- Works under the supervision of a GP
- Supports people with a likely dementia
- Will carry out 6-CIT & GDS-15
- Will support people through diagnosis
- Long-term to support to reduce the likelihood of a crisis developing
Dementia Support Worker: Hard to reach groups

• Main objectives: raise awareness of dementia, reduce stigma and raise awareness of healthy lifestyles
• Will work with anyone
• Will carry out 6-CIT if necessary
• Why we do what we do…
Questions?

Michael Hurt - Commissioning Manager: Older People’s Mental Health & Dementia

michael.hurt@walsall.nhs.uk
Close and reflections

- Thank you to all our speakers
- Presentations will be available on the SCN website – the link will be emailed to you along with a link to the evaluation survey
- Please return to the main conference room for our closing presentation
- Certificates of attendance are available to collect from the registration desk.