WM QRS West Midlands Quality Review Service

NHS

West Midlands Dementia Care Pathway Group

Review of Dementia Services

Report Date: October 2012 Visit Dates: May 2011 to January 2012

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INDEX

INTRODUCTION

West Midlands Quality Review Service (WMQRS) was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on the WMQRS website: http://www.wmqi.westmidlands.nhs.uk/wmqrs

Reviews of mental health services, health services for people with learning disabilities, dementia services and care of vulnerable adults in acute hospitals in the West Midlands were undertaken between May 2011 and January 2012. Full reports of each visit are available on the WMQRS website, including details of compliance with Quality Standards and membership of the visiting teams. This report contains the Dementia Services section from each of the 2011/12 visit reports. These should be read in the context of the full visit reports, including details of compliance with WMQRS Quality Standards for Dementia Services, Version 1.1 (June 2011).

These visits were organised by WMQRS on behalf of the West Midlands Dementia Care Pathway Group. The dates for each visit are given in Appendix 1.

The reports reflect the situation at the time of the peer review visits. Services may have changed and developed since these visits.

ACKNOWLEDGMENTS

The West Midlands Dementia Care Pathway Group and West Midlands Quality Review Service would like to thank the staff and patients of the West Midlands Dementia Services for their hard work in preparing for the reviews and for their kindness and helpfulness during the course of the visits. Thanks are also due to the visiting teams and their employing organisations for the time and expertise they contributed to these reviews.

Return to *Index*

DUDLEY & WALSALL HEALTH ECONOMY

The memory service at Walsall was not reviewed as it had already been reviewed by the Royal College of Psychiatrists 'Memory Services National Accreditation Programme'.

A visit to Dudley and Walsall health economy took place in May 2011 and the commissioning section from the report of this visit is included below. A later visit to Dudley dementia services took place in January 2012 and the commissioning section on page 7 details the findings.

Return to *Index*

COMMISSIONING – SERVICES FOR PEOPLE WITH DEMENTIA (MAY 2011)

NHS DUDLEY

Concerns

At the time of the review, NHS Dudley did not commission a Memory Service (covering diagnosis and assessment and / or follow up and ongoing care). Reviewers were told that a nurse-led service, with clinical supervision from South Staffordshire and Shropshire Healthcare NHS Foundation Trust, was to start in June 2011, on a pilot basis for one year. The dementia pathway shown to reviewers did not appear to be based on the National Dementia Strategy. Reviewers were also concerned that links between this service and services previously provided by Dudley and Walsall Mental Health Partnership NHS Trust (Trust-Wide) were not clear.

NHS WALSALL

No commissioning issues were identified as this service was not reviewed (see above)

Return to *Index*

DEMENTIA SERVICE (JANUARY 2012)

(SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST)

General Comments and Achievements

The Dementia Service had been running since June 2011 and the second clinical nurse specialist (CNS) had been in post since December 2011. The number of referrals to the service had started to increase since the service had been rolled out to the whole borough. (190 people had been referred since June 2011 and 40 of these had been in the three weeks preceding the review.) Dementia Advisers were based in each of the three Gateways and the two CNSs were based in the Brett Young Gateway in Halesowen. The service had engaged well with local GPs and staff should be proud of the progress they had achieved in the time available. A good range of cognitive assessments were used.

Good Practice

1 A good GP referral process had been developed with clear documentation and good communication with GPs about their responsibilities before referral.

Immediate Risk: None

Concerns

1 **Diagnostic and assessment process**

Reviewers were seriously concerned about the diagnostic and assessment process for a combination of reasons:

a. **Governance**

This service was provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust but clinical responsibility for patients at each stage of the diagnostic and assessment process was not clearly explained to reviewers and documentation provided was not consistent with verbal information given to reviewers.

b. **NICE Guidance**

NICE guidance on diagnosis of dementia was not being followed. The service did not provide a full range of assessment and diagnostic services as expected by NICE guidance. The service relied on GPs to have undertaken a physical examination and medication review. Some patients did not see a consultant or other appropriate senior doctor specialising in the care of dementia prior to diagnosis. For those people diagnosed with dementia by nursing staff, it was not clear diagnosis included appropriate consideration of medical co-morbidities, key psychiatric features associated with dementia, including anxiety and depression, and differential diagnosis. Structural imaging (CT or MRI) did not take place prior to diagnosis. Memory Clinics were not held.

c. **Competences of staff undertaking diagnosis and assessment**

Nursing staff were diagnosing “straight-forward” cases of dementia (as required by the service specification). Although the person specification for the clinical nurse specialist posts required ‘Clinical skills in the assessment and diagnosis of dementia”, reviewers did not see evidence at the time of the review that nursing staff had the competences needed for the role they were taking in the diagnosis and assessment of people with dementia (see above), in particular, competences in physical examination, medication review and differential diagnosis.

d. **Guidelines and Policies**

No operational policy or guidelines, including guidelines covering the assessment and diagnostic process, were evident at the time of the review.

Further Consideration

1 **Provider Liaison and Communication**:

Staff in some services for people with dementia were not aware of the roles of other services and reviewers were given several examples of operational and clinical issues which could have been resolved by better awareness and communication between services. As well as resolving clinical and operational problems, there may be opportunities for shared training, development and audit. Good liaison and communication between providers is particularly important for Dudley because of the number of different provider organisations involved in the care of people with dementia. Some of these providers met through the weekly multi-disciplinary meeting or were involved in the monthly Dementia Service monitoring meetings but both of these meetings had other primary functions.

2 People with dementia who were diagnosed before the summer of 2011 (2012 for some parts of the borough) had not had the information and support available since then from Dementia Advisers and Dementia Gateways. Further consideration of meeting the needs of this group may be helpful. Also, the role of Dementia Advisers was described as preparing a Personal Support Plan and then reviewing this plan with people with dementia and their carers. It may be useful to model whether three Dementia Advisers will be sufficient to carry out this role as the numbers of reviews builds up.

3 Consultant psychiatrist staffing may not be sufficient if NICE Guidance on the diagnosis and assessment of dementia is implemented for the whole of Dudley.

Return to *Index*

IN-PATIENT SERVICES (DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST)

General Comments and Achievements

At the time of the review, the in-patient ward for people with dementia had seven people in a ward with a capacity for 16. Most of the in-patients had challenging behaviour as well as dementia. Staffing was used flexibly with other wards in the hospital. There was a good sensory room. Links with consultant psychiatrists, day hospitals and CMHTs were good. The ward was not yet using the OASIS IT system but there were plans for this to be implemented.

Good Practice

1 Information for service users and their carers was good including a person-centred care plan, a Welcome Pack, information on 'Understanding what your named nurse can do for you' and a 'My Keeping Well' pack.

Concerns: None

Further Consideration

1 **Provider Liaison and Communication**: See above

2 In-patients were not able easily to access their rooms during the day.

3 It was not clear that nursing staff had specific competences for their roles in caring for people with dementia, especially if staffing levels were increased in order to increase capacity on the ward.

4 It may be helpful to review the stage in the in-patient stay at which information is given to service users and carers. Reviewers were told that the Social Worker input focussed on discharge planning, which though important, other relevant information and advice e.g. benefits advice, may be helpful earlier in the in-patient stay.

5 There was little difference in the decor in different areas of the in-patient ward. The corridors were almost identical and although there had been some attempt to paint the door frames and put visual prompts to identify rooms the environment was still very similar. Improving the decoration with the aim of specifically addressing the needs of people with dementia may make the environment more conducive for service users and carers.

Return to *Index*

COMMISSIONING (JANUARY 2012)

General Comments and Achievements

NHS Dudley had started to improve the care of people with dementia through the development of the Dementia Service. Links with Dudley MBC on developing services for people with dementia were good.

Concern

1 **Dementia Strategy**

A draft strategy for 2010-13 was available but this did not reflect the services being provided or planned at the time of the review. Completion of the strategy was planned on conclusion of the Dementia Service pilot. Reviewers were seriously concerned about the fragmentation and unclear governance of the diagnosis and assessment pathway (see above). The pathway for people referred to the Dementia Service did not comply with NICE guidance and was not clear about responsibilities for follow up and ongoing support. The pathway for people referred to consultant psychiatrists or CMHTs was not clear. The roles of the day hospitals and CMHTs in the ongoing care of people with dementia were not clear. Links between these services and the Dementia Advisers and Dementia Gateways were not evident. Reviewers were told that the in-patient unit now admitted mainly people with challenging behaviour and dementia (see above). This may be appropriate but it was not clear that this was part of a strategic direction supported by commissioners.

Further Consideration

1 Some staff were unclear whether the Local Implementation Team (LIT) included representatives from the Black Country Partnership NHS Foundation Trust. It may be helpful to review attendance to ensure appropriate representation of the service providing care for people with learning disabilities and dementia. It may also be helpful to review whether both a LIT and a Strategy Group are required.

Return to *Index*

COVENTRY & WARWICKSHIRE HEALTH ECONOMY

NHS COVENTRY and NHS WARWICKSHIRE PRIMARY CARE FOR PEOPLE WITH DEMENTIA

A programme of awareness-raising and information for GP's on reducing the use of anti-psychotic medication had started. A Coventry and Warwickshire project was focusing upon raising awareness within specialist care homes and increasing information available to them.

Return to *Index*

MEMORY SERVICES

HEALTH SERVICES FOR OLDER PEOPLE, INCLUDING PEOPLE WITH DEMENTIA

General Comments and Achievements

Coventry and Warwickshire Partnership NHS Trust provided a wide range of services for older people with mental health problems, including three 'single point of entry' referral and triage services (covering North Warwickshire, South Warwickshire and Coventry), four day hospitals, four community mental health teams (CMHTs), a hospital liaison team at University Hospitals Coventry and Warwickshire, six in-patient wards, a specialist support team for older people placed in residential and nursing homes (Coventry and Warwickshire), a Young Onset Dementia team (Coventry only), Memory Assessment Service (Coventry and Warwickshire), Admiral Nurses (Warwickshire only), Community and Assessment Treatment Team (Rugby only) and an Intermediate Care Service. The Memory Assessment Service included clinics, Cognitive Assessment and Treatment Services and Memory Assessment Clinicians who, following multi-disciplinary discussion, were diagnosing dementia in non-complex situations.. The review concentrated on the Young Onset Dementia Team, CMHTs and Memory Assessment Services. The review did not visit all in-patient wards, or look in detail at the work of the day hospitals or intermediate care team.

Reviewers were impressed by several aspects of the services offered (see below). Staff were committed and working hard to improve the care they provided. There were ambitious plans for the further development of services, including significant reductions in time from referral to diagnosis. Good information for service users was available. There was good partnership working with advocacy services. Reviewers were told that there was a good working relationship with the Alzheimer's Society.

Good Practice

1 The Young Onset Dementia service for Coventry was well-organised with clear referral criteria and a good care pathway, short time to completion of assessment, and a primary care liaison worker. A Young Onset Dementia Focus Group had been established to enable user input to the work of the service.

2 CPA Policy, 'My Care Plan' and associated training: The Care Programme Approach system was very good. There was a clear policy supported by a training programme, an electronic system of recording data and a contact card for all service users. The use of hand-held devices to record relevant data was being piloted. (NB. This policy was not yet in use in learning disability services.)

3 The environment and facilities for services for the Older Adult Services in the Caludon Centre were welcoming, bright and well-equipped.

4 Reviewers saw patients on the in-patient wards being treated with dignity and respect, with many supervised activities in progress. Good work on falls prevention had taken place.

Immediate Risks: None

Concerns

1 Data were not being collected on key performance indicators, including time to diagnosis. (Historical data from 2003 and 2006 were available.) It was therefore not clear how the activity and effectiveness of the services were being monitored and how the service re-design plans would be evaluated.

2 DOLS training and awareness: The Trust did not have a policy on Deprivation of Liberty Safeguards. (Reviewers were told that this was included in the Trust Safeguarding Policy but the Safeguarding Policy did not cover this area.) There was no ongoing programme of DOLS awareness-raising. DOLS was mentioned briefly in Trust induction but reviewers talked to several staff who said they had not received DOLS training. Reviewers were told that training was available through the Local Authority but staff were not aware that they could access this.

3 Variation across services and localities: Availability of services, staffing levels and pathways varied across Coventry and Warwickshire. In some cases this was a result of specific commissioning decisions (for example, the Young Onset Dementia service was available for Coventry residents but not for Warwickshire), in others it was a response to a specific service change (for example, the establishment of the Community Assessment and Treatment Team in Rugby) but in others it appeared to be based on history or the interest of particular clinicians. Teams were often not aware of the referral and acceptance criteria laid down in service specifications and these criteria were not usually reflected in operational policies. Reviewers suggested that the health economy considers together the availability of services in each locality, and the differences between localities, to ensure that these give an appropriate response to local needs.

4 The commissioned diagnostic pathway for Warwickshire involved service users going back to their GP for the GP to request a CT scan. This introduced delays and complexity into the pathway and the potential that appropriate reporting of CT scans may not be requested. Reviewers suggested that the Trust should work with commissioners to ensure that CT scans (including appropriate reporting) can be requested by the memory assessment services.

Further Consideration

1 The memory assessment services for older adults appeared fragmented. Reviewers heard about the single point of access in each locality and saw operational policies for many of the services. The pathway for an older adult referred to the services and the relationship between clinics, the Cognitive Assessment and Treatment Services and the Memory Assessment Clinicians were not clear, including about medical input to the process of diagnosis. How these services then related to the work of community mental health teams

for older adults was also not clear. There were plans to review the pathway and, in particular, to streamline assessment and diagnosis. Reviewers noted that there had been several previous attempts at service redesign and were not confident that the latest proposals would be followed through to full implementation.

2 The management structure for medical staff was separate from the operational structure and some medical staff did not appear to be involved in and committed to the proposed service changes.

3 Reviewers were told of 18 wte band 5 nurse vacancies on the in-patient wards. The mechanism for ensuring staffing levels were sufficient was not clear.

4 Links between older adult services and the Trust management and corporate functions did not appear to be as strong in services for older adults as in those for working age adults.

5 The service had six in-patient wards and four day services. This appeared high for the population served and the potential to reduce reliance on institution-based care should be explored with commissioners.

Return to *Index*

COMMISSIONING

NHS COVENTRY and NHS WARWICKSHIRE HEALTH FOR PEOPLE WITH DEMENTIA COMMISSIONING

General Comments and Achievements

Both NHS Coventry and NHS Warwickshire were actively working to improve the quality of dementia services for their populations. NHS Coventry had used CQuINS in 20009/10 and 2010/11 to remodel the patient pathway. NHS Warwickshire was a pilot site for the Skills for Care Carers and Dementia training. Training was delivered across wide range of agencies and co-facilitated by carers themselves. Good information, advice and support services were provided by Guideposts Trust in North Warwickshire and the Carers Support Service in South Warwickshire. These services offered support to carers of people with dementia. A training module on caring for people with dementia was also available.

Concerns

1 The commissioned diagnostic pathway for Warwickshire involved service users going back to their GP for the GP to request a CT scan. This introduced delays and complexity into the pathway and the potential that appropriate reporting of CT scans may not be requested. Reviewers suggested that commissioners should ensure that CT scans (including appropriate reporting) can be requested by the memory assessment services.

Further Consideration

1 The service had six in-patient wards and four day services. This appeared high for the population served and the potential to reduce reliance on institution-based care should be explored.

BIRMINGHAM & SOLIHULL HEALTH ECONOMY

MEMORY SERVICES

General Comments and Achievements

During the review of memory services provided by Birmingham and Solihull Mental Health NHS Foundation Trust, the visiting team looked in detail at the four Community Mental Health Teams (CMHT) for people aged over 65, the Birmingham Memory Assessment and Advice Service (BMAAS) and prescribing clinics. Reviewers visited one in-patient assessment ward. The Young Onset Dementia service was also reviewed although it was not always clear whether the evidence provided related to this service. It was similarly unclear whether all the evidence related to the services in Solihull and reviewers were aware that differences between Birmingham and Solihull may not have been fully explored.

The BMAAS service had been established for about a year and was still in a stage of development. This service had the potential to be a very good Memory Assessment Service if the issues identified in this report are addressed.

The STEPS team was moving away from a traditional model of day care and staff were enthusiastically embracing the associated changes. Reviewers were also interested in the adoption of a social problem approach to problem-solving whereby evidence from personality disorder services was being applied to older adult services and encouraged the evaluation of this approach.

Good Practice

1 The management of physical health was being actively promoted. Specialist nurses in infection control, diabetes and tissue viability were promoting good practice and were very involved in training other staff. A health care assistant was responsible for making sure physical health checks happened at out-patient clinics and on the in-patient ward. Physiotherapy staff played a very active role in the care of people with dementia.

Immediate Risks: None

Concerns

1 **Diagnostic and assessment process**

Reviewers were seriously concerned about the diagnostic and assessment process for a combination of reasons:

a. **NICE Guidance**

NICE guidance on structural imaging (CT or MRI) prior to diagnosis was not being followed.

b. **Competences of staff undertaking diagnosis and assessment**

Senior practitioners (nurses and occupational therapists) led the diagnostic process as Memory Assessment Clinicians but there was no evidence that these staff had the competences needed for this

work, including physical examination and medication review when this is required (for example, those described in the National Dementia Strategy (2009) and Regional Dementia Strategy (2008). Medical input to the diagnosis and assessment process was limited with only one session per week of consultant time available in BMAAS which was used for attendance at the multi-disciplinary meeting. [This concern links with that relating to staff training in the Trust-wide section of this report which states: The expected statutory and mandatory training for registered and un-registered staff was in place and monitored monthly. Monitoring information showed high levels of achievement in some areas but low in others, including equality and diversity. There were no competence frameworks showing the training expected for specific roles in individual services and no evidence of staff having achieved the expected competences. The skill mix within some services may also benefit from review as there appeared to be a relatively low proportion of registered staff. Reviewers noted that a new head of training and development had recently been appointed].

c. **BMAAS Assessment Process**

The commissioned pathway expected that physical examination would be undertaken in primary care prior to referral with medication review and other investigations (including structural imaging) being considered at the multi-disciplinary meeting. BMAAS used an assessment recording form (client record) and the Addenbrooke's Cognitive Assessment Tool, but there were no guidelines covering the assessment process and assessment documentation did not include any detail of physical examination, medication review and other investigations. Given the expected variation in physical examinations in primary care, clinicians undertaking the assessment process should be able to undertake a physical examination when their clinical judgement indicates this is required. (See point (b) about staff competences for their roles in the assessment process.) Reviewers were also concerned that multi-disciplinary decisions about medication review and requesting of other investigations were being taken with no evidence that a specialist practitioner with appropriate competences had seen the individual concerned. Medical staff were usually, but not always, present at the multi-disciplinary discussion and these decisions were therefore sometimes taken without any medical input.

The assessment process also did not cover other aspects expected by the Quality Standards, including social care assessment, assistive technology assessment and carers' needs assessment. The service referred to other teams for these assessments when required. Reviewers were concerned that this approach did not give the expected holistic assessment, especially given the lack of integration with social care described in the health economy section of this report and the delays in response from social care (see below, concern 2).

d. **Care Pathways**

The pathway described to reviewers was that people with a possible diagnosis of dementia were referred to the Young Onset Dementia Service or BMAAS, depending on their age. The documented pathway was unclear and was not the same as the pathway described to reviewers. The documented pathway showed referrals to BMAAS, CMHTs or Prescribing Clinics depending on the choice of the GP

and this pathway seemed to be being followed in practice. The Dementia Advisers, who were responsible for 'signposting' and advice, and who maintained contact with the client throughout their dementia journey, were not available to patients referred through Prescribing Clinics or CMHTs. People who had been referred more than a year ago (i.e. before the start of BMAAS) did not have a Dementia Adviser and there was no plan for ensuring they received relevant information, carers' assessments or other aspects of the service now being provided.

e. **Prescribing Clinics**

Doctors running the Prescribing Clinics were not generally involved in diagnosis, assessment or multi-disciplinary discussion. Reviewers were told that, before commencing treatment, these doctors would confirm the diagnosis on the basis of information provided. This expectation was not documented and, given the concerns above about the assessment process, reviewers considered that prescribing may be started without a robust diagnosis and assessment having been completed.

2 **Links with Social Care**

Clients who needed a social care assessment were referred to generic social workers and reviewers were told of several examples of delays in response and subsequent delays in accessing social care.

3 **Carers Needs Assessments**

Reviewers were told about several different systems for accessing carers' needs assessments. Carers of service users referred in the last year and of some in-patients would have access to a carer's assessment. The psychologist who undertook assessments of carers of in-patients was on a sabbatical and arrangements for carers' assessments during this time were not clear. The named nurse was not clear how carers' assessments would be obtained. Carers of CMHT service users could access an assessment through the Care Coordinator. It was not clear how carers of people being seen in Prescribing Clinics accessed carers' assessments. The Trust had audited carers' assessments and had showed that a low number of carers had been offered assessments.

Further Consideration

1 The ratio of registered to unregistered nursing staff on the in-patient ward appeared low (40:60 registered: unregistered during the day and 50:50 at night).

2 **Clinical Guidelines:** Services were not yet clear which care pathways they were expected to offer. Staff could access a range of guidelines, including NICE guidance, through the Trust website. Guidelines had not been localised to reflect local circumstances. This issue is identified as for 'further consideration' at this stage but will be of concern at any future review visits as progress should have been made by then. This issue also has implications for audit as, until clinical guidelines are in place, their implementation locally cannot be audited.

3 The environment in the in-patient assessment ward was relatively clinical and reviewers, especially service user reviewers, wondered if the level of security was necessary. Although the unit was new, several aspects of the design did not appear to have taken the needs of people with dementia into account.

4 The development of more focussed support for people with dementia in care homes was being considered. Reviewers supported the continuation of this work and considered that it had the potential to reduce the use of NHS in-patient beds.

5 Formalised shared care arrangements with GPs were not in place. This was being considered as an area for development.

6 In addition to the services reviewed, Birmingham and Solihull Mental Health NHS Foundation Trust provided 70 continuing care beds for people with dementia. Reviewers were surprised that these services had not been the subject of market testing.

7 Although STEPS staff were enthusiastic about their work and an interesting range of 'classes' was available, the numbers attending the classes appeared very low and reviewers were unsure about the therapeutic interventions being offered (and therefore the rationale for NHS provision of this service).

Return to *Index*

COMMISSIONING

BIRMINGHAM AND SOLIHULL JOINT COMMISSIONING

Concerns

Several aspects of the review of memory services at Birmingham and Solihull Mental Health NHS Foundation Trust require the attention of commissioners (see above).

Return to *Index*

HEREFORDSHIRE HEALTH ECONOMY

PRIMARY CARE

No specific issues about primary care of people with dementia were identified.

Return to *Index*

MEMORY SERVICES

General Comments and Achievements

This was an impressive service with many examples of good practice. Staff were welcoming and very positive. There was good feedback from carers, and from GPs, about the services provided. Team-work within the service was good. Reviewers were particularly impressed by the strength of multi-disciplinary and inter-agency working, including strong relationships with residential and nursing homes, the Alzheimer's Society and other voluntary organisations.

A member of staff with particular responsibility for people with young onset dementia had been appointed and so work targeted at the needs of this group was starting. A primary care-based memory assessment service was being planned with the aim of speeding up the diagnostic process. It was hoped that this would be operational by December 2011.

Good Practice

1 Workers who linked with Care Homes were in place. There were also very good training programmes for Care Home staff.

2 An Intermediate Care Team actively worked to prevent admission to hospital and Care Homes of people with dementia.

3 Good use was made of assistive technology, including use of *iPods* and *Memory-Apps.*

4 Good support was available for carers of people with dementia. Reviewers were impressed by the whole process of carer support including pre- and post-diagnosis counselling, an eight week training programme and information packs. There were plans to extend this work to service users as well as carers.

5 A training DVD and workbook had been developed with the University of Worcester and was about to be launched.

Immediate Risks: None

Concerns

1 **Clinical supervision:** Arrangements for clinical supervision were not robust, although some informal clinical supervision was taking place. This issue was identified in several of the services reviewed.

Further Consideration

1 The arrangements for multi-agency discussion of services for people with dementia may benefit from review. A group involving commissioners, providers and other agencies had been meeting but arrangements for future multi-agency work were unclear.

2 An acute liaison nurse, linking with Hereford County Hospital, was available, but reviewers were told that the workload and lack of cover for this nurse meant that the role was dominated by crises. It may be helpful to review whether additional acute liaison staffing could reduce length of stay and avoid future admissions.

3 Arrangements for accessing advice outside of normal working hours may also benefit from review. Reviewers were told of various arrangements for accessing advice in a crisis, through the GP or through the mental health crisis teams. Their response to the needs of people with dementia appeared to be variable.

4 Carers who met the visiting team were very positive about the support received when the Carers' Worker is available but said that the system did not work as smoothly when she was away. Cover for this role may benefit from further consideration.

Return to *Index*

COMMISSIONING

See Memory Services section of this report.

Return to *Index*

WORCESTERSHIRE HEALTH ECONOMY

MEMORY SERVICES

A range of services for people with dementia were available in Worcestershire, including an Early intervention Service, six community mental health teams which provided care for people aged over 65 with functional and organic problems, a team which supported people with dementia in care homes, admiral nursing, dementia advisers, an intermediate care worker and an acute liaison team.

In-patient care for people with dementia was also provided by Worcestershire Health and Care Trust but was not reviewed.

People with suspected dementia were referred to the Early Intervention Service, if they were thought to be in the early stages of the dementia, or to CMHTs if their disease was more advanced.

General Comments, Achievements and Good Practice

Reviewers considered that Worcestershire was well on the way to having a very good set of services providing holistic care for people with dementia. The services were looking positively to exploit the opportunities resulting from the recent organisational merger. Commissioners were also enthusiastic and involved in the development of services. Service user and carer feedback was very good.

The Early Intervention in Dementia Service had many examples of good practice, including good information for service users and carers. Staff of this service were enthusiastic and focussed on the development of the service.

Particular examples of good practice included:

1 Liaison with other services and with the voluntary sector was good. Dementia advisers were available to provide support to people diagnosed through the Early Intervention Service. CMHTs had good integration with social care. An acute hospital liaison service was in place, including 'flagging' of vulnerable individuals so that the liaison service was notified when they were admitted to hospital.

2 Service users were very pleased with the accessibility of memory clinics. Initial assessment took place at home and was followed by a discussion about the most appropriate next step. Carers felt very well supported and were particularly grateful that they always got to talk to someone when they rang up.

3 Admiral nurses were available throughout Worcestershire. Good links with Worcester University were in place. Action learning sets had been run as part of the development of the services.

4 A good structured primary care training programme was in place for all groups of staff. This ensured training appropriate to the level of involvement with the care of people with dementia.

5 A good pathway had been developed with Dementia UK on palliative care for people with dementia.

6 Very good training with long term care providers was in place. A leadership programme had been run and the services 'out-reached' into care homes.

7 Good public awareness programmes were run with lots of work with schools, local events and newspapers.

Immediate Risks: None

Concerns: None

Further Consideration

1 **Dementia Pathway in Community Mental Health Teams**

In contrast to the Early Intervention in Dementia Service, diagnosis, assessment and support offered to people with dementia referred to CMHTs did not yet meet several of the expected Standards. Memory Clinics were run but these used different assessment tools from the Early Intervention Service. It was not clear that information about all aspects of dementia was made available to people assessed and diagnosed. Dementia advisers were available to people supported by CMHTs but it was not clear that service users were routinely offered this support. It therefore appeared that those people with the greatest needs were being referred to the service with the less developed arrangements for diagnosis, assessment and support. This was reflected in the experience of users and carers who met the reviewing team.

2 Given the extent of organisational change taking place, it will be important to maintain the emphasis on memory services and a robust pathway for service users and carers.

3 Governance of the diagnostic process within Worcestershire Acute Hospitals NHS Trust may benefit from review. Reviewers were told that the acute hospital liaison service was undertaking assessments, discussing these with psychiatrists and then telling people their diagnosis while they were in hospital. It was not clear that patients following this pathway, especially those with a first presentation, had access to an appropriate range of assessment and diagnostic tests, and access to the support that was available in other settings.

4 The services and commissioners were giving further consideration to meeting the specific needs of people with young onset with dementia, alcohol-related dementia and those with learning disabilities who developed dementia. Reviewers encouraged continuation of this work.

Return to *Index*

COMMISSIONING

NHS WORCESTERSHIRE and ADULT JOINT COMMISSIONING UNIT

See Memory Services section of this report.

Return to *Index*

SOUTH STAFFORDSHIRE & SHROPSHIRE HEALTH ECONOMY

PRIMARY CARE

Several issues relating to primary care are identified in the Memory Services sections of this report.

Return to *Index*

MEMORY SERVICES

SHROPSHIRE COUNTY AND TELFORD & WREKIN OLDER ADULT COMMUNITY MENTAL HEALTH TEAMS and MEMORY SERVICES

Older adult CMHTs had responsibility for older adults with functional and organic mental health problems. These teams were responsible for memory assessment and initiation of treatment. If necessary, service users were referred to the memory service after three months of follow up.

The services were in the process of changing to a new model of care with the aim of providing a local service with specialist dementia advice available when needed through:

- Community teams for people with dementia
  It was planned that these teams will initiate memory assessment and will provide continuity of care for people with mild and moderate memory problems and those with more complex needs. Following referral, a team member will do an initial assessment within 20 days and arrange investigations. This will be followed by MDT discussion, further investigations will be arranged if required, a care plan will be agreed and treatment started.
- Dementia Service
  This service will advise on diagnosis and assessment and provide support to the in-patient ward. Additional staff were being recruited to this service.

General Comments and Achievements

Because the services were in the middle of change to a new model of care it was difficult for reviewers to judge the extent to which relevant Quality Standards were being met and would be met in the future. Some staff were not clear about the future arrangements, or had different views about how they would work in practice, which also caused some confusion.

Good clinical and managerial supervision arrangements were in place. Community teams had a good range of specialist nurses – although their future roles were uncertain. Work had taken place on intermediate care for people with dementia. In Telford these services were being strengthened and were continuing to work with service users for four weeks in order to avoid admissions and facilitate discharge from acute hospitals.

Good Practice

1 An acute hospital liaison nurse for older people worked proactively. Whenever community team or Chestnut Ward patients were admitted to Shrewsbury and Telford Hospital NHS Trust then she was notified, would visit them and worked to facilitate their discharge.

2 A good range of assessment tools was in use.

Immediate Risks: None

Concerns

1 **NICE Guidance on Structural Imaging**

NICE guidance on structural imaging was not yet robustly implemented. Reviewers were told that one consultant did not follow the guidance and structural imaging was not used routinely. Reporting by a neuro-radiologist was not available.

2 **Staff Competences and Skill Mix**

Staff competences for roles caring for people with dementia were not yet in place. A training matrix covered mandatory training but not specific competences for roles within the service. Staff had experience in caring for people with dementia but this experience may not be relevant to the model of care being proposed. In particular, there was not evidence of competences in the range of assessments needed for people with dementia. At the time of the review the skill mix of community teams included medical and nursing staff but not a clinical psychologist or neuropsychologist or an occupational therapist. A psychologist had been recruited and was about to start.

3 **Future Model of Care**

While recognising the need to balance ease of access and availability of specialist expertise, reviewers were concerned about the proposed model of care for a variety of reasons, including:

a. A dementia care pathway was available but it was not clear how this was going to be implemented in practice.

b. The proposed model of care involved GPs undertaking the physical examination, including neurological examination, medication review and requesting structural imaging with appropriate reporting. It was not clear that all GPs would have the appropriate specialist expertise in the care of people with dementia to provide this level of input to the diagnostic process.

c. Consultant psychiatrists from the proposed dementia service would, whenever possible, be part of the multi-disciplinary diagnostic discussion but would not usually have seen the patient.

Further Consideration

1 'Out of hours' specialist dementia advice was not commissioned. Out of hours advice was available from *ShropDoc.* The extent to which *ShropDoc* could provide specialist expertise in the care of people with

dementia and the amount of additional specialist dementia advice needed may benefit from further consideration.

2 Some of the community teams were co-located with social care but social care staff were not integrated into the teams. As part of developing the new model of care, opportunities for improving liaison with social care staff should be considered.

3 Education and training programmes had been run with some care homes and an in-reach service to care homes was being piloted at the time of the visit. Reviewers encouraged continuation and, subject to evaluation, roll out of this approach.

4 Further work on primary care education and training will be needed whatever model of care is adopted. The proposed model of care has significant implications for primary care and the associated training and development needs should not be underestimated.

5 Training in 'preferred priorities in care' and the Liverpool Care Pathway had previously been available. Existing staff had received this training but it was not clear how new staff would gain these skills.

SHROPSHIRE IN-PATIENT SERVICE (CHESTNUT WARD)

General Comments and Achievements

Chestnut Ward was an old facility but was kept clean and reasonably maintained. The ward had a good programme of structured activities including singing and 'pat dogs'. It was less clear how these activities were adapted to meet the needs of individual patients.

Good Practice

1 A good weekly review form was in use which was clear and detailed, including physical health needs and speech therapy and occupational therapy review.

2 The ward had good support from allied health professionals, including a full-time occupational therapist, daily physiotherapist, and weekly speech and language therapy and dietician visit. Physiotherapy technicians were involved in exercise activities with the aim of reducing the number of falls.

3 An acute hospital liaison nurse for older people worked proactively. Whenever community team or Chestnut Ward patients were admitted to Shrewsbury and Telford Hospital NHS Trust then she was notified, would visit them and worked to facilitate their discharge.

4 A good range of assessment tools was in use.

5 A discharge liaison post was working effectively and data had been collected which showed reduced length of stay as a result of this work.

Immediate Risks: None

Concerns: None

Further consideration

1 **Clinical Guidelines and Audit**

Clinical guidelines covering the therapeutic interventions offered by the in-patient service were not yet in place and, as a result, implementation of guidelines could not be audited.

2 The environment on the ward did not provide privacy and dignity for conversations between in-patients and their relatives. The ward was a long corridor with bedrooms at one end and the dining room and seating area at the other end. Relatives were not allowed in the seating area. The only place where carers could talk to relatives was in the corridor. The quiet room was kept locked.

3 Carers who met the reviewers commented that they were not offered a cup of tea when the tea trolley came round. Carers also commented that laundry often went missing.

4 Capacity and consent and section 17 leave review (when applicable) were not routinely recorded in the weekly review form. It may be useful to include these on the form.

5 Training in 'preferred priorities in care' and the Liverpool Care Pathway had previously been available. Existing staff had received this training but it was not clear how new staff would gain these skills.

SOUTH STAFFORDSHIRE - MAC UK NEUROSCIENCES Ltd

General Comments, Achievements and Good Practice

At the time of the review, this service had been operational in South Staffordshire for only three months. The service was commissioned for 7,000 contacts per annum. After three months the service had seen 561 new referrals and a total of 1400 referrals (including those transferred from CMHTs).

The service was commissioned to undertake diagnosis and assessment, and to follow up patients with a diagnosis of dementia who did not have complex needs. Several aspects of the service were still under development, including links with primary care and ensuring GPs undertook appropriate pre-referral screening and physical health checks. Good support for carers was available and links with the Alzheimer's Society were good. Clinics were provided in a wide variety of locations in order to facilitate local access to care.

Immediate Risks: None

Concerns

The service provided by MAC UK Neuroscience Ltd. was of serious concern to reviewers for a combination of reasons:

1 **Staffing Levels, Skill Mix and Competences**

Staffing levels were insufficient for the workload of the service. The service was commissioned for 7,000 contacts per annum and after three months had seen 561 new referrals and a total of 1,400 referrals. Staffing comprised one full time clinical lead psychiatrist, one clinical service manager, two band 6 and two band 5 nurses. At the time of the review, the South Staffordshire service was not able to see patients referred within the expected timescales. The service did not have staff with clinical psychology or neuro-psychology competences, although a non-clinical psychologist sometimes came from Bradford. No member of staff with occupational therapy competences was available. Evidence that staff had competences appropriate for their roles in the care of people with dementia was not available. Staff had not yet had DoLS training. A one day dementia awareness course had been run.

2 **Assessment Process**

The MAC self-assessment stated that the service did not undertake full neurological examinations as part of the assessment process. The assessments undertaken did not include assistive technology assessments or 'Looking to the Future' assessments. Reviewers were told that service users were referred to other agencies for each of these assessments. Arrangements for assessments of carers' needs also involved referral to another agency. This meant that the service could not undertake a holistic assessment of need and service users and carers may have to attend several organisations in order to have a full assessment.

3 **Facilities**

Memory clinics were provided in a wide variety of locations some of which did not offer appropriate facilities for physical examination (for example, fire stations).

See also section of this report relating to South Staffordshire commissioning of services for people with dementia (see below)

SOUTH STAFFORDSHIRE DEMENTIA SERVICE (SS&SHFT)

CMHTs in South Staffordshire provided care for people with dementia and more complex needs. These services were considered as specialist mental health CMHTs (see above) and their role in the care of people with dementia was not reviewed in detail. Because CMHTs were not reviewed for their role in the care of people with dementia and did not fully take on this role until October 2011, this report can give no assurance on the quality of the service provided.

Concerns

1 Approximately 150 people with dementia and less complex needs had been referred from CMHTs to MAC UK Neuroscience Ltd. in July 2011. Although these service users were not without care packages, this situation was difficult for all involved.

SOUTH STAFFORDSHIRE IN-PATIENT SERVICE (BASWICH WARD)

General Comments and Achievements

Baswich Ward was a 12 bedded in-patient ward for people with dementia. Referrals were usually from CMHTs caring for people with dementia. Staff were very committed and enthusiastic and were doing their best to provide good care in difficult circumstances, including making the most of the environment in the ward which was not purpose-built for the needs of people with dementia. The Ward Manager provided good leadership for the service. A good multi-disciplinary approach to care was evident, including consultant psychiatrist input. A sensory garden provided a pleasant outside space for users of the service. Good links with the dementia care team at Mid Staffordshire NHS Foundation Trust were in place. The ward psychologist and nurse consultant had implemented a programme of training for ward staff.

Good Practice

1 The ward had a very individualised approach to care, including flexibility over eating arrangements, a sensory room, use of life stories and good support for carers.

2 The ward psychologist provided outreach to care homes and input to their training programmes.

3 The ward psychologist and nurse consultant had implemented a programme of training for ward staff.

Immediate Risks: None

Concerns

1 **Staffing Levels**

The ward had 12 vacancies (three registered staff and nine health care assistants) out of an establishment of approximately 30 and so was heavily dependent on bank and agency staff whilst recruitment was in progress.

Further Consideration

1 Staff who met the visiting team did not have a good awareness of DoLS and were not able easily to give appropriate responses to scenarios.

2 Liaison with the newly established memory service provided by MAC UK Neuroscience Ltd. had not yet been developed. Developing a joint working relationship may be helpful to both services.

3 Social work staff were not integrated with the in-patient service and further consideration of ways of improving communication may be helpful.

Return to *Index*

COMMISSIONING

SHROPSHIRE COUNTY PCT and NHS TELFORD & WREKIN

Concerns

1 The section of this report relating to the Older Adult CMHTs and Memory Services identifies several concerns about the model of care which is being commissioned and towards which services are moving. A clear commissioning strategy is needed which ensures the National Dementia Strategy and NICE Guidance are implemented.

SOUTH STAFFORDSHIRE (STAFFORDSHIRE JOINT COMMISSIONING UNIT)

General Comments and Achievements

South Staffordshire commissioners had commissioned memory clinics from MAC UK Neurosciences Ltd[1], Dementia Advisers from the Alzheimer's Society and training for carers from *Approach.* The MAC UK Neuroscience Ltd. service had been operational since July 2011. CMHTs were commissioned to provide care for people with dementia with more complex needs[2]. GPs could refer patients directly to CMHTs if this was considered clinically appropriate. A Dementia Adviser Service and training for carers had been commissioned for South Staffordshire.

Concerns

1 Reviewers were concerned that services for people with dementia were commissioned in a fragmented way from several services. The commissioned pathway was not clear and simple for service users and carers.

2 Several aspects of the service commissioned from MAC UK Neuroscience Ltd. were of serious concern:

a. Commissioned activity levels were insufficient for the need. The service was commissioned for 7,000 contacts per annum. After three months the service had seen 561 new referrals and a total of 1400

[1] The service commissioned from MAC UK Neuroscience Ltd. covered diagnosis within 10 weeks of referral, preparation of care plans for all those diagnosed with dementia, annual reviews for all patients with dementia, memory clinic appointments, medicine reviews, sign-posting and information, work with carers on how to plan for a crisis and access to Dementia Advisers, partnership with other organisations, access for carers to training and support, screening and information gathering and provision of a care passport (advance directive) and antipsychotic medication prescribing (2 months only).

[2] The service commissioned from CMHTs covered skilled assessments of patients and their carers, services for patients with a diagnosis of dementia (severe and enduring), service provision in each locality, a service for patients with complex needs that are challenging in nature, a care home intervention service to support clients in that environment to prevent admission to acute beds, carer support for complex patients, and support to enable patients to remain at home.

referrals (including those transferred from CMHTs). Reviewers were told that about 150 people were in transition between CMHT care and possible care by MAC UK Neuroscience Ltd. (see dementia services section of this report) but had not yet been accepted by this service.

b. From September 2011 willing GPs were requesting structural imaging required for diagnosis of patients with dementia. It was not clear that GP requests would include appropriate neuro-radiology reporting. (When the service was set up GPs were asked to undertake blood tests and request scans. Some GPs were unwilling to do this and MAC UK Neuroscience Ltd. had been allocated a budget for scans but still used GP requesting wherever possible.)

c. See MAC UK Neuroscience Ltd. section of this report in relation to Staffing Levels, Skill Mix and Competences; Assessment Process and Facilities. In particular, the assessment process required on-going referral to other services instead of providing a holistic diagnostic and assessment process.

d. Service users did not have a Dementia Adviser available to them at all times. Dementia Advisers had initial contact and, for some service users, could be involved again later in the patient journey.

e. The service specification required one month monitoring of anti-psychotic medication whereas national guidance is that this should be for a minimum of three months. (MAC UK Neuroscience Ltd. were monitoring for a minimum of three months.)

3 See South Staffordshire Dementia Service (SS&SHFT) section of this report in relation to the services commissioned from CMHTs.

Further Consideration

1 'Out of hours' specialist dementia advice was not commissioned from any provider. The out of hours pathway included the Emergency Duty Team, mental health help-line, GP out of hours service, 999 and advice from the Crisis Resolution / Home Treatment team. It was not clear that any of these services would have appropriate specialist expertise in the care of people with dementia.

2 Although the commissioners' self-assessment said that a) social care and health services provided a range of training for staff providing long-term care for people with dementia and b) that this service was commissioned from CMHTs, no evidence of this was available during the course of the review.

3 Social care staff were not integrated with health services for people aged over 65. Reviewers were not clear why the benefits of integrated working apparent in services for adults of working age were not being extended to older adults.

4 The relationship between the MAC UK Neuroscience Ltd. annual review and GP QOF reviews was not clear.

Return to *Index*

NORTH STAFFORDSHIRE HEALTH ECONOMY

MEMORY SERVICES

Two ward areas and one of the five memory clinics were reviewed in detail.

General Comments, Achievements and Good Practice

Services to people with dementia were person-centred and provided by committed and enthusiastic staff. Service users and carers were very positive about the care they received. The service managed to achieve a very flexible response to service users' and carers' needs. Relationships with social care were good. The in-patient assessment ward for people with complex needs was well-organised and had a high rate of enabling people to return home. Specialist support was available for people with substance misuse and for people needing neuropsychiatry.

Good Practice

1 A very good dementia pathway was in place which had been audited. The diagnostic process at the 'hub' was very efficient, including the possibility of buses to the hub.

2 A specific Mental Health and Vascular Well-Being Service was in place with nurses trained in cognitive behavioural therapy.

3 A care home liaison team had undertaken a programme of training for care home staff.

Immediate Risks: None

Concerns: None

Further Consideration

1 The team was considering further improvements to the care provided including the development of a rapid assessment team.

2 Audit of GP pre-referral screening may be helpful to ensure that all GPs are undertaking the expected screening.

3 There were some differences in the pathway between Stoke and North Staffordshire. Further consideration and evaluation of these may be helpful to ensure that the most responsive services are provided for both areas.

Return to *Index*

COMMISSIONING

NHS STOKE and NHS NORTH STAFFORDSHIRE

General Comments and Achievements

Several commissioners were involved with commissioning services for people with dementia. A population needs assessment had not yet been undertaken. A Clinical Reference Group was in place and, for Stoke, a Local Implementation Team.

Further Consideration

1 As with mental health services (see above) reviewers considered that the involvement of so many commissioners had the potential for duplication and a lack of focus in interactions with providers, especially North Staffordshire Combined Healthcare NHS Trust. Reviewers suggested that commissioners should identify a lead commissioner for services for people with dementia. Reviewers were concerned that the progress made in improving services for people with dementia would not be sustained without a clear commissioning focus.

Return to *Index*

SANDWELL & WOLVERHAMPTON HEALTH ECONOMY

SANDWELL DEMENTIA SERVICES

PRIMARY CARE

A primary care-based pathway had been developed but this was not consistent with the pathway developed by the Memory Assessment Service (see below). Reviewers were told that communication between primary care and the Memory Assessment Service was not good. There were plans to appoint a Primary Care Dementia Liaison Worker. A shared care protocol was in place.

Return to *Index*

MEMORY SERVICES (BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST)

A Memory Assessment Service and two wards were reviewed, a 24 bed admission ward for people with organic mental health problems and an 18 bed ward for people with challenging behaviour. Community Mental Health Teams also provided care for people with both functional and organic problems but were not reviewed. The arrangements for community-based follow-up and ongoing support for people with dementia are therefore not covered by this review and no assurance of the quality of these services can be given.

General Comments and Achievements

Services for people with dementia in Sandwell had some examples of good practice but, overall, the services and organisations were not working together effectively to provide integrated services for people with dementia and their carers. Staff were enthusiastic and committed and, at a service level, staff were working hard to try and improve the care offered. A new Memory Assessment Service model had been introduced five weeks before the review visit and reviewers were told early indications were that this had reduced waiting times for memory assessment. Good links with voluntary sector organisations were in place. There were plans to appoint a Primary Care Dementia Liaison Worker.

Good Practice

1 The in-patient environment was clean, calm and well-organised. There was evidence of good interactions with patients and good input from psychology, physiotherapy, dietetics and medical staff – as well as care by the ward nursing staff. A 'Bar' area was set up for reminiscence and lounge areas were organised to make service users feel at home. The Therapy Suite provided a good environment, including for teaching. Decor on the challenging behaviour ward had been well thought out, suitably calming colours were used, period features and furniture were in place, and historic imagery was used to stimulate long-term memories (for example, Cadbury's chocolate advertisements). The reported impact was a significantly reduced use of anti-psychotics in managing challenging behaviour.

2 User and carer involvement mechanisms were well developed, including 'BUDS' (Better Understanding of Dementia for Sandwell) which provided Clubs, a Befriending Service, a Carer Support Service and Outreach Support; 'Making a Difference' groups for people aged over 65 and their carers, and a Dementia Cafe.

3 Post-diagnosis group sessions were run to provide education and support for people with dementia and their carers. Three groups were run regularly: a four week 'Dementia Information Group', a seven week 'Cognitive Stimulation Therapy Group' and an eight week 'Managing and Coping with Dementia Group'.

Immediate Risks: None

Concerns

1 Reviewers were seriously concerned about services for people with dementia in Sandwell for a combination of reasons:

a. No Partnership Board or equivalent group involving the service users and carers, primary care, PCT, Local Authority, Trust and voluntary groups was running. There had previously been a group but this was no longer operational. Relationships between the PCT, GPs, social care and the Trust did not appear to be working well enough to ensure effective care for people with dementia and their carers was being developed and maintained.

b. There was no effective strategy for services for people with dementia agreed by all major stakeholders involved in their care. The proposed service model was not clear and, at the time of the review, two inconsistent pathways of care were presented. The way in which these pathways linked with community teams providing follow up and ongoing support was also not clear.

c. Service users were not routinely given a written care plan or summary of their diagnosis and expected therapeutic interventions.

d. There were no guidelines for any aspect of the services, including referral, assessment, therapeutic interventions or discharge. There were no guidelines for referral for brain imaging. Reviewers were told that referral was based on individual clinical judgement and it was not clear that NICE guidance on referral for brain imaging was being implemented.

e. Reviewers were told by staff and by service users and carers about difficulties and delays in access to social care. Staff who met the visiting team were unclear about arrangements for referral for respite care. Arrangements for referral for assessments of carers needs were also unclear.

f. Staff were undertaking mandatory training but there was no evidence that staff had appropriate competences in their specific roles within services caring for people with dementia.

Senior leadership and direction from commissioners and providers will be needed to ensure that these issues are addressed and, in particular, to ensure that appropriate structures and relationships are developed which enable the development of high quality, integrated services for people with dementia and their carers.

Further Consideration

1 **Information for service users and carers**

Responsibilities for giving information to service users and carers were not clear and the stage in the pathway at which information was given was also not clear. Some service users and carers who met the reviewing team commented that they sometimes had too much information at one time. It may be helpful to review and clarify who gives information and when this is given.

2 **Dementia Service Care Pathway**

The dementia service care pathway proposed by the Trust and implemented five weeks before the review visit may benefit from further discussion and review. In particular, reviewers commented that: a) the pathway covered only the work of the Trust memory service rather than the whole pathway – the roles of other services were therefore not clear, b) there was no exit from the pathway, b) the role of community teams in the pathway was not clear, and c) the roles of the Primary Care Dementia Liaison Worker and Dementia Pathway Coordinator were not clear. This way in which this pathway linked with the primary care pathway also needed clarification. It appeared that the Trust pathway had been developed in isolation and had not been agreed by commissioners.

3 Reviewers saw little evidence of the way in which services were responding to the particular needs of service users and carers from black and minority ethnic groups. Given the ethnic mix of the local population, further work in this area may be helpful.

4 Plans for reducing the number of in-patient beds were already under discussion at the time of the review. Reviewers supported continuation of discussion of these proposals as part of clarifying the strategy for the development of services for people with dementia. In particular, reviewers commented that some service users appeared to have been in-patients for a long time (for example, two years) and alternatives to in-patient care may be more appropriate for their needs.

5 Plans for appointing additional medical support for liaison with the general acute hospital were progressing. Reviewers supported the approach being taken and encouraged further development of these links when an appointment is made.

6 'Safety first' reminders to staff were prominently displayed on the in-patient wards. Reviewers were pleased to see the emphasis on safety but wondered if these reminders were sited in the most appropriate places.

COMMISSIONING

The serious concerns identified in the Memory Services section of this report require commissioner, as well as provider, action and monitoring.

Return to *Index*

WOLVERHAMPTON DEMENTIA SERVICES

PRIMARY CARE

Pre-referral screening arrangements were in place and a revised shared care protocol had recently been agreed. Appropriateness of referrals to the Memory Service had improved since the revised protocol was introduced. IAPT services had been commissioned to provide care for people with mild cognitive impairment.

Return to *Index*

MEMORY SERVICE (BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST)

One ward area and one of the Memory Clinics were reviewed in detail. Community Mental Health Teams also provided care for people with dementia but were not reviewed and no assurance of the quality of these services can be given.

General Comments and Achievements

Services to people with dementia were person-centred and provided by committed and enthusiastic staff. Service users and carers were very positive about the care they received and commented on the 'caring family' approach of the service. The services managed to achieve a very flexible response to service users' and carers' needs. GP's were also positive about access to the memory services. Relationships with social care were good.

The Memory Service was well-established. People with dementia were also referred to Community Mental Health Teams. Reviewers were told that these people received the same care as in the Memory Service but that, at the time of the review, assessments could be undertaken more quickly in CMHTs.

A specific clinic for people with young-onset dementia was running and there was a support group for this group of service users. A wide range of local, regional and national information was available.

Multi-disciplinary team meetings were attended by a member of staff with particular expertise in assistive technology. Dementia Advisers were not yet in post but there were plans for these to be recruited by April 2013.

Good Practice

1 A care pathway and memory clinic, specifically tailored to care for those patients with Down's syndrome, ensured that people with learning disabilities were screened for dementia. Referrals were to the Learning Disability Service who undertook initial screening. If a diagnosis of dementia and treatment was to be considered then the individual was referred to the Learning Disability Memory Clinic. This clinic ran to a clear protocol, including shared care arrangements with the Memory Service.

2 Assessment for and use of assistive technology was discussed routinely in the multi-disciplinary team meeting, which was attended by a member of staff with particular expertise in this.

3 A Home Treatment Team provided additional support to people at home.

Immediate Risks: None

Concerns

1 **Post-diagnosis pathway**

The dementia pathway after diagnosis, responsibilities for follow-up and ongoing support and the relationship between the Memory Service and CMHTs were not clearly defined although, in practice, these seemed to work well.

Further Consideration

1 The team was considering further improvements to the care provided, including the development of a rapid assessment team, because there was a waiting time of seven weeks for assessments. Capacity and demand analysis with the aim of reducing waiting times for all referrals may be useful. It may also be helpful to consider whether streamlining the two separate referral processes (Memory Service and CMHTs) would help to give a timely, consistent assessment for all referrals.

2 Audit of GP pre-referral screening may be helpful to ensure that all GPs are undertaking the expected screening and using the new referral form.

3 Wolverhampton Council had commissioned a training and education programme about dementia for providers of social care from Worcester University. Establishing links with this programme may be helpful to ensure that it appropriately reflects the Wolverhampton dementia care pathway.

4 Some of the clinical guidelines expected by the Quality Standards were not yet in place and their implementation therefore could not be audited. Other audit work was undertaken. Appropriate governance of care coordination and care provided is particularly important because of the flexible, responsive nature of the service. This issue is categorised as for 'further consideration' at this stage but will be of concern if progress is not made in the next two years.

5 Mandatory training was in place but there was no evidence that staff had specific competences for their roles in the care of people with dementia and there was no framework showing the competences expected for the different roles in the services. As part of this work, it may be helpful to include competences in the care of people with young-onset dementia in the competence framework.

6 Arrangements for cover for the Lead Nurse in the Memory Service may benefit from review to ensure that the same level of care and support is available during her absences.

7 Clinics run by the Memory Service were held adjacent to the in-patient ward. This location may not be ideal, especially for people with early onset dementia

8 A more systematic approach to giving information on 'looking to the future' may be helpful. It may also be useful to ensure all staff are aware of the recently revised arrangements for providing support for service users and carers.

DEMENTIA IN-PATIENT WARDS – PENN HOSPITAL (BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST)

General Comments and Achievements

The staff on the in-patient ward were committed to improving the care of patients with dementia. Good rapport was observed between the staff and patients. Patients appeared well cared for and a good sensory room was available. A wide range of activities for patients took place during the day. A new ward manager had been in post since the autumn of 2011. Reviewers were told that mandatory training compliance had increased from 10% to 100%.

Good Practice

1 Collaboration with Wolverhampton Art Gallery had led to a more conducive environment for patients.

Immediate Risks: None

Concerns

1 The environment on the ward was not suitable for the care of people with dementia. Beds were in five or six bedded bays with limited privacy or dignity for patients.

Further Consideration

1 Some patients had been on the ward for over 18 months and alternatives to in-patient care may be more appropriate for their needs, especially because of the environment on the ward.

2 Some of the clinical guidelines expected by the Quality Standards were not yet in place and their implementation therefore could not be audited. This issue is categorised as for 'further consideration' at this stage but will be of concern if progress is not made in the next two years.

3 Mandatory training was in place but there was no evidence that staff had specific competences for their roles in the care of people with dementia and there was no framework showing the competences expected for the different roles in the services.

Return to *Index*

COMMISSIONING

No specific commissioning issues were identified, although commissioning involvement will be needed especially a) clarifying the post-diagnosis dementia pathway, b) monitoring work to reduce waiting times for assessments and c) ensuring people who have been in-patients for long periods are having care in the most appropriate setting.

Return to *Index*

APPENDIX 1 VISIT DATES

Health Economy	Visit dates
Dudley & Walsall	9th - 13th May 2011
Coventry & Warwickshire	14th - 24th June 2011
Birmingham & Solihull	5th - 14th July 2011
Herefordshire	13th - 15th September 2011
Worcestershire	20th - 23rd September 2011
South Staffordshire & Shropshire	4th - 13th October 2011
North Staffordshire	18th - 20th October 2011
Sandwell & Wolverhampton	17th - 19th January 2012
Dudley (Dementia Service)	20th January 2012