ITEM 4

North Yorkshire County Council

Scrutiny of Health Committee

6 September 2013

Harrogate Dementia Collaborative

Purpose of Report

1. The purpose of this report is to provide an opportunity for the Committee to be updated on the operation of the Harrogate Dementia Collaborative.

Introduction

2. Members may recall that in September of last year the Committee was informed that a Dementia Collaborative had been set up in the Harrogate area. Members heard how the initiative encouraged and supported work across organisational boundaries and helped to ensure that service developments are always considered through the eyes of service users and their carers.

3. The Collaborative has now been in operation for a full year and Janet Probert, Director of Partnerships and Innovation, Harrogate and District NHS Foundation Trust has asked for an opportunity to share with the Committee the progress that has been achieved.

4. A copy of the Harrogate Dementia Collaborative Year 1 Report is attached.

Recommendations

5. That Members note the work taking place to improve services for people with Dementia and their carers across the Harrogate area.

Bryon Hunter
Scrutiny Team Leader
County Hall, NORTHALLERTON

22 August 2013

Background Documents: None

HARROGATE DEMENTIA COLLABORATIVE

CHIEF EXECUTIVE OFFICERS END OF YEAR ONE REPORT

Version	Date	Document Controller	Record of changes
0.1	21st May, 2013	Michael Bewell	First draft for project group review.
0.2		Michael Bewell	Changes following review by Project Board

HARROGATE DEMENTIA COLLABORATIVE

LARGE SCALE CHANGE PROJECT

Section 1

Executive summary

The Harrogate Dementia Collaborative was set up to deliver large scale cross organisational change to improve the quality and experience people living with Dementia in Harrogate have in accessing health and social care services. This paper provides an update at the end of the first year on the progress made.

The project is governed and directed by a Chief Officers Project Board with representation from Harrogate and Rural Clinical Commissioning Group and the local providers of health and social care, HDTT, NYCC and TEWV.

The Board are pleased to report the project is making a difference for people living with Dementia and establishing a sustainable movement of continuous improvement. To achieve this, the project is using the Quality Improvement System (QIS) to drive rapid change through 5 – day workshops. In the first year, six rapid process improvement workshops have been run. Four more are planned next year. These have delivered measurable gains for people with Dementia across primary, community, hospital, mental health care as well as in care homes.

Sustaining improvement gains is notoriously difficult. Training is being used to provide sustainability for continuous improvement activity in the Harrogate area. After year one, two out of thirteen staff are now certified leaders in using QIS. In addition to this in-depth training, 60 staff have received one day training in using the QIS and over 120 staff have attended a lean introduction and awareness session.

The project is addressing Harrogate's priorities listed in the York and North Yorkshire Local Dementia Strategy. To direct improvement work, the project continues to engage with partner organisations within the collaborative, the third sector and independent sector. But, most importantly to ensure quality improvements are made from a user perspective, the project is involving the views of people living with Dementia and their carer through a series of focus groups. Wider cross organisational benefits have also been reported. Of the staff involved, 78% reported that cross working between the agencies had improved and the project was delivering benefits to the collaborating organisations. Wider benefits are being captured for each RPIW and will be evaluated at the end of the project.

Over leaf is a table that demonstrates how the Harrogate Dementia Collaborative is addressing the priority National Dementia Strategy issues. Full details are provided in section two of the report.

Priority	Outcomes
Early intervention and diagnosis for all	Improvement events in primary care and secondary mental health aim to double the number of people appropriately referred by GPs to the memory service to identify those with Dementia in our community who are currently undiagnosed. Waiting times to the memory service for first appointment have been reduced by 62% to 28 days
Implementing New Deal for Carers	Carers have reported to the project issues accessing information about the person they care for. At Dr. Moss and Partners, standard process is now in place to identify the carer on the patient record so information can be shared appropriately and without delay. Improved information about the key services accessed by people living with Dementia has been created and is available through the community teams. Signposting to the third sector prior to diagnosis has also been established at Dr. Moss and Partners.
Improved quality of care for people with dementia in general hospitals	The environment on Byland Ward has been improved so people with Dementia are better able to orientate themselves, locate and use key facilities such as the toilet and bathroom. Information to enable clinician's better care for patients with Dementia is now to hand with improvements in internal and external documentation processes. This includes an improved Pink Passport to carry key medical information about an individual along their care pathway. Decision making is more structured and focused. The new weekly multi disciplinary team meeting saves on average 300 minutes of clinician time a week. Further improvements are being tested now.
Living well with dementia in care homes	Improving communication and decision making processes has reduced admissions by 58.3% in four care homes.
An informed and effective workforce	A Dementia lead been established at Moss and Partners GP practice and additional staff Dementia Awareness training has been provided across all the sectors. Staff from the different agencies report that cross working is helping them to deliver better services. In the community the nursing team have implemented a new assessment tool that saves 22 min per assessment. This time can then be used o provide more value and quality to the individual.

Section 2 Harrogate Dementia Collaborative

End of year full report

1. INTRODUCTION & PURPOSE

The purpose of the Harrogate Dementia Collaborative

The National Dementia Strategy, Living Well with Dementia (2009) highlighted this disease as one of the greatest challenges facing our aging society. A five-year strategy was set out to make improvements to benefit people with Dementia by:

- Improving awareness across our communities
- Providing earlier diagnosis and interventions and
- Providing a higher quality of care

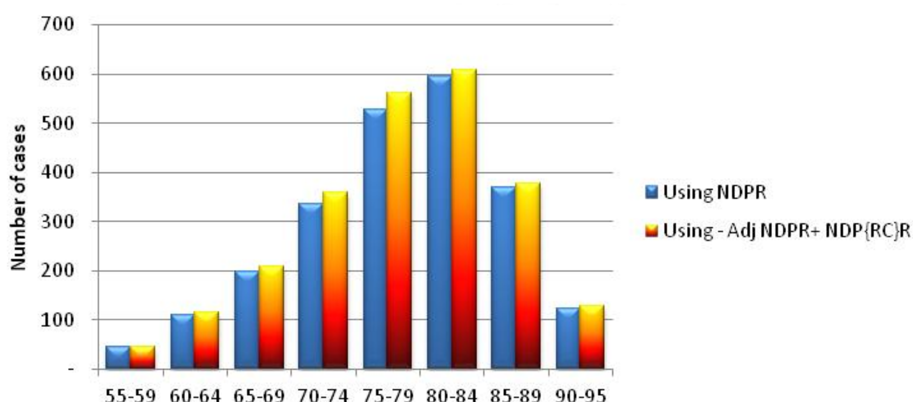
The focus on Dementia remains. On March 26, 2012 The Prime Minister's Challenge on Dementia was published (http://tinyurl.com/dementia-challenge). This document made clear the personal commitment of the Prime Minister and his wish to increase the scope and pace of Dementia services improvement work to push further and faster within three key areas:

- Driving improvements in health and social care
- Creating Dementia friendly communities that understand how to help
- Better research

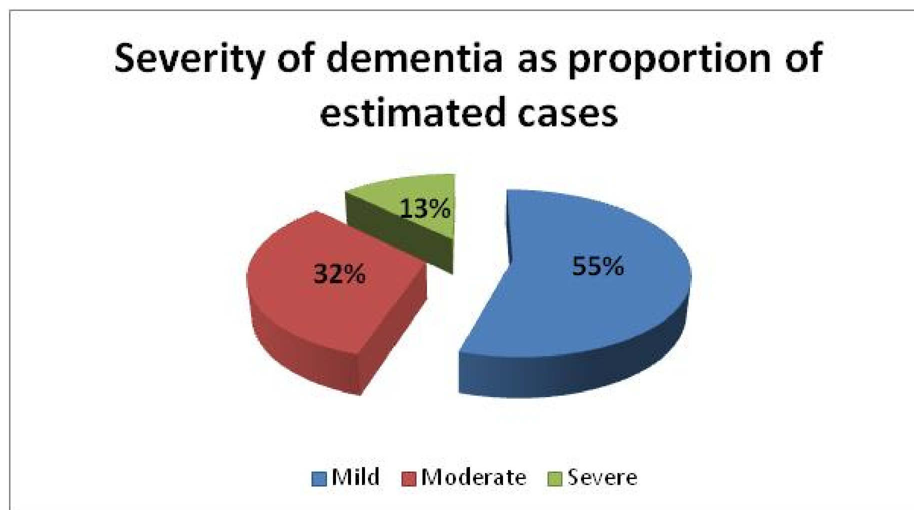
Harrogate has a larger than average older population whose average age is steadily getting older still. Within this aging demographic, the number of people with Dementia is increasing.

By just 2015, it is estimated cases there will be 1,705 females and 923 males with Dementia in the Harrogate and Rural District CCG. The estimated (Est.) cases are presented in the following graph by age group. The public health analysts use two models to predict the number of cases; NDPR and Adj NDPR. As can be seen the two approaches give similar results in the predicted number of cases.

Expected number of people living with Dementia in Harrogate by 2015

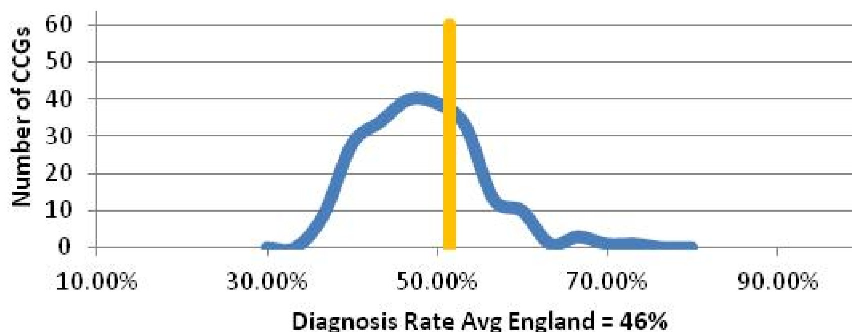


Dementia is a progressive disease and as it progresses an individual's requirements for more support increases. In the Harrogate area, the split between mild, moderate and sever cases is presented in the Pie Chart.



The National Dementia Strategy also raises the issue of diagnosis. The level of diagnosis as a percentage of predicted prevalence in North Yorkshire is 43% with the Harrogate CCG at 52%.

Comparing the diagnosis rate in Harrogate (yellow) with the range of diagnosis rates for CCGs across England



The scope of improvement

Ensuring Harrogate firstly identifies those with dementia and then has in place the right services of the expected quality and capacity to meet the demand and complexity is crucial. To achieve these aims, the Local Dementia Strategy prioritised for Harrogate a number of National Dementia Strategy Objectives to be tackled first:

- Objective 2: Good quality early diagnosis and intervention for all.
- Objective 6 Improved community personal support services
- Objective 8 improved quality of care for people with dementia in general hospitals
- Objective 11 Living well with dementia in care homes
- Objective13 An informed and effective workforce for people with dementia

The creation of a new Harrogate Dementia Collaborative was highlighted by local stakeholders within the North Yorkshire and York Dementia Strategy as a key and catalytic approach to bring together the different agencies, service users and carers for the purpose of improving Dementia care.

In February, 2012 the Harrogate Dementia Collaborative was formed. It brought together four organisations across health and social care that have all made a commitment to work together to address the local challenge presented by Dementia. The collaborating partners are:

- Harrogate District Foundation Trust (HDFT)
- North Yorkshire County Council (NYCC)
- Harrogate and Rural District Clinical Commissioning Group (HaRD)
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

The Chief Officers and organisations are:-

- Helen Taylor Director Health and Adult Services North Yorkshire County Council
- Helen Taylor; Director of Health and Adult Services
- Richard Ord Chief Executive Harrogate Foundation NHS Trust
- Rick Sweeney Vulnerable People's lead Harrogate and Rural District CCG
- Martin Barkley, Chief Executive, Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

This project is being driven by the Chief Executives of these organisations but has been led by a full range of professionals, service users, carers and clinical staff who, by sharing, learning and working together aim to make a significant and sustained contribution to the delivery of high quality services.

The collaborative aims to deliver large scale, cross organisational, change and, as well as address the national dementia strategy objectives, would improve

the quality of services, support individuals to live well with Dementia in the community and by removing waste drive an increase in value for money in the system.

The Chief Executive Officers agreed that lean methodology and tools would be used as the approach to remove waste in the system and to address inefficient processes such as duplication, poor stock control and many other issues that hamper, delay and prevent staff from providing the high quality service they would like to deliver. The Collaborative is using the Quality Improvement System, a method based on Toyota's approach but successfully adapted and adopted for healthcare settings by Virginia Mason Medical Centre in Seattle and further refined by the North East Transformation Service.

This report outlines the work of the collaborative through the 2012 / 2013 financial year highlighting the methodologies used and the outcomes of the project.

2. BACKGROUND INFORMATION

A Project Manager from TEWV was appointed on April 1st, to develop a project plan and lead on the implementation of the project across the organisations.

2.1 Project Objectives

To deliver a multi agency programme to improve quality of services for people with dementia who live in Harrogate by eliminating waste using (a) proven improvement methodology(s).

- Establish a service “system” that has the capability to support increased need for services accessed by people with Dementia in the future, taking into account the demographic changes that are occurring in an ageing population, at less cost
- Develop capacity and capability in using the Quality Improvement System and delivering RPIWs as a key change tool
- Learn how to use the Quality Improvement System (QIS) improvement methods and in particular rapid process improvement workshops (RPIWs) across and between organisations within the Harrogate locality

2.2 Guiding Principles

- That of promoting and enabling the independence of people who have a dementia.
- That people with dementia and their carers are partners in their care plans, the options involved and the decisions that need to be made.
- That there is no unplanned shifting of costs or risks between organisations.

2.3 Success Criteria

- Getting the right service to the right person at the right time
- Delivering improved Value for Money
- Increasing productivity
- Reducing hospital admission rate (both acute hospital and specialist mental health service admissions)
- For those people who do require admission to enable them to have as short a stay as possible in hospital commensurate with their needs
- That services in Harrogate are equal to, or better than, those described in the recent National Dementia Strategy.

3. THE PROJECT

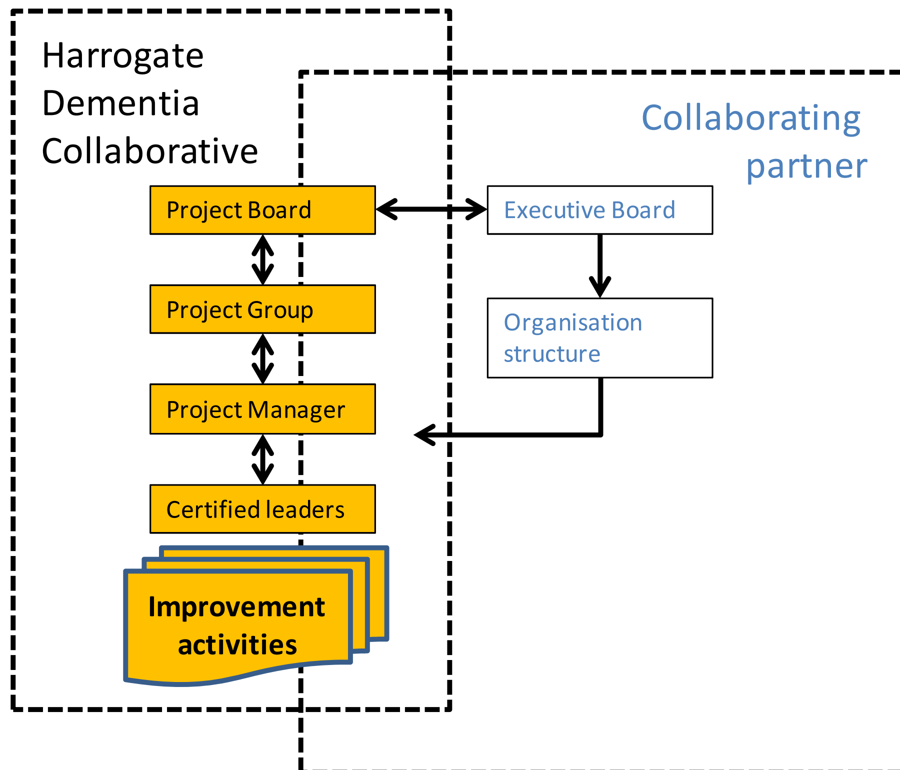
3.1 Governance

The Chief Executive Officers lead the project through a Project Board that meets monthly. The diagram below depicts how the governance structure functions. The Project Board sets the strategic direction that, through its membership, aligns to the vision and mission of the collaborating partners. All collaborative members, including the clinical commissioning group are included in the membership of the project board and project group to ensure there is equal influence over strategic and tactical decision making within the project.

3.2 The authority of the project board

- The Project Group will take decisions in supporting the monitoring and implementation of RPIW improvement activities within their individual organisation.
- It will monitor progress on achievement of the project plan.
- It will be responsible for communicating the project plan and the benefits that have been derived from the improvement activities.
- In executing these responsibilities, it will do so taking into account the views of the Project Board and other relevant groups within their own organisations and will, in turn, provide periodic reports to the Project Board.

Governance Structure



The Project Group and project manager operate more tactically to ensure the project delivers improvement events to deliver the project objectives. Events are led using trained and certified leaders in QIS from the Harrogate District. Collaborating partners provide support and resources into the RPIWs. The improvement activities resulting from RPIWs will deliver benefits to all the collaborating partners.

To ensure a successful project, the role of the project group is to:

1. Manage the project and monitor it progress
2. Recommend to the project board themes for the planned Rapid Process Improvement Events (RPIW)
3. Ensure that Rapid Process Improvement Workshops have a Director – level Sponsor who is able to meet the Sponsor Agreement for RPIWs
4. Take actions to support the scoping of agreed themes, setting boundaries, defining targets, and the planning of RPIWs
5. Identify and access to data sources to inform baselines and outcomes
6. Engage and communicate with key stakeholders for the benefit and progress of the project and improvement work including for example:
    - Identifying process owners
    - Identifying people to be involved or to be advisors in rapid process improvement events
    - Identifying where briefings about the project methodology are required
    - Opportunities to present project progress
7. Enable the project to access specialist individuals and resources across the organisations to support the delivery of the improvement events
8. Make timely and responsive decisions in areas identified by the Project Board to support the project
9. Support the Project Manager address risks and issues where these cannot be resolved by the Project Manager
10. Promote awareness and understanding of the Harrogate Dementia Collaborative and how the project successes support and align with the strategies of the member organisations.

3.3 Membership of the project group

- Lesley Allott, NYCC General Manager covering Harrogate
- Alastair Dewar, NYCC
- Paul Hyde General Manager North Yorkshire, TEWV
- Pratibha Nirodi Consultant Psychiatrist
- Fiona Bell Deputy Director Partnerships and Innovations, HDFT
- Jane Paisley Elderly Care Consultant and Dementia Lead for HDFT
- Jane Baxter, Commissioning Lead, HaRD CCG
- Keith Appleby Head of the Kaizen Promotion Office, TEWV

4.0 Training

A key component of the Collaborative is to train a number of leaders in the partners to be competent to facilitate change using rapid process improvement weeks and implementing lean tools into the workplace.

The target is to train 13 staff (see chart 1).

The training plan has prioritised training with HDFT and NYCC because, unlike TEWV, there is no culture of these tools being used in these organisations. To become a certified leader, the person must complete classroom testing, a verbal exam and facilitate two RPIWs as a workshop leader.

- All those on the certified leader programme have completed their classroom based learning.
- 12 out of 13 have facilitated at least one RPIW as workshop leader
- Plans are in place for all those on the programme to gain their certification within the project timescales

Chart 1

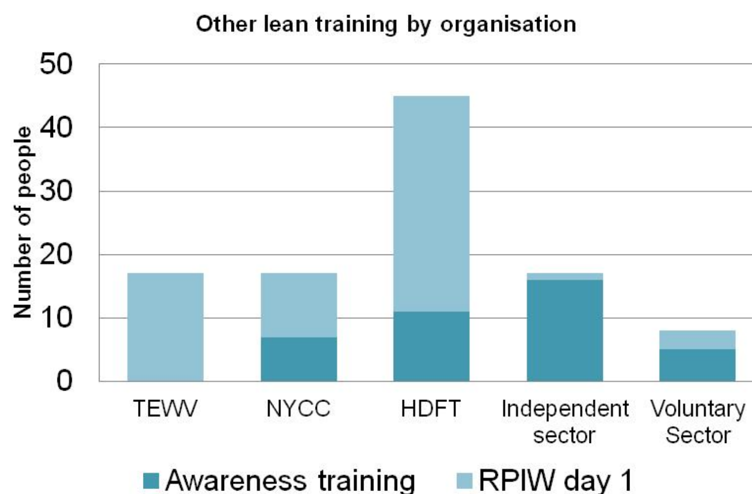


Chart 2

In an RPIW a key role is the Process Owner (PO). The PO is often not on the certified leader programme and the project provides additional training to support POs lead RPIWs.. This training has also been made available to other staff. The numbers of people who have received training, both the RPIW day 1 training, the process owner training and stakeholder training are listed in Chart 2.

5.0 Planning

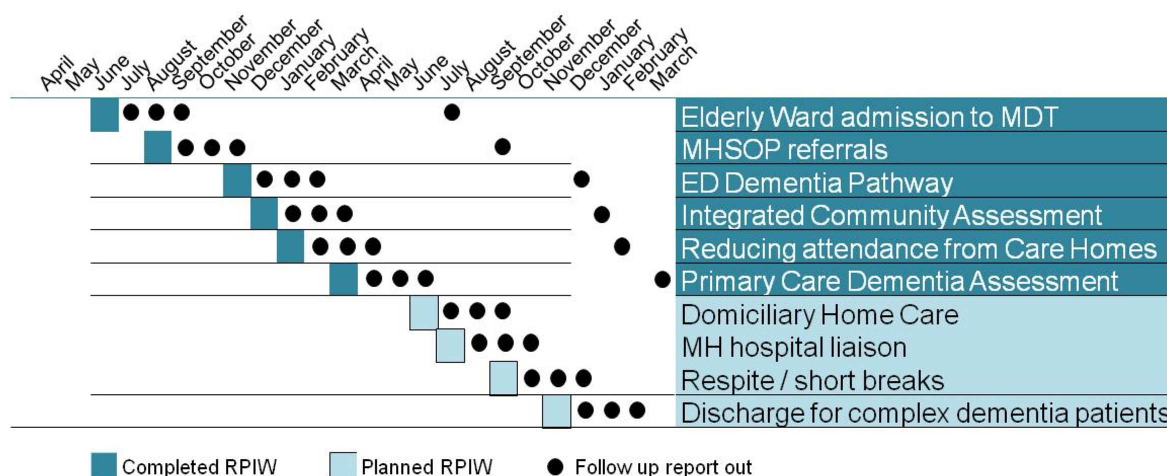
A high level mapping event took place the 17th April 2012. The event was well attended by staff from:

- Locality team members from North Yorkshire County Council
- GP representatives from Harrogate and Rural District Clinical Commissioning Group
- Medical, nursing and administrative representatives from Harrogate and District FT
- Mental Health Services for Older People
- Carers Resource
- Dementia forward

The map produced outlined the numerous processes involved in the care and assessment of an individual with a diagnosis of dementia or a suspected dementia. The map also highlighted the difficulties within those processes that may have a negative impact on patient experience and delay discharge and access to appropriate services.

A2 size maps were produced and provided to each organisation within the collaborative. This resource was used to set the RPIW themes

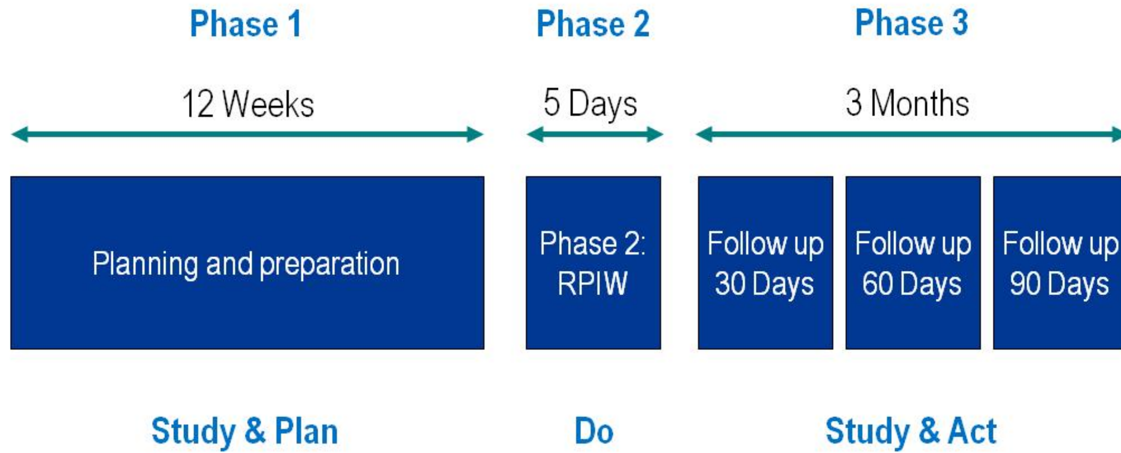
The themes within the project plan are presented below:



The year 1 RPIWs are shaded in green, the outputs and outcomes of these are reported in Section 6.

Each RPIW follows a standard planning schedule with key milestones at which progress against strict criteria is checked by those planning the event (workshop leads), the process owner and the sponsor. The process is represented in the diagram on page 14.

Standard process for the planning and delivery of an RPIW



6. RAPID PROCESS IMPROVEMENT WORKSHOPS

This section provides a high level summary of the work undertaken and the impact this has had.

6.1 The first 7 days following admission to Byland Ward; July 2012

- Sponsor: Janet Probert
- Process Owner: Anna Harper
- Number of staff involved 11

	Strategic Target	Impact on performance
1	Reduce length of stay for patients >65 with a diagnosis of Dementia From 19 days to 10 days	17.3 days (last data provided from 90 day time point) this is a 9% reduction. Data quality issues indicate more time points are required. Data requested.

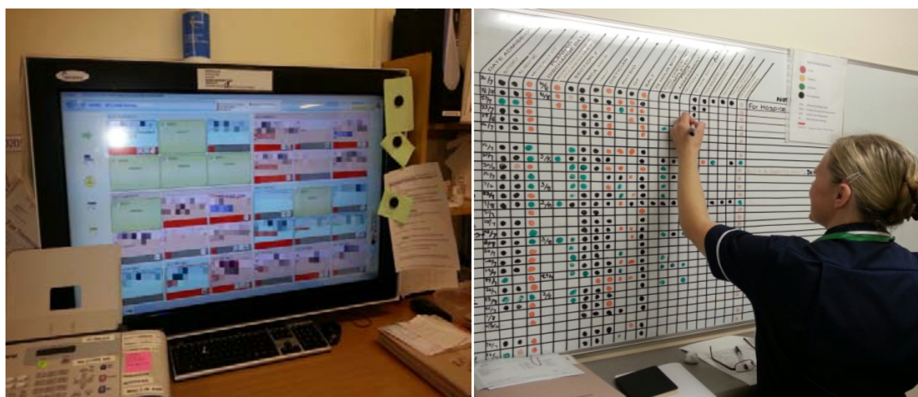
The number of Dementia patients on Byland Ward from prior to the RPIW to the 120 day point has increased by 80% from 8 out of 30 patients to 14 out of 30 patients.

	Improvement area	Action and impact
1	Improve Patient experience by increasing the number of categories scored above satisfactory in the King's Fund "Is this Ward Dementia Friendly" audit	Improvement made from 1 / 7 categories addressed to 3 / 7. The ward has improved the patient environment by using coloured bay door frames to orientate patients, better signs, coloured door frames and handles to help patients find toilets. Also a dedicated social area for patients and their families and visitors was identified and established.

	Improvement area	Action and impact
	Address the lack of information about dementia support for relatives and patients	A sign posting document to services provided by voluntary sector created during RPIW 6 has been produced to provide support and advice.
	Raise knowledge and awareness	48% of staff on Byland Ward have now received training in Dementia.
	Improve workplace organisation	• The workplace has improved from a level 1 to 3 The impact has been a saving on inventory by 53% (Chart 4) • Organising the ward has also saved walking distance, an example is 750m walking / day was estimated as saved for the process of preparing and delivering IV fluids.
	Improve timely decision making by improving the flow of information about the patient amongst the different professions and to increase the frequency of decision making	• Admissions slip amended to include mistake proof prompts • New MDT process to set up and run saves 300 min of professional time / week (chart 3) • 50% increase in patients having a discharge plan created in 72 hours (based on a review of MDT notes). • A daily decision making process now being tested from March 2013 to reduce batching of decisions • Visual control boards now rationalised and visual control now managed on the electronic boards

Environmental improvements

Pictures clockwise from top right showing: use of improved signs and coloured toilet seats and hand rails help use the facilities, coloured bay door frames and coloured door frames to locate toilets and showers, coloured frames and panels in bays help orientate patient, less wall posters improves calmness and better brighter ward notice



Pictures going clockwise, show improved workplace organisation and the new dedicated clinical preparation area, the manually updated patient flow board and the new electronic patient flow board that has superseded the

Charts 3

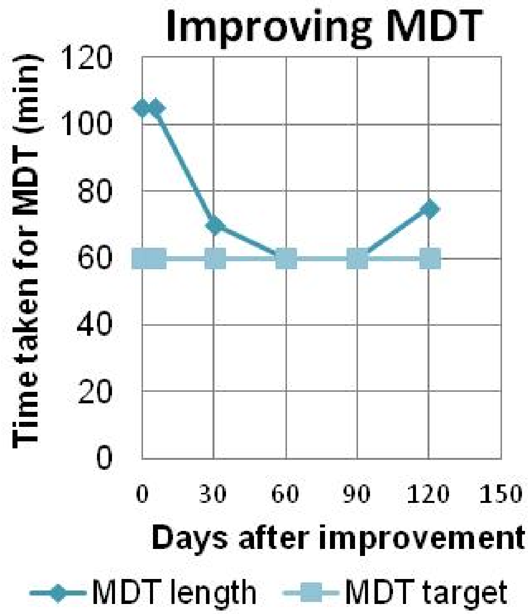
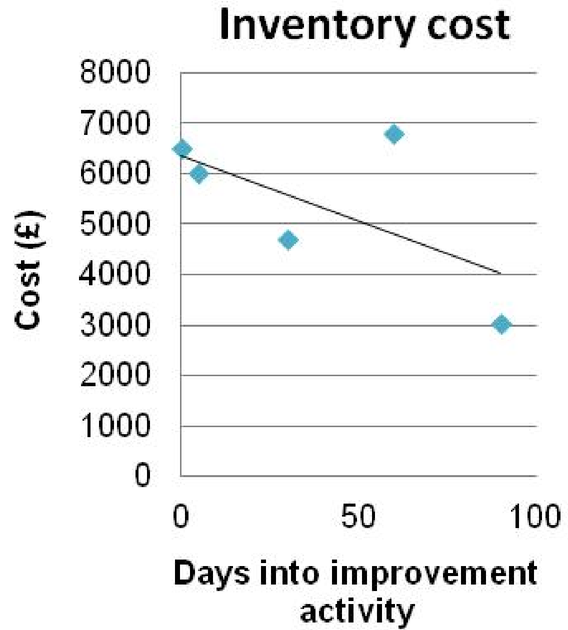


Chart 4



Shared learning

The work undertaken to improve the environment for patients living with Dementia has been used to inform work on a number of other ward locations led by the HDFT planning team including Oakdale and Jervaulx. The HDFT planning team also worked with NYCC to create a joint bid (for capital monies from DH for improving the environment. This bid was unfortunately unsuccessful.

6.2 Referral process from GPs to Mental Health Services for Older People; September 2012, Alexander House, Knaresborough

- Sponsor: Adele Coulthard and Paul Hyde
- Process Owner: Caroline Gomersall and Belinda Goode
- Number of staff involved 18

	Target	Impact on performance
1	Reduce waiting time for MHSOP services. All patients for the Memory Service to be seen by the nurse within 28 days	Target met and sustained

The solution's over there! Team games helped multi agency staff get to know each other and work together

RPIWs are hands on events. Offices were reorganised so the new, lean processes could start the week after.

Improvement area	Action and impact
Implemented one-piece continual flow to handle receipt of referral to allocation to a designated worker. The new process requires one CMHT duty worker and one admin worker. Tools used include electronic shared diaries and a visual control board that presents the caseload and casemix managed by each team member.	The process is faster • The Lead Time response to urgent referrals to RRICE reduced 85% to 24 hours • The Lead Time from receipt of referral to allocation of first appointment memory reduced 66.7% to same day • The Lead Time (minutes) from receipt of referral to allocation of first appointment memory reduced by 98% to same day • Importantly, the Lead Time from receipt of crisis referral to allocation of first appointment RRICE offered has been maintained Patients now get seen more quickly: • Number of days for patients to be seen by CMHT has been reduced by 28% to no more than 10 days • Number of days for patients to be seen by memory service has reduced by 62% to no more than 28 days

Charts 5

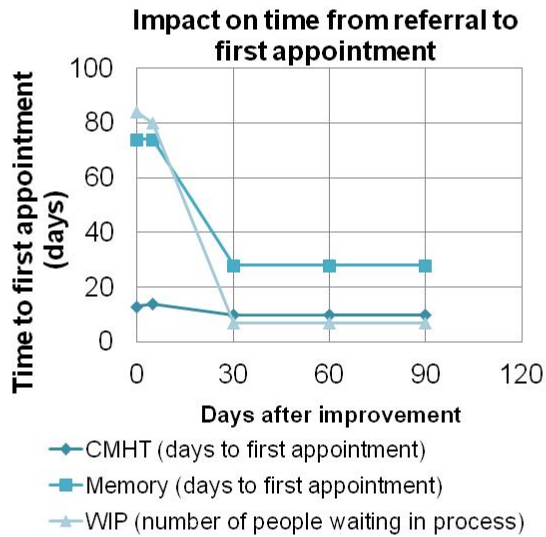
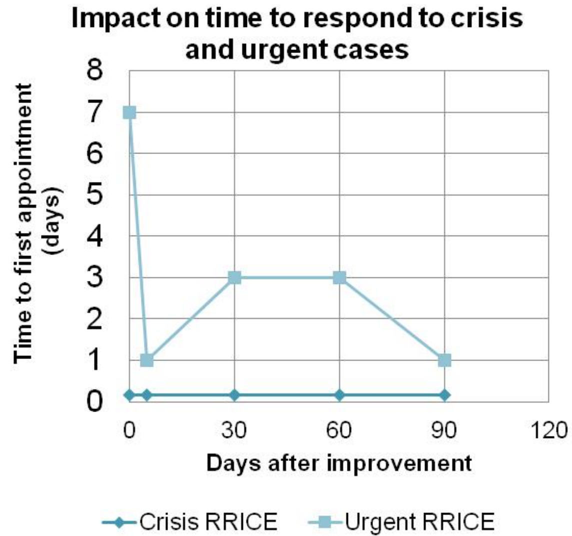


Chart 6



Note: the number of people waiting in process (WIP) are those people who have been referred but have yet to have an appointment.

The team also implemented a hot desk approach to enable better use of and access to IT equipment. Work to receive electronic referrals from GPs to reduce re-work in typing information into the CMHT's clinical system continues.

6.3 Emergency Department Dementia Pathway; 3rd to 7th December, 2012

- Sponsor: Janet Probert
- Process Owner: Tracy Mason
- Number of staff involved in RPIW; 7

The progress of this RPIW has been escalated to the Sponsor due to delays in measuring progress against targets. It is planned this will occur by 150 days (May 10th).

	Target	Impact on performance
1	Reduce length of time in ED for elderly patients with minor injuries by 30%	Trial out of hours reduced the lead time (from arrival at ED to departure) for minor injury by 42.7%. To be measured with older people in process.

Warming up was essential in the artic conditions!

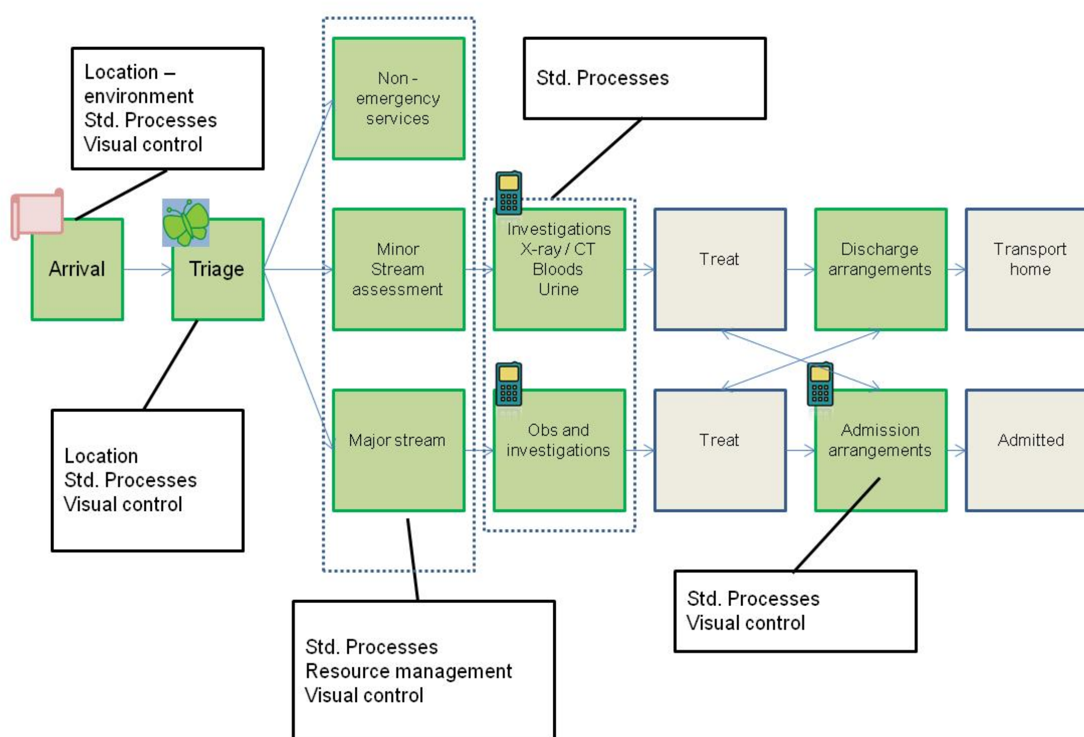
Recreating the spirit of Florence Nightingale!

Improvement area	Action and impact
Improve the identification of additional needs for older people by implementing a new triage process and the ability to identify with a butterfly (solid / outline) to inform colleagues involved in the patients care.	Lack of information about the patient need. This RPIW recommended the wider use of the Pink passport. This was taken forward in the RPIW working to reduce unnecessary attendance at ED
	Use of butterfly on clinical system. Roll out on IT system will occur with next systems release
	New standard process developed to flag additional needs to radiographers
	Additional staff have since received Dementia focused training.

Improvement area	Action and impact
New minor stream process tested and implemented out of hours to handle a key flow of patients	New triage and extended nurse practitioner-led assessment and treatment devised. Reduce lead time by 42.7 %
Delays in x-rays and CT	New minor stream process with ENP reduces lead time for x-ray by 73.3 %
New communication protocols between bed management, Fountains Ward and ED designed and VOIP phones provided to address delay in admission	Improvements did not have impact hoped for. Issues taken around admission process taken forward in a separate RPIW. New processes being tested over 30,60 and 90 days starting from June 10.

New value stream map to improve flow for patients with minor injuries

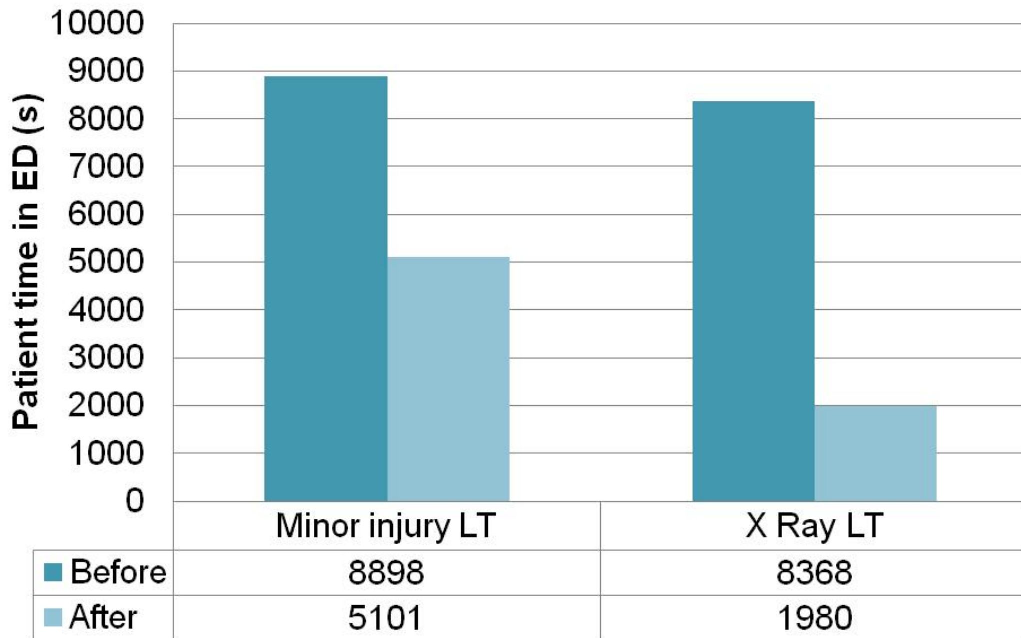
Product Quantity analysis in advance of this event illustrated that over 80% of people over 75 years old presented with a minor injury.



To meet demand, a patient needs to have been treated every 684s

Chart 7

The chart below shows the impact of the new minor stream processes run out of hours. These give a preliminary indication only and, when re-measured, only one person out of the four followed was an older person. Each bar represents the time taken to treat a patient in seconds.



6.4. Integrated Community Assessment 28th February, 2013

- Sponsor: Adele Coulthard, Helen Taylor and Janet Probert
- Process Owner: Alison Holmes (now Belinda Goode), Lynne Boyd and Mandy Welsh
- Number of staff involved in RPIW 15

	Target	Impact on performance
1	For people who need a second service, to reduce the time of the second assessment by 25% through removal of duplication	Where an individual needed a second services, the time take for the second assessment was reduced by 31%

The number of secondary referrals between the teams testing the new process has been low; five in three months.

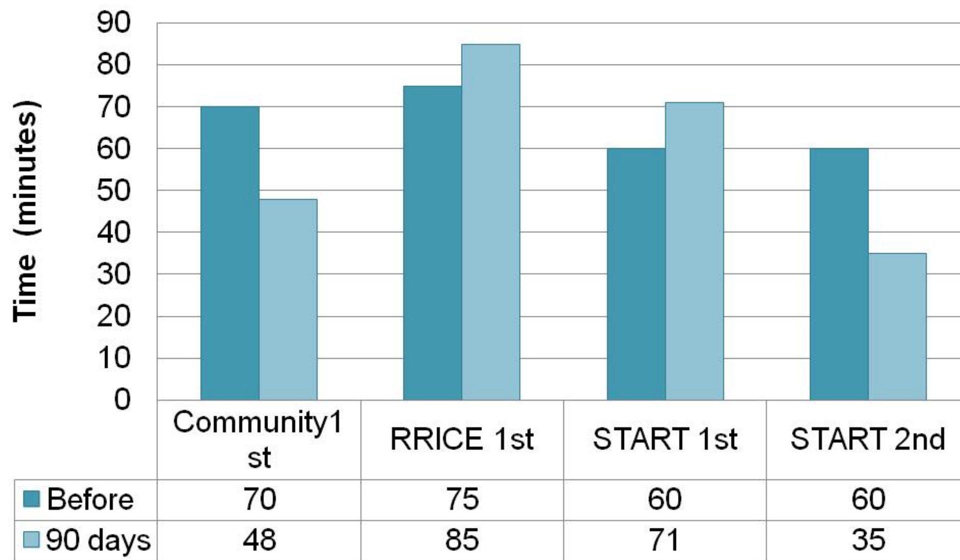
Improvement area	Action and impact
Develop a multi agency assessment tool	• The new multi agency community assessment (MACA) has been fully adopted by the Community nursing team and reduces time for first assessments by 31% to 48 min. • Using the MACA to inform the secondary assessment, that process was reduced by 10 min and is now 17.5% shorter RRICE* and START** first assessments are dictated by their IT systems and therefore their first assessments are now longer by 10 min (a 13% increase) and 21 min (35% increase) • RRICE and START have suggested the use of the MACA is only completed when referring onwards, re-measures at 90 days will be used to support evaluation because the time taken to complete the MACA is at 60 days 22.5% quicker than day 5.
• Information sharing agreements and governance agreements awaiting approval. • Secure N3 NHS mail to GSX email solution identified by NYCC. Licenses being established	• Agreement to use fax to share information until email solution • Reduction of waste to be measured once email to email solution in place
Install a feedback loop to confirm a second agency has picked up the referral and to report back signficant changes	• Acceptance of a referral has been fed back for 100% of the referrals within 48 hours
New quick guides for professionals and service guides for carers produced to reduce inappropriate referrals.	No inappropriate referrals made during testing

* **RRICE =** rapid response intermediate care service for older people with mental health problems

** **START =** *Short term assessment and reablement team*

Chart 8

This chart illustrates the change in the length of time to complete a core assessment before and after (at 90 days) of introducing the MACA (The bars each show the length of time take for assessments).



	Community1st	RRICE 1st	START 1st	START 2nd
Before	70	75	60	60
90 days	48	85	71	35

1st: for first initial assessment

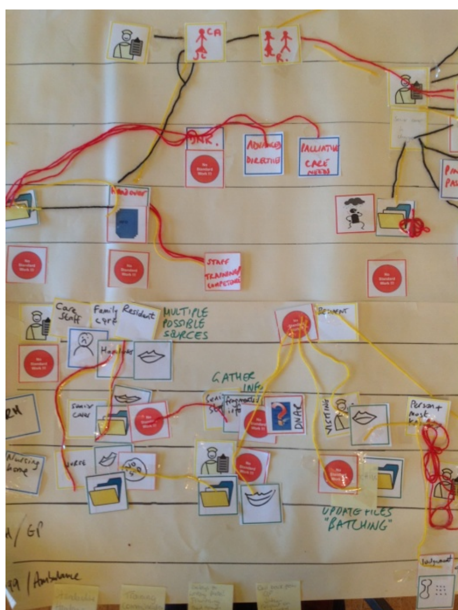
2nd: for secondary assessment (following a referral)

6.5 Reducing inappropriate attendance by residents living with Dementia from Care Homes, February 2013

- Sponsor: Angela Monaghan
- Process Owner: Terri Spruce
- Number of staff involved in RPIW: 12

Target	Impact on performance
Reduce number of residents with Dementia unnecessarily attending ED	Preliminary data only. For two care home reduction in a comparable 3 month period before and after from 12 admissions to 6. Performance data has been requested from YAS and HDFT

Improvement area	Qualitative feedback from care homes
Designed and implementing a best practice handover	• “We thought our hand-overs were good, the standard process has helped us sharpen them even more” • “Staff are now clear on their responsibilities and their role in reporting back” • “The standard process on the wall is a positive reminder to us to help run an effective handover” • “The handovers are focused with no distraction away from the job in hand”



Information flow mapping identified where communication problems were

Blinded by information! Staff were shocked by the volume of information, much was duplicated or of poor quality.

Improvement area	Qualitative feedback from care homes
Mnemonic RADAR (developed from original work by the Medicines Management Team for Vale of York CCG) introduced to meet principles in "Carers Matter - Every bodies business" for example "*Work together to involve all carers in decision making, and choices at* *all levels and at all stages in the caring role in a positive, timely and* *proactive way, following best practice in sharing information."*	• "Resident's files are updated in a more timely fashion" • "RADAR has really helped our newer staff be more confident in their communication around residents" • "RADAR has provided formalised approach to a process we expected to occur naturally" • "Because issues are reported early it has helped us catch them then when we can do something"
Designed and implementing a best practice, CQC compliant, layout of residents' files created with visual control to help find the right information	Reduce time to find information about resident by 30% (saving during simulation) • "It is really helpful that the format is the same in our 3 homes, because I then know where to look for certain information" • "Our files are now less cluttered and carry only the relevant information about the resident" • "The indexing helps when you are contacting the GP or ambulance service saving time to gather the right information together"
Establish the pink passport as the two way information vehicle to support a residents care within any environment	Rate of return of pink passports to be measured once pink passport amendments approved All care homes now incorporating the pink passport into their resident information
Designed and implementing a standard tool to support care homes escalate a resident's change in their health status.	• "When the home is really busy and chaotic, the escalation tool has been a useful prompt to help get the right information across The escalation tool has helped us proactively manage our residents" • "With the tool, out staff are much more confident in talking to GPs about a resident" • "The escalation tool is a good way of capturing the detail on care plans about action to take if a condition deteriorates "

6.6 Primary Care Dementia Assessment, May 2012

- Sponsor Rick Sweeney
- Process Owner Chris Watson
- Number of people in RPIW: 8

Target	Impact on performance
Increase rate of diagnosis from 43% for the practice	To be measured

Improvement area	Actions during RPIW
Identify patients at risk and awareness to increase demand by 100%	• All patients on GP register matching DES criteria are flagged • Patient awareness increased by increasing information available by 16% • Reception staff now have a process to raise behavioural changes to GP for more attention • Pharmacy staff now have process to inform GPs for attention change to dossett box
Dementia assessment. Target to double the number of assessments undertaken and shift work to nurse led.	• Dementia assessment process set up running via the nurse queue • Nurse led process using the MMSE • Training needs identified • One nurse trained (16%) • Assessment materials and good practice guides created • Process runs to takt time under testing
Improve sharing of information with carer	Flagging of care on clinical system
Pre-diagnostic support required	Pre diagnostic support signposting created with standard process to keep signposts accurate and up to date

7. NATIONAL DEMENTIA STRATEGY

Of 17 key objectives identified within the National Dementia Strategy to be achieved

over the next five years, seven have been prioritised for early delivery. This project has made some headway towards addressing the prioritised areas. The table below indicates how the different RPIWs impact on the different objectives.

	RPIW					
	1	2	3	4	5	6
Early intervention and diagnosis for all						
Improved community personal support services						
Implementing New Deal for Carers						
Improved quality of care for people with dementia in general hospitals						
Living well with dementia in care homes						
An informed and effective workforce						
A Joint Commissioning Strategy for Dementia						

Key to RPIWs:

- RPIW 1; First seven days on an elder dementia patient on Byland Ward
- RPIW 2; Process of referral into secondary mental health services for older people (including the memory service)
- RPIW 3: ED Dementia Pathway
- RPIW 4: Integrated Community Assessment
- RPIW 5: Reducing preventable admissions by residents with Dementia from Care homes
- RPIW 6: Primary Care Dementia Pathway

8. COMMUNICATION

The project has used newsletters to inform stakeholders about the project. These newsletters are distributed by the normal cascade mechanisms of the collaborating organisations:

- Four Quarterly Newsletters: August, October, January and April.
- Presentations: North East Dementia conference, North Yorkshire LINK Dementia Awareness Day (Harrogate), Public consultation event about local mental health service provision (Harrogate)
- Articles: Houses of Parliament (see Appendix 2) and the Harrogate Advisor (May 2013)
- The Knowledge Hub https://knowledgehub.local.gov.uk/group/harrogatedementiacollaborative/grouphub is being used to make available to a wider, professional audience the newsletters and the resources created (listed in Appendix 1)

8. Year 1 participant survey

A survey was carried out to get feedback from those involved in the Harrogate Dementia Collaborative. The survey indicated that of those who responded, they believe the collaborative:

1. Is improving cross organisation working
2. Has used tools from the lean quality improvement system in the workplace
3. Is delivering benefits to the collaborating partners and
4. Is improving service quality for people with Dementia

Charts 9 to 14 provide more detail. The survey indicates that year two needs to continue the training and awareness raising of the Quality Improvement System and the collaborative.

As the work is progressing, we are now seeing the outputs from earlier RPIWs building on later ones. For example, the awareness raising and pre diagnosis support signposting produced during the primary care RPIW has been shared with HDFT. The full catalogue of materials produced is listed in appendix 1.

9. Year 2 priorities

In year 2, the project shall focus on:

- Completing the training for 12 certified leaders
- Completing programme of 10 training RPIWs (see page 9)
- Holding a share and spread event in the locality
- Establishing a plan to take forward work on improving care and outcomes for people with dementia in the locality
- Establishing a plan to build on the relationships developed to provide benefits beyond Dementia
- Establishing a plan led by the individual organisations to maintain the skills developed through the programme
- Applying for relevant health and social care awards

Appendix 1. Catalogue of RPIW outputs by RPIW

Byland Ward; first seven days of an elderly dementia patient admission			
	Output produced	**Additional text**	**"Plan do study act" actions**
1	New Green admission slip	Cue for information about patient to mistake proof	
1	Multi disciplinary meeting (MDT) SPD	Agenda, roles and times for an MDT	Daily decision making now being trialled
1	MDT set up SPD	Ward clerk role to prepare for MDT	
1	Patient Flow Visual control SPD	White board	Use of electronic boards has superseded
1	5S level 3		
Referral process for CMHT, memory service and psychology			
	Output produced	**Additional text**	**PDSA actions**
2	Referral expectations	Guide from Scarborough MHSOP	
2	Referral receipt SPD	Standard processes for continuous flow cell	
2	Check list for urgent referrals	For staff to identify urgent case	
2	Check list SPD for duty worker		
2	Urgent referral SBARD	Communication tool	
2	Referral SPD team secretary role	Standard processes	
2	What can I expect	Patient guidance from Scarborough	
2	Confirmation letter	Standard letter to be sent to patient	
2	Electronic diaries SPD	TEWV standard work for using Outlook diaries	
2	Admin follow referral for initial assessment SPD	Admin role following assessment	
2	1st face to face contact assessor role SPD		

Referral process for C MHT, memory service and psychology continued			
2	Assessment SPD		
2	Its normal to forget	Patient leaflet	
2	Skills matrix	To support resource allocation for duty worker in cell	
2	Casemix case load	Visual control board t aid allocation of work	
2	HCA caseload progress	Visual control to ensure effective value add use of HCAs	
ED Dementia Pathway			
	Output produced	**Additional text**	**PDSA actions**
3	SPD ED coordinator		Still under testing
3	Rapid triage form		Still under testing
3	Butterfly symbol included in hospital clinical system		Still under testing
3	SPD ENP see and treat		Still under testing
3	SPD radiology order and follow up	Ordering CT scan out of hours	Still under testing
3	SPD request X ray	Change to allow prioritisation	Still under testing
3	SPD blood trolley		Still under testing
Integrated Community assessment			
	Output produced	**Additional text**	**PDSA actions**
4	MACA core assessment and SPD		
4	Obtaining consent SPD		
4	Governance statement		
4	Assessment feedback to other agencies form and SPD		
4	Change in circumstance feedback and SPD		
4	Referral acknowledgement form and standard process		
4	Patient information		
4	Professional quick reference guide for Harrogate and Rural District		

Reducing preventable admissions from care homes by residents with Dementia			
	Output produced	**Additional text**	**PDSA actions**
5	SPD documents and index guide		
5	SPD handover		
5	RADAR tool	Communication aid	
5	Escalation SPD and escalation tool	To better manage residents	
5	Key documents checklist	Mistake proof	
5	Pink Passport		
Primary Care Dementia pathway			
	Output produced	**Additional text**	**PDSA actions**
6	What is dementia?	For patient notice board	
6	“Seeking further advice”	Signpost guide to local services to provide pre diagnosis support	
6	Have you noticed?	Patient guide	
6	Terminology and phrases for use with patients about dementia	Tips for clinicians	
6	Dementia awareness checklist for Reception		
6	Dementia awareness checklist for Pharmacy		
6	SPD pharmacy raise dossett box		
6	SPD reception raising concern		
6	Mini mental health state exam	Standard process for nurses	Still under testing
6	Hints and tips MMSE	For the MMSE standard process	Still under testing
6	Nurse training matrix for assessment tool		Still under testing
6	SPD maintaining public awareness board		

Appendix 2: References to the Collaborative

Harrogate Dementia Collaborative mentions

Extract from the Houses of Parliament week ending May 17th 2013 where Right hon. Andrew Jones mentioned the work of the Harrogate Dementia Collaborative.

Andrew Jones (Harrogate and Knaresborough) (Con): It is a pleasure to follow the hon. Member for Croydon North (Mr Reed) and other Members from across the House who have given powerful speeches today. I congratulate the Backbench Business Committee on granting this debate and colleagues across the House on requesting it, particularly my right hon. Friend the Member for Sutton and Cheam (Paul Burstow).

This is an important debate because mental health is one of the last taboos in this country. There is still stigma, and that stigma has a devastating impact. The impact is on those who suffer, who can feel isolated and alone, who can face discrimination, who may be reluctant to seek help or the treatment they need and who worry that even suggesting there may be an issue will lead to pressure on families and challenges to careers. So tackling this taboo, removing this stigma, is important, and a way to do that is by encouraging openness, showing that is not just okay to talk about mental health, but right and important to do so. That is why debates such as these are so important.

The last debate we had here on the issue was one of the best I have heard since I started here. Members spoke powerfully and personally, and showed great leadership, particularly the hon. Member for North Durham (Mr Jones) and my hon. Friend the Member for Broxbourne (Mr Walker). Talking about the issue here, in our national debating chamber, helps to change attitudes. It helps those who suffer by demonstrating recognition of their challenges, and it places mental health firmly on the health policy agenda and also on our national agenda.

I have long been concerned that mental health care is a bit of a Cinderella service within our NHS, and that is why I have chosen to speak up about it more than any other health issue locally. Service users are often very vulnerable members of our community and are less able to speak up for themselves. Some of the most challenging, complex and moving pieces of casework I have had to tackle have all involved mental health issues.

Today I shall speak about two areas—dementia care and safe havens. Yesterday I attended the Alzheimer’s Society event in Portcullis House to launch dementia awareness week. Tomorrow I am opening a new care home for dementia patients in Starbeck in my constituency. We all know that dementia is an enormous problem. Every Member will deal with it in their constituency and every family will have to face it at some stage. There are an estimated 800,000 people in the United Kingdom who

suffer from Alzheimer's. In North Yorkshire we have the highest proportion of people aged 85 and over in the north, and we know that one in three people in that age category suffer from some form of cognitive impairment. That is more than 3,000 people in the Harrogate district, but we have a diagnosis rate of only 40% to 45%, so many people suffer without receiving the support they need. The average lifespan in my area for people after a dementia diagnosis is 15 years, so living with and managing the condition is critical.

Ian Swales (Redcar) (LD): I would like to raise a small point about living with the condition on behalf of my constituent, Caroline Simpson, who has dementia but is physically capable of walking a certain distance.

Her family have been unable to get a disabled person's parking badge. This is an example of the problems that occur in living with dementia.

Andrew Jones: My hon. Friend makes an important point. The challenges are not fully understood and the support that people need is not recognised. That example is just one of many forms of discrimination that can take place.

In North Yorkshire there have recently been some changes in the way the problem is tackled. The Harrogate Dementia Collaborative has been formed, which brings together different bodies. I have met the collaborative and it has told me of the progress it has made. Bringing good care together really makes a difference. It means bringing together the different providers: the local mental health trust, the foundation trust, social services and the voluntary sector.

A few ingredients have contributed to the progress that has been made: working together to provide that integration, which I have already mentioned, and cross-service working is not always easy within our public services; specialist memory nurses, who were not in place two years ago; a clearer pathway to correct and timely treatment, leading to great progress on waiting times; and a determination to provide care in the home or as locally as possible. I applaud the focus being placed on dementia nationally by the Prime Minister and by Health Ministers, both in this Government and the previous one.

When I meet mental health groups in my constituency, one of the issues they raise with me is the provision of a safe haven, a secure place where people can feel safe, and "safe" is the word that is used time and again. It is a place where they can find understanding of the challenges they face, where there is no stigma and where a supportive environment exists. Such places must be provided by local NHS mental health services, but they can also be supported by the work of the voluntary services. I would like to pay tribute to Harrogate Mind and its team, led by its chair, Mr Peter Thompson. I have visited its base, the Acorn centre on Station parade in Harrogate, and found it to be a friendly and relaxed environment with a fantastic

range of activities. Users have told me that they view it as an essential safe place for them. However, the provision of such places is also a public duty, something that must be recognised in the NHS and the police services, as the police are often on the front line in dealing with those who face mental health issues.

Lastly, I have been pleased to see the Government recognise the importance of mental health through publication of their “No health without mental health” strategy. I want to see mental health given the status it deserves.