

# Older People's Mental Health Liaison Service in an acute hospital trust: Doncaster.

## Evaluation report

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## **Foreword**

This evaluation report is the product of a great deal of hard work by many people over the last 12 months and for me is a very exciting evaluation that provides clear evidence and rationale for the commissioning of an acute Older Peoples Mental Health Liaison Service.

The initial business case for the pilot was clearly focused on the objectives of improving the outcomes and experiences of both the patient and their carers when they received services from Doncaster and Bassetlaw Foundation Trust, either as a inpatient or through attending A&E. The business case recognised that to achieve this, co-production and partnership working would be essential, but also things would need to be done differently. Underpinning this recognition was the QuIPP principles of Quality, Innovation, Productivity and Prevention.

My sincere thanks go to everyone who has contributed to this report, but also my thanks go to all those who made this pilot a success. My promise is that this report will now be considered in an effective and timely manner so a sound and robust commissioning decision can be made going forward.

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## Executive Summary

This report provides an evaluation of the Acute Older People's Mental Health Liaison Service operating in Doncaster Royal Infirmary (DRI) and Mexborough Montagu Hospitals. It is based on the analysis of data collected as part of a review led by Arc Research and Consultancy Limited that included active collaboration in quantitative data collation and analysis with Doncaster Bassetlaw Hospitals, NHS Doncaster CCG, Rotherham Doncaster and Bassetlaw Mental Health Trust and Doncaster MBC. In addition Arc Research and Consultancy Ltd undertook independent data collection and analysis of staff beliefs and attitudes, and patient and carer experiences.

Acute Older People's Mental Health (OPMH) liaison services provide mental health care to people being treated for physical health conditions in general hospitals. The co-occurrence of mental and physical health problems is very common among these patients, often leading to poorer health outcomes and increased health care costs. In 2011, in Doncaster, patients with dementia, depression or delirium co-morbidities spent on average 14 days in acute hospital. Other patients aged over 65 spent 5.5 days on average.

The introduction of a high quality, innovative liaison psychiatry service in Doncaster offers the prospect of saving money as well as improving health. The acute OPMH liaison service in Doncaster offers support to people over 65 who have mental health needs. The service is available Monday to Friday to anyone over 65 within the DRI and Mexborough Montagu hospitals. This report focuses on the impact of the service on those who have dementia, depression or delirium.

We conclude that the service generates significant cost savings and is excellent value for money.

We conclude that, in the first year of its operation, the acute OPMH service has increased ward staff beliefs that the mental health team improve the care of patients: 83% of staff participating reported 'direct, personal experience of the way the older people's mental health liaison team improve the care of people on [their] ward'. It may take time for the impact of the acute OPMH team's work to be felt in other ways. No overall impact was observed on: ward staff beliefs that they can now manage patients with mental health problems more effectively; ward staff's experience of work on the wards; or, on perceived levels of cooperation and team working on the wards.

We conclude that the acute OPMH liaison service has challenged existing models of care and adds to the quality of the following functions in DRI and Montagu settings: formulation of mental health diagnosis; formulation and management of care; formulation of discharge plans; medication.

Evidence generation systems are not adequate to allow fine-grained monitoring of patient experiences. Evidence collection mechanisms allowing a ward level analysis tied to patient number would enable more straightforward assessment of the impact of organisational changes on specific groups of patients such as these.

The service appears to have contributed to a reduction in rate of falls ( $p < 0.05$ ) experienced by patients with dementia, depression or delirium while in hospital. No such reduction was experienced by other 65+ aged patients. Changes to the rate of deaths in hospital and to discharge destinations were not statistically significant. While the data does not allow us to compare with previous years the actual levels of

complaints arising in relation to patients with dementia are at roughly 20% of the level that would be expected if they were similar to other patients. There is supporting evidence from staff to suggest that quality of care is improved by the work of the OPMH team.

We undertook a cost-benefit analysis of the acute OPMH liaison service using very conservative assumptions to ascertain whether or not the service was good value for money even if its claimed benefits are put at the bottom end of a plausible range.

The analysis of cost savings focused on the ability of the service to promote timely discharge from hospital to an appropriate discharge destination whilst avoiding an upsurge in re-admissions within 30 days. The hypothesis was that in some cases the work of the acute OPMH service would increase the numbers of bed days and in many cases it would reduce the numbers of in-patient bed-days. Based on a comparison of lengths of stay and rates of re-admission in similar groups of patients before and after the acute OPMH liaison service was introduced in January 2012, in place of a previous, very much smaller liaison service, we estimate that cost savings for patients with dementia, delirium and depression are in the range of £1.07 to £1.40 million a year.

All of the above should provide decision makers with a sound starting point for future planning. Our analysis indicates that the incremental cost of the acute OPMH liaison service is around £0.25 million a year. In comparison, we estimate on conservative assumptions that the acute OPMH liaison service generates incremental benefits in terms of reduced bed use valued at £1.32 million a year. This implies a benefit:cost ratio of more than 5:1.

During 2012, the quality improvements from this innovative new liaison service yielded an average change in length of stay of around 2 days (falling from 14 to 12 days) for the target group of patients.

In conclusion, the acute OPMH liaison service improves clinical outcomes for patients with dementia, depression and delirium by shortening their average length of stay and contributing to reduced rates of falls. Based on a review of the work that has been undertaken and the views of other ward staff, the work of the team improves quality by improving the care of patients on the wards. The acute OPMH service is good value for money for the health care system simply in terms of reducing length of stay without increasing readmissions. Any other health gains for patients are in addition to that.

## Introduction

This report provides a summative evaluation of the impact of the acute Older People's Mental Health liaison service operating in the acute hospital trust in Doncaster. The work covers the period from January to December 2012.

The report was [commissioned by NHS Doncaster Clinical Commissioning Group \(NHSD CCG\) formerly Doncaster Primary Care Trust](#) in partnership with Doncaster and Bassetlaw Hospital Trust (DBH) and Rotherham Doncaster and South Humber NHS Trust (RDASH). Work to develop the evaluation model began in June 2011.

The quantitative data underlying the findings of the report were identified, collated and analysed through the concerted and deliberate collaborative effort of Arc Research and Consultancy Ltd, NHSD CCG, RDASH, Doncaster MBC and DBH. Independent data

collection and analysis was undertaken by Arc Research and Consultancy Ltd with patients, carers, project staff and with hospital staff.

Gratitude is owed to the many people who gave their time to this work.

## **Liaison psychiatry**

The study "Counting the Cost" by the Alzheimer's Disease Society went some way to quantifying the situation encountered by people with dementia in acute hospitals<sup>1</sup>.

The report pointed out that "people with dementia over 65 years of age are currently using up to one quarter of hospital beds at any one time". They point out that the achievement of dramatically reduced waiting times and improvement on delayed discharges, whilst being a good thing in itself, has moved the emphasis from quality to quantity in many acute settings

Their study found significant levels of "unacceptable variation" in the quality of dementia care provided on acute general wards in hospitals across England, Wales and Northern Ireland. Although they found many examples of excellent local action, where the challenges of dementia are being recognised and addressed there were also examples of mediocre or neglectful care.

The report found that people with dementia stay far longer in hospital than other people who go in for the same procedure. The longer people with dementia are in hospital, the worse the effect on the symptoms of dementia and the individual's physical health. Discharge to "care home" settings becomes more likely and antipsychotic drugs are more likely to be used.

As well as the distress to the person with dementia and their families and carers, it was felt that increased length of stay was placing financial pressure on the NHS. It is clear from the evidence presented in their report that improving the experience of the large number of people with dementia in hospitals is key to improving the NHS overall and delivering the reform agenda.

The report concluded that "if people with dementia were supported to leave hospital one week earlier than they currently do, that savings of hundreds of millions of pounds might be achievable across the system as a whole".

It went on to comment that "much of the large sums of money currently spent on dementia in hospitals could be more effectively invested in workforce capacity and development, and community services outside hospitals to drive up the quality of dementia care on the wards, improve efficiency and ensure that people with dementia only access acute care when appropriate".

NICE Guidance (2006) states "*Acute Trusts should ensure that all people with suspected or known dementia using inpatient services are assessed by a liaison service that specialises in the treatment of dementia*"

These findings suggest that an effective liaison psychiatry service can promote a range of positive outcomes including cost savings.

Holmes and Montana *et al's*<sup>iii</sup> (2010) systematic review concluded: “Our findings suggest that liaison mental health services in general hospitals have the potential to be effective in improving outcomes such as length of hospital stay, discharge disposition and hospital costs”.

The RAID service in Birmingham is one such service. The RAID services focuses its work on the avoidance of admissions through efforts placed at entry and early assessment points within the hospital. In addition RAID emphasised the training of other hospital staff. It was an all age psychiatric liaison service. It was successful in demonstrating savings to the healthcare system by working in this way (Parsonage and Fossey 2011).

The OPMH liaison service in Doncaster differs from the RAID model in that it focuses on work with older people (65+) only, who have a co-morbidity of depression, dementia or delirium. Where RAID emphasises avoidance of admission, the OPMH service emphasises improving the management of care, the formulation of diagnosis and the safe and appropriate discharge of older people (65+) who have been admitted to acute hospital.

#### *The local position*

At the inception of the project there were 50,000 older people living in and around the Doncaster area with an estimated 5000 of those having some form of cognitive impairment (dementias and including mild cognitive impairments) and 3500 having some form of other mental health problems (Anxiety, Depression)

At that time, Doncaster have one district General Hospital with 655 beds. In addition there were two further hospitals under Doncaster and Bassetlaw NHS Foundation Trust in the Doncaster area, Tickhill Road Hospital with 62 rehabilitation beds and Mexborough Montagu with 56 beds.

The evidence indicates that Doncaster would have at any one time the following:

Table 1: Expected bed occupation

<b>Total Number of beds</b>	<b>773</b>
60% will be Older People	464
60% of these Older People will have Mental Health issues	278
80% of this 60% will have diagnosed or undiagnosed dementia	222
20% will have other mental health problem	56

At the beginning of the study, it is likely that at any one time that 222 patients in Doncaster Hospitals will have had dementia related co-morbidities which will affect their care and clinical outcomes and 56 patients will have other mental health difficulties which cause similar problems.

#### *The way the service delivered its work to meet this need*

The OPMH liaison service was launched in January 2012 in succession to much smaller liaison psychiatry service in Doncaster Royal Infirmary. It is part of a larger Care Home Liaison service.

The service was set up quickly and was designed with the expectation that there would be a need among patients for this service on the wards. It was not designed as a reactive

service waiting for referrals from the wards but aimed to integrate actively with emerging acute hospital multi-disciplinary teams and integrated discharge teams.

The principles of mental health work are different from a medical model in operation in many acute hospital wards in several important ways. The project team sought to bring their different skills and ways of engaging with patients with mental health problems to support care practices, clinical decisions, discharge decisions and post discharge care management.

The aims for the OPMH service were to undertake:

- Teaching activities with staff
- Diagnostic formulation
- Medicines management
- Management formulation
- Safe and appropriate discharge planning
- Second opinions on capacity
- MHA 1983 requests and medico-legal advice

Other supporting activities were:

- Indirect clinical care
- Generation of a multidisciplinary liaison service, not just team
- Contribution to dementia care pathways

See Appendix B for a more detailed description of the methods deployed by staff to undertake this work.

Key features of the OPMH liaison service model are as follows:

- The service offers a core of mental health specialist nurses plus a team leader who is also a mental health specialist, a physiotherapist, a consultant psychiatrist, a pharmacist, a care home liaison officer and three administrative workers within one multi-disciplinary team.
- All patients over the age of 65 with dementia, depression or delirium can be assessed, treated, signposted or referred appropriately.
- The service operates five days week, Monday to Friday. It emphasises meeting with all patients in the target group every day. Some of the OPMH team are allocated to particular wards. They work actively with patients and staff on those wards. Referrals are taken from the remaining wards.
- The service has provided formal awareness raising, some teaching and informal development on mental health difficulties to acute staff throughout the hospital. Staff on wards that have had an allocated OPMH staff member, received more informal development than other areas of the hospital.
- The service puts an emphasis on appropriate and timely discharge from acute wards.
- The service aimed to have an input to formulation of mental health diagnosis, medication, care management, discharge care planning and the timing of discharge decisions.

The service undertook 1031 formally logged new referrals with patients during the period January - December 2012. Many of these referrals will have had more than one contact.

The OPMH team allocated to specific wards undertook interventions with, on average, 72 people each month. Referrals from other wards averaged at 11 per month and 3 per month from A&E. Monthly rates were higher than these averages during the second half of the year. This could indicate an increase in the awareness and influence of the OPMH team as it became more established.

An estimated 175 short, informal advice, educational and training interventions were conducted by the team each month with other staff members e.g. providing advice on behaviour management.

## **Assessment of the clinical outcomes**

To what extent has the OPMH Service aligned the clinical outcomes of patients with mental health co-morbidities on acute hospital wards with other in-patients in terms of indicators such as length of stay, falls in hospital, death rates, dehydration, malnutrition and re-admissions?

Patients with dementia, depression or delirium as one of their co-morbidities on entering hospital now experience fewer falls whilst in the hospital environment than previously. At the same time, other patients aged 65+ did not experience the statistically significant changes in the rate of falls.

Example: The patient was a man, whose wife was diagnosed with dementia in Barnsley. He had his own memory impairment. The family understood dementia. The man had physical health problems too. He had been in a home and had had a fall and had not been eating or drinking. The OPMH staff member liaised with the Barnsley memory services as the son had mentioned the man had a memory problem. The man had been assessed in Barnsley and had been found to be within the normal range. The worker explained this to the son. His physical health had deteriorated. The worker did her own mental health assessment. He was now confused so he was moved nearer to the staff team on the ward. He was a high falls risk and a chair was placed next to his on the ward area so that staff could sit with him more easily to talk. Talking to him was a key way to limit the amount he walked about on the ward - so reducing his falls risk. The worker clarified things with the son and thanked the staff for taking the extra time to talk more with him.

Among DDD patients in 2012, the discharge destination rates and death rates while in hospital showed no statistically significant change ( $p < 0.05$ ).

Useful data on nutrition or hydration was not available to allow an assessment of the impact of the OPMH service on this key variable affecting patient well being in hospital.

Example: Staff had been concerned that a male patient was not eating and drinking easily. They had been helping him to eat and drink. On talking to him the OPMH staff member found he felt a stigma from being fed and helped to drink as he did not like it. He felt that he could eat and drink on his own, although slowly. She communicated this to the staff and he began to eat and drink slowly for himself. This was a small thing but one that he reported to have made a big difference to him.

The gap in the length of stay has reduced for the DDD group compared to other 65+ aged patients. DDD patients previously stayed for just over 14 days on average compared to 5.5 days on average for other 65+ patients. After the OPMH liaison service they now stay on average just under 12 days compared to 5 days for other 65+ patients. There were variations between the six most common HRGs.

Given the focus and direction of the work of the OPMH, and considering the other interventions occurring at the same time, it is plausible to attribute this marginal average difference of around 2 days to the impact of the OPMH service over and above the work of other initiatives within the hospital to reduce length of stay.

Later sections of this report deal with the calculation of this figure in more detail (cf page 15) and attribute a value to the savings this work creates.

Example: The patient was a woman in her 90s who lived with her son who was in his 70s. The son had learning difficulties. She had not been out of the house for 20 years and was not known to any services or registered with a GP. She had a long standing history of cognitive impairment but there was no medical history. For this reason it was very difficult to get a baseline for her. The son was desperate for her to go home. The woman went for surgery and may have had a delirium. It took a lot of work to unpick the situation and say what was right for her. The main options seemed to be to go to Positive Step, followed by going home; or, to go to Rowena to get a Mental Health diagnosis and then either go home or go into 24 hour care.

To get more information, time was spent by OPMH staff spent to neighbours and social care team members. The decision was made for the woman to go to residential care in the end. The concerns, after discussion with neighbours, was that when the son went out to go shopping, she would leave the house and be found wandering and the neighbours would have to take her home. The son had seemed unaware that this was happening. The risks from her behaviour and the lack of protective factors at home identified by OPMH staff were part of the best interests decision about where she went after discharge.

In conclusion, the major impact of the work of the OPMH team on patient outcomes has been to reduce the length of stay by around 2 days on average for DDD patients. Additionally, the service has contributed to the positive changes in the rate of falls among DDD patients in the hospital. There was no discernible effect on destination rates or death rates and that, while complaints arising in relation to dementia seem very low compared to what might be expected, we cannot say what, if any, impact the OPMH service has had on this.

## Patient experience and satisfaction

Patient experience measures were not sufficiently fine-grained to allow an analysis over time for patients with dementia, depression or delirium.

Complaints arising in relation to people who have dementia, were around one fifth of the level that might be expected if their rate of complaints was similar to those of other patients. Complaints data is only available for 2012. Whilst it is positive that the levels of complaints are low relative to other patients, the lack of comparison data with 2011 means we cannot draw conclusions about the impact of the OPMH liaison service on complaints. Case studies were developed with seven patients and family carers.

Quote from a patient: '[The OPMH staff member] were lovely. No complaints.'

Quote from a carer: 'The beauty of it was [the OPMH staff member] kept me informed . . . they approached me to say what sort of night he'd had. It made my time easier knowing I could just go in and spend time with him. '

Quote from patient: "I don't remember things too well, but [the OPMH staff member] was nice. [She] helped me".

Quote from carer: "Ward X was not the correct ward for him to be on so they transferred him to Gresley Ward. In my opinion this was like going into a totally different hospital. They were geared up."

Quote from carer "[the OPMH staff member] picked up instantly that Harry was 'in Lingfield' in Surrey where he had been as a child. "

The case studies illustrate how the OPMH team can impact positively on the care of patients. These experiences also provided examples of locations within the hospital that had managed the care of people with mental health problems well and locations that had not (See Appendix D for the case studies).

## Impact on staff

The OPMH team aimed to provide active support, education and training to other staff members on wards within the hospital. The extent of their activity in this area suggests that they did do this. We sought to establish what impact this had upon the experience and satisfaction of ward staff caring for patients with mental health co-morbidities on acute hospital wards.

A staff survey was undertaken across the wards where OPMH staff worked on two occasions. The survey considered four constructs. These were:

- General views about work in the ward and hospital
- Cooperation and team working
- Work with MH patients
- The extent of knowledge about the work of the MH team

A MANOVA statistical analysis was applied to the survey data. It was found to be significant overall (n=122 at time point one and n=66 at time point two; p<0.05). Only one construct showed significant differences within this, however.

There was no evidence of impact from the OPMH liaison service on staff's general views about work in the ward and hospital; on staff's views about levels of cooperation and team working; or, staff's views about work with patients with mental health needs.

This means that staff views about their general working environment and about levels of cooperation have not changed over the time period.

Interestingly, staff were not more confident that they could manage the care of patients with mental health needs than they had been before the OPMH team began its work. This raises a question about the effectiveness of the training and educational input that has been offered. Further analysis of the survey data may allow greater clarity to emerge about the current beliefs of staff about their capability to manage the care of these patients.

There were changes however in the extent of knowledge among staff about the work of the OPMH team.

Specifically, after one year of delivery, 83% of staff participating reported 'direct, personal experience of the way the older people's mental health liaison team improve the care of people on [their] ward'.

'Mental health involvement has improved my work and [level of] involvement when assessing clients. Rehabilitation, orthopaedic and surgical [staff] often in my opinion struggle with patients who have mental health issues.'

Quote from a ward doctor: 'I find her input very helpful. She adds to the understanding we have about the patients . . . [as] she is able to search into their backgrounds and find out things that we would not otherwise know.'

Consultant Geriatrician: 'The OPMH team are able to conduct an accurate assessment of mood and behaviour and decide on the most appropriate form of treatment, in collaboration with the patient, their carers and the clinical team.'

Similarly, three quarters of the ward staff participating felt that the "work of the OPMH liaison team either sometimes, mostly or always meant that patients went home early". 32% felt this was either mostly or always the case.

Quote from a staff nurse: 'She has been fantastic. She's been able to do things I do not have the time to do.'

Quote from a discharge facilitator: 'I couldn't do without her. We work very well together.'

Quote from an allied professional: 'The support, presence [and] contribution of OPMH have been valuable in everyway. We don't want to lose their contribution.'

'Older peoples' mental health is working very well within IDT. Especially [OPMH staff member: ZA].'

Quote from a Consultant Geriatrician 'The OPMH staff work closely with the integrated discharge team (IDT) to facilitate early and safe discharge from the hospital. The patients benefit from this relationship, as usually the IDT team do not know the patient and their issues as deeply as the OPMH who are able to spend more time with the patient, identifying their concerns and needs.'

A patient and her daughter had been very anxious about going home: 'The patient had a very poor memory - she'd forget about the cooker [at home]. [The OPMH staff member] persuaded the daughter that a microwave would be safer. The patient was concerned that she wouldn't have a cooker, repeating her concerns many times: "You are going to put a cooker in aren't you?". [The OPMH staff member] went through everything twice or more, calmed the daughter and kept reiterating with the patient who eventually calmed and became used to the idea herself. It was a lovely outcome because it meant she could go home.'

(see Appendix C for an explanation of the methods used).

In conclusion, the OPMH liaison team has not had an overall impact on the attitudes and beliefs of staff about their working environment, about levels of cooperation between staff, or about their confidence in working with patients with mental health problems.

The major difference has been that other staff are now more likely to believe that the OPMH liaison team can deliver meaningful improvements to care and length of stay through their direct work with patients.

## Economic evaluation

As noted in the introduction, there are cost savings in the local health economy that are attributable to the OPMH service. Savings were identified and valued in three areas: reduced length of stay among acute patients aged 65+ in DRI and Mexborough Montagu; avoidance of admissions to general wards at DRI after patients have been seen in A&E; Readmissions within 30 days. There was no change in readmission rates during the period. The evaluation's estimates of minimum and maximum annual savings (2009/10 prices) in each of these areas are shown in Table 2:

Table 2: Cost savings estimated due to changes to length of stay and readmissions.

	Minimum savings p.a.	Maximum savings p.a.
[1] Length of stay patients age 65+ who do not have DDD	£3.02m	£3.15m
[2] Length of stay of DDD patients only	£1.48m	£1.64m
[3] The effect of the change in ratio of bed days between DDD and other 65+ patients	£1.20m	£1.51m
[4] Avoidance of admissions at A&E	£0.12m	£0.14m
[5] Readmissions	£zero	£zero
[6] Total additional savings among DDD patients only arising from OPMH work [3+4]	£ 1.32m	£1.65m
[7] Total savings arising among DDD patients [2+4]	£1.7m	£1.8m
[8] Total savings arising among other 65+ patients [1]	£3.0m	£3.2m
[9] Total savings arising from changes to length of stay among all 65+ patients [1+2+4]	£4.6m	£4.8m

Taking only data for patients that have DDD (Row 6 in Table 2), at a mid-point of these estimates, aggregate savings are around £1.49m million a year. This compares with an estimated additional cost of the OPMH liaison service of around £0.25 per annum. The estimated cost savings are based on an analysis of administrative data on patient admissions and discharges.

The gain from the OPMH service is seen to be £1.24 million.

Data on four groups of patients are used in this analysis: first, a retrospective (pre-OPMH) control group, consisting of all patients aged over 65 who included a mental health diagnostic code for dementia, depression or delirium who were present on a

ward between 1st February 2011 and 31 October 2011; and second, an intervention group, consisting of all such admissions between 1st February 2012 and 31st October 2012. The third and fourth groups are formed from non-DDD patients aged 65+ for each of these time periods.

The data on patient admissions and discharges were used in various ways for the estimation of cost savings in the three areas identified above.

### *Length of stay*

Patient length of stay is affected by a wide range of factors. To explore the OPMH liaison effect a Health Intelligence Specialist recommended following the method used for the Variation in Inpatient Activity tool (VIA tool). This tool was developed to analyse hospital activity for diabetes patients. We are grateful to the Yorkshire & Humber Public Health Observatory (YHPHO) for their advice.

This method compares the actual and expected number of bed days for patients with Dementia, Delirium or Depression (DDD). 'Expected' figures are calculated by assuming those with DDD have the same bed occupation as patients without dementia of a similar age.

This can also be used to compare one patient group across two time periods, i.e. the actual DDD bed days in 2012 against the 'expected' bed days, assuming the DDD patients experienced the same bed occupation as those in 2011. (See Appendix A for an explanation of this analysis).

Bed occupation rates are known to vary by age. Use was therefore made of an aged standardised design in which the bed days spent by patients with dementia, delirium or depression in the intervention group were compared with corresponding patients in the control group. The analysis was undertaken making comparisons between the number of bed days within each group of patients. The differences in length of stay between the OPMH and pre-OPMH group were found to be statistically significant overall ( $p < 0.05$ ) and for each of the top six Hospital Resource Groups (HRGs) on admissions. This was true for both the DDD and non-DDD over 65 patients (See Appendix A for an explanation of the method used).

Comparisons of the average length of stay of DDD patients in the OPMH sample was 2.42 days shorter than among patients in the pre-OPMH control group. These differences represented 4228 days saved between the two groups over a 9 month period, equivalent to 5,637 bed-days in a full year.

However, during this period non-DDD patients aged 65+ also experienced a reduction in length of stay of 0.47 days on average. Since we are only interested in the effects of an intervention aimed at people with DDDs we have removed the effect of this reduction from the analysis. We have done this by analysing the change over time in ratio of DDD to non-DDD bed days. This allows us to separate out the impact of the OPMH service from the effect of other efforts to reduce length of stay within the hospital. On average the reduction in the length of stay attributable to the OPMH service for DDD patients was 2.07 days.

One point is that older DDD patients (over 75) had more bed days than expected if compared to younger DDD patients, a difference that increased from 2011 to 2012. The implication is that the pilot may benefit younger DDD patients more than older patients.

Gains in bed days may be more difficult to realise among older patients who may have more complex care needs both inside and outside of hospital.

The cost of a bed-day is put at £264.15, implying total annual savings in the range of £1.20 million to £1.51 million per year. The £1.20 million minimum estimate given in Table 2 is a statistically generated figure based on 95% confidence intervals.

#### *A&E admission avoidance*

There were 38 people referred from A&E to the OPMH team from January to December 2012 who were not admitted in response to the OPMH intervention. The savings from this source were estimated at a minimum of £120,000 and a maximum of £141,000 per year (based on 95% confidence intervals).

#### *Re-admissions*

The small changes to readmission rates between 2011 and 2012 were not statistically significant. While this results in no savings, it also suggests that risks are being well managed by the work of the OPMH team as it collaborates with others to ensure post-discharge care is in place.

#### *Gains arising from the OPMH liaison service on patients that do not have dementia, depression and delirium.*

We hypothesised that there may be positive impacts on care and outcomes for other patients in the same ward as those receiving the intervention. Where additional support is offered to improve the diagnosis and management of care of one group of patients whose behaviour and care needs may often be relatively demanding, the care of other patients in that environment may also be enhanced.

During the period of the study the age standardised bed days of non-DDD patients aged 65+ fell by an average of 0.47 days. In 2012, this represented 8,694 fewer bed days than would have been expected if the patients had experienced the same bed occupation as 2011. As we have seen in Table 2 (Row 8) this equates to a saving to the health care system of a minimum of £3.0m.

We cannot be certain about the extent to which the OPMH team's training and awareness raising efforts, together with the interventions they have offered on the wards, has effected this change in length of stay.

The OPMH staff have deliberately attempted to influence care and outcomes for patients with dementia, depression and delirium through work with other staff and their own interventions with patients. At its peak the OPMH team estimate they undertook 160-240 informal training, advice and educational interventions each month to provide support to other wards staff. Allowing for staffing changes and illness this equates to roughly 2,100 per year. The OPMH team logged referrals amounting to on average a further 85 formal interventions with patients each month (1031 for the year).

The staff survey, however, while showing statistically significant findings overall, shows no change in the beliefs and confidence of staff in their own ability to manage patients with mental health problems. However, staff are more aware of the work of the OPMH team and its role (see Appendix C: The staff survey). A rise over time in the number of

referrals from other wards also supports the notion staff are increasingly willing and able to identify appropriate cases to refer for OPMH input.

There is evidence of improved care and support to DDD patients from the OPMH staff working on the wards. We may infer that the OPMH service has contributed at least to some degree to the reductions in length of stay experienced by non-DDD 65+ patients on the same wards.

*Other factors that may impact on the reduction in bed days among patients aged 65+*

There are some other important factors that may impact on the reduction in bed days. These include three important hospital and community based initiatives.

In December 2011 a multi-disciplinary discharge team was introduced. The teams included Social Workers, Community Nurses, Occupational Therapists and Physiotherapists and was put in place to support the discharge process. During the planning for this service the OPMH liaison service had been identified as meeting the needs of this team to respond to the mental health needs of patients. The team's knowledge of care services in the community might be expected to contribute to positive risk taking within decisions to send patients home.

In December, 2011, just before the start of the OPMH liaison service, a social care assessment unit was set up (known as Positive Step). The aim was to provide a separate unit of 25 beds as a place to discharge those whose only reason for being in hospital was because they were waiting for a social care assessment. Positive Step included staff who were social care assistants. It is managed by the Local Authority. Positive Step might be expected to increase the number of people discharged earlier than they otherwise would have been.

Rapid response support, at discharge, for people in their own homes, was changed. In collaboration with the Local Authority, the Community Intermediate Care Team and the Local Authority Home Care teams were merged. This might be expected to have an impact on re-admission rates if care quality was improved. An effect on length of stay might also be expected if the Multi-disciplinary Integrated Discharge Team's confidence was improved about the safety of discharge into people's homes.

*Commentary*

Cost savings quantified include only savings generated within the Doncaster hospitals. All of these savings occur within the Doncaster health economy. The savings are described from an NHS perspective. There may be other economic consequences that are not included within this analysis for example within the care sector, local authority social services and among family carers.

To which health organisations the financial savings indicated by these results accrue will be determined by the intricacies of the payment by results system. It is an oversimplification to say that because there is a fall in the number of bed days experienced that it will be the commissioner that experiences the financial savings. For example, payments are made to the hospital trust using a formula that includes payments for each patient episode, that do not vary with the number of bed days used,

up to an agreed 'trim point'. When the number of days exceeds the 'trim point' this prompts extra payments.

Savings made will be distributed to providers and commissioners in line with the complexities of the 'trim point' system.

Which organisation receives the benefit of these savings does not bear on the judgement of whether or not the OPMH liaison service may be said to be good value for money.

#### Other costs and savings to the health care system

As part of their role OPMH team members signpost refer or encourage the referral of patients for therapies, further assessment and diagnosis by other health care providers both within the hospital (e.g. physiotherapy, psychotherapy) and outside the hospital (memory services, GPs for monitoring). Further analysis would be needed to assess the extent that these services would not have been used otherwise and the costs of their use to the health economy.

Qualitative evidence suggests the service may impact on choice of medications used both within the hospital and after discharge. Further analysis would be needed to assess the costs of changes to medication prescribed in the hospital and subsequently on discharge by GPs.

The input from OPMH liaison staff with patients with mental health problems should lead to the use of appropriate mental health pathways by these patients. This may result in improved mental health outcomes for these patients.

#### Methodology

The evaluation used a non-randomised design involving the use of a retrospective control group, where outcomes were compared with the outcomes from a group of patients who did not experience the new service.

A Randomised Controlled Trial was not appropriate in this case. This is because all of the patients would be expected to receive some of the benefit from the new service as OPMH staff were involved in training, awareness raising and work on all of the wards with the target group of patients.

To allow for sources of bias between the control and intervention groups we used and Standard Mortality Rate (SMR) method.

This method compares the actual and expected number of bed days for patients with DDD (dementia, delirium and depression). 'Expected' figures are calculated by assuming those with DDD have the same bed occupation as patients without dementia of a similar age.

This can also be used to compare one patient group across two time periods, i.e. the actual DDD bed days in 2012 against the 'expected' bed days, assuming the DDD patients experienced the same bed occupation as those in 2011.

This has been achieved by calculating an indirect standardised rate – in this case a Standardised Mortality Ratio (SMR). This technique controls for age so that differences in the outcomes are independent of the age structure of the patients concerned. Though

frequently used to measure mortality, an SMR can be applied to any count of events, in this instance the number of days spent in hospital.

#### Some limitations of the approach

An SMR standardises for age but does not control for other variables that might explain the differences between two patient groups. It is a simple form of analysis compared to more sophisticated techniques, such as regression models.

#### Strengths

The overall dataset contains a high number of patients and bed days – this makes the 'total' results less susceptible to random variation that can arise due to low numbers, meaning the confidence intervals are narrow.

Indirect standardisation minimises variance, giving a smaller standard error and narrower confidence intervals than the direct method. It is therefore useful when dealing with statistical significance of small population.

Mortality SMRs are reliant on the accuracy of population estimates and the correct coding of deaths, both of which can introduce error. In contrast, the data used in this study is of high quality - the number of patients, their length of stay and the reason for their admission is well understood and reliably recorded.

## **Conclusion to the assessment of economic cost and benefit**

The starting point for the assessment of economic cost and benefit are how the costs and benefits compare to 'service as usual'. Do the extra benefits of the new service outweigh the extra costs.

We compared the cost and benefits of the new OPMH liaison service with the previous small scale service in operation. The benefits were assessed during a period that included engaging new staff and building the team and its relationships with the acute hospital ward staff. The measures used in the study design compare the outcomes in terms of bed days, readmissions and admissions avoided in the two circumstances.

The additional cost of the OPMH service, over and above the cost of the previous service, was £0.25m. How much do the additional benefits of the reduced bed days achieved by the OPMH service exceed the additional costs of this service?

Following Parsonage and Fossey (2011) we will take a conservative approach to assessing the value of bed days. They note that hospital costs declines with length of stay. For this reason we will use marginal bed day costs to estimate the value attributable to the OPMH liaison service.

We have used a figure of £264.15 per day based on the marginal or 'excess' bed day cost as used in payment by results. This is derived from a national average figure (2009/10) of £255 that has been adjusted by a market forces factor appropriate to Doncaster.

We calculate that, measured in this way, the total additional savings from the OPMH service were £1.49m a year. This equates to 5,637 saved bed days a year at £264.15 per bed day. More conservative cost assumptions that allow for cost savings and the bottom end of the probable range put this value at £1.32m a year.

The total additional costs of the OPMH liaison service are £0.25m. Using the more conservative cost assumptions, this produces a benefit:cost ratio of just over 5:1.

These benefits are in addition to any direct health benefits that may have accrued from the service.

Two points of interest may be noted: first, of the total bed-days saved, 83% come from the wards where the OPMH staff were allocated to work directly with patients and only 17% from referrals from other wards within the hospital. This implies that direct management of patients has had bigger impact on length of stay among these 65+ patients who have dementia, depression or delirium, than the awareness raising activity and formal and informal training of staff has had. This is reflected in the staff survey where on average staff confidence in dealing with mental health issues has not improved; and also that around 80% of staff had 'direct, personal experience of the way the older people's mental health liaison team improve the care of people on [their] ward'.

The second point is that this finding adds to the findings from the recent RAID study (Parsonage and Fossey 2011<sup>iii</sup>). The RAID study found roughly the opposite position, where direct work with patients resulted in only 9% of savings and the training effects were much stronger resulting in the remaining 91% of the savings. However, the RAID service focussed on all ages with an emphasis on interventions at MAU to prevent admissions. The OPMH liaison service focused on appropriate and timely discharge once a patient had been admitted, and a small component of the work was also to take referrals from A&E. The indications are that there are gains to be made both from direct mental health input into inpatient care among older people and into all age admission prevention.

## **Areas for further development**

### *Staff development*

Further analysis of the staff survey data may yield insight into where to focus the development of staff confidence and capability to manage the care of people with mental health problems.

### *Monitoring and patient experience*

Improvements to monitoring systems and patient experience and feedback systems to allow a more fine-grained analysis, particularly at ward level, would facilitate the tracking of organisational changes to allow the speedy assessment of their impact.

## **Appendix A: Methods: analysis of occupied bed days and readmissions and cost calculations**

### Statistical Method

Advice was sought from the Yorkshire & Humber Public Health Observatory (YHPHO) regarding analysis of hospital activity data. A Health Intelligence Specialist recommended following the method used for the Variation in Inpatient Activity tool (VIA tool). This tool was developed to analyse hospital activity for diabetes patients.

This method compares the actual and expected number of bed days for patients with DDD (dementia, delirium and depression). 'Expected' figures are calculated by assuming those with DDD have the same bed occupation as patients without dementia of a similar age.

This can also be used to compare one patient group across two time periods, i.e. the actual DDD bed days in 2012 against the 'expected' bed days, assuming the DDD patients experienced the same bed occupation as those in 2011.

This has been achieved by calculating an indirect standardised rate – in this case a Standardised Mortality Ratio (SMR). This technique controls for age so that differences in the outcomes are independent of the age structure of the patients concerned. Though frequently used to measure mortality, an SMR can be applied to any count of events, in this instance the number of days spent in hospital.

Worked example;

	DDD patients		Non-DDD patients		Reference rates	Expected days
	Actual days	Actual no. patients	Reference days	Reference no. patients		
65-69	834	113	12,098	3,661	3.31	373
70-74	1,626	160	14,611	3,899	3.75	600
75-79	2,613	241	17,802	4,091	4.35	1,049
80-84	6,929	533	19,974	3,472	5.75	3,066
85+	9,900	818	28,855	3,539	8.15	6,670
Total	<b>21,902</b>	1,865	93,340	18,662		<b>11,758</b>

SMR (actual / expected) = 21,902 / 11,758 = 186.3,

Percentage difference (SMR – 100) = 186.3 – 100 = +86.3%

DDD patients spent a total of 21,902 days in hospital between February and October 2012. If they have experienced the same length of stay as non-DDD patients, after adjusting for age, we would ‘expect’ these patients to only record 11,758 days. Converting this to a ratio this equates to an SMR or 186.3, or 86.3% more days than ‘expected’.

This method has then been repeated to compare different pairs of outcomes, for instance;

- DDD in 2011 (actual) versus 65+ in 2011 (expected),
- DDD in 2012 (actual) versus 65+ in 2012 (expected),
- DDD in 2012 (actual) versus DDD in 2011 (expected),
- 65+ in 2012 (actual) versus 65+ in 2012 (expected)
- DDD aged 75+ (actual) versus DDD aged <75 (expected)\*
- 65+ aged 75+ (actual) versus 65+ aged <75 (expected)\*

\*The latter two are not age-standardised using the SMR method as age is the variable of interest.

The data has also been analysed by six Health Resource Groups (HRGs) for each of these iterations (cardiovascular, influenza & pneumonia, injuries to the hip & thigh, other diseases of the urinary system, circulatory & respiratory disease, and nervous & musculoskeletal systems).

Once the actual, expected, SMR and percentage change has been calculated, the figures can be visualised using charts.

### **Strengths and limitations**

Admissions and length of stay vary greatly with age. Such variation complicates comparisons between two patient groups that have different age structures. If one group is older than another then we would expect this group to have more admissions and a longer length of stay. An SMR is an indirect method of standardisation to address this issue.

Indirect methods apply age-specific rates from a reference group to the group of interest to give an expected number of events – observed and expected counts can then be compared. Direct methods work in the opposite direction – age-specific rates from the group of interest are applied to a standard population to give a rate that would occur in the subject group if it had the standard age-profile.

### Limitations

SMRs cannot be used to compare different patient groups directly because each group weighs the age-specific rates differently. Two groups can be compared to the same reference group but should not be directly compared to each other.

As an example;

	Subject group	Reference group
SMR comparing DDD and 65+ in 2011	DDD in 2011	65+ in 2011
SMR comparing 65+ in 2011 and 2012	65+ in 2012	65+ in 2011

Though both SMRs use the same reference group, the two SMRs should not be compared with each other. This prevents a cross comparison of results, limiting the inferences that can be made. This also means that the results cannot be compared with SMRs derived from studies in other areas or hospitals.

An SMR standardises for age but does not control for other variables that might explain the differences between two patient groups. It is a simple form of analysis compared to more sophisticated techniques, such as regression models. Some less common HRGs have a low number of patients, particularly for the DDD category. This introduces greater variation and widens the confidence intervals, making the results less precise.

### Strengths

The overall dataset contains a high number of patients and bed days – this makes the ‘total’ results less susceptible to random variation that can arise due to low numbers, meaning the confidence intervals are narrow.

Indirect standardisation minimises variance, giving a smaller standard error and narrower confidence intervals than the direct method. It is therefore more appropriate when dealing with statistical significance of small population. This is relevant to those Healthcare Resource Groups (HRGs) with low counts, and is why indirect standardisation has been used rather than direct standardisation. Mortality SMRs are reliant on the accuracy of population estimates and the correct coding of deaths, both of which can introduce error. In contrast, the data used in this study is of high quality - the number of patients, their length of stay and the reason for their admission is well understood and reliably recorded.

### Useful links

Variation in Inpatient Activity (VIA) tool;

<http://www.yhpho.org.uk/default.aspx?RID=105866>

Technical brief describing common public health statistics, including SMRs;

<http://www.apho.org.uk/resource/item.aspx?RID=48457>

Table 3, below shows the calculation of figures in Table 2 in the main document.

Table 3: Cost savings estimated due to changes to length of stay and readmissions.

	Minimum savings p.a.	Maximum savings p.a.
[1] Length of stay patients age 65+ who do not have DDD	$18,662 \times 4/3 \times 0.46 \text{ days} \times \pounds 264.15 = \pounds 3,023,468$ = £3.02m	$18,662 \times 4/3 \times 0.48 \text{ days} \times \pounds 264.15 = \pounds 3,154,823$ = £3.15m
[2] Length of stay of DDD patients only	$1,865 \times 4/3 \times 2.35 \text{ days} \times \pounds 264.15 = \pounds 1,543,605$ = £1.48m	$1,865 \times 4/3 \times 2.49 \text{ days} \times \pounds 264.15 = \pounds 1,635,555$ = £1.64m
[3] The effect of the change in ratio of bed days between DDD and other 65+ patients	$1,865 \times 4/3 \times 1.83 \text{ days} \times \pounds 264.15 = \pounds 1,202,040$ = £1.20m	$1,865 \times 4/3 \times 2.30 \text{ days} \times \pounds 264.15 = \pounds 1,510,762$ = £1.51m
[4] Avoidance of admissions at A&E	$38 \times 11.96 \times \pounds 264.15 = \pounds 120,051$ = £0.12m	$38 \times 14.09 \times \pounds 264.15 = \pounds 141,431$ = £0.14m
[5] Readmissions	£zero	£zero
[6] Total additional savings among DDD patients only arising from OPMH work [3+4]	£ 1.32m	£1.65m
[7] Total savings arising among DDD patients [2+4]	£1.7m	£1.8m
[8] Total savings arising among other 65+ patients [1]	£3.0m	£3.2m
[9] Total savings arising from changes to length of stay among all 65+ patients [1+2+4]	£4.6m	£4.8m

## **Appendix B: The work of the OPMH liaison service.**

### ***1.0 Introduction***

This appendix describes the work of the Older People's Mental Health (OPMH) liaison team in the acute hospitals in Doncaster. It draws on the team's experiences and includes some of the successes and the challenges they have faced.

The principles of mental health work differ from the medical model in operation in many acute hospital wards in several important ways. The OPMH team sought to bring their different skills and ways of engaging with patients with mental health problems to support care practices, clinical decisions, discharge decisions and post discharge care management.

The role of OPMH staff is seen as being to look more broadly at the person. Mental health is looked at as an experience.

'Does [the patient] want this changing? We do not treat the problem. We ask what the impact is on the person's life and ask how is the best way to work with this? It is not the same as 'treat the problem'.'

### ***2.0 The team***

The OPMH team comprises one 0.5 whole time equivalent band 8 mental health nurse, one whole time equivalent band 7 with operational responsibility for the team and four band 6s. There is a mental health trained physiotherapist and administrative support. Towards the end of 2012, one 0.5 whole time equivalent pharmacist was engaged. There is one 0.2 whole time equivalent consultant psychiatrist who provides input with acute patients.

The OPMH team is part of a wider Care Home Liaison team located in the Mental Health Trust.

All but one of the OPMH team members was allocated to a specific group of wards. For most, referrals come from the nursing staff on their wards and through personally identifying patients that need assessment. The workers see the patients that are identified with a problem or where staff are uncertain over whether the presenting symptoms are a delirium, depression or dementia. The workers do MH assessments e.g. looking at bloods for infection, medicines, exploring the patients social history and using assessment tools.

These patients often have complex needs.

The one staff member who does not have an allocated set of wards takes referrals from across the hospital including A&E and MAU.

### **2.1 The role of the specialist mental health nurses**

The role of OPMH Mental Health specialist nurses working on acute wards was to:

- Conduct timely, specialised assessment and formulation of care, making recommendations to support identified needs and risks.
- Offer support, information and advice to ward professionals, patients and their family.
- To be a resource for ward staff patients and families, improving understanding of mental health and wellbeing, reducing stigma and improving dignity.
- Facilitate a better overall experience on the wards for patients who have mental health difficulties.
- Advocate for patient's rights and wishes.
- Work collaboratively with other services and families to formulate safe and effective care management and timely discharge planning.
- Provide better quality of care so patients were not disadvantaged because of their mental illness.

OPMH workers provide opportunities to discuss thoughts and any concerns, identifying any potential unmet needs, or may prompt ward staff members to do so.

## **2.2 The role of the OPMH Physiotherapist**

The role of the OPMH team physiotherapist is to provide support to ward physiotherapists with the way they work with people who have dementia, depression or delirium. For example supporting them to identify appropriate goals to set with these patients. The work includes improving the observational skills of physiotherapists so they can notice the early signs of dementia, cognitive impairment and depression. It also involves showing other physios how to observe others and interpret signs relating to memory, but also relating to the patients physical awareness and physical ability, and their ability to follow commands and instructions. The work of the OPMH physio ensures patients are signposted appropriately and ensuring that issues to do with mental health that are not picked up by ward physios are noticed and activity is adjusted accordingly.

Work for the OPMH physiotherapist comes from several sources. On some wards, e.g. 'fractured neck of femur' wards, everyone is screened. Some of those on the elective wards are also screened. Also some are referred from the Multi-Disciplinary Team (MDT) and there are some verbal referrals from other staff on other wards, in particular where the patient does not have a clear diagnosis of dementia, depression or delirium.

Towards the end of 2012 the team engaged a pharmacist.

## **2.3 The role of the administrative team**

The administrative team is 'absolutely critical' to ensure clinicians' time is released to see patients and to ensure the delivery of timely correspondence and documentation that is necessary to progress appropriate clinical care.

'Without responsive admin things just can't get done!'

'We would be snowed under without their support. [The admin team] type up the reports. They answer queries we have while we are on the ward. This saves time in not having to go back and forward between base and the hospital. The sorts of queries tend to be about the history of patients and important information about where they are from.'

The admin team form an important part of the link between the DRI and the OPMH team's clinical staff:

'They may also contact us while we are on the ward about referrals of new patients from DRI and from the community. Before we got the extra administration help it was very difficult.'

## **2.4 Aims of the OPMH team**

The overall aims for the OPMH liaison service were to undertake:

1. Teaching activities with staff
2. Diagnostic formulation
3. Medicines management
4. Care management formulation
5. Safe and appropriate discharge planning
6. Second opinions on capacity; MHA 1983 requests and medico-legal advice

Other supporting activities were:

7. Indirect clinical care
8. Generation of a multidisciplinary liaison service, not just team
9. Contribution to dementia care pathways

Each of these activities is described below.

## **3.0 The work of the OPMH liaison team**

### **3.1 Teaching activities**

Teaching was undertaken in two ways: through formal awareness raising activities and by working alongside other ward staff demonstrating appropriate behaviours; and, by responding to queries about care and behaviour management.

Staff education is a large part of the role. In particular this includes issues around the Mental Capacity Act 2005. The understanding of the Mental Capacity Act by ward staff varies. For example: the OPMH team regularly point to the importance of doing an assessment of need before doing an assessment of capacity.

'Often our role is to provide education in this area and support staff with complex capacity assessments.'

OPMH team believe that ward staff are now recognising when the patient requires mental health input.

Informal education and support is provided regularly. The OPMH team give advice to the ward staff if they have immediate concerns. The worker on one ward observed good practice from nursing assistants to de-escalate emotionally charged situations. She has complemented the ward staff on the way they handle these situations.

Example: supporting staff to develop techniques for managing behaviour - e.g. when a patient is displaying purposeful walking she encourages staff to use diverting tactics rather than confrontational ones.

'I'm doing lots of informal education for staff and they are interested. Student nurses get very little training about mental health.' (Rehab)

Example: Ward [25] staff used to wonder why she was always asking about Urinary Tract Infections. The OPMH worker doesn't even have to mention it now. Everyone is asking for themselves.

'By being there and having a presence I have a massive influence on staff." Even experienced staff mix up psychosis, dementia and confusion e.g. 'she is confused because she is seeing things.' (Rehab)

it is hoped that the formal and informal education will lead to the ward staff becoming more informed about mental health and accepting and value the mental health staff working alongside them.

The OPMH consultant and team leader meet the OPMH team members every week for supervision to support them with their experiences in engaging with staff on the wards.

In terms of development it could be argued that one to one training is undertaken every time an intervention occurs with a ward nurse. OPMH staff have learned from the ward staff too.

'The biggest training with nursing staff is demonstrating things that will work; for example, noting that someone has delirium. Saying this to the nurses, and that it will go away when his illness goes away. And then seeing that it happens'.

'The ward staff need a soft hand. They haven't got the environment to help people with dementia. They aren't trained for this. I've got a lot of respect from the staff up there.'

Over the year, basic dementia awareness sessions were also run with 150 people within the acute hospital including speech therapists, physios and nurses. The team developed a leaflet on dementia to raise awareness for all hospital staff. It went on everybody's pay slips so the gardeners, the clinical staff, the domestic staff all received one..

### **3.2 Diagnostic formulation**

As new staff members integrating into multi-disciplinary teams (MDTs) there were initial challenges for both existing team members and the OPMH staff.

MDT (Multi Disciplinary Team) meetings are a place where all patients are discussed. The OPMH team use these meetings to suggest things that might not be considered by other people/professionals. For example a nurse might think that the symptoms a patient is presenting with are depression, but the OPMH worker might think that these are more likely to arise from the patient's physical condition or vice versa.

Where patients are becoming isolated the OPMH staff might encourage ward staff to promote greater participation so they get a more social experience.

The OPMH team will often pick up referrals from MDT. At MDT, staff include discharge facilitators, the consultant, SHOs, intermediate care team members (rehab, falls clinic), physiotherapists, pharmacists and staff nurses. At MDT other staff may ask for OPMH team views or the OPMH workers may offer advice. Sometimes other staff ask the OPMH workers to speak to a family e.g. about helping the patient cope when they get home, perhaps if they are not sleeping well, or about how the family member will cope when the person comes home. The worker might give information about social care and other information about where to go for help eg carers voluntary organisations so that the family member won't feel that they are coping on their own.

Mental health trained staff have fairly rigid frameworks for diagnosing mental health problems. Efforts were deliberately made to support OPMH staff members engaged in MDTs so that they felt able to maintain their position in the face of organisational pressures to do otherwise. The consultant psychiatrist and the senior clinical nurse undertook regular supervisions with staff with this as part of the focus. As one ward doctor put it "the [OPMH staff member] sticks to her guns".

Part of the OPMH team's role is to debate with doctors about whether the person has a delirium rather than a cognitive decline/dementia. They state their opinion to the doctors.

At first there was resistance to the input of OPMH staff members on ward rounds. Some doctors had an attitude of "who are you to tell me!". In many cases through persistence of the OPMH staff, attitudes have changed. OPMH staff sense that there is still resistance among some staff but latterly there have been what OPMH staff see as 'breakthroughs' with doctors who have responded least enthusiastically to OPMH input.

'There is a structure to diagnosis that is necessary in MH that is absent among medical colleagues. So a precision to diagnosis is required. WHO symptoms/diagnostic criteria are described. Medical colleagues do not know the level of detail that we know for MH diagnosis. We offer clarity about whether a person does or does not meet the absolute criteria for depression or dementia. We offer objectivity into diagnosis. So we can be more dichotomous about whether they have a mental illness.'

'This means we can be more assertive, undertake purposeful action and bring an end to activity in hospital and take it beyond the hospital into the community.'

Example: we find a person with a history of not coping (not a medical diagnosis) and the staff on the ward can become distracted with this and length of stay becomes protracted. By saying this is not a MH issue and can be sorted elsewhere so they can go home to sort things out through the care home, the care package at home or MH treatment in the community if it turns out it is needed.

OPMH staff will ask questions and gather information that doctors and ward staff do not have the time to get. Their training and their view of the Mental Capacity Act leads them to gather opinions from people within the family, neighbours, care providers, social workers and others that may have a view on what the person is normal behaviour is

like. This exploration helps to ensure that appropriate information and people are included in decisions for diagnostic and care purposes.

Quote from staff nurse: 'The OPMH worker seemed to have a relationship with him because of this we knew more - her chats about his home life gave her and us information about him . . . She has lots of time to spend with patients. At first we weren't getting anywhere with him . . . It has raised our awareness of patients like George. We are busy with other things.'

### **3.3 Medicines management**

Where there is good engagement during ward rounds, OPMH staff views are actively sought by doctors seeking additional background information on the patient.

Quote from staff nurse.: 'The OPMH staff member advised about medication. She gave us information from her speciality that gave us a better understanding. His transformation was great. He started smiling, eating, drinking, mobilising. He was still incontinent but he started to tell us about this. He started to tell us about his food - his likes and dislikes; flavours he liked.'

OPMH staff have actively challenged the use of anti-psychotic drugs where they deem it inappropriate. This has not always been an easy thing to do. On other occasions OPMH staff have suggested changes to drugs where they believe them to be either inappropriate or where alternatives to drugs might be considered.

'It is [now] quite rare the patients on my wards get prescribed anti-psychotic medication for agitated patients.'

If appropriate, OPMH workers recommend to doctors to change these sorts of medications if a patient arrives on the ward taking these drugs, due to the impact such medications can have and the risks associated. Sometimes other interventions or medications may be more appropriate and less detrimental. These recommendations may be backed up with reference to NICE guidance on the use of anti-psychotic drugs with patients who have dementia or delirium, where sometimes the use of anti-psychotics is appropriate.

Example: A woman was seeing spiders and voicing her concerns. She had high levels of distress at these hallucinations and was getting very anxious. She was not yet physically well enough to do rehabilitation. She was, however, in need of social activity as she was isolated. The worker asked for her to go to the therapy group where there was a coffee morning type atmosphere. She was nervous about going. The worker went with her and stayed for about half an hour until the woman settled in and was talking. The woman did not voice distress about her hallucinations half as much after this. Soon afterwards she started on anti-psychotic drugs. The consultant asked for the worker's opinion on this before prescribing them.

### **3.4 Management formulation**

An important aspect of the role is supporting ward staff directly in ensuring the effective management of the care of patients on the wards. Care of patients has been affected as a result of the input of OPMH liaison staff.

The OPMH team consider whether or not mental health issues need to be managed straight away. They feel that they 'own the assessment' over time and take this *risk* from the medical team. 'We do not always need to make a quick judgement.'

'Medical staff may have rushed or not taken appropriate risks and more patients have been discharged to care homes as a result. Mental Health staff understand care at home managed through a package at home and we review the package. If it is not working then review and go to a care home if needed.'

Care options are known by the OPMH team.

'We can enrich care planning decisions in work with the medical teams to give choices in care planning that wouldn't have been considered otherwise.'

The OPMH team provides a resource for other staff to clarify mental health concerns e.g. memory problems; grief reactions; queries about whether behaviour is delirium related; how to engage with patients about something they might be doing. The aim is to help ward staff to decide if what they are witnessing is an eccentricity or if there is more to it e.g. not getting out of bed, not eating or drinking, becoming isolated; or perhaps to do with safety. Suggestions to do with safety concerns for example might be: increasing observations; increasing light levels; moving the patient closer to the staff station; or, reducing the opportunity for risk to themselves and to others.

'I am seen as part of the ward team. I have fantastic working relationships with the staff. I am invited to the staff meetings. I must be part of the team. I take an interest in what they do too. I am learning from them too. It is a two way thing.'

The intention is also to improve care in its more mundane aspects e.g. sitting down, lying down, going for a walk; banal, routine bits of care that are needed so that the patients are attended to in a thoughtful and compassionate way. Seemingly quite small changes to the way someone's care is managed can make a big difference:

Example: with domestic staff facilitating people to drink a cup of tea; if someone is confused you can't give her something and walk away. What is better might be crouching and kneeling down and talking to them whilst they have a cup of tea. In addition the staff member gets more enjoyment from the contact with the patient. It is a more meaningful and humane interaction than just providing sustenance

Some consultants on specialist and rehab wards now actively ask for mental health input in the ward round e.g. in rehab, asking for a mental health view to help understand about why the person is presenting in a particular way.

'This helps enrich the understanding of why a person may not be engaging with therapeutic interventions. Equally the interventions are then enriched.'

The OPMH team undertake risk assessment and deploy risk management/minimisation strategies promoting access, and inclusion, personal adaptation encouraging hope and recovery via personalised therapeutic collaborative approaches. If required the OPMH worker can aid safe and effective care formulation and discharge planning. The intention is to reduce the risk of inappropriate interventions/treatment or referral. The team advocate the principles of the Care Program Approach (CPA), the Mental Health Act, the Mental Capacity Act 2005 and the National Dementia Strategy.

Example of providing advice: Staff had been concerned that a male patient was not eating and drinking easily. They had been helping him to eat and drink. On talking to him he felt the stigma of this as he did not like it. He felt that he could eat and drink on his own, although slowly. She communicated this to the staff and he began to eat and drink slowly for himself. This was a small thing but one that he reported to have made a big difference to him.

The OPMH team make a plan of care for the patients. Relatives may not know what's happening with the care of the patient or what the plans of the doctors are, or the medications they are on. The worker actively talks to the relatives. The OPMH staff spend time with patients to find out their understandings of what is going on and what should happen; their wants and wishes for their future care; and, what they want when they leave hospital.

The OPMH physiotherapist supports ward physios to improve the patients post-op management. In particular the worker supports ward physios to help the management of the care of patients who also have depression, dementia and delirium. The work aims to ensure that patient's stay is not lengthened by

- supporting pain control
- ensuring appropriate physiotherapy care for people with post-op infections that have led to delirium
- ensuring they improve to a level that rehab can manage.

Time is spent each day by the OPMH physio to review the notes of new arrivals; talk to ward physios to see if there are problems; gather information on the life history of patients to help to build relationships and so help with rehabilitation; look at medication and bloods results; if known to a care home, talk to them about whether or not the residential home can continue to meet any new needs the person may have; finding out when the person is usually awake. If they are awake most nights then it is probably best to approach them for physio during the afternoon. Time is also spent to identify matters that would or might affect their discharge and then planning ways to resolve these.

'We make a difference by being involved with the family from right at the very beginning. I ring the family with the patient's permission and say I've been asked to see your relative. I ask if they would like feedback.'

The OPMH worker forms a point of contact for the family and this is important for the way they do their work. The family is proactively involved and provides important information on how the person was before they came into hospital.

'I feel we are much better at this than other areas of health.' The OPMH team feel that they have a good working relationship with other staff too as 'otherwise they wouldn't let us do it.'

One of the OPMH staff was allocated specifically to take referrals from other wards including A&E and the Assessment Unit in the hospital. The process is slightly different here:

[Formulating a care plan]: 'I empower and educate staff rather than doing it myself. I leave a clear plan for the ward to formulate discharge. Much of my clinical work is single assessments.'

For this OPMH worker, time is spent reading notes and preparing before meeting the patient and feeding back to the ward staff if the worker thinks medication should be prescribed or particular actions need to be taken:

'If it is delirium, then I say it is delirium. The vast majority of people I see have no mental illness. It is the wards that are needing certainty. I sometimes work with family members. Especially where there is a new diagnosis and attempted suicides that are seen in hospital wards. I'm trying to get background information.'

### **3.5 Safe and appropriate discharge planning**

The OPMH team felt that the philosophy of the mental health process contrasted with that generally present on the medical wards in the acute hospital.

The different philosophy was felt to enrich discharge planning.

'Patients are more engaged as mental health staff talk to them. Advocacy is there that was not there before when previously medical Consultants may look at what the person *needs* not what the person *wants*. OPMH teams include the person's preferences, especially in discharge discussions'

Example: 'A patient wants to go home rather than to stay in but has a risk of falls. There are community Occupational Therapists, physios, social workers, and others who can in-reach and provide support as part of RDaSH. We can do this and are well informed about it'.

Non-statutory services are now included in a discharge plan or carer support plan e.g. the Alzheimers Society. The OPMH team now contributes to other efforts aimed at discharge and re-admissions.

'A depth to discharge planning is now present that affects - risk reduction - provides safety nets and includes a wider range of different agencies that can be used.'

'We don't know how far the discharge plan is followed through by other services.'

The aim of the OPMH team's work within the Integrated Discharge Team (IDT) was to maintain the focus on mental health at discharge so that the recommendations of the OPMH team staff on the wards are carried through. This work recognised the different pressures at play to get people out of hospital.

"Sometimes I will suggest... to keep them in slightly longer to optimise a safe and effective discharge if a delirium is resolving."

Everyday there is a multi-disciplinary meeting when a discussion about each patient takes place and individual clinicians feed in to the IDT; notes are updated and the discharge is progressed. The allocated IDT worker will talk through the discharge plan with the OPMH team worker on the ward if needed to clarify any matters.

The OPMH staff do a range of work that informs discharge decisions these may include discussions with family members, with GPs, possible referrals to IAPT, memory clinic, Community Mental Health team, Age UK, Social services, carer support service, voluntary organisations and/or discussions with a clinical psychologist about an appropriate care pathway upon discharge, should further psychological support be required.

The worker makes recommendations when the mental health assessment is completed about discharge. If support is needed she will send a letter to the GP. If the patient is already known to the Mental Health services then the people they are seeing already will be contacted to let them know they are leaving hospital. Sometimes the CPN is informed - though they are directed through the GP.

The OPMH team provide support to identify the type of care that a patient needs. They support ward staff to take positive risks to allow people to go home when they might otherwise be kept in hospital for further assessment.

Key things staff identified for allowing them to take these positive risks were their:

- training
- experience of having worked in the community
- background information and knowledge of the care home's in the region, which gives a greater understanding of the implications of an what is an appropriate and an inappropriate placement.

When there is no diagnosis this presents particular difficulties with discharge as there is no baseline against which to measure what is normal for that person. This means it is difficult to say with confidence when it is OK to send them home. This in turn leads to an increased stay in hospital while the situation is investigated. These investigations may be worthwhile as a better understanding may reduce the rate of return to hospital. OPMH staff attempt to get to know the patient in order to assess their rehab potential correctly. It is intended that, by having better knowledge, this will lead to better discharge decisions so that the right discharge destination will be chosen.

Example: A women in her 90s who lived with her son in his 70s. The son had learning difficulties. She had not been out of the house for 20 years and was not known to any services or registered with a GP. She had a long standing history of cognitive impairment but there was no medical history. For this reason it was very difficult to get a baseline for her. The son was desperate for her to go home. The woman went for surgery and may have had a delirium. It took a lot of work to unpick the situation and say what was right for her - perhaps to go to Positive Step next and then she may go home; or, she may go to Rowena to get a Mental Health diagnosis and may then go home; or, go into 24 hour care. To get more information, time was spent talking to neighbours and social care team members - other OPMH team members were involved to do this. The decision was made for the women to go to residential care in the end. One concern, after discussion with neighbours, was that, when the son went out to go shopping, she would

leave the house and be found wandering and the neighbours would have to take her home. The son had seemed unaware that this was happening. The risks from her behaviour and the lack of protective factors at home were part of the best interests decision about where she went after discharge.

A purple mental health assessment document has been developed and a copy is retained in medical notes; a copy is given to IDT and then the assessment recorded in the electronic database used by the mental health trust (RDASH).

### *3.5.1 Managing risk*

There are times when a mental health assessment allows ward staff to take a positive risk to send a person home. For example if someone is presenting with confusion, the OPMH worker may look at the case and identify that the person is appropriate for discharge, reassuring other staff members that it is OK to do this and that further assessment can be done in the community. The worker would liaise with the GP, Memory clinic and Community MH team to get this to happen. If they are known to the Memory Clinic they would be asked to monitor the person more closely for a period, post discharge.

Example: a woman who is medically fit and ready to go home went into emergency respite for a week while her daughter prepared. Her daughter had her own mental health needs. She was also waiting for a special bed that had been agreed by the OT assessment. The daughter requested an assessment of her Mum. The assessment identified that she was confused. The OPMH worker reassured the family she was within the normal range and the confusion they had seen on the ward resulted from an infection. If more confusion arose it could be another infection. The OPMH worker rang emergency respite to pass on information about the infection and the confusion so they knew to contact the GP if this happened again.

Sometimes length of stay can be longer as a result of an OPMH team interventions. While the OPMH team will see patients within one day of referral, complex cases will lengthen the stay with the involvement of a social worker.

Staff in Rehab no longer have to wait as long for a psychiatric assessment.

Sometimes ward staff have wanted the patient to have a perfect sleep pattern and/or perfect health before discharge. However, if patients are able to cope (with evidence from the patient's history) with their sleep patterns then it can be OK for them to go home. Where an OPMH team member makes an assessment this can enable other staff to take positive risk to send a person home.

Example: the worker took a referral about a woman in her 90s in intermediate care. She was fine physically and in theory able to go home, but she was behaving bizarrely after being given instructions about doing new things e.g getting on and off the comode or using her frame in a new way. The OPMH worker did an MMSE assessment and she did well except for on the visual/spatial elements. She could not cope with visual /spatial and copying type instructions. Written instructions were better for her and worked fine for her. There was nothing the matter with her memory. She was deaf as well and this

had clouded things. She was, in fact, OK to go home though it appeared that she was not. She was fine doing things her own familiar way. The family had no concerns about her going home. The woman went home with a care package which she had happily agreed to. Ward staff would have felt it too great a risk to send her home and she would have had a longer stay in hospital if their concerns had not been allayed by being able to explain her behaviour effectively.

Sometimes OPMH team explanations about what is going on can affect other staff's views about a patient's potential for rehabilitation. This in turn can affect the decision about where they should go on discharge.

Example: ward physios came to the OPMH physio about a man who was disengaged and who had poor behaviour while his blood was improving. They felt he had little rehab potential. He had been in hospital a long time. The worker explained to the ward physio that his behaviour may be to do with low mood and to a slow resolving delirium. The OPMH worker explained to the ward physio that this meant that any goals that were set needed to be realistic and not to over challenge him so he could achieve them. The OPMH worker talked this through with the physio. In the end the patient went to Positive Step as this was the most normalised destination for him. In intermediate care the time pressure on rehab is less intense.

Sometimes the OPMH input during one visit to hospital may lead to a shorter stay on a later occasion. When there has been a mental health assessment this provides a baseline for if a person enters hospital again at a future point. The next time the person comes in the baseline helps to plan their next discharge. The presence of a baseline may help to answer questions like whether or not the person's situation has changed and so whether or not the person's care package needs increasing.

Best Interest meetings may sometimes be recommended by the OPMH team in order to bring to a head decisions on discharge. The OPMH worker sometimes chases up staff to attend the Best Interest meetings so that discharge is not delayed.

### *3.5.2 OPMH may sometimes lengthen stay*

In rehabilitation settings the intervention of the OPMH staff can sometimes lengthen a person's stay in hospital. If a person is identified with mental health problems towards the end of their rehabilitation then a mental health assessment may indicate a number of steps need to be taken to ensure that the person can return home safely.

Sometimes a formulation of a mental health diagnosis and a decision about a person's best interests may take a while to achieve.

'A 65 year old was admitted to the acute hospital. A rough sleeper with a water infection. He was transferred from the acute hospital to the AIM unit. I was asked to see him in the acute hospital. He was terrified and spoke to nobody and wouldn't interact. He had nowhere to live. I saw him. He said he 'yes' twice and that was it. He had lived in a caravan in one of the villages. The Police confirmed that the caravan had now been destroyed as a hazard. I assessed him for 2 weeks when he moved to AIM. The question: was does this man have dementia? Does this man have depression? During the two weeks on AIM his mood improved. He got a bit feisty and was choosing to disengage. His mood had lifted. He was

asking to leave but not attempting to leave. I took the consultant Psychiatrist in. The patient responded better to a man. We decided he had alcohol related dementia and that at that time he lacked capacity.

Sometimes it takes weeks to formulate a plan of care. Sometimes it is easier and better to walk away and say I don't know if he has capacity or dementia. This is an example of where we decided he would be better off in a care home - against his wishes.

This is a good example of how having the AIM step down bed helped us to make a good decision.'

### *3.5.3 Impact on readmissions*

Delayed discharges increase the risk of patients becoming de-skilled or institutionalised. When this happens it impacts on recovery, independence, confidence and self worth. Avoiding these effects by preventing unnecessary delays to discharge could make emergency re-admissions less likely.

In rehabilitation wards the OPMH input aims to place people in the most appropriate discharge settings. The OPMH worker can determine whether the person will need an EMI care setting or will be OK in normal residential care homes. The worker discusses with IDT and the complex social care workers about where to place people with mental health problems. OPMH input can have an effect on readmissions.

'A man in his 80s had recurrent infections leading to short lived deliriums. He had been in hospital a long time. Initially he had had depression. Anti-depressants had been prescribed and he became very well. The worker did a cognition assessment and he seemed OK for discharge. His cognition was OK for his age. The man's case was picked up by a complex social worker who queried going home as he did not have much family. We decided he had capacity to make decisions and talked to him about what he wanted. The social worker spoke to him and said that he had said he wanted to go into 24 hour care. This came as a surprise to the OPMH worker after their previous discussions. A meeting was set up with the nephew, niece and a good friend of his. The man said he had felt pressured by the social worker into going into 24hr care. As a result of the meeting the man will go home now and pay for his own care for night sitting and assistive technology will be put in place to help him. He is quite independent and likes to do things himself. This puts him at risk of harm. As a result of the intervention of the worker and the MDT meeting there is also a plan B in case it doesn't work out at home. The man is happy for there to be a plan B of going into care. The plan B may avoid there having to be another stay in hospital and doing all the expensive lengthy process all over again. He was an extra week in hospital before he went home while the equipment was brought for his home.

### *3.5.4 Continuity/Care Home Liaison:*

If a person is moving from hospital to a care home and has specific mental health needs the service is able to provide continuity through the Care Home Liaison Service. This

enables support with transition and often the OPMH worker will accompany the patient in the transport to minimise behavioural issues and offer reassurance.

### *3.5.5 Avoiding admission.*

Sometimes it can be in the patients interests and in the hospital's interests to avoid an admission. This can be so for admissions where the person normally lives in another area:

'An older lady was referred after an overdose of 17 antidepressants. She was from out of the area so there was nothing on our own system about her. If she lived in Doncaster I'd know I could send her a CPN in the morning. If I sent her home to Pontefract it could not be confirmed what would happen. I rang Pontefract and got her admitted there so she can be assessed near home. So this is good for her. There are benefits to that for Doncaster as it is difficult and complex to organise out of area admissions and discharges. I rang Pontefract and good communication led to the bed in Pontefract being organised.

The OPMH worker allocated to take referrals reactively from A&E and MAU undertook 38 assessments during 2012 that led to the person not being admitted or being discharged directly from these locations.

## **3.6 Second opinions on capacity; MHA 1983 requests and medico-legal advice**

OPMH staff provide challenge to ward staff and doctors to support the appropriate application of the Mental Capacity Act. This includes encouraging appropriate levels of consultation.

'Sometimes if a person is on anti-psychotic drugs, it can be assumed that they lack capacity. Sometimes I ask other staff if they have asked what the patient wants and they respond - 'Oh not yet.''

MCA 2005 requires that the least restrictive setting for the person is chosen. The OPMH team's approach 'has frequently changed the discharge destination for the person.' Providing advice on the use of the Mental Capacity Act is seen as an important part of what the OPMH team do. Support is also given to ward staff on when to do an assessment of capacity and on how to assess capacity and also filling in forms for MCA1 and MCA2.

'We now use the MCA 2005 closer to how it should be used. Do they ask friends, neighbours about their views on the interests of the person? Medical staff almost never would. We do these and talk with staff on the ward when it is unlawful for them not to. Supporting ward staff to be less risk averse and supporting people actively in their open homes. Take the risk; manage the risk.'

Support is also given in relation to the deprivation of liberty act where she advises staff when to bring in the DOLs worker to take this further, either for the patient's safety or for their own safety.

## **4.0 Challenges**

The challenges facing this team as they engaged with what for many of them was the new working environment on an acute hospital ward fell into two main categories. These were challenges that were:

- 'personal', and these were largely to do with how the team managed their feelings and the process of integration; and,
- 'organisational', and these were to do more with way in which the existing organisational structures worked, and to do with managing the relationships between the different organisations.

These challenges are outlined below.

### **4.1 Personal**

Various issues arose that seemed to be to do with working as an mental health trust staff member in an acute health trust hospital.

Initially, it could be hard to be in a room full of people who did not have the same mental health background.

'At first I was shocked and mortified by what was said and would jump in to say things. Less is said now in these meetings that seems wrong to me.'

After a year in post, one OPMH staff member regarded that the working relationships with the medical staff on the ward were good on the whole.

"The nurses are lovely. They understand a lot more now why somebody behaves in a particular way. They will often pick up on the fact that a patient has a mental health issue and request that I need to talk to them, They are good at de-escalating situations with patients"

It has not always been easy to undertake this work with patients in a ward setting.

A man with dementia was ready for discharge. His wife who also had dementia was in respite care. There was a natural co-dependency between the couple and the ward-based OPMH worker said it was essential that the wife was at home with appropriate care package before the man was discharged. It did not work out that way and he was discharged first, before she could return home from the respite care. He came back into hospital because of poor coping and an infection. The worker felt he should have gone to the GP for the infection. This situation could have been optimised with the help of a community social worker. However, this would have required meetings with the community social worker and it would have taken another two weeks to arrange discharge. The ward OPMH worker had been in the room when the decision to discharge had been made. She had voiced her view but it still went ahead.

Sometimes OPMH staff had a sense of powerlessness to effect change on the wards directly.

This area of practice can feel draining, largely because OPMH workers are feeding into systems and cultures in another organisation which are difficult to change.

At first the OPMH team felt a degree of scepticism from the ward staff but now other staff recognise some benefits from their presence.

## 4.2 Organisational

There have been problems with access to IT whilst in the acute hospital and with parking on the hospital site.

Sometimes organisational systems, communication failures or work pressures seem to mean that the plans are not carried through or that good decisions are not implemented. This can be frustrating.

Example 1: 'A suicidal man who was depressed. He had end stage cancer and his pain was not under control. He was stuck on the ward and he was unhappy. The man was referred to the worker for a mental health assessment on a Friday. This was an inappropriate referral to her, as the person was suicidal and depressed because they were dying. What they needed was a MacMillan nurse straightaway. The worker said this to the ward staff. The MacMillan nurse did not arrive until after the weekend due to delays in the referral process.'

Example 2: 'A discharge facilitator asked me for an assessment. The patient was not happy and the ward staff found him very difficult to engage with. He had refused to discuss his care. Ward staff saw possible OCD traits. I was asked to see him to make an assessment. After an initial poor start I found a way for him to open up, when I met his challenge to take him off the ward. After going outside to smoke (he hadn't smoked for 3 days) he opened up about his situation and what he felt he needed. He was a carer for his wife who had dementia. He himself had COPD and had anxiety and what he reported as carer stress. He didn't want an assessment; he like the informality of the conversation. He explained that he wanted his and his wife's needs taking account of. He needed a social care assessment. I went to IDT and discussed his wife's situation and the social care needs at home. I discussed the situation with the Memory Clinic who noted that his needs had not been identified and agreed to bring forward the date of the next appointment there and to consider him in the equation this time. He was discharged with a care plan in place. I felt that I could not solve all the problems that he faced in the period that I knew him but had managed to increase his understanding of the situation. He had felt that the only solution was for his wife to go into care. I felt that he had his own stress that was different from the carer stress that he was experiencing, due to the COPD, anxiety and low mood. He felt that he didn't like change and reported needing lots of time to prepare for changes.

He wanted to be discharged home but he was considering major changes at the time about himself going into care in the future or moving closer to his family and he wanted all these things sorting out before he went home, taking both his and his wife's needs into consideration. His coping strategy was to smoke and used his inhaler as a support and attempted to normalise his problems. He did want to go home but refused an OT assessment and eventually took a care

package. On the day of discharge he seemed very emotional and asked for a full physical review. He was discharged. The care package went in and seemed to go well. But he was not sleeping well at home and his son soon got in touch to try to get a bed that was raised at the head like in hospital to ease this. He didn't get a head rest before he came back into hospital.

I thought the main reason for his readmission related to his ability to cope in the house that had been empty since his wife had gone into care.'

It can be frustrating not to be listened to, and sometimes organisational processes move too slowly:

A woman was repeatedly admitted. Mental health assessments were repeatedly requested by doctors. I said that they needed to see to her physical needs. I requested a case conference for end of life planning. She was not eating or drinking. I had seen her several times during her different admissions. She had said that she was particularly close to her daughter and that she always wanted to be at home with her daughter. The doctors wanted to do anything but let her go home. They said she did not have capacity. I assessed her and determined that she knew that she would die and was fed up of having all these things done to her. I determined that she had capacity and had said that she did not want anything else and had said months previously that she didn't want any more. She had had five admissions. She always recognised me on each admission. I informed IDT, saying the woman did not want these things to happen and that a Best Interests meeting/case conference was needed to allow her to be discharged home as this was probably the best place for her. I spent time with the daughter to help her prepare for the death of her mother. Before the best interests meeting/case conference could happen the woman died.

### ***5.0 Barriers to effective implementation***

The following barriers and limitations on effectiveness were identified by the OPMH team:

Ward staff can be too busy to do some kinds of supportive work. Ward staff often would like to spend more time with patients or have other opportunities to offer social interaction and cognitive stimulation, but may be unable to due to their other responsibilities and busy ward demands.

There are occasional delays in social worker or occupational therapist allocation and involvement, due to staff availability.

There can be limited availability and accessibility of appropriate community services following discharge.

Reduced choices: misunderstandings and possible stigma associated with mental health and illness can limit the options that staff may consider.

Indirect referral pathways: "It would be good if I could refer straight to the Memory Clinic without going to the GP and asking them to monitor the situation

before deciding if the MC is needed." This would reduce delays and short cut the process.

Can't get timely care packages: 'If I find someone with care needs at home, I can find them a care package that afternoon. Why do we have this difficulty to get people out of hospital with a care package?'

Medication: 'We do intervene on a patient level e.g. when a patient is walking around unsettling other patients. Some doctors flatten them with drugs. This [is] not adhering to the drugs guidance. We do challenge this . . . but certain practice needs to shift and this requires a monumental change for staff.'

Sometimes there is not a pathway: 'A man was admitted to MAU. He had a known dementia. He was aggressive. It was a Friday afternoon. There were documented problems at home. He had been brought in by ambulance and the police after his wife had rung about his aggressive behaviour. I saw him quickly and saw the A&E staff member and asked them to send him to an EMI nursing home. It was clearly documented in the A&E notes that there was no reason for his admission. But there was no pathway that could be used to help him get an EMI nursing home once he had been *admitted* to hospital. It was an unnecessary admission. If we had seen him in A&E he would not have been admitted. He stayed in hospital for another four weeks. He then went into an EMI nursing home. The risk was not taken to send him home. People don't understand what admitting him does.'

Follow through from the care plan to actual delivery in the community: 'Sometimes plans are communicated well. Sometimes not. There are lots of interfaces that must work for this to be effective for example: on the ward; in the discharge meeting; in the community based care. Communication is hit and miss. Information sharing between teams and within them is important e.g. if GPs and community nurses don't know that discharge teams have done the care planning then it is not going to happen.'

## **Appendix C: Survey methods**

The study received a favourable ethics opinion from the Forum for Independent Review of Ethics. A control group design was ruled out as the service was planned to be hospital wide. For this reason the preferred design was a repeated (time series) population survey of the ward staff. All staff on particular wards were invited to participate service initiation and 12 month points. The response rate achieved was 34% for the initial survey (n= 122) and 18% for the second survey (n=66).

The design included three main control variables. These were: staff grade; staff occupation and ward.

Measured variables related to staff experience about the following areas of their work (as measured by several questions). Specific constructs were elicited from experienced ward staff about the nature of their experience on a ward to do with:

- General views about work in the ward and hospital
- Cooperation and team working
- Work with MH patients
- The extent of knowledge about the work of the MH team

### **Analysis**

A MANOVA was undertaken to compare the data between the two time points. Data was analysed by the four construct groupings. Results of the analysis indicated how far staff experience had changed.

### **Results**

Pillai's trace statistic rather than the Wilks was used, as the pillai's trace is more robust to violations of the assumptions required by a MANOVA. This data set had different numbers of participants in each group. However, as the group size is over 30 the MANOVA is considered quite robust to this violation. Four cases were removed as the MANOVA analysis is sensitive to outliers.

The MANOVA was used to compare the experience of acute hospital ward staff, at two points during the introduction of the OPMH liaison service, in relation to their general views about work in the ward and hospital; cooperation and team working; work with mental health patients; and extent of knowledge about the work of the mental health team.

The multivariate result indicated a significant difference in the staff experience of working on acute wards before and after the arrival of the OPMH liaison service, Pillai's Trace = .20 F (4, 144) = 8.75, p < .001.

## Appendix D: Case studies

This appendix contains seven case studies. The case studies present experiences of family carers, patients and staff on the wards. Case studies were selected to illustrate the work of the acute OPMH service in the context in which it is delivered.

The case studies include the direct reported experience of family carers, patients and/or staff and their views on the care patients received in hospital. All names have been changed.

### Case study 1: Fiona and Margaret's experiences

Fiona, a family carer's positive experience of the work of the OPMH team

### Case study 2: Ian and George's experiences

A ward sister's view; a ward doctor's view; and, Ian, a family carer's positive view of George's stay in hospital and their view of the negotiation to ensure George's wishes were taken into account.

### Case study 3: David and William's experiences

A discharge coordinator's view; a ward doctor's view; and, David, a family carer's view of contrasting experiences on Ward 17 and Gresley, and positive experiences of the work of the OPMH staff.

### Case study 4: Jenny and Brian's experiences

Jenny describes extreme, poor experiences as a patient on Ward 16 and Ward 24. She describes a difficult task that the OPMH staff managed acceptably.

### Case study 5: Kevin, Shauna and Dick's experiences

A ward nurse's view; and Kevin and Shauna's family carer views.

Both describe how OPMH staff understood how to support and manage the challenging behaviour displayed by Dick, supporting other staff to do this and supporting the family in the decisions they needed to take.

### Case study 6: Jean and Graham's experiences

Jean, a family carer, describes her negative experience in A&E, and both positive and negative experiences on the DRI ward and her generally positive view of the support she and Graham received from OPMH staff in the Montagu Rehab ward.

### Case study 7: Georgina and Harry's experiences

Georgina had a very poor experience negotiating the care for Harry after he left hospital. She felt heavily pressured by doctors and the council social worker to take him home. Her experience of the OPMH staff and Ward 25 were both very positive. Her experience of the Renal unit was very poor.

## Case study 1: Fiona and Margaret's experience

### Audrey, an OPMH team member's view

Margaret was confused when she arrived on the ward. She was spitting and aggressive. It was agreed for the OPMH worker, Audrey to speak to Margaret's daughter, Fiona. Margaret believed she was being kept hostage and the daughter thought it was hallucinations. The treatment for her physical conditions was completed and she was now eating and drinking appropriately. She was discharged home with the GP to monitor the situation. It was suggested that the daughter should talk to a social worker about care and the daughter said she would look into it.

### A Local Authority social work team Assessment Officer's view

I had a conversation on the phone, a meeting and received a long letter from Audrey about Margaret. I used that as reassurance that when she went home that the GP would know more about it. This meant that if it came to it that she needed to go to the Memory Clinic, then they would know about it already.

it gave me more justification for putting extra care in. Margaret had strange ideas about letting carers in. Audrey's report will help to provide evidence for why it is needed. I hadn't had that before from the hospital. Audrey was excellent.

### A DRI discharge facilitator's view

The lady came in with confusion. I referred her to The OPMH worker immediately. Every day I go through my patients. Any with known dementia, depression, delirium or confusion I refer to her. She looks at them on her system. She can go onto the system so she is prepared for when she comes on the ward. We work well together as a team.

Audrey organised the case conference. The physio, the social work, the family, Audrey and me were there. The daughter became happy - less anxious for her mum to go home. She did not live nearby and was concerned as her mum had refused to let carers in in the past. We got the lady home. Audrey uncovered that she was becoming unsafe around the cooker and it needed to be replaced with a microwave. We needed to get rid of the cooker. The daughter was concerned. Margaret was concerned.

Audrey liaised with the social worker and the council were involved and the daughter - who was putting things off - and with Margaret who had a very poor memory. Margaret would forget about the cooker. Audrey went through everything twice or more. She calmed the daughter. The daughter began to accept. Audrey kept reiterating with Margaret, who was anxious and saying "you are going to put a cooker in aren't you". She was OK in the end. She calmed her and

got her used to the idea of not having a cooker and getting a microwave. Audrey's work meant I didn't have to do all this. It was a lovely outcome.

#### [Fiona - a family carer's view.](#)

Fiona is the daughter of Margaret who is in her 80s. This is Fiona's experience of Margaret's stay in hospital

I was very concerned. The morning she went in she was dizzy. She was OK when she went in then she changed. She went in on Sunday. I went out crying. It was as if she was dying. I asked a nurse. The nurse said she was very confused. She'd been abusive and was spitting. They said not to worry about that though.

After one night my mother said 'I want you to call the Police. I was held hostage by the mafia.' She was hallucinating. I told the nursing sister who said they'd try to get her to talk about it.

After a while she became less confused.

After I'd visited once, Audrey introduced herself. I rang Audrey and had a meeting with all of the staff. At the meeting Audrey was able to allay my fears. She gave me a leaflet about dementia. I talked through with Audrey who said she noticed when she did her assessment that she had been getting better. She helped me understand what to do with the hallucinations. She suggested I should go along with it. She was very helpful and extremely patient with my mother "when you are ready Margaret". She was very kind and helped me. She said I could ring after Margaret had gone home from the hospital even though her role had finished.

At the [discharge] meeting it was informal. I was quite bombastic about organising care. I realised she was going blank at times in the meeting and she couldn't comprehend what was going on.

Audrey was extremely understanding and helpful. The Assessment Officer from social services has been an absolute brick.

Margaret was on Kingfisher ward. The only thing I've got to complain about was that her nurse was very sharp with my mother: 'Don't you go to the toilet?' she said. My mother said 'When I need to I press the buzzer but nobody responds so I wet myself'. It was not nice to hear.

The physio was very good. The nurses were good. The nurses were really pulled out with work. Some nurses were really good. One was rather sharp to me.

At the meeting it was clear they wanted mum out because she was bed blocking. The nursing sister had previously said to me 'Can't you take your mother?' I said no. The discharge nurse said at the meeting "the daughter refused to take her mother in over Christmas". I felt this was a breach of confidentiality and caused

friction between me and my mother. I am registered disabled and can't physically manage her. I was cross at this.

## Case Study 2: Ian and George's experience

### A Rehab ward sister's view

George was known to us as he came from Tickhill Road. He was low in mood and not compliant. There was no aggression. He had a poor diet and was apathetic; not motivated or participating in care or physio. The Tickhill Road nurses said this wasn't like him.

I found the OPMH worker, Audrey's, input very valuable. She advised about medication. She gave us information from her speciality that gave us a better understanding. His transformation was great. He started smiling, eating, drinking, mobilising. He was still incontinent but he started to tell us about this. He started to tell us about his food - his likes and dislikes; flavours he liked.

Audrey seemed to have a relationship with him [and] because of this we knew more - her chats about his home life gave her and us information about him.

There is a lack of understanding among us nurses and she's raising our understanding about mental health. And so the patients are now getting more from us too.

Audrey gets on very well with patients. She has lots of time to spend with patients. At first we weren't getting anywhere with him. He was blanking everything.

We are doing things differently now. Audrey is being an ambassador for promoting the OPMH service. It is so easy in this day and age to neglect the patients needs to do with mental health problems. We don't tend to afford the patients the right approach; low mood and depression, we don't cater for effectively.

George went home with a care package. He would not have gone home, [he would have gone into care]. Audrey's presence gave us an awareness of mental health problems. We made a decided effort e.g. repositioning his chair so he could see better. It has raised our awareness of patients like George. We are busy with other things.

Regarding the Intentional Rounding tool, [it is] for checking whether the person has a drink and other things like the buzzer is nearby. It is easy enough to tick a chart. Audrey started to make the tool more effective because we knew what to ask. George did start to tell us he liked Horlicks. [We] did get Horlicks and he was offered it. He was a falls risk and she was more able to talk to him and confirm with him about the buzzer. She was better able to build a relationship with him.

Audrey has been very supportive with other patients too. [She has become] an integral part of our work. I have done Rehab for a very long time and mental health has always been overlooked.

#### A ward doctor's view

Audrey [the acute OPMH liaison worker] helped with assessing his mental health state - formally confirming what we suspected about his capacity to make decisions; liaising with family about further steps to get him out of hospital. There were doubts about George's capacity. Audrey carefully confirmed he had capacity. Audrey was proactive in getting hold of the family and [working on] discharge with the family. George retained capacity. Audrey was involved in advising George and his family about possible consequences. She spent a lot of time with the family.

This was lovely to have and meant ward nurses would not be bogged down with this [and with] talking to the family.[It was a] learning process so that eventually George could go home. She talked about possible risks too.

#### Ian - a family carer's view.

Ian is the nephew of George

George had started in a Rotherham hospital and moved to DRI then Tickhill Road and then to Mexborough Montagu. We were contacted to arrange discharge. A multi-disciplinary meeting was set, as the hospital social worker was indicating that George would need care.

There were eight people at the meeting to discuss George's discharge: the care company rep, physio, ward nurse, Audrey [the Acute OPMH liaison nurse], a trainee, Me, and George came over and invited himself in and stayed for 10 minutes. [The meeting] was to discuss where George was to be discharged to. We had to satisfy the social worker that we could take care of him at home. The social worker was pushing for him to be looked after in a care home, due to his risk of falls, and the high input of care services he would require. She stated that she had discussed this with George and he would go into care, however George's wishes were to return home if at all possible. The social worker was in doubt whether George was capable of making his own decision, but we all thought he was, and the mental health nurse also agreed. We, the relatives, challenged the social worker and said that we had made suitable arrangements for care at home, and as George would self fund, if that's what he wanted, that's what he would have.

The combination of relatives, neighbours and care company worked well [to make this decision] a viable option.

The approach of the medical staff was quite good - my wife and neighbour are both nurses. We were getting pushed towards a home by the social worker, but we insisted as a family and we said 'no, it is George's wish'.

The discharge coordinator wanted to get him into a home as a temporary measure while we got the care package in place to push things along. This meant we couldn't shop around [no time]. We had less than a week to put this package together. After the meeting (Wednesday) George was discharged on the Friday, we were lucky that we have nurses in our family, who stood up for George against "the system", or George would have ended up in a home regardless of his wishes.

I think he was well looked after. I am quite happy with his stays in hospital. I am concerned that older people are shifted from one hospital to another, and this can upset their mental health by causing confusion, as it did with George.

George was discharged home and required a short admission approx. 2 weeks later, due to a possible mini stroke, or similar episode. He was able to spend Christmas at home, and is currently enjoying the benefits of individual care at home.

### Case Study 3 David and William's experience

#### Audrey - an OPMH team member's view

William was known to Barnsley memory clinic. His wife was known to memory services too. William had a poor sleep pattern.

#### A DRI discharge coordinator's view

On arrival I will pick up on their diagnosis. Any time I see dementia, with or without diagnosis, or confusion I immediately refer to Audrey. She always feeds back. She points us in the right direction. She digs things up. When she's completed her side of things and if not appropriate for her she [helpfully] makes suggestions.

I couldn't do without her.

We do have difficult discharges to help people get home.

William came from Bolton upon Dearne. He was supposed to have had a dementia screen there. He had been having falls. He had mental health problems. Audrey got in touch with Rotherham about the assessment they had started and she completed her own assessment. Her input helped with liaising with social worker being involved and with the family. She did her assessment and a diagnosis of dementia so he then got a proper placement in an EMI. Without this he could have gone to inappropriate nursing home.

She is just amazing as we can make decisions with her input.

#### A ward doctor's view

Audrey was completely involved. He was diagnosed with dementia.

It meant he had appropriate treatment timing.

He was agitated and his day and night [cycle] was switched. He was active at night and lethargic in the day time.

Changed the drugs and tried to introduce a non-pharmacological intervention. She had conversations with his son about whether he will be able to go home. His wife had dementia.

Audrey tried to get information from the son and worked as an intermediary between me and the son about his son's views. This is useful to me as the son felt he was [getting] follow up and for making plans for the future. The son had issues and worries about the future. Audrey could spend more time so got more information that you can't get in the first meeting on mental and social issues. Also about the functional disability of William's wife. The son had questions about William's UTI. He had not mentioned them to me.

Audrey spent time to understand the use of anti-psychotics in another patient. She followed up with background assessments and helps to find the history of patients that I do not have time to find out.

#### David - a family carer's experience

William started to have falls. He had four hospital admissions in 5 days.

On the fourth day he was admitted through A&E and transferred to MAU. He was there for 2-3 days. He was assessed as postural hypotension leading to falls as he had very low blood pressure when he moved from a sitting to standing position.

He was moved to Ward 17 where his bed was close to the nurses station.

When the falls had started that week there had been a change in William. I noticed he was starting to have vacant episodes where he was not really there - distant, lethargic. He used to be very bright.

During his time in Ward 17 he was under Dr Apple who is a Parkinson's expert. I was not satisfied with the treatment. I thought it was more than postural hypotension. We saw Dr Apple together. William went into a vasovagal seizure. The DRI then agreed with me. Dr Apple had wanted to see William stand. He went rigid and his head went and it had been difficult to get him to sit down. The medical staff originally thought it was Vascular Parkinsonism. They discounted this through lots of tests. William had a UTI at this point so the diagnosis was difficult.

Ward 17 was not the correct ward for him to be on so they transferred him to Gresley Ward. In my opinion this was like going into a totally different hospital. They were geared up.

As a carer arriving on Gresley we went through the whole same process again as we went through in Ward 17. We found this hard.

They were very helpful though. No transfer of notes seemed to happen. I wasn't sure if Gresley was not looking at the notes for the medical condition - they didn't seem aware of the vasovagal seizures.

For example when he was in an ordinary chair he kept trying to get up. I was surprised - they should have known that he should not be standing up. He had a few falls on the ward before this was sorted out with alarms on his chair.

The first person that talked to me was a discharge coordinator. I was telling her I was the next of kin and should be informed. I said I was in no way happy with them talking about discharge without me being involved.

Audrey [the Acute OPMH liaison service staff member] was the next person I talked to. She asked about William and if he'd had any mental health assessment. She had a conversation with William. She came back and talked to me. I explained how he'd had an assessment in Barnsley. If it weren't for Audrey and her experience of working with Barnsley we would have had a nightmare getting the notes across. It seemed like an impenetrable barrier to me. Audrey and other staff got the information from Barnsley. Then she could do her own assessments. William had COPD and dysphagia. His cough reflex was going and I knew he'd be in hospital for a while.

Audrey shared the Barnsley assessment with me. She kept me informed with everything she did. She reviewed her medical notes and looked at his medication and history of medical notes from Barnsley. Dementia sufferers have a lag from medication and she changed this so she could do her assessment. The beauty of it was she kept me informed.

What it meant to me? There was frustration in Ward 17. I took a few weeks off work. Whenever I went on Gresley, they approached me to say what sort of night he'd had. It made my time easier knowing I could just go in and spend time with him. He needed a lot of stimulus and I could go and talk through the paper with him. I knew they were doing the right things.

On Ward 17 you were perpetually having to chase up the staff to find out what was going on. I'd spend my hour and a half with him seeing what he was like and trying to find out what's happening. The difference on Gresley is that they tell you all that first thing and so you can sit back and relax and spend time with Dad.

Discharge. The consultant had a chat with me. She explained about William's medical problems and future problems that were likely related to COPD. He no longer had a UTI and was medically fit for discharge.

The discharge coordinator arranged for a meeting with me, social services from Barnsley, nurses representing the NHS, DRI and Audrey. Audrey didn't stay. It was a busy time but she was available.

We went through a huge decision tool to work out the level of care William would need. If nursing care was needed etc. Audrey brought her mental health assessment in too. It was agreed that nursing care was needed due to his risk of falls. I made it clear that I wouldn't find care until this assessment was done (DST assessment).

The assessment covers communication skills, mobility, can he make informed decision etc. Every answer is graded as a collective decision that we were all happy with. Both Barnsley Social Services and the NHS representatives said it was such a refreshing change to do it this way. It was very easy actually to find consensus. It is a very clever document. It were easy for us to say: 'Yes. That's Dad'. Rarely were we beyond a couple of grades of difference in opinion.

We were agreed that William needed to be in a home with nursing care. Homes can't be recommended to us by them. We wanted somewhere near Mum. Mum was cared for at home. So we had to find somewhere. Barnsley social services had identified all those with nursing care and with beds available.

I sat with staff from the care home. The manager did her own assessment in hospital. She said the home could care for his needs. She let me know and I talked to the hospital and got the medication together. It was 4 days later a call came from the hospital saying William would be transferred from hospital by care home and hospital staff. It went pretty smoothly. I think we'd have got in the way if we'd been there. it was late in the afternoon. My brother came over the next day.

One of the health care assistants on Gresley took to William - always talking about his farming and pit days.

I don't think the question of hunger or thirst ever came into play. They always did what they said they'd do on Gresley as they'd told me what they were going to do, or I was able to ask, or they would say what had happened with the tests.

On Ward 17 it was hard to get them to understand us about the seizures that dad was having and to acknowledge them. Only when they saw one did it make a step change in their actions. They did do what they said they'd do though.

William started to hide his teeth or glasses. We couldn't find them. They weren't even aware that he was missing them. I had a look around and he had hidden his teeth. His glasses were on another patients head. A bag of clothes went missing. It's still gone.

Dr Apple never listened to me until he saw him have an episode himself. In stark contrast to Gresley where they knew to talk to me about William.

Carers and family of dementia sufferers should be listened to more.

[On the wards] they used the Alzheimer's society's "This is me" document. They allowed Dad to fill it in. They used this as background to talk to him. It was quite incorrect. I made it more correct about his past, but the majority was different.

Do you remind him of the other relationships? I was written out of the document.

Staff need to take care when a dementia patient is consulted to make sure that the family are a part of the process. When he has forgotten something or remembers incorrectly, then what is the right way to deal with that? We need support for that.

## Case study 4: Jenny Smith

### Audrey - An OPMH team member's view

Jenny had arrived with what seemed to be a delirium but there was uncertainty about this diagnosis. She was agitated and distressed.

The OPMH staff member undertook a differential diagnosis process to see if her behaviour was to do with a psychological problem or was an organic one. It seemed to be more likely to be a psychological problem than an organic problem.

Jenny's behaviour on the ward was very agitated and her husband was concerned about if she would be OK at home.

The decision was made for her to go home with a clinical psychology referral in the community.

### Jenny and Brian, her partner's experiences

Jenny is 75. She had worked as a nurse for 26 years. She retired from her job at the DRI 13 years ago. She lives with her husband Brian, in their own home.

Brian had worked on the ambulances and has now retired.

Jenny arrived in hospital on a Monday and was sent to the MAU (Ward 14) from where, in the afternoon, she was transferred to Ward 16 - the stroke ward - where she spent four nights. After this she was transferred to Ward 24 where she stayed for 10 days. She was then discharged home.

Brian was with her from the beginning of her time in Ward 14. 'I had felt very anxious and I was kept informed [as] I could ask the sister. She was very good'

Jenny remembers only snippets of her time on Wards 14 and 16 as she was confused and doesn't remember the transfer between Wards 16 and 24.

On Ward 14 she was nil by mouth and had a 'mouth like a bird cage bottom'. I said I'm diabetic (type 2) and have had nothing to eat or drink all day. Sister said 'We'll get you a drink of water then.' It was the attitude that was really bad. The student nurses and one of the staff nurses and one or two of the health care assistants were nice. 60% were nasty.'

On Ward 16, her view however was that 'the nursing staff were way below the acceptable level'. Jenny had been asked not to go to the toilet on her own so as to reduce the risk of her falling. She understood this. The sister had said 'I'd rather stop what I'm doing than see you fall.' Jenny thought this was good. But later she had asked a health care assistant for help to go to the loo and he had said he wouldn't help 'as he'd seen her walking' and his colleague said that 'if he's not

then she wouldn't help either. She felt trapped in a double bind: 'if I couldn't get to the toilet and then wet myself I'd have been wrong again ... I walked down and felt upset.'

On another occasion 'I found a lady on the floor. There was no-one in sight. I went over. Nurses instinct. I saw a health care assistant and asked him to fetch staff - 3 times. The lady was having a haematemesis. I got a rollicking off the sister who said 'It's nothing to do with you.' I feared that if I hadn't interfered no-one would have come. She had a right go at me. I was very upset. [Later] the doctor stopped at the bottom of my bed and said "thank you. It would not have been so good if you hadn't interfered." I didn't do anything but it didn't help how I was treated.'

'The nursing staff were atrocious. I worked 26 years in NHS and I never upset anyone.'

At the time of the transfer between Ward 16 and 24, Brian got a phone call to say Jenny was going to Ward 24. 'Within half an hour I had another call to say that a doctor had said she was ready to go home.'

'When I went in she was no better than when she'd arrived. The nurse said the doctor had looked at the CAT scan and nothing was needed. I asked had anyone read the notes - especially the front page. She blinked. She said she did not know where the doctor was. I said I would make a complaint. He then materialised within five minutes. Within five minutes the doctor said he hadn't read the notes. After he'd read the notes he sent us up to Ward 24.'

Jenny can recall some of her feelings and her care on Ward 24.

'I was feeling anxious and I vaguely knew I had had a brain bleed. I can remember Dr Apple coming to the bottom of my bed. Nice lady and she said here you are. Get that on. You are going for an MRI'.

Jenny recounted experiencing fear in her dealings with Ward 24 nursing staff during the night. 'There were two of them on nights and they were nothing but bullies. They went to the same charm school.'

'The ward staff nurse on nights - I used to stutter when I spoke to her - I said 'Staff. Don't shout at me. I were shaking when I saw it was her.'

On another occasion on seeking help from a ward nurse during the day the response she got was 'I am not going to look at your leg! You ask your team leader! I started crying. I didn't know who my team leader was or that I had one. Half an hour later they came to look. There was panic stations then and a doctor came. Honestly their patient approach is terrible.'

On another occasion 'I fell out of bed. The pressure mat had slipped under the sheet. I turned over and the sheet went. I went and fell out of bed and shouted 'I'm going!'. Someone pressed the buzzer and no-one came. Another patient went to get help. She said she's fallen out of bed. They [the nursing staff] said "she'd

better get back in then". They said get up and get into bed. She put her foot at the side of me and said 'get up and get into bed.'

X-rays showed that her toe had been broken. Her elbow was heavily bruised and sore. A decision was made to provide cot sides for the bed. These were not put in place. 'It got to 11.40pm and they hadn't come.' She went to the nurse station and 'they were rude' and said for her to do it herself. 'I said I would wait as she was busy. Next morning [when I awoke] I did not have any cot sides.'

During her stay on Ward 24 she had a sore mouth that she felt needed looking at. 'Each time, I asked the nurses who delivered the medicine if they could look at my sore throat. She looked and said it looks alright. When I came home I had a mouth full of thrush - really obvious.'

'Nobody was doing anything. Four or five were really nasty.'

Brian would ask Jenny if he wanted to find out what was happening for her 'When I approached the staff at the station about what was happening I found it difficult to get answers - can't blame the nurses - they were just that busy.'

[One day] the OPMH nurse took us into a day room. 'She were lovely. Brian knew she was coming. She had a piece of paper I could see. She asked me "Can you clear this up about you stealing at night?'' Jenny was very upset indeed about this. Staff had written down observations that she had been very aggressive and had been stealing. 'I felt dirty. I never felt so demeaned in all my life as when she was telling me that'. The OPMH nurse explained that if 'I'd not known about it that was fine.' She had explained that it was not something to be concerned about as when you are confused you might do things that you would not normally do. However, while she acknowledges she was aggressive at times, Jenny has taken this very hard. She continues to find it difficult to explain it to herself, as it was an accusation of something that she would never do and, when she looked, can find no evidence of having anything that does not belong to her.

'I weren't very well when I went in but they've just about finished me off.'

Discharge occurred from Ward 24. Brian felt that 'there was very poor liaison with me - first I knew she were coming home is when staff nurse came over to talk to me at 8pm to say "right you can go".' They had told Jenny earlier - 'they were telling Jenny things but she was confused and might not tell me'.

Generally he felt that 'no-one ever said anything to me after Ward 14. After that it was Jenny telling me what were happening.'

On reflecting about her experience, Jenny acknowledged that the 'workload was very high. I was unhappy with the attitudes. Nobody did me any harm. I bet some of them talks better to their pet dogs that I got spoke to.'

'If I were dying and I could say no. I'd say no, not DRI. It were a poor experience. I'd not go in again.'

On reflection Brian made some general observations that those staff giving out medication 'never actually watched to ensure that patients actually took the medication. I had to ask if anyone had actually seen Jenny take the drugs.' Equally hospital support workers brought meals and took them away - 'no-one checked to see if anyone had eaten anything' and 'for the old ones - they did not even take the lids off'.

'I told the sister - who had said she was aggressive about asking for a cup of tea - I said to her: "a diabetic that has gone all day without food and drink may get aggressive - has anyone ever taught you that?"'

For the future: Jenny lives at home with Brian. She will begin psychotherapy sessions that she hopes will help her to work through her feelings.

Brian describes Jenny as a very mild and affable person.

## Case study 5: Kevin, Shauna and Dick's experience

### A ward nurse's view

Audrey, the acute OPMH team member, was there to give us advice - especially to the less senior staff on how to cope with Dick's challenging behaviour, so they could explain [some of the] diversional [approaches] and how to cope with his behaviour e.g. how staff were speaking to him, not saying 'no, no, no sit down.' [but] letting him walk around. She encouraged using diversionary tactics [like] 'do you want a drink?'; or 'Are you in pain?'

Dick was always wanting to get out. He would bang on doors, or try to go down the fire escape. When confronted he would try to hit the staff. The more senior staff knew how to let him go out of the hospital. At times he would leave the hospital. We would go with him and coax him back using conversation.

That used to be his norm [at home] - walking round and round the estate. His son told us this. The 'This is me' form was used to find this out.

Has Audrey's worked helped in any way? I'm sure, I hope it has, and it should do for the other staff e.g. one health care assistant each shift was booked to sit with him and walk round with the staff. If there was a concern, the advice was: don't confront him. Let him go, and shout for help.

Audrey checks the medication to see they are not over-prescribed Lorazepam.

On discharge Audrey will have done his mental health assessment. We used the decision support tool and had a safeguarding meeting with his son and the social worker and me. Audrey chaired.

Audrey is very good at it. She discusses things with the relatives and with the patients.

We get quicker mental health assessments using the mini-mental, and more history from families gives us a bigger picture. She's got time to arrange to meet the families. The nurses on the ward see visiting family at visiting times but they are really busy with five other things to do at the same time so don't have time to talk like Audrey does.

#### Kevin and Shauna - family carer's views.

Kevin is Dick son and, with his partner Shauna, they care for Dick. Kevin's Mum has dementia and was cared for by them at home.

Dick was a bit disoriented. A care [worker] found him collapsed on the bathroom floor. It was a prostate problem. He had a poisoned blood stream [from a] UTI.

A&E: the ambulance took him. The care [worker] phoned me, and I went in. It was chaotic. I arrived at 8.30am. We arrived on the ward in the evening about 12 hours later.

A&E is next to the resuscitation ward. They were run off their feet. They did a blood test. It was a waiting game to see the results. Emergencies were coming in that fast. Dad were out of it. I had to help him to the toilet.

Assessment ward: he was dehydrated and fighting with everybody. He didn't know what was happening to him. It was very distressing. He was very aggressive. They had to sedate him. Three times. He's a big guy.

The next morning the nurse and doctor spoke to us and they were very concerned. They asked if Dick had made any request if he had had a cardiac arrest. They tried to forewarn us. They were concerned that they weren't trained to look after him. We needed to look after his wife 24/7 as she has dementia. We tried to organise respite for her at Stenson Court. She was too upset so it didn't work.

MAU staff were really good. They were not trained to deal with mental health or dementia. He would not let them work on him. He was confused by the water infection. Distressed and confused.

I felt helpless. There was nothing I could do to help him. It is upsetting and gets you in the pit of your stomach. He will never come home. In spite of his escape tactics.

On Ward 25 he was constantly trying the doors. He would sit on the chair and stake out by the door. If it opened he were off like a rocket. He'd walk round the ward and was getting over the infection. He managed to get out of the fire exit one day.

They really got on with him on that ward, the staff. I took some photos in and the staff were really interested. The staff wanted us to bring some and were keen we

brought some. The staff asked us lots of questions about his life - born on a farm, other parts of his life. Things they could relate to him. He is obsessed with if you've got a car. As he wants to go home.

My first thoughts about Ward 25 were, when you see some of the patients, you think its probably a bit of a mad house. Where my Mum is it's different - they have all 'gone' in their own ways.

Were you listened to? Any of the nurses - if there was anything you wanted [they'd help]. You could try and talk to Dad. He understands chocolate and biscuits. The nurses worked this out for themselves.

What impressed me was, I had this picture in my head of how it would be [- not good]. I just thought they were really caring. A lot were on one to one care. That male nurse would walk round and round with my dad. They were so lovely. When we went they were all waving good bye to him. It was better than I expected it to be. I had expected a not very nice ward. I'd expected it to be full of crazy people wandering around not getting the right care.

They were all getting the care they needed. It takes a special type of person to do this job. They deal with it in the right way.

What I found most upsetting was to see how poorly Dad was. I was really emotional. I talked to the staff about how I felt. I got upset and the nurses listened. I have feelings of guilt. [A nurse] said you've got nothing to feel bad about, what you are doing, putting your Mum into care.

Audrey talked about being in a home. I had a bit of hope about him getting better. She sat and chatted and talked to me about that it would not get better.

They did loads of work helping him, getting him into a home. They suggested to have a look at the Royal for EMI nursing.

There was a big meeting. Audrey, the social worker, head nurse, me and my brother about what to do with Dad. They assessed him for EMI nursing care and looked at different aspects of what was wrong with him. There are so many sections to it. There was a lot to go through. To see if Mum and Dad were suitable to go into a joint home. Dad has been so demanding. Before, Mum had always followed him. Mum seemed free and happy in her new care home. Getting Dad and Mum together might be a drain on Mum. It was unanimous to put them in a different home. He is on tablets to keep him mellow. It was a very hard decision to make to put them apart. It was discussed about the reasons why they should and should not be together. After everything was discussed it was clear cut

We had the opportunity to say anything. Oh yes, yes. No stone was unturned. There was relief to know where you stood with both Mum and Dad. You try and rely on these people. You look to them for professional help because you heart strings were being pulled.

My brother (in Manchester) hadn't seen them. He wasn't sure. And a week later he changed his mind. But when he saw them in the home he agreed we were right.

It was hard to talk to my brother who had not seen the things I've seen.

Discharge: I came with him in the ambulance. On the journey . . . he knows he's out and [he was] looking at the racecourse and places he knows. But he didn't know it at all. I stayed with him for a few hours in Benton House, then he started walking and wanted to get out. They said to me that you can go any time you like, we'll look after him. He seemed to talk to one of the carers there. A man. He can get him to do things and can sit and eat biscuits and laugh with him. He is domineering, my Dad.

[In hospital] he was on drugs to start but always drank his tea and ate his food.

On Ward 25 the staff always did what they said they were going to do. In A&E: No. Not good. Nothing seemed to be happening. Some look like they are just chatting and seem so bloody slow. Some of them just plodded around. The problem was they did not communicate with you. No-one was coming to tell you. I don't know what is happening.

## Case study 6: Jean and Graham's experiences

### Audrey - an OPMH team member's view

Graham was a lovely man. His sleep pattern had changed. I tried to get the Rehab staff to stimulate him by going to the day centre and to become more social. The staff accompanied him to the day centre and for social activities. We tried to keep him awake during the day by talking to him and keeping him awake.

Jean, Graham's daughter, required support. It had been difficult for her to accept that her father had dementia. Since her Mum had died she had looked after her Dad at home. He came into Wentworth ward for Rehabilitation. He was not really rehabilitation material. Jean had wanted to take him home and we felt it was in his best interests for him to go to the Rowena AIM unit for further assessment to see if he could go home. He went to 24 hour EMI residential care. Lots of support was given to Jean throughout.

### Jean - a family carer's view

Jean is Graham's daughter. My father was living with me. He had a bladder problem and was in lots of pain. I called the GP who said don't wait until lunch. She said call for an ambulance. He went to DRI in an ambulance as an emergency.

They would not allow me to go into A&E with Dad. I said 'look I'm his carer. he'll be in distress'. I had to wait in the waiting room. They knew he had dementia. They came back and asked me. I waited for about 30 minutes. I kept asking and asking if I could go and see him (on a previous visit I had slipped in - poor security). I think that it is bang out of order. It is like taking a child from you. You just wouldn't allow it.

After 20 minutes they moved me nearer to the door ready to go in. I waited about another 10 minutes. Then I went through to my Dad and was able to reassure him. He was in a lot of pain because he couldn't pass water. We waited for a doctor to come. A lady doctor came to him to put a catheter in his penis. She couldn't do it so he was in more agony. It needed a surgeon. They explained this. We waited forever and ever. We arrived at A&E at 9.30am. The surgeon arrived at 11.30 ish. The surgeon could not put the catheter in. 'It needs someone cleverer than me' he said. Next they needed the consultant. We were waiting to be taken to the consultant. Dad was in agony. He had had lots of morphine but he was still in agony.

We went to urology and were waiting for Mr Apple, the consultant, while he finished his botox clinic, until 4.30. All this time he had a day of agony. It was just fortunate there was a consultant to see anyway. The nursing staff did not want me to go in initially. But let me go in in the end. The nurses were good, Mr Apple was good. Ever so caring. He managed to release a lot of the blockage and couldn't see anything else. Dad ended up on a medical ward.

On A&E they were exceptionally busy I could see that. Mostly elderly people waiting. It is bang out of order that self inflicted youngsters get treated as a priority. They need to be in a separate unit for those who have alcohol or drug related problems. They are draining resources away from people who really need it. Everybody knows it but nobody is saying it or acting upon it. I felt frustrated as it was draining to see Dad in agony. In a lot of pain. By the time we got to urology I was annoyed and anxious. We waited in that department for a further two hours before seeing the Consultant, Mr Apple.

I could talk to the nurses if I needed to. They were lovely without exception. I'm not sure which ward he was on. A medical ward. In a single room at the DRI. In a room on his own. On drips, catheter and a bag. The doctors asked me about what had happened. He was in for three weeks.

When I came in one time something had happened. His heart rate had gone up or down. From that time on he got more confused. They took him off Warfarin at the same time. No-one explained what they were doing. If I'd have asked they might have just said he was trying to get out of bed and they were frightened of him falling.

He was looked after lots of the time by the student nurses. They were brilliant. They are young. Without exception I was impressed. Their enthusiasm, their willingness, their maturity. There is a lot of compassion out there. You feel for

them and think: 'don't lose that spirit of wanting to help'. I don't want them to get into 'being in the nurses station' and to stop being involved.

They moved him opposite the nurses station. Half the time you just felt ... you always felt you were interrupting the senior nurses at the station as they were always on computers. I didn't want to interrupt them. There were that many different uniforms. So I tended to ask the students.

Graham was never thirsty. They always seemed to be popping in at any point and he was not hungry. He had a good appetite. I did try to be there to feed him though. He gets the shakes on and so I'd feed him with a spoon and a baby mug. You can tell them a million times but they don't think to do that. From past experience on an assessment ward he was being asked if he wanted inappropriate things - like soup. I had seen it before in DRI where people left food and it was not eaten. So I fed him myself.

The doctors and nurses did listen to me yes. And they did do what they said they would do, like helping him to the toilet. The youngsters were brilliant.

After 3 weeks they decided to move him to Mexborough Montagu. They said in the morning 'go home and I'll call you when we are ready'. I wasted all day. I phoned up regularly. They were waiting for transport.

I got a call at 8.30pm to say they were moving him. I said they couldn't. They did. He was disoriented and distressed with it and it was not good to do. No thought. It is all about transport, not an appreciation about moving someone at that time of day.

The atmosphere at Montagu was totally different. My heart sunk. There were no young ones around initially on the ward because they do not work night shifts. They showed me the bed he'd be in and I put some things out. The staff were older. It was a night shift about to come on. I thought 'Oh for goodness sake'. It was the demeanour of the staff - she looked like someone who wanted to go out and have a cigarette never mind looking after my dad. I could feel her hardness. You get that sense with the older ones of that hardness. I am still angry about the move at that time of day. I think: what would happen if it was an elderly person with no family? It is scary. Nobody there to meet them. I would have been happy to go in the ambulance with him. But they wouldn't allow me in.

Graham was in Montagu for five weeks. He was moved there as he was no longer medical. They said it was a rehab unit. It just is not. I know that is ultimately its aim once the new building is finished. He needed to get his confidence walking again. They asked me what I wanted for him. I said I needed his sleeping pattern right and for him to be able to go up stairs. Plus he is now incontinent through his urinary condition 'caused by the intrusion and damage they must have caused when admitted to DRI'.

They tried to get his sleeping pattern sorted out. It didn't work. They put him on Lorazepam. I said this is ridiculous to the doctor. Every time I went he was asleep

in a chair. He was just drugged up in the chair. He had 1/2 in the morning and one at night. The doctor was brilliant and said he could see it was not doing him good. After 2 or 3 weeks they prescribed him Melatonin. I said you need to knock one off as it is not working. He started on 1/2 Melatonin as well as the other drug. The psychiatrist said they had good results.

It is too bright on the ward and as much as they try they can never be in full darkness can they. And that affects the sleeping patterns - that and being next to the nursing station because of his falling out of bed all the time.

In Montagu the student nurses were the ones that looked after him mostly. There are lots of other great nurses but there are not enough staff when there are no students around.

Audrey, she came over. She had empathy. At the beginning I wanted him to come home but they said he can't go up stairs. Plus my arm doesn't work for lifting. I can't cope if I had to lift him. Plus the sleepless nights. When you are not sleeping yourself, I couldn't cope.

Since he has been in Rowena he can now go up stairs.

The food in Montagu is significantly better than DRI.

In Montagu they were frightened about him falling. so they wanted to keep him in the chair. I said it is affecting his quality of life. They wouldn't let him take himself to the toilet. He went to the toilet on his own once. When he came back he was very pleased. I clapped and said well done Dad. The nurses were up in arms. They were worried about him falling. How is that rehabilitation?

So it wasn't until I said to them: what are you doing about rehab? They said OK there's a list [of people before him]. He is stuck in a chair waiting til its his turn! It took me to have a fall out with them to have him on the list the next day! That worked for him, but what about those who have no-one to speak up for them? Regarding the physio - eventually they said he's not coping with the stairs. Sometimes he wants to do it. sometimes not. The physio room is artificial and looks exhausting. If it was more realistic, or actually going up and down stairs for a reason, then people will do it. It needs a proper flight of steps with an end result to it - a drink at the top - not three steps in a physio room.

At same time the staff have moved from Tickhill Road. They were having to merge the staff teams. Staff were unhappy as they were having to travel further.

Did they do what they said they'd do? No. Eye drops were needed. One in the morning and two at night. I asked if they had got it right. I looked at the notes. They had it the wrong way round. They said they'd change it and said they'd ask the doctor to do it. They had not changed it when I asked again on two occasions. On the third occasion I spoke to the doctor and she actually changed it. They don't understand how important it is to get the eye drops right.

They did not rush him home. That was useful for me as I was trying physio for my shoulder. They knew my situation.

On the move to Rowena: Audrey said you need to think about what you want to do next. I was devastated as I thought he'd get back on his feet. I'd get upset. She said it wasn't doing him any good keeping him in. She arranged a meeting. She brought someone over from DRI - a social worker - I thought at this time she'd brought reinforcements in case I disagreed. She said about Rowena. A unit upstairs at Rowena House. It did me a favour as I'd started to look for a care home. They got him going up and down stairs. His incontinence has settled itself. It did wonders. I'm now waiting for a place to emerge at a care home. The week after the surgery on my shoulder I got a phone call from Rowena asking me to find somewhere for Graham. I said I'd had surgery and that I just cannot. At that point there was an embargo on accepting people downstairs at Rowena. I said why is there an embargo? Nobody knew why or who to speak to about it. As it is a Local Authority place I thought I'd phone Adult Services. Someone at the local authority said the embargo has been lifted and she said that this didn't make sense. Nobody at Rowena knew about it.

The next day I got a call from the social worker on the upstairs Rowena rehab unit saying they had a place on the downstairs EMI unit. Not what I want but its going to have to happen. Who in their right mind would want to go into a council run care home? This was my initial thought. Since then I have come to see the good of it.

Overall - its like you've got to be speaking up for Dad all the time to get results. I'd like to think they were taking immediate action. They do not.

Three months after his admittance to the EMI unit at Rowena I am pleased that it worked out as it did as I can see that Council Care Homes are generally much better than Private Care. The carers are on shorter shifts and the vast majority have been there for some time which gives a degree of consistency. There are still issues but at least I can go every day to make sure he is well taken care of. Yet again it is the residents that have no-one to look out for them who are vulnerable to not receiving the best of care.

### Case study 7: Georgina and Harry's experience

I was battling on, on my own, and should have asked for help and then had three nights in a row with the paramedics out.

I agreed to have carers into the house. I was put under a great deal of pressure to have him home. The doctor said do you want him home? I said yes. I wondered: what were they planning? Nobody said anything direct. I was so bad with my heart problem they didn't want to say (paramedics).

I had a Tickhill road CPN. He really made me face up to how things had got too much for me to manage. There was lot of incontinence. I couldn't get him out of his chair [at home]. Everything was soaked in urine. His mobility had gone. Audrey [the OPMH team member] was not yet involved.

I [then] spent 11 hours in A&E with him. The taxi driver had parked in a police spot and had carried him into A&E. It was very, very busy. No complaints about the A&E people. It's the length of time it takes ... they can't help that when they are busy. Constant repetition exhausts you. Distraction techniques worked [with Harry] in A&E but it is exhausting to keep repeating everything about why people aren't coming. Even when they are coming!

This was the beginning of the worst times. One Friday morning I went to pieces. This is not me. Harry was admitted to hospital and was transferred to the Renal unit. Some of the nurses... they need training for working with people with dementia. His mobility had gone. They would shout at him telling him to stand up straight while he walked. Ward 25 [in contrast] are brilliant as they are used to mental health issues. These didn't have any patience at all. We had to say 'hey! stop it!' He was sitting in the toilet shouting for us 'cos he didn't know where he was'. I had difficulties pinning a doctor down about what was going to happen next and had to keep repeating that he was allergic to penicillin. He went to Ward 25 when they finally realised he needed it. He couldn't get out of his chair. He wasn't feeling well because of the kidney infection. He couldn't tell us how he was feeling.

Ward 25 - He was there 3 weeks. I kept being asked at various points 'has he got a social worker?'. I couldn't get through to the doctors about the difficulty of coming home. They did not listen about the danger time: - 2-5 am in the main time for falling so this is very difficult.

His physiotherapy meant his mobility was better in the hospital. He would say 'I'm walking fine,' and, 'I don't have trouble walking', but we would laugh and say how it wasn't the same at home. But the doctors wouldn't listen to that. The doctors suggested that he have carers to come in four times a day for 15 minutes at a time. But that is not enough to get him dressed. It would take me nearly an hour to get him organised. He wasn't able to find his things or his room [at home]. It was difficult to explain to the doctors why some plans won't work. My angina was getting worse as well as part of this. And I had total exhaustion.

I was allowed to go in at any time on Ward 25. I'd be in from 9-5 all day.

The doctor said - he can go home, his knee is fine, he is talking to me, he has had an infection. I got mad. I pointed to him and said to him - 'that is the wrong knee!. Please look at your notes!'

Harry was not in Doncaster in his head. The doctor went away. The OPMH staff member, Audrey then arrived. Audrey picked up instantly that Harry was 'in Lingfield' in Surrey where he had been as a child. He had lived there in a epileptic colony. The doctor had been impatient. He had not read the notes. This causes distrust. Audrey picked up instantly Harry was 'in Lingfield'. Audrey whispered in my ear 'Oh love, I don't think you are going to be able to let him come home.' Officially she shouldn't have. She was reassuring me that it wasn't just trying to shovel him out. And the guilt I have. And when he starts at me 'you've dumped me and I've been dumped before'. This is his personal story. Audrey explained there were procedures to go through.

[At home] I'd tried to get him to go to a community activity so I could also go to community activities or meetings. People come to help me from the youth club and elsewhere.

[While Harry was in hospital] the social worker rang the house. [She] didn't introduce herself and was difficult to understand. She said there would be a meeting. Harry wasn't at Rowena at this point. I was still under pressure to have him home. I knew really that the odd night at home would not help. I knew nothing of the voucher system. We had never claimed anything. We always managed to get things through people we know. I got attendance allowance for Harry. The CPN had helped me to get the attendance allowance.

I've nothing really but praise for the girls on Ward 25.

People don't understand the system. We found it difficult to find out which department the social worker was working for. The Office of Public Guardian is who she turned out to be working for.

I'd let things get on top of me 'cos I kept doing things for myself alone. We had a meeting with the girls at Rowena with a choice of 'home' or 'EMI care'. I understand they made a decision that he needed to go to EMI. My daughter and I started to look around. Audrey was going to the meeting but was a little bit late. I was not with my daughter. My neighbour (who's been helping) said 'I will go as you are under such pressure'. I didn't want Harry to go into care but I couldn't manage any more. Everybody was there. The social worker was there. Audrey was not there. The social worker asked for another meeting the next week. The neighbour- who is confrontational - said that will not be good and will freak him

out. A phone call arrived from Audrey to say 'Do not make a decision without me'. Everybody had a cup of tea until Audrey arrived.

He is so much better in care.

At the meeting, I asked them if she is prepared to sign an 'unsafe dismissal'. The Alzheimer's Society suggested I might ask this. The social worker had not read any report that Audrey had written. She was making decisions without the facts. When Audrey arrived she started to use the right words - I was still only beginning to understand what to ask for. The decision was made that he would go into care. This was on the Monday.

My daughter came up to look at care homes. The Stenson Court care home had done an assessment and the manager said Harry could go there. This would be very convenient.

On the Friday morning I got a call from the social worker. Previously the GP had said 'If you want to, then contact me'. The social worker wanted to come up and inspect the bungalow to see if it was suitable for him to come home. I had forgotten that we had had the 'decency work' in the house and that the bath had been changed to allow for my angina. I immediately thought: why had she needed to come herself on her own? I went to pieces.

After the [council] social worker's call it took me six hours of relaxation exercises to calm down. This seemed such a shock to suddenly go from getting on OK and for Harry to go to Stenson Court and then the social worker asking to review the house for him to come home.

My daughter insisted on the [council] social worker visiting on the Monday so she could be there. The social worker said it had to be at 9am when my daughter [who works and lives away] could not get there. She kept putting things from the council in front of me - she was suggesting putting in a hoist for Harry. This was obviously not going to work in our bedroom.

Then I [talked to] a hospital social worker and I talked to the CPN who came to the meeting. My daughter came up too. My chest was getting so tight because we felt so under pressure to have him home. Audrey couldn't attend the meeting. At the meeting the [council] social worker said - 'before we start this meeting I will tell you what will happen.' I could not breathe with the angina. I did some relaxation exercises. Then had a little spray. I went unconscious. They pressed the button for the crash team. I came round. I'd not done this for seven years. The [council] social worker said 'she'd had a little sleep'. My daughter and the CPN were very cross at this. I was kept in overnight.

I had been struggling with not having the knowledge about who to ask [for help and information].

During the subsequent meeting that had happened in Rowena, the hospital social worker said 'sometimes I think we social workers don't realise what effect we can have on people'. Near as we'd get for an apology. Harry was then sent to Stenson Court. It was difficult for him to settle in. Audrey had not been involved in the transfer - it had been her day off.

He had falls in Stenson Court that led him to go to Ward 25. The paperwork on his medications did not arrive on the Ward quickly and the staff member on the ward actively chased it up. From there he moved to the Royal care home where he receives nursing care.

Audrey helped so much with the form for the funding and it would not have been done as well without her. The social worker sent off the form for the funding.

Then, there is no phone call. I've had to find the information about the money by keeping ringing to check with social work to see if it was sorted.

Was he ever thirsty on Ward 25? He was often asked and no he wasn't. I was there quite a lot. On other wards I had to ask for water.  
Was he hungry? No, Ok there.

Social workers need to visit the care homes more frequently and not to take things at face value. They need to be more aware of dementia care. They need to take time to read the notes and reports before making decisions.

People sometimes kick up a fuss when they are not told the basics about getting a care home place - that there is a procedure to go through to get the care home organised - unless you just want to find one yourself.

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