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NHS Health Education North West

Case Study: Seconding a Specialist Practitioner in Mental Health into an Acute Integrated Discharge Team

In October 2010 a proposal was made by a multi-agency group of Cheshire and Wirral Partnership NHS Foundation Trust (CWP), the Countess of Chester Hospital NHS Foundation Trust and the local social services provider, Cheshire West and Chester Council, to place a specialist practitioner in mental health (SPMH) into the Integrated Discharge Team of the Countess of Chester NHS Foundation Trust.

The aim of introducing this role was to facilitate the timely, safe discharge of patients over 65 years of age with possible dementia, delirium, or mental health issues, who would otherwise experience increased length of stay or delayed discharge from hospital. The multi-agency group identified the need for a practitioner with experience and knowledge to set up a new service, integrate it within the acute hospital setting and have the skills to evaluate it. It was also important that the practitioner was adept at assessing, identifying and managing risk in both the hospital and community setting.

An initial six month pilot was conducted, which was then extended for a further twelve months to enable a review of the outcomes of intervention to take place. A bespoke audit was carried out, comparing patient information regarding diagnosis, inpatient pathways and length of stay, between a group of patients who had intervention and those who did not. A qualitative audit of patient and staff experience was also conducted, targeting all of those who had received intervention and all staff who had utilised the service. Results from both aspects of the audit showed that the specialist mental health practitioner had a significant impact on the service: reducing length of stay, improving the quality of care of the patient and their family, and improving the staff experience. Consequently the appointment was further extended and the SPMH continues to play a valuable role in the Integrated Discharge Team (IDT).

Key Outcomes

- The initial audit demonstrated that patients who received intervention from the SPMH had a combined stay in hospital of 2,925 hours less than those who had no intervention.
- The second phase of the audit demonstrated that 86% of the patients who received intervention from the SPMH were able to return to their admission address in comparison to 71% of the non-intervention group.

- The audit demonstrated that there was very little impact of SPMH intervention upon readmission rates in comparison with the non-intervention group; the age group and associated comorbidities of the population included in the audit were highly likely to influence the need for readmission. However, of the patients from the intervention group who were readmitted 100% (107/107) were able to return to their admission address in comparison to 40% (43/107) of the non-intervention group.

- Data received from the qualitative audit indicated 100% consistent satisfaction in relation to the intervention received from the SPMH. 96% of colleagues targeted indicated they felt that the support from the SPMH supported/developed their working practice and knowledge.

Background

Cheshire and Wirral Partnership NHS Trust was formed in 2002 and achieved foundation trust status in 2007. It has over 1500 foundation trust members and employs more than 3,000 staff across 95 sites serving a population of over 1 million people. The Trust provides inpatient and community mental health services for adults and older people as well as learning disability services and drug and alcohol services across Cheshire and Wirral. CWP also provides physical health services in Western Cheshire and specialist services within Liverpool, Bolton, Warrington, Halton and Trafford.

In September 2002 8.9% of older people occupying NHS acute beds had been declared fit to leave hospital but had not yet done so for a variety of reasons. This equates to more than 4,100 older people on any given day. Delays in discharge can undermine quality of life and increase dependence upon institutional care (National Audit Office, 2003). To address this the multi-agency group of CWP, their neighbouring acute trust (the Countess of Chester Hospital NHS Foundation Trust), and social service providers (Cheshire West and Chester Council), developed a proposal for a 6 month pilot post of a specialist practitioner in mental health.

Key Aims

- To reduce the length of stay of the target group through the intervention of the SPMH
- To show that this group, having received intervention from the SPMH, returned to their original place of residence following discharge from hospital
- To demonstrate whether intervention from the SPMH had an impact upon reducing readmission rates of the target group

Key Stages of Setup

The need for the post was identified in the Delayed Discharge Forum which was a multi-agency group set up to identify causes of delayed discharges at the Countess of Chester Hospital and formulate appropriate solutions. Delirium, dementia and general mental health disorders were identified as being one of the largest causative factors in delayed discharges and a proposal was developed for a specialist practitioner in mental health to work within the Integrated Discharge Team in an attempt to reduce length of stay, facilitate more people returning to their admission address rather than nursing home placements and reduce the need for readmissions. A proposal was formulated and funding was obtained from the Department of Health's Delayed Discharge Grant.

The job description and recruitment method was a collaborative process between the stakeholders involved in the discharge forum. The post advertised was for a Band 7 practitioner with experience in older people's mental health, with a desired requirement of knowledge and experience of research and audit. After a recruitment period of 2-3 months the post commenced in Dec 2010 as a 6 month pilot until June 2011; it was then extended further and continues to this day.

How it Works

The service operates between 8.30am and 4.30pm Monday to Thursday. The specialist practitioner for mental health works proactively with the Integrated Discharge Team to identify patients with dementia, delirium, cognitive impairment or other mental health issues at an early stage of their hospital stay.

The majority of cases consist of dementia or delirium. Some cases already have a formal diagnosis but this is not always the case; the role focuses on behaviours and needs rather than being diagnosis led. A typical case can consist of a patient who experiences an episode of delirium with associated confusion and agitation with no previous memory problems, and who, when the delirium is resolved, returns to having no memory problems or mental health issues. In some cases families report cognitive deficits pre-illness that have not been formally assessed or diagnosed. In these cases, the practitioner would refer the patient to the memory service, once recovered from physical ill health, or they would make recommendations to the GP for a referral at a later date. During the four years of the post to date there have been two referrals for other mental health issues, specifically depression.

The specialist practitioner acts as a liaison between the Community Mental Health Team (CMHT) and the Integrated Discharge Team in those cases that were already known to mental health services, in order to facilitate timely reviews and smooth discharge planning. For those patients not previously known to these services, the SPMH supports the Integrated Discharge Team in identifying areas of community

support needed to facilitate timely, safe discharges. The SPMH also acts as a co-ordinator to bridge the transition between hospital and the community, ensuring robust care plans are in place that meet the individual needs and risk profile of each patient.

The risk management of all cases follows a common pro-forma, predominantly that of information gathering. The presenting problem is identified (e.g. delirium following infection) along with the difficulties the problem poses for the patient returning to the admission address (e.g. confusion, aggression or agitation). Families are involved in the information gathering to identify home circumstances, support available, potential risks and the possible wishes of themselves and the patient. Other members of the care team are consulted and their assessments and clinical opinions are shared. A multi-disciplinary team decision is then made as to the viability of the patient's safe return to their admission address to continue recovery in a familiar setting. Prior to any discharge contingency plans are drawn up with patients, families and all involved in the community care provision, to ensure that all parties are clear in the management of potential risks.

The specialist mental health practitioner works closely with different services including social workers, care agencies and primary care mental health services, giving them links to access support for people with mental health problems, which may previously have been difficult to access, such as the Intensive Home Treatment Team for mental health and the Rapid Response Team/Community Matrons for physical health. When a patient is discharged from hospital the SPMH visits within 2-4 days and reviews the community based intervention plan. They identify any gaps in the initial discharge plan and co-ordinate community based services to bridge the gaps. They continue to offer community support for up to 6 weeks post discharge and then refer on to longer term support agencies if required. The SPMH utilises close links with voluntary agencies, such as the Alzheimer's Society and Age UK, in the on-going support of some cases. Due to the workload of the practitioner, they are unable to offer open-ended support to people who have cognitive impairment. Often the input of the practitioner is the only involvement the patient has received and a referral to the excellent voluntary agencies for ongoing support is very welcome and necessary.

Resources/support

The Band 7 SPMH was initially funded for six months by the Department of Health's Delayed Discharge Grant. The post was then extended to facilitate an audit of the outcomes of intervention and subsequently funded through social services recurring monies. As a result of demonstrable positive outcomes for both patients/carers and the workforce, the funding has continued indefinitely. The provision of the SPMH was via Cheshire and Wirral Partnership Trust as a secondment post and day-to-day management is via the Integrated Discharge Team at the Countess of Chester Hospital.

Example case

An 86 year old gentleman was admitted displaying symptoms of delirium such as acute confusion, disorientation and agitation. He had two previous admissions with a diagnosis of pneumonia. The patient was also experiencing visual hallucinations and was expressing delusional ideas as well as aggression. He did settle when his wife was present and she would spend much of the day with him.

The SPMH was asked to assess the patient for his suitability to go home as it was hoped he would settle in his familiar home environment. At the initial request the practitioner did not feel he was safe to leave hospital as his behaviour was unpredictable and the risk on keeping him safe at home appeared too great. The practitioner maintained contact with the ward and reviewed the patient daily, after a further 4 days treatment he was more settled but remained confused and disorientated.

The practitioner embarked upon an information gathering exercise, speaking to the family to ascertain home circumstances, identify potential risks at home, and determine their feelings about the patient's discharge. The practitioner also spoke to medics and nursing staff to determine the patient's current medical and care status, and to therapists to determine the patient's functional ability.

From the information gathered the practitioner was able to identify potential risks in the community and formulate a community based care plan to meet the patient's functional and risk needs. This included utilising the support of hospital based social workers to arrange a four times daily package of care for support with personal care needs. They also had a discussion with the family to arrange downstairs living as there was a falls risk and the patient was unsafe to use the stairs, and gave advice about maintaining a safe home environment.

As the patient was more settled his family were keen for him to go home, they were given information about his condition and a contingency plan was agreed with them. The practitioner contacted the patient's GP to advise of his recent presentation and ongoing physical health needs. District nurses were also contacted to ask for their support on discharge. The patient was discharged home and the practitioner visited him at home within the initial 24 hours.

He had been a little restless when he initially went home although his family reported he had immediate recognition of his surroundings when he arrived home. He had slept well and was much calmer then when in hospital. He did recover from his illness and when the delirium resolved there was no evidence of any cognitive impairment or mental health problems.

The patient was readmitted 6 weeks later with a further episode of pneumonia. His presentation was similar to that of his previous admission in that he became confused, disorientated and unsettled, however a lengthy readmission was avoided as the practitioner was able to alert the medical care team as to his previous presentation and facilitate a quicker treatment plan. A timely appropriate discharge plan was in place and the patient was again able to return home.

Clinical supervision and overall management responsibility of the practitioner is via Cheshire and Wirral Partnership Trust. Supervision is on a monthly basis. In the initial months of the post it was a 'lifeline' for the practitioner and as situations arose they would keep a reflective log to explore and discuss during supervision. The opportunity to reflect on their practice with another mental health practitioner is considered to be particularly helpful and reassuring. Many of the initial meetings consisted of reflection around professional relationships and management of difficult situations. The practitioner was able to develop their self-awareness and skills in tact and diplomacy. It was also an opportunity to identify and address professional development needs.

Key Challenges

- The integration of a mental health practitioner into an acute hospital setting posed an initial challenge. Staff were reticent and unsure of how to use the service. It was a new service and they had no previous knowledge or experience of what they could expect or how the practitioner could help. The practitioner was available to discuss cases and was very flexible in their approach; they regularly attended ward rounds and IDT meetings to identify cases at an early stage and encouraged staff to consider their input. As positive outcomes and benefits of the practitioner presence became apparent the integration was increasingly successful.

- The SPMH had never worked in an acute hospital setting before and the integration of the post posed a personal challenge for them, in effect they were a lone mental health worker within an unfamiliar setting. They felt very much out of their comfort zone and the difference in culture, systems and expectations between mental and physical healthcare provision was very apparent in the early stages of the post. This again was overcome with the passage of time and the practitioner's professional development within the acute hospital setting. They also linked up with the psychiatric liaison team based in the acute hospital for peer/caseload supervision, business meetings and the maintenance of their own professional identity.

- As the post was completely new, the practitioner was able to develop their own systems and processes, however they tried to avoid a rigid approach to facilitate acceptance and utilisation of the skills and knowledge that they offered.

Key Learning

- Intervention from the SPMH had a positive impact upon length of stay and discharge destination for patients over 65 with dementia, delirium or other mental health issues.

- It could be suggested that comprehensive discharge planning during an inpatient stay, coupled with a timely home review and robust co-ordination of community services, is important to ensure positive health outcomes for the elderly population in acute hospitals.

- The personal growth of the practitioner was immense in the initial phase of the post and has continued as the post evolves. The practitioner has established enhanced skills in developing productive relationships, learnt to be more patient and understanding of the roles and pressures of other professionals, and developed strong working relationships with outside agencies such as homecare providers, care homes and voluntary agencies. This has taken perseverance and a consistent presence/approach – a method that has been replicated in all aspects of the post, which has helped with the acceptance and reliance upon it within the acute hospital setting.

Sustainability

The post continues four years after its pilot and the audits carried out during this time have demonstrated that the post has met its initial objectives of reducing the length of stay of the target group and ensuring patients return to their original place of residence through the intervention of the SPMH.

The role has evolved over that time due to the changing needs of the older population and the needs of the acute hospital. The approach has always been flexible and encouraging of questions and challenges and redevelopment, which appears to have facilitated the acceptance and appropriate use of the service. It has been sustained due to the continued commitment from multiple agencies in the development and improvement in the care of the local older population whilst they are in an acute hospital setting.

The post is well established and accepted by the multi professionals it interfaces with, this has been largely due to the approach and knowledge of the practitioner tasked with setting it up. However, during its evolution the role has devised working guidelines within which it is possible to operate in order to have consistency for the practitioner and for the expectations of those using the service. It is hoped that should the current practitioner leave the post, their successor would be able to maintain the standards set as well as develop the role further which a new approach can often lead to.

Next steps

- A further audit of length of stay, discharge destinations and readmission rates to compare initial findings is planned. There have been inpatient developments in the Countess of Chester Hospital NHS Foundation Trust in the care of the elderly, such as dementia specialist nurses. The next audit will be an opportunity to review the impact their intervention has had upon the work of the SPMH.

- A more detailed satisfaction questionnaire is planned to gain more depth of information from patients', carers' and professionals' experience of using the service. This will inform the future development of the service.

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