

Perth & Kinross  
Intermediate Care Demonstrator Site  
For People & Carers Living with Dementia

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# 1 Executive Summary

A study was commissioned by the Joint Improvement Team (Scottish Government) to identify the contribution of Intermediate Care for people living with dementia to manage the shift in the balance of care for the partnership in order to achieve the outcome of an increase in independence at home.

The initial task within the demonstrator areas was to consider the existing pathway of care and provision, development or redesign requirements, identify gaps in services and to scope out the impact on shifting the balance of care through proposed changes.

Partnership Services for Older People identified that a key challenge for Perth & Kinross for the future was to develop intermediate care services for people living with dementia and their carers by developing models of care which were effective, efficient and sustainable. A 'test of change' commenced within the Perth City Locality in June 2009 with an end date of 28 February 2010 looking at two areas of development.

- An early supported discharge service (transitional care at home team) was established for acute wards within Perth Royal Infirmary to ensure a co-ordinated and seamless pathway for patients.
- Education and training programmes for care home, secondary care professionals and social care officers to support an improvement in patient care and to reduce care home admissions.

On completion of the project a full evaluation (Part A & B) was undertaken with improved clinical outcomes being realised for patients living with dementia in relation to:

- Reduction in length of stay in an acute hospital environment with no delays in discharge experienced by the patient.
- An improved co-ordinated and seamless transition from hospital to home with a reduction in the number of transfers / hand offs patient's experience in their care pathway.
- Reduction in multiple emergency admissions.
- Improved user / carer satisfaction with the service provision and the care and treatment provided by experienced and trained health and social work professionals working within the transitional care at home team.
- Reduction in mainstream home care packages on discharge from the transitional care at home service.
- Earlier detection of patients who had not been known to Psychiatry of Old Age Services previously allowing earlier planning, support and services to be put in place.
- Cost benefits for health and local authority in the form of bed days, readmissions and reduction in care packages.
- Improved knowledge and confidence in the recognition and management of people with cognitive impairment / dementia and / or delirium for health, social work and care home professionals.
- Provision of a more person centred approach to care.

There is enough evidence to suggest from the outcome of this project that further tests of change are essential in order to streamline services across Acute, Intermediate Care, Older People's Mental Health Teams and mainstream home care to consolidate a sustainable, flexible pathway which offers continuity of care and a person centred approach for people living with dementia and their carers.

## 2 Recommendations

- Work collaboratively with Local Authority partners to agree (internal / external) training modules in enablement and dementia awareness that are appropriate to the level of skill and experience of each individual Social Care Officer and Health Care Assistant.
- A review dementia care pathway to ensure that an enablement and person centred approach to care is included.
- Work with acute colleagues to support the development of dementia champions for each acute hospital ward to ensure that early detection and intervention is carried out and diagnostic tools utilised as part of any inpatient stay.
- Continue with the increase in the dementia liaison nurse's hours to support the early identification of people with cognitive impairment and delirium across Perth Royal Infirmary.
- Rotate Older People Mental Health Team nurses with the Dementia Liaison Nurse to ensure continuity of care for the patient and continual learning of the management of acutely ill patients who have suffering from cognitive impairment.
- Continue to roll out Dementia Care Mapping and training across Acute Services and Psychiatry of Old Age Wards.
- Work collaboratively with Local Authority partners to establish the Social Care Officer re-ablement approach and access to telecare.
- Breakdown the barriers between intermediate care and mainstream Older People Mental Health Teams ensuring patient flow is appropriate and seamless.
- Review the traditional models of community mental health teams in line with current proposals for Strathmore incorporating the whole spectrum of a patient's journey from early detection / intervention to end of life care, palliative care to provide a co-ordinated and seamless care pathway.]
- Develop awareness raising programmes and / or menu of care directory on services / options available for people living with dementia in the Perth & Kinross area.

### 3 Background

When the concept of intermediate care was first introduced it was seen as an opportunity to restore people to optimal health following an episode of acute physical illness. Older People with mental health needs were often explicitly excluded from intermediate care developments. This may sometimes have been because of a commonly held misconception that older people with mental health problems could not benefit from rehabilitation or could not benefit in a limited time. Too literal an interpretation of the original guidance that it should last for typically no longer than 6 weeks supported this exclusion criterion. Other key factors that led to the exclusion of anyone with an underlying mental health need were the lack of staff in intermediate care trained in mental health care and a lack of specialist mental health support to intermediate care.

Perth & Kinross provided several options for intermediate care services for frail older people prior to the commencement of the 'Test of Change'. These services although they did not specifically exclude people living with dementia, did not often admit this patient group due to the level of criteria and also the capacity within the service

### 4 Project Initiation Plan

A joint project structure (Appendix 2) was established with health and local authority to oversee the planning, implementation and evaluation of the 'test of change' using Project Management Prince II methodology.

It was agreed by the project board that Perth & Kinross would test 2 improvement areas in the Perth City Locality:

#### **PART A Transitional Care at Home Service**

Assessment within acute service admission wards (Ward 4, 7 & 8) to identify patients presenting with cognitive impairment / dementia and / or delirium and who may benefit from an early supported discharge service supported by the Transitional Care at Home Team comprising of a Transitional Care Nurse and three Social Care Officers with a special interest in dementia care.

This team had access, as and when required, to other professionals who provided support, advice, and assessment eg pharmacy, occupational therapy, physiotherapy, community nursing, Community Psychiatric Nurses (CPN) and psychiatric consultant. The Transitional Care Nurse was available Monday to Friday 8.30 am to 4.30 pm and the Social Care Officers provided a service 7 days a week from 8 am to 10 pm. Links were made with out of hour services such as community alarm, evening and overnight community nursing, social work services, mental health services etc.

A model of care was developed with criteria and care pathway (Appendix 3).

Initially the criteria (Appendix 3) stipulated that the duration of the service would be for short term intervention of up to 6 weeks but this stipulation was removed in August 2009 as there was low numbers of patients being accepted on to the Transitional Care at Home Service due to the restrictive criteria and to allow for a more flexible person centred approach.

## **PART B Education & Training Programmes**

To support prevention of admission from care homes an education and training programme was commissioned from Stirling Dementia Centre. This comprised of a 6 month module pack with facilitation support from the Centre and a Senior Charge Nurse from Psychiatry of Old Age Services at Murray Royal Hospital.

An in-house education and training programme was also developed and delivered to the Social Care Officers (transitional care at home team) and Acute Sector Staff on the management of patients with mental health needs. In addition to this, the social care officers were provided with training in enablement, rehabilitation, and basic nursing skills prior to the project commencing.

## **5 Method/Aims/Objectives**

The overall aim of the project was to identify the intermediate care contribution to a managed shift in the balance of care, capturing and disseminating the experiences of partners, and developing practical tools, evidence and solutions to assist other local partnerships meet relevant national outcomes for people living with dementia and their carers with the objectives being:

- Map current patient flow and pathway of care and existing provision, development or redesign requirements and identify gaps in service provision to inform possible future improvement changes
- Provide a person centred care service
- Be part of a whole systems approach to care.
- Facilitate timely discharge from hospital, where possible.
- Encourage active enablement as part of the care pathway
- Promoting use of new technology eg telecare
- Prevent avoidable admissions to long term care direct from the acute sector
- Have an active education and training agenda for Care homes, staff, users and carers
- Participate in developing an audit and research base for Intermediate Care.
- Inclusion
- Equality & Diversity
- Measure demand for service and identify other opportunities for improvements
- Provide alternatives to admission, if capacity of service allows within second phase of project.

### **The methods used were:**

1. Process Mapping of patient pathways.
2. Evaluation using qualitative and quantitative metrics.

### **5.1 Process Mapping**

Process mapping was undertaken with the multi disciplinary team in April 2009 prior to the project commencing. It looked at the patient pathway for people who presented with dementia and / or delirium on admission or during their stay in Perth Royal Infirmary and the number of possible transfers and assessments within the pathway a patient may experience (**See Appendix 1**).

There are 2 admission routes within Perth Royal Infirmary, Accident & Emergency referrals or GP referrals straight to the Medical Assessment & Admission Unit (Ward 4). The process map identified that a ***patient could be transferred on several occasions prior to discharge*** which

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could result in increased confusion and decreasing independence, thereby causing delays in discharge and increasing length of stay. **88% of patients not accepted on to the service experienced one or more transfers during their stay in hospital.**

With the establishment of the Transitional Care at Home Team there was **one point of contact / referral route for the acute sector**. The Transitional Care Nurse **proactively assessed patients** within Wards 4, 7 and 8, Perth Royal Infirmary for signs and symptoms of confusion, delirium and / or dementia to discharge on to the Transitional Care at Home Service thereby providing a **co-ordinated and seamless transition** from acute services back to their home environment.

The Transitional Care Nurse **worked collaboratively** with Local Authority Social Care Officers and had **direct access** to this service. **67% of the patients did not experience a transfer to another location within the health service prior to discharge**. The 33% of patients who did experience a transfer were admitted to Ward 4 (Medical Admission & Assessment Ward) and transferred to another ward in acute within 24-48 hours of admissions.

## 5.2 Evaluation Methods

A quality plan was developed prior to commencement of the project to ensure that the quality the project delivers is of a standard acceptable to all involved in its creation and is explicit to the requirements of the project. The purpose of the plan was to define the quality techniques and standards to be applied, along with the various measurements, and the various responsibilities for achieving the required quality levels during the project. It also allowed capture of baseline information and development of local data capture tools. The success criteria agreed were:

- The reduction in bed days in acute services (Heat target T1)
- Support the reduction in delayed discharges (National Outcome)
- Reduction in multiple emergency admissions
- Reduce inappropriate admission into long-term institutional care
- Reduce admissions to acute hospital from care home
- Early Diagnosis & Management of Patients with Dementia (Heat target)
- Reduction in care package
- Better Support for carers (National Outcome)
- Satisfaction of users and carers on the provision of services (National Outcome)
- Improvement in the quality of healthcare experience (Heat Target T7)
- Be part of a whole systems approach to care.
- Provide alternatives to admission to hospital and where appropriate facilitate timely discharge from hospital, where possible.
- Complements developments on other parts of the system e.g. telecare, brain care team
- Have an active education and training agenda for staff and users.
- Have an active education and training agenda for care homes

# **PART A**

## **TRANSITIONAL CARE AT HOME SERVICE**

## A.1 Reduction in bed days in both Acute and Primary Care Inpatient Services

**Control Indicator:** Average and individual length of stay, of inpatients who present with dementia, delirium or confusion who were not accepted onto the Transitional Care at Home Service due to the service being at capacity, declined or resident outwith Perth City.

Thirty three patients were assessed by the Transitional Care Nurse, who potentially may have benefited from being discharged from hospital using an intermediate care service, but not accepted on to the Transitional Care at Home Service during the time period June 09 to December 09. The reasons and percentage of patients not accepted onto service are shown in figure 1.

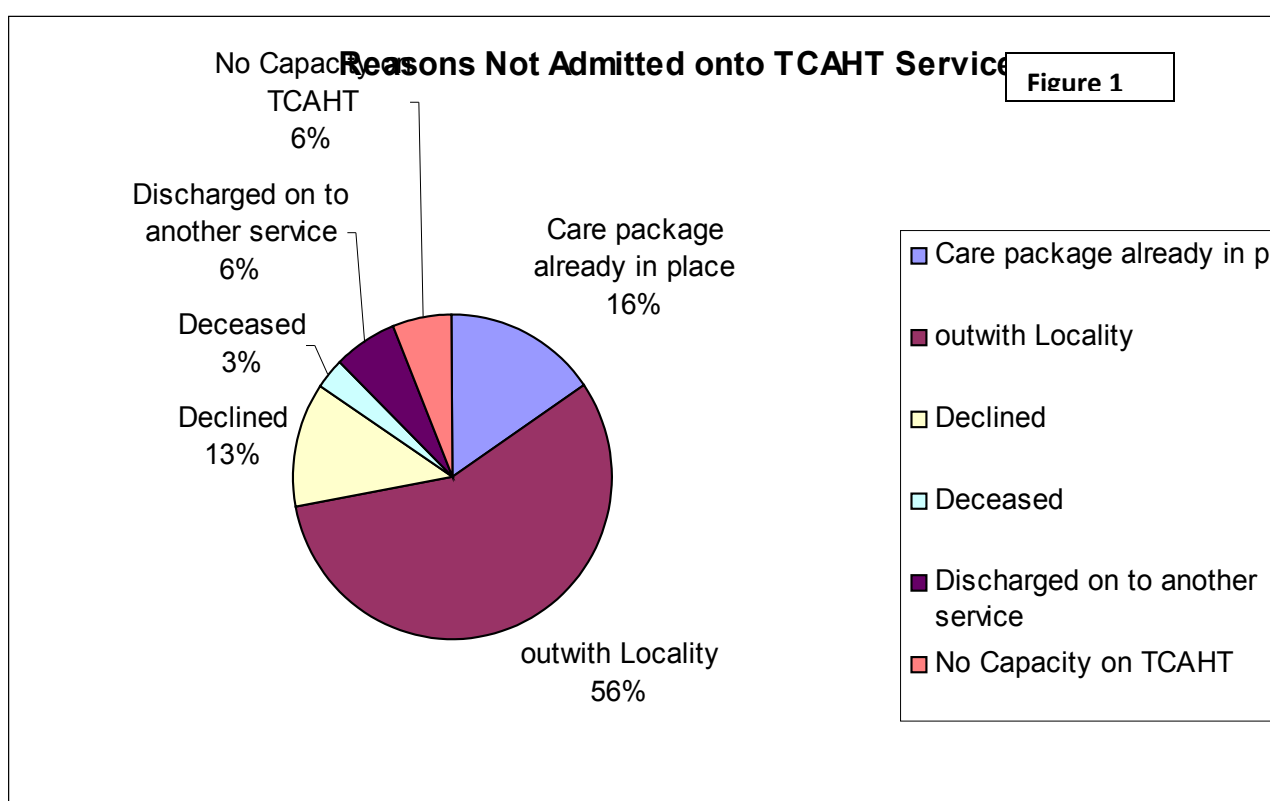
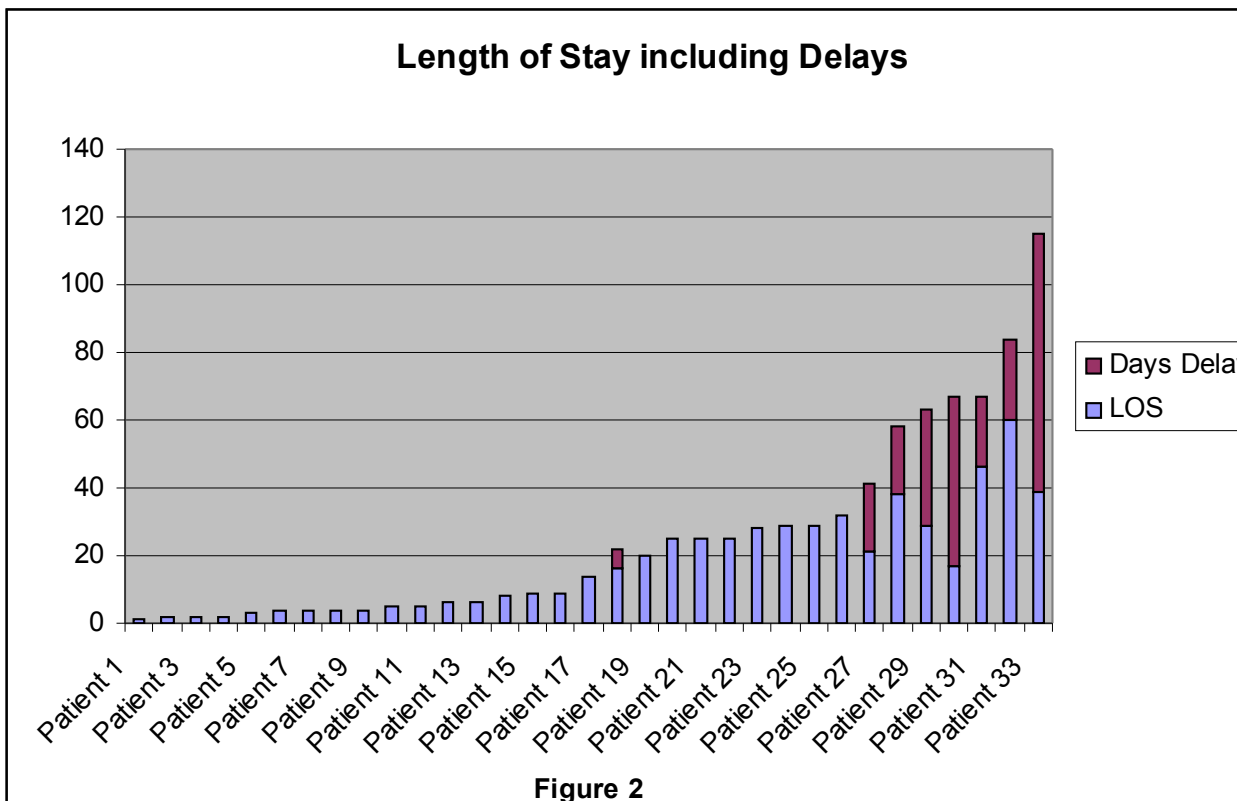


Figure 2 shows the length of stay for each individual patient in hospital for the unmet need category, the minimum length of stay was one day and the maximum length of stay was 115 days. The average length of stay for all patients was 25 days and the median length of stay was 14 days, which includes delays in discharge. 24% of patients experienced a delay in discharge. If delays in discharge are excluded the total length of stay would be 567 days with an average length of stay of 17 days and a median length of stay of 14 days.



**Figure 2**

**Project Indicator:** Average and individual length of stay of inpatients who present with dementia, confusion or delirium who were accepted on to the service (Figure 3).

Fourteen patients were accepted on to the Transitional Care At Home Team Service (TCAHT) during the time period June 09 to January 10 from acute sector wards. The minimum length of stay was 4 days and maximum 23 days. The average length of stay was 11 days with a median length of stay of 10 days. There were no delayed discharges.

An additional patient was discharged home using the Transitional Care at Home Team who was identified in a primary care rehabilitation ward. The patient had become a delayed discharge and was waiting for a home care package. It was decided due to capacity within the service to discharge the patient using this service. This patient is not included within the length of stay results.

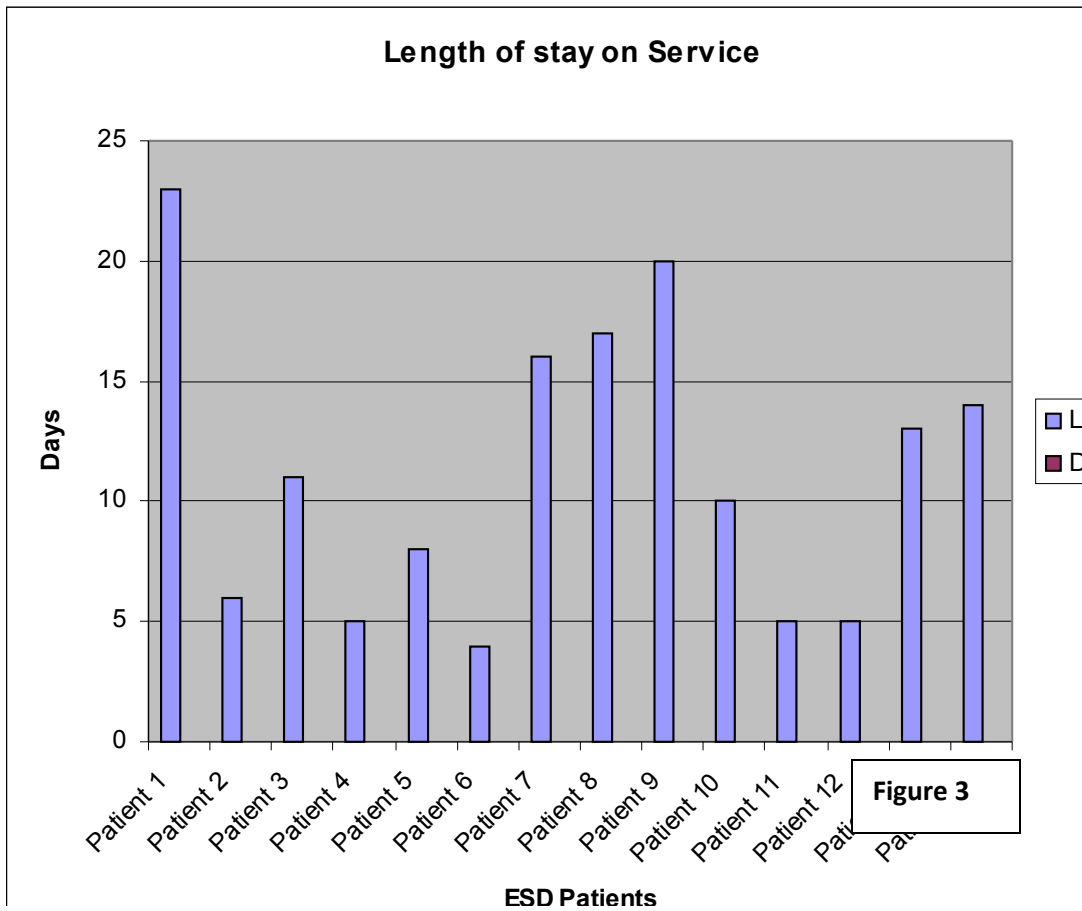


Figure 4 shows the comparison between the average and median length of stay for patients who received an early supported discharge through the Transitional Care at Home Team Service and those who did not.

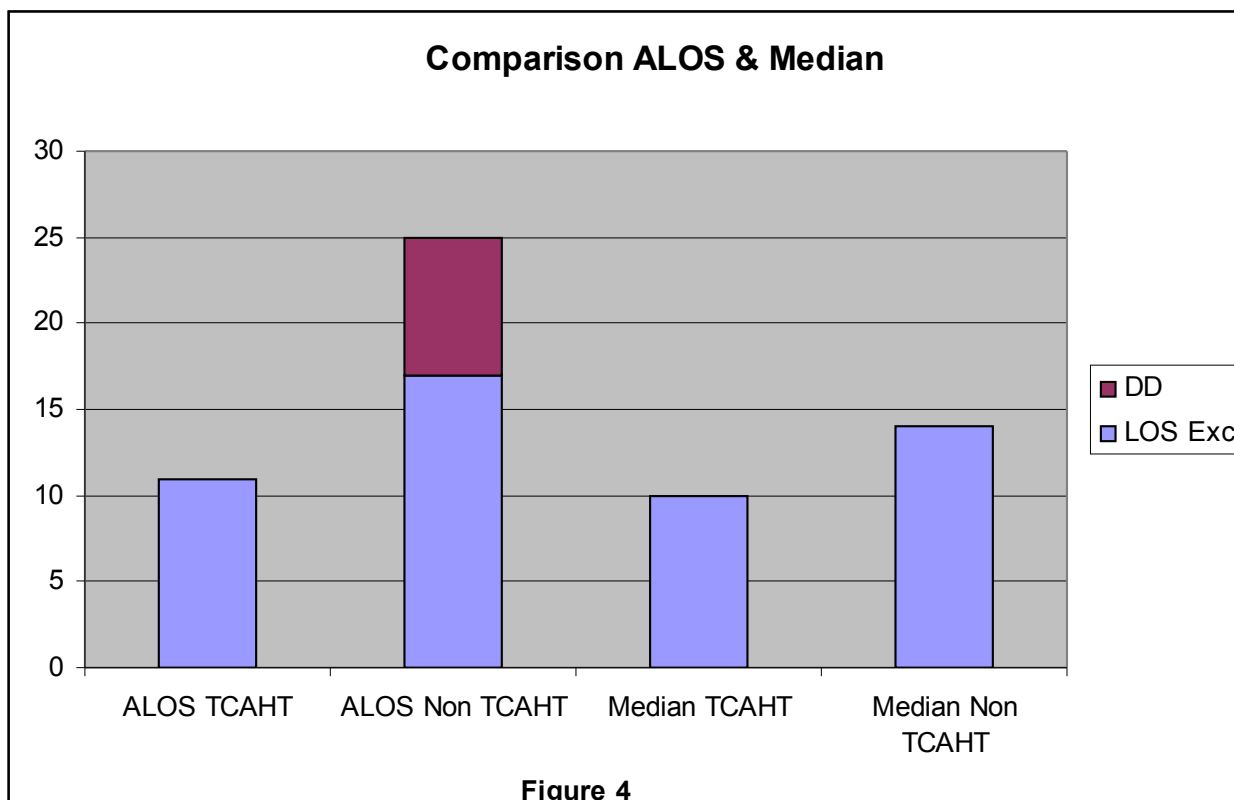


Figure 4

There has been a reduction in the average length of stay by 14 days and a reduction in the median length of stay by 4 days. If delay in discharge length of stay in the comparison group (unmet need) is excluded the average length of stay reduction is 6 days.

## A2 Cost of Service

For patients that were not discharged to the Transitional Care at Home Team Service there was a total of 818 bed days used at an estimated cost of £259,306<sup>1</sup>. The mean cost per patient was £7,857.76.

For patients discharged to the Transitional Care Home Team Service there was a total of 157 bed days used at an estimated cost of £49,769. Mean cost per patient was £3,554.93. This amounts to a reduction of 55% in the mean cost of bed days per patient (£4,302.83).

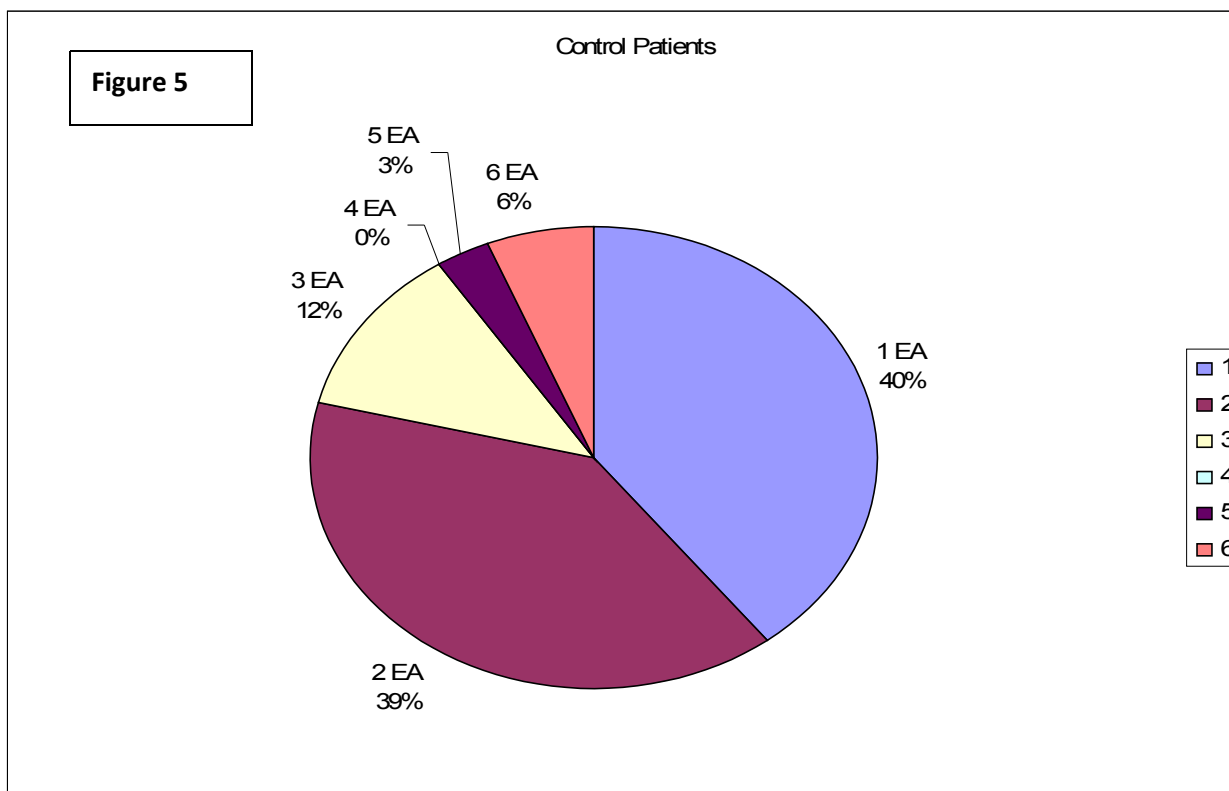
Consideration must also be given to the cost of the Transitional Care at Home Team Service which would include the cost of the Transitional Care Nurse, Social Care Officers, Physiotherapist, Occupational Therapist and Pharmacist. However, the benefits could be that through service redesign and partnership working this support would come from core services.

## A3 Reduction in Multiple Emergency Admissions

Control: %age of patients who were not accepted on to Transitional Care at Home Team Service who had two or more emergency admissions during the time period June 09 to February 10.

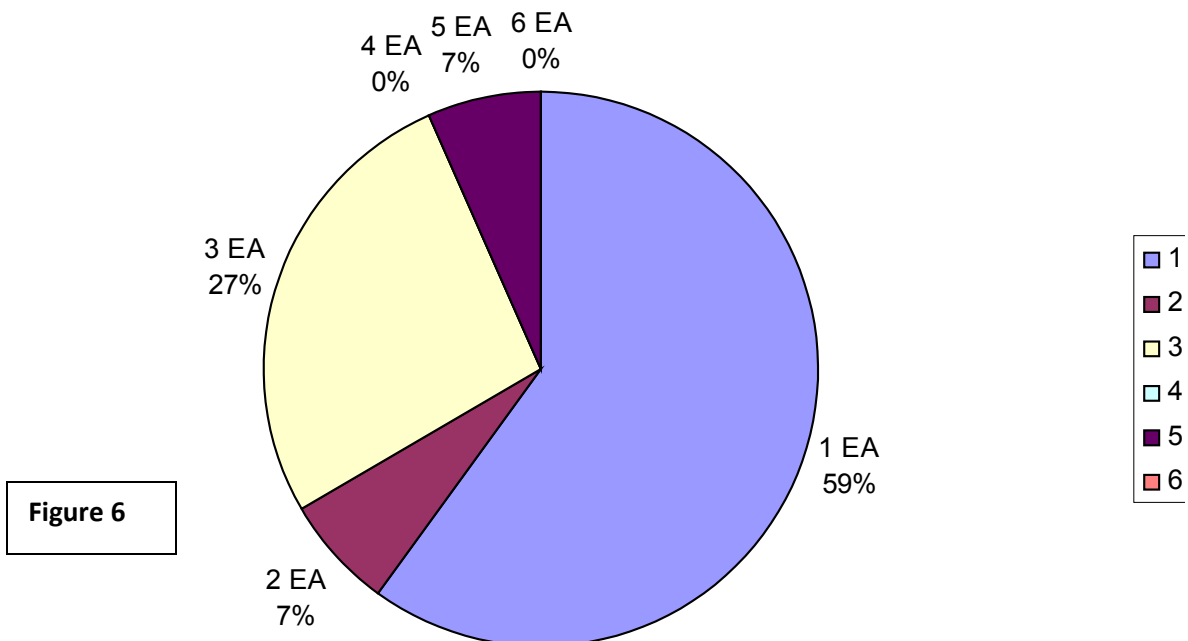
<sup>1</sup> Average bed day cost for General Medical Bed in PRI £317. Source Scottish Health Service costs year ended 31/03/09.

60% of the patients who were not admitted to the service were readmitted to the acute sector as an emergency admission. 21% of patients had more than 2 emergency admissions (Figure 5).



Project      %age of patients who were accepted on to Transitional Care at Home Team Service who had two or more emergency admissions during the time period June 09 to February 10 (Figure 6).

## Emergency Admissions Project Patients



**Figure 6**

41% of patients admitted to the service incurred another emergency readmission. 20% of patients were readmitted whilst on the Transitional Care at Home Team Service. The reasons for readmission were:

- Fall at home. Very complex medical pathology. Two subsequent readmissions and is currently still an inpatient.
- Urinary sepsis. Discharged home and referred to CPN services.
- Dislocated hip prosthesis. Readmitted 3 days after discharge from hospital. Discharged home with care package from mainstream home care.

20% of patients were readmitted on discharge from the Transitional Care Home Team Service. All were doing well on service but care broke down once transferred to mainstream services. Discussions with the Transitional Care at Home Social Care Officers indicated that the perceived reasons for patients incurring an admission to hospital were:

- Independent home care providers were sometimes used to provide the care required. The patient was unknown to them and often there was a lack of understanding of the patient's needs and how to manage them.
- Transitional Care at Home Social Care Officers often provided a rapid response service for carers, sheltered housing wardens etc if patient presented with confusion. The Social Care Officer would then contact the Transitional Care Nurse for advice and often prevented admission to hospital. This service was not provided in mainstream home care or through the independent home care providers.

- Mainstream home care and independent providers could not provide the specific time requirements that patients and carers often required and sometimes did not attend at the time agreed.
- There was no continuity of care provision with often different carers going in to the patient's home.

#### A4 Reduce Admissions into Long Term Institutional Care

**15% of patients who did not receive a service from the Transitional Care at Home Team Service were discharged from hospital to Long Term Institutional Care.**

**13% of patients who were discharged on to the Transitional Care at Home Service were initially assessed by acute staff as requiring admission to long term institutional care.** The Transitional Care Nurse assessed these patients and discharged them home using the Transitional Care at Home Service.

One of these patients was rehabilitating well on the service, with the social care officers preventing this patient from being readmitted to hospital at the weekend, unfortunately on discharge from the Transitional Care at Home Service to mainstream home care, the patient's mental health deteriorated and was admitted to EMI Care. This may have been caused by mainstream home care social care officers' not having the skills and knowledge required to support and manage patients living with dementia and also the restrictive time limit for undertaking assessed care needs.

A further two patients were rehabilitating well whilst on the Transitional Care at Home Service, but on discharge, one patient was admitted to respite care on the request of their family who are now requesting admission to long term institutional care, the second patient is currently an inpatient and is being assessed for potential guardianship. All three patients had no identified carer.

Figure 7 provides the discharge locations for patients accepted on to the service and also for patients who were not accepted on to the service.

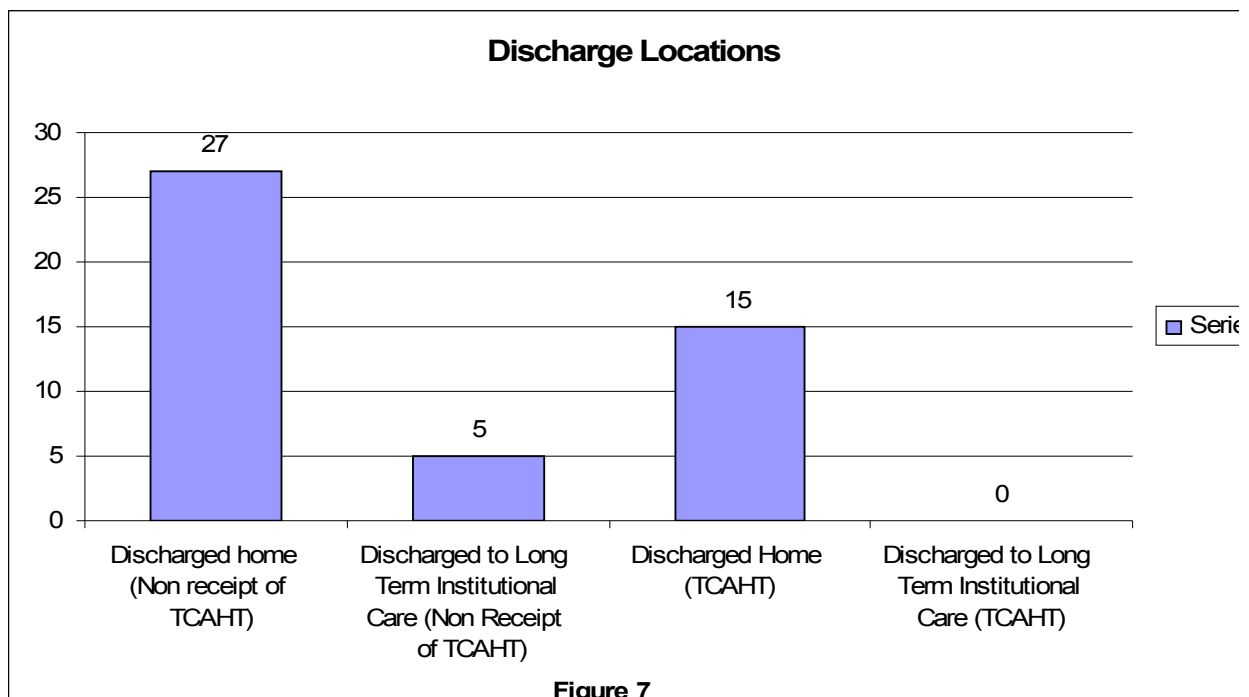
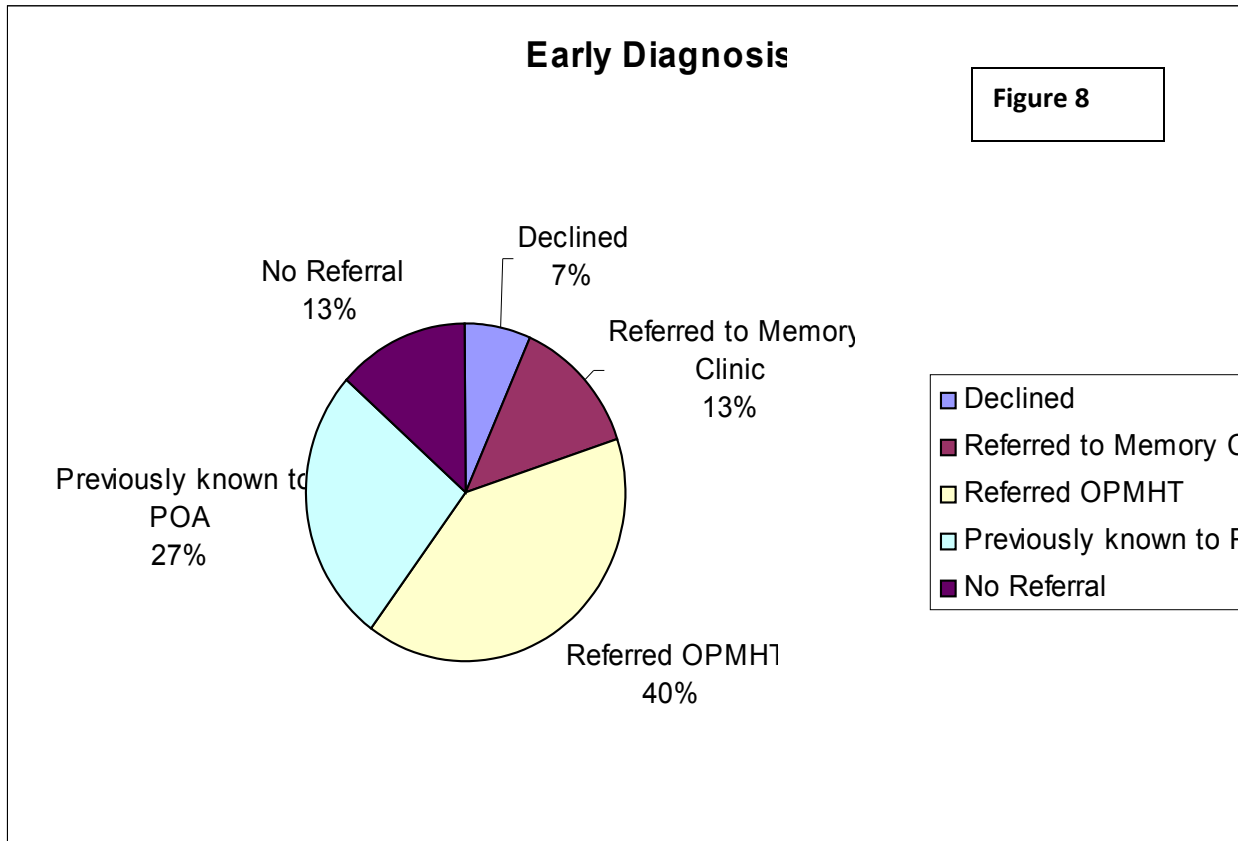


Figure 7

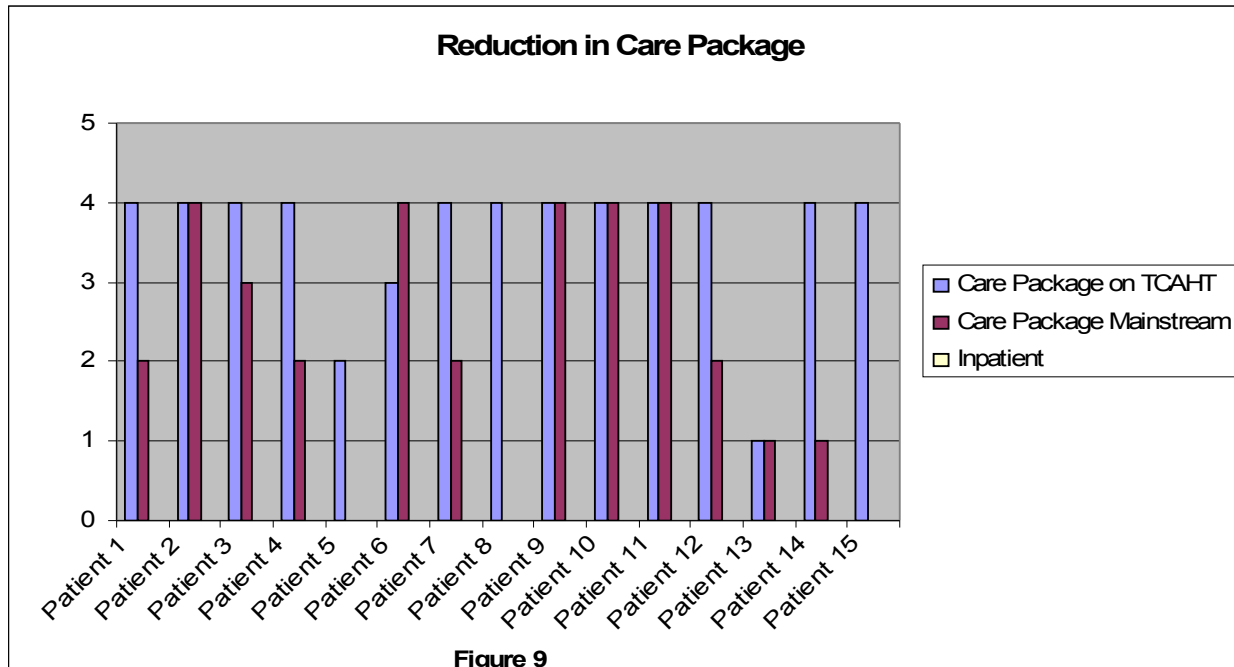
## A5 Early Diagnosis & Management of Patients with Dementia

60% of patients who received a service from the Transitional Care at Home Team were not previously known to Psychiatry of Old Age Services. All were referred to either the memory clinic or the Older People's Mental Health Team for further assessment of needs (figure 8).



## A6 Reduction in Care Package

46% of patients received a reduction in their care package on discharge from the Transitional Care at Home Service and transfer to mainstream home care services. This equates to a 26% reduction in home care visits per week for this group of patients. Figure 9 shows the reduction in care package.



Patient 5 on discharge from Transitional Care at Home Service had no care package in place. Patient 8 is currently in hospital and patient 15 is in respite care, on request of family. 7% of patients were assessed as requiring an increase in their care package on discharge from the Transitional Care at Home Team.

## A7 Provide Alternatives to Hospital Admission

Two patients were identified by community care for prevention of admission to hospital and were supported by the Transitional Care at Home Team Service. One patient was discharged with no other services in place and one was admitted to mainstream home care with a 4 x daily care package.

## A8 Better Support for Carers

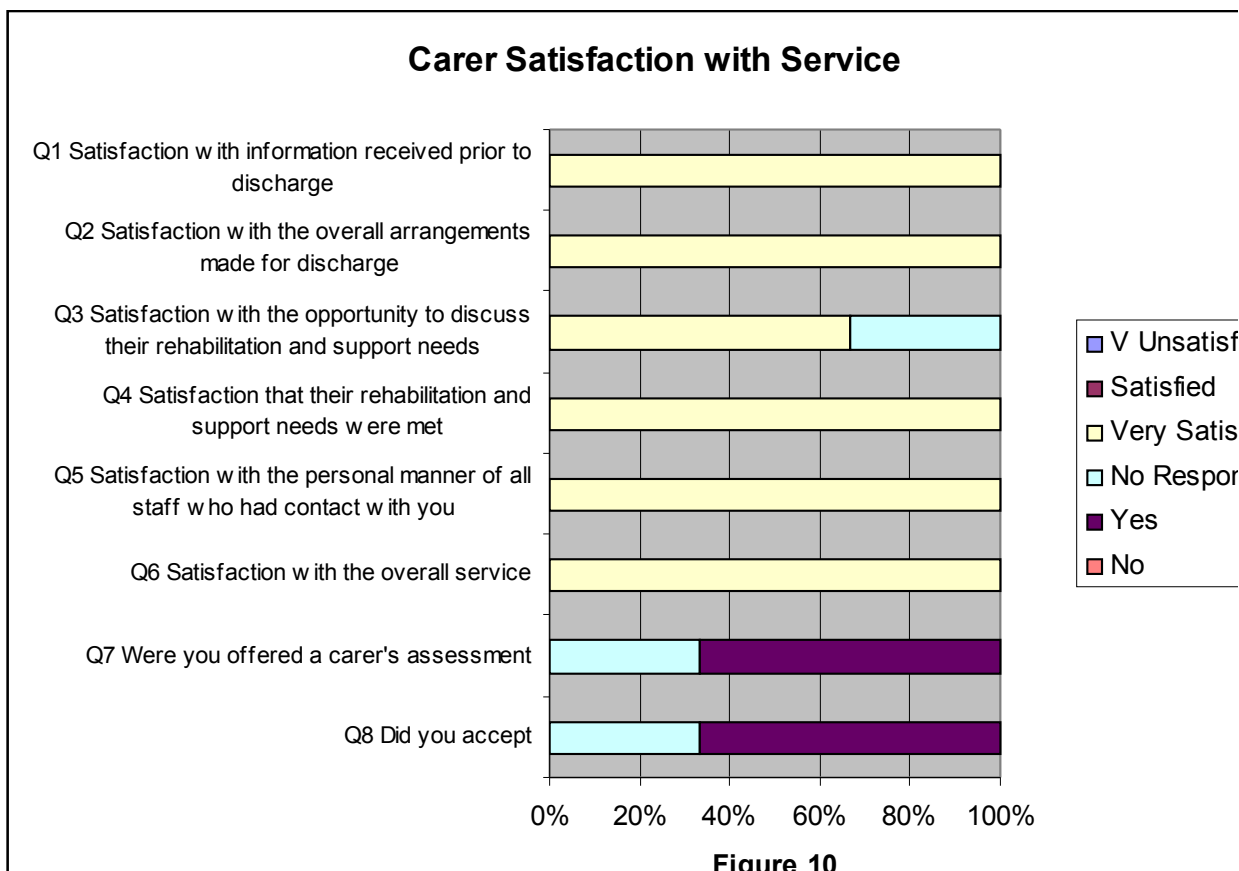
**Indicator:** Number of Carer's assessments completed for those caring for people with dementia.

A baseline figure was obtained from Perth & Kinross Housing Community Care from their SWIFT Information system for the period April 08 to March 09. There were 5 carers assessments completed for this time for people identified with dementia, mental health problems and alcohol problems (across the whole of Perth & Kinross).

During the project there were 6 carers identified, all were offered a Carer's Support Assessment. All declined. Subsequently, two carers indicated within the carer's satisfaction questionnaire that they had accepted a Carer's Support Assessment.

**Indicator:** Questionnaire from carers of patients to establish their satisfaction with the support offered by the Transitional Care at Home Team.

Six carers were identified from the 15 patients who received support from the Transitional Care at Home Team. 50% of these returned completed questionnaires (Figure 10).



Overall carers were very satisfied with every aspect of the service provided.

Additional comments: 'As a carer for my Mother and Father, I do sometimes feel frustrated not knowing who to turn to when Mum becomes ill as GP only prescribes pain killers. Brilliant service provided by TCAHT but feel monthly/two monthly follow ups should be provided.'

**Indicator:** Questions included within the Carer's Diary to establish satisfaction with the support received.

Three carers agreed to complete the diary on a daily basis whilst the person they care for was on TCAHT service. Only one carer diary was partially completed.

The Carer's Diary was developed jointly by Perth & Kinross Dementia Managed Clinical Network, Alzheimer's Scotland and Perth & Kinross Psychiatry of Old Age Service, Perth & Kinross CHP. The diary is completed on a day to day basis by the carer and allows them to express their experience of services provided, the impact of any good or bad experience for the family, user and carer, and also allows them to identify how the service could be improved.

One carer completed the diary over an 11 day period whilst receiving support from the Transitional Care at Home Team. The carer expressed that they were very grateful to the support provided by the social care officers and the excellent one to one interaction provided to their loved

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one. The carer detailed which professional attended, why and what interventions were undertaken to support the carer and the user.

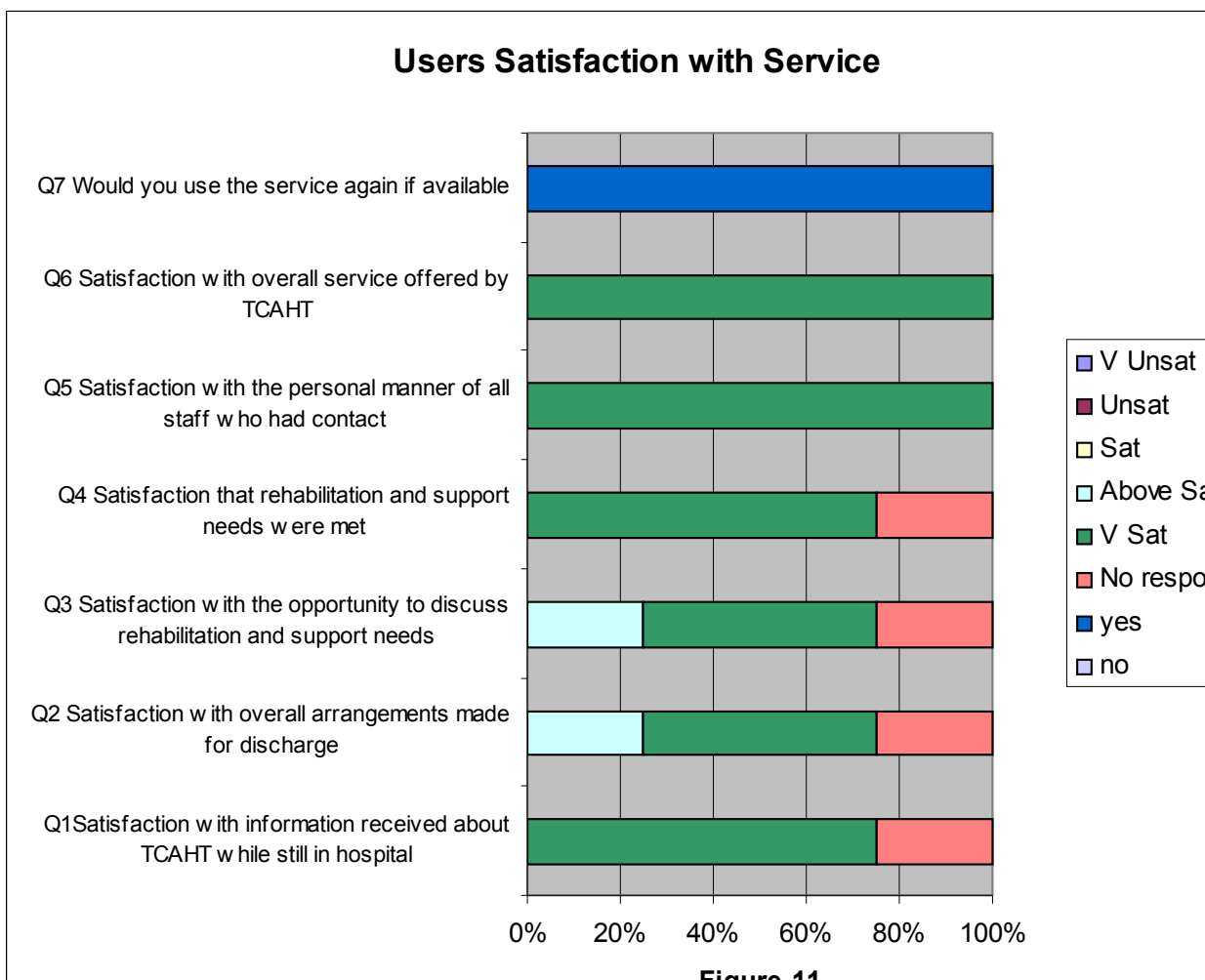
### A9 Improvement in the Quality of Healthcare

There is no baseline data to measure an improvement or conceived improvement in the quality of healthcare experience.

During the project carers and users satisfaction with the service received was collected by means of a satisfaction questionnaire.

Five user questionnaires have so far been returned (33%).

Figure 11 shows the results of the questionnaires. Overall users were very satisfied with the service and would use the service again, if available. There is a need to examine the low response rate and identify other methods of collecting users' views who may not be able to complete a questionnaire.



Many of the carers provided additional comments in relation to the quality of the service and care received whilst on the transitional care at home service. One carer expressed that the service should be available for longer and that the user became very upset when initial carers were pulled out.

The results of the carer's satisfaction with service are shown under item A8.

## **A10 Patient Stories**

The Transitional Care Nurse was also asked to provide an overview of four patient's journey who received a service from the Transitional Care at Home Team Service.

### **Mrs X**

Mrs X had a diagnosis of dementia and was discharged on TCAHT following a hip fracture. She lives alone and previously had refused carer's access. She had a CPN and she was under adult support and protection because she had written cheque's to bogus work men. My opinion was that she lacked capacity to make informed decision regarding her welfare and finances, however she was a very independent lady and was consistent in her wish to return home. She reluctantly accepted a supported discharge.

#### **Safety measures put in place:**

Key safe so carer's could gain access and to reduce fall risk.

Telecare equipment to inform us of her whereabouts in her home, in particular during the night. We discovered she was more at risk of falls during the night because of the commode we put in place. Commode removed. Telecare equipment informed us she was sleeping well.

Mrs X had very poor short term memory so a list of details was left for her on a daily basis to remind her of what was happening on that particular day.

E.g. Gas man coming at 10.30am. All professionals/carers can gain access, please do not rush to answer door. Please remember to use your zimmer. This proved successful.

Mrs X was initially unhappy about carer's coming in to assist her, however quickly became used to seeing the same faces and began to trust them.

She done very well on TCAHT, she was reviewed 3 months following discharge from the service and although not too happy to see me she was still doing well. She was discharged from her CPN.

**Mrs Y**

Mrs Y had a diagnosis of dementia and was discharged on TCAHT following accidental overdose of her cholinesterase inhibitor. Mrs Y also a very independent lady who lacked capacity. She had a CPN and she was very reluctant to accept care, often refusing carer's entry. She lives in sheltered housing and often was the cause of concern when she would go out during the night and knock on other residents door's and on occasions would leave the premises to go shopping. She was very paranoid and suspicious of the warden and some of her fellow residents.

Mrs Y done very well on TCAHT. A key safe was installed to allow carer entry and a telecare door exit monitor. Mrs Y began to trust the carers and looked forward to them coming, she made comments to the MHLN that she was happy with her care and thanked her. Her relationship with the warden and fellow residents improved and she began to mix with them again. The warden stated "what a difference since she has accepted the care coming in, she is more pleasant, less paranoid, not disturbing her neighbours and I have not been alerted during the night, I am enjoying the respite"

Unfortunately when the TCAHT period was complete and her care was transferred over to mainstream the warden said things broke down. She became more paranoid and stopped taking her cholinesterase inhibitor. She is now being considered for guardianship.

**Mrs Z**

Mrs Z lived alone and had cancelled her care package herself prior to hospital admission. Discharged on TCAHT she was very reluctant to accept care, however, very quickly began to trust the carer's and during her TCAHT period asked the carer to put some money (over £9000) in the bank for her.

Mrs Z was prone to periods of delirium caused by urinary tract infections and the carer's prevented re-admission during the TCHAT period. Unfortunately as soon as the TCAHT period was complete she became acutely confused again and was admitted to EMI care.

When she was in care it was discovered a family member who was unknown to us was living in her house, we had never seen him during the TCAHT period.

**Mr W**

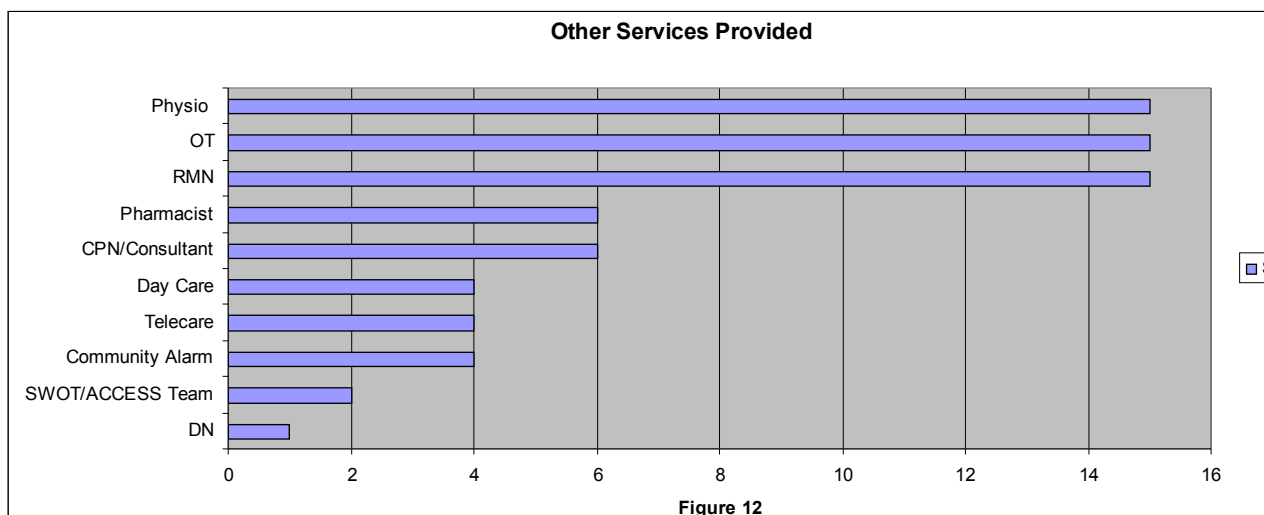
Mr W lives alone and was discharged home following a hip fracture. He had a history of alcohol excess, cognitive and functional; decline.

It was felt his mood was low as he lacked motivation and he tended to take to his bed. He required much persuasion to get him up in the morning. He done very well on TCAHT and never asked for a drink. Unfortunately things broke down when discharged from TCAHT, his niece said he did not cooperate with the "new carer's" he went into respite care. He is home now, however not doing well and he is now being considered for guardianship.

### A11 Complements Developments on Other Points of the System

Four patients were assessed as requiring additional support to ensure their safety at night through the use of the telecare and community alarm technology in the form of door, falls, heat, smoke, flood and quiet care monitors. Five patients already had community alarm installed. There were twenty seven call outs to the emergency mobile team over the nine month period from seven of the patients.

Figure 12 shows the contacts with other services.



# **PART B**

## **EDUCATION & TRAINING PROGRAMME**

## **Have an Active Education & Training Agenda for Ward Staff / Care Home Staff and Social Care Officers**

### **B1 Care Home Education and Training Programme**

A letter inviting Perth City Care Homes with EMI units was sent out asking the care homes to indicate their interest in participating and agreeing to meet the conditions of the education and training programme. Initially three care homes indicated an interest to participate with only two of the care homes returning the completed sign off form. An individual meeting with each of the care home's managers was made to ensure their understanding of the commitment required.

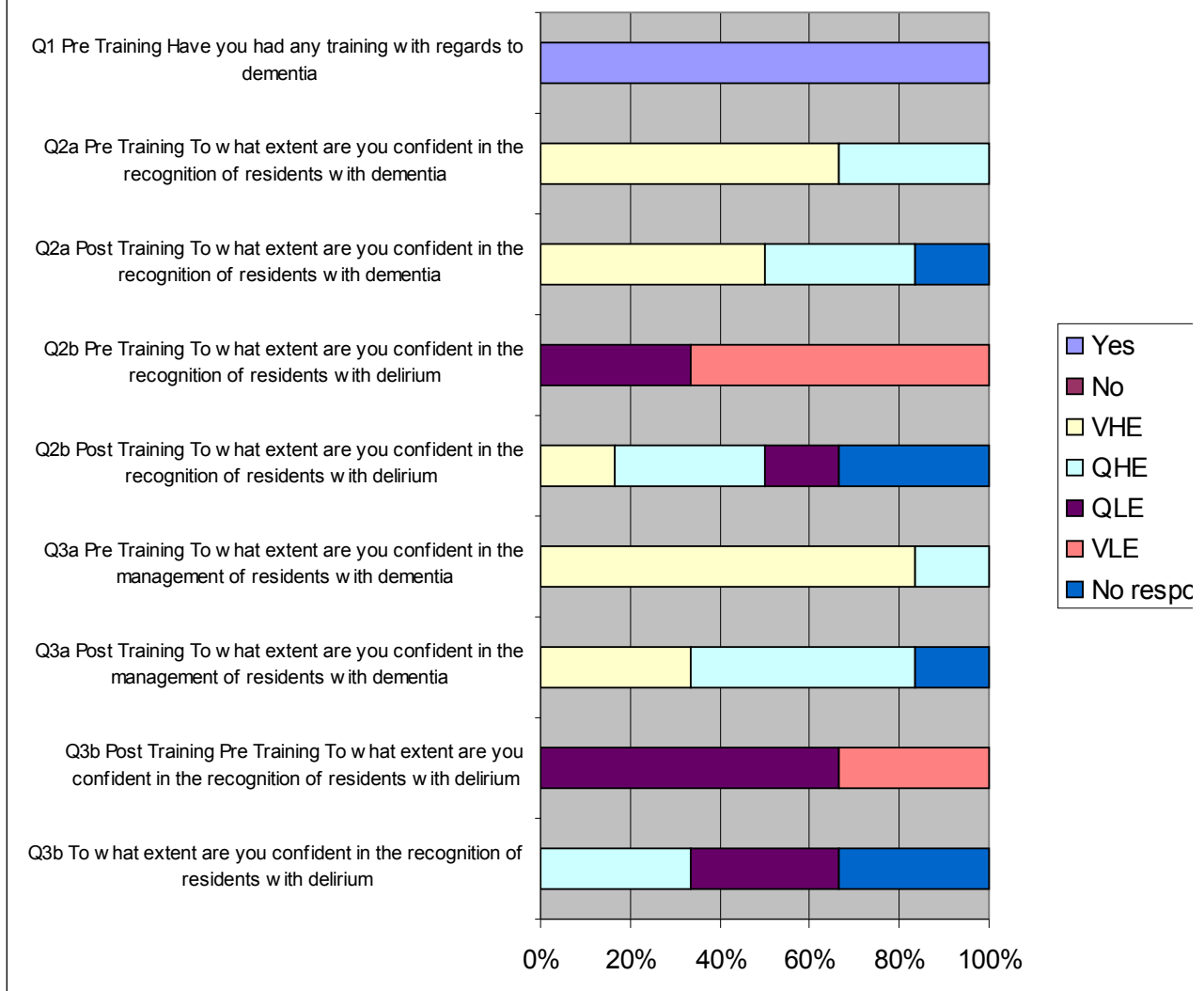
The Stirling Dementia Centre's six part self study course for Care Home Assistants was funded through the project to provide education and training on understanding the needs of people living with dementia, and how to communicate and manage their behaviour. It required the chosen care home to commit to training a member of their staff, who met the course criteria, to become the course facilitator with support from Stirling Dementia Centre, to provide dedicated time for 8 care home assistants of 3 hours per week over a 6 month period and also dedicated time for the facilitator and care home assistants to take part in group discussions. The programme contributes towards an NVQ or SVQ in Health and Social Care and supports the care home to meet the standards set by the UK four care inspection groups. The programme commenced in August 2009 with initial support provided by a charge nurse from Psychiatry of Old Age until the Care Home Manager attended the facilitator training course in October 2009.

Craigieknowes Care Home was chosen as the manager and staff were enthusiastic and showed a willingness to commit to the time requirement. Craigieknowes Care Home manages 21 EMI beds. They had had 7 emergency admissions to Perth Royal Infirmary in the 6 months period prior to participating. During the period August 09 to February 10, there were 7 emergency admissions to Perth Royal Infirmary. Admissions to Psychiatry of Old Age, Murray Royal Hospital will need to be collected and analysed.

Monitoring of admissions from this Care Home continues and will be reviewed again in August 2010 to evaluate whether the education and training programme has made an impact on admissions.

A questionnaire was developed pre education and training for the care home assistants to complete (Figure 13).

## Care Home Pre & Post E&T Questionnaire



VHE – Very High Extent; QHE – Quite High Extent; QLE – Quite Low Extent; VLE – Very Low Extent

100% of the staff identified to participate in the education and training module have had previous training in dementia through the following courses:

- Dementia Care Mapping course at Bradford University
- Person Centred Care of dementia residents

Six of the care home staff completed and returned questionnaires. Pre & Post education & training, care home staff indicated that they already feel confident in the management and recognition of patients living with dementia. Pre education & training, staff indicated that they have low confidence in the management of patients with delirium. Post training, staff indicated that they were more confident in the management and recognition of patients with delirium.

Care Home Staff were also asked pre education and training what benefits did they hope to gain from attending the programme:

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- Not very good at managing residents who are physically aggressive.
- Will put what is learned on course into everyday work practice
- Improved understanding
- Improved confidence
- To provide the best care possible.

On completion of the programme the care home staff were again asked how they felt they benefited from the programme and how the residents of the care home will benefit:

- Better understanding of different conditions.
- Able to formulate effective ways to providing care through identifying the unique needs of individual residents.
- Better understanding of what people need.
- Provided with an improved insight into dementia.
- Improved understanding of how to look after people with dementia / delirium
- Better understanding of how to approach people with dementia / delirium.
- Increased patience.

Initial indications are that the care home staff have benefited from the programme and are now putting their new skills and knowledge into practice.

## **B1.2 Dementia Care Mapping**

Dementia Care Mapping was also undertaken prior to the education and training programme with the care home.

A charge nurse and a staff nurse working within the Psychiatry of Old Age Ward at Crieff Community Hospital undertook the dementia care mapping process. One nurse is in the process of completing the 'Advanced User Status' training through the University of Bradford. The course is approved as a credit bearing module (20 credits) at Higher Education Level 2 or 3 (equivalent standard to second or third year of a degree course). The second nurse is trained to 'Evaluator / Trainer Status' which is part of a post graduate course.

Dementia Care Mapping is an observational tool and a process, which is designed to help staff consider and improve the quality of care for people with dementia through the application of person centred care. When carrying out observations or a 'map' a Dementia Care Mapper(s) observe people continuously for a number of hours. The mapper observes patients' behaviour, mood and engagement and records this on a six point scale. The mapper also captures the quality interactions with staff for each person they are observing through Personal Detractors and Personal Enhancers. Once the mapping exercise is completed, the mappers prepare a report and provide a briefing to the care home on their observations and proposals for improvement.

Pre education and training, the improvements identified were:

- The Care Home provided a range of activities for residents but it is noted that a minority of patients were excluded possibly due to disability; activities should therefore be made more accessible for all residents so that everyone has the opportunity to join in.
- Staff should try to sustain positive interactions with residents for longer periods especially with those who may be more isolated due to communication difficulties.

- Provide opportunities for residents to participate in more meaningful occupation throughout the day, for example, setting tables, dusting.
- Encourage residents to access outside space.
- Care Home provide a range of objects around the home on walls and surfaces, mappers questioned whether they were accessible to all residents.

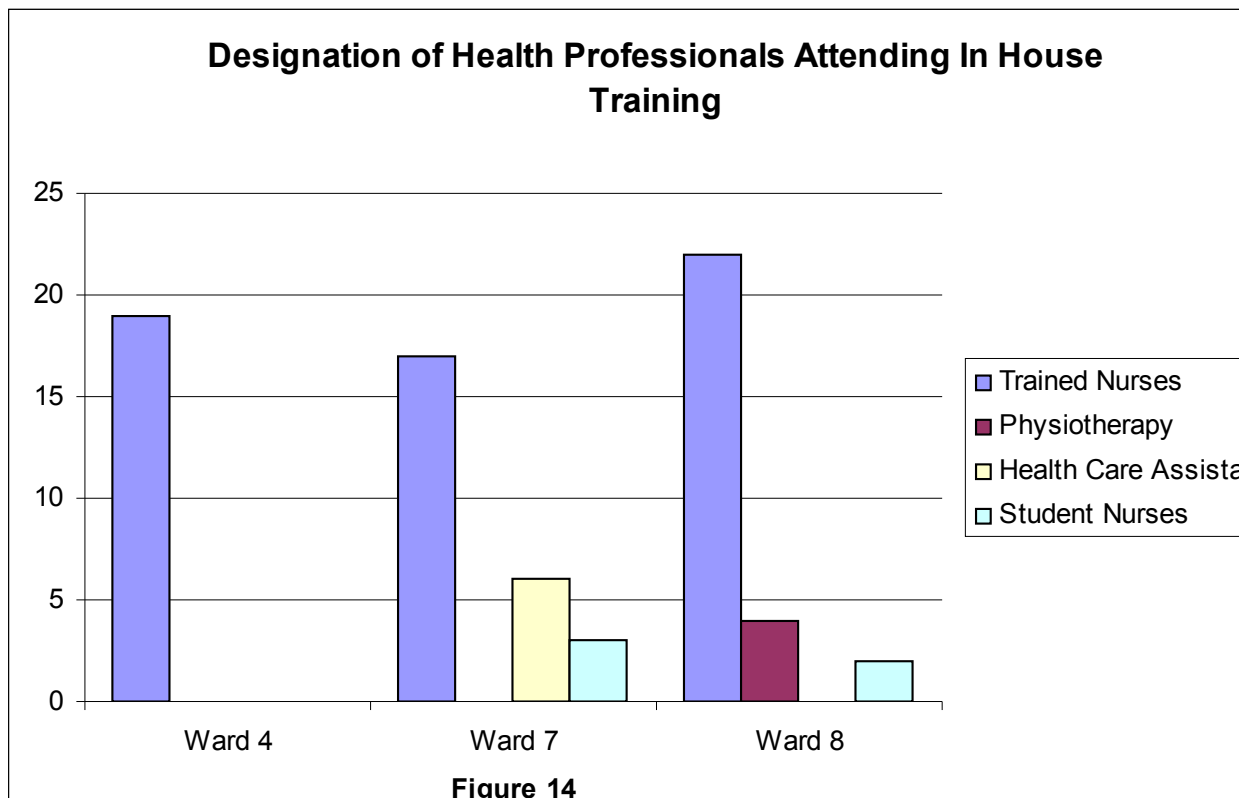
In March 2010 on completion of the education and training programme Perth & Kinross CHP's Dementia Care Mappers undertook their final care mapping of the care home. They identified there was improved staff interaction with residents, during organised group activities residents were not excluded who had a disability, staff were encouraging residents to actively engage with objects and that objects were being rearranged to stimulate interest. Additional improvements could still be made within the care home and this was discussed with the manager and staff during the briefing session.

## B2 Acute Sector Staff Education & Training Programme

The Transitional Care Nurse developed an in house programme of training for staff working in Wards 4, 7 and 8. The course covered 3 areas:

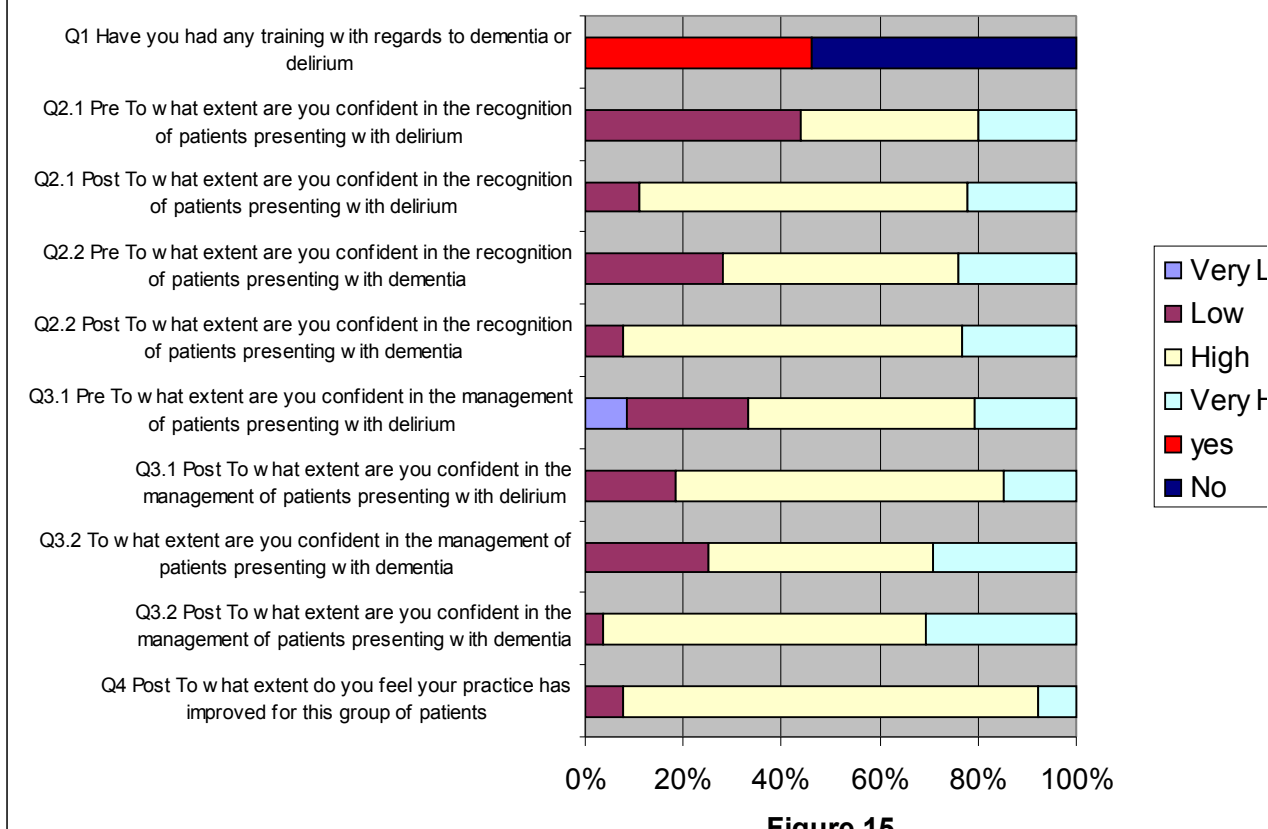
- Dementia
- Delirium
- Behavioural and Psychological Symptoms of Dementia

A total of 72 health professionals have participated in the in house training programme (figure 14).



A questionnaire was also developed pre education and training for staff attending these courses, there was a 36% return rate. Figure 15.

## Health professionals pre & post training



Pre education and training, 53% of professionals indicated that they had had no training with regards to dementia or delirium. Of the 47% of professionals who indicated that they had had training, majority stated that it was outdated or received during nursing modules training.

Health staff indicated an improvement in confidence, recognition and management of patients presenting with dementia and delirium after completion of the in-house training programme.

They indicated that they had a better understanding of the symptoms, treatment and medication management for patients presenting with dementia or delirium and also that within a busy acute setting that they feel that they do not have the time to provide the appropriate interaction that this patient group requires. Staff also indicated that they would like to receive further ongoing dementia training.

### B2.1 Dementia Care Mapping

Dementia Care Mapping was also undertaken within Wards 4, 7 & 8 where the following observations were made:

- Periods of interaction between staff and the patients observed were few and very brief which could cause feelings of isolation. On one occasion no consent was obtained from a patient prior to an intervention taking place. It was felt that the ward staff would benefit from additional training in communication methods.
- Dementia Awareness training was also recommended to enable staff to recognise that patients with dementia often display withstanding or withdrawn behaviours when they are unable to communicate needs or their attempts to communicate are unresponded to.

- Although mappers witnessed patients being encouraged to be independent in personal care, eating and drinking, and staff did check to see if patients were in pain or had enough to drink, these actions were not always followed up. Staff could ensure they prompt the patients to actually take the medication and fluids.

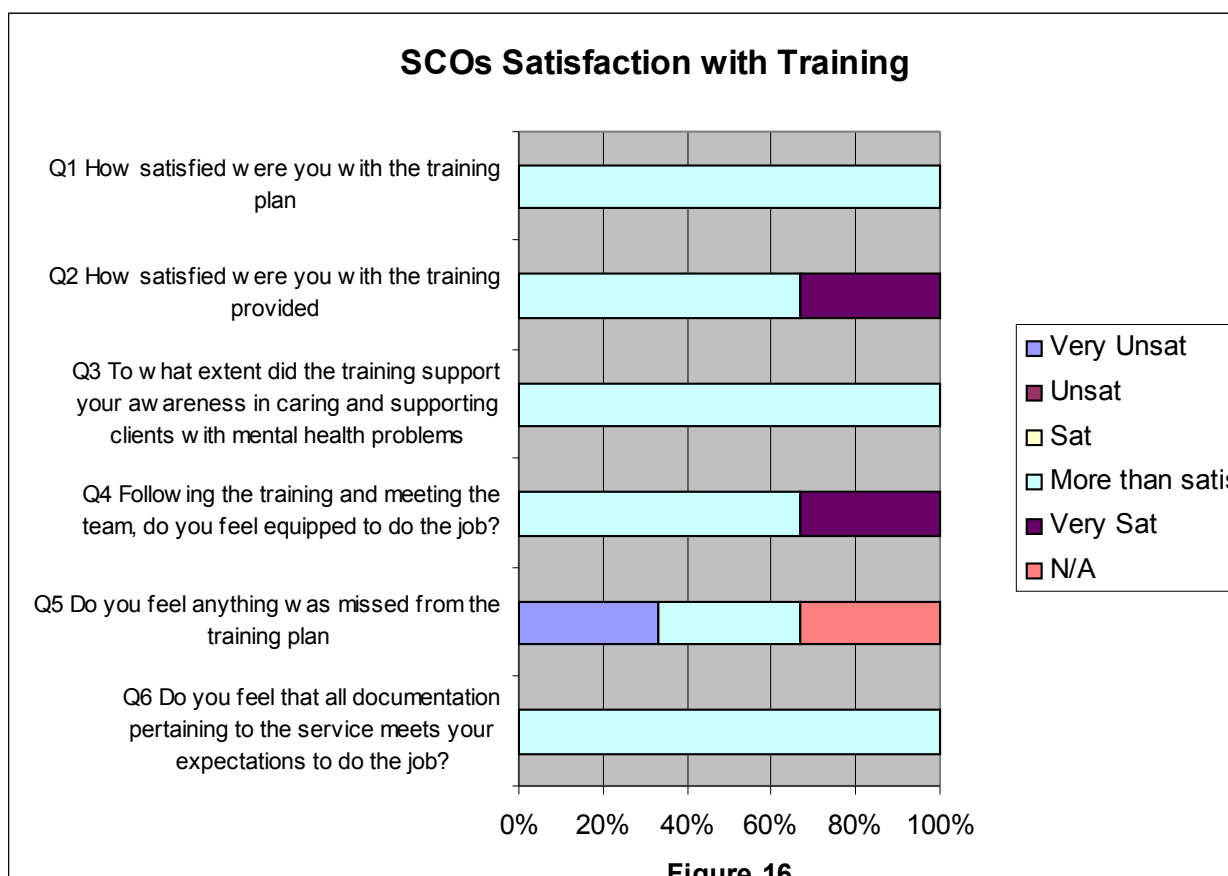
Dementia Mapping post training is to be undertaken early June 2010.

### B3 Social Care Officers Education & Training

An education and training plan was developed for the Social Care Officers (SCOs) who would be employed within the Transitional Care at Home Team Service. Training was held over a two week period prior to commencement of the service. Areas covered were:

- Dementia
- Medication
- Physiotherapy
- Enabling Approach
- Community Alarm Awareness

Social Care Officers were also requested to complete a questionnaire post training in relation to their satisfaction with the training provided (Figure 16).



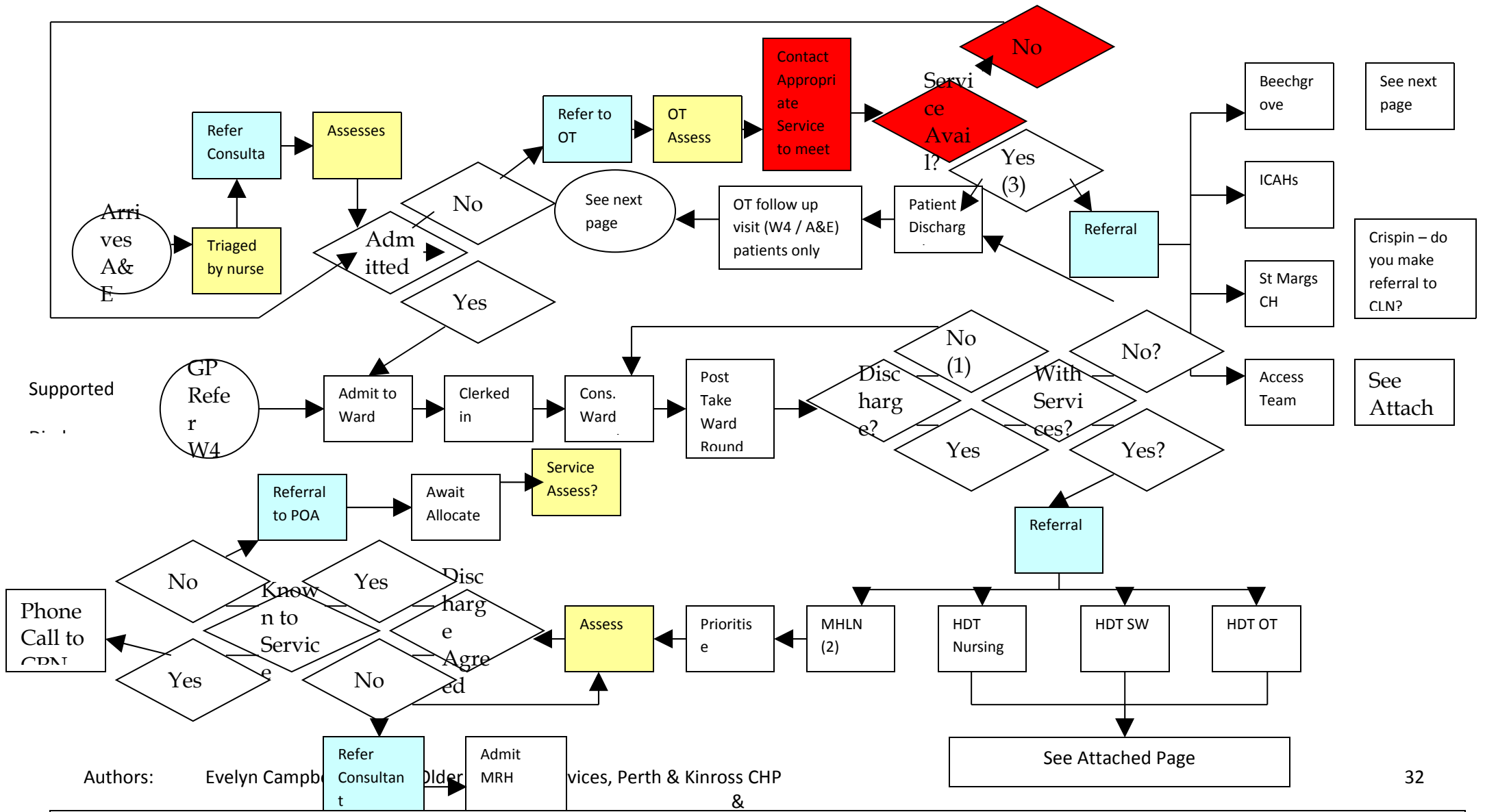
#### Other Comments

- Overall training was very well delivered, presented and structured. Content geared towards equipping SCOs with new skills to combine with skills already gained through past experiences, provided good skill mix.
- Assisted, supported and reiterated skills gained through past experiences, also providing new and differing ways of dealing with situations and supporting people with mental health problems.
- Training helps to look at different ways and new ways to assist and support clients with mental health problems. Also builds on skills that already gained through past experiences.
- As post is new and exciting, hopeful with what has been learned through training will enable me to carry out the job to a high standard of care with every belief that the team will provide their full support throughout.
- Lots of documentation to support training received, also to carry out the duties expected so as to come to a successful conclusion by delivering high quality care to some of the most vulnerable people in society.

The Social Care Officers who were employed to work within the Transitional Care at Home Service were all experienced and fully qualified care officers working within mainstream home care services and were able to quickly translate their training into practical skills to improve the quality of care through the application of person centred care for people living with dementia. A review of the training programme would need to be undertaken for new employees to home care services to ensure a more graduated approach in line with experience and skill.

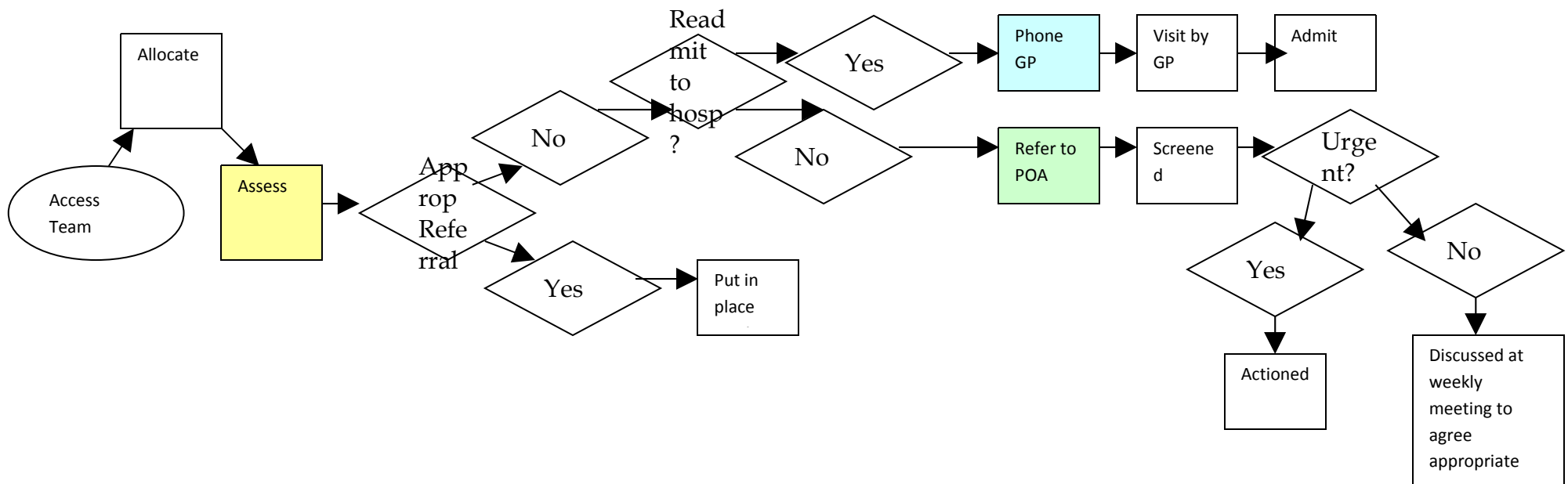
# APPENDICES

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Patient if in ward 4 is aimed to be moved within 24 to 48 hours and may possibly have various transfers to other wards.  
 Wards will often refer to all services or will not refer to MHLN – other Discharge Team will refer to MHLN. Some consultants in Acute will not refer or take assessment from MHLN and wait for consultant POA to assess.  
 (3) If first choice service not available will contact 2<sup>nd</sup> choice, 3<sup>rd</sup> choice etc until no more choices left.



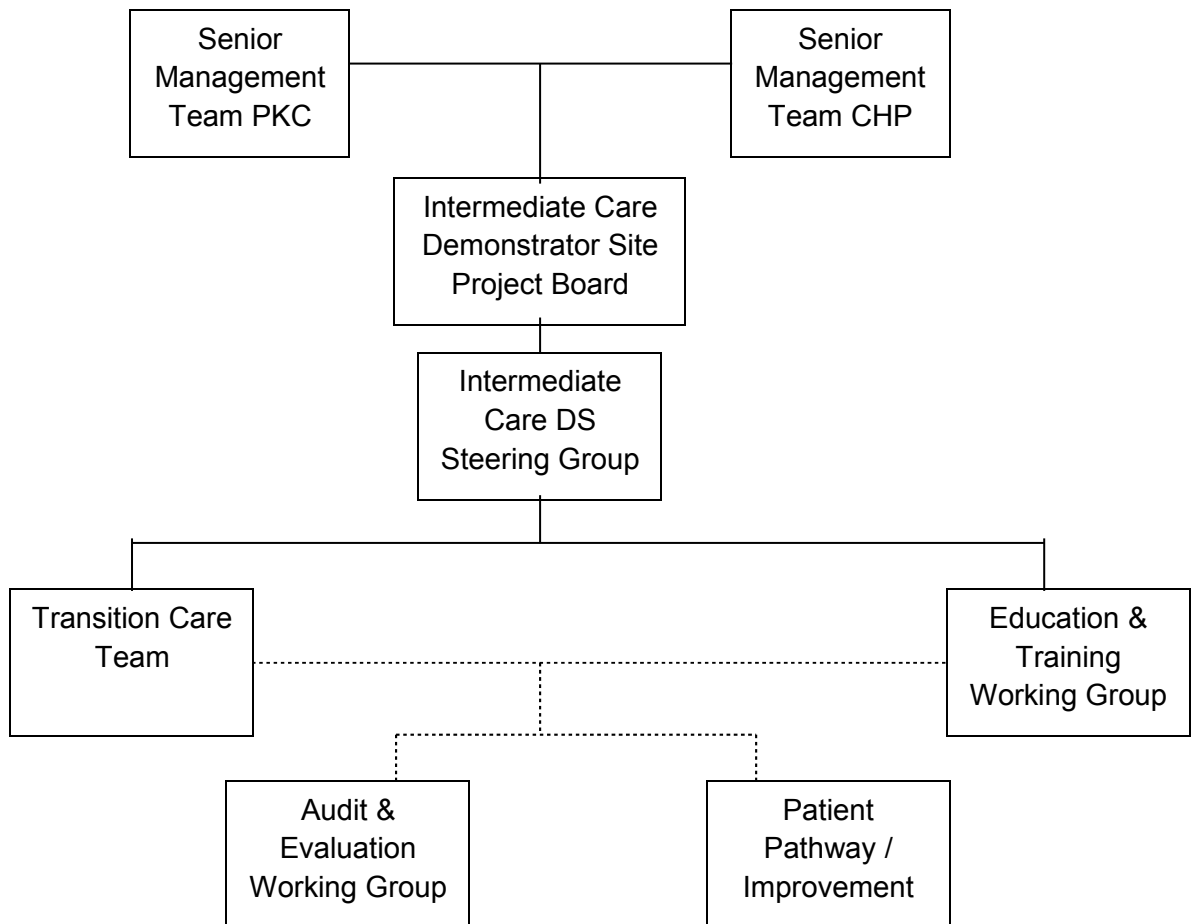
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## CAR PARK

- Education & Training for Ambulance Crew & GP
- Perth GPs can admit straight to St Margarets
- No OT / Physio out of hours
- What degree of dementia would benefit from intermediate care service
- Definition of care group – Mental Health Problems including Cognitive Impairment, Confusion, Depression, Delirium, Associated undiagnosed symptoms
- No dedicated crisis service to support discharge or prevent admission for people to refer on
- Services do not identify options for keeping people in their own homes
- No holistic short term assessment bed
- Referrals sometimes are sent to Access Team direct from Ward
- Criteria for ICAHs restrictive
- Waiting list for POA
- Red alert people discharged quickly and inappropriately
- Transitional care – MHLN sometimes follows patient out into nursing home or own home environment to assess and review but no capacity to do often
- Home Care crisis team required – model being looked at?
- Consultant on ward may block referral to MHLN and goes direct to consultant POA
- Ninewells no discharge planning – no mental health, OT or social work liaison
- Single point of contact
- What happens out of hours, where and who do you contact for service
- A&E – 4 hour breach rule
- Service has to be simple
- Crisis response not offered through ICAHs for any other groups due to capacity – only given on rare occasions. GPs may become confused when we promote crisis response service for people with mental health problems.
- Need to promote that this service will offer support to people in the community for longer rather than being admitted to long term care earlier

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*Project Organisation Structure*



## **Roles and Responsibilities**

### ***Project Board***

The Project Manager will seek guidance and support from the Project Board.

The Project Board will meet on a regular basis to review progress reports from the Project Manager, ensure an agreed project plan is followed and that risks, issues and changes are being identified and managed effectively.

The Project Board will also perform the following key, high level functions:

- Ensure that the project meets its objectives and delivers the projected benefits
- Ensure agreement amongst stakeholders as to what the objectives and benefits are
- Ensure strategic fit of the project objectives and benefits
- Obtain commitment from stakeholders to the delivery of the benefits
- Formally close the project and ensure that the end of project report and lessons learned are documented and approved
- Ensure that the post implementation review takes place
  - Sign off and own the project brief, business case and project initiation document
  - Agreeing all major plans and organisational structure of project
  - Authorising any major deviations from the agreed stage plans
  - Signing off the completion of each stage, including the deliverables, and giving approval to start the subsequent stage
  - Communicating information about the project to the organisation(s) and stakeholder groups as necessary
  - Ensuring that the required resources are available
  - Resolving any conflicts escalated by the Working Groups
  - Agreeing the project tolerances for time, quality and cost
  - Providing overall strategic guidance for the project
  - Agreeing controls to manage the risk(s) associated with the project
  - Providing advice and direction to the Project manager
  - Resolving deviations from plans or escalating as necessary

### ***Project Leads / Project Manager***

The Project Leads / Manager has the authority to run the project on a day to day basis on behalf of the Project Board within the constraints laid down by the Board.

The Project Leads / Manager's prime responsibility is to ensure that the project produces the required products, to the required standard of quality and within the specified constraints of time and cost. The project manager is also responsible to the project producing a result that is capable of achieving the benefits as defined in the invitation letter from the Joint Improvement Team.

- Plan and monitor the project
- Produce Project Initiation Document
- Prepare project, stage and if necessary exception plans in conjunction with project leads, team and appointed project assurance roles and agree them with project board.
- Manage the risks, including the development of contingency plans
- Liaise with related projects to ensure that work is neither overlooked nor duplicated
- Be responsible for change control and any required configuration management

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- Prepare and report to the project board through highlight reports and end stage reports.
- Liaise with project board or project assurance roles to assure the overall direction and integrity of the project.
- Agree technical and quality strategy with appropriate members of the project board.
- Prepare the lessons learned report.
- Prepare any follow-on action recommendations required
- Prepare the end project report
- Identify and obtain any support and advice required for the management, planning and control of the project.
- Be responsible for project administration.

### ***Workteam Team Managers***

The Team Manager (s) prime responsibility is to ensure production of those products defined by the Project Manager to an appropriate quality, in a timescale and at a cost acceptable to the Project Board. The Team Manager reports to and takes direction from the Project Lead / Manager.

- Prepare plans for the team's work and agree these with the Project Manager
- Manage the team
- Direct, motivate, plan and monitor the team's work
- Take responsibility for the progress of the team's work and use of team resources and initiate corrective action where necessary within the constraints laid down by the Project Board
- Advise the Project Manager of any deviations from plan, recommend corrective action and help prepare any appropriate Exception plans.
- Pass back to the project manager products that have been completed and approved I
- Ensure that all project issues are properly reported to the person maintaining the issue log
- Ensure the evaluation of project issues that arise within the team's work and recommend action to the Project Manager
- Liaise with project assurance
- Attend any stage assessments
- Arrange and elad team checkpoint meetings and produce checkpoint reports as agreed with the Project Manager
- Ensure that the appropriate entries are made within the quality log
- Identify and advise the project manager of any risks associated with the work package
- Ensure that all identified risks are entered on the risk log
- Manage specific risks as identified by the project manager

### ***Work Team***

The Work Team members are responsible for carrying out the planned project activities in their area of expertise. The deliverables from these activities should be in line with the measurement criteria detailed in the Project Initiation Document. They are also responsible for identifying, developing and conducting training in their area as required.

The work team members are responsible (in their area) for the consistent use of the standard processes designed to identify, track and resolve issues, risks and changes. Attempts should be

made to resolve these at source or escalate to the Project Manager if a satisfactory solution cannot be identified.

The Work Team members will ensure that progress on activities carried out in their area is documented prior to the performance meeting with the Project Manager.

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### 3.6 ***Initial Criteria for Referral***

1. Patients' with a presentation of dementia or delirium, which has been identified within the acute setting (Ward 4,7 and 8)
2. The patient lives in Perth City and the patient requires short-term intervention for up to 6 weeks (Perth City, Luncarty, Scone, Almondbank / Pitcairngreen)
3. The patient is safely mobile with an aid or with carer supervision.
4. Patients should be over the age of 65 but consideration will be given to those patients under 65 who may benefit from the service
5. The patient or power of attorney can consent to the service
6. The patient behaviour is manageable in the patient's own home
7. The patient is medically suitable and can be safely supported at home without overnight care
8. The patient has a no/minimal homecare package but requires an increase in care package.

## **Amended Criteria for Referral (August 2009)**

### ***Criteria for Referral***

1. Patients' with a presentation of dementia or delirium, which has been managed within the acute setting
2. The patient is able safely mobile with an aid or with carer supervision.

## Appendix 4

### ***Aims and Objectives of the Transitional Care Team***

The Aim of the transitional care at home team is to:

- To assess the mental health needs of patients within ward 4, ward 7 and 8, Perth Royal Infirmary for patients living in Perth City.
- To work in a collaborative and proactive manner to prevent delirium, improve management of patients with dementia and delirium and hence delays in the patients discharge from acute services.
- Provide and deliver education/advice on the management of patients with dementia and delirium.
- Improve and prevent delays in the patient's journey and facilitate a seamless transition from acute care to the patient's own home, while providing a coordinated patient journey and ongoing review.
- To enhance joint working across all involved organisations.
- To reduce length of stay in acute services and improve patient outcomes
- To embed the NHS Tayside Management of Delirium in Adult and Older In patients into acute care practice
- To support acute ward staff with the discharges of complex patients and patients in a delayed discharge situation
- To promote best practice, in relation to discharge planning, working within the boundaries of the Joint Health and Social Discharge Protocol and facilitating discharge planning at the earliest opportunity.
- To provide a fast, coordinated, reliable and consistent service
- To support and care for unpaid carers, to enable them to remain emotionally and physically well enough to continue to care and work with carers to provide services and support which will help them to maintain their own health and wellbeing.

**Article I. Project: Intermediate Care Demonstrator Site**  
**Article II. Issues Log**

Ref. No.	Issue	Date raised	Raised by	Action by	Target date for resolution	Comment / Action
1 · 1	Equipment fitting. Present process allows assessment and ordering by OT on wards and fitted by JEL store with response within 48 hours. TCAHT would require fitting prior to discharge from hospital. Issues with annual leave.	17/06/09	ARob	ARob	July 09	<p>Liaising with Carol Cowan, Sue Muir and E McIntosh</p> <p>Board Meeting 17/07/09 issue was raised re equipment. JD confirmed direct access should be allowed. SM to check and report back.</p>
2 · 1	Weekend discharge. Family requested. TCAHT unable to take as no support to carers in event of a crisis.	29/06/09	PB	ICDS Steering Group	Sept 09	<p>Agreed at Steering Group in July that PDSA Scenario would be given to SCOs in relation to complex cases to identify training, support required.</p> <p>NM/FD/JF to action.</p>

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Ref. No.	Issue	Date raised	Raised by	Action by	Target date for resolution	Comment / Action
3 · 2	Unable to use office for staff training in Ward 4. Was asked to use computer in corridor where there were distractions and USB did not work on computer.	29/06/09	PB	ICDS Steering Group	August 09	Highlighted at group. PB to monitor and report back if problem continues.
4 · 3	Criteria for Access to service may be too narrow may result in low uptake to service.	15/07/09	SM	ICDS PB	September 09	Agreed at 17 July meeting that criteria should be amended. All referrals to be taken, no-one to be excluded. SM to amend criteria and forward to all concerned.
5 · 4	SCO not attending until after 10 am to only patient on service as SCOs being used to support ICAHs.	08/10/09	PB	PB	October 09	Discussed with Riverview staff. Carer to attend at 8 am.
6 · 5	At working group meeting was informed patient being transferred to mainstream services but due to current presentation patient not ready for transfer	08/10/09	PB	PB	October	Discussed at meeting. Riverview staff intimated this cannot be extended. Discussed with SM, Patient to remain on service for another week.
7 · 6	Client with complex needs doing well on TCAHT. Client fell and sustained fracture. Lady high fall risk. SCO not able to attend to her until 10 am in morning. Readmitted to PRI	08/10/09	PB	TCAHT Working Group		AR discussed with home care services to ensure social care officers visited at the same time every day as agreed in patient care plan.

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## Risk Log

SMART	Description of Risk and Impact (incl. cost, time, quality and benefit)	Likelihood of occurrence	Severity of impact	Risk Category	Risk Management:	
					Action	Owner by / when
	<b>Detailed description of the risk highlighting all relevant history and reference points</b>				<b>Detailed description of risk reduction strategy.</b>	<b>Full details of risk owner and when the risk reduction strategy will be in place.</b>
R1	Failure to obtain buy in from all key stakeholders	L	M	M	Full consultation with all relevant stakeholders being undertaken and views taken into consideration. Consultation to be included within overall project plan	Intermediate Care Demonstrator Site Project Board and Working Groups
R2	Budgetary Restrictions	L	L	L	Proposal paper to include resource implications for tests of change prioritised	Project Board
R3	Project exceeds cost or time resources available	L	M	M	Realistic timeline with key milestones and contingency to be developed in liaison with working groups	Project Manager and Working Groups
R4	Transition Care Team service is not fit for purpose	L	M	L	Explicit outcome measures with evidence base to be developed and monitored on regular basis	Audit & Evaluation Working Group
R5	Loss of key personnel during planning and implementation of new model	L	L	L	Robust workforce plan with contingencies to be developed	Project Board and Project Manager
R6	Risk of Union to workforce plan – may cause delay in implementation	L	M	L	Ensure Union negotiations are time limited and that change management strategies in place	Project Board

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SMART	Description of Risk and Impact (incl. cost, time, quality and benefit)	Likelihood of occurrence	Severity of impact	Risk Category	Risk Management:	
					Action	Owner by / when
	Detailed description of the risk highlighting all relevant history and reference points				Detailed description of risk reduction strategy.	Full details of risk owner and when the risk reduction strategy will be in place.
R7	Health and Council priorities change	L	L	L	Project Board to monitor and ensure that all relevant information is provided to the Working Group to make changes required through change management process	Project Board
R8	Due consideration not taken during redesign of other projects / initiatives that may have an impact	L	M	M	Full consultation and robust links with other projects/ initiatives to be agreed in advance	Project Board & Project Manager
R9	Posts may have to go through ERG process and A4C process	H	M	M	HR processes to be identified with discussion with HR ongoing	Project Team / Project Manager
R10	Failure to meet proposed success criteria and within timescales stated	M	L	L	Quality Plan to be developed and continual evaluation and monitoring to take place. Lessons learned log to be completed on monthly basis to ensure evidence collection.	Audit & Evaluation Working Group / Project Team / Project manager
R11	Inadequate communications between primary, secondary care and social care to support effective co-ordination of patient care.	L	H	H	Ensure appropriate consultation & involvement with secondary care and local authority in all proposals which may have an impact	Project Team / Board
R12	Concurrent workload commitments Other workload commitments of project Board and Project team members may lead to potential conflict.	L	M	M	Assess the impact on intermediate care implementation timescales; ensure that the Project Board are aware of the implications to the project in both cost and time. Confirm status at Project Team meetings	Project Team / Board
R13	Inadequate evidence of benefits of to patient/client care. Failure to collate and feedback evidence improving patient/client care	L	M	L	Ensure quality plan developed, incorporate a Quality and Performance team within the project to ensure a robust Quality and Performance Framework is developed for the project	Audit and Evaluation Working Group

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SMART	Description of Risk and Impact (incl. cost, time, quality and benefit)	Likelihood of occurrence	Severity of impact	Risk Category	Risk Management:	
					Action	Owner by / when
	Detailed description of the risk highlighting all relevant history and reference points				Detailed description of risk reduction strategy.	Full details of risk owner and when the risk reduction strategy will be in place.
R14	Too Low / High Demand for service	L	M	M	Ensure continual monitoring and reporting of capacity of transition care team. If demand low identify other improvements that can be taken forward. If too high identify reason and solution	Project Team / Project Board
R15	Identified Care Home may not be able to commit fully to requirements for education and training	M	H	H	Consult with identified care home and ensure full commitment prior to commencement of education and training. Continue to meet with care home representative to identify and find solutions for any identified issues.	Education and Training Workstream
R16	Unable to obtain baseline information from central information systems for identified success measures in PID	M	M	M	Identify other sources locally.	Audit & Evaluation Working Group.

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**Total Budget for Project**

<b>Staffing</b>	<b>JIT Funding</b>	<b>CHP Funding</b>
Registered Mental Health Nurse Transitional Care Nurse	£39,258	£0
Social Care Officers x 3 Transitional Care at Home Service	£54,922	£0
Stirling Dementia Centre Education Pack Care Home	£1,500	£0
Backfill Dementia Care Mappers x 2 Dementia Care Mapping Care Home & PRI	£0	£3,136
Registered Mental Health Nurse to cover holidays for Transitional Care Nurse & Facilitator for Care Home Education & Training Programme	£4,320	£1,200
Intermediate Care Co-ordinator Transitional Care at Home Workstream Lead	£0	£11,492
Project Manager 0.5 WTE	£0	£9,432
Occupational Therapist Mental Health	£0	£937
Pharmacist	£0	£963
Registered Mental Health Nurse Workstream Lead Care Home Education & Training	£0	£7,156
Physiotherapist	£0	£1,095
<b>TOTAL</b>	<b>£100,000.00</b>	<b>£35,411.00</b>

**The funding above excludes Psychiatry of Old Age Consultant's time and Senior Managers time in relation to the project eg Assessing and reviewing patients, Project Steering Group; Project Board.**