

## **Changing Attitudes, Improving Outcomes:**

### **Appraising the Dementia CQUIN (Commissioning for Quality and Innovation)**

**(September 17<sup>th</sup> 2014, Kingsway Hospital, Derby)**

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#### **Introduction**

The hospital dementia CQUIN was introduced in 2012 as a result of a call for national CQUINS and extant publicity about the poor experience of people with dementia in general hospitals. The initiative was developed to improve the care of people with dementia in the general hospital, setting out to address the issue of the low rates of correct identification of people with dementia in hospitals and also to identify those who might be at risk in view of their age, physical ill health or the presence of delirium. Improved identification and diagnosis by promoting the referral of patients suspected of having dementia for a specialist assessment was a cornerstone of the CQUIN.

The current CQUIN has five components for people over the age of 75, admitted as an emergency and who have been in hospital for three days. The “Find, Assess (later assess and investigate) and Refer” programme was developed, identification of a clinical lead and providing information for carers. The payment for the individual components is as follows:

Find:	20%
Assess:	20%
Refer:	20%
Information for carers:	30%
Clinical Lead:	10%

The age of 75 (chosen because it was a measure which recognised that this was the biggest change in dementia awareness and care the hospital system had ever witnessed and there was a need to manage the development, while accepting that the system needed to be stretched rather than overwhelmed). The fact that someone had to be in for three days was to avoid complications in assessing people who are very physically ill and in whom the inquiry would be clinically inappropriate.

The meeting on the 17 September 2014 was inspired by a conversation between the two of us about the dementia CQUIN and how it has influenced practice. The headline aims of the meeting were to:

- Outline current practice in the dementia CQUIN
- Describe the influence of the CQUIN
- Review ideas about next steps in the CQUIN's history

### **Format**

There were six presentations then discussions in groups: one considering liaison psychiatry and another defining what a quality CQUIN would look like and a third describing what a dementia friendly hospital would look like. The day was completed by a plenary session.

Simon Thacker: described the experience of the CQUIN in Derby where Liaison Psychiatry nurses had originally agreed to perform the Assess and Refer components of the CQUIN. By Spring 2014, only 1 in 20 patients who had been positive on the screening question received a memory assessment service referral. The team gained the impression that the case-finding question was sometimes addressed robotically to the patient (although the question is worded though so it is a question a clinician could ask him or herself about the patient) creating the risk of inaccurate findings.

Louise Allan described the experience in Newcastle citing the high administrative efforts, distracting from work on delirium.

Rachel Thompson outlined the work of the Royal College of Nursing in promoting a multicomponent model of dementia care in general hospitals.

George Tadros described his work in Birmingham with savings mostly derived from older adult care, which are accruing from a RAID model of Liaison Psychiatry. He described a joint clinic a geriatrician which, crucially, includes follow-up of people with delirium.

Simon Kitchen presented the work of the Dementia Action Alliance in generating community-wide awareness of the condition.

Michael Hurt outlined the transformational change in Walsall in raising the profile of dementia. Links with a wide variety of stakeholders and good interpersonal relationships between colleagues were cited as important drivers of change.

### **Liaison Psychiatry Group**

- The dementia CQUIN has been a powerful lever for raising dementia awareness but the process has incurred a large opportunity cost in clinical time.
- Delirium needs to be carefully considered - quiet delirium in hypoactive patients with delirium and dementia can easily be overlooked.

- We need to follow-up delirious patients more carefully to limit the risk of recurrence and readmission.
- All diagnoses have to be subject to revision. The distinction between dementia and delirium can sometimes best be made over time.
- Assessments should be multidisciplinary - assessments by a single clinician may be prone to error.
- This session underscored the importance that both psychiatrists and physicians place on delirium. Improving delirium care (including prevention) is a valuable paradigm by which to change attitudes towards people with dementia and plausibly improve outcomes.

### **Components of a Quality of Care CQUIN**

- Measuring and using patient/carer experience
- Education across the board –dementia is everyone’s business
- Dedicated dementia support posts
- Bay nursing to increase support and activities
- Adapting environments
- Developing relationships/sharing information with care homes
- Continuity of care
- Personalised care plans as part of a dementia care bundle informed by family/carer consultation
- Multi-disciplinary working essential
- Culture of openness to scrutiny
- Use of observational tools

### **Creating the Cognitively Friendly Hospital**

- This will take more than CQUINs
- Multidisciplinary education of staff as to the vulnerability of people with dementia to delirium
- The recognition of delirium as a medical emergency that needs to be prevented and promptly dealt with if it supervenes
- A team approach to cognitive impairment involving close observation of frail, elderly patients utilising the signs of delirium as a sign of equal importance to pulse, blood pressure and temperature
- Jointly employing the skills of medical and psychiatric staff in the most acute areas such as the Medical Assessment Unit along the lines of the RAID model

- Recognising the long-term effects of delirium on cognition and function even before a dementia syndrome is confirmed – delirium is still considered by social services to be solely a medical problem and often does not fulfil eligibility criteria for social care input

## General conclusions

Three points emerged:

- The dementia CQUIN, in general, was welcomed as an initiative to broaden the profile of the disorder in the general hospital, had excited discussions around cognitive impairment and had been a stimulus to improve care
- While dementia is a powerful concept but there was a need to capture the profile of delirium, perhaps in a CQUIN, as the two are inextricably linked, in order to deliver optimal care.
- Looking across health and social care and emphasising quality was regarded as key.

## Acknowledgements

We would like to thank Keith Waters for his wise chairing and Tuhel Miah and colleagues for the organisation of the meeting.

## Appendix: key slides

### Along came the CQUIN and from the outset....

#### Positives

- Raised profile of dementia
- Made cognitive assessment compulsory for over 75s
- Did allow a mechanism to detect delirium to be included in admission
- Helped to drive our other plans in this area
  - FMN, focus chart, dementia nurse



#### Negatives

- No evidence for the case finding question
- It's about money not patient care
- Delirium given lower priority than dementia
- Not linked to the NICE guidance on delirium



## Pros and cons of the CQUIN (Louise Allan)

**Dementia**  
Commitment to the care of people with dementia in hospital settings

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**SPACE – principles to support good dementia care**

1. Staff who are skilled and have time to care.
2. Partnership working with carers.
3. Assessment and early identification of dementia.
4. Care plans which are person centred and individualised.
5. Environments that are dementia-friendly.

See [www.rcn.org.uk/dementia](http://www.rcn.org.uk/dementia)

Supported by RCN Foundation

**Dementia**  
Scoping the role of the dementia nurse specialist in acute care (2018)

**Dementia**  
Meeting needs & the role of dementia nurse specialists in acute care (2018)

## Principles of care of people with dementia in hospital (Rachel Thompson)

### **CQUIN in acute trusts: the Walsall Experience**

- Risks & Sign tool (included in the pathway paperwork)
- Within 48 Hours of admission
- All referrals direct directly to Memory Assessment Service
- Target over 65s but report nationally on 75
- Use of 6-CIT as the tool and used across Walsall
- Part of an agreed pathway (existing subtype or assess)
- Exclusion criteria set: existing diagnosis of dementia, end of life, refusal, level of consciousness, learning disability, sensory impairment, delirium but then triggers....
- Confusion Assessment Method (CAMS)
- Carer strain tool & carer survey
- Out of area patients referred to their respective GPs

Implementation of the CQUIN (Michael Hurt)



## What we did

- **Launch event** - 15th October 2012 with Norman Lamb and Prof Alistair Burns
- **Taskforce** – led by NHS Institute but with wider expertise
- **Economic case** - CHKS report. £265 million a year from increased length of stay
- **Resources** - D:KIT created around SPACE principals



The Right Care: creating dementia friendly hospitals



 NHS  
Institute for Innovation  
and Improvement

I commit my organisation to becoming a **dementia friendly hospital** and working in partnership with the **Dementia Action Alliance** to achieve this.



## What happened?

- **140 acute trusts** (90% of eligible and 24 non-acute trusts) committed to becoming dementia friendly
- **88 submitted Action Plans** and joined their local Dementia Action Alliance
- **Continued engagement** through webinars and DAA events
- **18 months on** .... follow up survey

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## Impact and motivations

- Mixed motivations for signing up (37% patient profile, 32% PM Challenge and 31% CQUIN)
- 98% report senior managers at their hospital are still committed to becoming dementia-friendly
- 85% report committing to become dementia-friendly made a difference to their trust
- 35% of hospital trusts claim to already be 70% dementia-friendly

The work of the Dementia Action Alliance (Simon Kitchen)



Rapid Access Interface and Discharge (RAID) – George Tadros

## The Delirium-Dementia Nexus

- \* 40% of acute admissions aged 70 and over have dementia
  - \* 27% have delirium
  - \* 19% have delirium-dementia
- Whittamore 2014*
- \* 2/3 dementia was moderate to severe
- Sampson 2013*

The Dementia-Delirium Challenge – Simon Thacker