Pennine Care NHS
NHS Foundation Trust

Equality Delivery System (EDS2)
Grading Report 2014-15

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Equality and Diversity Team

CONTENTS

Benefits

Benefit 1	Service improvement
Current Baseline	Trust has not implemented the EDS2 before
Benefit 2	Demonstrate Compliance with the Commissioning Contract
Current Baseline	Trust has not implemented the EDS2 before
Benefit 3	Demonstrate compliance with the CQC, Equality Act 2010
Current Baseline	Trust has not implemented the EDS2 before

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About us

Pennine Care NHS Foundation Trust provides mental health and community services to people living in the boroughs of Bury, Oldham and Rochdale. We also provide mental health services in Stockport and Tameside and Glossop, as well as community services in Trafford.

Our services are located in hospitals and in the community and work closely with local councils, NHS organisations and the community and voluntary sector.

We provide a range of services for people who have serious mental illness such as schizophrenia and bipolar disorder, as well as more common mental health problems including depression, anxiety and dementia.

Mental health services include:

- Working-age adult inpatient and community services including crisis resolution and home treatment, assertive outreach and early intervention older people's inpatient and community services.
- Community-based drug and alcohol services.
- Community-based child and adolescent mental health services (CAMHS).
- Psychiatric Intensive Care Unit (PICU).
- Some low secure care intensive rehabilitation services.

Our community services provide a wide range of treatment and care for the whole community, helping to keep people out of hospital and ensuring that they receive the highest quality care.

Community services include:

- Dentistry
- Health visiting and school nursing
- District nursing
- Sexual health services
- Cancer and end of life care
- Long term conditions management
- Health improvement and wellbeing
- Learning disabilities
- Therapies

1. Introduction

1.1 Purpose

This report describes our approach to implement the Equality Delivery System (EDS2) and the Trust's performance against the EDS2 Goal 1. EDS2 is an assessment tool designed to measure NHS equality performance with an aim to produce better outcomes for people using and working in the NHS and to gather equality evidence that demonstrates compliance with the Public Sector Equality Duty (PSED) of the Equality Act (2010).

The implementation of EDS2 supports our strategic objective to promote equality throughout the planning, development and delivery of our services whilst appreciating and respecting the diversity of our local community and staff.

1.2 EDS2 Aims

The aim of the EDS2 is to improve services for people who belong to vulnerable and protected groups. The objective is to assess health inequalities and provide better working environments, free of discrimination, for people who use, and work in, the Trust.

1.3 Background

Over the past few years, there have been significant changes in health and social care regulations such as CQC registration requirements, Equality Act (2010), NHS constitution and the Human Rights Act. These laws / regulations aim to tackle inequalities and drive improvements in service delivery. In particular, under the Equality Act (2010), the Trust has a legal duty to promote equality and diversity and to ensure that everyone - patients, public and staff - have a voice in how we are performing and where we should improve.

1.31 Equality Act (2010)

The law talks about treating everyone in good and fair way. The Equality Act (2010) sets out when it is unlawful to discriminate and harass a person and it gives rights to our service users, carers and employees to raise complaints regarding discrimination. The law protects people from discrimination on the grounds of so called 'protected characteristics' (age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race including nationality and ethnic origin, religion or belief, sex and sexual orientation).

1.32 Public Sector Equality Duty (PSED)

Section 149 of the Equality Act (2010) requires us to demonstrate compliance with the "Public Sector Equality Duty" (PSED) which places a statutory duty on the Trust to address unlawful discrimination. The remit of PSED is very broad and covers decision-making, policy development, budget setting, procurement and employment functions. The PSED has two parts:

General Duty to:

- Eliminate unlawful discrimination, harassment and victimisation, and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.

- Foster good relations between people who share a protected characteristic and those who do not.

Specific Duty to:

- Publish information to demonstrate compliance with the general duty by 31st January each year.

  - Our equality monitoring information mainly covers:

    - ✓ Service user equality monitoring
    - ✓ Patient Advice and Liaison Service equality monitoring
    - ✓ Incidents equality monitoring
    - ✓ Compliments and complaints equality monitoring
    - ✓ Workforce equality monitoring
    - ✓ Trust membership equality monitoring
    - ✓ Estates equality monitoring
    - ✓ Equality Analysis

- Prepare and publish Equality Objectives at least every four years.

  - Our current Equality Objectives are:

    - ✓ Information and monitoring – effectively monitoring to improve the usefulness of information
    - ✓ Communication – improving communication between the Trust and service users and carers, voluntary and community groups, staff, and primary care
    - ✓ Engagement – improving engagement with a range of stakeholders.
    - ✓ Learning and development – ensuring the Trust meets mandatory requirements and provides training that responds to the needs of staff
    - ✓ Making the organisation more reflective of the communities we serve

1.4 Who will monitor our compliance with the Equality Act (2010)

The Equality and Human Rights Commission is responsible for monitoring and enforcing the PSED of the Equality Act (2010), failure to comply with the PSED may result in enforcement actions. EDS2 is a part of our commissioning contract and we are required to submit the annual return to the commissioners in the beginning of November every year. Care Quality Commission (CQC) will also monitor the equality aspect of our service delivery.

2 What is EDS2

To support NHS organisation to perform well on equality, NHS England introduced a National Framework called “Equality Delivery System” (EDS2). It is an audit tool designed to measure NHS equality performance against four goals. The tool sets out four goals around equality, diversity and human rights. Within the four goals, there are 18 standards or outcomes, against which we assess and grade our equality performance. The focus of the EDS2 outcomes is on the things that matter the most for patients, communities and staff.

EDS2 is also applicable to the people from other disadvantaged groups, including people who fall into 'Inclusion Health' groups, who experience difficulties in accessing, and benefitting from, the NHS. These other disadvantaged groups typically include but are not restricted to:

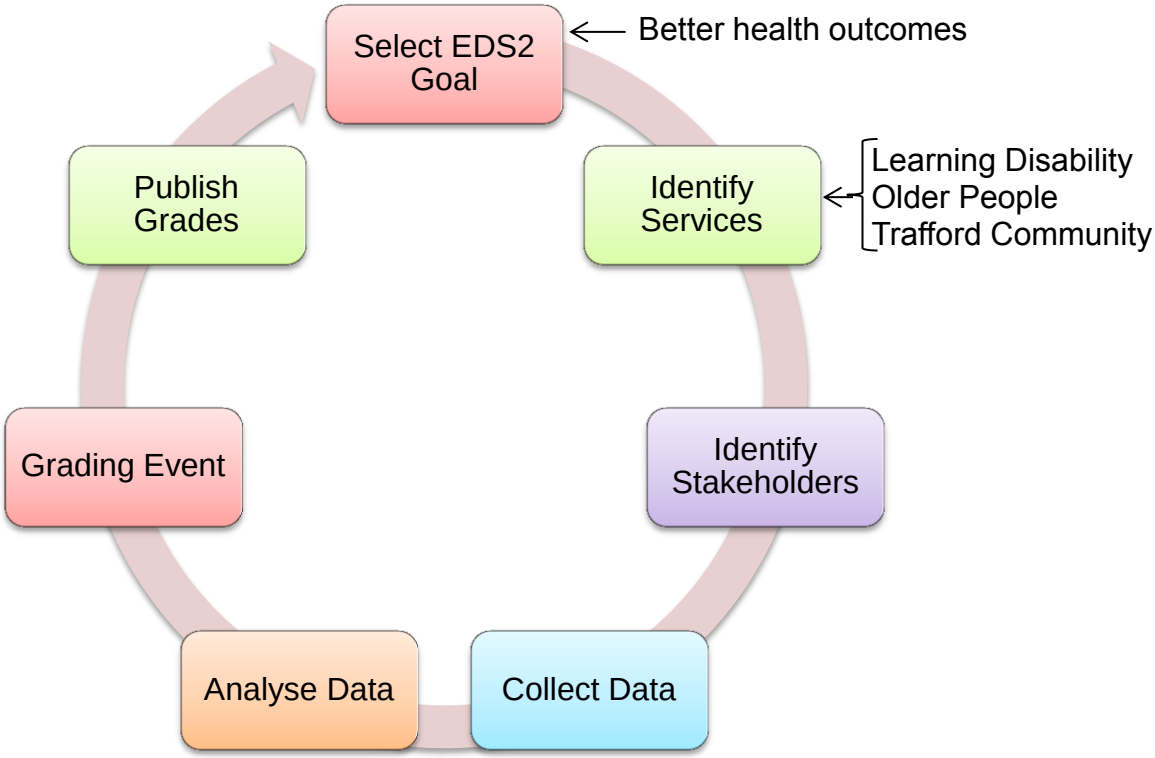
- People who are homeless
- People who live in poverty
- People who are long-term unemployed
- People in stigmatised occupations (such as women and men involved in prostitution)
- People who misuse drugs
- People with limited family or social networks
- People who are geographically isolated

EDS supports good practice in relation to other health care frameworks such as:

- Care Quality Commission (CQC) Registration Framework
- NHS Outcomes Framework
- NHS Constitution
- Human Resources Transition Framework (FREDA)

3 EDS2 Project Implementation Cycle 2014-2015

The EDS2 has 18 outcomes, nine examine equality in service delivery and nine examine equality in workforce development. The project cycle will be repeated every year to gradually focus all services across all outcomes for all aspects of all protected characteristics. The project has been implemented in 7 stages:



3.1 Select EDS2 Goal

The Equality Delivery System (EDS2) consists of 4 Goals:

1. Better health outcomes
2. Improved patient access and experience
3. A representative and supported workforce
4. Inclusive leadership

Within the above four Goals, there are 18 outcomes, against which we are required to assess and grade our equality performance (see appendix A for full description on EDS2 outcomes). This year (2014-2015), the Trust has selected Goal 1 “Better Health Outcome for all” and following five outcomes are related to this Goal:

1. Services are designed, procured and delivered to meet the health needs of local communities
2. Individual people’s health needs are assessed and met in appropriate and effective ways
3. Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed

4. When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
5. Screening, vaccination and other health promotion services reach and benefit all local communities

3.2 Identify Services

The Trust approach to target the service areas was selective, informed or where there was a local evidence to suggest any equality issues within the protected / vulnerable groups or people who are most at risk (old age). Commissioners' priority areas had also informed the selection of service areas. Following services were participated in 2014-2015:

- Learning Disability Services
- Older people Services
- Nutrition / Dietetics, Musculoskeletal (MSK) physiotherapy, Podiatry

Learning disability is defined as a ""significantly reduced ability to understand new or complex information, to learn new skills. It also includes reduced ability to cope independently which starts before adulthood with lasting effects on development (Department of Health. Valuing People: A New Strategy for Learning Disability for the 21st Century. 2001).

Musculoskeletal (MSK) physiotherapy relates to treatment of muscles, tendons, bones, joints, nerves, ligaments and cartilage

3.3 Identify Stakeholders

The aim of the stakeholders was to assess our equality evidences and approve the grading of the outcomes. Typically, local stakeholders comprise: patients, carers, neighbouring NHS Trusts as critical friends, local CCGs, members of local community groups and voluntary organisations, staff networks, FT Governors, staff and representatives of staff-side organisations. With support from PALS, local stakeholders were identified and an invitation was sent to all.

3.4 Data collection

A data collection tool was designed in line with the aims and objectives of the EDS2". The data / evidence against the five-outcomes within the Goal 1 were collected on two-protected characteristics (Age and Disability) in the form of case studies / patient stories, policies and guidelines. The case studies enabled the Trust to capture a wide range of information around service delivery processes, systems and procedures. Individual team managers / governance manager have facilitated the data collection and case studies writing (see appendix B for data collection tool).

3.5 Data Analysis

The aim of the data analysis was to find out that at what extent the evidence we have collected are meeting the EDS2 outcomes. For each of the EDS2 outcomes we have selected to audit, we are required to produce evidence demonstrating:

- Analysis of service delivery data by protected groups
- Evidence of engagement with the protected groups;
- Evidence of action plans for the areas that require improvements.

In consultation with the respective service leads, the qualitative data was analysed and aggregated for appropriate scoring based on EDS2 grading system (Purple, Green, Amber and Red). Where there were performance gaps, it was accepted as part of our equality action plan to address the areas for improvements.

Grading Key:

We are doing very well People from all protected groups fare as well as people overall	Excelling
We are doing well People from most protected groups fare as well as people overall	Achieving
We are doing OK People from only some protected groups fare as well as people overall	Developing
We are doing badly People from all protected groups fare poorly compared with people overall	Undeveloped

3.6 Grading Event – Presentation Engagement with the local stakeholders

Prior to the grading event, a training workshop was organised for the stakeholders to develop an understanding around the EDS2 grading process and the evidence evaluation. Representatives from the local Healthwatch, Trust's Patient Advice and Liaison Service (PALS), Governors, Service user and members from staff group attended the EDS2 grading event.

At the grading event, information / evidence was presented on two-protected characteristics (Disability and Age). Working with others the stakeholders decided:

- How the Trust meet the needs of people
- How safely, effectively and fairly we treat people
- Can everyone have a say in their care

There were a total of 5 tables, each table had a facilitator, who discussed and wrote down comments from each delegate. All the stakeholders review and discussed the evidence provided against each outcome to agree a grade.

3.7 Grading Result

The table below provides a snapshot of the Trust EDS2 grading result. The implementation of the EDS2 highlighted good practice however; it also identifies areas for improvement. With regards to the outcome 1.3, the Trust needs to further strengthen partnership working with other providers.

Services	Outcome 1	Outcome 2	Outcome 3	Outcome 4	Outcome 5
Learning disability					
Older People					
Nutrition / Dietetics, Musculoskeletal (MSK)physiotherapy Podiatry					

Action Plans for Nutrition / Dietetics, Musculoskeletal (MSK) physiotherapy (Trafford only)

1.3 **Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed**

Work by the Transition Board to improve the Transition of children and young people through to adult services is ongoing. There is representation on the Transition Board from Trafford divisions CYPS and Adult services. The divisional Patient Experience manager is currently working closely with the LA's Transition lead for CYPS. A progress report on the joint work will be provided in a future report. A Patient Experience / Engagement strategy, which is applicable to all service users, including those who are in transition, is one of the divisional business unit annual business plan objectives. The final draft will be available as evidence on completion. There are plans in place for health and social care integration.

1.5 **Screening, vaccination and other health promotion services reach and benefit all local communities**

Work in progress with CCG to undertake a co-produced Therapy review to ensure service is fit for purpose and addresses the health needs of all service users.

Action Plans for Learning Disability Services

1.3 **Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed**

The service is currently working with social care partners to further develop this area. Work has already begun by the directorate playing a key role in local SEND agenda plans

4. EDS2 implementation – our achievements and learning

The implementation of the EDS2 further reinforced our commitment to strengthen our partnership working with local social care providers. The service users from the services we have assessed (Older People, Learning Disability, Nutrition/Dietetics, Musculoskeletal (MSK) physiotherapy) rely more on health and social care services than other groups within the protected characteristics. The implementation and monitoring of the action plans for the areas of improvement will be led by the relevant service leads. Services are actively working with social and health care partners to achieve the action plans.

The outcome of the action plans will be analysed against the 3 aims of the Public Sector Equality Duty by the Equality and Diversity team which reports to the workforce and organisational development governance group to identify any patterns of discrimination, exclusion or under/over representation. This is monitored via quality governance group which reports to the Board. The E&D team will provide an update on the progress of these action plans in our next EDS2 report.

This is our first EDS2 report, by implementing the project we have achieved:

- Effective engagement and partnership working with our stakeholders
- Increased awareness amongst staff around equality and diversity
- Improved equality data collection

The EDS2 project has also provided us with valuable learning opportunities. We have learned to improve stakeholder engagement, particularly for those stakeholders who are unable to participate in the EDS2 grading.

EDS2 plan for 2015-2016

The EDS2 project cycle will be repeated next year to select services based on commissioners' priority areas and where there is local evidence to suggest any equality issues within the protected / vulnerable groups or people who are most at risk.

Publishing the report and feeding back to stakeholders

The engagement and feedback from the grading event will inform our action plans and where there are performance gaps, we will address the areas for improvements. The final report is to be circulated to all of the stakeholders that we have engaged with. The report is also to be made available on the Trust website.

Appendices

Appendix A: Equality Delivery System - Goals and Outcomes

Goal	Outcome
1. Better health outcomesl	1.1 Services are commissioned, designed and procured to meet the health needs of local communities
	1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways
	1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
	1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
	1.5 Screening, vaccination and screening programmes reach and benefit all local communities and groups
2. Improved patient access and experience	2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
	2.2 People are informed and supported to be as involved as they wish to be in decisions about their care
	2.3 People report positive experiences of the NHS
	2.4 People's complaints about services are handled respectfully and efficiently
3. A representative and supported workforce	3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
	3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
	3.3 Training and development opportunities are taken up and positively evaluated by all staff
	3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source
	3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
	3.6 Staff report positive experiences of their membership of the workforce
4. Inclusive leadership	4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
	4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
	4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

Appendix B: Data Collection Tool

Goal 1 Better Health Outcomes
Service Learning Disability 2014-2015

Pennine Care NHS
NHS Foundation Trust

Outcome 1.1	**Services are designed and delivered to meet the health needs of local communities**			
Team OR Service Name	**How we are doing based on case study** /commentary / Narrative (please write an issue / task or a situation and how we dealt with it, mainly case studies E.G journey from point of entry to further referral or exist, pathway support / health and social care integrating - our action OR process to meet the outcome Or areas for improvement with action plans	**Grade**	**Evidence /Location**	**Action required**
		Achieving		
		Excelling		
		Developing		
		Undeveloped		

Grading Key:

We are doing very well People from all protected groups fare as well as people overall	Excelling
We are doing well People from most protected groups fare as well as people overall	Achieving
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Appendix C: Learning Disability Services Evidence Description

1. Services are designed and delivered to meet the health needs of local communities

All clients are involved in the development of person centred meaningful objectives which are incorporated into a care plan. This is agreed with the client and their family and documented in line with the Person Centred Review Policy. Clients are involved in the review of the support they are provided from our overnight services. This follows person centred approaches and informs the support provided.

2. Individual people's health needs are assessed and met in appropriate and effective ways

All clients are involved in care planning and documentation includes best interest processes as required. All approved documentation for care planning and reviewing is kept up to date on the Trust intranet for staff to access.

Health inequalities are addressed by clinicians following agreed clinical pathways. The physical health pathway highlights how we address these issues as part of a clients support; the pathways are based on evidence based and focus on implementing the directorate principles.

3. Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed

All children and young people are supported through the transition process from children's to adults services. This provides the family with a named link worker during this period.

All the LD Teams provide comprehensive assessment and interventions to address the health inequalities experienced by learning disabled people. This is particularly important during the transition process to adult care services or to secondary care.

Action Plan: We are currently working with our social care colleagues to further develop this area. Work has already begun by the Directorate playing a key role in local SEND agenda plans.

4. When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse

Learning Disability Directorate has recently developed a Quality Strategy; this focuses on maintain quality by clients accessing safe services.

All clients who access LD services have a comprehensive risk assessment and risk management plan. This enables them to access opportunities and community facilities.

Providing safe support to vulnerable people whose behaviour may challenge is a priority for the service. The positive behavioural support pathway and intervention policy keeps people safe and promotes people staying within their own homes.

5. Screening, vaccination and other health promotion services reach and benefit all local communities

The service has engaged with local health trainers to provide healthy eating advise and support in an accessible format for people with an LD and to ensure healthy food opportunities in 24 services

The Adult teams provide a wealth of health promotion opportunities for learning disabled people. This involves joint working with health colleagues to ensure reasonable adjustments are in place to address health needs.

Appendix D: Trafford Community Services Evidence Description

(Evidence relate to Nutrition and Dietetics, MSK Physiotherapy/Podiatry Service)

Musculoskeletal (MSK) physiotherapy relates to treatment of muscles, tendons, bones, joints, nerves, ligaments and cartilage. Musculoskeletal physiotherapists provide assessment, diagnosis and treatment for patients with musculoskeletal pain and dysfunction.

1. Services are designed and delivered to meet the health needs of local communities

All patients referred to the service are involved in the development of a person centre management/care plan. The care plan goals are agreed with the patient and or family member/carer. Patients have the choice of 2 treatment locations and limited choice of treatment times. There is the option for patient to request to receive treatment from male or female member of staff. The MSK service continues to improve its links with the local leisure centre so that patients can signposted to these facilities when the episodes of care by MSK have finished. All staff in the service are aware of the interpreter and translator service and there is evidence available on the usage of this service. Patient information leaflets which outline the risks and benefits about the MSK treatments provided are available and provided to patients as part of the consent to treatment process. The leaflets are available in different formats, e.g. braille, and languages, upon request. Where patients are identified as having a specific health need, e.g., a Learning Disability, the MSK staff take steps to ensure reasonable adjustments are made to improve the patients experience, e.g. the patient may be allocated to a more experienced clinician, more time may be allocated to the appointment slot, and Easy Read literature will be made available when necessary. The division has implemented a Single Point of Access Service during the last 12 months, which enables patients referred to our services to book their appointments from 8am until 8pm, improving the patients experience for all patients referred to any of the 6 services who's referrals are dealt with by SPOA. MSK is one of the 6 services.

All patients accessing Nutrition and Dietetic Services are involved in their individual care planning and goal setting process. Group sessions and 1 to 1 care is offered depending on the needs of the service users, Domiciliary treatment is available for any patient who is unable to attend a clinical setting and who meets the domiciliary visiting criteria.

2. Individual people's health needs are assessed and met in appropriate and effective ways

A Women's Health Physiotherapy service has been set up specifically to address pregnant women's needs. All patients accessing MSK services are involved in their individual care planning and goal setting process. The service has approved care planning documentation available which is easily accessible by all staff. Specific measures have been identified and implemented by the service, e.g. space is made available for nursing mothers who attend all MSK services, priority is given to patients that are unable to care for their dependants, patients are informed that a private room is available for consultations with the staff if required, informed consent to treatment practices are undertaken with the patients being informed about risks and benefits, verbally and with appropriate PILs, before treatment is provided

3. Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed

There is an established Trafford Transition's Board which is in the development stages of work to support children and young people through the general transition process from children's to adults MSK services where required. However the Adult MSK service can demonstrate some examples where they engage with service users from some protected groups on how service changes are discussed and transition is effected smoothly, e.g., an onward referral process to the local Leisure Trust following completion of MSK episodes of care MSK, referrals to Adult IAPT services, to Falls Group in the community, Asian Women Only Community Rehabilitation Group and to Specialist Weight Management Service.

Action Plan

Work by the Transition Board to improve the Transition of children and young people through to adult services is ongoing. There is representation on the Transition Board from Trafford divisions CYPS and Adult services. The divisional Patient Experience manager is currently working closely with the LA's Transition lead for CYPS. A progress report on the joint work will be provided in a future report. A Patient Experience / Engagement strategy, which is applicable to all service users, including those who are in transition, is one of the divisional business unit annual business plan objectives. The final draft will be available as evidence on completion. There are plans in place for health and social care integration.

4. When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse

All patients who access the MSK service have a comprehensive clinical and risk assessment undertaken, which results in a robust safe and effective management plan. In line with the approved Trust's Induction and Mandatory training policies all MSK staff complete mandatory training, which includes E & D training, Safeguarding

training and medical devices training and ensuring safe use of equipment. There is evidence of MSK staff reporting incidents that involve all patients. The Trust had developed and implemented a Quality strategy which covers all the 3 quality domains, patient safety, clinical effectiveness and patient experience. The MSK service has access to a Community Matron who specialises in Dementia if required. All staff have to complete Dementia Awareness training.

All patients who access the Nutation and Dietetic service have a comprehensive clinical and risk assessment undertaken, which results in a robust safe and effective management plan. All staff have completed the Trusts mandatory training which ensures all patients using their service are treated with dignity and respect. The service ensures patients know a private consulting area can be made available if necessary. Patients can be treated by a HCP of the gender they request if possible. All staff have to complete Dementia Awareness training.

5. Screening, vaccination and other health promotion services reach and benefit all local communities

Action plan

Work in progress to work with CCG to undertake a co-produced Therapy review to ensure service is fit for purpose and addresses the health needs of all service users.

Appendix E: **Older people Services Case studies / Evidence**

1. Services are designed and delivered to meet the health needs of local communities

Intermediate care MH liaison team provides MH assessment, care planning discharge support and follow up care for patients over 65. Intermediate care offers bed based and home based support for individuals requiring rehabilitation following changes in their physical health status e.g, following hip fracture surgery, infection or patients who have complex physical needs / mental health problems

Depending on our assessment if there is an indication of cognitive problems such as dementia and delirium; staff works with the GP to obtain a full physical health assessment and dementia screening (combination of blood test and urine test). We also take a social history, with valid consent from the patient. We also speak to family, carers to get collateral history (based on protected characters) to get the full understanding of the patient history to deliver an effective intervention.

Hospital discharge MH Liaison Team: Supports discharge of older people with MH problem (diagnosed or undiagnosed), once they discharged, we offer follow up in the community (either at their home or in the care setting) through CPNs who coordinate care with others (social care providers).

Adult social care MH Liaison Team: Receive referrals from social workers for clients with diagnosed / undiagnosed MH issues for assessment as part of the wider care planning. Visit people homes / care setting for mental health assessment.

RAID Team: a 365/7 days service, composed of mental health practionnaires, support workers, plus sessions from consultant psychiatric to provide support to the acute hospital with patients having co-morbidities (physical). Acute wards refer patient with mental health problems for an assessment and this is completed within 24 hours. Collaborate with family and ward staff to get to know history to develop and implement a care plan and to maintain their independence.

Case Study

Patient A has a diagnosis of borderline personality disorder; she was admitted to the XXX ward following an incident in a care home where she became aggressive and broke a fellow residents arm. She has previously had cancer of the oesophagus and was treated for this by having a larangectomy (removal of voice box). The patient needed extra support from staff whilst on the ward and staff required training on how to manage the tracheotomy should it become blocked. On admission the patient was seen with the staff by a specialist nurse from ENT who did a training session with the staff on how to use the suction machine and how to help the patient with this should she require this. The patient requires regular visits to the outpatients department at north Manchester hospital where they replace the valve when it becomes dislodged

and this enables patient A to be able to communicate effectively with the staff on the ward.

Case Study

A patient (having diabetes, angina, mild cognitive impairment, and cellulitis), discharged from Hospital. A social care worker was concerned about her mood and asked us to assess her mental health. We found that she was recently moved to an accommodation nearer to the family but her accommodation was not suitable. The CPN adopted a collaborative approach and coordinated with the social worker, housing and supported the service user to move into extra care housing that would meet her social and clinical needs. The outcome was her diabetes was managed through onsite support workers, her social inclusion increased ten-fold, her anxiety reduced and her mood improved.

2. Individual people's health needs are assessed and met in appropriate and effective ways

Case Study

Patient B came into Ramsbottom Ward with a diagnosis of dementia; she then had a fall during the admission and fractured her pubic bone. The patient was initially seen by the on call doctor who requested an x ray of the pelvis due to the area the patient was expressing the pain. The x ray was carried out by the Acute trust who rang to say the x ray was clear, later in the week the report for the x ray came to the ward and reported the fracture that was initially missed. The patient was later seen by physio on the ward who provided her with a walking frame in order to aid her recovery and maintain her mobility.

3. Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed

Mental health liaison services for older people can be requested to complete mental health assessments for individuals that may have not had any previous contact with mental health services and therefore have undiagnosed mental health problems; it has been evident on completion of an initial assessment that some individuals have had challenging and complex mental health needs for some time and they have only been identified as a result of a crisis situation.

Mental health liaison services for older people work collaboratively with secondary care providers and are able to access support for those patients; who are assessed to have chronic and enduring mental health needs, via the older peoples CMHT to ensure that patients' needs are met by specialist services if required.

There is a pathway in place to ensure patients care is smoothly transferred from mental health liaison services for older people to secondary care CMHT services and this involves collaborative multi-disciplinary case discussions, a written care plan and practitioner hand over of care to an identified care co-ordinator. Patients and their carer's, family and social care workers (the referrer) are involved in the decision making process about the involvement of secondary care services and are provided with regular updates throughout the transitional period of progress.

Enhancing systems of communication is an on-going process and to ensure robust measures are in place to maximise communication is a priority between these two services (MHLS for OP and CMHT for OP) staff are regularly mandated to attend multi-disciplinary team meetings. These meetings are the central point for patient care discussions and support the transitional process; another benefit is that different professional groups attend and the patients' needs can be matched through the process of discussion to the most suitable professional carer from the service.

Patients are actively involved in decision making and consent is always obtained from the patient or their formal representative for changes in care provision and they are given clear rationale behind any proposed changes to care.

Mental health liaison services for older people access two IT systems (one via Pennine Care and one system through the local authority) and as a result care pathways and transitions in care can be recorded for the benefit of both the local health and social care providers.

Case Study

Mrs S was referred to hospital discharge liaison by a social worker concerned about Mrs S's low mood following a stroke. The liaison practitioner conducted a comprehensive mental health assessment and this process identified that Mrs S and her husband were both experiencing significant cognitive impairments and had been cared for solely by their son at his home. Unfortunately a week earlier the son had suddenly died and a neighbour had alerted social services to the situation at the property. Mr S also was able to access a mental health assessment from the liaison team in his own right.

Mrs S was admitted to hospital and Mr S received interim support from social care however the level of his impairment meant he had limited insight into his care needs and refused to engage with a care package provided by the local authority.

Mr and Mrs S' assessment was discussed by the liaison practitioner at the CMHT multi-disciplinary meeting and the risk issues and outcomes from both mental health assessments were identified; as a result care was transferred from mental health liaison services to the CMHT for older people in order for their complex and enduring needs to be supported. The local authority social worker was updated throughout this process and was able to access written documentation via their records system.

Case Study

Patient C was admitted to the ward with a diagnosis of dementia and it was soon decided by the staff and the patient's family that the patient would no longer be able to be cared for at home. The staff on the ward completed a nursing assessment that recommended the level of care for the patient should be residential care with dementia specialism. The social worker allocated to the family helped the family to look for the appropriate care setting and also there was a carer support worker in place to assist the patient's wife who was feeling very guilty about the prospect of the patient going into 24 hour care. The patient was assisted with family to complete a life story book in order to help the home he was going to live at to understand the personality of the patient and what he liked and disliked when he moved so that the transition was easier for the family and the care home staff

4. When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse

Lessons learnt from the francis report: Team proactively work on the acute wards / medical ward to support acute staff in recognising early dementia signs and how to deliver care. Participate in clinical audits (falls, slips and trips, medicine monitoring)

Case Study

when patients are admitted to the ward, the process of discharge planning starts immediately, this means that the patient is referred to the community mental health team so that a member of the community team is in place from early on in the admission in order to ensure that everyone involved in the patient care has a clear idea of the patients' needs and is able to plan them in collaboration with the staff on the ward and the consultant.

5. Screening, vaccination and other health promotion services reach and benefit all local communities

The Trust provides education and training to the wider health sector and the voluntary sector (Acute Trusts, LAs), this includes dementia prevention, promotion and education through regular seminar on the wards / community. Deliver mandatory training on dementia, delirium and depression to the acute trust staff.

We provide training and health education to anyone from cleaner to security guards, care homes managers, students.

Staff developed a 4me vascular dementia cue card (self-help strategies in managing the condition once it has been diagnosed) to help people with vascular dementia to

maximise their health a way of reducing the risk of further vascular events (strokes, heart attacks)

Case Study

Patients on wards, during the winter months are given the opportunity to have the flu vaccination. The staff would first contact the GP of the patient in order to assess if the patient has already been given the jab by them, then the pharmacist on the ward will check the drug cards and notes for any allergies that may arise when the jab is given. Lastly the patient or carer, if the patient does not have capacity, will be asked to sign a consent form to allow the staff to give the jab.