CCG Evaluation October 2015
Adult (18+) Mental Health Hospital Liaison Service

Debbie Smith, Service Director, RDaSH
June Lovett, Assistant Chief Nurse, TRFT
Dr Graeme Tosh, Team Consultant, Liaison Service
September 2015
The Brief

Drivers for Change
- No health without Mental Health
- National Mental Health Strategy
- Better Care Fund parity of esteem
- Mental Health Crisis Concordat

To provide
an all age(18+) service which:
- improves the patient & carer experience
- improves access to assessment & appropriate services during mental health crisis
- reduces admissions to TRFT
- decreases length of stay
- reduces re-admission
The Service

• £790K investment from the Better Care Fund
• Launched in April 2015
• Clinically led with medical expertise
• 24/7 A&E admission avoidance
• Specialist liaison in reach to wards 8 am – 8 pm 7 days a week
• Support for 16-18 years olds overnight and at weekends
Impact: Emergent Evidence

Outcome of ED Referrals

- Discharged
- Ref to Social Services
- Ref to MH Ward
- Ref to Memory Service
- Ref to CMHT
- Ref Care Home Liaison Team
- Discharged to GP
- Ref to out of area
- Ref to IAPT
- Ref to Comm Therapy Team
- Ref to Intensive Comm Therapy Team

Outcome from ward referrals

- Discharged
- Ref to Social Services
- Ref to MH Ward
- Ref to Memory Service
- Ref to CMHT
- Ref Care Home Liaison Team
- Discharged to GP
- Ref to out of area
- Ref to IAPT
- Ref to Comm Therapy Team
- Ref to Intensive Comm Therapy Team
- Ref to Recovery
Reducing length of stay

Dementia Patients as a Percentage of Admissions

Average Length of Stay for Dementia Patients

2014-15 | 2015-16

Rotherham Doncaster and South Humber NHS Foundation Trust
Service Performance

• 512 referrals
• Main reason
  – Adult: self harm
  – OP: dementia/confusion
• Demand high in morning & early afternoon
• Scenario: August 2015
  – TRFT spike, not reflected in Liaison referrals
  – 8 referrals known to RDaSH
  – 9 re-presentations
  – Working with Crisis team on frequent ED attendees
Contacts

August scenario

- The majority of contacts seen within an hour
- Adult average duration 44 minutes  
  - Longest 90: shortest 1
- OP average duration 30 minutes  
  - Longest 140: shortest 5
The TRFT perspective

- Patient and carer experience
  - understanding
  - support
- Referrer experience
  - speed of response
  - 1 hour SLA in ED
  - confidence in decision making
- New mental health pathway, basis for the Emergency Centre
What Patients & Carers Say

Thanks so much, I hope that we can get him sorted now as we are stuck with where to go next, I am glad he is being honest about his drinking and how this is affecting him. I didn’t realise that we would get the help from your service today ... I feel if we would not have ... we would be burying my son. Mother CDU Patient

It’s great to be able to speak to someone about this and know I will get help when I get home as well, it’s such a relief. Parent A1

Thank you so much. I have never felt so well in my entire life and it’s thanks to the input from the liaison team, I really do feel better. Patient

Wow, it was a big step for me to talk and open up. I am glad you were there to talk to and I know I will get help now. Patient

Thanks for your help, I think my daughter is on the road to recovery with your input. The app and self help guides are brilliant ... I will use them with some of the foster children I look after. I am so glad you have been involved with my daughter. The service is brilliant. Patient’s mum

... we just didn’t know what to do, we were so shocked, but your input has really helped. We don’t feel as hopeless now. Patient’s Parent

156 compliments
0 complaints

Rotherham Doncaster and South Humber
NHS Foundation Trust
I spoke to the lady once she had been seen by you and she felt a great benefit someone speaking to her, she stated that it was a worry on her mind that no one wanted to talk to her about her mental health problems, but feels a lot better now this has been broached with her.....we can now discharge her home instead of waiting 48 hours for her to see the psychiatrist. You visiting the ward today has saved us 4 bed days, I am really shocked how easy it was. Midwife Wharncliffe

I’m really surprised how quick you responded to the referral ... it’s hard for us to get our head around that you will see people before they are medically fit, but we are finding it really helpful. Nurse B1

Thank you for highlighting this. We need an Emergency Multi Agency meeting because of this and well done on the prompt action of the team. You have potentially averted a child death with your input. Children’s Social Services

This patient is too high risk, but with your input it’s made us realise she isn’t and she is safe to go home. Sister B10

It’s great that the patients you have admitted all have FACE and FNA completed ... it’s saving the ward so much time and helping in the continuity of the patients care. Bed Manager

Thank you for advising us, it has stopped me misinforming the patient and their family, it would have previously took ages for me to find the information out. ED triage nurse
Value Added

• Improved patient and carer experience
• TRFT
  – Staff
  – Savings
• Impact in the Community
  – Crisis Team
  – Care Homes and Residential Homes
• Partnership working
  – Dementia
  – Crisis Concordat
  – Frequent Attendees
Challenges and Next steps

• All-age
• Single point of access
• Education
• Parity of Esteem
• Environment
• Hand over and information management
• Transitions
Adult Mental Health Hospital Liaison Service

Evaluation Event October 2015

Debbie Smith
Service Director

September 2015
Adult Mental Health Hospital Liaison Service

1. Objectives
The Mental Health Hospital Liaison Service was commissioned in November 2014 as a two year pilot with the remit of establishing an integrated acute service for adults and older people, including those with dementia. The 2015-16 investment was £790K. The service brief is to:

- reduce the number of admissions from Accident and Emergency
- reduce length of stay
- improve access to assessment and appropriate services during MH crisis
- reduce re-admission

The service is clinically led, with medical expertise and operates from The Woodlands on the site of the Rotherham Acute Hospital.

The service provides:

- mental health expertise to the Emergency Department (ED) 24 hours a day, 7 days a week for admission avoidance for those 18 and over
- specialist adult and older peoples liaison in-reach activity to wards 8 am – 8 pm 7 days a week
- support for 16 – 18 year olds overnight and at weekends

2. The Current Service
The service launched on 1 April 2015 following approval of the business case in November 2014. A phased approach to implementation was taken due the recruitment process, however we now have a full complement of staff apart from 1.6 WTE band 6 nurses (a maternity cover and a vacancy). Physiotherapy and social work services are provided from within the general acute sector and from the RDaSh integrated services (social care).

The team have been working 8am -8 pm weekdays since May, reducing attendance at the Emergency Department (ED) and facilitating timely discharge, as well as freeing up the Crisis Team to focus on community work and follow up. This has had an effect on the number of people accessing secondary care mental health by dealing with mental health crisis proactively. The team began weekend working began in September.

A new ED pathway has been developed which has become the basis for the development of the Emergency Centre pathway which will go live in July 2017. The Liaison team now respond within an hour in ED, rather than waiting for the patient to be medically fit, significantly contributing to meeting 4 hour waiting targets. Clearly work cannot always be done with the patient at this stage, but carer feedback indicates early support is highly valued, impacting on their peace of mind and outcomes which will influence their confidence in the quality of care. Preparatory work can also be put in place for those patients who need further input from a secondary care service.
3. Performance Monitoring

The CCG carried out a successful quality visit in July and actions arising from this are being implemented. An independent service evaluation will be carried out by Sheffield Hallam University which will be presented at the evaluation meeting in October 2016. A performance dashboard (attached) has been developed which is reviewed monthly by the Mental Health QIPP Committee. Work is on-going with the Rotherham Foundation Trust (TRFT) to produce performance information including benchmarking data for the agreed KPIs of reduced admission, length of stay and re-admission. Information is not currently recorded to measure re-admission with mental health presentations or admission from care/residential homes.

4. Value Added

4.1 Patient and Carer Experience Qualitative feedback is being collected consistently. There have been 156 compliments and no complaints since the service launched. Patient and carer feedback consistently shows that specialist mental health expertise helps them feel understood and supported and has enabled them to access services quickly. All patients who have received a service from the Liaison team are given a crisis plan and outcome assessment, in accordance with the crisis concordat action plan.

4.2 Referrer Feedback Feedback from TRFT has been positive. Speed of response, knowledge transfer and support in decision making are consistently noted. There is clear qualitative evidence that specialist support has helped with risk assessment in relation to discharge, supporting patients and carers and saving bed days.

4.3 Partnership Working and Dementia The Liaison Team work closely with TRFT’s dementia nurse. This is evidenced in recent work around delirium, often confused with dementia. A joint pathway and information leaflet are being developed and a ‘Think Delirium’ week is planned for November.

4.4 Impact in the Community Investment in the Liaison Service has enabled the Crisis Team and Care Home Liaison Team to focus more time in the community. The Liaison Team now respond to ED referrals, resulting in a 17.6% decrease in daytime referrals to the Crisis team. The increased capacity in community activity will, in time, reduce presentations and representations in ED and prevent people being pulled into secondary care mental health unnecessarily.

4.5 Crisis Concordat and Frequent Attenders The Hospital Liaison Service contributes to the Rotherham crisis concordat, a national initiative to support people experiencing a mental health crisis ensuring agencies work together for the benefit of patients and carers. It establishes principles of good practice to raise standards and strengthen working arrangements. Part of this work includes working across agencies to reduce frequent attenders to ED. The hospital liaison pathway co-ordinator is working with GPs, 111, Yorkshire Ambulance Service and South Yorkshire Police to develop multi-agency case management for frequent attenders. Good practice guidelines for early intervention have been developed and training is planned for mental health care co-ordinators for late 2015.
4.6 **Partnership working with alcohol services** These two services work closely together to support patients, carers and make best use of resource. Two scenarios are highlighted in the case study appendices.

5. **Challenges and Future Priorities**

5.1 **Adult All-age**
The service is an 18+ adult service for adults of working age and older people. This is the first combined adult service in Rotherham Mental Health, which has presented challenges for cross age specialism working. Work is on-going to define the core skills and activities across age specialisms and articulate specialist requirements, in line with guidance provided by the Royal College of Psychiatrists and the Joint Commissioning Panel for Mental Health. 16+ patients are supported in the evenings and at weekends. As data builds demand will be analysed in order to review levels of resource and the balance of specialist expertise. TRFT have requested a single contact number for all-age including CAMHS, which is being progressed through phase 2 of the transformation plan. TRFT would like a single liaison service. A CAMHS liaison worker has recently been appointed, but is not currently part of the Mental Health Hospital Liaison Service, however this post offers the opportunity to develop clear and effective patient pathways for young people.

5.2 **Education**
The main focus to date has been awareness raising and knowledge transfer around specific cases. Dementia training has been delivered to a ward. Work is required to develop a more consistent and sustained approach.

5.3 **Access to social services and physiotherapists**
The business case for physiotherapists to be based in the team was not approved as it was deemed there was sufficient resource within the hospital. There is no evidence to date to suggest that this has been an issue. Further work is required to develop relationships and analyse any impact on response times and outcomes.

5.4 **Working Environment**
The liaison team will be part of the Emergency Centre when it opens in July 2017. The team is currently based at Woodlands at the back of the hospital site. Space within the hospital is very limited. There is a room in CDU to see patients and a small office space. There is nowhere private in ward areas to carry out assessments.

5.5 **Handovers and Record Keeping**
TRFT patient records are currently paper based. The Liaison team therefore have to record information on the paper notes and RDaSH electronic records. There is concern that these notes are either not taken account of in decision making or not seen in a timely way as it can be difficult to find somebody to handover to. It is also inefficient to record information twice. The patient may be asked for the same information multiple times, a point highlighted by Healthwatch. This was raised in planning for the Emergency Centre and the principle of collecting information once and using it many times has been adopted.

5.6 **Service Evaluation**
RDaSH are working with TRFT, CCG and Sheffield Hallam University to develop ways of evaluating our service and collecting the required data to ensure service outcomes are fully captured and that we can effectively measure the impact. This includes the ability to share and analyse information across the health and social care system. For example frequent attenders intelligence can promote more effective ways of working across agencies in future.

6. Conclusion
The Mental Health Hospital Liaison Service has been well received by patients, carers, TRFT and the CCG and RMBC commissioners. This is a significant step in developing parity of esteem in the acute hospital, which will be further developed through education and training. There is clear evidence of improved patient, carer and referrer experience. The investment has enabled faster response rates in ED and there are early indications of reduced admission and length of stay. The service will be evaluated over the coming year as more information becomes available and the financial impact will be assessed. Further work is required in developing the all-age model and providing a single point of contact.
Case Studies

Evidencing the Impact of Mental Health Expertise in ED
Diagnosis: Eating Disorder
Date: 29/06/2015

Scenario:
A phone call was received from an ED doctor with an enquiry to ask if a patient was known to mental health services. He reported that he had concerns that the patient had an eating disorder, she was severely dehydrated and they were planning to rehydrate and discharge her. Silverlink records indicated that there had been numerous ED attendances in the past 12 months. Queries had been raised as to whether the presentation was psychotically driven and she had been referred to the Crisis Team but always absconded from the hospital prior to being assessed by them.

The Liaison worker discussed the case with ED doctors. The patient had not been eating or drinking for a sustained period and was severely malnourished with significant weight loss. The doctors stated that they thought is may help with her overall care if the liaison worker assessed her to get a holistic view of her presentation.

Following assessment, it was evident that the patient was actively psychotic. There was evidence of persecutory delusional beliefs that she had people in her home that had told her that her food was poisoned resulting in her throwing her food away. She reported that she had cameras in her home that were watching her die. There was evidence of her being guarded, suspicious and paranoid about the staff in the hospital and the assessing liaison worker. There was evidence that the patient lacked capacity due to her presentation and completely lacked insight into her current experience.

The ED department admitted her to ward B1 and the liaison nurse instigated procedures to assess the patient under the mental health act. The patient subsequently attempted to leave the ward and was detained under section 5(2) of the mental health act and later section 2 of the mental health act. She was then conveyed to the mental health unit.

Outcome
Medical staff were treating the patient purely for dehydration and malnourishment. The liaison intervention triggered a mental health assessment enabling the cause to be addressed, thereby providing appropriate help to the patient and breaking the cycle of repeat visits to ED.

Good Practice Elements:
- Patient was not being treated for mental health issues however with the input from Liaison team the patient was noted to be mentally unwell and was detained and receiving appropriate treatment for her illness.
- Excellent communication between two different services to fully meet the needs of the patient.
- Excellent interfacing with TRFT.
- Liaison team visited ED and inputted into the care of the patient.

Challenges Identified:
- Mental health needs not recognised initially, so referral to the liaison service was delayed
- The patient could have been detained in TRFT prior to being medically fit which would reduce the need for the use of Section 5(2) by TRFT staff.

Action Planning:
- More education to ED staff re recognition of mental health issues.
- Possible MH screening to be introduced into ED.
- Further interfacing work with AMPH’s to look at detentions under the MHA prior to patients being medically fit.

Case Study Evidencing the Impact of MH Expertise on Length of Stay
Diagnosis: pain resulting from depression
Date: 29/06/2015

Scenario:
A referral was received from ward A7 after the patient had been on the ward for 6 weeks with pain in her right side, with no known physical cause.
A mental health assessment was completed with the patient’s consent. The assessment indicated the patient was suffering with severe anxiety and low mood that was linked to her current social situation; however it was apparent that she had had suffered from underlying mild depression for many years linked to childhood bullying. She was reviewed by the consultant psychiatrist and started on anti-depressant and anti-anxiety medication, replacing her pain relief medication as the anti-anxiety medication was also used for neuropathic pain. The patient reported a huge benefit from this as she believed she was becoming dependent on the increasing amount of medication that the general hospital were prescribing her.

Over a period of two weeks the liaison worker did some intensive CBT therapy with the patient because she was now suffering with panic attacks at the thought of leaving the general ward. The patient participated in graded exposure work and she was given self-help guides to work with when she was not working with the liaison team. The liaison worker noted that the patient struggled with reading, so an app version of the self-help guide was used. The patient reported that this alone helped as she was embarrassed about her inability to read properly, she reported that this helped her with her confidence.

On participating in an MDT with the patient and the general hospital staff, the patient was informed that she had no physical problems and that her pain was a result of a physical manifestation of her anxiety. The patient was then discharged home. The patient’s mother praised the liaison team for the use of the app and reported that she felt this had really benefitted her daughter, so much so that she was going to look at using it with her foster children and discuss it in her foster parent forums. The mental health team referred her to IAPT and back to her GP for further support.

Impact:
- The underlying causes of the patients symptoms were addressed
- The patient received personalised help which addressed her specific needs
- The patient was discharged

Good Practice Elements:
- Liaison team were able to do brief CBT and graded exposure work with patient this enabled a timely discharge from the general hospital.
- Liaison team were able to utilise social media and up to date technology to help in the patients recovery and do build on the work the team were doing to benefit the patient.
- Education to the general staff on the ward re mental health problems and the differing presentations of mental health problems.
• Liaison was able to reduce the amount of addictive medication the patient was taking and combine treatment for anxiety and pain relief.
• Patient had a clear plan on discharge from the hospital regarding further help with her mental health.

Learning Points
• The patient had been in hospital for 6 weeks prior to being referred to the liaison team. Awareness raising is ongoing.
Case Study Evidencing Partnership working with Alcohol Liaison:

Date: 10.09.2015

Scenario 1:
Referral received from the Clinical Decision Unit that indicated that when the patient was admitted they were under the influence of alcohol. On checking the relevant systems the patient was not known to mental health services however the patient was noted to have numerous attendance to his G.P with alcohol misuse issues. The hospital liaison team contacted the alcohol liaison team to discuss the patient and it was agreed to see them together to save the patient having to complete two separate assessments. On completing the assessment it was apparent that the patient was in more need of mental health services, than input from the alcohol liaison team. Therefor the MH team took ownership of the case.

Scenario 2:
The Alcohol Liaison Team contacted the Mental Health Hospital Liaison team regarding a patient on A4 who was completing an alcohol detox. The Mental Health Team carried out an assessment and felt that it was not a true picture of the patient’s mental health as it was difficult to attain much information due to the patient being in a state of alcohol withdrawal. Once the patient had completed the alcohol detox and had been free of alcohol for three weeks, there remained concerns regarding the patient’s presentation. The Liaison Team assessed the patient again and once again found it difficult to make an assessment as there was very limited information that the patient could provide. Her memory was assessed by the clinician and the patient and the patient scored very low. The clinician requested an assessment from the consultant psychiatrist which was done jointly with the Alcohol Liaison Team and the Mental Health Liaison Team. The patient was given a diagnosis of Alcohol induced dementia which triggered the patient to have extra support and input from both services. Due to the advancement of the patient’s illness she required 24 hours nursing care.

Impact
Collaborative working with Alcohol Liaison Team resulting in an accurate diagnosis to
i. benefit the overall outcome for the patient
   ii. Address the route course, removing repeat hospital admission to address the symptoms
Reflective Practice/Case Study Proforma

Team: MENTAL HEALTH LIAISON TEAM

Date: MAY 2015

Scenario: ADMISSION UNDER MENTAL HEALTH ACT TO WOODLANDS MENTAL HEALTH UNIT.

79 year old male, hospital admission.
Referral received from Clinical Decision Unit 14/05/2015 at 12.40 hrs. Seen at 13.30 hrs.

Previous history

- Referred to memory clinic March 2015 by G.P
- 06/05/2015- Attended ED with son following an overdose of 8 Paracetamol.
- Assessment/risk assessment completed. Advised to see GP regarding prescribing antidepressant.
- 14/05/2015 – Further attendance at ED with further overdose.

Assessment:

- Capacity to consent to assessment established.
- Cognition – Cognitive deficits evident, MOCA 10/30. Dismissive of this.
- Perception – No Delusions/hallucinations.
- Mood – Subjectively low in mood, “wanted to die”, and “fed up”. Unhappy tablets “didn’t work”.
- Significant risks identified: - Putting affairs in order, repeated overdose? Not expecting visitors. Poor appetite with weight loss, some apathy/loss of interest. Family describe “changes in personality”.

Management Plan:

- Initial assessment, then subsequently reviewed with Associate specialist Psychiatrist.
- “No guarantee that I would not do it again”.
- Formal Mental Health Act assessment requested.

Patient Experience:

- Aggressive, agitated. Attacked AMHP. Police attendance required.
- Admitted to Brambles Ward under Section 2 of the Mental Health Act.

Outcomes:

- Rapid response.
- Considered least restrictive options first.
- Risk assessment identified escalating risk.
- Triangle of care. Collateral history from family contributed to formulation. Family concerned by presentation and risks.
- Multi-disciplinary working.
Any Challenges Identified:
- Difficulty in diagnosis. Severe frontal temporal atrophy and temporal horn measurements 12mm following investigations. On-going management /risks. Depression.
- Impulsive Behaviours.
- Safety of others, environment when became aggressive. The distress and aggression of the patient.

Action Planning Required:
- New Emergency Department design and facility will provide more appropriate environment.
Reflective Practice/Case Study Proforma

Scenario: SUPPORTED DISCHARGE FROM MEDICAL WARD FOLLOWING OVERDOSE.

May 2015
80 Year Old Female
- Admitted to hospital having been found on floor at home by daughter following opiate overdose.
- No previous contact with services/mental health problems.
  Referral received 22.05.2015 at 14.50 hrs.
- Seen on Ward at 15.00hrs for 1 hr 45 mins.

History and Presentation:
- Capacity assessed. Fully capacitated. Consented to interview.
- Following fractured shoulder * (October 2014) quickly disclosed, “Life changed dramatically”.

Cognition
- No issues identified.

Perception
- No evidence of delusions/hallucinations.

Mood
- Feelings of increasingly low in mood resulting in overdose. Concern re loss of independence – burden on family, husband suffered a long death from cancer (pain). “Wouldn’t like to go through same”.
- Chronic pain issues which she felt had not been addressed.
- Overdose intentional, “sorry it didn’t work”. Some planning indicated.
- Significant risks identified.

Management Plan:
- Agreed to further Mental Health Liaison Team intervention/monitoring whilst further tests were undertaken. Support given on ward regarding actions/feelings, medication concerns.
- Risk monitored. Concern re: any unsupported discharge identified/agreed with ward.
- Discussed with Psychiatrist, suggested commencement of Duloxetine 30mg od.

Follow up:
- Initially upset, having seen impact on family of overdose, would not consider suicide again.
- Ward staff informed Mental Health Liaison Team when fit for discharge.
- Patient informed of plan and agreeable with community follow-up. Letter/plan to GP.
- 29.05.2015 – Seen at home by community staff (OP). On-going risk assessment and care planning.
- Care plan agreed.

Patient Experience
- Positive feedback from patient, “felt she had been listened to”.

*Note: The referred item occurs after a hyphenated word, indicating it may be part of a compound term or a specific mention of an event or condition.
• Returned home in supported manner as soon as medically fit, left hospital same afternoon after physical investigations completed.

**Outcomes**
• Further admission to mental health inpatient facility avoided/Acute Hospital not prolonged.
• Mental Health care plan formulated prior to this.
• Risk assessment. Defusing of emotional distress on ward. Safety established.
• Appropriate prescribing.

**Any Challenges Identified:**
• On-going care plan.
• Liaison with other disciplines, e.g. pain management.
• Delay in prescribed Duloxetine.
• Discharge arrangements re: medication (? Administration system).

**Action Planning Required** Use of reflection/liaison with RFT as above to build systems to improve care as identified above Consistent approach /application to other wards.
## OPMH Liaison Services

### Current Month

<table>
<thead>
<tr>
<th>Ref</th>
<th>KPI</th>
<th>Target</th>
<th>Current Month Position</th>
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<tbody>
<tr>
<td>1</td>
<td>Total number of referrals</td>
<td>n/a</td>
<td>↓</td>
</tr>
<tr>
<td>2</td>
<td>Source of referral</td>
<td>n/a</td>
<td>↓</td>
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<tr>
<td>3</td>
<td>Reason for referral</td>
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<td>↔</td>
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<tr>
<td>4</td>
<td>Time of referral</td>
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<td>↑</td>
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<tr>
<td>5</td>
<td>Response Time (referral to contact waiting time)</td>
<td>n/a</td>
<td>↔</td>
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### Graphs

- **Total Referrals**
- **Source of Referrals**
- **Reason for Referrals**
- **OPMHS Time of referral (in hours)**
- **Response Time**
<table>
<thead>
<tr>
<th>Ref</th>
<th>KPI</th>
<th>Target</th>
<th>Current Month Position</th>
<th>Description</th>
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<tbody>
<tr>
<td>6</td>
<td>Number of contacts</td>
<td>n/a</td>
<td></td>
<td>There were 217 contacts in August</td>
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<tr>
<td>7</td>
<td>Contact Duration</td>
<td>n/a</td>
<td>↓</td>
<td>The average contact duration is 30 minutes, with longest being 120 mins and shortest 5 mins</td>
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<tr>
<td>8</td>
<td>Outcomes of those referrals received from A &amp; E</td>
<td>n/a</td>
<td>⇪</td>
<td>The main outcome for A&amp;E refs was discharge</td>
</tr>
<tr>
<td>9</td>
<td>Outcomes of those referrals received from wards / CDU</td>
<td>⇪</td>
<td></td>
<td>The main outcome of those ward based refs was discharge alongside ref to MH ward and memory services</td>
</tr>
<tr>
<td>10</td>
<td>Compliments and Complaints</td>
<td></td>
<td>↓</td>
<td>A separate summary of compliments has been circulated which includes ref feedback. There are significantly less than in Adult services as a direct result of the client group.</td>
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<tr>
<td>Ref</td>
<td>KPI</td>
<td>Target</td>
<td>Current Month Position</td>
<td>Notes</td>
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<td>--------------------------------------------</td>
</tr>
<tr>
<td>11</td>
<td>Frequent attenders</td>
<td></td>
<td></td>
<td>There were 9 patients with more than one ref in June</td>
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<tr>
<td>13</td>
<td>Out of Area refs</td>
<td></td>
<td></td>
<td>There were 9 OOA ref for older peoples in August</td>
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