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Dynamic Support Register – Clinical Support Tool

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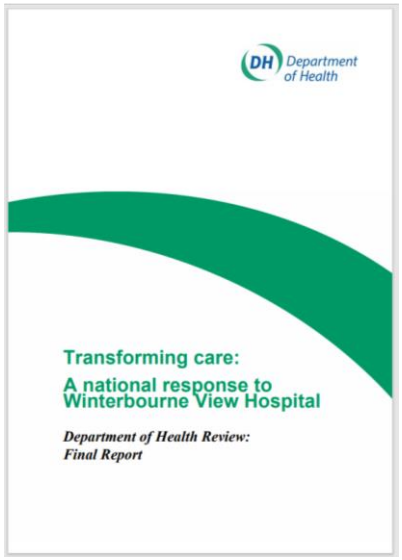
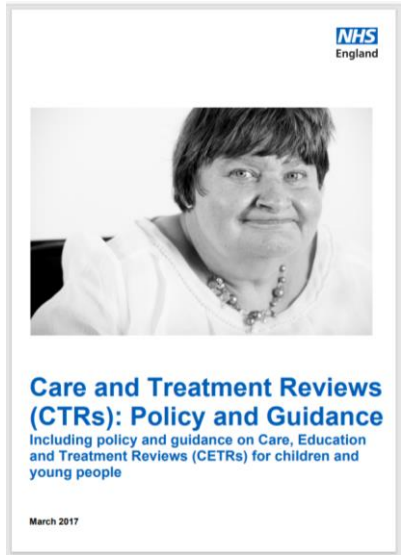
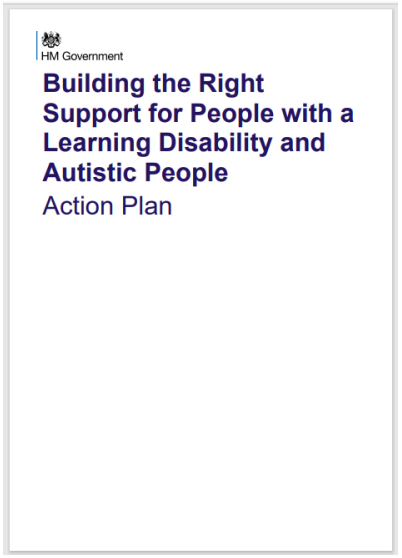
Ambition: What are we trying to address?



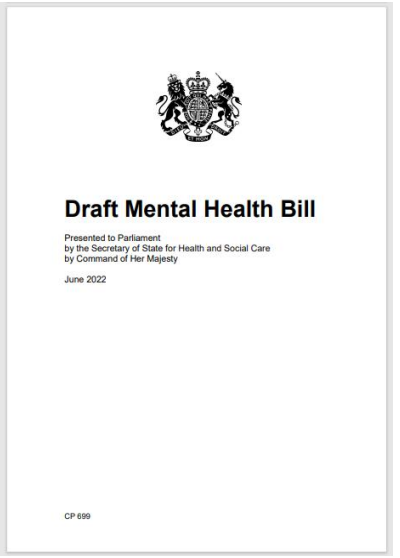
Drive to reduce inpatient admissions



DSRs mandated in policy



DSRs continue to be mandated



…and placed in law?

*new guidance on use of DSRs due for publication in Autumn 2022

Ashlee's story

Background	At risk behaviours when unwell
Age 23 years old **Age of engagement with services** CYP and adult LD – initial at 16 and then continued into adult services **Main problem areas** Atypical Autism, Moderate LD, Anxiety disorder, OCD, Unspecified nonorganic psychosis & history of self harm. **Admissions to hospital** Informal admission to A&T unit in 2019	Withdraws from all social contact Stops eating and drinking Stops all verbal communication Increase intensity of obsessional behaviours (Checking behaviours) Reports having more nightmares and not sleeping well Will try to self-injure, by cutting her arms with anything sharp May have thoughts to harm/kills herself and may plan dates and times and how and when this will occur.

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A's story

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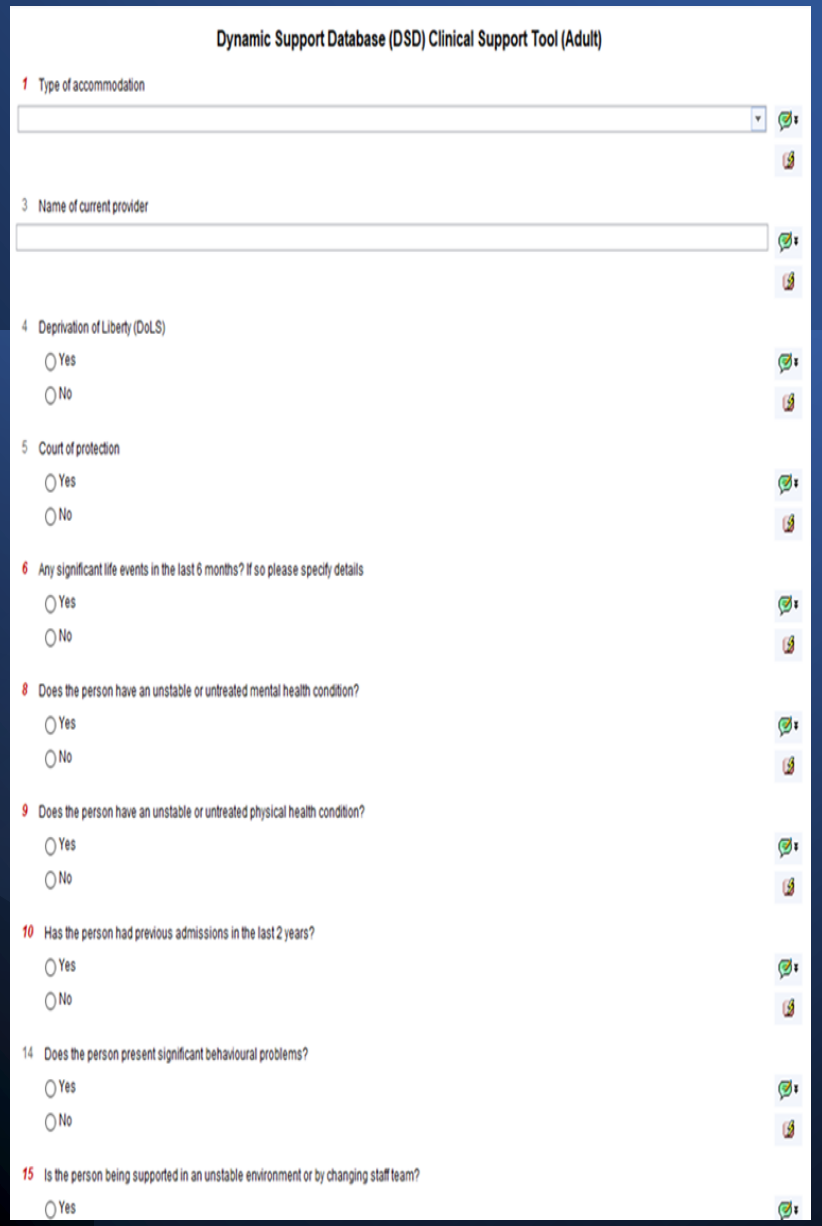

Dynamic Support Database (DSD) Clinical Support Tool (Adult)

1 Type of accommodation

3 Name of current provider

4 Deprivation of Liberty (DoLS)
- Yes
- No

5 Court of protection
- Yes
- No

6 Any significant life events in the last 6 months? If so please specify details
- Yes
- No

8 Does the person have an unstable or untreated mental health condition?
- Yes
- No

9 Does the person have an unstable or untreated physical health condition?
- Yes
- No

10 Has the person had previous admissions in the last 2 years?
- Yes
- No

14 Does the person present significant behavioural problems?
- Yes
- No

15 Is the person being supported in an unstable environment or by changing staff team?
- Yes

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Stratification of risk	Development of the DSD clinical support tool
❖The Care and Treatment review policy stated commissioners should hold a register of those at risk of admission ❖Commissioners in the local area sought a tool that would standardise ratings and provide consistency leading to clear actions and expectations	❖Risk factors were recognized within policy ❖Factors were taken and weighted ❖RAG rating developed based on the scores ❖Psychometric properties including face validity and interrater validity tested as part of the process

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Outcomes- RAG rating and management strategies

No current risk of admission identified

Potential risk of inpatient admission/residential placement

Imminent risk of inpatient admission/residential placement.

Referral made to services as 'usual'

Lead professional identified

Aims of input clarified and working to meet them

MDT meeting

Review assessments, formulation and care plans

Intensive Support Team referral made

ICBs made aware

Intense MDT Working

Request CE(T)R

Enhanced Care Planning

Re-formulate plans to reduce risk

Regular contact with individual, family, care team and commissioners

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Levels of impact outcomes

Individual level: appropriate support at the right time and place. ‘What I want you to do when’ (RAG rated plans)

Staff members: Structure of plans. Stratification of need. Identification of risk of admission

Trust-wide: understanding numbers and patterns of risk of admission. Service planning.

National context: geographical implications. Consistency of ‘5%’ at risk suggestion

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Cost outcomes

Economic analysis of the Intensive Support Service in reducing admissions to hospital for people with a Learning Disability

Dr Jane Leadbetter (CT2) and Dr Hannah Wieringa (CT1 LAS)

Background

The "Dynamic Support Database (DSD)" is a database required to be held by commissioners which identifies individuals with a learning disability (LD) who are at risk of admission to hospital. This was implemented following recommendations made as part of the "Transforming Care" agenda[1]. Cheshire and Wirral Partnership Trust (CWP) created a DSD clinical support tool in 2017 to help stratify risk. It involves a series of yes/no questions, completed by a health professional annually, or when circumstances suggest a change in risk. Based on the responses, a total score is generated, and a corresponding "green", "amber" or "red" category is assigned, with green corresponding to least risk of inpatient admission, and "red" to the highest risk. An intensive support service (ISS), made up of a clinical psychologist; associate practitioners and clinical support workers; along with consultant psychiatrist input, was created at the same time as the DSD clinical support tool. Service users identified as "red" on the DSD are offered intensive support from the ISS; with the aim of preventing admission to hospital where possible and appropriate.

Aim

To identify the cost benefit of using the DSD tool and ISS through reducing admissions to hospital for patients with a learning disability within CWP.

Methodology

We collected data for two time periods; 1st January 2016- 31st December 2016 and 1st January 2018- 31st December 2018. Between these dates we looked at the number of people open to the Community Learning Disability Teams (CLDT) within CWP and the number of those who were admitted to an Assessment and Treatment (A&T) unit or to a general mental health bed. This allowed us to compare admission data pre (2016), and post (2018), introduction of the DSD tool and ISS. We obtained the data by liaising with the information analysis department within CWP.

Data collected:

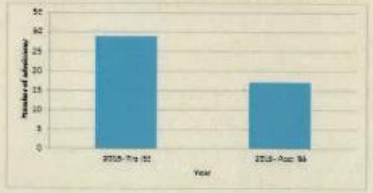
- Number of patients open to CLDT teams in CWP who were admitted in 2016 (pre DSD)= 29
- Number of patients open to CLDT teams in CWP who were admitted in 2018 (post DSD)= 17.
- Average total cost of an inpatient bed (not shared due to confidentiality reasons)
- Joint cost of ISS teams in CWP (not shared due to confidentiality reasons)

Analysis:

- Difference between number of patients admitted in 2016 and 2018=
  - **29-17=12**
- Average total cost of an inpatient bed **(A)**
- Money saved due to reduction in hospital admissions **(B)** =
  - **12 X A**
- Combined cost of three intensive support teams within CWP **(C)**=
  - **Cost of each team x 3**
- Money saved **(D)**=
  - **B-C**

Results

In total there were 12 fewer admissions for adults with LD to any mental health ward in 2018 compared with 2016, as shown in Graph 1.



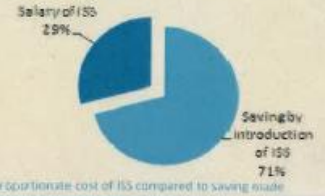
Graph 1: comparison between number of admissions in 2016 and 2018

1: https://www.england.nhs.uk/wp-content/uploads/2017/02/model-service-info-290217.pdf

Results continued

Taking into account the average cost to the trust of an inpatient admission to an A&T unit specifically (as this was the destination for most patients) combined with the number of admissions avoided (B), compared to the combined cost of three ISS teams within CWP (C), the average annual estimated saving to the trust is **£1,409,500** (D).

Compared to the total cost of the ISS, Graph 2 demonstrates that the saving made is well over double the cost, and as explained below, this may be some what of a conservative estimate.



Graph 2: proportionate cost of ISS compared to saving made

Conclusion

Analysis of the data concludes that introduction of the DSD tool and ISS support has been significantly financially beneficial. However we do note the limitations of the data, as discussed below. Although not used as part of the analysis, we noted that the median length of stay for inpatients in 2018 was longer than 2016. Having discussed this with colleagues on the A&T units, we hypothesise that since introduction of the DSD tool and ISS it is only the more complex patients who are admitted to inpatient units, with the less complex patients at risk of admission being supported in the community by the ISS. We feel that the increased length of stay reflects a more holistic approach that is taken nowadays. As there are less patients admitted and subsequently reduced pressure on beds there is more time available to focus on all aspects of the patients' health and social care needs. We hypothesise that this will lead to these complex patients needing fewer admissions in future.

Recommendations

- We recommend continued use of the DSD and ISS within CWP, and suggest this is extended on a more national basis given the financial benefit afforded.
- A qualitative study into the biopsychosocial impact of the ISS and hence reduced admissions, from patients' and their families perspectives, may be beneficial, as it is important to bear in mind not only the financial rewards but the quality of life benefits afforded by reducing admissions for patients with a LD.

Limitations

- Average cost of an A&T unit inpatient stay has been used to estimate average cost of inpatient stay; but not all patients were admitted to an A&T unit, some to general mental health wards, with lower staff to patient ratios and presumably lower associated costs. This should in theory strengthen our argument about the financial benefit of this model.
- The cost of an LD bed is highly variable depending on factors such as level of observations etc., whereas we have used an average cost.
- An assumption was that the reduction in admissions between 2016 and 2018 is solely due to the DSD/ISS ; in reality this is likely multifactorial.
- We did not take into account admissions to out of area beds, however we assume that this is an unlikely occurrence, as it is very rare that simultaneously both A&T units would be closed to CWP admissions.
- We assumed that the ISS only spend their time on "red" patients whereas in reality they support other patients on the database.
- Cost of ISS was calculated as the cost when fully staffed which may not have been the case for all three teams throughout the whole of 2018.

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Economic analysis

Leadbetter & Wieringa (2018): DSD-CST and intensive support

Estimated annual saving to health system: £1,409,500

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Utility and spread

- Development of DSD-CST in a CLDT
- Research supported Trust-wide
- Standard Operating Procedures developed through workstream of the North-West Operational Delivery (ODN) Network
- E-learning and training materials developed through CANDDID and NHSE
- NHSE videos by people using inpatient and community services and family members
- NHSE recommendation of DSD-CST on website
- Training on CANDDID site and Learning Hub
- Invitation to review and input into DSR/CT(E)R policy guidance due out

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Dissemination of success

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Value

- All Trusts need a dynamic support register, however no need to re-invent the wheel.
- DST Clinical support tool is freely available
- Clear standard operating procedure (when to refer to intensive support, when to organise a CTR)
- E-Learning freely available
- Follow-up support provided
- Patient Experience:

Dynamic Support Register Ashlee's story – YouTube

[Dynamic Support Register Ashlee's story - YouTube]

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Learning Hub E-Learning

- Link: [Resource details (learninghub.nhs.uk)]
- Free, available to all and updated
- Ranked 4th most viewed training within the Learning Hub in previous 3 months

NHS Learning Hub BETA

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Involvement: project initiatives and outcomes

- Research
  - Number of admissions (Washington, Bull & Woodrow, 2019)
  - Face Validity (Mottershead & Woodrow, 2019)
  - Inter-rater Validity (Bohen & Woodrow, 2020)
  - Number of admission (Gibson, Eick, Meddings & Woodrow, in press)

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Involvement

- Experience of paid carers during crisis (Manandhar, Cooper-Taylor & Woodrow, submitted
- Economic Analysis (Leadbetter & Wieringa, n.d.)
- Carer satisfaction:

Dynamic Support Registers in Practice - Norman's Story - YouTube

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Summary

The Dynamic Support Database – Clinical Support Tool is the only validated tool to support stratification of need in relation to risk of admission

The Dynamic Support Database – Clinical Support Tool is objective, easy to use, cost effective and clarifies service pathway (when, where and who)

The Dynamic Support Database – Clinical Support Tool is free to use with e-learning support