

# Dementia Strategy Working Group

## Annual report

### January 2010

## 1. Background

- 1.1. About a quarter of all hospital beds are occupied by people with dementia over the age of 65. The number of people with dementia will increase by nearly 40% in the next 15 years, and 150% in the next 45 years due to demographic changes leading to an older population. In BaNES the number of people with dementia on a GP register will increase from 2219 in 2007 to 2833 in 2021 (27% rise), and in Wiltshire from 5520 in 2007 to 8367 in 2021 (51% rise). At the RUH Bath we have been driving forward improved standards of care for people with dementia – significant progress has been made in the last 12 months but much is still to do. This report sets out the progress in 2009 and the work plan for 2010.
- 1.2. There is increasing National recognition of the importance of ensuring the highest possible standards of assessment and care for patients in hospital with dementia. There are 3 key National drivers:
- a. **The National Dementia Strategy** contains a chapter relating to General hospital care. It emphasises the need to identify leadership for dementia in general hospitals, defining the care pathway for dementia, and the commissioning of specialist liaison older people’s mental health teams to work in general hospitals. The SHA has conducted a review of dementia services within SouthWest NHS, and RUH is included in the BaNES report and to a lesser extent the Wiltshire report.
  - b. **The Alzheimer’s Society report** “Counting the cost” (2009) highlights a wide variation of care standards in general hospitals, and a lack of staff training in dementia care. The report can be accessed via our intranet dementia website or directly at <http://alzheimers.org.uk/countingthecost>. It

sets out 9 recommendations which we have included in our revised workplan for 2010.

- c. **The financial scenario** of little or no growth in NHS resources over the next few years means that there is an ever more pressing need to reduce excess bed days. As many of these will be occupied by patients with dementia, improving care for such patients could reap real financial dividends. The Alzheimer's Society estimates that with better care and discharge planning nationally a minimum of £80m annually could be saved and more likely several hundred million. This would translate into at least £350,000 at the RUH Bath. The National Audit Office has estimated the excess cost to be more than £6 million per year in an average general hospital.

**1.3.** There is therefore a need to recognise that nearly everyone involved with the care of patients on adult wards must be more than just competent at understanding the complexities of managing someone with dementia and their carers effectively. This will equally include general medical wards and surgical wards, as well as specialist older people's wards.

1.4 The RUH dementia strategy working group was set up in September 2008 to take forward an action plan developed by a multi-agency workshop which met in July 2008. Details of this workshop outcomes are shown in appendix 1 and minutes of our group meetings to date are available on our website on the RUH *intranet* :

[http://webserver.ruh-bath.swest.nhs.uk/clinical\\_directory/dementia/index.asp?menu\\_id=13](http://webserver.ruh-bath.swest.nhs.uk/clinical_directory/dementia/index.asp?menu_id=13)

## **2. Terms of reference**

**Membership of the group is shown in appendix 2.**

1. To drive forward improvements in assessment, treatment and care for older people with dementia at RUH

2. To influence the development of the mental health liaison model at RUH
3. To implement the RUH dementia strategy action plan, notably :
  - a. To support development of a care pathway for dementia patients, from the Emergency Department incorporating education, training and awareness raising.
  - b. To foster stronger links with community services to improve admission avoidance and more timely high quality discharge.
  - c. To maximise the use of information obtained from users and carer surveys relating to dementia care at the RUH
4. To liaise with PCT groups to influence the commissioning strategy for dementia.
5. To produce an annual report on dementia care at the RUH

### 3. Key Achievements to date

- 3.1 Firstly, The RUH has been commended in the SouthWest NHS dementia report 2009 for its focus on improving dementia care. In the view of the authors of this report the RUH is well ahead of most general hospitals in the region, although the working group recognise we are currently not a beacon of excellence, until we can have sufficient assurance from audit work.
- 3.2 The dementia strategy group meets bimonthly with good attendance and engagement. Dr Nick John, Consultant Geriatrician, is the clinical lead for dementia at RUH. Dr John was part of the Southwest NHS dementia review group in 2009 which visited many Trusts in the Southwest to review dementia services. The insights he gained from that review have been invaluable to the group.
- 3.3 **A case note audit** was undertaken in October 2008, and a further survey of cognitive assessment in 2009, and their results have informed our current plans.
- 3.4 **Awareness raising** – several methods have been used to raise staff awareness, including a stand in the atrium at the launch of the dementia strategy, a new website and an article in the RUH Insight

Newsletter. A poster has also been produced. The communications team is engaged with the group.

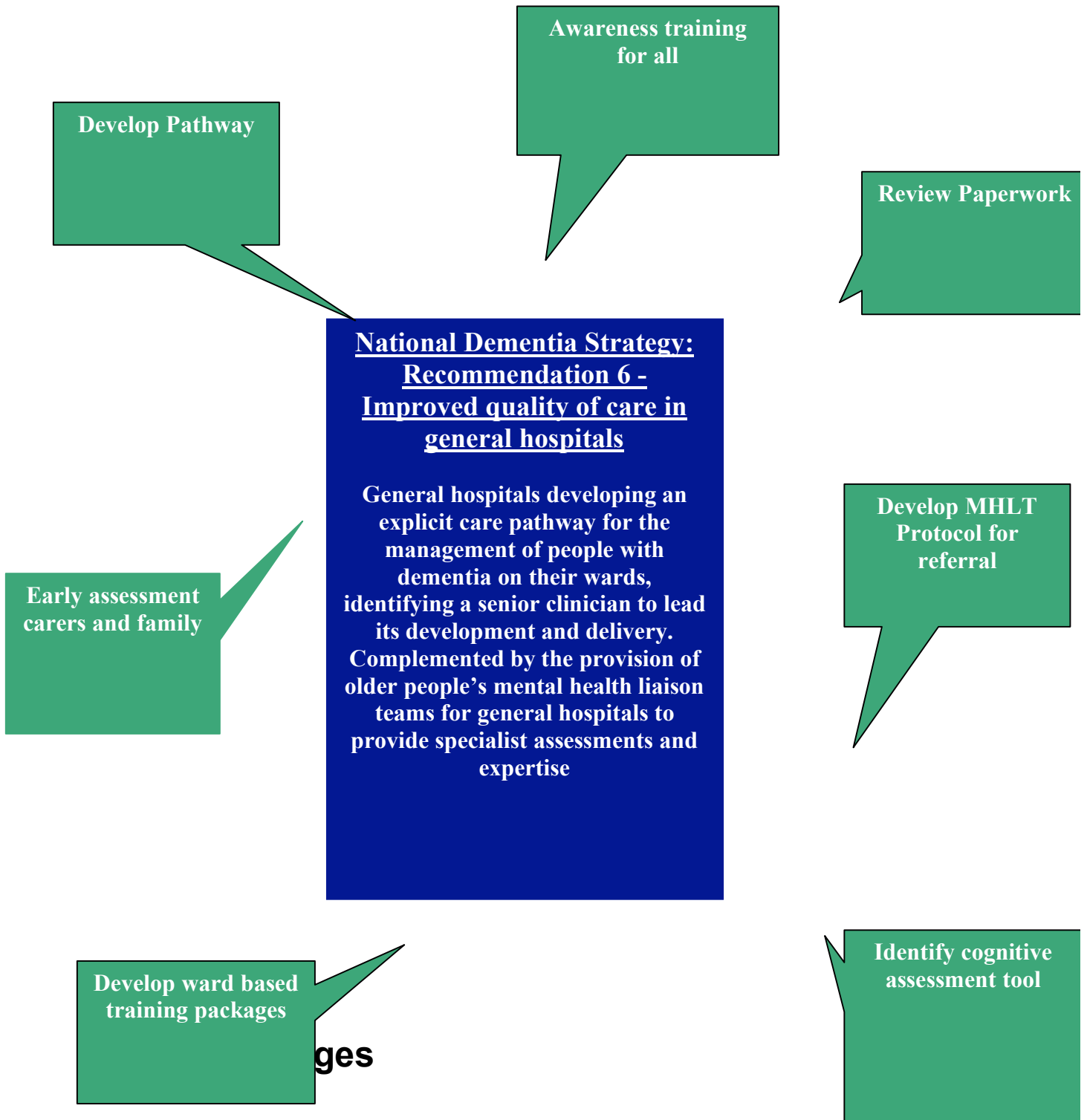
- 3.5 Care Pathway** – We have agreed an internal dementia care pathway which is published on our intranet.
- 3.6 Training** – Ben Amor, Mental Health Liaison Nurse (AWP) leads this programme supported by Neil Mason. It is a single 3 hour session running three times per month. **Numbers to date (Ben, could you please add)**. It was noted that there were not large numbers from the surgical wards to date. Although the training is non mandatory currently, the training is proving popular.
- 3.7 Dementia intranet website** – was launched in October 2009 to provide additional support and training material for staff.
- 3.8 Environment** – we have purchased and are due to trial new “dementia friendly” signage on Combe Ward, funded by the (former) Care Services Improvement Partnership. An environmental audit has been undertaken.
- 3.9 Cognitive Assessment Tool** – agreed and now in place.
- 3.10 Discharge planning / community services** – the working group has social work representation and discussions are ongoing around improving the discharge planning process, furthermore work is ongoing in other fora.
- 3.11 Liaison with PCTs** – members of our group are represented on PCT dementia groups, and our minutes are also circulated to the leads in each area.

### **3.12**

#### **BaNES Dementia SHA report 2009 – excerpt relating to RUH:**

*“At the Royal United Hospital Bath NHS Trust, there has been an active, clinically-led project to review the experience of people with dementia and improve their experience of care within the hospital. A clinical audit of case notes from a range of specialities was carried out in August 2008 for people with dementia or cognitive impairment. A detailed work plan was produced following a workshop of clinicians and practitioners. The work plan examines ten themes including care pathway, documentation, cognitive assessment tools, raising staff awareness and training. There has been effective leadership from two Care of the Elderly consultants in the Trust with good support from other disciplines. A comprehensive pathway for care within the Royal United Hospital Bath NHS Trust has been developed with emerging evidence about reduced length of stay. There remains an ongoing challenge to engage with other specialities and change practice within the context of other pressures within the Trust.”*

# RUH Dementia Strategy



Several challenges exist and will take time to improve.

Firstly all staff on adult wards must receive training which may need to become mandatory. Ensuring this happens is difficult when staffing levels are tight.

Secondly we need a fully integrated older adults mental health service – we currently have good nursing support, but need more medical psychiatric input, and ideally specialist OT input. PCTs are the main commissioners of mental health services in acute Trusts and AWP and members of our group are actively engaged with commissioners.

Thirdly we need to further assess and improve the patient experience. Frequent ward moves are very disorientating for people with dementia, though this is mainly dependant on reducing bed occupancy. We are working with the Alzheimer's society and our Head of Patient Experience to see how we can review this, perhaps by innovative use of the Patient Experience Tracker.

The key ongoing issues are set out in our work plan for 2010.

## **5. Workplan for 2010**

<i>Theme</i>	<i>Action</i>	<i>Lead</i>	<i>Timescale</i>
<b>1. RUH mental health team for older adults</b>	Continue commissioning work with AWP and PCT partners to progress the preferred model for liaison	ALL	April 2010
<b>2. Training /awareness</b>	.Reconsider training as part of mandatory training package	-Heather Devey	April 2010
	Ongoing training for all staff (practitioners and support staff) with more ward based support	Ben Amor/ Sue Leathers	March 2011
	Consider a role for more champions across the hospital	Dementia group	Jan 2009
	Hold a big event to maintain awareness	CD/ NJ	Summer 2010
	Maintain and promote website for dementia care at RUH	CD/ NJ/ SL	ongoing
	Maximise publicity		ongoing
<b>3. Seeking patient and care views – assessing the patient experience</b>	Use local patient stories	SL with Alzheimer's society Strategic Group to debate	Feb 2009
	Involve Alzheimer's society and PALS to understand both	ALL	ongoing

	positive and negative comments re dementia care at RUH		
<b>4. Audit/ ward charter</b>	Institute ward audit and awards for wards meeting best standards Develop dementia charter for wards	Dementia group with Alzheimer's Society	By Sept 2010
<b>5. Nutrition</b>	Look at systems for encouraging carers in at mealtimes/ seek meal preferences Increase volunteer support at mealtimes	Dementia group with nutrition group and Alzheimer's Society	April 2010
<b>6. Documentation</b>	Possible changes to improve data collection re cognition and pre-morbid history Flag up complex discharge patients at very early stage	SL with Anne Plaskett  May need documentation change	May 2010
<b>7. Ward environment</b>	Evaluate signage on pilot ward and develop a roll out plan if successful	MD/ SL	November 2010
<b>8. Reduce levels of agitation and boredom on wards</b>	Consider how to increase social interaction/ role of music and activities especially to reduce sedative usage	Dementia group with Alzheimer's society	October 2010
<b>9. Community services</b>	Ensure intermediate care services are available  Ensure commissioning priorities of the Trust include dementia, older people's mental health needs and look to the third sector as well as in-house services.	Lead commissioners in PCT/RUH	ongoing

	Consider a joint workshop with community providers	Dementia group to discuss	By April 2010
<b>10. Discharge Planning</b>	<p>Ensure goals set on admission and when reached, discharge the person.</p> <p>Pursue joint health and social care discharge packages.</p> <p>Look at use of telecare to support discharge of hospital patients</p>	<p>Strategy group</p> <p>Highlight to cluster group cases where discharge problems have occur and using casenote review</p> <p>MD/ Dementia group with PCTs / OT leads</p>	ongoing

## Appendix 1

## Summary of workshop held July 2008

### 1. Project aims

In the context of existing work to reduce unnecessarily prolonged lengths of stay and reduce delayed discharges, RUH committed to a short project in partnership with CSIP SW to:

- a) Review some actual pathways in and out of hospital of people with dementia.
- b) share and discuss the findings with a wider group of clinicians and managers
- c) consider necessary actions to strengthen care for dementia patients in RUH

Key outcomes from this work are anticipated to be

- Improve the care experience of inpatients with dementia at RUH, based on local analysis
- Improve organisational performance, in terms of reducing prolonged lengths of stay in hospital and numbers of care home placements relating to inpatients with dementia
- Agree how local systems and staff awareness relating to dementia could be strengthened, and agree how and by whom these will be taken forward.

### 2. Key themes

The following issues were highlighted for each key theme:

#### A. Information gathering

- **Use of RUH Emergency Patient Record.** Felt this was a useful tool but not completed in full, esp. on admission, and collated in right place. Information record not always signed/legible or available for use for next admission. (These issues also apply to the use of the scheduled care patient record, for example for hip replacements). This reflects limited staff awareness about cognitive impairment in many ward areas outside specialist older people's care.
- Record **does not trigger the necessary discussion with relatives** (i.e. from and about the carer or support from home). Need system for recording pre-morbid history, which is esp. important for people with cognitive impairment.
- **More patient and public involvement** in this project – for example seeking the views from carers support groups about their relatives experience in hospital, and what information was requested and shared relating to discharge options.
- A **diagnosis** of dementia can be useful to alert ward staff (and should not always be necessary to involve Mental Health Liaison). The key information however, is awareness of any cognitive impairment on admission, be it dementia or delirium.
- Need a consistent approach with RUH and amongst community partners to **measuring cognition** where appropriate: i.e. when to use which tool and how to monitor cognition.

- Need to **clarify the approach of local community services** to supporting early discharge and rehabilitation for people with cognitive impairment, via the current RUH project on developing a directory of community services

#### B. Patient Orientation

- Lack of **pre-admission information** and lack of **carer involvement** esp. if delirious, leading to poor communication and a lack of understanding of the needs of individuals and increased confusion
- Clear **introductions** and staff **consistency** of message,
- **Frequent moves, poor signage**, the location of bathrooms and toilets and the lack of explanation can impact on behaviour and the length of stay, **training for all staff in the management of people with cognitive impairment** and dementia is needed to ensure that patients and carers have good information on admission.
- The ward routine tends to lead to **social isolation and boredom**
- **Mixed accommodation** is still an issue in some areas and **noise** can increase disorientation,
- Medical and nursing **interventions** e.g. drugs, catheters – **are they always necessary or** are essential interventions **being missed** e.g. nutritional support

#### C. “Discharge process”

- People with dementia are **excluded from intermediate** care services, which often covers rehabilitation but not reablement
- Acute hospitals hold the lead responsibility for ensuring proper discharge arrangements. If people have unpredictable needs or require night time care/support , this can hold up discharge from hospital The R.U.H. has a **‘risk averse’ culture**
- Diagnosis (of **dementia**) is **perceived to hinder discharge** and have negative connotations
- There is a **lack of awareness** of the needs of people with dementia amongst mainstream staff. **Shortage of trained RMNs** and CPNs means that mainstream staff must be able to meet the needs of people with dementia

D. **“Community support and links”**

- The **support in the community is inconsistent** across boundaries and the information regarding what is available and when and to whom is difficult to obtain. Information needs to be relevant, accurate and current and often it is not. There is of **little knowledge the range** of non statutory services
- **Intermediate Care often does not take people with dementia** and there are limited specialist services and many of them are not able to offer reablement and rehabilitation
- There is **no residential rehabilitation** available for people with dementia ( Like Saffron House Bristol) and domiciliary community support e.g. homecare, lacks **flexibility** and is not available 24/7
- The **mental health liaison team** is very well thought of but needs to be enhanced with clear referral protocols, an understanding of their role and an easy access route – one call
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## **Appendix 2. Members of Working group**

Lead Director – Francesca Thompson, Director of Nursing

Ben Amor	Liaison Nurse, AWP
Pat Bateman	MAU
Louise Connolly	Occupational Therapist RUH
Maggie Depledge	Head Occupational Therapist, RUH
Heather Devey	Practice Development Lead, RUH
Dr. Chris Dyer (Chairman)	Consultant Geriatrician, RUH
Dr. Fiona Harrison	Consultant Psychiatrist, AWP
Theresa Hegarty	Head of Patient Experience, RUH
Dr. Nick John (Clinical Lead)	Consultant Geriatrician, RUH
Professor Roy Jones	Director, RICE
Sue Leathers	Matron Older People's Unit, RUH
Neil Mason	Community Services Manager, AWP
June Thompson	Hospital Social Work Team, BaNES
Kay Webber	Senior Sister, Orthopaedics, RUH
Rachael Wilkinson	Physio, RUH
Pat Wilson	Alzheimer Society, Bath