

DEMENTIA SCRUTINY REVIEW

‘THE CARE OF PEOPLE WITH DEMENTIA IN AN ACUTE HOSPITAL SETTING’



DEMENTIA

**A Report produced by The Health & Wellbeing
Overview and Scrutiny Committee**

**FINAL REPORT
FEBRUARY 2011**

WIRRAL BOROUGH COUNCIL

**‘THE CARE OF PEOPLE WITH DEMENTIA IN AN ACUTE HOSPITAL SETTING’
SCRUTINY REVIEW**

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1. EXECUTIVE SUMMARY AND RECOMMENDATIONS

The National Dementia Strategy for England, launched in February 2009, stated that up to 70% of acute hospital beds were occupied by older people and up to a half of those may be people with cognitive impairment, including those with dementia and delirium. The Strategy document continues: “The majority of these patients are not known to specialist mental health services and are undiagnosed. General hospitals are particularly challenging environments for people with memory and communication problems, with cluttered ward layouts, poor signage and other hazards. People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation”.

The Alzheimer’s Society Report, ‘Counting the Cost’, produced in 2009, estimated that people with dementia over 65 years of age are occupying one quarter of hospital beds at any one time. The same report found that people with dementia stay far longer in hospital than other people without dementia who go in for the same procedure. The report states that:

“The longer people with dementia are in hospital, the worse the effect on the symptoms of dementia and the individual’s physical health; discharge to a care home becomes more likely and antipsychotic drugs are more likely to be used. As well as the cost to the person with dementia, increased length of stay is placing financial pressure on the NHS”.

Reports such as ‘Counting the Cost’ (Alzheimer’s Society, 2009) and the Interim report of the National Audit of Dementia (The Royal College of Psychiatrists, December 2010) both estimate that 750,000 people in the UK have dementia. The ‘Joint Strategic Needs Assessment’ for Wirral, produced by Wirral NHS for 2009/10, estimated that there were 4,266 older people with dementia in Wirral. This is significantly higher than the number of people recorded with dementia on GP registers in Wirral.

According to data recorded on Dr Foster (2009)¹, Wirral has a significantly higher number of hospital admissions for senile dementia when compared to the national average and the North West. It was estimated that emergency admissions for senile dementia in Wirral were 53.8% higher than expected against the national average.

The development of the National Dementia Strategy, launched in 2009 and the Local Care Pathway in Wirral have both raised the profile of the care of people with dementia. Both strategies include the provision of care to people with dementia during a stay in an acute hospital. The evidence presented during the course of this Scrutiny Review resulted in the Panel Members identifying a number of principles regarding the care of patients with dementia in an acute hospital setting.

In turn, these principles inform the more detailed recommendations which are included in this Report. Indeed, some of these principles are already highlighted within the National Dementia Strategy and the Local Care Pathway in Wirral. However, it is necessary to recognise the financial climate which the public services, including the NHS, now face. Some of the recommendations may, therefore, be achievable more quickly than others.

¹ Dr Foster Intelligence is a public-private partnership that aims to improve the quality and efficiency of health and social care through better use of information

The following principles underpin the recommendations which are formulated in this Report:

Not to admit patients with dementia to hospital if at all possible.

If a patient with dementia is admitted to hospital, their stay in hospital should be kept to a minimum period and, while in hospital, the patient should be subject to as few moves as possible.

While in hospital, the patient with dementia should be supported to minimise disruption to their normal daily routines, for example, meal times and personal care.

During a stay in hospital for a patient with dementia, both the dignity of the patient and the involvement of the carer(s) should be central to the processes.

Whenever possible, a patient with dementia should be discharged to the residence of origin.

It is widely acknowledged that the impact of a stay in hospital, in some cases, is that the patient with dementia is not able to return home and, as a result, has to go into residential care. The experience of going into hospital can be extremely confusing for a patient with dementia. A combination of the disruption to everyday routine, the chance of infection, a period without stimulation and safeguarding issues mean that hospital can be a risky place for a person with dementia. It is, therefore, considered by many professionals that **hospital admission should be avoided if at all possible** for this group of patients. The Panel Members were informed that the best option is to provide low-level support early in order to prevent periods of crisis. Furthermore, members were told that early intervention is most cost effective. In order for admission rates to be reduced, alternative forms of care will have to be provided in different locations, including in the community. Although progress has been made in Wirral, further changes need to be made to provide greater patient choice. The creation of a Crisis Response Team or a Specialist Home Care Dementia Service, as exists in other areas, such as Liverpool, should help to prevent some hospital admissions.

However, it is inevitable that a significant number of patients with dementia will be admitted to acute hospitals. In these circumstances, **the disruption to the patient will be minimised if the length of stay is reduced to a minimum and the number of moves within the hospital are kept to as few as possible.** The early identification that the patient has dementia is instrumental in enabling hospital staff to offer an appropriate care plan. The availability of a register of patients with dementia and / or a dementia passport would assist staff. In addition, processes to ensure that the maximum amount of information is received from the carer or nursing home, at the time of admission, would significantly assist in the care planning. Once admitted, it is not unusual for a patient to be moved up to four times, which may increase the level of confusion for a patient with dementia.

From the point of admission, it is considered that **patients with dementia should be supported to minimise disruption to their normal daily routines, for example, meal times and personal care.** Normalising the hospital setting, by, for example, involving family to help with personal care and feeding would be less disruptive, and may facilitate return to home more promptly. This, in turn, would reduce costs and improve the patients' outcomes. Fundamental to this approach is the direct

involvement of a carer(s) / family member(s) in the planning and, if appropriate, the delivery of some of the care. During this Scrutiny Review, a number of carers insisted that a major concern for them was the nutrition and personal care given to the person for whom they cared. Those concerns can best be allayed through hospital staff developing a closer relationship with the carer(s) and mutual trust being gained. Disruption to the patient may also be minimised by environmental changes on the wards, some of which have already taken place.

During a stay in hospital for a patient with dementia, both the dignity of the patient and the involvement of the carer(s) should be central to the processes. The dignity of the patient can be best preserved through the quality of the care provided by hospital staff. Evidence from carers during this review suggested that some staff appeared to not have sufficient understanding of the requirements to care for patients with dementia. There seems to be a recognition by the majority of witnesses (to this Scrutiny Review) that not all staff understand and are able to respond to the demands of dementia. A common theme, both from national reports and from local evidence, is the need to ensure that hospital staff have received adequate training and feel as comfortable as possible while caring for patients with dementia. Again, significant progress has been made by Wirral University Hospital Trust; an example of which is the Trust having been the first in the country to include input from the Alzheimer’s Society in providing relevant training to staff.

It is recognised that significant effort and progress has been made by both Wirral NHS and Wirral University Hospital Trust to provide a more efficient discharge process for all patients. It is particularly important that the period in hospital for a patient with dementia is reduced to a minimum. Clearly, an efficient discharge process, which minimises delays, is, therefore, particularly important for this group of patients. Anecdotal evidence suggests that this is not always the case. In addition, **whenever possible, a patient with dementia should be discharged to the residence of origin.** Many of the professional witnesses interviewed during the review insisted that a hospital bed was not the correct place for long-term care choices to be made. However, evidence from the Alzheimer’s Society Report, ‘Counting the Cost’, produced in 2009, estimated that, nationally, over a third of people with dementia who go into hospital from living in their own homes are discharged to a care home setting.

Overall, the fundamental dilemma is to provide a balance between the short-term gain (of needing physical support) and the long-term deficit (of being away from familiar surroundings for a lengthy period) which may exacerbate dementia.

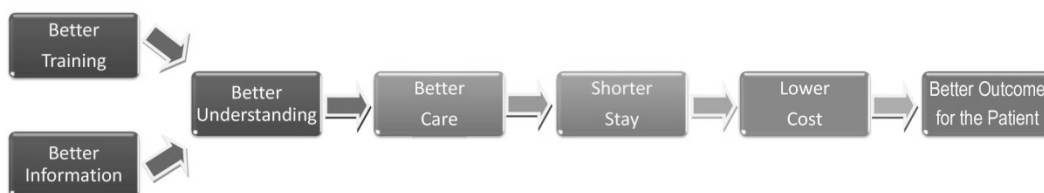


Figure 1: Potential Impact of Improved Staff Training and Information Flow

In considering the evidence found during the review, the Panel Members have formulated the recommendations shown on pages 6 and 7. These recommendations underpin the principles which are described above.

RECOMMENDATIONS

1 **Alternatives to hospital admission** (Para 6.3.1)

Wirral NHS, GPs and Social Services are encouraged to continue to enhance services which reduce the need for people with dementia to be admitted to hospital if at all possible. All staff are encouraged to look positively at alternatives rather than admission to hospital and critically assess whether it is in the best interests of the patient.

2 **Register of patients with dementia / dementia passport** (Para 6.3.2)

The creation of a local register of patients with dementia, accessible to hospital staff, should be investigated as should the development of a dementia passport. These will enable the early identification of patients with dementia on admission to an acute unit.

3 **Receipt of information regarding the patient with dementia** (Para 6.3.2)

Processes should be developed to ensure that, at the time of admission of a patient with dementia, maximum information is received from the carer or nursing home. This could include the development of a simple questionnaire to be used in such circumstances.

4 **Minimise the number of moves within hospital** (Para 6.3.2)

Wirral University Teaching Hospital (WUTH) is requested to develop processes to minimise the number of moves for patients with dementia within the hospital.

5 **Assistance at meal times / personal care** (Para 6.3.3)

Ward staff should welcome offers of help from family / carers to minimise disturbance to the patient with dementia during a stay in hospital. This could include family members being able to support relatives at meal times and aspects of personal care without being pressured to do so.

6 **Information flow with carers** (Para 6.3.3)

The special role of carers of patients with dementia should be recognised by staff. Processes should ensure that greater information exchange with carers is established at the outset. This should include ongoing care and developments towards discharge.

7 **Environmental issues on the ward** (Para 6.3.5)

In order to assist patients with dementia, Wirral University Teaching Hospital is encouraged to investigate further environmental improvements to wards where appropriate. These might include:

- Clear signage to identify bathroom / toilet
- Use of pastel colours
- Positioning of beds in the ward
- Use of side rooms
- Alarm system to prevent patients with dementia from wandering, especially at night when staff numbers are reduced
- Use of Activity Lounge for patients with dementia

8 The role of specialist dementia nurses (Para 6.3.5)

The role of specialist dementia nurses, to be deployed wherever needed in the hospital to support other acute staff, should be considered.

9 Safeguarding (Para 6.3.6)

The deployment of security staff to manage patients with dementia should be avoided if at all possible. (Further recommendations for staff training and availability of experienced staff reflecting the number of patients with dementia on a ward at any one time should assist with the management of disruptive behaviours).

10 Discharge planning (Para 6.3.7)

Support is given to the principle of long-term care needs not being decided from a hospital bed. Planning for discharge from the time of arrival must involve the carer(s) with the prime objective being to discharge the patient to the residence of origin wherever possible.

11 Care requirements following discharge (Para 6.3.7)

Appropriate discharge needs include:

- Reducing the time taken for the care assessment
- Prompt availability of care packages including reablement support

An alternative pathway for patients with dementia may involve the development of a short-term assessment unit and / or an intermediate care service.

12 Staff training (Para 6.4)

Participants in training sessions regarding the care and management of patients with dementia should be expanded to include:

- Doctors
- Ward managers
- Triage nurses
- Paramedics and ambulance staff
- Security staff

More staff from all appropriate wards should be involved in dementia training, which could include on-line modules.

13 Crisis Response Team / Specialist Home Care Dementia Service (Para 6.5.1)

Recognising that any move from familiar surroundings is likely to exacerbate dementia, people with dementia should be cared for in their own home or residential / nursing home if at all possible.

Therefore, Wirral NHS is encouraged to investigate the feasibility of developing a Crisis Response Team and / or a Specialist Home Care Dementia Service to keep patients with dementia in a familiar environment.

14 Nursing Homes (Para 6.5.2)

The current work undertaken by Wirral NHS to provide support to nursing homes to enable fewer patients to be admitted to hospital is endorsed. This practice should be extended wherever possible.

2. ACKNOWLEDGEMENTS

This Report presents the findings of a Scrutiny Review into the ‘Care of people with dementia in acute hospital’. The Review was undertaken by a Working Group which was set up by the Health & Wellbeing Overview and Scrutiny Committee. For many people with dementia, a stay in hospital and subsequent recuperation can be a stressful and frightening experience, both for that person and for family members. The Panel hopes that this Scrutiny Review has, in a small way, enabled some of the thoughts of residents to be heard and to be reflected in future decision-making.

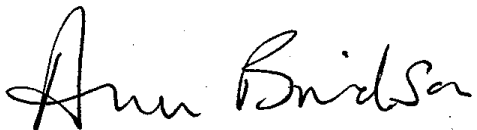
Dementia is increasingly being recognised as providing a major challenge for service providers and communities. Already a substantial issue, the numbers of people living with dementia is expected to rise significantly over the next few years. The challenge is going to become greater. The National Dementia Strategy, first adopted in 2009, laid the foundations for the UK’s response. It is important that local communities now take that work forward. Although this Scrutiny Review focused primarily on the relationship between people with dementia and acute hospitals, this is only one facet of the national strategy. It is hoped that the recommendations which form part of the Report will further develop the good practice that exists within Wirral University Teaching Hospital and other partners.

The Panel would like to thank all those people who willingly agreed to contribute and to provide information to this review. In particular, the Panel thanks the staff at Wirral University Teaching Hospital who have facilitated a number of visits to Arrowe Park Hospital during the course of the review. Thank you also to all of the staff from Wirral University Teaching Hospital, Cheshire and Wirral Partnership Foundation Trust, NHS Wirral, Wirral Borough Council, Age Concern and Alzheimer’s Society with whom they have met and exchanged ideas. There were many varied contributions to the review process.

A significant part of the evidence gathered during the review was generated by discussion and written submissions from carers of people with dementia. The Panel is extremely grateful to all of those contributors. In particular, thank you to the participants in the two focus groups as well as to the staff at Age Concern and Alzheimer’s Society for facilitating those sessions. Thanks are also due to those other interested parties, such as carers’ representatives, who contacted the panel.

Thank you to the Panel Members who have all contributed fully to the review, which I hope will contribute to the development of service provision in this area. In the future, it is important that the impact of all of the recommendations is reviewed and that progress is monitored.

Thank you to all for your participation and contributions to this Review.



Councillor Ann Bridson (Chair of the Members’ Panel)

3. PANEL MEMBERSHIP

The Dementia Scrutiny Panel was appointed by the Health & Wellbeing Overview and Scrutiny Committee on 22nd June 2009. The purpose of the Panel is to carry out a Scrutiny Review of the care of people with dementia in acute hospitals. The panel will make any relevant recommendations for changes, which in the first instance will be discussed by the Health & Wellbeing Overview and Scrutiny Committee. The following members volunteered to be members of the Panel:

Councillor Ann Bridson (Chair)



Councillor Denise Roberts



Two former members of the Panel who were involved in most of the ‘Evidence Gathering’ stage were:

Former Councillor Chris Teggin



Councillor Sheila Clarke



The Scrutiny Support Officer for this Scrutiny Review was Alan Veitch.

4. BACKGROUND AND ORIGINAL BRIEF

The Hospital Discharge Scrutiny Review was held during 2008/9, with the final report being presented to the Social Care & Health Overview and Scrutiny Committee meeting held on 25th March 2009. During the evidence-gathering stage of the review, issues were raised with the Panel Members regarding support for people with dementia in hospital and in the community. The final report of the Hospital Discharge Scrutiny Review included the following section:

6.7 Needs of Specialist Groups - Dementia patients

Evidence, particularly from the voluntary sector, has raised a number of issues relating to patients with dementia and their treatment in hospital. A representative of a third sector organisation commented that:

“As a society, there is a need to look at creative alternatives to keep people at home. At present, people are being admitted into residential care earlier than they really need to”.

The discharge process for dementia patients is often longer than average. To many such patients, the environment is confusing and they do not understand why they are in hospital. However, the point was made to the Panel that the real issue is that there is often no adequate support available to keep the person with dementia in their own environment.

The Panel suggested that further scrutiny should take place into issues for patients with dementia.

The Scope Document for the Dementia Scrutiny Review, attached as Appendix 1 to this Report, was agreed by the Health & Wellbeing Overview and Scrutiny Committee on 22nd June 2009. It was agreed that the review would concentrate on the following issues:

- Management of patients with dementia in an acute hospital setting.
- Impact of patients with dementia on other patients during a stay in hospital.
- Are there alternative approaches which allow more patients with dementia to be cared for outside an acute hospital setting?
- Is it possible to keep more people with dementia in their own home for as long as possible?
- What support is available for carers?
- Is it possible to support more people with dementia in residential or nursing home rather than acute hospitals?

The Panel commenced work in attempting to find answers to these questions.

5. METHODOLOGY FOR THE REVIEW

The Panel has employed a number of methods to gather evidence:

- 1 Meetings / visits with officers
- 2 Meetings with carers of people with dementia
- 3 Written evidence from individuals

Details of these witnesses are available in Appendix 2 to this Report.

In addition, evidence was sought from written documentation / reports, details of which are shown in Appendix 3 to this Report.

6. EVIDENCE AND RECOMMENDATIONS

6.1 Introduction – Dementia in an Acute Care Context in Wirral

6.1.1 The Scale of the Problem in Wirral

Dementia is a syndrome that can be caused by a number of progressive disorders that affect memory, thinking, behaviour and the ability to perform everyday activities. Alzheimer’s disease and vascular dementia are two of the most common types. Dementia mainly affects older people, although there is growing evidence of cases that start well before the age of 65. People with dementia are at an increased risk of physical health problems and become increasingly dependent on health and social care services and other people.

Reports, including ‘Counting the Cost’ (Alzheimer’s Society, 2009) and the interim report of the National Audit of Dementia (The Royal College of Psychiatrists, December 2010) both estimate that 750,000 people in the UK have dementia. A further report, ‘Dementia 2010: The economic burden of dementia and associated research funding in the United Kingdom’, produced by the Alzheimer’s Research Trust estimated that over 820,000 people in the UK live with dementia, representing 1.3% of the UK population. The cost to the UK economy is £23 billion per year in terms of health and social care, informal care and productivity losses. This is estimated to be more than the cost to the UK of cancer (£12 billion per year) and heart disease (£8 billion per year) combined. The Alzheimer’s Research Trust report estimates that 37% of all dementia patients in the UK are in long-term care institutions costing in excess of £9 billion per year in social care. Health care costs are estimated at about £1.2 billion of which hospital inpatient stays account for 44% of the total.

The ‘Joint Strategic Needs Assessment’ for Wirral, produced by Wirral NHS for 2009/10, estimated that there were 4,266 older people with dementia in Wirral. This is significantly higher than the number of people recorded with dementia on GP registers.

Table 1: Dementia Prevalence on GP registers (2008/9) in Wirral

<i>Area</i>	<i>Number of Patients</i>	<i>Prevalence (%)</i>
Bebington & West Wirral	628	0.58
Birkenhead	895	0.59
Wallasey	313	0.43
Wirral (Total)	1836	0.55

Source: Wirral Joint Strategic Needs Assessment, 2009-10 (as supplied by Wirral NHS)

As part of the Quality Outcomes Framework (QOF), GP Practices are expected to produce a register of patients with dementia. In Wirral, a total of 1,836 people were recorded on the registers between April 2008 and March 2009, which gives an unadjusted prevalence rate of 0.6%. This is slightly higher than the North West and England GP practice prevalence rates which for England is 0.4% and the North West is 0.5%.

The ageing population means that the number of people with dementia is expected to rise considerably over the next few years. The projections for the number of people in Wirral aged 65 years and over with dementia, between 2008 and 2025, are shown in Table 2.

Table 2: Projections of Dementia Prevalence in Wirral for over 65s (from a base figure of 2008)

<i>Dementia by Gender</i>	<i>2008</i>	<i>2010</i>	<i>2015</i>	<i>2020</i>	<i>2025</i>
Males 65+	1374	1455	1686	1977	2282
Females 65+	2892	2953	3133	3366	3771
Total 65+	4266	4408	4819	5343	6053

Source: Wirral Joint Strategic Needs Assessment, 2009-10 (as supplied by Wirral NHS)

These estimates suggest that rates of dementia in older people will increase by 13% between 2008 and 2015. Rates will increase by 42% by 2025.

The National Dementia Strategy for England, launched in February 2009, argued that up to 70% of acute hospital beds were occupied by older people and up to a half of those may be people with cognitive impairment, including those with dementia and delirium.

According to data recorded on Dr Foster (2009), Wirral has a significantly higher number of hospital admissions for senile dementia² when compared to the National average and the North West. This is a trend that has occurred over the last few years. For Wirral in 2008/09, there were 690 emergency admissions for senile dementia. It is estimated that emergency admissions for senile dementia in Wirral were 53.8% higher than expected against the national average. The average length of stay for all dementia admissions was 21.2 bed days/admission. This is actually lower than the national average length of stay, which is 28.5 days.

However, Dr Foster data only records primary diagnosis. Information recorded through Secondary Uses Service (SUS) (2008), records both primary and secondary diagnosis and has identified that there are more dementia related admissions to hospital when the secondary diagnosis is taken into account. In 2008/09, 1,075 people aged 60 and over, were admitted on a primary or secondary diagnosis of dementia (13.31 per 1,000). The total number of emergency admissions (for people aged 60 and over) was 2,470 (which means that some people were admitted more than once).

The figure of 690 emergency admissions had the primary cause of admission as 'senile dementia'. This raises the question of why so many people with dementia were admitted to an acute hospital rather than receiving another form of care; a question that is discussed later in this Report.

6.2 **Responding to the National Dementia Strategy**

6.2.1 **The National Dementia Strategy**

The first National Dementia Strategy for England, titled 'Living Well with Dementia' was launched in February 2009. The aim of the strategy is that all people with dementia and their carers should live well with dementia. Three key areas for improvement were identified as:

- Improved awareness
- Earlier diagnosis and intervention
- Higher quality of care

The Joint Leads of the National Dementia Strategy, Sube Banerjee and Jenny Owen, in launching the strategy, wrote:

“This is a comprehensive strategy which requires us to transcend existing boundaries between health and social care and the third sector, between service providers and people with dementia and their carers. Our vision is for a system where all people with dementia have access to care and support that they would benefit from”

Although this Scrutiny Review investigated specifically the care of people with dementia in acute hospitals, the need for joint working of a variety of service providers is a theme that recurs throughout this Report. The National Strategy identified 17 key objectives:

² Senile dementia is a clinical term used to categorise a range of dementia related conditions, including Alzheimer's disease

Table 3: Objectives of the National Dementia Strategy

<i>Objectives</i>	
1	Improving public and professional awareness and understanding of dementia
2	Good-quality early diagnosis and intervention for all
3	Good-quality information for those with diagnosed dementia and their carers
4	Enabling easy access to care, support and advice following diagnosis
5	Development of structured peer support and learning networks
6	Improved community personal support services
7	Implementing the Carers' Strategy
8	Improved quality of care for people with dementia in general hospitals
9	Improved intermediate care for people with dementia
10	Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers
11	Living well with dementia in care homes
12	Improved end of life care for people with dementia
13	An informed and effective workforce for people with dementia
14	A joint commissioning strategy for dementia
15	Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers
16	A clear picture of research evidence and needs
17	Effective national and regional support for implementation of the Strategy

Source: National Dementia Strategy: 'Living Well with Dementia, February 2009

Although only Objective 8 refers specifically to the care of people with dementia in general or acute hospitals, many of the other objectives are relevant to this Scrutiny Report as they underpin the services available to people with dementia which may prevent their admission to hospital in the first place or may enable more effective and efficient discharge after a stay in hospital. The Strategy document specifically identifies a series of actions to enable the delivery of Objective 8, 'Improved quality of care for people with dementia in general hospitals'. These are:

- Identification of a senior clinician within the general hospital to take the lead for quality improvement in dementia in the hospital
- Development of an explicit care pathway for the management and care of people with dementia in hospital, led by that senior clinician
- The gathering and synthesis of existing data on the nature and impacts of specialist liaison older people's mental health teams to work in general hospitals
- Thereafter, the commissioning of specialist liaison older people's mental health teams to work in general hospitals

The Strategy document observed that:

"There is a lack of leadership and ownership of dementia in most general hospitals. There are also marked deficits in the knowledge and skills of general hospital staff who care for people with dementia. Often insufficient information is sought from relatives and carers. This means that person-centred care is not delivered and it can lead to under-recognition of delirium and dementia. Currently, families are often excluded from discharge planning, so false assumptions may be made about whether it is possible for people with dementia to be cared for at home".

The National Dementia Strategy document was supported by an Implementation Plan, which set out how the Department of Health intended to support delivery of the strategy through its national and regional structures. However, subsequent to the change of Government following the General Election in May 2010, a further document has been published in September 2010. This document, 'Quality

outcomes for people with dementia: building on the work of the National Dementia Strategy’, highlights the priorities of the new Government within the strategy. The priority objectives are now defined as:

- Good-quality early diagnosis and intervention for all
- Improved quality of care in general hospitals
- Living well with dementia in care homes
- Reduced use of antipsychotic medication

With respect to ‘Improved quality of care in general hospitals’, the document comments that:

- 40% of people in hospital have dementia
- The excess cost is estimated to be £6 million per annum in the average General Hospital
- Co-morbidity with general medical conditions is high
- People with dementia stay longer in hospital

The document puts particular emphasis on implementation plans being developed at a local level and specifically refers to the education and training needs of the workforce working with people with dementia.

The importance of the need to improve the care of patients with dementia in acute hospitals is made in the report, ‘Acute Awareness – Improving hospital care for people with dementia’ produced by the NHS Confederation in 2010. That report comments that:

“The National Dementia Strategy highlights the need to improve care for people with dementia in hospital. This is, in fact, one of the objectives of the strategy, but hospitals need to act soon if they are to meet the goals of the national strategy and the needs of an increasing number of patients with dementia”.

6.2.2 Development of the Dementia Care Pathway in Wirral and Future Priorities

The local response to the National Dementia Strategy has been positive, with one leading professional in the field commenting:

“The National Dementia Strategy was a good starting point. The recommendations and objectives were all sensible. All of the recommendations apply to Wirral”.

The Local Care Pathway has now been developed in Wirral and is being used as a guide to commission services by Wirral NHS. The pathway was developed through the involvement of stakeholders from primary and secondary health care, social services, the Third Sector, carers and people with dementia. Subsequently, work was done with CSED (Care Services Efficiency Delivery) from the Department of Health to help develop a Pathway for Care, responding to the 17 objectives highlighted by the National Dementia Strategy. A key aim of the pathway is to enable more resources to be made available earlier in the process following diagnosis. In respect of Objective 8 (‘Improved quality of care for people with dementia in general hospitals’), the Wirral Pathway has identified the development of dementia training for staff in the acute hospital as a key priority.

More recently, a Dementia Care Pathway is being developed by Wirral University Teaching Hospital to specifically define the care of patients with dementia during a stay in the acute or general hospitals. The identification of a senior clinician within the hospital to lead on quality improvement in dementia care is encouraged, as outlined in the National Strategy. Within the context of Wirral Borough Council, it is also important to note that ‘Improve support for those with mental health problems’ is included as an aim in the Council’s Corporate Plan for 2008 – 2013. It is hoped that this will result in the issue of dementia remaining high among the priorities of the Council.

The evidence presented to the Panel Members during the course of the Review identified a number of principles by which the care of patients with dementia in acute hospitals should be provided. In turn,

these principles inform the more detailed recommendations which are included in this Report. Indeed, some of these principles are already highlighted within the National Dementia Strategy and the Local Care Pathway in Wirral.

The following principles underpin the recommendations which are formulated in this Report:

Not to admit patients with dementia to hospital if at all possible.

If a patient with dementia is admitted to hospital, their stay in hospital should be kept to a minimum period and, while in hospital, the patient should be subject to as few moves as possible.

While in hospital, the patient with dementia should be supported to minimise disruption to their normal daily routines, for example, meal times and personal care.

During a stay in hospital for a patient with dementia, both the dignity of the patient and the involvement of the carer(s) should be central to the processes.

Whenever possible, a patient with dementia should be discharged to the residence of origin.

Subsequent sections in this Report will investigate key areas of service delivery for people with dementia in Wirral's acute hospitals, ranging from pre-admission, the patient's experience on the ward, the discharge process, and services post-discharge.

6.3 The Stay in Hospital: The Experience for Patients and Carers

6.3.1 Pre-admission

One of the principles to guide the ways of working recommended by the Panel Members is "not to admit patients with dementia to hospital if at all possible". However, if a patient with dementia becomes ill or carers become incapacitated, there is currently little evidence of emergency care being provided specifically for people with dementia in their own home. Although there are some general admission prevention services already available in the community, extension of this type of service and the improvement of support to prevent crises from occurring is seen by the Panel Members as a high priority. An example of this type of service already established is the intravenous therapy in the community.

A health professional commented that:

"The best treatment for a person with dementia is to treat them at home. Hospitals are confusing, noisy, provide the opportunity for little sleep and carry the risk of infections. The thrust of national strategies is to keep people out of hospital, especially, people with dementia".

While another added:

"Once in the hospital system, it is in the nature of the environment that a patient will become more dependent. If a patient is in hospital for two or three weeks their circumstances can become more difficult. Therefore, keeping them out of hospital is imperative".

A consultant informed the panel that:

“The best option is to provide low-level support early on in order to prevent periods of crisis. Early intervention is most cost effective”.

Certainly, support to a carer(s) can be instrumental in ensuring that a person with dementia is able to remain in their own home for longer. As an example, information-giving for carers is very important for people with dementia. Providing information such as the available resources, the nature of the illness, what to expect, how to make choices and planning to make those choices are all very important. Information is the key because it enables families to plan.

‘Inappropriate’ admissions

During this Scrutiny Review, the main reasons for the admission of patients with dementia were described as:

- Carers may no longer be able to cope, which can result in the person with dementia being admitted to hospital. If there is not enough support, then a crisis will develop. The easiest option can then often be to admit the person with dementia to Arrowe Park hospital.
- People with dementia are more likely to get physical problems, for example, they may forget to take medicine. If they have a physical illness this may make the patient more confused. The treatment involves looking for a medical cause of the problem.

Research documented in ‘Counting the Cost’, the report produced by Alzheimer’s Society in 2009, shows that of those admitted with a physical problem, the primary reasons for hospital admission were falls, broken hips or hip replacements, urine infections, chest infections and strokes.

Strong support was given by those interviewed during this Scrutiny Review for the principle of avoiding hospital admission for people with dementia if at all possible. Panel Members have reached the view that staff should be expected to look positively at alternatives rather than admission to hospital and critically assess whether it is in the best interests of the patient. A hospital professional explained:

“When a patient is admitted through A&E, a lot of investigation can be done within four hours. If initial tests can be done and no physical illness is identified, do they need to be admitted? There is a strong case to argue that the patient should either go home or go to another facility. How can this process be better managed?”

- Urgent care could be put in place, via Social Services, to keep the patient at home.
 - A short-stay assessment unit could be available for patients with dementia while a care package is put in place. A small assessment unit is much better for patients than a busy hospital ward.
- If a demented person does not need to be there, being in hospital will create confusion”.

Specific actions aimed at reducing admissions in general have a high priority within Wirral NHS. It is expected that these policies will predictably impact on people with dementia. Some of these initiatives will be discussed in more detail later in this Report (see Sections 6.5 ‘Alternatives to Hospital for Patients with Dementia’). Nevertheless, admissions of people with dementia to acute hospital are inevitable, typically in the case of crisis or end of life care.

The recent Alzheimer’s Society Report, ‘Support. Stay. Save. – Care and support of people with dementia in their own homes’, published in January 2011 argues:

“There are significant perceived negative repercussions when people with dementia and carers do not receive enough support. Insufficient support is thought to lead to an exacerbation of needs and is frequently believed to result in avoidable admission to hospital and early admission to long-term care.”

Another report produced by Alzheimer's Society, 'Counting the Cost' found that 47% of carers who were surveyed suggested that being in hospital had a significant negative effect on the general physical health of the person with dementia, which was not a direct result of the medical condition.

RECOMMENDATION 1 Alternatives to hospital admission
Wirral NHS, GPs and Social Services are encouraged to continue to enhance services which reduce the need for people with dementia to be admitted to hospital if at all possible. All staff are encouraged to look positively at alternatives rather than admission to hospital and critically assess whether it is in the best interests of the patient.

6.3.2 The Admission Process

Identification that the patient has dementia - Register of people with dementia

The care provided for a person with dementia in an acute hospital can be directly influenced by the early identification, at the time of admission, that the patient has dementia. The importance of this issue is highlighted in the report, 'Acute Awareness – Improving hospital care for people with dementia' produced by the NHS Confederation in 2010, which comments that:

“Ambulance services and hospitals often come into contact with people with dementia that has not yet been identified and 50 per cent of dementia in a general hospital is unrecognised. Early identification in hospitals is essential to effective care planning and can lead to improved outcomes for the patient, as it reduces the likelihood of that patient's physical and mental health worsening during their stay. The NAO (National Audit Office) argues that effective identification of patients with dementia at admission, together with more proactive, coordinated management of their care and discharge, could produce savings of between £64 million and £102 million a year nationally”.

Although GP practices are encouraged to hold a dementia register, action based on the register is not mandatory. The incentive for a GPs' register is provided by the Quality Outcomes Framework (QOF); but not the use of the data. Furthermore, it has already been discussed earlier in this Report (see section 6.1.1) that although GPs are encouraged to hold a register of patients with dementia, analysis shows that there are many cases that remain undiagnosed or, at least, not registered. There is certainly no centralised register available to hospital staff at the time of admission. The development of access to such a register would be beneficial in order to aid care planning.

Identification of patient requirements

The NHS Confederation report, 'Acute Awareness – Improving hospital care for people with dementia' comments that:

“Once patients are identified as having dementia it is very important that their particular needs are recognised and understood. Systems need to be in place to ensure that patients can tell hospital staff how long they have had their condition, what makes the patient feel more comfortable, what needs to be done to ensure that meals are appropriate and other important personal details”.

In the past, the Alzheimer's Society has produced a leaflet titled, 'This is Me', which can be used by the person with dementia and / or their carer to fill in when they are admitted to hospital. This captures important data that will assist with care planning. It may be possible to draw on the experiences of Leighton Hospital at Crewe where a proforma was developed called "Information about Me to help You" that patients and carers can complete together with staff. The proforma highlights how it can be discerned that the patient is in pain or is feeling anxious plus personal information such as their previous employment, hobbies and likes and dislikes. The Privacy & Dignity Matron at Leighton Hospital, Phil Pordes, is quoted:

“The key to success we feel is the involvement of patients, carers, families and friends in the care planning process from admission”.

In addition, Wirral University Teaching Hospital Trust and Wirral NHS have done some work on developing the concept of a dementia passport, as has been used previously for people with learning difficulties. A health professional commented:

“Patients with Learning Disabilities possess a Health Passport which provides a great deal of information. However, a Health passport is not available for patients with dementia, for example, to describe what a patient likes to eat, medication requirements, and so on”.

At the time of admission, there is a need for maximum information to be obtained from the carer or the nursing home. Evidence suggests that this problem is most pronounced for those patients admitted from a residential or nursing home. Discussing the circumstances of her mother’s admission to Arrowe Park from a respite care home, one carer informed the panel:

“Information was given to the Respite Home. However, once in hospital, there is a need to identify what the patient likes to eat. That was not done”.

It later transpired that no personal information had evidently been transferred to hospital staff.

A hospital professional informed the panel:

“15% of elderly admissions come from care homes. The passing of information from residential care homes to hospital staff is often poor”.

Meanwhile another manager commented:

“The patient journey may involve spending several hours in A&E. It is important that in those circumstances someone is available to give information to the hospital staff, for example, last night the wife of a patient was present to give staff a full history of the patient’s condition. From a residential home setting, it is important that someone accompanies the person with dementia in to A&E. As an example, it is important that hospital staff need to understand the drugs regime of the patient and what works for them”.

RECOMMENDATION 2 Register of patients with dementia / dementia passport

The creation of a local register of patients with dementia, accessible to hospital staff, should be investigated as should the development of a dementia passport. These will enable the early identification of patients with dementia on admission to an acute unit.

RECOMMENDATION 3 Receipt of information regarding the patient with dementia

Processes should be developed to ensure that, at the time of admission of a patient with dementia, maximum information is received from the carer or nursing home. This could include the development of a simple questionnaire to be used in such circumstances.

The admission process

Particular concerns were raised during the review regarding both the length of the admission process and the possible number of moves for the patient within the hospital. Anecdotal evidence suggests that patients who do arrive in A&E can remain there for a considerable period prior to a decision regarding admission. Cases were cited when patients have been in A&E from 9.30am until 6.00pm. It is, therefore, extremely difficult for a person with dementia to cope for that length of time. As a result, a key issue is how the person with dementia is triaged. However, a health professional did advise the Panel Members:

“In the case of a patient with dementia, it is hoped that they will be moved on quite quickly. While on the assessment ward, a full nursing assessment will be carried out with as much information as possible being gathered from the carer or family member”.

With respect to the number of moves between wards, the comment was made:

“The admissions process means that patients may move up to four times and then occasionally within a ward. There are not a lot of beds sitting empty on wards. Therefore, there is often little flexibility”.

A health professional added:

“As the hospital is so busy, it is inevitable that patients are moved. There is a difficult balancing act that does not go in favour of the patient with dementia”.

RECOMMENDATION 4 Minimise the number of moves within hospital

Wirral University Teaching Hospital (WUTH) is requested to develop processes to minimise the number of moves for patients with dementia within the hospital.

6.3.3 Experience on the Ward

Care provided on the ward

Considerable concern was expressed by carers who attended the focus groups regarding the level of care provided on the wards. It is recognised that the presence of patients with dementia on acute wards add to the pressures on staff. However, all patients must receive adequate levels of care and the dignity of the patient should be preserved. The frustration of some carers is reflected by comments to the Panel Members:

“I believe patients with dementia need to be treated with dignity and from many visits to hospital, I have observed this is sometimes not the case because staff don't have time and are not actually in with the patients a lot of the time but have to spend time around the desk. There is often a reason for a dementia patient repeating requests and the temptation may be to ignore rather than spend time getting to the reason. Staff need to have the time to manage the dementia patient for that patient's sake and for the other patients nearby”.

“Staff did not seem to realise that it is not like dealing with a normal patient” .

“Families simply do not know what happens outside visiting times”.

“There needs to be a lot of trust when caring for a person with dementia”.

“Emotionally it is as bad as caring for a child”.

A common theme from many of the carers was their belief that a significant number of staff, including nursing staff, appeared to have insufficient understanding of the requirements to care for patients with dementia. In turn, this reflected on their judgement of the level of care provided to the dementia patient. Nevertheless, an experienced health professional reflected that:

“On a busy acute ward, how can you give the extra time that the patient with dementia needs?”

Nutrition / personal care

One specific area of concern for carers is that of the nutrition and personal care of the person with dementia. Circumstantial evidence suggested that support is not available to all patients. For instance, there is anecdotal evidence of patients losing their personal items such as spectacles and dentures.

One experienced worker with dementia patients remarked:

“There are cases where meals are left at the end of the bed because no one helps the patient to feed”.

Meanwhile, a family member told Panel Members:

“It was not that mum was not eating and drinking; she needed help. The family members sat patiently with mum and slowly but surely she gained weight. People with dementia have to have someone willing to spend time with them. The family did not know what she had been given to eat. If we had gone at meal times we would have helped. However, visiting times were between 3.00pm to 4.00pm and between 7.00pm to 8.00pm. Drinks were always found to be full. However, when helped, mum would usually drink most of it while we were there”.

And a carer said:

“No visitors are allowed in the hospital at meal times. It is assumed that staff will do their best given the time constraints. However, often if food is taken in to hospital, the patient will eat it. Some visitors would do anything either in a Care Home or in hospital to help care for their family member. However, the carer is never asked”.

Another carer added:

“There were six patients in the same bay; all in a similar condition. All six were not able to take drinks. Nurses don’t have the time. We helped others to drink and took in some clothes for another lady. All that is needed is some TLC. What about all those patients who didn’t have anyone to care for them”?

However, a health professional commented that:

“Some patients do not want to eat. Staff will also sit and feed patients at meal times if necessary. Family members are encouraged to do that if they want. However, there is a double-edged sword as nurses cannot appear to be pushing families to do it. The role for family members in helping to feed patients is determined by the ward manager”.

As a result, it has been suggested that greater involvement of family helpers could be made. It is fully recognised that family members / carers should not feel that they are overly pressured to be involved. However, the point was made that many family members are willing to provide that support. Indeed, one carer informed the panel that she was not encouraged to stay as it would disturb other patients. In the future, it may be possible to offer more flexible visiting times for carers of patients with dementia so that they can help care for the patient who, in turn, would feel more comfortable. The involvement of carers could go beyond meal times and extend into other areas of personal care. Particular concern from carers was raised regarding assistance that is available to assist patients in toileting. Additional support from carers and family members is likely to reduce the disturbance to the routine of the patient with dementia, as it is recognised that the patient can deteriorate quickly if not given support.

However, it is also recognised that, in practice, it is not all relatives who want to actively help. Some may prefer to opt out. In the past, there have been attempts to raise a campaign to get volunteers for assisted feeding on wards. A scheme in Cardiff enabled a named volunteer, who visited twice per day, to be allocated to a patient. Outcomes for the patients were seen to have improved. However, such a scheme will generate issues regarding the training of volunteers and the responsibility of the hospital for the volunteers. Clearly any scheme that invites volunteers or carers into the hospital must take account of safeguarding and infection control.

With regard to further assistance for patients at meal times, suggestions during the review included simply chopping the food into small pieces, alternative menus being written on a board or coloured pictures of the menu being given to patients. There could also be a dignified form of cover to protect the patient’s clothes, for example, an attachable napkin rather than a bib.

RECOMMENDATION 5 Assistance at meal times / personal care

Ward staff should welcome offers of help from family / carers to minimise disturbance to the patient with dementia during a stay in hospital. This could include family members being able to support relatives at meal times and aspects of personal care without being pressured to do so.

Contact with carers

A key issue for carers is the relationship which is developed with hospital staff and the subsequent transfer of information. It is important that the information flow is two-way and carers feel involved in the process. The circumstances of patients with dementia were summarised by a representative of the voluntary sector who commented:

“The relationship with staff is different for patients with dementia. There tends to be little day-to-day information. Staff do not share information with family members”.

A Carer’s representative added:

“I believe carers need to be more closely involved when the patient is on the ward as the carer can give information which will assist in managing the care of the patient”.

Meanwhile, a carer commented:

“It was hard to get information from hospital staff”

Although leaflets are available in information racks, it is still difficult to ensure that people collect the right general information. Therefore, improvements could be made in this area, perhaps through the development of a special advice point. Indeed, the panel met one carer who had only recently been put in touch with Alzheimer’s Society, six years after his wife had been diagnosed with dementia. This suggests that the need for better signposting spreads well beyond the acute hospital wards. However, it is important that the special role of the carer of a person with dementia is recognised. That can only come through the development of a direct relationship between hospital staff and the carer(s).

RECOMMENDATION 6 Information flow with carers

The special role of carers of patients with dementia should be recognised by staff. Processes should ensure that greater information exchange with carers is established at the outset. This should include ongoing care and developments towards discharge.

6.3.4 Impact of Patients with Dementia on Other Patients During a Stay in Hospital

There are inevitable conflicts that arise both from the viewpoint of staff and of patients resulting from the presence of patients with dementia on acute wards. From the perspective of staff, issues arise regarding ward management as well as behaviour management. The concerns and dilemmas of hospital staff were summarised by a senior health professional:

“As Patients with Dementia are confused, they do impinge on other people in the ward. Sometimes they will wander around the ward or open lockers, and so on. Particularly at night, the disturbance can lead to non-demented patients not being able to settle very well. This can lead to some non-demented patients being rude with comments such as “I don’t want to share a ward with mad people”. It is not unknown for a patient with dementia to get into someone else’s bed or to take their clothes off. The reaction of other patients can sometimes be sympathetic; sometimes offended. Each ward has a mixture of bays and single rooms. The hospital is now in the process of moving towards single sex wards. If a patient with dementia is in a bay, they may disturb other people around them. Alternatively, if the patient with dementia is in a single room, they may wander off as it is more difficult for staff to monitor their movements. Staff on the ward have to deal with an increasing number of situations that they did not anticipate when they did basic training. The care of patients with dementia is going to become an increasing problem”.

Another health professional commented:

“It is difficult to manage patients with dementia in a ward. It is very hard, particularly if the patient is mobile. On the late shifts there are only four members of staff on the ward. It is particularly difficult if there are two or three patients with dementia in the ward at the same time”.

It is obvious that other patients will expect the staff to be able to do something about the situation. The Panel Members were informed that there are cases when members of staff do get abused. Behaviour can also be worrying for other patients. The positioning of patients on the ward is a judgment for staff as well as depending on the availability of beds. Side rooms are available on the ward, although these are often used for infection control. However, if a patient with dementia is in a side room, it becomes more difficult to observe that patient. The Psychiatric Liaison staff, who are based at Arrowe Park, are available to intervene and help to assess individual needs. It was reported that they are very helpful in suggesting techniques to manage patient behaviour. A professional commented:

“Sometimes it can be our behaviour and our treatment of the individual, not the patient with dementia that sparks the problems”.

One health professional did suggest to the Panel Members that if all patients with dementia were nursed on the same ward it would allow the more experienced staff to care for them. It would also be less disruptive for other patients. Meanwhile, it was reported that there are added pressures for staff on late shifts and night shifts. As an example, staff would find it easier if there was an alarm system on the ward. Staff are not allowed to lock the doors on the ward. Therefore, it is not possible to allow patients to wander about as “they could be off to the bus stop”. In conclusion, it was noted from interviewees that if there are a number of patients with dementia on the same ward, the nursing care available to other patients is likely to suffer.

Meanwhile from the perspective of other patients and their visitors, other priorities emerge. The differing impacts on other patients can perhaps be summarised by the following two statements, each witnessing very different experiences:

A patient in a medical ward for 48 hours:

“A lady with dementia was in the same bay as myself. Very distressed and demanding. I could not speak more highly of the care and attention she was given almost constantly by the staff. They fell over backwards to reassure and calm her. I did not feel that the needs of other patients were neglected as a result”.

Another patient witnessed very different circumstances:

“I experienced a stay in Arrowe Park hospital which included a major operation followed by a period of recovery. I was located in a male-only ward containing six beds. I had no complaints about the staff who carried out their duties, sometimes under difficult conditions. However the behaviour of one patient sometimes during the day but more so during the night was completely unacceptable. At that time he would throw off the bed clothes followed by his pyjamas and lie naked on the floor. Following this, he would crawl from bed to bed in a threatening manner although I am not aware that he actually attacked anybody. The on-duty nurses were summoned and they, with some difficulty, returned him to his bed. This was followed by a short period of normality after which he repeated the same activity. The same routine continued for a few weeks following which a decision was taken at a higher level which resulted in his removal to a more secure ward.”

As these examples show, part of going into hospital is the interaction with other patients, some of whom will have some form of dementia. Not all of these contacts are negative. In fact, a professional commented:

“I have witnessed many very positive contacts between patients with and without cognitive impairment”.

Evidence shows that the effect of a patient with dementia can be distressing for other patients, especially if the patient is shouting. It can be a frightening experience and patients cannot rest properly. In addition, examples were quoted such as a person dying in one bed adjacent to a patient with dementia, which has led to complaints from relatives. However, a hospital professional reported: “Generally, most patients are incredibly understanding and try to help. They can see that staff are busy. There are complaints from patients because they have had disturbed sleep for days. In some cases, they understand but are not happy because they have had a bad experience”.

6.3.5 Ward Environment and Organisation

Environmental issues

The Panel Members were informed that the environment is a key issue for people with dementia. The use of pastel colours and appropriate signage is seen as important. Some wards have made significant effort with signage. There is work taking place to assess, for example, how wards are decorated with colour schemes for particular areas such as a toilet door or the signage.

Progressive work has taken place elsewhere to identify improvements to the hospital environment on behalf of patients with dementia. Such work has taken place at Leighton Hospital in Crewe (Mid Cheshire Hospitals NHS Foundation Trust). Phil Pordes, Privacy & Dignity matron, is quoted:

“To help improve the environment there are coloured doors at the entrance to each bay and accessible, clear signage which are helping patients with dementia find their way to and from the bathroom/toilet; promoting both continence and dignity. An Activity Lounge is run twice a week where patients with dementia enjoy games, singing and memory boxes”.

The result of the work which has taken place at Leighton hospital has raised considerable interest.

Although there are already some examples of good signage at Arrowe Park, the Panel Members were informed that there is a need to look at possible pilots to improve ward areas, ensuring that best value is obtained from any available resources. Further research is required in this area to identify the effect of these changes. Clearly, if there is a limited pool of money it needs to be focused wherever evidence shows that improvements for patients will be forthcoming. This is one of the areas that the Dementia Strategy Group at Arrowe Park has developed.

Within the ward, positioning of beds is important too. This is a judgment for the staff as well as depending on the availability of beds. Although side rooms are available on wards, they are sometimes used for infection control. However, even when side rooms are available, the professionals were not unanimous regarding the wisdom of placing patients with dementia in side rooms. It was pointed out that, although providing a quieter environment, a patient can also be more isolated in a side room. Furthermore, in the case of a patient with dementia, it becomes more difficult for staff to regularly observe the patient.

RECOMMENDATION 7 Environmental issues on the ward

In order to assist patients with dementia, Wirral University Teaching Hospital is encouraged to investigate further environmental improvements to wards where appropriate. These might include:

- **Clear signage to identify bathroom / toilet**
- **Use of pastel colours**
- **Positioning of beds in the ward**
- **Use of side rooms**
- **Alarm system to prevent patients with dementia from wandering, especially at night when staff numbers are reduced**
- **Use of Activity Lounge for patients with dementia**

Separate dementia ward

There are examples from elsewhere, such as Nottingham University Hospitals and Mid Cheshire Hospitals NHS Foundation Trust (Leighton Hospital in Crewe), where a ward has been developed for managing particular behaviours. During this Scrutiny Review, the issue of providing a separate ward for patients with dementia has been explored with many of the witnesses. The vast majority of those health professionals who were interviewed showed little enthusiasm for the principle of such provision. As patients with dementia should only be in an acute hospital because they are suffering from another physical condition (other than their dementia), the most common view was that patients with dementia should be entitled to the same level of care that is available on the specialist wards that are available around the hospital. All patients should be dealt with on a ward which is relevant to their physical illness, for example, a patient with dementia in hospital for a knee replacement should be on an orthopedic ward. The proposal also raises the question as to whether wards for patients with dementia are being recreated in an acute hospital while closing beds in psychiatric units. Furthermore, it was pointed out by a health professional that:

“Dementia is so common that all staff should be able to deal with it to a certain level. It is a basic requirement”.

Role of specialist dementia nurse / champion

Even though a specialist dementia ward may not be available in an acute hospital, the role of specialist dementia nurses could apply across all relevant wards. A key issue in the development of the Dementia Care Pathway is the need to have adequate staffing levels. A carer commented:

“There should be a specialist nurse who can be called on to provide care for the patient and to talk to the family”.

And a representative of the Voluntary sector added:

“The best option may be for a team of specialist dementia nurses available to go to wards to support other staff”.

The NHS Confederation report, ‘Acute Awareness – Improving hospital care for people with dementia’, quotes a carer who makes the request:

“Have a dementia lead or a specialist team: we can’t expect all the hospital professionals to be specialists in dementia. After all, people are not normally in hospital because of their dementia and we need someone to treat the condition they have been to hospital for. But if staff know they can call on a team who will help them understand how the care plan can be adapted to include the needs of people with dementia too, we can improve the care of the patient and probably help them leave hospital earlier”.

Regarding the delivery of Objective 8 (‘Improved quality of care for people with dementia in general hospitals’), the National Dementia Strategy raises the prospect of the deployment of specialist liaison older people’s mental health teams in general hospitals. The strategy document comments that:

“Specialist liaison older people’s mental health teams are already advocated by the NICE/SCIE (National Institute for Health and Clinical Excellence / Social Care Institute for Excellence) guideline on dementia services. They can provide rapid high-quality specialist assessment and input into care planning for those with possible mental health needs admitted to general hospitals, including input into ongoing care and discharge planning. They will generally consist of a multidisciplinary team of three to four members of staff (part-time consultant, staff grade doctor, nurse and psychologist/ therapist) with administrative support and a base in the general hospital. They can cover the whole range of mental health problems in older adults, not just dementia. These teams can then work closely with the designated general hospital lead to build skills and improve care through the hospital. They need to have good links with the social work assessment teams based in or linked to the hospital. They are already provided in some but by no means all hospitals”.

Although, liaison psychiatrists are available on the Arrowe Park site, specialist dementia nursing staff, to be deployed wherever required at a point in time, would also be beneficial. These staff could supplement ward staff when particular difficulties arose. Although dementia champions are, in theory, deployed on wards, evidence suggested that a champion was not consistently available in all relevant wards. However, it was remarked that the deployment of dementia champions wherever possible “ensures that there is more experience than in most hospitals”.

RECOMMENDATION 8 The role of specialist dementia nurses

The role of specialist dementia nurses, to be deployed wherever needed in the hospital to support other acute staff, should be considered.

6.3.6 Safeguarding

The Panel Members were informed that, with regard to safeguarding, national statistics of abused older people show that 60% of the recorded incidents are against patients with dementia. Clearly, the Wirral University Hospital Trust must have and does have mechanisms in place to safeguard all patients.

There are many causes, in the general hospital, outside of dementia that can lead to cognitive impairment and agitation and there have to be appropriate systems to manage this in the general hospital. Positive comments were made regarding the aggression management team within Arrowe Park and the adult safeguarding team. Indeed, the dementia pathway identifies the need for appropriate risk assessment, training of staff and an appropriate environment leading through to identifying early warning signs and the management of aggression itself. In addition, security systems on wards to prevent patients from wandering, particularly at night when staff ratios are lower, would potentially enhance the safety of more vulnerable patients.

It is clearly the case that staff need to distinguish between patients with dementia and patients who may be elderly but just upset, suffering medication side effects or grumpy. Anecdotal evidence suggested that, in circumstances of aggression management, staff may call in security to manage a patient. The wisdom of calling in security men, who are likely to appear frightening and aggressive to a patient with dementia, was raised. The point was made that nursing staff are probably more adept at managing a patient’s response.

RECOMMENDATION 9 Safeguarding

The deployment of security staff to manage patients with dementia should be avoided if at all possible. (Further recommendations for staff training and availability of experienced staff reflecting the number of patients with dementia on a ward at any one time should assist with the management of disruptive behaviours).

6.3.7 Discharge Process

Speed of discharge process

One of the principles that the Panel Members are proposing is: “If a patient with dementia is admitted to hospital, their stay in hospital should be kept to a minimum period and, while in hospital, the patient should be subject to as few moves as possible”. It is fully recognised that discharge planning is a major challenge, not only for the hospital trust but also for related partner organisations.

With regard to the care of patients with dementia, a health professional commented:

“It is worth reinforcing the point to limit a stay to as short a time as possible”.

However, it is fully recognised that Wirral University Teaching Hospital Trust and Wirral NHS have invested considerable time and effort on reviewing and improving the general discharge process over the last two years. Significant progress has been made in re-designing processes to enable a more efficient and effective discharge system. If a patient with dementia has to be in hospital, the work already undertaken by the Integrated Discharge Team should help. As an example, on a daily basis, appropriate staff, including the patient flow practitioner and a social worker, discuss discharge requirements for each patient on the ward from the day of admission, including gathering information about circumstances pre-admission. In the case of a patient with dementia, the process should include the carer, who needs to be involved in order to determine their needs.

However, it is inevitable that the planning process will be more difficult in more complex cases. Therefore, delays can occur. It was explained that delays may occur for a number of reasons. Once in the acute care environment there is a sense that all investigations and treatment need to be done prior to discharge, for example, occupational therapy, physiotherapy, social services assessment and so on. Professionals, families and care homes appear to have an expectation that all the issues will be resolved during the stay in hospital. In some cases, the patient cannot go home until the package of care has been increased or the residence has been changed and delays can occur whilst funding is arranged.

In order to reduce the length of stay in hospital for a patient with dementia, it was suggested that Community Psychiatric Nurses should be contacted at the earliest opportunity following admission. This would enable planning for the potential support at home to begin as soon as possible. The workload of the duty social worker and also the fact that Social Services sometimes do not get involved in the process early enough were also cited as examples of potential delays in the planning process.

Overall, evidence suggests that relatively few discharges are delayed due to waiting for care packages. However, it is possible that where this is a cause of delay, the proportion involving patients with dementia may be relatively high as they are among the more complex discharge cases. There was also anecdotal evidence, on the other side of the coin, of a family feeling under pressure to arrange for the patient to be discharged 'too early' in order to avoid the possibility of losing the place in the Care Home. Otherwise a longer period in hospital would have allowed a further period of occupational therapy. Nevertheless, the availability of occupational therapy should not be a reason for a delay in discharge anyway as that service should be readily deliverable in a care home.

Anecdotal evidence suggests that a key issue is that some patients are being discharged with no adequate care plan. There continue to be negative comments based on the experiences of carers. It is essential that carers are an integral part of the discharge planning process. A key issue for discharge planning is to ensure that patients are aware of the plans for their discharge as soon as possible. The aim should be to give the patient / carer an indication of discharge plans within 24 hours of admission.

A carer's representative also made the point that the hospital should be more proactive in ensuring that, at the point of discharge, adequate physical support / care is available for the patient, particularly when the carer is elderly.

In conclusion, it should be recognised that, in the case of patients with dementia, there is a balance between the short-term gain (of needing physical support) and the long-term deficit (of being away from 'normal' surroundings for a lengthy period).

RECOMMENDATION 10 Discharge planning

Support is given to the principle of long-term care needs not being decided from a hospital bed. Planning for discharge from the time of arrival must involve the carer(s) with the prime objective being to discharge the patient to the residence of origin wherever possible.

Destination following discharge

A health professional informed the Panel Members:

“A stay in hospital can often ‘tip’ a patient with dementia into residential care. It can also sometimes be the case that the stay away from home can allow the carer to reflect that they are no longer able to cope”.

Meanwhile, another added:

“In terms of discharge planning, the aim should be that no one leaves from a hospital bed and moves to a residential care bed”.

And another:

“The best place for the person comes down to a balance for the individual between their physical health and their mental health”.

The number of specialist care beds for people with dementia in Wirral was seen as a major issue by some of the witnesses interviewed during this Scrutiny Review. Current options available to avoid 24 hour care include the Wirral Admissions Prevention Service (WAPS) who will care for people in the community. However, there is not a HARTs service (Home Assessment Reablement Team) to support enablement specifically for the rehabilitation of patients with dementia. On the assumption that long-term decisions should not be made from a hospital bed, there need to be greater options of intermediate care. Other options at present include the rehabilitation wards at Arrowe Park (wards 36 and 25) or 24 hour care.

In terms of options for a patient with dementia, needs are more complicated and not as easy to plan for as people with physical health needs where care required tends to be more predictable. Limited specialist places in the community are available, for example, 10 tenancies at Cherry Tree House for those with a high-level need. For those in their own home, the challenges are even bigger. Support may not be available when it is most needed. It was pointed out that one potential gap in the current service is night-time support.

The impact of a stay in hospital on a person with dementia can be profound. It is sometimes the case that, after a physical illness, a patient with dementia never quite gets back to the level that they were before the illness. It is not always possible to get people back to where they were. As a result, evidence has suggested that patients with dementia are discharged too often into 24 hour care. The Alzheimer’s Society Report, ‘Counting the Cost’, produced in 2009, estimated that, nationally, over a third of people with dementia who go into hospital from living in their own homes are discharged to a care home setting.

One officer informed the Panel Members:

“Once admitted to hospital, there is a high possibility that the patient will eventually be discharged to care and not back to their own home”.

A hospital manager explained:

“Once a patient is in hospital, it is necessary to look toward the possibility of 24 hour care. There is a need to give people the choice to have appropriate packages of care. It is true that patients with dementia become more disabled in hospital because they get more confused, are more susceptible to infections, and so on. If they are turned around at the front door they may not end up in care”.

One experienced health professional commented:

“There is currently a gap in the provision of interim or intermediate care beds for patients with dementia. Relatively few people go to beds provided by the Cheshire and Wirral Partnership Trust. The new bed provision at Clatterbridge looks very promising, with outside access and lots of single room accommodation. However, overall, there are a reduced number of beds for dementia services. Therefore, lower numbers of patients are going to that sort of setting. As a result, a patient is now more likely to end up in an Acute General Hospital Ward. There is now more provision of care for patients with dementia in the private sector than there use to be, but as some are very difficult cases, not everyone might want to take them on. There is also an issue regarding the provision of respite care in the community”.

Meanwhile, another made a request for the future that there was:

“The need for intermediate care for mental health problems, either provided through a central service for Wirral or alternatively through a locality-based service.”

It is recognised that the development of reablement and intermediate care services for older people, which will include people with dementia, is already a priority of Wirral NHS and other partners. It is understood that there are currently 13 specialist beds for patients with dementia in Wirral provided by Cheshire and Wirral Partnership Trust. Although the average occupancy rate is estimated to be 85 % (or the equivalent of 11 full-time beds), the occupancy rate does fluctuate.

Care packages

It can take time to assess the package of care that is required. The medical assessment can take a number of days before the case is passed to social care for approval and then brokerage. A further time constraint depends on the availability of an agency to pick up the care package. This, therefore, raises the question of whether services can be facilitated faster, particularly in cases where this would prevent a patient from being discharged into a care home. A more efficient process, reducing the need for large quantities of paperwork, would enable cases to be dealt with more quickly. It was reported that assistance provided by the Patient Flow Practitioners in completing the Decision Support Tool information has helped to speed up this process. One health professional commented:

“It takes a minimum of two or three weeks to get a patient through the assessment bureaucracy”.

Meanwhile, another added:

“If you get a system where you have to fill in pieces of paper there will be delays”.

Followed by another who said:

“The paperwork is immense. It is a hideously slow progress”.

The early involvement of social workers, as well as carers, in the discharge planning process helps to mitigate against any delays occurring.

RECOMMENDATION 11 Care requirements following discharge

Appropriate discharge needs include:

- **Reducing the time taken for the care assessment**
- **Prompt availability of care packages including reablement support**

An alternative pathway for patients with dementia may involve the development of a short-term assessment unit and / or an intermediate care service.

6.4 Staff Skills and Training

As discussed earlier in Section 6.3.3 ('Experience on the Ward'), a common theme from many of the carers was their belief that a significant number of staff, including nursing staff, appeared to have not sufficient understanding of the requirements to care for patients with dementia. The NHS Confederation report, 'Acute Awareness – Improving hospital care for people with dementia' comments that:

“Awareness can be raised through internal training. Dementia leads play a key role in this, both by ensuring that dementia is high on the hospital training agenda and by being able to support staff who need to improve their knowledge of the condition. While it is important for professionally regulated staff to receive detailed training on dementia, any training strategy needs to include other front-line staff, ambulance crews working in patient transport, healthcare assistants, porters and catering staff. All these groups should have some knowledge and understanding of dementia”.

However, it is recognised that significant effort and progress has been made by Wirral University Teaching Hospital Trust regarding staff training specifically in the care of patients with dementia. One senior health professional informed the panel that:

“There is good training for staff regarding dementia. Conflict resolution training is also included”.

The National Service Framework for Older People (developed in 2001) included a standard that all areas should have an expert in older people's care. The implementation of this standard led to an audit of skills. The average trained nurse recorded a self-perception of coping with patients with dementia as very low. Since that time, the staff have been re-audited and, although self-perception has increased, it is acknowledged there was still more to do. There is recognition that, although staff need to be confident in managing the patient with dementia, many do feel uncomfortable in caring for such patients. There is a need to raise the general level of understanding of dealing with patients with dementia. Indeed, the point was made that there is such a high throughput of patients with dementia in the acute hospital, particularly the DME wards (Department of Medicine for the Elderly), that staff really must be trained in the competencies to manage this type of patient.

Nevertheless, there is no statutory requirement at all for the hospital to train non-medical staff in caring for patients with dementia. The Trust has not placed a mandatory element on the training, although Departmental managers will encourage staff to attend and Ward managers suggest the names of attendees. The interim report of the National Audit of Dementia (The Royal College of Psychiatrists, December 2010) estimates that 95% of hospitals do not have mandatory training in dementia awareness for all staff whose work is likely to bring them into contact with patients with dementia. The argument was made to the Panel Members that it would not be feasible for the dementia training to be mandatory. Trainers are not available to provide sufficient time and bigger groups of attendees would reduce the benefits of the course. There is also the cost of releasing staff from the wards with the resultant cost of backfill for the staff.

It is important to recognise that Wirral University Teaching Hospital was the first trust in the country to obtain input from the Alzheimer's Society in providing relevant training to staff. The training enabled staff to develop coping mechanisms for managing patients with dementia. The courses, for which there was a waiting list, were delivered separately for trained nurses and untrained staff. In addition, there were courses for which the target audience was non-clinical staff such as porters and cleaners. The courses incorporated the dignity of patients, included role play and were very interactive.

Although staff on some wards have practical expertise, not all have been formally trained in caring for patients with dementia. A particular problem was described with respect to bank staff, some of whom are claimed to have limited training and experience of patients with dementia.

There is general support for the provision of dementia training and willingness to attend from many staff. However, there appears to be a difficulty in arranging for some groups of staff to attend the training sessions, for example, staff in Accident & Emergency Department (A&E), security staff, ward managers and doctors. There is anecdotal evidence that following the training, staff do not receive adequate support when they return to their wards and try to apply their training.

As one witness informed the panel:

“It is more cost-effective to prevent issues from occurring than it is to recover from them”.

Evidence suggests that a major priority for the future should be training of staff. Indeed, the Dementia Care Pathway proposes that dementia training course is compulsory for certain staff groups. Although higher attendance at dementia training courses is to be encouraged, the availability of on-line training modules may be useful method to supplement the more traditional form of training that has been available.

In the longer term, the Panel Members support the principle of training in the care of patients with dementia being more fully integrated into undergraduate courses for nursing. Clearly, this can only be achieved through the support of the appropriate national bodies, such as the Nurses and Midwives Council. Therefore, qualifying bodies should be encouraged to ensure that professional training fully incorporates dementia awareness.

RECOMMENDATION 12 Staff training

Participants in training sessions regarding the care and management of patients with dementia should be expanded to include:

- **Doctors**
- **Ward managers**
- **Triage nurses**
- **Paramedics and ambulance staff**
- **Security staff**

More staff from all appropriate wards should be involved in dementia training, which could include on-line modules.

6.5 Alternatives to Hospital for Patients with Dementia

6.5.1 Caring for More Patients at Home

Increasingly, over recent years, greater emphasis has been placed on encouraging people with dementia to be at home. However, carers need to be supported for that to happen. Otherwise, there will be more carer breakdown. During the review, managing people with dementia at home was widely seen as a positive approach. However, further progress is required to avoid the problem of a person with dementia having to go into hospital when they are not ill, for example, because of carer breakdown. There has been a culture that, once in hospital, a person with dementia is more likely to be discharged into full-time care. In addition, pressure can also come from the carer who, as a result of their family member being in hospital, realises that they are not able to cope with the responsibilities of caring anymore. It is therefore difficult to ensure, that once admitted to hospital, a patient with dementia is returned to the residence from which they were admitted.

The recent Alzheimer’s Society Report, ‘Support. Stay. Save. – Care and support of people with dementia in their own homes’ reports that, following a carers’ questionnaire, it was estimated that 83% of carers and people with dementia said being able to live in their own home was very important to the person with dementia.

If there is not a service in the community to assess and support them, a person with dementia may well turn up at hospital. As a result, they are likely to be admitted. There is wide recognition that a change of environment is likely to cause problems for a person with dementia. The Panel Members were informed by a health professional that:

“It is true that patients with dementia become more disabled in hospital because they get more confused, are more susceptible to infections, and so on. If they are turned around at the front door they may not end up in care”.

However, the Panel Members were informed that 60% of patients are admitted with chronic confusion. Medical staff do not know whether it will settle in a day or two. In theory, the suggestion to treat more people with dementia at home sounds like a good suggestion but, in practice, it can be difficult to separate dementia patients from those with sub-acute confusion. It is further recognised that the care for patients with dementia is very time-consuming for staff in any setting.

One health professional informed the Panel Members that:

“The question needs to be asked ‘Why cannot conditions be treated in the community?’. If a patient is admitted because of their dementia it says failure in the system to me”.

Meanwhile, another commented that:

“If people are acutely unwell they need to be in hospital. Once they are fit, they should no longer be in hospital. There is a need to have services in the community to support them”.

The case for change was summarised by one witness:

“The feedback I receive from staff in the General Hospital is that there are a number of patients with dementia who do not need acute care but who are admitted to the general hospital around a crisis or end of life care. A culture shift will need to take place in order for this to change. This is around earlier diagnosis and pre-planning. Once the diagnosis is made we know the likely course of the illness and what challenges they are likely to face. There are currently limited community based resources to support a patient in crisis available for people with dementia”.

A computerised model developed two years ago (CSED - (Care Services Efficiency Delivery) determined how best to intervene. A key message is that if you do not intervene at an early stage, subsequent intervention will not have a big impact on admissions to hospital during a period of crisis. The best option is to provide low level support at an early stage (to prevent a crisis occurring). This level of support also gets the family into the practice of accepting help. It can be the case that a person with dementia is admitted into hospital because the carer(s) did not know where to get help from.

However, some frustration was expressed as there are few services to provide a quick response to crises in Wirral. It can take a significant length of time to get packages of care set up, particularly in more complex cases. As an example, on a Friday afternoon, the easiest option is admission to Arrowe Park rather than trying to provide support services to keep a patient with dementia in their own home. Wirral NHS no longer has a Fast response Team which formerly provided support for up to 48 hours in an emergency. A witness commented to the panel:

“The most important issue is to understand the real reason for a patient being in an acute hospital. A significant number of patients are admitted into hospital because their family members cannot cope. The simpler solution is for the patient to be admitted, as there is nowhere else to take him. There is a need for rapid access mental health services”.

While another added:

“Where, other than hospital or their GP, can people go in an emergency?”

And another commented:

“The system ought to be able to provide fast response to crisis, for example, what happens if a carer is taken ill? In general, the current support services are provided on a 9 to 5 basis. Can we facilitate services faster to prevent a person with dementia from having to go into care by which time care packages have to go to brokerage. This greatly extends the timescales for being able to put services in place”.

However, all of the facilities and support in the community are not currently in place to enable that to happen. The links between the hospital and the community are not as robust as they need to be. There is currently no specialist dementia home care service in Wirral. It was explained that one difficulty with planning services for a person with dementia is knowing the stage of the disease and assessing how long it is possible to keep someone at home. Evidence available to the Panel Members suggested that in some areas, for example, Liverpool, there are more services to keep people with dementia out of hospital, for example, short-term care packages. The specialist home care service in Liverpool is regarded as having been very successful at keeping people in their own home. This service is an integrated service which includes health and the Community Psychiatric Nurses, who are key to the provision. Therefore, a patient has to have a definitive diagnosis in order to qualify for the service. It is possible to manage behaviours because of the close relationship between the care services and health staff. Although the Crisis Resolution Home Treatment Service exists in Wirral, patients with dementia are specifically excluded. This service, run by the Cheshire & Wirral Partnership Trust, is geared for mental health patients rather than dementia.

A senior professional commented:

“There is a case for creating a team to intensively care for patients with dementia in their own homes. The aim should be to facilitate caring at home for longer”.

There are other barriers to enabling people with dementia to remain in their own home. There is a fundamental challenge which needs to be met. It is not true that it is unsafe for a person with dementia to be at home and that it is safe elsewhere. There are risks in both scenarios. Care homes are not risk-free. It was explained to Panel Members that it is important to understand that it is not risks versus safety; but risks versus another set of risks.

In the future, improved technology will help to keep people in their own homes. Although assistive technology can be very useful, it also raises particular challenges when related to patients with dementia. The client needs to have an understanding to be able to push buttons at the appropriate time. However, the use of technology such as sensors and pressure pads can be very useful. As an example, sensors were fitted in the home of a man with dementia. It was discovered that the man was getting out of bed during the night and wandering in the house in an attempt to find the fridge in the kitchen. As a result, it was possible for the man’s eating patterns to be changed, which resulted in him being more settled. Assistive technology enables that detailed type of assessment.

Enhancement of services such as the development of Dementia Support Services, provided by the Alzheimer’s Society and the re-design of the Memory Clinic service in Wirral, to enable better links to the voluntary sector, will enhance services available in the community. Suitable sites are also being sought in the three localities of Wirral (Bebington & West Wirral, Birkenhead and Wallasey) in order to provide a more accessible service with better signposting to further services.

There is also generic work taking place that is not aimed specifically at patients with dementia but which may also help. As an example, ‘Integrated Care at Home’ is being developed in each of the three localities. It will enable more of the 24 hour, seven day service for people at home. This will include up-skilling to allow the provision of intravenous therapy and so on.

On the occasions when admission to acute hospital is necessary for a person with dementia, it may not always be possible for them to be discharged back to their own home. Professional advice throughout the review was clear that long-term decisions, such as moving to a care home, should not be made from a hospital bed. Therefore, in this context, the greater availability of intermediate beds has been seen as a very positive step in order to enable quicker discharge from the acute wards, although some professionals did argue that specific mental health provision was needed. The same case was made for the provision of respite care in the community.

RECOMMENDATION 13 Crisis Response Team / Specialist Home Care Dementia Service
Recognising that any move from familiar surroundings is likely to exacerbate dementia, people with dementia should be cared for in their own home or residential / nursing home if at all possible. Therefore, Wirral NHS is encouraged to investigate the feasibility of developing a Crisis Response team and / or a Specialist Home Care Dementia Service to keep patients with dementia in a familiar environment.

6.5.2 Residential and Nursing Homes

An NHS Wirral report, 'Implementation of the National Dementia Strategy' estimates that, at a national level, at least 50% of long term care residents have dementia. It is understood that there are too many people with dementia in long-term care, although this figure is now starting to reduce. A witness informed the panel that approximately 15% of elderly hospital admissions come from care homes. It is frequently the case that a person who is moved to a care home will end up in hospital. For many of these patients it is not helpful in the long-term. The case was made that there is not sufficient specialist dementia care available in care homes. A health professional commented:

"The system for providing specialist medical care for care homes in the UK is very poor".

During the review, it was claimed that, with additional support, it should be possible to reduce the number of admissions from residential or nursing homes. As an example, a patient with dementia who has a chest infection could be cared for in a residential home given WAPS (Wirral Admissions Prevention Service) support. Nursing homes must provide sufficient staffing as per Care Quality Commission regulations. Although Wirral NHS will provide advice and support, there is a legal requirement on nursing homes to provide adequate staffing levels.

In the past, much work has been done to provide support and advice to Nursing Homes in the borough. If there is a need for injections and antibiotics, WAPS (Wirral Admissions Prevention Service) are available to provide support. However, Wirral NHS is also working on a plan to further develop a service to work with nursing homes to prevent admissions. Nursing homes have nurses, but they are not specialists. Therefore, a scheme is being developed whereby Wirral NHS will support nursing homes, provide training and provide specialist skills. This project will cover both nursing and residential homes. Training is provided to nursing homes by Wirral NHS on topics such as nutritional standards and continence.

There is also an ongoing project with EMI (Elderly Mentally Infirm) to reduce medication for the elderly. One care home found that by increasing fluid intake, the number of falls and broken bones was reduced. Likewise, the aim is that by reducing medication, the number of falls can also be decreased.

In terms of the future, Quality Premiums linked to activities may help to provide incentives to care homes to provide different services.

RECOMMENDATION 14 Nursing Homes
The current work undertaken by Wirral NHS to provide support to nursing homes to enable fewer patients to be admitted to hospital is endorsed. This practice should be extended wherever possible.

Appendix 1 : Scope Document for the Dementia Scrutiny Review

Date: 1st July 2009

Review Title: 'The Care of People with Dementia in Hospital' Scrutiny Review

<p>Scrutiny Panel Chair: Cllr Ann Bridson</p>	<p>Contact details: 0151 201 7310 mobile: 07759 587597</p>
<p>Scrutiny Support Officer: Alan Veitch</p>	<p>Contact details: 0151 691 8564</p>
<p>Departmental Link Officer: Jeanette Hughes, Department of Adult Social Services, Wirral Borough Council</p>	<p>Contact details: 0151 604 7226</p>
<p>Panel Members: Cllr Ann Bridson Cllr Denise Roberts Cllr Sheila Clarke Cllr Chris Tegg</p>	<p>0151 201 7310 mobile: 07759 587597 0151 652 3309 0151 608 1154</p>
<p>Other Key Officer contacts: Michael Monaghan, Wirral University Teaching Hospital</p>	
<p>1. Which of our strategic corporate objectives does this topic address? 1.1 To Improve Health and Well-being for all, ensuring people who require support are full participants in mainstream society, in particular: - To Improve support for those with mental health problems - To Promote greater independence and choice</p>	
<p>2. What are the main issues? 2.1 Management of patients with dementia in an acute hospital setting. 2.2 Impact of patients with dementia on other patients during a stay in hospital. 2.3 Are there alternative approaches which allow more patients with dementia to be cared for outside an acute hospital setting? 2.4 Is it possible to support more people with dementia in their own home? 2.5 What support is available for carers? 2.6 Is it possible to support more people with dementia in residential or nursing home rather than acute hospital?</p>	
<p>3. The Committee's overall aim/objective in doing this work is: 3.1 To improve care management in an acute hospital setting for both patients with dementia and for other patients. 3.2 To identify possible alternative approaches to hospital admission for people with dementia and their carers.</p>	
<p>4. The possible outputs/outcomes are: 4.1 Improved services in a hospital setting for patients with dementia. 4.2 Better experience for general patients who have interaction with patients with dementia. 4.3 Identify possible alternatives to acute hospital admission. 4.4 Ensuring that assessment and discharge of patients with dementia is effective and in the shortest possible timescale. 4.5 Reducing the number of admissions of people with dementia. 4.6 Assisting people with dementia to maintain their life skills. 4.7 Ensuring that patients with dementia are safeguarded. 4.8 Improving the experience of the carers of people with dementia</p>	

<p>5. What specific value can scrutiny add to this topic? To use the experiences of those who work closely with people with dementia (such as hospital managers, advocates, family / carers, charitable / voluntary organisations and the Older Peoples Parliament) in order to identify any changes which would lead to the outcomes listed in section 4 above.</p>																			
<p>6. Who will the Committee try to influence as part of its work? 6.1 Wirral University Teaching Hospital 6.2 Wirral NHS 6.3 Cheshire and Wirral Partnership NHS Foundation Trust 6.4 Department of Adult Social Services, Wirral Council 6.5 Appropriate Cabinet members, Wirral Council 6.6 Private sector residential and nursing homes</p>																			
<p>7. Duration of enquiry? Aim for the final report to be available before the Health and Wellbeing Scrutiny Committee due to be held on 10th November 2009</p>																			
<p>8. What category does the review fall into?</p> <table border="0"> <tr> <td>Policy Review</td> <td>X</td> <td><input type="checkbox"/></td> <td>Policy Development</td> <td>X</td> <td><input type="checkbox"/></td> </tr> <tr> <td>External Partnership</td> <td>X</td> <td><input type="checkbox"/></td> <td>Performance Management</td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Holding Executive to Account</td> <td></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> </table>		Policy Review	X	<input type="checkbox"/>	Policy Development	X	<input type="checkbox"/>	External Partnership	X	<input type="checkbox"/>	Performance Management		<input type="checkbox"/>	Holding Executive to Account		<input type="checkbox"/>			
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External Partnership	X	<input type="checkbox"/>	Performance Management		<input type="checkbox"/>														
Holding Executive to Account		<input type="checkbox"/>																	
<p>9. Extra resources needed? Would the investigation benefit from the co-operation of an expert witness? The review will be conducted by councillors with the support of existing officers. However, the panel are looking for advice from people with expertise on this topic.</p>																			
<p>10. What information do we need?</p>																			
<p>10.1 Secondary information (background information, existing reports, legislation, central government documents, etc).</p> <p>10.1.1 Recent Committee reports.</p> <p>10.1.2 Relevant evidence that arose during the Hospital Discharge Scrutiny Review.</p> <p>10.1.3 Relevant Department of Health documents, including the National dementia Strategy.</p> <p>10.1.4 Reports from other councils into similar topics.</p>	<p>10.2 Primary/new evidence/information</p> <p>10.2.1 Experience of carers / family members.</p> <p>10.2.2 Experiences gathered from support groups, charitable / voluntary organisations and the Older Peoples Parliament.</p> <p>10.2.3 Interviews with key officers.</p> <p>10.2.4 Relevant statistics on diagnosis and admissions of patients with dementia.</p>																		

<p>10.3 Who can provide us with further relevant evidence? (Cabinet portfolio holder, officer, service user, general public, expert witness, etc).</p> <p>Contacts may include: Carers and family members. Carers Groups Age Concern (including the Devonshire Centre) Sue Newnes (Alzheimer’s Society, Wirral) Other charitable / voluntary organisations Ken McDermott and other representatives from the Older Peoples Parliament,</p> <p>Wirral NHS Tina Long (Director, Strategic Partnerships) Debbie Mayer (Acting Deputy Director, Strategic Partnerships) Jenny McGovern (Integrated Commissioning Manager) Heather Rimmer (Interim Head of Integrated Commissioning and Mental Health)</p> <p>Wirral University Teaching Hospital Michael Monaghan (Director, Nursing and Midwifery) Lesley Hutchinson (Patient Flow Manager) Marie Jeffries (Lead nurse for Medical Directorate) DME Consultants</p> <p>Cheshire and Wirral Partnership NHS Foundation Trust Peter Cubbon, Chief Executive Avril Devaney, Director of Nursing, Therapies and Patient Partnership Dr Andrew Ellis, national expert</p> <p>Department of Adult Social Services, Wirral Borough Council Jeanette Hughes, Team Manager Pete Gosling, Principal Manager</p>	<p>10.4 What specific areas do we want them to cover when they give evidence?</p> <p>10.4.1 Current arrangements</p> <p>10.4.2 Areas for improvement</p> <p>10.4.3 Possible management of people with dementia outside the acute hospital setting.</p>
<p>11. What processes can we use to feed into the review? (site visits/observations, face-to-face questioning, telephone survey, written questionnaire, etc).</p> <p>11.1 Discussion with family / carers and support groups, etc..</p> <p>11.2 Desk-top analysis</p> <p>11.3 Interviews of staff</p> <p>11.4 Possible written questionnaire aimed at family / carers (similar to that produced on Hospital Stays by the Older Peoples Parliament)</p>	
<p>12. In what ways can we involve the public and at what stages? (consider whole range of consultative mechanisms, local committees and local ward mechanisms).</p> <p>12.1 Family and carers</p> <p>12.2 Relevant organisations, for example, Older Peoples Parliament, Age Concern and Carers groups</p>	

Appendix 2 : List of Witnesses

The Panel has employed a number of methods to gather evidence:

1. Meetings / Visits with officers

A series of individual meetings has taken place at which the Panel Members could discuss relevant issues with key officers from each of Wirral University Teaching Hospital Trust, Cheshire and Wirral Partnership Foundation Trust, Wirral NHS (PCT) and Wirral Borough Council. Meetings were also held with representatives of the Third Sector. Those interviewed during the course of the review were:

Wirral University Teaching Hospital Trust (Arrowe Park Hospital)

Alison Wilkinson (Ward Manager, Ward 22 – Department of Medicine for the Elderly – DME)
Andrew Swan (Adult Protection Lead)
Chris Kennedy (Directorate Manager, Emergency Care)
Chris Turnbull (Clinical Director, DME)
Dr John Russell (Consultant, Department of Medicine for the Elderly – DME)
Lesley Hutchinson (Patient Flow Manager)
Mike Brett (Ward Manager, Ward 37 – Medical / Respiratory)

Wirral NHS

Lisa Cooper (Clinical Director, Provider Services)
Tina Long (Director of Strategic Partnerships)
Debbie Mayor (Acting Deputy Director, Strategic Partnerships)

Cheshire and Wirral Partnership Foundation Trust

Dr Andrew Ellis (Clinical Director, Adult Mental Health Services)
Dr Mike Rimmer (Liaison Psychiatrist)

Wirral Borough Council

Pete Gosling (Principal Manager, Access & Assessment, Department of Adult Social Services)
Anne Bailey (HARTS - Service Development Manager, Department of Adult Social Services)
Jeanette Hughes (Team Manager, Department of Adult Social Services)

Third Sector

Myrtle Lacey (Chief Executive, Age Concern, Wirral)
Chriss Kenny (Senior Manager Care Services, Devonshire Centre)
Sue Newnes (Support Services Manager, Alzheimer's Society, Wirral)
Ken McDermott (Representative of Wirral Older People's Parliament and Carer)

2. Meetings with carers of People with Dementia

During the review, Panel Members aimed to learn from the experiences of those most closely involved in caring for people with dementia. Therefore, two focus groups involving groups of carers were held as follows:

Devonshire Centre, Age Concern – 26th November 2009
Lonsdale Centre, Alzheimer's Society – 21st April 2010

3. Written Evidence

Written evidence was received from a variety of sources. This included specific evidence received by email from the following:

Sandra Wall (Wirral Older People's Parliament)
Jean Maskell (Carers Representative, Wirral LINK)
Sheila Kennedy (Member, Wirral LINK)
Keith Troughton (Merseyside Fire & Rescue Service)
Julia Simms (Head of Medicines Management, NHS Wirral)

Appendix 3 : References

Wirral documents

'Dementia Services in Wirral', Report to Social Care, Health and Inclusion Overview and Scrutiny Committee, 24th November 2008.

'A Strategy for Services for Older People with Mental Health Needs', produced by NHS Wirral and Wirral Department of Adult Social Services, April 2009

Wirral Joint Strategic Needs Assessment, 2009/10, produced by Wirral NHS

Wirral NHS document 'National Dementia Strategy', which provides a response to the National Strategy for Wirral.

'Investment to help Wirral dementia patients', Wirral Borough Council Media Release, dated 11th February 2009

'Wirral to lead the way on new National Dementia Strategy', Wirral Borough Council Media Release, dated 27th June 2008

National reports

'World Alzheimer Report 2010: The Global Economic Impact of Dementia', Alzheimer's Disease International, dated 2010

'Dementia 2010: The economic burden of dementia and associated research funding in the United Kingdom' – A report produced by the Health Economics Research Centre, University of Oxford for the Alzheimer's Research Trust

'Living Well With Dementia: A National Dementia Strategy', Department of Health, published 2009

'Living Well With Dementia: A National Dementia Strategy – Implementation Plan', Department of Health, published 2009

'Quality outcomes for people with dementia: building on the work of the National Dementia Strategy', Department of Health, September 2010

'Acute Awareness – Improving hospital care for people with dementia', NHS Confederation, 2010.

'Counting the Cost – Caring for people with dementia on hospital wards', Alzheimer's Society, 2009

'Support. Stay. Save. – Care and support of people with dementia in their own homes', Alzheimer's Society, January 2011

'Improving Dementia services in England – an Interim Report', National Audit Office, 14th January 2010

'National Audit of Dementia', Interim Report, The Royal College of Psychiatrists, December 2010

Other Documents

'Dementia "losing out" to cancer in funding stakes', BBC website, 3rd February 2010

'Mental Health Intermediate Care team for Older Adults', Mental Health News, January 2010

Mental Health News, 'Dementia Care in an acute setting', Mental Health News, 14th July 2010 – referring to work undertaken at Leighton hospital, Crewe.

DH Care Networks website, 'CSED supporting successful Integrated Care and Support Pathway Planning (ICSPP)', 22nd February 2010

Appendix 4 : List of tables

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