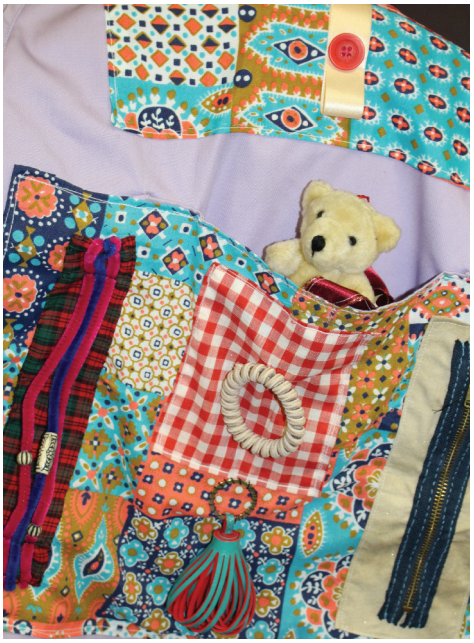
Luton and Dunstable University Hospital
NHS Foundation Trust

Dementia Strategy

2019 – 2021

NHS
Luton and Dunstable
University Hospital
NHS Foundation Trust



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Foreword

Our dementia strategy aims to support the Luton & Dunstable University hospital's key strategic objectives and has been developed using evaluation of services and patients and carers feedback.

- *Delivering integrated care providing the best care for our patients living with Dementia.*
- *Being a major emergency care centre delivering excellence in both surgery and acute medicine for our patients with Dementia.*
- *Advancing our commitment to training and teaching by developing staff skills, which will include access to the level of Dementia training appropriate to their roles within the Trust.*

The views of our patients and their carers have been considered throughout the document. Work has already been achieved over the past three years which has enabled the Trust to support our patients living with Dementia and achieve national benchmarking standards;

- ***Creating a positive dementia friendly environment:*** *we know that creating a Dementia friendly environment can support the person with Dementia to orientate themselves and feel calmer. Several wards and departments were awarded the Dementia Action alliance certificate to acknowledge their efforts in becoming a Dementia friendly environment.*
- ***Promote activities that improve the wellbeing of patients and carers.*** *We introduced a 'pat dog' session open to our patients living with Dementia.*
- *We continuously recruit into dementia support volunteer roles with the Trust.*
- *Some of our therapy teams have begun small group sessions on our elderly care wards offering reminiscence and social stimulation.*
- *John's campaign has been embraced by the Trust and allows the carers of a person living with Dementia to stay with them on the wards and in departments as they wish to do so. We offer support with concessionary parking and restaurant discounts for food and drink.*
- *We have participated in three rounds of the National audit of Dementia and utilised their analysis to develop improvements and actions.*
- *Delirium screening is currently a focus within the Trust. This has been accompanied with an awareness and staff education campaign to ensure the correct assessment and diagnosis leads to correct treatments and management.*
- *Dementia Pathways and guidelines have been developed and aligned with national recommendations and benchmarks.*
- *We recently introduced the 'Red bag' initiative as part of a local implementation plan which promotes the sharing of information between care homes and the acute sector.*

This strategy also aims to align itself with national strategy and recommendations; Living well with Dementia' (2009) and NICE guidelines 97 (2018). NHSi dementia assessment framework 2017.

	Preventing well	Diagnosing well	Supporting well	Living well	Dying well
Hospital admission					
In patient care					
Discharge from hospital					
Workforce training and culture					

Alignment with the NHS England transformation framework 'The well pathway'.

Introduction

Dementia is a progressive condition and there is currently no known cure although research continues to take place nationally and internationally. The term dementia is used to describe a range of conditions which affect the function of the brain. An individual can experience a progressive decline in many areas of function. The highest risk factor is for developing Dementia is age. As a result of the increasing prevalence of Dementia the government as identified Dementia as a major priority and challenge for health and social care.

It is well reported that people with dementia admitted to hospital experience longer length of stay and are more likely to be readmitted than patients without Dementia.

'Counting the cost' report by the Alzheimer's society (2009) highlighted that people with Dementia often leave hospital with poorer health and well-being than when they arrived.

The Prime ministers challenge on Dementia 2020 has set the standards of care for people living with dementia in hospital. The dementia action alliance has recently updated its 'dementia friendly charter' (2018) and supports and encourages organisations to work towards becoming dementia friendly.

Locally it is estimated that there are 1,670 people living with Dementia in Luton (2016), and a further 2087 within Bedfordshire. It is estimated that 1 in 14 of the general population over 65yrs has dementia. Figures suggest that 69% of care home residents have dementia or memory loss. The projected growth for the retired population in Luton is 40%, with a further growth for our very aged population at 91%. (ONS 2013).

Health Inequalities & Dementia

Black and south Asian ethnic groups: People in these groups are more prone to risk factors such as cardiovascular disease hypertension and diabetes which all increase the risk of dementia and contribute to higher prevalence. It is thought that people from ethnic minority groups are less likely to receive a dementia diagnosis for a number of reasons such as;

Difficulty in accessing services, poorer understanding and awareness, the stigma may be greater in some communities. Local primary care services and third party support services are trying very hard to address this issue in the local community.

Sexual identity is an area that is only beginning to be addressed in dementia. Studies have shown that 41% of older lesbian, gay and bisexual people live alone compared to 28% heterosexual people. It is identified that issues with sexual identity is sometimes leading to loneliness and isolation. Sexual identity is an area that is only beginning to be addressed in Dementia.

There are a number of dementia risk factors related to socioeconomic situations such as lack of activity and early year's education, loneliness and isolation and levels of poverty.

The main themes emerging from feedback we receive along with national guidance and standards have helped form the key objectives within the document. Within each objective there will be several ambitions to achieve. Progress will be mapped within a workplan and will be shared with the trust quality committee.

This is me earlier in admission great idea

Put music on

Working to become Dementia Friendly

More time for walking / avoid deconditioning

Hospital Admission

Where someone has a suspected diagnosis of dementia we will continue to work towards supporting improvements with a timely diagnosis as mandated by NHS England. As part of our admission assessment and screening we will continue to identify those patients who require further specialist assessment and recommend they are referred to the local memory clinic services. Supporting timely diagnosis when the patient wants it, or if the carer needs it.

Delirium screening on admission will help identify those patients with an acute episode of confusion. We aim to embed a Delirium assessment into our admission assessment Performa's. The management of patients with delirium will be guided by our locally agreed clinical guidelines for the diagnosis, assessment and management while in hospital.

When someone has an existing diagnosis of dementia we will continue to use an identifier symbol to alert staff to additional needs that may be managed.

Our ambitions: HOSPITAL ADMISSION

***We will** ensure we know as much as possible about the person with Dementia on admission by engaging with carer or the person living with Dementia to complete the 'This is Me' biography.*

***We will** continue to strengthen our systems to identify the person with Dementia.*

***We will** embed the appropriate assessment tools for delirium*

***We will** insure the correct assessments take place for those suspected of Dementia to support diagnosis in a non specialist setting as recommended by NICE.*

***We will** continue to offer a dementia friendly approach to care in our OPD.*

***We will** continue to work on our estates and facilities to insure a dementia friendly design is adopted where possible, which helps support people with dementia to orientate themselves to their surroundings and guides them around the ward to maintain their independence and avert distress.*

John's Campaign

Avoid too many ward moves

It would be good to have some sensory items as activities

Control the pain/ use of appropriate pain tools

Patient Care

Delivering a person centred approach to care using the VIPS model of care will be our continued aim (D.Brooker). During a patients stay in hospital it may be necessary to move wards for many reasons. We acknowledge this can cause further confusion or disorientation. we aim to keep any bed moves to minimum and base any decision to move a patient on clinical need and for the benefit of the patient only. We have developed enhanced care guidelines, which aims to provide the correct level of supervision to minimise risk. We know it is important to engage with people so aim to provide meaningful activities to stimulate our patients when the environment and situation is right for the person with Dementia. We will continue to recruit Dementia volunteers and encourage our independent support workers to engage. We acknowledge that eating & drinking difficulties are common in people with Dementia and can be made worse during a hospital admission. We have an established nutritional steering group who work on improving the experience for all patients and look at way to deliver nutrition in a dementia friendly manner. We have already developed risk feeding guidelines, and introduced the use of a finger food menu, picture menu and snacks with our protected mealtimes. During protected mealtimes we encourage the carers to visit; John's campaign is embedded in the hospital.

Behavioural and psychological symptoms of Dementia can be distressing for patients, staff and families. We have a Psychiatric liaison service available for in-patient referrals. Managing distressed behaviours forms part of our training programme to enable more meaningful activity. We acknowledge that antipsychotic medications can have a significant effect on person with Dementia.

Dementia is a life limiting illness, it is important to have conversations about end of life care so that patients and caregivers have the opportunity to discuss and make decisions in the final stages of their illness. Unfortunately people living with Dementia are admitted to hospital at the end stages of their illness and conversations about their wishes have not always been timely. The hospital will continue to identify people living with Dementia who are in the later stages of the disease and work with community care services to support on-going palliative care where required.

Our ambitions: IN-PATIENT CARE

We aim *to promote a Dementia friendly environment.*

We will *continue to work with our palliative care teams to provide adequate discharge support for those identified in end stages of their disease.*

We will *minimise and manage ward and bed moves only if clinically indicated*

We will *support staff to deliver and manage pathways for Behavioural psychological symptoms in Dementia.*

We will *support and facilitate meaningful activities on the wards to promote wellbeing.*

We will *support additional needs identified during outpatient visits.*

Discharge From Hospital

Discharge from hospital is often complicated. The preference is often to return home, however in some cases the risk is deemed too high and further MDT assessments are required to determine the most appropriate place for discharge. These decisions will only occur under the guidance of the Mental Capacity Act 2005.

Third sector agencies can provide support in the community for those with Dementia and carers. We have established good links with these services and continue to utilise them where appropriate. The dementia nurse continues to work with these agencies to build supportive links

Our current aim is to plan a timely discharge. This is facilitated by planning discharge from point of admission, and involving the carers of people with Dementia where appropriate. Many wards offer appointments with the lead consultant and all ward areas have a discharge coordinator as a point of contact. All wards hold daily ward meetings to plan the on-going management of patients and their discharge.

The importance of sharing relevant information with care homes and utilising the national initiatives such as '**Red Bag**' have been implemented in conjuction with the local clinical commissioned groups.

If we suspect a likely Dementia diagnosis we are guided by our locally agreed pathways and make recommendations in our discharge letters to the GP for referral to the local memory assessment services. If our Psychiatric liaison service has been involved in the assessment or management of a patient they will ensure the correct follow up in the community is arranged. The Trust has links with community services and third party provision as required for signposting.

Our ambitions: DISCHARGE FROM HOSPITAL

We aim to keep hospital admissions as short as clinically possible, for the benefit of the person with Dementia.

We aim to promote a safe 'at home first' approach by positive risk taking to enable the person with dementia to be as independent as possible.

We aim to promote the continuity of care by coordinating and providing good levels of communication with community services.

We aim to ensure that discharge is efficient and aim to get the person with Dementia home earlier in the day.

We will support carers by providing post discharge connections with on-going care giving services.

We will arrange for palliative support where required and encourage GP's to consider Gold standards framework to enable advanced care planning and hospital avoidance plans to be developed in the community.

Workforce Training and Culture

The Prime Minister's challenge on Dementia specifies that by 2020 all NHS staff will have received dementia training appropriate to their role. The Dementia core skills and education framework HEE 2015 helps support these aims. Currently our Tier 1 basic awareness is incorporated on our induction programmes. Our Tier 2 training is aimed at developing current staff knowledge and skills for those staff who have daily contact with people with Dementia. The current training supports the care certificate and Preceptorship programmes at tier 1 training.

Tier 2 training is available monthly, this includes face to face training along with simulation and workbooks to supplement the learning. Electronic learning is encouraged by all staff using our e-learning systems (e-lfh).

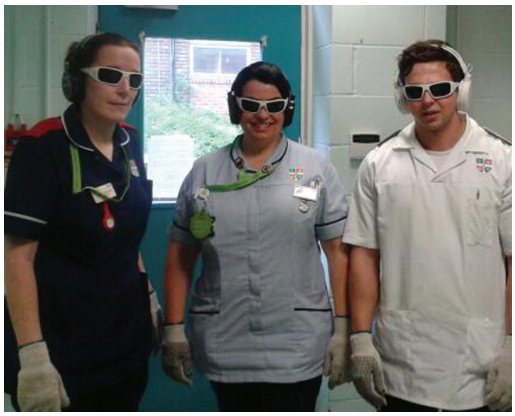
Our ambitions: **WORKFORCE TRAINING AND CULTURE**

To have identified Dementia champions in each clinical department or ward area.

To provide 'dementia friends' sessions for non clinical staff.

We will continue to facilitate mandatory training programmes.

We will develop and maintain an education programme to meet the requirements of the HEE framework.



Dementia strategy References

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Where we are now	Where we want to be Year 1 – Dec 2019	Where we want to be Year 2 – 2020	Where we want to be Year 3 - 2021	How will this be measured?
Hospital admission We have an identifier in place and ask carers to complete biographical information on admission to hospital. In order to support timely diagnosis of Dementia we continue to screen all over 75yrs on admission (>72hrs) to hospital and identify the person living with Dementia. We have established a delirium strategy group to improve the awareness and recognition of Delirium for all patients.	Continue to monitor the use of the butterfly and 'This is me' biography as a quality marker and report. Develop guidelines for patients who are diagnosed with Dementia while in hospital to insure the correct follow up and referrals are made. Add Delirium awareness to the staff education programmes for all clinical staff groups. Provide a recommended assessment for Delirium in our hospital admission proforma. Insure medical staff are utilising correct asesments.	Commence carer support sessions on a fortnightly basis. Review benefits of using this system of feedback (if time resources allow) Work in collaboration with primary services to support hospital avoidance plans for people living with Dementia. NAD fifth round	Pilot an alternative method of biographical information and gather feedback from staff and carers. Complete a Delirium audit. Design alternative methods of sharing information that is important to the person with dementia.	Monitor the numbers of Delirium diagnosis in hospital. Outcomes and feedback from co-productive workshops & actions taken. National Audit of Dementia 5th round. Delirium audit.

Where we are now	Where we want to be Year 1 – Dec 2019	Where we want to be Year 2 – 2020	Where we want to be Year 3 - 2021	How will this be measured?
Patient care Nursing staff are taught how to utilise the biographical information to guide and influence the person centred careplan. Nursing staff are made aware of VIPS model of care during their mandatory training programmes. The implementation of our enhanced care guidelines has improved the risk assessment and identification of patients requiring close supervision. Staff training includes advise on the management for challenging behaviours. We continue to seek feedback from our patients and carers form across the Trust. Dementia nurse specialist continues to support clinical staff in recognising end stages of Dementia and future management. Outpatient departments are working to become Dementia friendly; offering earlier appointments, identification at arrival, additional support if required.	Continue to consider new methods of distraction for use by staff. Support staff through education and training in understanding behavioural symptoms and how to manage them in a safe way. Provide ward based learning. Continue with charitable fund raising for resources to deliver improvements in the environments and resources. Support staff to deliver person centred care by focusing on VIPS model of care. Work with community groups to seek feedback. Co-productive workshops Bi-annually to review the local patient pathways. Establish the numbers of patients with Dementia being identifies as end stages and on palliative pathways while in hospital or on discharge. Any future ward or department refurbishments will include dementia friendly design features and improving the environments for people with Dementia. Audit ward moves to establish if this is a current issue for our patients with Dementia.	Work with therapy staff to include group therapy and activities on the wards. Audit staff training & feedback Encourage fundraising activities on wards. Develop new goals for Dementia care fund and consider a big build project for a dementia lounge/garden. Have carer involvement on PLACE inspection teams and representation on dementia steering group. Improve the recognition of end stage dementia and insure correct discharge planning is arranged. NAD fifth round Minimise ward moves unless clinically required. Re audit.	Review the current pathway for pre surgical assessment and elective care. Re-visit out patients clinics for update and staff involvement.	Monitor activities on the wards. Patient experience & feedback. Carer feedback. Staff questionnaire. Numbers of patients with Dementia referred to palliative care team to increase. Average number of bed moves to remain at 2. Action plan progress following the recommendations from NAD fourth round PLACE Results of NAD spotlight audit on psychotropic medications. Outpatient user feedback.

Where we are now	Where we want to be Year 1 – Dec 2019	Where we want to be Year 2 – 2020	Where we want to be Year 3 - 2021	How will this be measured?
Discharge from hospital We have a system in place which involves appropriate social services referrals as part our discharge planning and in more complex cases our community liaison teams assist with CHC assessment and support placements where required. This is governed by the legal frameworks of the mental capacity Act. Close links with third party and voluntary sector is established for local areas for signposting and additional support. We have already implemented the red bag scheme within the trust to support information sharing. Diagnosing in hospital is rare but referrals are made to the dementia nurse specialist to provide follow up information and guidance.	Improve referral mechanisms for community follow up with Dementia services. Work with local CCG's on the continued use and development of the Red Bag initiatives. Develop and implement a delirium passport to support those patients being transferred into a health monitored bed.	Take part in NAD fifth round Carry out a telephone follow up calls to carers to establish any issues. Review delirium pathway Review MCA audit by safeguarding team to identify any areas	Review complaints. Develop an action plan from NAD fifth round published recommendations	Root cause analyse from delayed transfer of care audit. User feedback. Increased collaborative referrals into and out of the acute sector. NAD Action plan review from MCA audit. Feedback from Delirium health bed facilitators.

Where we are now	Where we want to be Year 1 – Dec 2019	Where we want to be Year 2 – 2020	Where we want to be Year 3 - 2021	How will this be measured?
Workforce training and culture We have developed a training programme to support the recommended learning outcomes within the national knowledge and skills framework. Ward hostess training has been provided, linking the finger foods and picture menus with the person with Dementia. Harms free training linking dementia care , falls management, continence and pressure area care.	Identify Dementia champions in each department. Establish and refresh an alternative approach to identifying the Dementia champions on the wards. Utilise the group email system for dissemination of information to the Dementia champions. Hold three Dementia friends' sessions. Promote collaborative approaches to harm free care by providing 'harm free clinical study sessions.	Take part in NAD fifth round Offer Dementia friend's sessions aimed at non clinical staff. Develop a standard training programme for hostess and domestic staff. Review current training programmes alignment with National framework. Identify a carer or patient to support our training programme. Hold three Dementia friends sessions	Hold a dementia champions training day to consolidate good practice in each area. Review training programme. Hold three dementia friends' sessions.	ESR training records to reflect training offered. Numbers of dementia champions on each ward. Number of dementia friends to increase.