The Geller Commission: Consultation to reduce unwarranted or avoidable dementia-related hospital occupancy in England.

Consultation questions

Pre-admission

- What are the main reasons for hospitalising a person living with dementia?

  Fellows identified a range of reasons for hospitalising persons living with dementia including behavioural issues associated with dementia such as agitation or wandering. In addition, infections, for example in urine or chest are strongly associated with secondary delirium and exacerbation of dementia symptoms.

  Other factors include carer stress - when family members feel that they can no longer cope with the needs of the person suffering from dementia; and other breakdowns in care support, for example when the spouse who is the main carer is admitted to hospital and the partner with dementia accompanies them in the ambulance as it is felt to be a risk if they are left at home or where behavioural and psychological symptoms of dementia (BPSD) have caused a breakdown in care and where reassurance is sought that there is not a physical health issue driving the deterioration.

  Unrelated physical health issues e.g. pneumonia, intestinal obstruction (often from simple constipation), fractured hip etc will of course also necessitate admission whether in a person living with dementia or not.

- What additional resources and support do carers and families need to prevent hospitalisation?

  Fellows suggested that a range of additional resources and support for carers and families are required. They consider that improved “sitting services” to allow relatives/carers to leave the house regularly are necessary as well as regular funded respite for people living with dementia and improved telehealth access to ensure safety when carers/families are not present.

Some Fellows identified the need for carers and families to be able to access a Proactive Rapid Response psychiatry service that can step in and intervene when BPSD develop.

Where care breaks down but the person living with dementia is unchanged from their baseline "normal" there needs to be ready access (24hrs) to emergency care support without conveying to hospital. This is important as transfer to hospital, a new environment, often leads to further deconditioning and a longer hospital stay.

- <u>What additional resources and training do hospitals and healthcare professionals need to prevent avoidable admissions?</u>

  Fellows consider that awareness has greatly improved over the years but often we still do not have rapid access to increased support for people with dementia, whether it be for admission avoidance or enhanced discharge. Where support does exist, there is sometimes lack of awareness of the service or how to access it. Fellows support efforts to increase the awareness of, and ability to rapidly contact, those community services which could take on the care of people with dementia on discharge. In addition, access to community social work to access packages of care rapidly to reduce the inpatient stay and ensure that there is a safety net of care on discharge is essential.

  Community old age psychiatry teams/mental health teams must be adequately staffed and resourced. They can assess and review people with dementia on discharge and must continue input over the longer term rather than discharging the patients from their caseloads as happens often at present.

- <u>What do you think could help in reducing avoidable hospitalisations?</u>

  Again, adequately staffed and resourced Community old age psychiatry teams/mental health teams who can assess and review people with dementia on discharge and continue input over the long term rather than simply discharging the person from their caseloads as happens at present are essential.

  Respite facilities in the community setting must be expanded and additional provision of community bed facilities specific for people with dementia in need of assistance– similar to learning disability units – where one to one urgent respite can be provided at short notice.

  GP teams who know the patients and their circumstances need to be able to rapidly access community services to avoid admission.

  Support for residential care (and to some extent nursing) homes when care needs of residents increase – again particularly around development of behavioural issues related to dementia – is required in order to avoid "crisis admissions" when care homes have been trying to escalate concerns about inability to manage care needs.

- What are the best approaches to preventing hospitalisation?

  Teams in the community (mental health/social work) providing ongoing input and accessibility to people with dementia after a diagnosis of dementia are extremely important.

  As referenced above, dedicated respite facilities, local to the person, to allow rapid access respite when a crisis is developing are also essential.

  More generally, extra focus is needed on earlier diagnosis and referral to post diagnostic support. This will require an increase in old age psychiatry resource and memory clinics.

- Do you have examples of good practices from which we could learn?

  One Fellow highlighted that in a previous area he worked there was a jointly managed ward between old age psychiatry and geriatric medicine for people with dementia and suggested this worked well for people with delirium and dementia who needed admission and shortened hospitalisation. He also wished to recommend the University of Stirling's Dementia Services Development Centre (https://www.dementia.stir.ac.uk/) and information provided by the British Geriatrics Society: https://www.bgs.org.uk/dementia-delirium-and-brain-health

Integration & Care Planning

- What are the barriers to needs assessment and the creation and delivery of care plans for people living with dementia?

  Fellows referred to their experience of seeing an exponential rise in the number of people with dementia without associated resource back up e.g. in social care and community mental health teams.

  Some Fellows also cited a lack of earlier recognition and diagnosis and ongoing stigma associated with 'dementia'.

- What specific aspects of care within our hospitals can be improved to support people living with dementia?

  Fellows had a range of ideas in this area. They felt it was important to ensure that all healthcare staff who may encounter people with dementia in the hospital setting have training in the management and care of people with dementia and delirium.

  Fast track pathways for people with dementia to be placed on the appropriate ward/unit or discharged home with appropriate community back up and support were fundamentally important.

Teams trained in specific care of people with dementia/BPSD/Delirium (liaison psychiatry / Mental Health nurses) must have a significant presence in all general/acute hospitals.

"Acute Delirium Units" akin to "Acute Stroke Units" to manage those with dementia and superimposed delirium, ensuring that the environment and care provided is optimal, are necessary.

Social work teams should be based on wards in hospital to work with hospital teams and families to access appropriate care if and when needed. Fellows in Scotland indicated that most social work teams are now community based and not ward or hospital based.

Funding for appropriately trained activity co-ordinators which would improve distraction therapy or reminiscence therapy for patients and in turn free up nursing staff is considered important also.

A laser like focus needs to remain on rapid and effective discharge with appropriate support, when medically ready, to prevent deconditioning / delirium.

- What steps do you think need to be taken to improve the diagnosis of dementia for people once they are in the hospital and the support they receive after a diagnosis?

  Training for those integrally involved in the care of people with dementia in hospital (e.g. geriatricians) to make the diagnosis of dementia and start treatment when appropriate is of course essential. This would include providing ancillary support to perform detailed cognitive assessments as inpatients. Also training of those in the front line is essential to identify dementia in paopel presenting with acute clinical problems whi=o may have underlying, undiagnosed dementia.

  Consideration should also be given to establishing roaming 'Cognitive Assessment Teams' in acute hospitals – comprising, for example, a clinician psychologist and occupational therapist (OT) trained in memory assessment while people are in hospital.

- How can community services improve how they collaborate with hospitals throughout the patient journey?

  Building on some of the comments above, Fellows wished to emphasise their desire to see social workers based in hospital units, mental health teams working in acute and general hospitals and joined up computerised systems that link GP notes, social work notes, mental health notes, and acute hospital notes.

- Do you have examples of good practices from which we could learn?

Simplification

- How can technology be used to identify and improve clinical bottlenecks for discharge?

  Linking all IT systems between hospital services, psychiatry, general practice and social work is necessary to improve shared learning, provision of information and reduce repetition.

  People living with dementia and their families should also have quick access to technology (infra-red door alarms / camera systems / RING equivalent doorbells) for patients' homes to improve safety at home.

- How can transportation services better support the discharge process?

  Fellows emphasised that the transportation for people with dementia going home must occur early in the day so they have the ability to be orientated with their home environment in daylight. Transportation services also needed to be adequately resourced to better support a timely discharge process.

- How can carers and families be better supported throughout the patient journey?

  Fellows indicated there should be provision of support staff who work across the hospital and can engage in community interface with knowledge of social work systems / access to grants / access to charity support (e.g. Alzheimer's Society).

- Do you have examples of good practices from which we could learn?