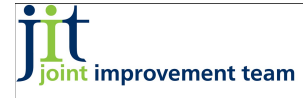




The Dementia Services  
Development Centre



# **Role and Contribution of Intermediate Care in Supporting people with Dementia**

**Report from the Conference on the Role and Contribution of Intermediate Care  
in Supporting People with Dementia Conference**

**Organised by the Joint Improvement Team with the Dementia Service  
Development Centre, University of Stirling**

## **INTRODUCTION AND OVERVIEW**

This report summarises the presentations, discussions and ideas which emerged from the Role and Contribution of Intermediate Care in Supporting People with Dementia Conference held on 12 October 2009 at the Dementia Service Development Centre, University of Stirling in Stirling. The Joint Improvement Team and the Dementia Service Development Centre hosted the event which was attended by planners, managers and practitioners from health, housing and social work.

The purpose of the conference was to share some of the work underway across Scotland, and beyond, to support people with dementia. The conference also aimed to explore how we develop and deliver a range of intermediate care services to prevent avoidable admission to hospital, enable timely discharge from hospital, delay admission to long term care and improve outcomes for people with dementia and their carers. A number of areas relevant to dementia care were covered during the day.

The event was chaired by Professor June Andrews, Director of the Dementia Service Development Centre with introductory remarks from Margaret Whoriskey (JIT). It commenced with an overview from Professor Jane Gillard on the development and implementation of the National Dementia Strategy for England. Geoff Huggins from the Mental Health Division, Scottish Government then set out how the dementia strategy for Scotland was being developed. Alison Thompson from the Mental Welfare Commission and Alison Rees from the Care Commission then discussed the findings, key messages and recommendations from the Remember, I'm still me report on the quality of care for people with dementia living in care homes in Scotland. There followed a brief discussion and question and answer session on the topics from the morning.

Delegates were then asked to take part in a series of parallel sessions prior to and after lunch.

Following the parallel sessions, the afternoon session commenced with a presentation by Professor Alasdair MacLulich, Professor of Geriatric Medicine at the University of Edinburgh on Delirium and unnecessary new institutionalism of older people and could intermediate care help prevent this? Dr Emma Reynish, Consultant Geriatrician, NHS Fife followed by discussing intermediate care and dementia in the Fife area. A panel discussion on what can we contribute towards improving the care of people with dementia then took place. Professor June Andrews then thanked the delegates for their engagement during the day.

## **ABOUT THE REPORT**

The report provides an overview of the presentations from the day and summarises the views and comments from the discussion sessions in the morning and afternoon.

The views and opinions contained in the report are those expressed by the delegates and speakers attending the conference in their personal capacity. Speakers' presentations are available on the JIT website.

## **Acknowledgements**

The conference was funded by the Joint Improvement Team and organised by JIT and the Dementia Services Development Centre.

## MORNING SESSION: OVERVIEW OF PRESENTATIONS

Living Well with Dementia – the National Dementia Strategy and the Role of Intermediate Care Services

*Professor Jane Gillard National Dementia Strategy Programme Manager*

Professor Gillard provided an overview of the Department of Health Living Well with Dementia strategy (available at:- <http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/NationalDementiaStrategy/index.htm>) and commented on the prominence of dementia as a priority now in the UK, Europe and wider. The DoH strategy is relevant to all people with dementia wherever people are – at home; care home; hospital; prison and the underpinning vision is for :

*‘People with dementia & their carers helped to **live well** with dementia, no matter what the **stage of their condition** or **where they are** in the health & social care system’.*

There are 4 key themes :

- Raising professional and public awareness and understanding
- Early diagnosis and support
- Living well with dementia
- Delivering the National Dementia Strategy - Making it Happen

The key themes are supported by 17 objectives:

Objective 1: **Awareness and understanding**

DH website - dementia portal  
Public awareness campaign

Objective 2: **Early diagnosis and intervention**

Target commissioners  
Baseline review of all services

Objective 3: **Information**

Alzheimer’s Society review

Objective 4: **Easy access to care - dementia advisor**

Demonstration sites

Objective 5: **Peer support and learning networks**

Demonstration sites

Objective 6: Community **personal support** services

- evidence of early intervention versus intensive community support;  
specialised versus generic services

Objective 7: Services within the **carers** strategy  
Working with Carers Strategy team

Objective 8: **General hospitals**  
Leadership and workforce

Objective 9: **Intermediate care**  
Refreshed guidance issued with more focus on dementia

Objective 10: **Housing, housing-related and telecare** support  
Think Tanks involving policy makers; practitioners; academics – what  
guidance needed re role and contribution of extra care housing?

Objective 11: **Care homes**  
Workforce

Objective 12: **End of life care**  
Working with End of Life Care Strategy programme

Objective 13: **An informed and effective workforce** across all services  
Review of training and education needs and gaps

Objective 14: **Joint Commissioning Strategy**  
Published Joint Commissioning Framework  
Procurement guide

Objective 15: **Improved assessment and regulation**  
Working with Care Quality Commission

Objective 16: **Research and evidence**  
Research Summit 21 July – Cause, Cure and Care

Objective 17: **National and regional implementation support**

There are 7 priority areas, which all have a link with intermediate care, focusing on:

Early diagnosis

Improved personal support for people in own homes

Support for carers

Support for people with dementia in acute hospitals and care homes

Developing the workforce

Commissioning

## **Implementation Programme -**

- **Two year programme of implementation support** (within this Comprehensive Spending Review)
- **Designated national lead for each Objective**
  - Work with national bodies and/or across regions
  - Project plans for each Objective to be published
- **Regional implementation programmes**
  - Regional partnerships with Strategic Health Authorities, Joint Improvement Partnerships, Alzheimer's Society, Association of Directors of Adult Social Services etc
  - Agree regional priorities
  - Support to localities

## **Intermediate Care**

Revised guidance published August 2009 as part of Prevention Package

Definitions: -

- Targeted at people who would otherwise face prolonged hospital stays or inappropriate admission to acute inpatient care, long-term residential care or continuing inpatient care
- Provided on basis of comprehensive assessment
- Planned outcome
- Time limited
- Involves cross-professional working. Inclusive of older people with mental health needs
- "Appropriate rehabilitation therapies with people with dementia and physical health needs have been shown to be successful in enabling them to return home and to stay out of institutional care"
- Shared working protocols
- Differences of interpretation or priorities best managed by collaborative review of service operation
- Reviews should take place at regular intervals

## **Commissioning Intermediate Care**

Commissioning decisions based on measures such as: -

- Number & occupancy of beds in acute, community and care home settings
- Rates of emergency admissions to hospital of people aged 75+
- Costs of occupied bed days
- Average length of stays for certain conditions, inc dementia

- Rates of new admissions to care homes
- Number of repeat admissions of people over 75 to hospital/care homes
- Discharge locations from acute care of people over 75
- Locations of people 3 & 6 months after leaving intermediate care
- Number of people receiving intensive home care

The strategy includes a number of case studies relevant to supporting people with dementia.

Jane concluded her presentation by posing a number of questions to be considered:

Do you know the need of your local population? Can you answer the commissioning questions?

What would good quality intermediate care for people with dementia look like? Is your service fit for purpose and fit for the 21st century?

Are people with dementia involved in the development and delivery of intermediate care locally? Is their involvement real and meaningful?

What outcomes do people with dementia want from intermediate care?

What outcomes do carers want from intermediate care for people with dementia?

What outcomes do commissioners want? Are the answers to these 3 questions compatible?

## Dementia Strategy for Scotland

*Geoff Huggins, Mental Health Division, Scottish Government*

Geoff Huggins set out the work underway to develop a dementia strategy for Scotland with dementia now identified as a national priority.

This builds on work to date in relation to

- Integrated Care Pathways – accreditation underway with planned second stage to be in place by 2011
- HEAT targets relating to diagnosis which connects to follow up interventions, physical checks, carers assessment etc.
- Mental Health Collaborative to support local areas

There are 5 workstreams focusing on:

1. Treating and Managing Challenging Behaviour and use of medication
2. Assessment and diagnosis and pathways building on the ICP

3. Improving general hospital response
4. Rights, dignity and personalisation
5. Health improvement and public attitudes

It is expected that initial proposals from these groups will be available in January 2010 and strategy in place by the end of April 2010.

Consultation is underway on work in progress and a national stakeholder event has taken place in December.

## **Remember I'm still me**

### ***Alison Thompson, Mental Welfare Commission and Alison Rees, Pharmacy Adviser, Care Commission***

Alison Thompson began by giving some background to the report "Remember I'm still me" which was published by the Care Commission and Mental Welfare Commission in May 2009.

The report is the result of a series of unannounced visits to 30 care homes in Scotland. The visits were organised because concerns had been raised about a number of aspects of care, including the use of medication in care homes. Whilst the purpose of the visits was not to focus on intermediate care or dementia, she hopes that the key findings and recommendations can relate across care homes into all aspects of care, including services for people with dementia. She noted that 40% of people in care homes have a diagnosis of dementia.

The visits focussed on 10 areas of care in detail.

Examples of some of the key findings included;

- Health and social care were making good assessments before admission, but these were not being actively used within the care home.
- Individual preferences of residents were not being recorded and only 24% were found to have adequate recording of life history in their notes.
- Care reviews, whilst happening on a regular basis, seldom included the individual. There was little evidence of ongoing involvement from social work or GPs, with GP and AHP visits predominantly being reactive in nature.
- Activity for residents outside the care home is minimal with half of all people never going out.
- There is poor awareness of financial and guardianship options and the use of resident's funds to improve quality of life was not evident in the majority of cases.

Alison Rees then went on to give some detail on the medication findings.

They reviewed 1,335 medication records and 130 personal plans focussing on records, administration of medication and challenging behaviour and use of medication.

Examples of the findings:

Poor recording of ordering, use of medication and disposal of medication.

75% of residents are taking one or more psychoactive medicines.

33% of residents are taking anti psychotic medicines.

Anti depressants are the most common drugs prescribed, with many residents receiving an anti depressant with a sedative effect.

Many residents had been on the same medication for some time.

Summing Up:

10 key messages for care in care homes

1. Know the person as an individual.
2. Activities should be an integral part of life in a care home.
3. Environment should be improved.
4. Money management requires improvements.
5. Healthcare must continue to be assessed.
6. Regular review of medication by GP & Pharmacist.
7. Use of medication for challenging behaviour must be a last, not first resort.
8. Freedom of individual must be respected.
9. Medical treatment must be in line with the law.
10. Staff must be competent to provide care.

Additional recommendations for medication use included:

- Improvements to pharmacological guidance
- Reviews of medication
- Prescribing and guidance must be in line with best practice

The Scottish Government has agreed to use these findings to inform the development of the dementia strategy.

The Mental Welfare Commission will follow up on individual cases identified as part of the review.

The Care Commission will follow up with requirements for each individual care home.

## **Morning panel discussion:**

The main points from the morning panel discussion were:

There is an opportunity for the dementia strategy to focus on the role and contribution of intermediate care.

Stigma and fear of dementia is an issue for older people – also concerns about lack of services and support. This needs to be addressed through effective information and support for individuals and carers.

There are issues relating to application of AWI (Part 5) in general hospitals.

Better information is required re admissions to hospitals etc – need to include dementia as ISD code.

The objective is to change the system but how do we implement changes to the system?

Although you always hear about the bad stories of care for people with dementia, there are many good stories and positive progress is being made

## **KEY POINTS/ISSUES FROM PARALLEL SESSIONS**

### **Parallel Session 1 : Care Pathways**

#### **Facilitators : Anne Hendry and Duncan Mackay**

Anne and Duncan gave an update on the Pathways workstreams that are part of the national Reshaping Care for Older People programme and the emerging Dementia Strategy. Anne proposed a central role for Intermediate Care in supporting older people with dementia to return or remain at home. Delegates discussed the challenges and opportunities in implementing this model of care within Partnerships and how it would interface with other community and specialist services.

Key issues and potential solutions discussed included:

#### **Workforce development and balance of generic and specialist models**

- Build confidence through staff training and development, including opportunities for job shadowing between intermediate care teams, specialist community mental health teams, falls teams and out of hours services.
- Use the NES / JIT Intermediate Care Capability Framework
- Specific training on dementia and delirium for staff and unpaid carers
- Home carers and untrained staff provide support across all care groups yet professionals often restrict their scope to specific care groups. Needs robust dialogue and more extensive use of skill mix.

**Budget tension between prevention and complex care - Potential for eligibility criteria for Free Personal Care to increase focus on complex care at expense of low level interventions.**

- Build community capability and make more effective use of the community and voluntary sector, volunteers and befriending.
- Learn lessons from Local Area Co-ordination developed for people with Learning Disability and from North Lanarkshire's Locality Link Officers that act as navigators, advocates and enablers for participation.
- Make more use of Personal Budgets to help people have more control

### **Carer Needs**

- Build support for carers into planning of services, particularly through extended hours, overnight care
- Design more flexible models of day care and day opportunities

### **Assistive Technology / Telecare**

- Telecare solutions help manage risk but staff and family carers need support and training to build confidence.
- Greater public dialogue over acceptable risk and maximising capacity

### **Housing models**

- Sheltered housing offers a suitable environment when people can't be managed in their own home

### **Sustainability**

- Mainstream intermediate care where safe and appropriate to make best use of community resources
- Better joint working between professions and agencies
- More use of joint teams and generic support workers

## **Parallel Session 2: Models of Intermediate Care**

Both presentations offered a helpful – and interestingly similar model of location of intermediate care within the health and social care matrix of services. See slides

Points of note from discussion

- Understanding of the range of intermediate care service provision remains limited for many. A number of participants believe intermediate care to be a bed based model when this is not the case with several partnerships having established or developing community intermediate care services.

- Importance of identification of intermediate care outcomes and their influence on health and social care performance indicators.
- Leadership/champions and location of services can significantly influence the success of integrated working and the effectiveness of an intermediate service.
- Organisational, professional and clinical silos remain a barrier to redesign of services in many areas.
- Workforce development including capability in managing people with dementia within mainstream intermediate care is key. Some examples of how partnerships are doing this include, reflective practice days, joint development programmes, and use of locality link officers. The Intermediate Care Capability Framework was also recognised as a tool which can be used.

## **Parallel Session 4. Therapeutic Approaches**

**Facilitator : Margaret Whoriskey**

***David Findlay, Consultant Psychogeriatrician, NHS Tayside  
Ken Laidlaw, Consultant Clinical Psychologist, NHS Fife and  
Edinburgh University***

***Andy Shewan, Old Age Psychiatry Liaison Nurse, NHS Tayside***

The role and contribution of therapeutic interventions for people with dementia in hospital and community settings was explored with a focus on multidisciplinary approaches and psychosocial interventions.

The presentations set out the contribution of therapeutic approaches in relation to direct treatment with individuals; consultancy and advice to primary care and acute hospital teams and as members of multidisciplinary teams.

David Findlay set out a number of assumptions:

- The higher up this hierarchy any therapeutic intervention can be made the more likely it is to be successful
- More than one strategy can be pursued simultaneously
- Dialogue more effective than checklist

He stressed the

- importance of effective diagnosis and exclusion of delirium; physical problems, drug toxicity and consideration to depression and anxiety.
- It is important to have a focus on individual, carer and environment.
- Approaches to include psychological relating to behavioural issues; pharmacological for review of medication and use of psychotropic medication etc; environmental to assess physical environment and level of stimulation.

- It is important to include a focus on recreational /diversionary activities and alternative therapies.

Ken Laidlaw focused on psychological approaches and evidence from research studies

- There is good evidence of the effectiveness of psychological approaches in treating mild to moderate depression in older people although very limited evidence around older people with dementia in this regard.
- There is good evidence of the effect of 'active' psychological interventions for care givers of people with dementia. Cognitive Behavioural Therapy works best at reducing distress with individual interventions more effective than group. Studies show that effective care giver psychological interventions can reduce /delay long term admission to care home.
- Decreased Quality of Life in Dementia is associated with behavioural and Psychological disturbance rather than cognitive impairment (Banerjee *et al.*, 2006)
- Sign (86) guideline suggests "Multilevel behaviour management interventions may be more effective than individual interventions at improving behaviour and well-being in people with dementia"
- Fossey *et al.*, (2006) demonstrated that training support interventions for nursing home staff in dealing with challenging behaviour resulted in a reduction in the prescription of neuroleptics.
- Bird *et al.*, (2002) systematically evaluated a psychosocial intervention for challenging behaviour in dementia and demonstrated a 42% improvement in behaviour

Ken Laidlaw described a challenging behaviour service in Newcastle that works directly with care givers to prevent breakdown in care arrangements.

He concluded by stating that we have a lot of work to do to ensure that older people with dementia are not excluded from intermediate care services and have access to appropriate therapeutic approaches.

## **AFTERNOON SESSION: OVERVIEW OF PRESENTATIONS**

### **Intermediate Care and Dementia: Predicting the Local Burden**

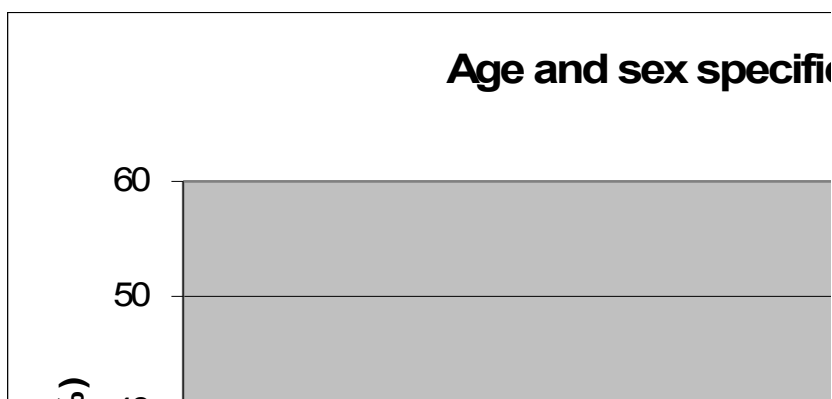
***Dr Emma Reynish, Consultant Geriatrician, NHS Fife***

Emma presented results from the European Collaboration on Dementia and translated these to the context of the local population in Fife:

- Number of people with dementia predicted from EUROCODE: 5748
- Number with dementia currently on GP database: 2211
- Gap represents undiagnosed dementia (about 60%)
- Up to 2/3 of the population with dementia are over the age of 80 yrs

- A large number of people with dementia lack a formal diagnosis

She then described the finding of the ICTUS study : a longitudinal observational study of treatment and management across Europe in 1380 people with Alzheimer's disease. At baseline this group were a mean of 0.4 years from diagnosis, mean age 76 years and had mean MMSE of 20.5. Only 11% lived alone. Many had other health problems such as high blood pressure (39%), diabetes (12%) or a history of falls (18%). Around a quarter suffered from depression. Most needed only minimal assistance with basic Activities of Daily Living. Neuropsychiatric symptoms associated with challenging behaviour were not common in the majority of people with mild to moderate Alzheimer Disease.



Emma shared data from 159 65+ emergency admissions to Victoria Hospital. These represented around 20% of the over 65 emergency admissions. 42 (26%) of the 159 people assessed had AMT score of 7 or less, likely to have dementia. Only 7 of these people (17%) had an established diagnosis of dementia. A third had a history of falls and around a quarter had carers who reported problems coping at home.

None of the people with cognitive impairment studied had been referred to the local Intermediate Care team. This surely is a missed opportunity for earlier intervention and consideration of safe alternatives to admission to hospital.

### **Delirium and unnecessary new institutionalisation of older people: could intermediate care help prevent this?**

**Alasdair MacLulich, Professor of Geriatric Medicine, Age range University of Edinburgh**

Alasdair explained delirium is common (30% of geriatric inpatients), serious (~ 20% are dead in one month), underdetected and undertreated. It can persist for weeks or months, impedes rehabilitation, increases length of stay, risk of long-term cognitive impairment and new institutional care.

The DSM IV definition for Delirium is:

(1) A disturbance of consciousness (reduced clarity of awareness of the environment, with reduced ability to focus, sustain, or shift attention),

(2) A change in cognition (eg. memory impairment) or a perceptual disturbance, and

(3) Acute onset of hours to days, and tendency to fluctuate.

(4) Evidence of general medical or drug aetiology

Additional features include other cognitive deficits, poor comprehension / disorganised thinking, altered arousal, psychotic features and sleep-wake cycle disturbance. It is often misdiagnosed. Dementia with Lewy Bodies shares some features but dementia onset is mostly much slower and attentional deficits are less prominent than delirium. Depression is associated with a flat affect, slower onset and less severe cognitive/ attentional deficits.

It has multiple causes including direct brain insults (eg hypoxia, some drugs, hypoglycaemia, stroke and traumatic brain injury) and aberrant stress from infection, myocardial infarction, acute renal failure and psychological stress.

Delirium is a partly preventable medical crisis to be diagnosed and treated early by:

- Oxygenation, hydration and early mobilisation
- Education, early recognition and treatment of problems (eg Infection)
- Reduction of medication burden on brain
- Treatment of pain and constipation
- Correction of sensory deficits (vision aids, amplifiers)
- Avoidance of urinary catheter

The Caplan Reach – Out RCT from Australia showed home rehab was cheaper and patients had significantly less delirium than in a rehab ward.

Intermediate care allows time for rehab / recovery from delirium in a setting that is more stimulating, less chaotic with fewer interruptions at night and more continuity of staff. Benefits have to be set against the additional transition, the need for staff training and access to specialist and acute interventions when required.

A simple and effective way of improving delirium and dementia care in acute hospitals is to make sure that all older patients in hospital are screened for cognitive impairment, and to couple this with a plan to make a formal diagnosis and take action.

### **Afternoon Panel Discussion:**

The panel were asked how can we go away and do something which would result in quick wins or for any strategic changes which would improve dementia care in the short term.

The suggestions were that:

- Allied Health Professionals could make clearer how they could contribute towards dementia care.
- Caring for people with serious delirium/dementia at home can be safe but there is a massive variation across Scotland on how people are supported due to different levels of risk tolerance. Risk tolerance is greater for more experienced staff and dementia care should not depend on the judgement of an individual. There is no substitute for knowing the person who you are working with and not being fully informed could result in bad judgement. We should think about public protection and risk in a different way.

Quick wins suggested were:

- the need to be specific and ask specific questions of the patient, ask care managers what is the most challenging behaviour, and ask carers what challenges they face.
- social care and old age psychiatry need to work together to share the skills which they have and break down the barriers which exist between them.
- diverting people from Accident and Emergency services and having discussions with care providers and NHS 24 about reducing the transfer of people from care homes to Accident and Emergency departments. The consultant could visit the person in their care home or at home instead of the person visiting hospital.
- end silo thinking and provide integrated training for staff who care for people with dementia.
- there should be joint commissioning and planning of services and resources should follow the person.

Some quick wins were suggested for intermediate care and these included:

- working together - an example was given of NHS Lothian's challenging behaviour service which is based on models in England and Northern Ireland.
- sharing models which worked successfully.
- persuading each hospital ward to have a person to undertake testing for cognitive behaviour in each patient.
- to make assessments outside an acute hospital setting and to ensure that clinical care is done well at the right time.
- to stop talking about care homes and call them out of home care and have services provided in them e.g, visits by social workers, GP's and consultants.

Professor Andrews concluded the event and welcomed further dialogue and sharing of good practice. The outputs from the event will inform the developing Dementia Strategy and Reshaping Care for Older People Programme and development of intermediate care guidance.