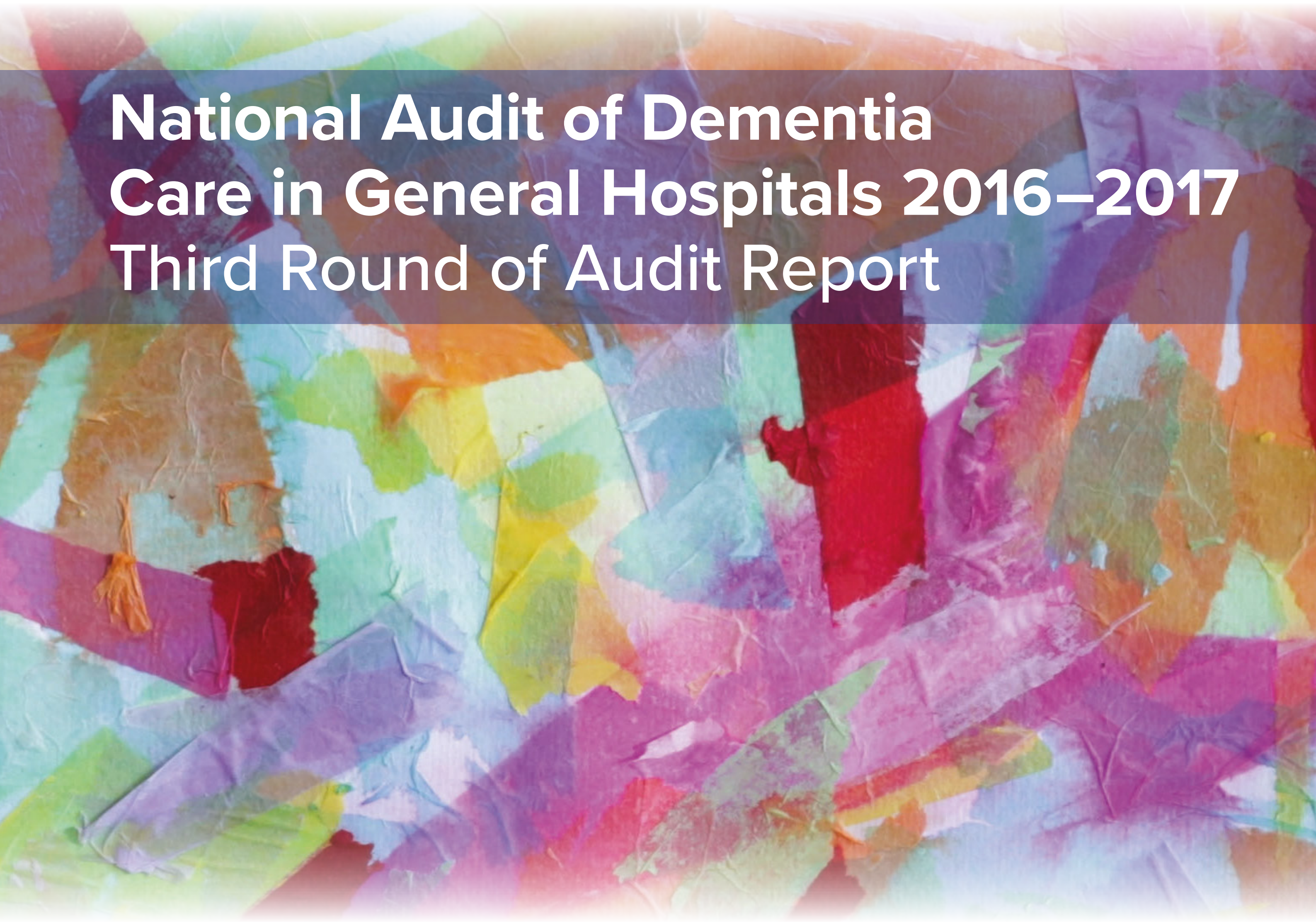
DEMENTIA CCQI
NATIONAL AUDIT OF DEMENTIA

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS



National Audit of Dementia Care in General Hospitals 2016–2017

Third Round of Audit Report

age UK
Love later life

Alzheimer's Society
United Against Dementia

BGS
British Geriatrics Society
Improving healthcare for older people

DAA Dementia Action Alliance

HQIP
Healthcare Quality Improvement Partnership

JC

Royal College of Nursing

Royal College of Physicians

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Many thanks to Hwyl for permission to use the cover artwork. Hwyl is an art project run by Dementia Matters in Powys (DMiP) and Arts Alive Wales based at the Brecon War Memorial Hospital. The project focuses on working with elderly patients on hospital wards, with their families, carers, the ward staff and artists on a weekly basis.

With thanks to Rhiannon Davies (DMiP) and Tessa Waite (Arts Alive Wales).

Audit Governance

The National Audit of Dementia is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Welsh Government. It is managed by the Royal College of Psychiatrists' Centre for Quality Improvement, working in close partnership with professional and service user representatives. We work with professional bodies, voluntary sector providers and campaigning organisations:

- Royal College of Psychiatrists
- Royal College of Nursing
- Royal College of Physicians
- British Geriatrics Society
- Alzheimer's Society
- Dementia Action Alliance
- Age UK
- John's Campaign.

Representatives from partner organisations collaborating in the audit comprise our Steering Group, together with four representatives of the experiences of people living with dementia and carers, and the audit Project Team. See Appendix F for a list of Steering Group members.

Conflicts of interest

Members of the Steering Group are asked to declare any conflicts of interest at outset and prior to each meeting. This is included as a standing item on the agenda. Should a conflict of interest affecting the conduct or results of audit be declared, the member may be asked to absent themselves from all or part of the discussion, at the meeting and subsequently.

This audit was commissioned by the Healthcare Quality Improvement Partnership (HQIP). The report is produced and published by the Royal College of Psychiatrists' Centre for Quality Improvement.

Authors

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Content is advised and approved by all members of the Steering Group. For full details of the Steering Group members and the Project Team, please see Appendix F.

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Foreword

Round 3 of the National Audit of Dementia care in general hospitals – achievements and continuing challenges in improving the quality of care

This report presents the results of the third round of the National Audit of Dementia (NAD).

The report of the second audit round in 2013 demonstrated the significant progress hospitals had made to improve the care of people with dementia by making changes at organisational level, ensuring that clinical leaders and champions were appointed to support dementia care and improving key physical assessments. However, the report also identified room for further improvement, in particular a need to have Executive Board level leadership in dementia care, training provision, cognitive and delirium assessment, and information collated to support care and discharge.

Dementia remains a government priority in England and Wales. The Prime Minister's Challenge on Dementia 2020 emphasised the need to improve hospital care for people with dementia and make hospital environments more 'dementia friendly' and the Welsh Government has just completed a national consultation on the Dementia Strategy for Wales 'Together for a Dementia Friendly Wales 2017-2022'.

Hospitals are facing a very challenging time needing to make considerable savings against a backdrop of continuing reorganisation. Nevertheless, hospitals have continued to work hard to improve dementia care locally and nationally. 164 acute Trusts in England are signatories to the Dementia Action Alliance (DAA) Dementia Friendly Hospital Charter. Hospital leads for dementia and their colleagues share news and details of their initiatives via the DAA and local networks. Hospitals also participated in targets set by the national CQUIN for dementia, aimed at identifying and assessing patients with dementia admitted acutely to hospital, improving staff training, and supporting carers and targets set locally by Clinical Commissioning Groups.

This report updates the previous audit findings with organisational information obtained from Trusts and data drawn from an audit of the casenotes of people with dementia. However, this audit introduced two new initiatives; specific questionnaires for carers and staff. The results of these are also included in this report and provide an important insight and perspective on the quality of care and the support and training staff receive for people with dementia.

In this round of audit, we present for the first time summary measures to show the extent of progress each hospital has made. There are seven scores based on information about governance, assessment, nutrition provision, discharge, information and communication, and the overall carer rating of care.

Once again, we had a very high level of participation in Round 3 of the audit. 199 hospitals across England and Wales took part (98% of eligible hospitals), demonstrating the commitment hospitals and Trusts have to improve the care of people with dementia.

There has been continued change at organisational level, showing commitment to dementia friendly hospitals. Nearly all hospitals have or are developing a dementia care pathway under the direction of a senior clinical lead. Leadership and staff support is also provided through champions for dementia at ward and directorate level. Most hospitals have a dementia working group or committee which meets regularly, and have taken steps to include carers more directly in the care of people with dementia, notably by joining John's Campaign to ensure that carers can be more involved with the person they care for.

However, previous audit reports found that organisational changes do not necessarily translate into improvements in dementia care. This is shown once again in the Round 3 report.

Training in dementia awareness is now provided by more hospitals on induction or as mandatory training, but some staff felt training could be improved or increased. The carer survey also showed that carers did not always feel that staff were well informed about the needs of people with dementia, and sometimes, did not deliver care of a sufficiently high standard. However, overall nearly 70% of carers felt that care was very good or excellent, and most carers felt staff treated patients with respect.

Only 38% of staff agreed that additional staffing was provided if the needs of the people on their ward were high. The most frequent suggestion from staff on how dementia care could be improved was better staffing.

There is a need to further improve cognitive assessment and delirium screening. People with dementia are particularly at risk of delirium, which is a frequent cause of their admission to hospital. Delirium can prolong and complicate stays in acute hospitals. Better understanding of the association between the factors measured in this round of audit and the development of delirium is urgently needed. For example, poor hydration and nutrition and night time bed moves are well known contributory factors to the development of delirium. Half of the staff surveyed did not think that night time bed moves were avoided always or most of the time and 24% of staff working on wards did not think that people with dementia had their nutritional needs met always or most of the time.

High quality, effective care for people with dementia, more than ever requires strategic planning, commitment and leadership at all levels. This report presents updated recommendations to regulators, commissioners and clinicians. Its recommendations provide a benchmark by which individual hospitals, departments, teams and clinicians can make measured and cost effective differences to care and experience for those with dementia and their families.

We recognise the significant amount of work involved in undertaking this audit and are extremely grateful to all the staff who took part, in particular hospital Audit leads.

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Interview with Dr Trevor Jarvis B.E.M

Hospital care “We’re getting there”

Dr Trevor Jarvis, BEM, is an Ambassador for the Alzheimer’s Society, and has worked for many years with national and local government, charity and healthcare organisations to improve the lives of people with dementia. In July 2013, Trevor was awarded an honorary doctorate from Bradford University in recognition of his work to improve the lives of people living with dementia and in the 2014 New Year’s Honours list, Trevor was awarded a British Empire Medal for his campaigning. In 2013, he addressed a G8 summit of world leaders on living with dementia.

Trevor was diagnosed with dementia in 2001. Since then he has been campaigning for better understanding of dementia, and a key focus of his work has been training staff in health and social care, using his personal experiences to highlight the problems that arise when staff lack understanding and to show how care can be improved. He continues to give talks to health care professionals in and around his home town of Doncaster.

Dr Jarvis kindly agreed to speak to the NAD team about his personal experiences of hospital care as a person living with dementia, and his priorities for better care.

NAD Could you tell us something about when hospitals got care right and when they didn’t?

TJ Many years ago, staff didn’t have the awareness that they have now. Dementia wasn’t talked about. When I went into hospital 14 years ago, you were on your own, with no one who understood what difficulties you might have, no one to help you with simple things like getting ready for bed – alone in a strange environment. You’d be in a ward with a lot of people, four or six to a bay, and it’d be noisy. Or they might move you to a side room, to be away from noise, but with no one to see if you needed help. At least in a six bed bay someone might help you if you needed to call a nurse and couldn’t find the buzzer – but if you were on your own, that couldn’t happen. People like us have different capabilities and needs, and they couldn’t see we need to be assessed as individuals. That’s one of the main points I make when I’m giving a talk to staff – don’t assume you know better – find out.

NAD Have you had different experiences since then?

TJ Oh yes, during a later admission, it was much better. The anaesthetist was brilliant. He came to see me and introduced himself, explained everything, and he said, “Trev, when you come around from the anaesthetic, everything will be strange at first. You’ll be in a different room. But you’ll see me first, I’ll be there. I will be with you throughout.” And he made sure he was and I had that reassurance.

NAD So do you think it's important, that continuity, knowing someone who's dealing with your care?

TJ Yes, that contact's important. Understanding and respect. That's not what used to happen. I had an experience with a consultant once, it was for pre-planned surgery. I saw the consultant with my wife Ann. He explained the procedure, and asked me if I understood. I said yes, I understood. He asked me if I agreed, I said yes, I agreed. Then he gave the consent form to my wife to sign. When I said, shouldn't I be signing that, he said "No. You. Have. Dementia. People with dementia don't sign forms". Well, I told my GP about this – and I ended up having that procedure in a different hospital.

NAD So there was a lack of respect?

TJ That's something I think is changing with understanding. 14 years or more ago when I first saw a psychiatrist for tests, he was rattling out the questions, didn't give me time to answer, barked at me to answer Yes or No. The nurse took me out in the end, she could see it was no good. The psychiatrist I see now is fantastic. Other specialists I've seen since have also been brilliant. They explain everything and keep me informed, they always make sure I'm involved and know what's going on. This is all staff in the hospital as well, I've given talks to surgeons, doctors, nurses, porters, assistants. And things have changed. Before, if you were on a ward, someone bringing the lunch round might just leave it there, not telling you what's going on, and then come back and just think "oh, he didn't want it" and take it away. They know that's no good now. There's a scheme, called the Butterfly Scheme, run by Barbara Hodkinson, and it helps with everything like that. They put a little symbol of a butterfly by your bed or on your notes, and then everyone you meet knows that you need that communication, and they're trained in what to do. Just simple things: "Morning Trev, here's your cup of tea, can you drink it like that?" Or "Hello Trev, I'm so and so, is there anything you need help with, would you like a drink?" Everyone on the ward is trained – porters and domestics – and they know if they see someone looking confused or lost, to say "are you all right sir or madam" and help them, or get a nurse. In a lot of hospitals, there are special dementia wards where they make sure they can provide this care – Mallard Ward in Doncaster is one – you know everyone in the ward has that level of training and it's amazing.

Knowing about these changes, takes away the fear and apprehension you once would have had – at one time, I would have been concerned about going into hospital. Now, I feel I could walk in feeling a lot more safe and secure.

NAD Do you think everyone will have a better experience now?

TJ Well, it's that staff knowledge and understanding that's the key to it all. You can get problems if you have a high turnover of staff – that can affect care homes in particular. And sometimes these days, I'm asked to give a talk, and it's cancelled or it's a lot smaller, because of cutbacks or they're short staffed so staff can't be released for training. That does cause me some concern. I know there's no bottomless pot of gold and everyone has to save money, but then you think of people going to work in those hospitals and homes without that understanding. They need training.

They also need to keep their minds focussed on what will help people like us. When they introduce a system, like these new booking in systems they have now, where you have to enter your date of birth on a screen – I can't use those. I always explain. One time I did say to a receptionist "Excuse me, I have a problem using the machine" only to be told, "Well, booking you in is not our job any more". Well that got sorted, it doesn't happen when I go there now – and maybe she was having a bad hair day – but people need to think. It only makes their job easier if people like us have the right support.

NAD People with dementia often say that supporting the person that cares for them is very important. Do you think your wife has had the right support from hospitals?

TJ Well – my wife Ann has had [some health problems]. I care for her and she cares for me. If I go to hospital, she comes with me – if she goes, I go with her.

On one occasion, she had to be taken into hospital by ambulance and it took a long time to see anybody. At 2am, the doctor said she was ready for discharge, and we should go home. I said, "You don't understand, I can't take her home". He had Ann put in a wheelchair, pushed through pouring rain across the car park and we were put in a taxi. We'd come as an emergency, I didn't know whether I had my keys, or any money on me, and no one bothered to check. Luckily it turned out I did or we'd have been left at our door in the rain at 3am.

When you're discharging someone, you have to understand their home situation, and that's important for carers, as well as people with dementia.

NAD What's your top message for hospitals?

TJ Talk to Trevor – all very well talking to Ann, or other family, but it's me that's going into hospital. Talk to me, keep me informed, don't just put me to one side. Find out about me, don't just assume that you know. We keep a little booklet that tells you a lot about me, what I'd like help with, what I don't need help with, everything like that. That's for staff information and needs to be followed up on the ward. Train staff so that they can see people as individuals. Understand that it can make their job easier.

Something I've just heard about that hospitals do now is about the right of the person with dementia to have someone with them – and this is something I've been fighting for all these years. It's important when you're in hospital to have someone you know allowed to be there. They have a little card (a Carer's Passport) and it lets them go in any time[a]. It's helpful to ward staff too, if there's someone there who knows all about the person, and maybe helps with personal care. I'm delighted this is happening. It's another example of change for the better. Things have changed. We are getting there.

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[a] John's Campaign http://johnscampaign.org.uk

Executive Summary

Background

The National Audit of Dementia (NAD) care in general hospitals is commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England and the Welsh Government, as part of the National Clinical Audit Programme. NAD examines aspects of the care received by people with dementia in general hospitals in England and Wales.

Audit management and governance

The audit is managed by the Royal College of Psychiatrists in partnership with:

- Royal College of Nursing
- Royal College of Physicians
- British Geriatrics Society
- Alzheimer's Society
- Dementia Action Alliance
- Age UK
- John's Campaign.

Who should read this report

In line with HQIP Reporting for Impact guidance, this report is designed to provide information for:

- People who receive care or provide care for someone – people with dementia and their families
- People involved in providing care – professional staff, managers and Trust Boards working in general hospitals in England and Wales
- People involved in commissioning care – NHS England, Welsh Government, clinical commissioning groups
- People who regulate care – including the Care Quality Commission, clinical audit and quality improvement professionals.

Data collection and reporting

Data for this round of audit were collected April–November 2016. This report was published 13 July 2017.

Service user and carer participation

Representatives with experience of living with dementia or caring for someone who has dementia sit on the Steering Group which advises on all aspects of the project, together with representatives from the organisations above. Development of the carer questionnaire for this round of audit was informed by the Imperial College Patient & Public Involvement panel. Carers involved in testing the questionnaire returned comment on content and format.

Data collection and anonymity

No patient identifiable data was collected for the audit of casenotes. Staff and carer surveys were distributed with prepaid envelopes for direct return to the Project Team, or completed online. No identifying details were requested.

Carers who completed the questionnaire for this round of audit made frequent comment on the quality of care received by people with dementia (see page 38). The comments provide very useful insight and context and we present a breakdown of comments and show comment excerpts. To protect anonymity, we have not used verbatim comments.

Dementia in general hospitals

Dementia is the term used to describe a range of symptoms caused by diseases which damage the brain, such as Alzheimer's disease, or a series of strokes. Symptoms vary extensively but may include memory loss and difficulties with thinking, language and problem solving, and changes in mood and behaviour[b].

For a person with dementia, these symptoms are severe enough to cause significant problems in daily life. Dementia is most prevalent in people over the age of 65 and the likelihood of developing dementia increases with age. People are not generally admitted to hospital for dementia. Common reasons reported by the Alzheimer's Society[c] previously include falls, hip fractures, stroke, urinary tract and respiratory infections. In this audit, 50% of the primary causes for admission were either falls, hip fracture or dislocation, respiratory related or urinary infections.

Admission to hospital is exceptionally difficult for people with dementia. Illness or injury, loss of familiar surroundings and routine, and a busy task centred environment can all worsen dementia symptoms and increase the risk of delirium. The Alzheimer's Society cites figures obtained from Department of Health stating that people with dementia in hospital account for around 3.2 million bed days a year[d]. Governments in both England and Wales have identified dementia care in hospitals as a priority for improvement. NHS England is committed to supporting the implementation of the Prime Minister's Challenge on Dementia 2020 Implementation Plan and supports the Dementia Friendly Hospitals initiative of the Dementia Action Alliance.

[b] https://www.alzheimers.org.uk/info/20007/types_of_dementia/1/what_is_dementia
[c] https://www.alzheimers.org.uk/download/downloads/id/2907/fix_dementia_care_-_hospitals.pdf
[d] https://www.alzheimers.org.uk/download/downloads/id/2907/fix_dementia_care_-_hospitals.pdf

Two previous rounds of this audit have taken place, reporting in 2011 and 2013. Round 2 of the audit found that some improvement had taken place in care processes such as assessment and discharge planning, and increased support for dementia in hospital from the introduction of senior clinical leads, dementia champions, and training provision. The second round report recommended collecting feedback from the carers of people with dementia and staff who provide care, to gain a better understanding of important aspects of care such as communication and understanding individual needs.

The third round of NAD collected data between April and November 2016. One hundred and ninety-nine hospitals in England and Wales took part in the audit and were asked to complete four elements[e]:

- A hospital level organisational checklist
- A retrospective casenote audit with a target of a minimum of 50 sets of patient notes
- A survey of carer experience of quality of care
- A staff questionnaire on providing care and support to people with dementia.

Ninety-eight percent (199/203) of hospitals eligible to participate across England and Wales submitted data for all or part of the audit. In total, the audit received 199 organisational checklists, 10047 casenote submissions, 14416 staff questionnaires and 4664 carer questionnaires.

Overview of results

The National Audit of Dementia (care in general hospitals) measures the performance of general hospitals against criteria relating to care delivery which are known to impact upon people with dementia while in hospital. These criteria have been derived from national and professional guidance, including NICE Quality Standards and guidance, the Dementia Friendly Hospitals charter, and reports from the Alzheimer's Society, Age Concern and Royal Colleges. These have been compiled as a set of standards, which can be found on the audit website, together with their sources and the questions used for measurement in this audit.

This report contains results from data sets made up of the combined data submitted by all hospitals in England and Wales taking part in the third round of audit. Results from all four of the tools in this round are presented together.

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[e] www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/dementia/nationalauditofdementia/thirdroundofaudit.aspx

Audit themes

Audit standards are measured across each of the tools. Therefore, data submitted are presented thematically, with data from each tool presented together.

The themes are:

1. **Assessment**
   Data from the casenote audit. This looks at whether people with dementia admitted to hospital have received a comprehensive assessment, and how well each element of assessment is carried out.
2. **Information and communication**
   Data from the organisational checklist, casenote audit, staff and carer questionnaires. This looks at communication systems in use in the hospital, evidence of their use in casenotes, and presents feedback from carers and from staff about the quality of communication.
3. **Staffing and training**
   Data from the organisational checklist, staff questionnaire and carer questionnaire. This looks at staffing provision, the extent of training delivery in hospitals and presents feedback from staff on training quality.
4. **Nutrition**
   Data from the organisational checklist and staff questionnaire. This looks at whether hospitals have services that provide for the needs of people with dementia and presents feedback from staff on service quality.
5. **Discharge and hospital transfer**
   Data from the organisational checklist and casenote audit. This looks at the extent of planning for discharge from hospital for people with dementia and whether they and their carers are adequately informed.
6. **Governance**
   Data from the organisational checklist and staff questionnaire. This looks at the involvement of hospital leads and the Executive Board in leading, planning and monitoring care, review of the environment and carer engagement.

In this round, we find that hospitals have begun to implement many of the improvements needed to support the care of people with dementia, notably in training provision, ward level leadership, and the use of services which accommodate complex needs. However, feedback from carers and from staff shows that progress in many areas is yet to take place, or is inconsistent. There is still some way to go before changes are embedded.

Scoring in Round 3 of audit

For the first time, we present hospital level scores. The scoring system allows easy comparison between hospitals on the different themes of the audit and a table of all scores per hospital can be found in Appendix A. There are seven scores, each relating to an audit key theme, plus the carer overall rating of care. The range of scores nationally is presented within each results chapter, where relevant.

Scores are derived from separate data sources and should be viewed independently. For example, a hospital's score for Assessment should be compared to other Assessment scores, rather than the other scores for that hospital. This is because a hospital's highest score may not reflect its area of greatest achievement, if it is a theme in which all hospitals have scored highly. The full method for the scoring is shown in Appendix B.

Not every hospital has received a complete set of scores. To receive a full set, hospitals were required to provide one complete organisational checklist, more than 19 casenotes, 20 or more staff questionnaires and 10 or more carer questionnaires. Hospitals with fewer than the required number, have not received a score for that theme.

National mean averages for each score are presented on page 22.

Key findings

Delirium recording requires improvement

In more than half of casenotes of people with dementia, there was no recording of an initial screen or check for symptoms of delirium. Inconsistency in what is recorded and communicated may affect clinical care and thereby increase a person with dementia's risk to developing delirium.

Personal information to support better care must be accessible

A ward spot check carried out during the audit looked for the document with key personal information about care needs and communication that should be completed for people with dementia, and found that only half of these patients had one in place. Forty percent of staff said that they could not access this information most of the time, and under half of carers said definitely, staff were well informed.

Services must meet the nutritional needs of people with dementia

Catering services in hospitals should be able to provide for the needs of people with dementia, who may not be able to eat full meals at regular times and need finger food meal alternatives and snacks available at any time to ensure they are nourished. Less than 75% of staff said that they could obtain finger foods or snacks between meals for these patients. Twenty-four percent of staff thought people with dementia had nutritional needs met only sometimes, or were not met.

Championing dementia means supporting staff

To support staff to deliver better care, nearly all hospitals have created dementia champions at ward level. Just under 70% of carers gave a high rating to care overall. Staff said they needed more support, especially out of hours when less than a quarter of staff said they could access specialist support for dementia always or most of the time.

Involve the person with dementia in decision making

Where a change in residence after discharge (e.g. from their own home to a care home) was proposed, just over one third of patients did not have their consent to begin this process recorded, or evidence that a best interests decision making process had taken place, in the case that they lacked capacity.

Key recommendations

Below we present the key recommendations for this report, relating to the key findings above. The full list of recommendations can be found on page 87. Each theme also contains the associated recommendations.

Delirium

Medical and Nursing Directors should:

- Ensure that hospitals have robust mechanisms in place for assessing delirium in people with dementia including:
    - At admission, a full clinical delirium assessment, whenever indicators of delirium are identified.
    - Cognitive tests administered on admission and again before discharge.
    - Delirium screening and assessment fully documented in the patients notes (regardless of the outcome).
    - Care offered in concordance with the delirium evidence-base recommendations when the assessment indicates symptoms of delirium.
    - Results recorded on the electronic discharge summary.
- Ensure staff receive training in delirium and its relationship to dementia, manifestations of pain, and behavioural and psychological symptoms of dementia.

Personal information use

- **National Commissioners (Welsh Government, NHS England)** should propose a nationally backed monitoring programme aimed at embedding the collection, sharing and use of person centred information. This should include a clear expectation that once gathered, this information will follow the patient between providers, and this will be monitored.

- **Ward Managers** should audit implementation/use of personal information collected to improve care for patients (e.g. *This is Me* or other locally developed document). The result of the audit should be fed back to the dementia champions/dementia lead and ward staff.

Nutrition

- **Clinical Commissioning Groups and Health Board commissioning services** should ensure that tenders let by Trusts for new catering contracts always specify provision of finger foods for main meals and access to a range of snacks 24 hours a day.
- **Medical and Nursing Directors** should promote the attendance of key carers to support care, but ensure that this is complementary to, and not instead of, care delivered by staff. The level of input by carers, and how carers feel about the level of input they have been asked to deliver should be monitored through carer feedback, complaints and PALS enquiries. Carer satisfaction should be seen as a marker of good care. Ward managers should be supported to ensure carers supporting patients should not be asked to leave at mealtimes/stopped from helping with meals (this excludes emergency and urgent care and treatment).

Dementia Champions

- **The Chief Executive Officer** should ensure that there is a dementia champion available to support staff 24 hours per day, 7 days per week. This could be achieved through ensuring that people in roles such as Site Nurse Practitioners and Bed Managers have expertise in dementia care.

Decision making

- **The Safeguarding Lead** should ensure that staff are trained in the Mental Capacity Act, including consent, appropriate use of best interests decision making, the use of Lasting Power of Attorney and Advance Decision Making. Training should cover supportive communication with family members/carers on these topics.

Future rounds of audit

It is expected at the time of writing that the audit detailed in this report will be repeated in 2018, reporting in 2019.

Audit activity in 2017-2018

Clinical Outcomes Programme Publication (COP)

The audit will be submitting data from key measures derived from the casenote audit and carer and staff questionnaires for publication as part of the COP. This programme brings together and publishes quality measures from a range of audits and helps support their inclusion via accessible platforms such as NHS Choices.

Optional casenote audit

The casenote audit tool is open until the end of July 2017, to allow hospitals who wish to build a year on year record of performance to submit further cases.

Spotlight audit on psychotropic medication

This module will look at medication which may be prescribed for behavioural and psychological symptoms of dementia, received by patients with dementia admitted to hospital in April 2017. The module will be rolled out in August, with a closing date in October. The full report will be completed in February 2018.

Quality Improvement Workshops

Following publication of the national and local reports, audit leads can attend one of eight quality improvement workshops taking place around England and Wales in September and October 2017.

The workshops will be led by Maureen McGeorge, who has many years' experience in the development and use of improvement programmes in healthcare. Workshops will help leads to devise practical applications to address shortfalls identified by audit.

Average Hospital Scores across England and Wales

Average hospital scores across England and Wales
The scores represented are averages from 7 scoring themes in this report based on data submitted by 199 hospitals in England and Wales. See Appendix A for all hospital scores.

Audit Background and Development

The National Audit of Dementia (care in general hospitals) measures the performance of general hospitals against criteria relating to care delivery which are known to impact upon people with dementia while in hospital.

The previous (second) round of audit, (reporting in 2013), showed that while significant progress in the care provided to people with dementia in general hospitals had taken place, some aspects of care still needed to evolve. The third round of audit collected data between April and November 2016. One hundred and ninety-nine hospitals in England and Wales took part and were asked to complete four elements[f]:

- A hospital level organisational checklist
- A retrospective casenote audit with a target of a minimum of 50 sets of patient notes
- A survey of carer experience of quality of care
- A staff questionnaire on providing care and support to people with dementia.

The staff and carer questionnaires were newly created for Round 3 of audit. The casenote audit and organisational checklist were altered from their Round 2 format to reflect:

- New guidance produced since the last round of audit, including NICE Quality Standards setting out principles for the care and treatment of people with dementia
- A revised remit for the audit, which specified a shorter casenote audit with greater possibilities for comparison, and an organisational checklist geared more towards actions taken by hospitals (rather than policies in place).

Ninety-eight percent (199/203) of hospitals eligible to participate across England and Wales submitted data for all or part of the audit. In total, the audit received 199 organisational checklists, 10047 casenote submissions, 14416 staff questionnaires and 4664 carer questionnaires.

Development of new tools

In the first two rounds of audit, hospitals only had to submit organisational data and an audit of the casenotes of 40 patients. Results gave insight into how well prepared hospitals were to provide care, and some information on key aspects of care such as the extent of comprehensive assessment, which should be carried out for all older or frailer patients. We were aware from the outset that information on the day to day experience of care as a person with dementia in hospital was needed to provide a true picture of care. Round 1 of the audit included an optional element of ward level audit, including feedback

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[f] www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/dementia/nationalauditofdementia/thirdroundofaudit.aspx

from ward managers, environmental audit, feedback from staff and a joint patient/carer questionnaire. Observations of care, in a form specially designed for the acute environment, were also included. Hospitals were invited to select up to three wards for this. A sample of 145 wards from 55 hospitals took part.

Results of the optional audit and in particular the observations of care gave valuable insight into the general ward culture and in particular staff support and communication needed to provide person centred care. However, the results were based only on a sample of hospitals and the information could not provide a national comparison between hospitals.

Dementia has remained a key national priority for health services since the outset of audit in 2008. Government in England and Wales have restated the need to improve dementia care in hospitals, other care settings and the community. National Care Quality Incentives (CQUIN) relating to assessment of people with dementia and better communication with carers have been rolled out in England and Welsh Government targets and guidance have included the same priorities. Organisations representing healthcare professionals and carers have highlighted for many years the need for better dementia care and have come together to emphasise the need to support staff and to involve carers, most recently through Triangle of Care[19]. The Dementia Action Alliance now works with 164 acute hospital Trusts in England signed up to the charter for Dementia Friendly Hospitals, which includes many of the standards and criteria of the National Audit of Dementia.

The first two rounds of audit found no relation between organisational policy relating to care of people with dementia and recorded practice. The engagement of Trusts and Health Boards with the agenda for dementia friendly hospitals made it possible to shift the focus of the audit onto what practical steps organisations had taken. It has also made it possible in this round to collect additional data from staff and carers relating to quality of care, and from staff on the support they receive to provide this care. Staff and carer feedback capture aspects of the quality of care as it is experienced, especially in relation to communication of the needs of people with dementia. It is particularly important at a time of complex reorganisation and budgeting pressure on the NHS as a whole, to look at different aspects of care systems and how they are functioning.

As in previous rounds of audit, improvements to governance and policy at the hospital level are not always reflected in the care experience, as shown from patient notes and feedback from carers and staff. After three rounds of audit, we can look back at previous results and say that, at a national (England and Wales) level, changes have taken place but that it takes some time for them to be partly or fully implemented.

In Round 1 of the audit, only 30% of hospitals reported a system in place, such as *This is Me*[g], for documenting and transmitting the important details about the person with dementia's preferences and needs to aid care provision. By Round 2, this had increased greatly to 74%, and is now at 99% in Round 3. Casenote results showing this information

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[g] https://www.alzheimers.org.uk/info/20113/publications_about_living_with_dementia/415/this_is_me

is present, are by contrast at only 57%, but this is an increase from 45% in Round 2 and 43% in Round 1. A new element of audit, a spot check carried out in 3 wards in each participating hospital, found the information was in place at the bedside for only 50% of patients.

In Round 1, 49% of staff from the selected wards in a sample of 55 hospitals said that personal information about the person with dementia was routinely collected for use in care. In the current round, 60% of staff from 183 hospitals participating in this part of the audit said this information was available to them always or most of the time. Forty-five percent of carers said they had definitely been asked about the needs of the person they look after to help plan their care; a further 35% of carers responded that this had happened to some extent.

Results do suggest improvement over time, but feedback from staff identifies a variety of reasons which influence implementation of desired levels of best practice. These include the time and support provided to staff to complete the activity, training and mentorship in the importance and use of information, approaching and engaging carers to provide information, and perceived necessity of retaining the information (which often travels home with the patient without any copy kept for review on subsequent admission).

This single example shows the value of data collection from different sources, helping us to see that it takes time, education and repeated promotion for new ideas and schemes to be embedded into every day ward life. In addition, the practicalities of doing so are often more complex than originally imagined. This should be taken into account when comparing data across tools in this report; policy may arrive some time before practice. It remains to be seen how well results of casenotes, staff and carer surveys reflect organisational change in any subsequent round of audit.

Development of scoring

In previous rounds of the audit, results of participating hospitals have been compared against the mean national average and range for each individual question, but no overview comparison between sites has been available. For the first time, we present hospital level scores.

There is a score associated with each theme with the exception of Staffing and Training, for which we could not obtain comparable data. In addition, the carer questionnaire produces a score allocated by carers to the quality of care overall. The scoring system allows easy comparison between hospitals on the different themes of the audit and a table of all scores per hospital and the ranges can be found in Appendix A. The full method for the scoring is shown in Appendix B.

Scores are derived from separate data sources and should be viewed independently. For example, a hospital's score for Assessment should be compared to other Assessment scores, rather than the other scores for that hospital. This is because a hospital's highest score may not reflect its area of greatest achievement, if it is a theme in which all hospitals have scored highly. The same can be applied for low scores.

NB: Not every hospital has received a complete set of scores. To receive a full set, hospitals were required to provide one complete organisational checklist, more than 19 casenotes, 20 or more staff questionnaires and 10 or more carer questionnaires. Hospitals with fewer than the required number, have not received a score for that theme.

National mean averages for each score are presented on page 22.

Methodology

Audit standards

The National Audit of Dementia (care in general hospitals) measures the performance of general hospitals against criteria relating to care delivery which are known to impact upon people with dementia while in hospital. These criteria have been derived from national and professional guidance, including NICE Quality Standards and guidance, the Dementia Friendly Hospitals charter, and reports from the Alzheimer's Society, Age Concern and Royal Colleges.

Standards are updated for each round of audit via a literature review of latest guidelines, reports and recommendations. New guidance reviewed for this round includes National Institute of Health and Care Excellence Quality Standards 1 (*Dementia: support in Health and Social Care*) and 30 (*Dementia: independence and wellbeing*), in particular with relation to the quality of communication.

The standards for this round of audit can be found on the NAD website.

Data collection and audit structure

Data for the third round of National Audit of Dementia were collected between April and November 2016. Data was collected via both a secure online survey portal and, in the case of the carer and staff questionnaires, on paper forms accompanied by prepaid envelopes addressed to the Project Team. All four tools were piloted with ten volunteer hospitals in 2015 and necessary adaptations were made before the audit proper in 2016. A separate report on the pilot study is on the NAD website.

Table 1: Data required from each hospital for Round 3 of audit

Data collection tool	Data submission period
One organisational checklist	April–June 2016
Data from the casenotes of people discharged with a diagnosis or current history of dementia, with a minimum target of 50	June–November 2016
Staff questionnaires to be distributed to staff in three chosen wards admitting people with dementia and available online to all staff in the hospital who work with people with dementia	June–October 2016
Carer questionnaires to be distributed to family members, friends or professional carers who visited a person with dementia during the data collection period. It was also available online	June–September 2016

Data collection tools

Organisational checklist

Participants were asked to complete one organisational checklist per hospital. The checklist asked for information on: routine collection and reporting of data to the Executive Board; staff training; carer engagement; environmental review; the collection of personal information about patients with dementia and food provision.

Data was submitted by audit leads with input from senior staff from the Clinical Governance Board and Information Services (or equivalent).

Casenote audit

The retrospective casenote audit asked hospitals to submit data from a minimum of 50, and a maximum of 100, casenotes. This allowed hospitals with larger potential samples to submit a larger proportion of their available casenotes and thus provide a more representative sample of their data, if they chose to. The audit asked questions on admission, assessment, personal information, care planning and delivery, as well as discharge. Casenotes were eligible for audit where admissions were 72 hours or more and for patients discharged in April and May 2016. Where necessary to achieve a good sample size, hospitals were allowed to include some patients discharged in June also. Casenotes were identified by hospitals using a list of ICD 10 codes for dementia (provided by the Project Team). Where patients had more than one admission during these months, only the first admission was used.

Data was submitted by audit leads with input from colleagues from audit departments, junior doctors, and dementia champions.

Carer questionnaire

The carer questionnaire was newly developed for Round 3 of audit by the Patient Experience Research Centre at Imperial College London. It consists of ten questions. Eight questions were identified by a panel of carers as top priority items relating to the care of people with dementia and as questions which all carers/family members visiting people with dementia in hospital would find relevant, and would be able to answer. The Friends and Family Test question was also included for validation and comparison. A further question on support provided by the hospital to the carer was added by the Steering Group post pilot. The questionnaire also featured a free text comment box for any additional feedback.

The paper version of the carer questionnaire was distributed by staff to carers and family visiting patients during the months of June, July, August and September 2016. Questionnaires were anonymous and returned directly to the Project Team in freepost envelopes. The online questionnaire was publicised via social media and on posters displayed around participating hospitals but the response rate for this method of collection was extremely low in comparison to paper returns. Online questionnaires had an additional question about the period when the person with dementia had been in hospital and only those from 2016 were included in analysis. The online and paper questionnaires were analysed together as one sample.

Comments in the carer questionnaire were examined and any identifying information removed as they were entered. Serious incidents reported in comments which indicated an ongoing problem that the hospital should be informed about immediately, were fed back during data collection, with anonymity preserved. All comments were fed back to participating hospitals as soon as initial cleaning was complete (in December 2016), so that they could immediately address issues identified.

Staff questionnaire

The staff questionnaire was newly developed for audit via a process of consultation with staff based at the ten sites that took part in the pilot. Workshops identified key items for inclusion in the survey and the preferred format for questions. The online version of the questionnaire was distributed via a link to all staff working in inpatient facing roles. The paper version was handed out to staff working on three wards which hospitals identified as having particularly high admissions of people with dementia. Questionnaires were distributed between June and September 2016 and the online version was available from July to the end of October 2016.

The questionnaire was not distributed to staff in support roles (such as catering staff and porters) as there were extremely low returns during pilot for these groups of staff. Post pilot, the survey was split into sections to be completed according to job role, with only nursing staff completing all questions. The questionnaire was anonymous and paper copies were returned directly to the Project Team in freepost envelopes.

It was originally intended that the paper and online staff questionnaires would be viewed as separate samples – to allow comparison between staff answers when working on a ward with higher numbers of patients with dementia and staff working in other areas of the hospital. During data analysis, it became apparent that sample sizes for many hospitals were inadequate when samples remained separate but if samples were combined, this provided reasonable samples for the majority of hospitals. Analysis showed no significant differences between answers from online questionnaires and answers from paper questionnaires, and it was thus decided the two samples should be combined.

Prize draw

Both the staff and carer questionnaires had a prize draw entry to encourage participation. Freepost postcards attached to the questionnaires were returned to the Dementia Action Alliance so that they could not be associated with questionnaire responses. Five winners for each survey were selected by a representative at the Alzheimer's Society and were contacted by the Project Team to claim their £50 voucher for a high-street store of their choice.

Patient experience
It was not possible for this round of audit to include a patient questionnaire. The combined carer and patient survey included in Round 1 of the audit returned very little data – less than 2 questionnaires per ward. This was generally because the person with dementia was not aware of their diagnosis and so could not be given a questionnaire, the patient had no carer to support them or the patient was too unwell. The National Audit of Dementia Project Team will be carrying out a separate focus group on the contents of this report with people with dementia who have experience of being in a general hospital. The discussion from this group will be published on the NAD website in early 2018.

Inter-rater reliability

The audit asked hospitals to re-audit five casenotes from the submitted sample using a second auditor so that matching casenotes could be compared for reliability. The Project Team advised that the first five casenotes should be used for this where possible. Where this was not possible, any five were selected. The inter-rater reliability analysis can be found on the audit's website. Scoring has not be adjusted according to inter-rater reliability results.

Additionally, for this round of the audit, five hospitals were randomly selected to take part in quality assurance visits, during which an audit clinical lead carried out a random check of 10 of the casenotes submitted for the audit. This is an additional reliability check to compare data recording and reporting between hospitals.

Case adjustment

The Project Team have explored the influence of sample demographics on scoring. For example, the impact of gender, age and ethnicity on scores have been examined. Comparing the unadjusted and adjusted hospital scores, the differences were very small. This meant there were no meaningful adjustments to be made and therefore, all scores have been left in an unadjusted format.

Changes made to the data

During the process of quality assuring the data received, the following changes were made:

- Across all four audit tools, when it was possible to confidently identify data errors in comments returned, responses were changed and this change recorded. Where it was not possible to identify an error with complete confidence, no change was made.
- Duplicates identified in casenotes, staff or care questionnaire datasets were removed.
- Where comments showed that there was no diagnosis of dementia (i.e. where a coding error had been made), casenotes were removed.

- Where it was indicated that patients had not been admitted for 72 hours or more and the hospital was unable to confirm a length of stay of more than 72 hours, casenotes were removed.
- Where two answers were selected on the paper versions of the carer and staff questionnaires, the more moderate response option was selected. For example, where a respondent selected both "yes, always" and "yes, most of the time", the latter was entered onto the data collection system. This reflects the fact respondents felt unable to confidently select the more positive response option only.
- Where staff completed sections of the paper version staff questionnaire that were not applicable to their job role, these answers were removed.
- Staff questionnaires were removed when completed by ineligible job roles or staff working in ineligible areas of the hospital e.g. staff working only in accident and emergency departments.
- All identifying information was removed from comments in staff and carer questionnaires.
- Items were removed from reporting where analysis or expert advice indicated that the data was not of sufficient quality. This included results on employment of dementia specialist nurses per hospital.

All quantative data cleaning and analysis were completed in IBM SPSS Statistics 21 by the Project Team. All qualitative data analysis was completed in Microsoft Excel using pre-agreed coding frameworks (informed by the data) and cross-checked by coders.

Outlier policy

The outlier policy can be found on the NAD website. It has been informed by the Healthcare Quality Improvement Partnership and Department of Health guidance on outliers (2011).

Hospitals who have been identified as outliers on the specified outlier items have been contacted prior to the publication of this report.

Participation in the Audit

The National Audit of Dementia is applicable to all general acute hospitals which provide general acute services on more than one ward to people over the age of 65, in England and Wales. For this round, all identified eligible hospitals were invited to participate and registration ran for a year prior to the start of data collection. Two hundred and three hospitals in England and Wales were identified as eligible for audit and 199 signed up to participate. One hundred percent of Trusts/Health Boards and 98% of hospitals registered.

Table 2: Participation in Round 3 of audit by region

Region in England and Wales	Number of eligible hospitals	Number of participating hospitals	Percentage of hospitals participating
London	31	28	90%
North (formerly North West, North East, Yorkshire and the Humber)	60	59	98%
Midlands (formerly West Midlands, East Midlands, East of England)	49	49	100%
South (formerly South West, South Central, South East Coast)	46	46	100%
Wales	17	17	100%
All	**203**	**199**	**98%**

A breakdown of data submissions made by 199 participating hospitals is shown in Table 3.

Table 3: Data received per tool in Round 3 of audit

Audit module	Number of hospitals participating	Data received	Average per hospital	Range
Organisational checklist	199	199	N/A	N/A
Casenote audit	195	10047	52	22–99
Staff questionnaire	198	14416	73	2–282
Carer questionnaire	196	4664	24	1–104

To protect the anonymity of participants, hospitals with fewer than 5 carer or staff questionnaires will not receive any data on the survey in their local reports. Hospitals with 5-9 questionnaires will not receive any demographic information on the questionnaires in their local reports. This means 195 hospitals (98% of hospitals who participated in the questionnaire) will receive all of their data on the staff questionnaire and 148 (76% of participating hospitals) will receive all of their carer questionnaire data in local reporting.

Of the participating hospitals, 76% met the minimum target of 50 casenote returns and 93% of hospitals submitted at least 40 casenotes. All hospitals able to participate in the casenote audit, submitted sufficient casenotes to receive a local report.

Table 4: Breakdown of casenote submissions in Round 3 of audit

Sample size	Number of hospitals (n = 196)	Percentage of hospitals
70 + casenotes	9	4.6%
60–69	9	4.6%
50–59	131	66.8%
40–49	37	18.9%
22–39	9	4.6%

How the Audit Findings are Presented

National results

This report contains overall results from hospitals in England and Wales taking part in Round 3 of the audit. Results from all four of the tools in this round are presented together. A summary of the results of the audit for each participating hospital (scores) is presented in Appendix A. Information on scoring is provided on page 25 and national means are presented on page 22.

Audit themes

Audit standards are measured across each of the tools. Therefore, data submitted are presented thematically, with data from each tool presented together.

The themes are:

1. **Assessment** (casenote audit)
2. **Information and communication** (organisational checklist, casenote audit, staff and carer questionnaires)
3. **Staff support and training** (organisational checklist, staff questionnaire and carer questionnaire)
4. **Nutrition** (organisational checklist and staff questionnaire)
5. **Discharge and hospital transfer** (organisational checklist and casenote audit)
6. **Governance** (organisational checklist and staff questionnaire)

Comparison with previous rounds of audit

To look more closely at what the organisation did in practice, policy based items were removed from the organisational checklist. New questions are included on training provision, review of the environment, carer engagement and staffing level review. The casenote audit was shortened to reduce the resources needed to complete it. Sections on referral to liaison psychiatry and prescription of antipsychotics were removed as results were not comparable between sites. Both these subject areas will be analysed in separate studies[h]. New questions were included on appropriate use of the Mental Capacity Act in the case of a change in residence, and copying the discharge summary to GPs. Response options were amended on assessment of functioning, personal information collection and cognitive assessment at discharge.

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[h] National Audit of Dementia module on prescription of antipsychotic medication/LP Maestro study at https://medhealth.leeds.ac.uk/info/615/research/1541/liaison_psychiatry_measurement_and_evaluation_of_service_types_referral_patterns_and_outcomes_lp-maestro/2

Comparison between Rounds 2 and 3 of the audit is included where the items remained the same or sufficiently similar, but not for changed or added items.

National data presented from the different rounds includes all hospitals that participated in that particular round, meaning some hospitals may be included in the national figures for one round and not for another. One hundred and ninety-one hospitals have submitted data for all three rounds of audit. All 191 hospitals have participated in the organisational checklist in all three rounds and 182 hospitals have participated in the casenote audit in all three rounds. The staff and carer questionnaires were newly created for this round of audit therefore it has not been possible to draw any comparison between rounds on these items.

A presentation of all items in each tool with comparison to Round 2 is presented as a separate document on the website.

Recommendations

Key messages and recommendations can be found within the Executive Summary. Each results chapter contains detailed recommendations relating to associated theme. The full list of recommendations can be found on page 87.

Results

- Carer Overall Rating of Care
- Assessment
- Information and Communication
- Staffing and Training
- Nutrition
- Discharge
- Governance

Carer Overall Rating of Care

Involvement and inclusion of carers can lead to better care for people with dementia[19]. Hospitals have taken steps to involve carers, including development of strategies for engaging carers, and adopting the aims of John's Campaign, allowing a family carer to remain with a person with dementia and support them during admission (see Governance theme, page 71). One of the key aims for this round of audit was to collect feedback from carers which could be compared across hospitals, and to ask them to rate the care that was received by the person they care for while in hospital.

We received 4664 carer questionnaires in total, ranging from less than 5 to 104 from a single hospital.

The questionnaire asked about aspects of care and about communication between staff and the patient and carer. Good communication with the carer is fundamental to better quality care, so this part of the questionnaire produces its own score, shown in the Information and Communication theme. Carers were also asked to rate the quality of care overall on a five-point scale ranging from Excellent to Poor. This overall rating of care produces a score per hospital; 148/199 hospitals have been scored for carer rating of care.

Figure 1: Range, ranking and national mean of 'carer rating of patient care' scores (148 hospitals in England and Wales)

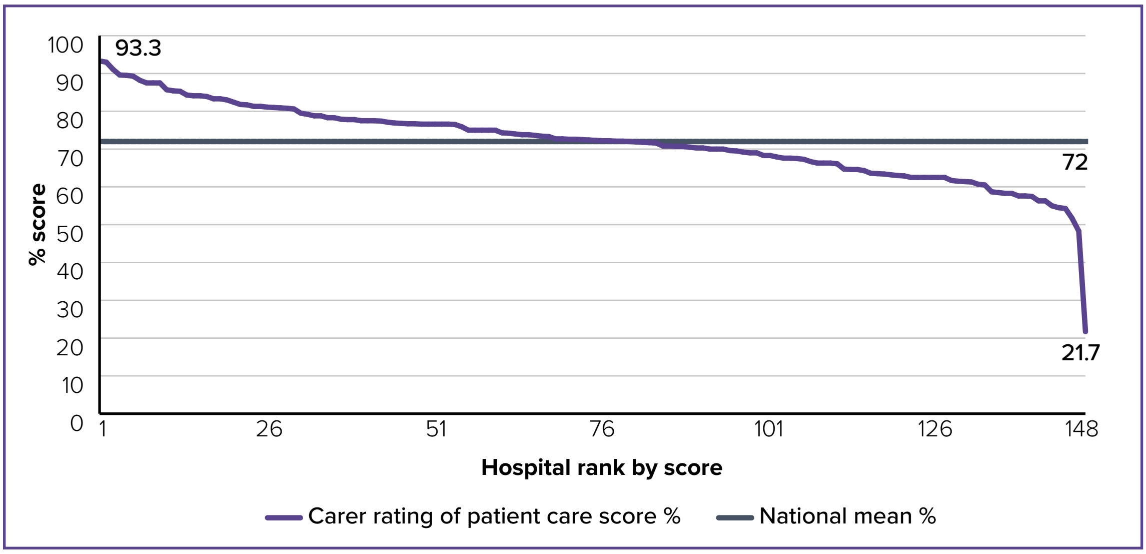


Figure 1 shows the range of scores. Only one hospital scored less than 25% and only two less than 50%. Sixty hospitals scored 75% or above with three hospitals scoring over 90%.

Carer Comments

Carers were asked to make any further comments on care using a free text comments box. In total, 2425 questionnaires were returned with at least one comment which amounted to 10370 separate comments on a range of subjects. Forty-three percent of these were generally positive. The full breakdown of comments shows those themes most frequently noted by carers.

Patient Care

35% (3614/10370) of all comments were about patient care. Of these comments:

✔ 18% said care was generally good or made another positive comment about care	✘ 17% said care was generally poor or made another negative comment about patient care
✔ 3% said staff were well informed and understood the needs of the person with dementia	✘ 13% said staff were not well informed and did not understand the needs of the person with dementia
✔ 1% said the person received enough help with personal care	✘ 10% said the person did not receive enough help with personal care
✔ 4% said that staff delivered high quality care appropriate to the needs of the person	✘ 9% said staff did not deliver high quality care appropriate to the needs of the person
✔ 1% said the person was helped with food and drink	✘ 7% said the person was not helped with food and drink
✔ 3% said that the person they care for received good medical care, including pain relief	✘ 7% said the person they care for received poor medical care or treatment, including pain relief
✔ 2% said the person was treated with respect	✘ 1% said the person was not treated with respect
✔ 1% said that stimulation or activities were available	✘ 2% said stimulation or activities were lacking

“…I was very disappointed that mum was left in bed for 4 weeks with no physio. Her previous mobility has been lost and she is currently unable to walk. She was also left to urinate in bed rather than use a commode… Also, her hearing aid was lost and the bottom set of teeth were lost.”

Perceptions of Staff

27% (2815/10370) of all comments were about perception of staff members. Of these comments:

- ✔ 45% listed specific positive qualities of members of staff e.g. helpful, professional, happy, caring
- ✔ 9% said that staff were generally good
- ✔ 9% specified that nurses were good
- ✔ 5% said that the staff were outstanding
- ✔ 5% specified that doctors were good
- ✔ 5% said allied health professionals were good
- ✔ 1% commented on other positive aspects of staff
- ✔ 1% said staff had a positive effect on the person they care for (e.g. made them feel comfortable, happy)

- ✘ 7% listed specific negative qualities of members of staff e.g. unhelpful, unprofessional, unfriendly
- ✘ 1% said staff were generally poor
- ✘ 3% said nurses were poor
- ✘ 1% said that the staff were very poor e.g. actively rude, appalling attitude
- ✘ 4% said doctors were poor
- ✘ 2% said allied health professionals were poor
- ✘ 2% commented on other negative aspects of staff
- ✘ 1% said staff had a negative effect on the person they care for (e.g. caused patient distress, made patient cry/agitated)

“Staff were warm and friendly and built a good rapport with mum. Took time to listen to her and understand her needs. Supportive dementia team...”

Communication

17% (1712/10370) of all comments were about communication. Of these comments:

- ✔ 6% said that communication with members of staff was good
- ✔ 3% said they were involved in decisions made about the person they care for
- ✔ 2% said communication was generally good
- ✔ 1% said written information about the person they care for was good (e.g. This is Me form)
- ✔ 1% said they were asked about the needs of the person they care for as part of care planning
- ✔ 1% commented on another positive aspect of communication

- ✘ 29% said communication with members of staff was poor
- ✘ 19% said they were not involved in decisions made about the person they care for
- ✘ 13% said communication was generally poor
- ✘ 4% said written information about the person was poor or misused e.g. not read, not visible
- ✘ 4% said they were not asked about the needs of the person they care for as part of care planning
- ✘ 6% made another negative comment on communication
- ✘ 10% said communication between staff was poor

“There is a problem of communication between doctor and carer. In general doctors attend patients in the morning. Carers can only visit in the afternoons and have to rely on the patient to relate what the doctor has told them. At best this is incomplete and unreliable...”

Other

6% (646/10370) of all comments were about another aspect of the hospital stay. Of these comments:

- ✔ 49% made a generally positive comment (e.g. very good, excellent, wonderful etc.)
- ✔ 17% made another positive comment, including comments about staffing levels and discharge/care transfer

- ✘ 13% made a generally negative comment (e.g. appalling, dreadful, disgusting etc.)
- ✘ 20% made another negative comment

“I loved [the ward], it was a lovely stay for my mother... Brilliant all round.”

Staffing levels

5% (473/10370) of all comments were negative about staffing levels. Of these comments:

- ✘ 44% said the hospital was understaffed
- ✘ 43% said staff were too busy, overworked or didn't have time to care
- ✘ 14% made another negative comment about staffing

"The ward was clearly understaffed which reflected on the quality of care available. The available staff tried their best but were clearly all under pressure. Paper work appeared to be excessive and seemed to take a disproportionate amount of staff time. Any patient unable to feed themselves had to rely on a cover or relative… No fault of the staff who were clearly doing their best."

Discharge/Care Transfer

4% (465/10370) of all comments were negative about discharge/care transfer:

- ✘ 54% said that discharge was unsafe, poorly planned
- ✘ 19% made another negative comment about an aspect of discharge/ care transfer
- ✘ 10% said the person they care for was readmitted after a failed discharge, or had a prolonged admission
- ✘ 9% said communication was poor between the hospital and other services/ places of care
- ✘ 8% said they were not informed about the discharge of the person they care for

"We were not informed of the discharge date and time which was a concern as we needed to ensure that there was someone to meet the patient… we had been assured we would be advised of this."

Support for Carers

3% (306/10370) of all comments were about support for carers. Of these comments:

- ✔ 52% said that they felt well supported as a carer
- ✔ 6% said that food, drinks or other facilities were provided for them (e.g. parking, overnight stay)
- ✔ 5% made another positive comment about support for carers
- ✘ 24% said that more support for carers was needed
- ✘ 6% said that food, drinks or other facilities were not provided for them (e.g. parking, overnight stay)
- ✘ 8% made another negative comment about support for carers

"Support we received as a family over a long period has been wonderful. Everyone has been very patient and understanding and taken time to help us understand…Thank you."

Environment

2% (195/10370) of all comments were about the environment. Of these comments:

- ✓ 31% were positive e.g. ward was clean or spotless, ward was calm and quiet
- ✗ 44% made another negative comment about the environment
- ✗ 13% said that the ward was dirty or dusty
- ✗ 12% said equipment on the ward was unsuitable (e.g. memory board, clock, furniture)

"I feel that with a patient who is mobile, sometimes a ward atmosphere is not conducive to them getting better and dementia patients struggle with noise in a busy ward. It would be really useful to have a quiet area to take patients to do activities or just to sit and listen to… The activities guy was very attentive and tried his best. He was very motivated to make a difference to the patients' lives."

Adverse Incidents

1% (144/10370) of all comments were about an adverse incident that occurred during the hospital stay. Of these comments:

- ✗ 39% said that the person they care for had a fall while in hospital
- ✗ 19% said the person they care for was injured while in hospital
- ✗ 12% said the person they care for went missing while in hospital
- ✗ 11% said the person they care for experienced a medication or treatment error while in hospital
- ✗ 11% said another adverse incident occurred while the person they care for was in hospital (e.g. consumption of toxic substance)
- ✗ 8% said the person they care for lost weight whilst in hospital

"I was very unhappy that my mother fell out of bed during the night and we were not informed. We only found out by looking at her notes. Staff must have been aware of her fall but did not approach us during visiting time…"

Assessment

In this theme, we present data from the casenote audit about the physical and mental status assessments which people with dementia received during their hospital admission.

The last round of audit showed increases in the completion of physical health assessments but with room for further improvement to ensure that all patients are receiving a full assessment as specified in British Geriatrics Society guidance[7].

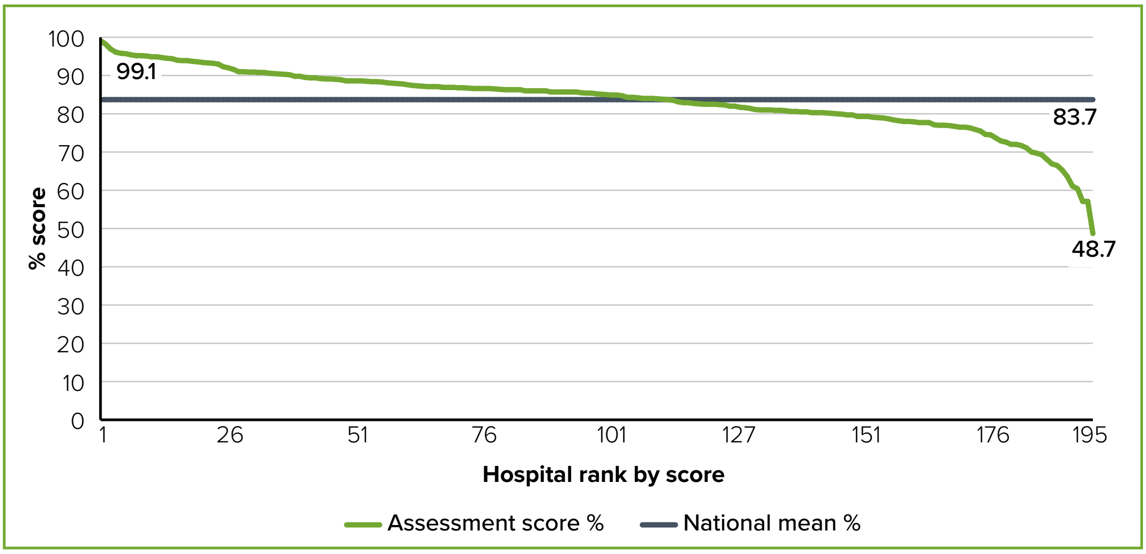
Assessment score

The assessment score is calculated using the information collected in the casenote audit on the following assessments:

- Mobility
- Nutritional status
- Pressure ulcer
- Pain
- Continence
- Functioning
- Delirium screen (or initial assessment).

The mental status assessment data was not included in the score as this can be carried out post-discharge at the patients' place of residence (or another care facility).

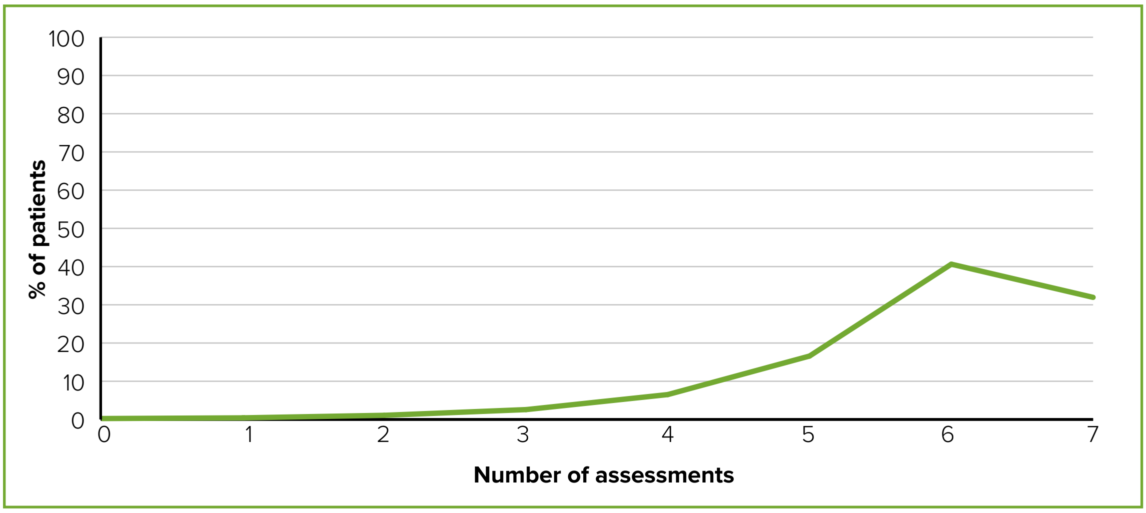
Figure 2: Range, ranking and national mean of hospital scores for assessment (195 hospitals in England and Wales)



Most hospitals (88%, 173/195) scored over 75%. Three hospitals (2%) scored under 60% and just one under 50%. Four hospitals did not take part in the casenote audit and did not receive a score.

Figure 3 shows the percentage of patients from the total sample receiving any number of the seven scoring assessments. Forty-one percent of patients received a total of six assessments and 11% of patients received four or fewer assessments.

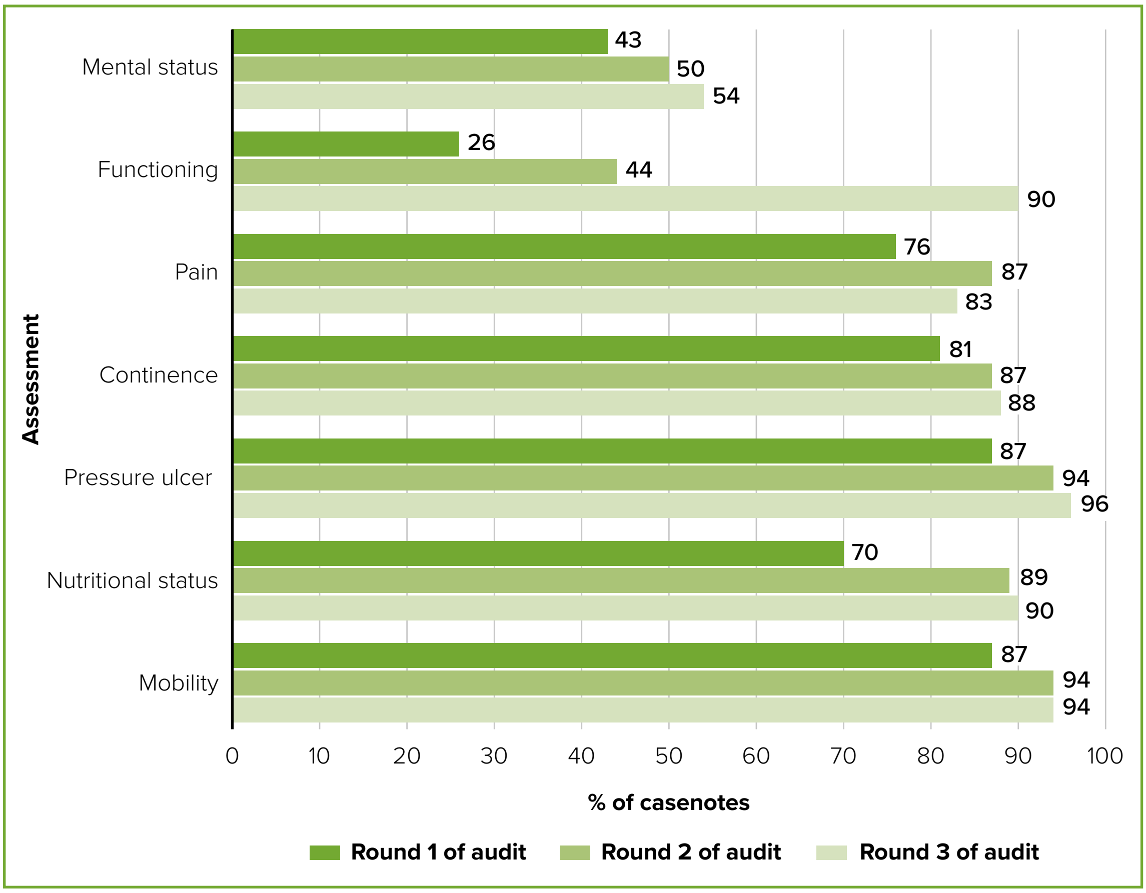
Figure 3: Percentage of patients in the national sample receiving 0-7 of the seven scoring assessments



Comprehensive assessment for older people in hospital

Patients who are older or frailer, including people with dementia, should have a comprehensive assessment so that a holistic plan for treatment and long term support can be produced[7]. Figure 3 shows a breakdown of the seven assessments included in all three rounds of casenote audit to date.

Figure 4: Assessments completed in national sample of casenotes for all three rounds of the audit



Overall, the results for physical assessments are very similar to those from the previous round. Ten percent or more of patients are not receiving an assessment of nutrition, pain, continence or functioning, and pain shows a small (not significant) decrease.

The assessment of functioning question was broadened in Round 3 to include non-standardised assessments (e.g. performed by an occupational therapist or physiotherapist). This accounts for the increase from 44% in Round 2 to 90% (8350/9294) in Round 3. Forty-five percent (4212/9294) of patients received a standardised assessment of functioning which is comparable to the 44% in Round 2.

Fifty-four percent (4684/8682) of casenotes included evidence that a standardised mental status test had been carried out, which is not a significant improvement from 50% in Round 2.

Assessment of delirium

Delirium can affect over a quarter of older patients in hospital and may have long-lasting effects on cognition, as well as physical decline[10]. Delirium is five times more likely to affect people with dementia[6], who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary.

Forty-five percent (4466/10047) of casenotes showed that an initial assessment for indicators of delirium had been carried out. This is a seven percent improvement since last round, but means that over half of patients were not screened for delirium. Feedback from sites suggests there may be some inconsistency in what is considered a screen or assessment for delirium, and whether it is recorded in the patient's notes. The percentage of patients who were clinically assessed for delirium following a screen has stayed about the same at 85% (2220/2603).

Summary

Overall, the results in this theme show little change since Round 2 of the audit. However, in some areas such as mobility and pressure ulcer assessment this was already completed in over 90% of cases, and most change although small is positive, with the exception of pain.

Physical health assessments have generally increased but by a far smaller percentage than between Rounds 1 and 2. Assessment of functioning is the only assessment to have improved by a substantial amount due to further response options provided in the question.

Assessments for mental status and delirium remain at around 50% of casenotes, showing a less than 10% change in both areas. This is particularly notable because of the impact these are known to have on length of stay and quality of life.

The similarity between results in Round 2 and 3 across all assessments is clear. It should be considered whether assessments, regardless of the outcome, are being recorded consistently.

Recommendations for Assessment

The Medical Director and Nursing Directors should:

- Ensure that hospitals have robust mechanisms in place for assessing delirium including:
  - At admission, a full clinical delirium assessment, whenever indicators of delirium are identified.
  - Cognitive tests administered on admission and again before discharge.
  - Delirium screening and assessment fully documented in the patients notes (regardless of the outcome).
  - Care offered in concordance with the delirium evidence-base recommendations when the assessment indicates symptoms of delirium.
  - Results recorded on the electronic discharge summary.
- Ensure staff receive training in delirium and its relationship to dementia, manifestations of pain, and behavioural and psychological symptoms of dementia.
- Ensure that structured pain assessments are in use and properly recorded for people with a diagnosis or current history of dementia.

Information and Communication

In this theme, we present data from the organisational checklist, casenote audit, staff and carer questionnaires about information sharing and communication within the hospital.

Round 2 of the audit recommended that hospitals should ensure all patients with dementia are easily identifiable to staff throughout the hospitals and that each patient should have a personal information document accessible in their notes. In Round 3, we asked hospitals, staff and carers about:

- Information about the patient with dementia
- Communication between staff
- Involvement of carers and people with dementia in care.

Information and communication score

The scores for information and communication have been calculated based on information from the staff and carer questionnaire.

Table 5: Questionnaire items included in each of the information and communication scores

Staff information and communication score	Carer information and communication score
Availability of personal information	Communication between staff and carers
Ability to accommodate individual needs and preferences	Involvement of carer in care decisions
Communication between staff	Staff informed of needs of patient with dementia

Figure 5: Range, ranking and national mean of scores for staff rating of information and communication (182 hospitals in England and Wales)

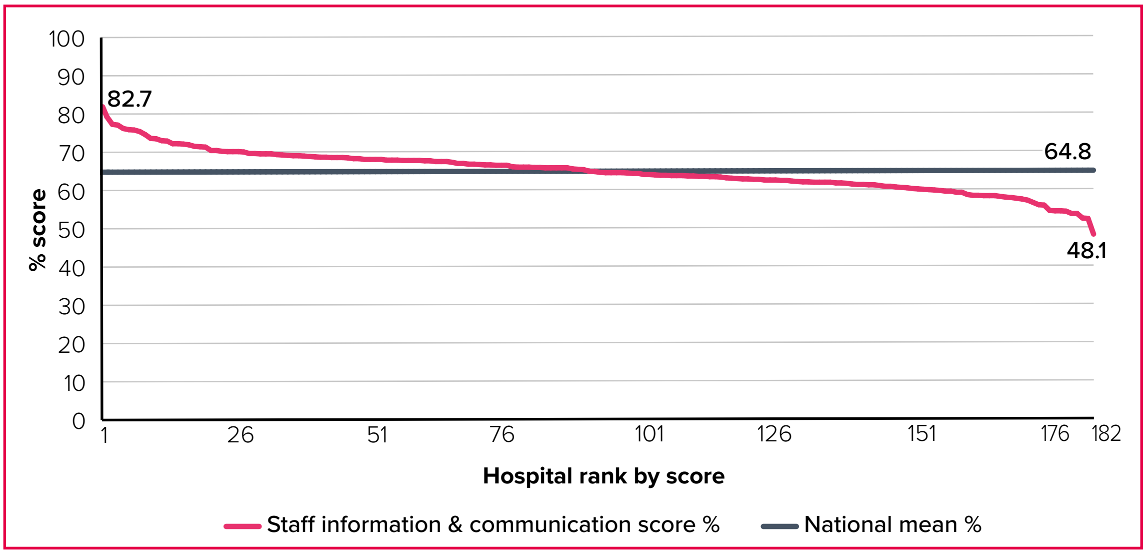
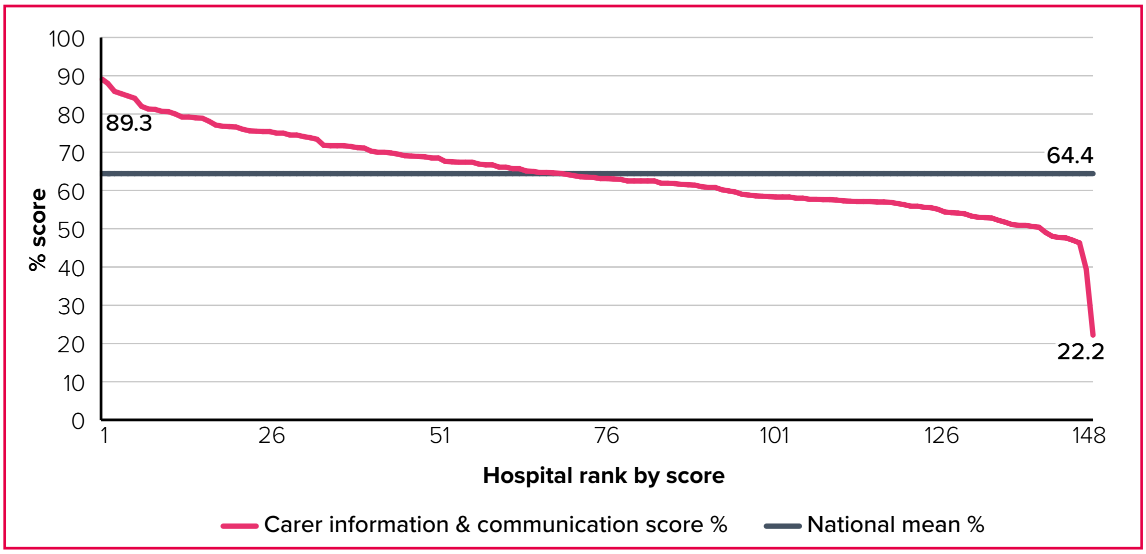


Figure 6: Range, ranking and national mean of scores for carer rating of information and communication (148 hospitals in England and Wales)



Figures 5 and 6 show the range of carer scores appears much wider than that for the staff scores. Just eight hospitals have a carer score of under 50%. The majority of hospitals scored between 55% and 75% for the staff rating of communication, with only one hospital scoring over 80%. The majority of hospitals score between 55% and 73% for the carer rating, with 11 hospitals scoring over 80%.

Information about the patient with dementia

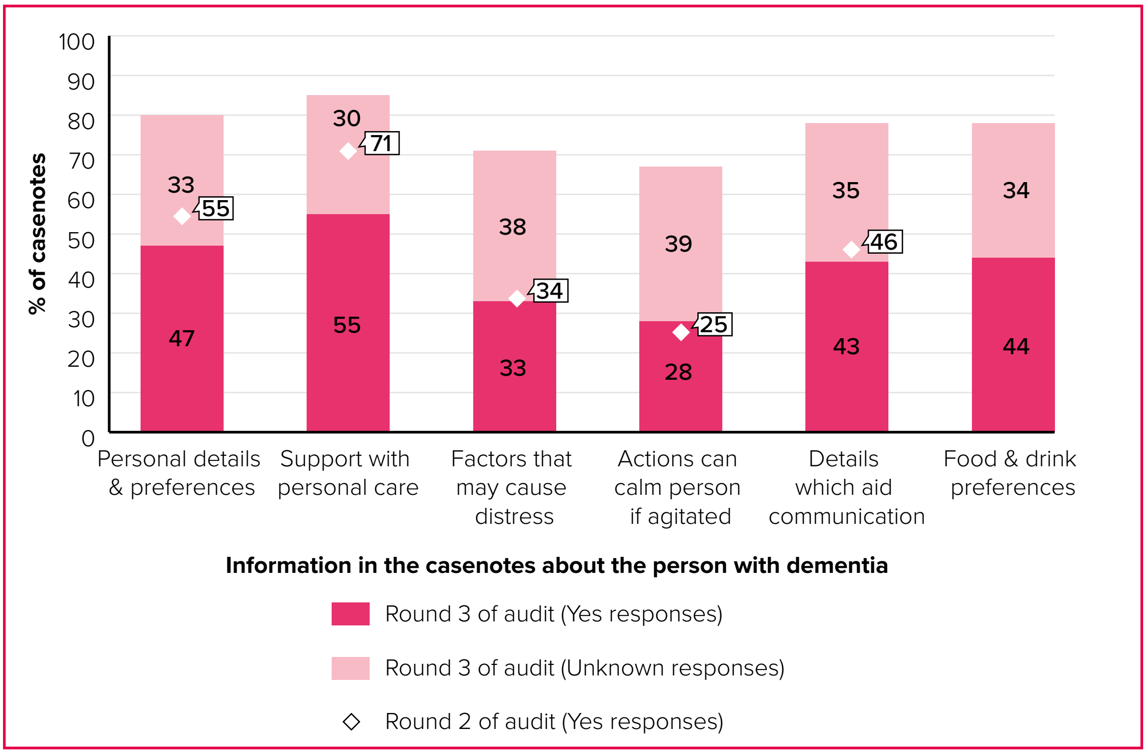
A personal information document helps staff provide person centred care, and should contain information about what the person with dementia would like help with and their preferences regarding things like food and drink. It can also detail family and life history, information to aid communication and any information regarding what may cause upset or agitation. These details help staff to understand and anticipate individual needs and involve the person with dementia in care decisions.

Nearly all hospitals (99%, 196/199) reported they had a formal system in place for gathering information about the person with dementia; a great improvement from 74% in Round 2. Of these hospitals, 93% (183/196) said staff were encouraged to approach carers and/or relatives to collect this information. All hospitals (100%, 196/196) reported that their proforma or template collected information about the patient's personal details and factors which may cause distress. One hundred and ninety five out of 196 hospitals reported the information document collected details to aid communication and on how the patient communicates and understands information. Most hospitals reported that their proforma collects information about reminders and support with personal care (99%, 193/196) and support/actions that can calm the patient if agitated (99%, 194/196).

Results from the audit of casenotes show 57% (5727/10010) of patients' notes contained a section dedicated to collecting information about the patient from the carer, next of kin or a person who knows the patient well. This is an improvement of 12% from the second round of audit (45%).

Evidence from the casenotes audited show inconsistent recording of important information (see Figure 7). Patient information about factors that may cause distress (33%, 1818/5583) and support/actions that can calm the patient if agitated (28%, 1564/5539), are least often recorded in casenotes, as in Round 2. The apparent decrease from Round 2 in types of information collected is due to a change in analysis. In Round 2, some hospitals answered that the information was present in casenotes, and then clarified that they used a form which always went home with the patient so they could not be certain about the information the form actually contained. For Round 3, we therefore included a response option 'Unknown' for use in these cases.

Figure 7: Comparison of casenote information about the person with dementia in Rounds 2 and 3 of audit



NB: The item on food and drink preferences was not collected in Round 2 of the audit.

Mini audit: documenting personal information in practice

Participating hospitals were asked to choose three acute adult wards within their hospital with the highest admissions of patients with dementia. They were asked to audit a total of ten patients, checking to see if a personal information document (e.g. Alzheimer's Society *This is me*), was present at the bed side or in the daily notes folder.

A median of ten patients were checked per site. Of the patients checked at each site a mean average of 49% had a personal information document present. This ranged from 0-100% of patients checked.

Carers' perspective: Dementia patients' needs and quality of care

Forty-five percent (2053/4524) of carers said 'yes, definitely' staff asked them about the care needs of the person they look after and 35% (1563/4524) responded 'yes, to some extent'. Under half of carers (47%, 2130/4578) said definitely, staff were well informed and understood the needs of the person they looked after, and 43% (1980/4578) said that this was true to some extent.

When carers were asked if staff delivered high quality care appropriate to the patients' needs, 54% (2489/4592) answered 'yes, definitely' and 36% (1672/4592) 'yes, to some extent'. Seventy-six percent (3471/4569) of carers said definitely that they felt staff treated the patient with respect and a further 21% (952/4569) answered 'yes, to some extent'.

Carer comments about quality of care

"Staff were very helpful, kind. They answered all the questions that they were asked. Very friendly and respectful... they couldn't do enough..."

"...He was admitted for a [screening] but his mobility was not understood by the daily care team at all. Each person who helped him in our presence had to be told by us that he could not walk unaided or transfer from bed to chair to toilet or that his dexterity is poor meaning he needs help to eat and drink. My daughter and I felt nervous that this lack of understanding over the course of each day was dangerous and frustrating for the patient who was becoming increasingly confused. To leave a packet of sandwiches sealed on a table for someone who cannot open it is cruel... His medication was confusing the staff and he became aggressive and difficult to nurse. We were not listened to by the staff ...Please listen to carers as they do have valuable contributions!"

Staff perspective: Information about the person with dementia

More than half of staff (60%, 8597/14345) felt that personal information was available to them to help them care for the patient with dementia, always or most of the time. Sixty-eight percent of staff (9003/13329) said that they had opportunities to use this information always or most of the time. Sixty-two percent (8904/14333) of staff felt they were encouraged always or most of the time to accommodate patients' individual needs and preferences.

Communication between staff

Staff working within the ward and other areas of the hospital used by the patient need to be aware of the persons' dementia to anticipate their needs. Round 3 of the audit asked hospitals whether they had a system in place to ensure staff on the ward, and staff from other care areas, are aware of the person's dementia and how it affects them. The majority of hospitals (91%, 180/199) now have a system in place to ensure all staff in the ward are aware of the person's dementia and most hospitals (70%, 140/199) have a system to ensure staff from other areas are aware of the person's dementia.

The most common method used by hospitals to indicate a person's dementia to staff is a visual indicator. This suggests use of the Butterfly Scheme[i], Forget Me Not or other locally developed systems (see Tables 6 and 7).

Table 6: Systems in place on the ward to help staff identify patients with dementia

There is a system in place on the ward so that staff are aware of the person's dementia	Round 3 % (n out of 199)	Round 2 % (n out of 210)
	91% (180)	49% (102)
System in place (more than one can be in use):	Round 3 % (n out of 180)	Round 2 % (n out of 102)
Visual indicator	91% (164)	70% (71)
Alert sheet/electronic flagging	24% (43)	8% (8)
Patient notes	34% (61)	15% (15)
Other	19% (34)	8% (8)

Table 7: Systems in place across the hospital to help staff identify patients with dementia

There is a system in place across the hospital so that staff from other wards are aware of the person's dementia	Round 3 % (n out of 199)	Round 2 % (n out of 210)
	70% (140)	41% (87)
System in place (more than one can be in use):	Round 3 % (n out of 140)	Round 2 % (n out of 187)
Visual indicator	87% (122)	62% (54)
Alert sheet/electronic flagging	19% (26)	13% (11)
Patient notes	21% (29)	13% (11)
Other	18% (25)	13% (11)

Staff perspective: communication between staff

Staff completing the staff questionnaire were asked how often they spoke as a team about the way they provide care and support to people with complex needs (including dementia). Half of staff (50%, 6203/12457) reported they frequently spoke as a team about the care/support provided to people with complex needs, whilst 37% (4636/12457) said they occasionally spoke about this and 13% (1618/12457) reported that they almost never or never did.

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[i] http://butterflyscheme.org.uk

Involvement of carers and people with dementia

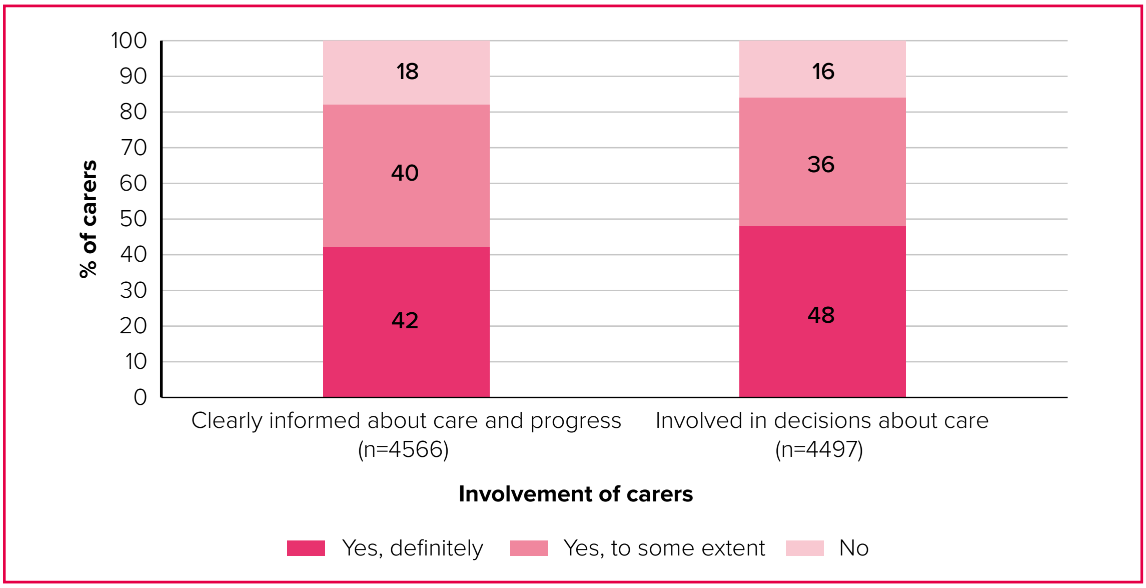
Carers and relatives of the patient who are normally involved in providing care, should have the opportunity to be as involved as they would like in decisions about care and treatment. Good communication between staff and the carers and families of the person with dementia helps ensure that the person with dementia receives the information and support they need[19].

Most hospitals (82%, 163/199) said the dementia lead or dementia working group collects feedback from carers about the verbal and written information provided to them by the hospital.

Carers perspective: involvement of carers in decisions about care

The carer questionnaire asked carers if they felt they were kept clearly informed about the patients care/progress and if they were involved as much as they wanted to be in decisions about care (see Figure 8).

Figure 8: Carer questionnaire responses about being kept informed and involved in care decisions of the person with dementia



Support provided to carers

Carers should be offered an assessment of their needs when the person they look care for is discharged[17]. In Round 3, 67% (2605/3868) of carers had their needs assessed prior to discharge of the person with dementia. In Round 2, 72% were assessed.

One question on the carer questionnaire asked carers how supported they felt by the hospital while the person they care for was admitted. Fifty percent (2204/4379) said that they were very satisfied with the support they received and 34% (1487/4379) said they felt somewhat satisfied. Sixteen percent (688/4379) of carers said that they felt somewhat or very dissatisfied.

Carer comments about hospital communication

"You sometimes get conflicting information from one person to another. Some staff are better informed… than others."

"Specialist staff were helpful and supportive to both me and my husband…The problem came with general staff on the ward who didn't apparently read his "passport" which I had carefully completed, and didn't appear to understand the anxiety and distress generated by being in an unfamiliar place…."

Summary

Overall, results from the organisational checklist show that there has been significant improvement since Round 2 in developing systems for gathering information about patients with dementia, ensuring staff are aware of patients' dementia and in involving carers.

Further improvement is required around collecting personal information about the patient in practice, and making it available to staff. Information regarding actions which may help to calm a patient, are important in ensuring that the care provided is person centred.

Most carers felt that staff treated the person with dementia with respect, but were less definite about how well informed staff were and the quality of care they were able to deliver. Carer feedback also pointed to deficits in communication and involving the carer in care provided.

Recommendations for Information and Communication

National Commissioners should:

- Propose a nationally backed monitoring programme aimed at embedding the collection, sharing and use of person centred information. This should include a clear expectation that once gathered, this information will follow the patient between providers, and that this will be monitored.

Clinical Commissioning Groups/Health Boards should:

- Specify in contracts with care homes that the personal care story/information sheet that is completed for each resident should accompany them on any admission to hospital.

The Chief Executive Officer should:

- Ensure that carers for people with dementia can communicate with clinicians in order to share and receive information. Carers should be given the opportunity to speak to staff privately, ensuring that their privacy and that of patients is respected.

The Medical Director and Nursing Directors should:

- Incorporate a heading for discussions with relatives/carers within the patient notes/healthcare records, and ensure staff are aware of its purpose.

The Senior Clinical Lead for Dementia should:

- Ensure that copies of the personal information document (such as Alzheimer's Society *This is Me* or other locally developed document) are available on the ward and that the information is kept accessible to staff and visiting carers.

Ward Managers and Multidisciplinary teams should:

- Audit implementation/use of personal information collected to improve care for patients (e.g. *This is Me* or other locally developed document). The result of the audit should be fed back to the dementia champions/dementia lead and ward staff.

Staffing and Training

“By 2020, we would wish to see all NHS staff having received training on dementia appropriate to their role.”

Prime Minister’s Challenge on Dementia 2020[12].

In Round 2 of the audit, we recommended that all staff in general hospitals, including support staff, should receive dementia awareness training. We also recommended that training frameworks, with clearly defined competency levels for the various staffing groups, should be established.

In Round 3 of audit, to gain a picture of dementia training and staffing levels in general hospitals, we asked staff, carers and the organisations about:

- Flexibility of staffing levels
- Numbers of staff trained
- The format of dementia training
- The effectiveness of dementia training.

Staffing and training score

For this theme, it has not been possible to score hospitals. At the time of audit, too few hospitals could provide information to allow for any comparison regarding the numbers of staff who had received training.

Staffing levels

Although there have been numerous publications from various organisations on safe staffing levels in acute hospitals, there are currently no mandatory national standards on staffing numbers or ratios. The National Institute for Health and Care Excellence (NICE) has guidelines on measuring required ward staffing levels for adult inpatient wards in general hospitals[16], but these guidelines do not specify expected staff to patient ratios and NICE has not published guidelines specifically for older people’s wards. The Royal College of Nursing has published recommendations about staffing levels in various acute environments but these are also non-compulsory[18].

NHS England recommends that hospitals use an evidence-based decision making tool such as the ‘Safer Nursing Care Tool’ for calculating ward staffing levels[15]. Tools such as these do take into account the patients on the ward and their needs (ward dependency levels), but there is no nationally regulated tool and the use and interpretation of such tools is left to individuals and hospitals.

The organisational checklist asked hospitals whether an evidence-based tool is used to establish staffing levels at an organisation level. Almost all (99%, 197/199) hospitals answered positively to this question. Eighty-eight percent (176/199) of hospitals also said that ward staffing levels were made available to the public on a monthly basis.

Staff were asked whether they thought the ward they work on is able to respond to the needs of people with dementia when they arise. Seventy-eight percent (7137/9148) agreed that this was possible always or most of the time. Staff were also asked if extra staffing support is provided when dependency needs of the ward increase. Only 11% (977/9143) of staff said 'yes, always', 28% (2516/9143) said 'yes, most of the time', 43% 'yes, sometimes' (3887/9143) and 19% (1763/9143) answered 'no'.

In the staff questionnaire, 36% of all comments from the suggestions box related to staffing levels and how staff believed this impacted on the care and support of patients in their hospital.

Staff suggestions about staffing levels

"Most times, [I] go home feeling guilty because of the lack of care given to individuals because [I am] having to watch confused/wandering/upset patients and feel that [I] have neglected others, all due to not enough staff."

Healthcare assistant

"More staff!! Constantly understaffed on the wards, no time to provide adequate care, staff are frustrated that even when brought to the attention of senior managers, this is justified by other wards being just as unsafely staffed, or worse."

Registered nurse, Band 5 or 6

Carers were asked whether the person with dementia was given enough help with personal care by hospital staff; 55% (2456/4433) of carers replied 'yes, definitely', 34% (1515/4433) answered 'yes, to some extent' and 10% (462/4433) 'no'.

Carer comments about help with personal care

"Grandad was so well looked after, he said to me he is in a hotel having a week off. Grandad has dementia and the nurses let me talk to grandad on their telephone... Grandad was washed, dressed and shaved while in hospital every day – something that never happened in his care home. Grandad is moving to [location] on his discharge, he is very well and happy after his stay in hospital. He loved the food and drink. Thank you to everyone who looked after grandad...."

"...the patient has had the following experiences: fell over and gashed his head, had his dentures broken, new dentures found under his bed, he was wearing another patient's spectacles – somehow, they got crossed, not enough attention or thought given to his meal selections..."

Staff training

Dementia training framework

Since the *Prime Minister's Challenge on Dementia 2020*[12] and the *2015-16 Mandate from the Government to Health Education England*[11], Health Education England has created a dementia training framework for use by care and health staff. The framework, known as the *Dementia Core Skills Education and Training Framework*[21], has three tiers, beginning with basic awareness training which aims to improve knowledge, skills and attitudes of all staff. Tier two is for those who work regularly with people living with dementia and tier three is intended for those working in leadership roles.

In Wales, *Good work: A dementia learning and development framework for Wales*[8] has been developed by the Care Council for Wales, NHS Wales, Public Health Wales and Welsh Government, to be used across the care and health sector. The Welsh framework also has three distinct levels of training; 'informed', 'skilled' and 'influencer'. The levels follow a similar training pattern to the three tiers described by NHS England, although the 'informed' level in the Welsh framework, consists of Dementia Friends training (provided by the Alzheimer's Society) only.

Since the introduction of these national frameworks, it would be expected that more hospitals would report having a training and knowledge framework which identified necessary skill development in working with, and caring for, people with dementia. In Round 1 of the audit, 23% of hospitals had a framework. In Round 2, this had increased greatly to 78% of hospitals. In this third round, it increased further to 96% (190/199) of hospitals reporting that they have a knowledge and training framework for dementia care in place.

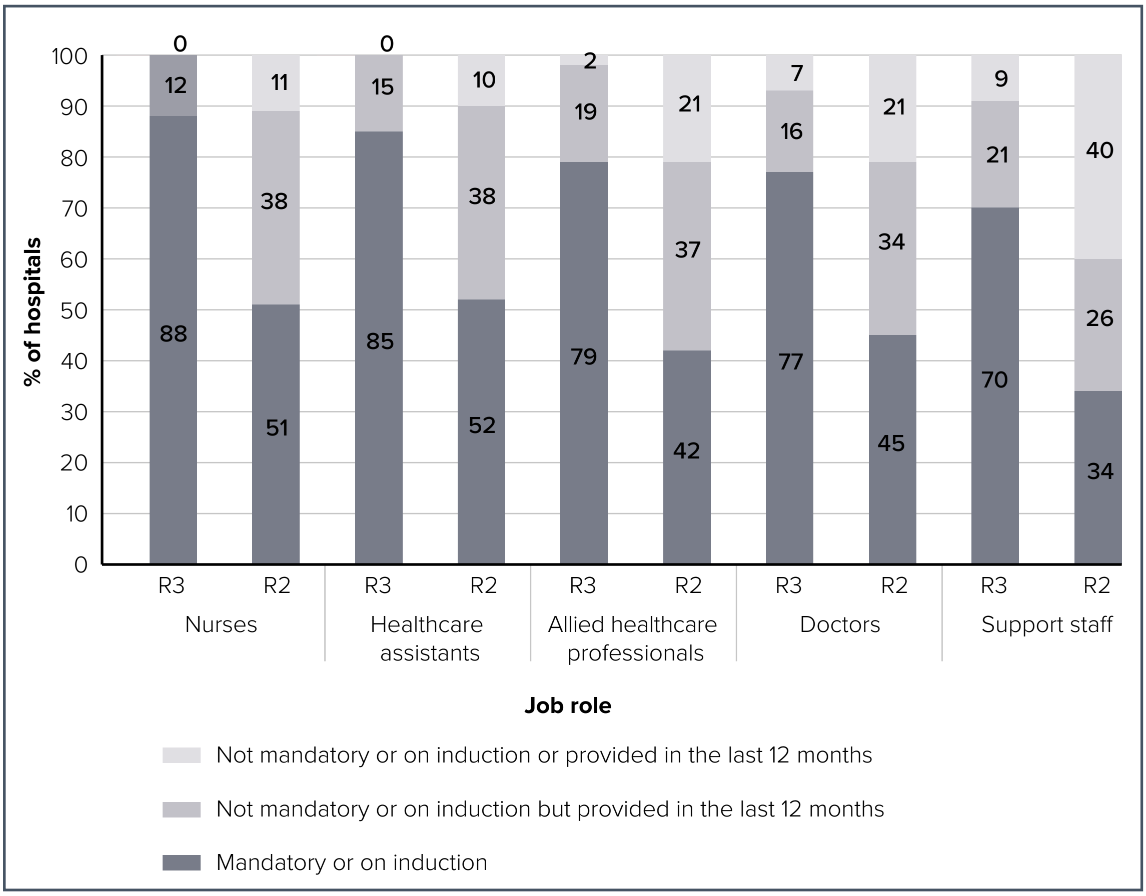
Hospital data on people receiving dementia awareness training

Round 3 of audit asked hospitals to provide details on the number of staff trained in dementia awareness in the last three years. Only 17% (34/199) of hospitals were able to confirm training figures for at least one of the years specified. About a hundred hospitals could provide training figures at an NHS Trust/Health Board level only. The remainder were unable to provide information on the numbers of staff trained.

We asked for feedback from hospitals which were able to provide hospital level training figures. Methods of data collection ranged from the dementia lead in the hospital maintaining their own records, to a formal records training system being held and updated by the learning and development department. The depth and use of this information also varied across organisations; some report that they are able to find this information on an individual basis and use it for personal reviews. Other hospitals simply keep total figures (in which individuals are not distinguishable) to report to organisations such as Health Education England. These data (or lack of), and their various uses, show that monitoring of the new training frameworks has not yet been consistently implemented across hospitals.

Although it was not possible to collect and compare information on the number of staff trained between hospitals this round, it has been possible to compare Rounds 2 and 3 on whether training provided by the hospital is mandatory, provided on induction, or provided in the last 12 months. Figure 9 shows this comparison broken down by staffing groups. Overall, all staffing groups now have more dementia awareness training on induction, or as mandatory training. All hospitals (n=199) reported that training had at least been provided in the last 12 months to nursing staff. Doctors and support staff remain the staffing groups with the lowest levels of training provided by the hospital.

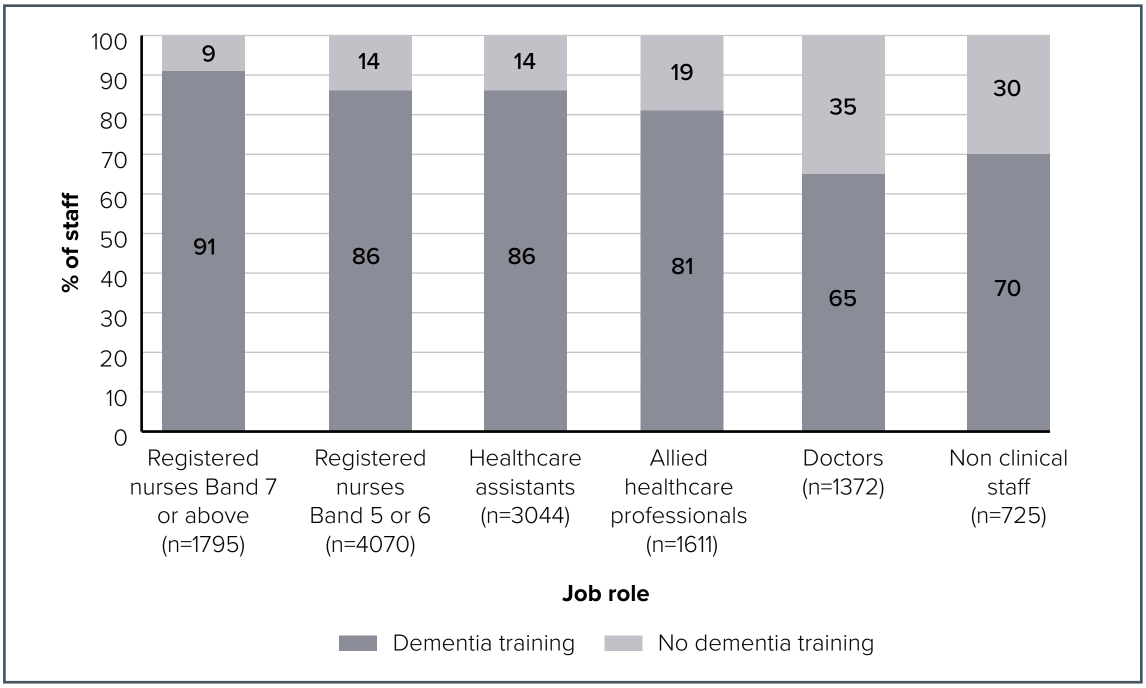
Figure 9: Proportion of hospitals providing dementia awareness training to different staffing groups, and whether training was mandatory/provided on induction or provided in the last 12 months (2015-2016)



Staff questionnaire data on dementia training

The staff questionnaire asked whether staff had received any training in caring for, and supporting, patients with dementia. Figure 10 shows that at least 80% of most staff groups received at least one form of training in dementia – apart from doctors and non-clinical staff (e.g. ward based administrative staff) who reported less training. It should be noted when comparing the groups 'support staff' (in the organisational checklist) and 'non-clinical staff' (from the staff questionnaire), that the organisational checklist included job roles such as porters and housekeepers, whereas the staff questionnaire did not.

Figure 10: Proportion of staff reporting they received some form of dementia training from the hospital they currently work at, by staffing group



In Round 1 of the audit, just 29% of hospitals reported that training included the involvement of people with dementia, their carers and used their experiences; this increased to 66% in Round 2, and then again to 82% (164/199) of hospitals in Round 3. This is an especially encouraging trend given the comments made by Dr Trevor Jarvis earlier in this report (page 11).

Dementia training formats

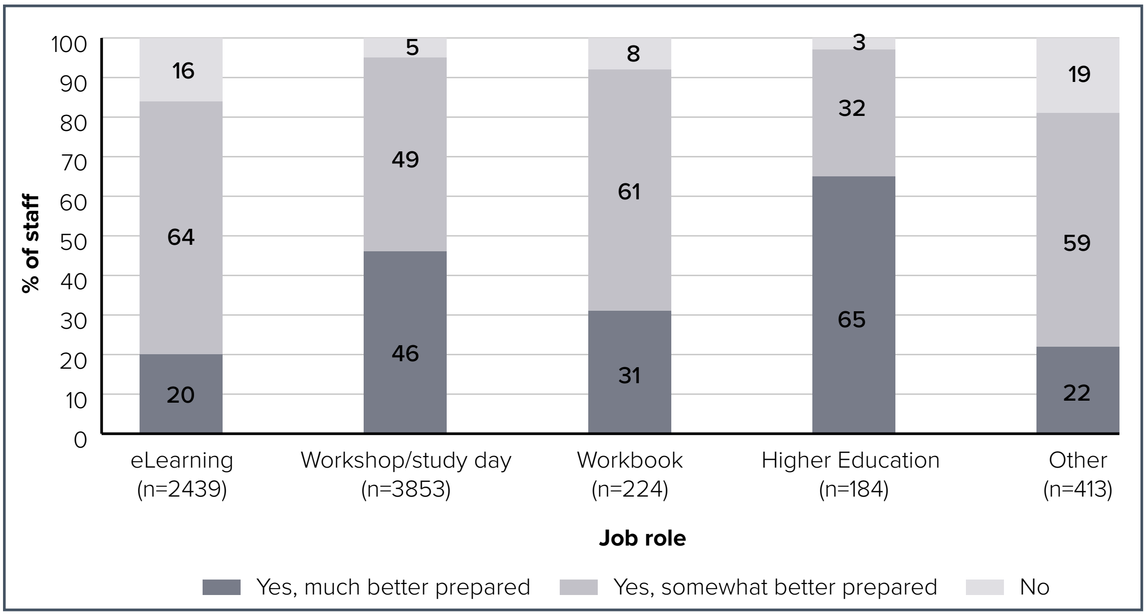
The organisational checklist and staff questionnaire responses similarly report the most and least used formats of dementia training.

Table 8: Most and least common dementia training formats according to hospitals and staff

What hospitals said:	What staff said:
91% (181/199) of hospitals provide dementia training in the form of a workshop or study day.	The highest proportion of staff reported they had attended a workshop or study day (53%, 7030/13,205).
73% (145/199) of hospitals provide eLearning for dementia training.	43% (5653/13,205) of staff said they have had dementia training in the format of eLearning.
29% (58/199) of hospitals offer some other format for dementia training (e.g. workbook, virtual dementia training).	15% (1912/13,205) of staff had received training in another format (including workbook).
23% (45/199) of hospitals offer a higher education module in dementia.	5% of staff (713/13,205) had undertaken a higher education module in dementia.

Members of staff completing the staff questionnaire were asked whether the training they received had made them feel better prepared to care for and support people with dementia. Figure 11 illustrates responses of staff who received any one type of training (people who received more than one type are not included in this graph).

Figure 11: Proportion of staff reporting preparedness to care for people with dementia according to the one format of training received



Of staff who had received two types of dementia training, 51% (1431/2822) reported that they felt much better prepared and 46% (1296/2822) felt somewhat better prepared. Of those who reported that they had received three or more types of training in dementia, 73% (536/735) said that they felt much better prepared and 26% (191/735) felt somewhat better prepared.

Staff suggestions about dementia care training

"eLearning does NOT increase awareness or engagement with the issue. Dementia is a very pertinent issue, and should receive more attention in training than it does currently."

Doctor

"I feel rushed to do my eLearning – have to do it as well as working on ward so I get distracted and don't really absorb the information."

Healthcare assistant

"Much more training – experiential learning for all clinical staff should be compulsory to understand what it is like being a patient with dementia. I think this would be a very powerful way of getting staff to have a much better understanding of patients' needs. We all need to become specialists in this, not just some staff – this can only come through training and relating this to practice. We all need training in how to manage patients with delirium who become aggressive."

Registered nurse, Band 7 or above

Summary

Almost all hospitals report using an evidence-based tool for establishing staffing levels (which usually include ward dependency levels). However, the staff questionnaire showed that not all staff think that adequate staffing is available to meet the needs of people with dementia in hospital.

The introduction of the national dementia training frameworks in England and Wales appear to have had a positive impact on dementia training in hospitals. Ninety-six percent of hospitals now report the adoption of a training framework for dementia. The levels of mandatory training, or training provided on induction, has increased across all staffing groups; though disparity between staffing groups remains, with doctors and support staff receiving less training than others.

The organisational checklist and the staff questionnaire agreed that the most commonly used training methods for staff are study days, workshops and eLearning. The staff questionnaire was useful in providing some more information about dementia training in hospitals. It showed that out of the two most commonly used dementia training methods, staff rated the eLearning method less favourably than a face-to-face workshop or study day session.

Overall, in this theme of the audit there have been some encouragingly significant changes and improvements. The introduction of the staff questionnaire has allowed direct comparison with the organisational checklist and this has added further understanding of dementia training and staffing levels in general hospitals in England and Wales.

Recommendations for Staffing and Training

The Medical Director and Nursing Directors should:

- (With the Education Lead for the Trust or Health Board) ensure that training in dementia awareness is a priority for all staffing groups. eLearning should not be relied on as the sole medium for delivering training in dementia awareness.
- (With the Head of Therapy Directorate) keep central training records on all staff receiving training in dementia, enabling them to be aware of the levels of awareness and expertise in the hospital.

Health Education England/Care Council for Wales should:

- Incorporate training on delirium and its presentation in people with dementia, including Behavioural and psychological symptoms of dementia, into Tier 1/“Informed” level training for healthcare staff.

Nutrition

Nutrition is a new theme for Round 3 of the audit, presenting data from the organisational checklist and the staff questionnaire about food provision for people with dementia.

It is estimated that a significant proportion of people with dementia living in the community are malnourished or at high risk of becoming malnourished[1,2]. When people enter hospital, problems with eating and drinking may be exacerbated by illness, pain or the unfamiliarity of the setting. Food and drink which is unsuitable for the person, is presented without adequate support, or is given at an unfamiliar time will also increase difficulties with intake.

In this round of the audit, we asked about:

- Food services suitable for people with dementia.
- ‘Protected’ (uninterrupted) mealtimes.
- Feedback from staff on how well food services work for people with dementia.

Nutrition score

The nutrition score is derived from items in the organisational checklist. For further information on scoring, see page 25. In planning provision of food and drink suitable for people with dementia, hospitals should ensure:

- A range of foods are made available which can be eaten without cutlery and are equivalent to full meals. These are known as finger foods. Finger foods can allow people with dementia to maintain independence and enjoy food at their own pace
- Food is available throughout the day and night (24 hour food services). People with dementia may be accustomed to particular times for meals and find it easier to eat and drink then. They may also experience changes in their sleep pattern due to dementia or to the unfamiliar hospital setting and require support not to miss meals
- Protected mealtimes are established in all wards admitting people wdith dementia but carers should be allowed to attend to offer support/encouragement
- There is a carer’s passport or other scheme in place to ensure carers of people with dementia can visit at any time, including mealtimes. The carer’s knowledge about the person, and the reassurance that they provide, can be extremely important in all aspects of care. People with dementia have a right to the support of their carer at all times, when the carer is able to, and wishes to, provide this support. The hospital can recognise this through schemes such as a Carer’s passport which ensure that the carer is not excluded at mealtimes or other important times.

Figure 12: Range, ranking and national mean of nutrition scores (199 hospitals in England and Wales)

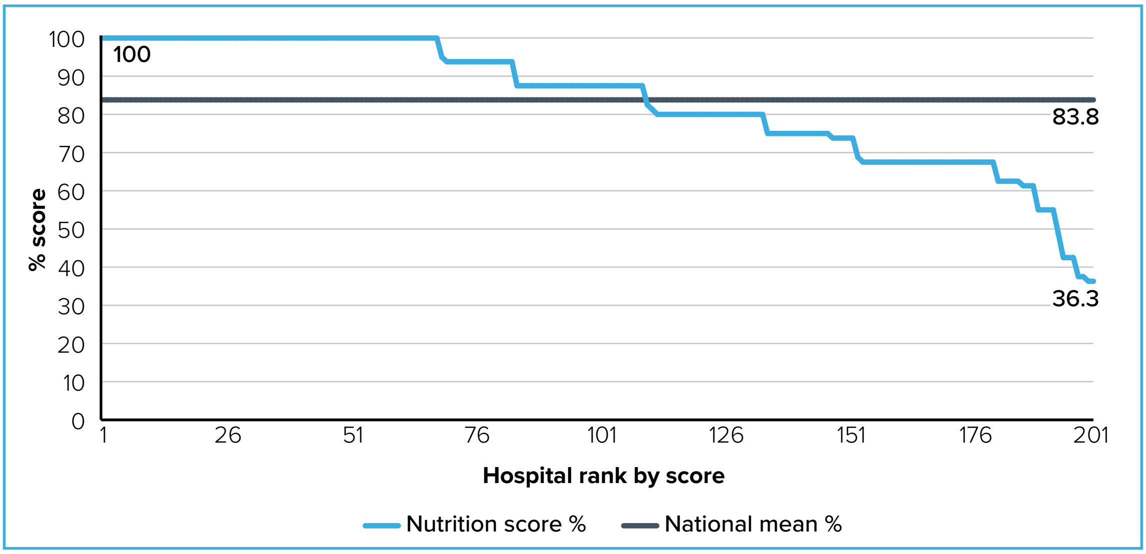


Figure 12 shows a wide range of scores for nutrition. Most hospitals (73%, 146/199) achieved a score of 75% or above, with 34% of hospitals (68/199) achieving the maximum score of 100. Four percent of hospitals (8/199) scored less than 50%.

Providing finger food

The staff questionnaire asked nurses and healthcare assistants working on wards at mealtimes, about accessing finger foods and snacks between meals for people with dementia, and protected mealtimes. The organisational checklist asked about the same topics.

Most hospitals (65%, 130/199) reported they can provide complete meal finger food options every day (a further two said they can do this 4-6 days a week). For the remaining 67 hospitals, only sandwiches or wraps are available as alternatives to a main meal. Around two thirds of ward staff (65%, 5754/8822) said that they could access finger food for people with dementia always or most of the time.

Staff suggestions about finger food

"Finger food, availability of more dementia friendly snacks. Nutritionally it would be ideal at times if there was access to food they may enjoy – families will often bring in items that they know they enjoy but for those who don't have accessible family etc., it is difficult to often obtain something different that they may prefer."

Registered nurse, Band 7 or above

24 hour food services

Most hospitals (86%, 171/199) said that they can provide some food services over 24 hours. Fifty-nine percent (101/171) of these provided a range of foods including lighter hot meals as well as toast, soup etc. Thirty-seven percent (64/171) could provide simple foods such as bread, cereal, yoghurt and biscuits, and 4% (6/171) could only provide biscuits or snacks.

Seventy-three percent (6675/9119) of ward staff said that they could access snacks for people with dementia between mealtimes always or most of the time.

Staff suggestions about 24 hour food services

"I work nightshifts and no suitable food is left for patients overnight and we are often asked for late evening/night snacks from patients. It is not a good feeling to not be able to provide a snack for patients who often do not eat sufficient amounts in the day. I have often given food/drink of my own to patients in order to help."

Healthcare assistant

"Flexibility around mealtimes would be optimal for patients with dementia but honestly, I have not worked in a single hospital in London or the surrounds where this can be accommodated – the problem is with using a third-party catering service."

Allied healthcare professional

Protected mealtimes

Nearly all hospitals said mealtimes were protected in all wards admitting people with dementia (98%, 195/199). Eighty-nine percent (173/195) of these hospitals monitored protected mealtimes to ensure that they were not interrupted. In the previous round, 97% of hospitals with protected mealtimes monitored adherence.

Only 68% (5944/8788) of ward staff surveyed thought that mealtimes had been kept free of clinical activity in the previous week always or most of the time. This was after excepting for any emergency situations that had arisen.

Staff suggestion about protected mealtimes

"If all the transfers [and admissions] could be held off for even one hour a day, it could make a huge impact on the time we can spend supporting patients with dementia at mealtimes."

Registered nurse, Band 5 or 6

Carer passport/John's Campaign

Only a minority of hospitals (11%, 22/199) said that they did not have a carer passport or similar scheme so that the carer could come in at any time to support the person with dementia. Seventy-nine percent (9402/11978) of ward staff agreed that a carer for a person with dementia could visit at any time, always or most of the time.

Staff suggestions about carer passports/John's Campaign

"Make mealtimes more fun. Find out people's mealtime routine. Possibly having music in the background, family members bring in food and eating with patients with dementia to reinforce their understanding that it is mealtime. Families that visit the ward on open visiting, play an important role in maintaining nutrition needs are being met. Familiarity of loved ones remains vital in supporting people with dementia."

Registered nurse, Band 5 or 6

"I feel we are quite liberal with our visiting times on the ward but it would be good to be able to actively encourage relatives of dementia patients to visit whenever they can."

Doctor

Communicating nutritional needs

Eighty percent (7238/9090) of ward staff said the nutrition and hydration needs of people with dementia were communicated at handover/briefings and 76% (9330/12263) said people with dementia had their nutritional needs met, always or most of the time.

Summary

Most hospitals provide or commission food services intended to meet the nutritional needs of people with dementia. However, these services do not seem to be consistently available across hospitals. There were discrepancies between hospital reported provision and staff feedback. This may reflect that provision and/or staff awareness is not always consistent with hospital policies. Feedback from staff demonstrates the importance of monitoring how well services are provided.

Most hospitals are implementing schemes to ensure that carers of people with dementia can visit when they need to, increasing support and reassurance to the person. However, it is important that organisations always recognise that people with dementia may not have family or friends who are able to undertake this support. For many reasons, including ill health, work, family commitments and the distance required to travel to hospital, family carers may not always be able or choose to visit. Ward staffing levels should ensure that support with food and drink is provided whenever needed.

Recommendations for Nutrition

Clinical Commissioning Groups/Health Boards should:

- Ensure that tenders let by Trusts for new catering contracts always specify provision of finger foods for main meals and access to a range of snacks 24 hours a day.

The Medical Director and Nursing Directors should:

- Promote the attendance of key carers to support care, but ensure that this is complementary to, and not instead of, care delivered by staff. The level of input by carers, and how carers feel about the level of input they have been asked to deliver should be monitored through carer feedback, complaints and PAL enquiries. Carer satisfaction should be seen as a marker of good care. Ward managers should be supported to ensure carers supporting patients should not be asked to leave at mealtimes and/or stopped from helping with meals. (This excludes emergency and urgent care and treatment).

The Senior Clinical Lead for Dementia should:

- Target local Trust quality improvement initiatives aimed at ensuring the nutritional needs of people with dementia are met.

Ward Managers and Multidisciplinary teams should:

- Encourage carers to attend mealtimes whenever they want and ensure their input is valued.

Discharge

This theme presents findings from the casenote audit and the organisational checklist about the discharge or transfer of care for patients with dementia.

Round 2 of the audit recommended that improvements should be made to discharge planning and communication, paying particular attention to discussing discharge support and care needs with the patient and their family/carer. In line with this, it encouraged hospital staff to summarise and record important information related to the person's dementia and/or delirium in the discharge documentation.

The Round 2 recommendations also highlighted that the Executive Board should be notified of instances where less than 24 hours' notice of discharge was given to the carer[20]. This was therefore added as an item in the organisational checklist for Round 3.

Discharge planning

The unfamiliarity of the hospital environment can create additional stress and upset for people with dementia; patients should return to their place of residence as quickly as possible. Timely coordination is essential as delays in initiating discharge planning can cause prolonged admissions[14].

Round 3 of the audit shows that 47% (2483/5242) of casenotes initiated discharge planning within 24 hours of admission. This has increased by 8% but is still less than half of casenotes audited (casenotes in which there were medical reasons why this could not be initiated were excluded from analysis).

A named person or team was identified to coordinate the discharge plan in 82% (5807/7083) of casenotes. This is an 18% increase from Round 2 of audit, impacted by a change in the question to allow for named teams (as well as individuals).

In Round 3, 85% (6234/7329) of casenotes contained a single plan/summary for discharge, an increase from 69% in Round 2. Sixty percent (4211/6995) of discharge plans/summaries documented support or care needs, similar to Round 2 results (62%).

Most patients or carers received a copy of the plan/summary (81%, 5621/6975), an improvement of 15% from the last round. A copy of the discharge plan/summary was sent to the GP/primary care team 94% (6701/7156) of the time.

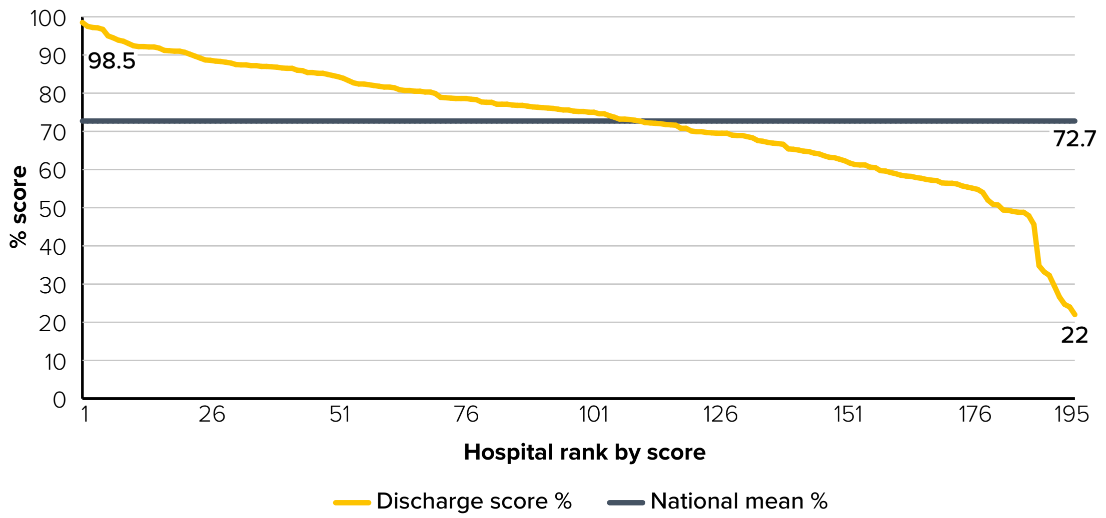
Discharge planning score

The score for discharge is based on items from the casenote audit. The questions asked whether there was evidence in the notes of discussions regarding the patients' place of discharge and support needs with:

- The person with dementia
- The carer or relative
- The consultant responsible for the person's care
- Other members of the multidisciplinary team.

The results for these questions have not changed significantly since Round 2, the largest percentage change is 3%. Figure 13 shows that there were 22 hospitals who scored 90% or above and 15 hospitals who scored less than 50%.

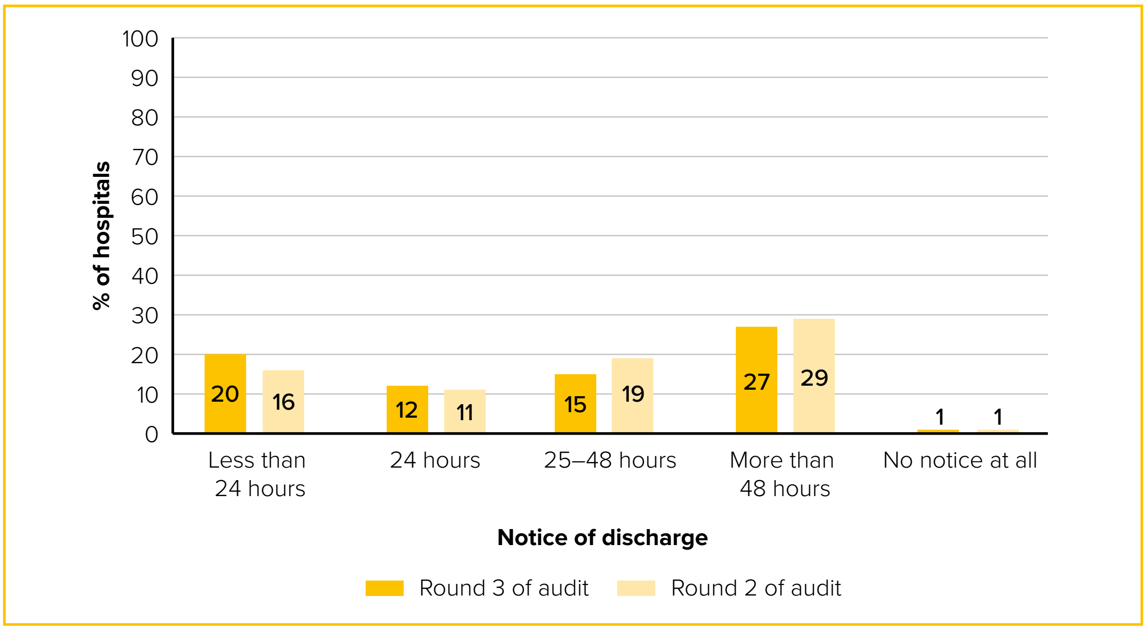
Figure 13: Range, ranking and national mean of discharge scores (195 hospitals in England and Wales)



Carer Involvement

Carers and family should receive adequate notice of discharge in order to make any necessary arrangements. Since the last round of audit, the percentage of casenotes where notice of discharge was provided remains unchanged at 74% (5389/7329). Figure 14 shows that when notice of discharge was given, the length of notice has generally decreased.

Figure 14: Notice of discharge given to carers and family in Round 2 and 3 of the audit



NB: Twenty-four percent (1770/7329) of casenotes indicated that this information was not documented and 2% (132/7329) had no (contactable) carer or family. Patients who, for example, self-discharged or who were on an end of life care plan have been excluded.

Round 2 of the audit recommended that hospitals should report, review and investigate any discharges where less than 24 hours' notice was given and we asked about this in Round 3. In the last year (2015-16), 6% (11/199) of hospitals compiled and reported instances where less than 24 hours notice of discharge was given to the carers or family to the Executive Board.

Carer comments about discharge

"…On discharge my relative was sent home with a poor care pack (practically non-existent, even though we constantly informed the hospital of our concerns over her mental health, age related)… Home 1 day and already it's a nightmare trying to get relative sorted. Had to have ambulance and GP out in 24 hrs, relative totally confused. Very unhappy."

"1st failed discharge – discharged far too early… led to re-admission. 2nd discharge – way too soon and rushed. Led to… being home severely agitated in the care of an 85-year-old who also has dementia – highly unsatisfactory."

Assessment before discharge

At the point of discharge, 22% (1639/7329) of patients had their level of cognitive impairment assessed (using a standardised tool) and summarised. This shows little change from Round 2 results (19%). In Round 3, hospitals were asked to state the reason why an assessment of cognitive impairment was not completed. The majority of casenotes did not contain a recorded reason why this was not assessed (78%, 4444/5690). There has been a 10% increase in casenotes that recorded the cause of cognitive impairment for discharge (69%, 5067/7329).

Symptoms of delirium and behavioural and psychiatric symptoms of dementia (BPSD) remain unrecorded in more than half of casenotes. Behavioural and psychological symptoms of dementia is used to describe the non-cognitive symptoms and behaviours of dementia including wandering, aggression and delusions. Delirium was summarised for discharge in 48% (1133/2367) of casenotes and behavioural and psychiatric symptoms of dementia in 45% (635/1426) casenotes.

Assessments of people in care homes

The first two rounds of audit showed people living and returning to care homes were less likely to have their level of cognitive impairment assessed at discharge. There has been almost a 10% increase in people with dementia coming from, and returning to, a care home (nursing or residential), who had this assessment at discharge (Round 3, 17%, 437/2522; Round 2, 9%). The number of people with dementia who came from and returned to their own home who had their cognitive impairment assessed at discharge, remained about the same at 24% (836/3445).

Capacity and consent to change of residence

Major decisions regarding changes upon discharge (such as a change in residence) should be made with the patient and recorded in the casenotes. If the person with dementia does not have the capacity to make the decision, there should be a recording of a best interests decision making process[5].

Where there was a recorded referral to a social worker for an assessment of housing and care needs due to a proposed change in residence, 34% (558/1649) of casenotes did not have a record of the patient's consent or a best interest decision.

Summary

Slight improvements have been made to the initiation of discharge planning within 24 hours of admission between Rounds 2 and 3 but this still did not happen in over half of casenotes.

Since Round 2 of the audit, good progress has been made in the coordination of a single discharge plan or summary, including the dissemination of this to the patient or carer/family. Further work is needed to ensure that support and care needs of the patient are included in this summary. Sufficient involvement of the carer, notice of discharge and discharge plans can be crucial to a successful discharge.

Assessments of mental health needs before discharge are important for continuing care in the community. The cause of cognitive impairment, along with a summary of any symptoms of delirium or behavioural and psychiatric symptoms of dementia that a patient experienced during their admission, should be clearly recorded.

A change in residence can have a substantial impact on a patient and the audit results showed that a third of casenotes did not record the patient's consent or a best interests decision making process when such a change was proposed.

Recommendations for Discharge

The Medical Director and Nursing Directors should:

- Ensure that hospitals have robust mechanisms in place for assessing delirium including:
    - At admission, a full clinical delirium assessment, whenever indicators of delirium are identified.
    - Cognitive tests administered on admission and again before discharge.
    - Delirium screening and assessment fully documented in the patients notes (regardless of the outcome).
    - Care offered in concordance with the delirium evidence-base recommendations when the assessment indicates symptoms of delirium.
    - Results recorded on the electronic discharge summary.

Safeguarding and Dignity Leads should:

- Ensure staff are properly trained and informed on the need for the appropriate presence and participation of the patient in discussions about the patient's care, treatment and discharge. Discharge discussions should include a comprehensive note of who was present and the views expressed. The appropriate presence and involvement of the carer(s), as determined by patient consent or best interest decision, should also be recorded.
- Ensure that staff are trained in the Mental Capacity Act, including consent, appropriate use of best interests decision making, the use of Lasting Power of Attorney and Advance Decision Making. Training should cover supportive communication with family members/carers on these topics. (See e.g. *NHS England's Dementia: Good Care Planning*).[j]

[j] https://www.england.nhs.uk/wp-content/uploads/2017/02/dementia-good-care-planning.pdf

Governance

In this theme, we present findings from the organisational checklist and staff questionnaire about governance and processes in the hospital.

In this round of the audit, we asked about:

- Care pathways for people with dementia
- Involvement of the Executive Board
- Dementia working groups
- Dementia champions
- Carer engagement
- Continuity of care
- The environment
- Staff views of the support they receive.

Round 2 of the audit recommended that all hospitals should have a care pathway for dementia in place by June 2014, supervised and implemented by a senior clinician. The audit also recommended better scrutiny of key information by the Executive Board and that all hospitals should have dementia champions and dementia specialist nurses.

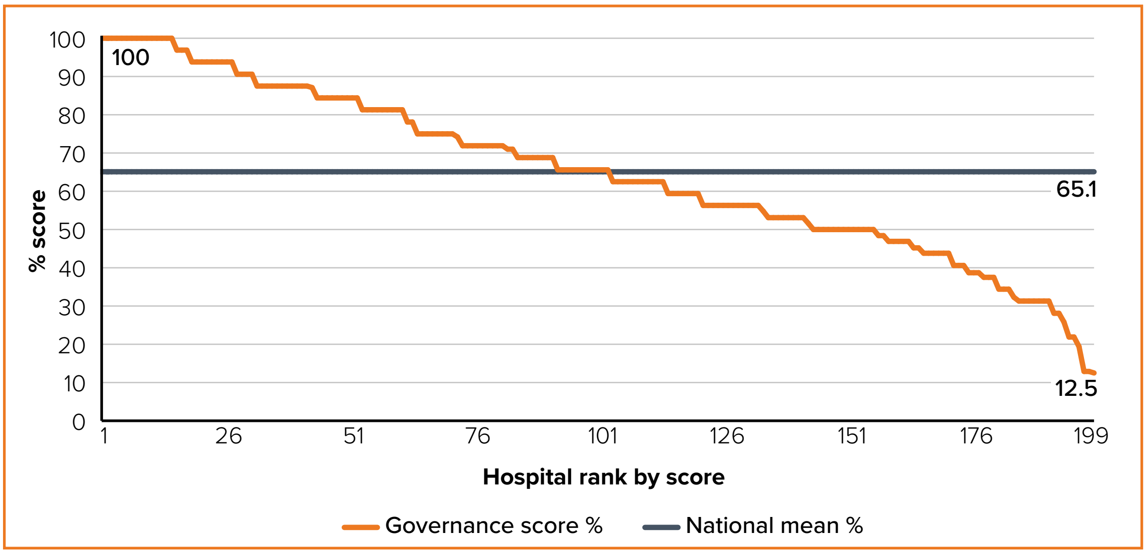
Governance score

The overall score for governance is based on hospital responses to nine key questions from the organisational checklist relating to:

- Care pathways
- Involvement of the Executive Board
- Dementia champions
- Dementia working group
- Carer engagement.

There is wide variation in the range of scores for governance (12.5%-100%). Forty-four hospitals scored under 50%. The majority of hospitals scored between 50-100%, with 61 hospitals scoring over 80%.

Figure 15: Range, ranking and national mean of governance scores (199 hospitals in England and Wales)



Care pathway and clinical leadership

Most hospitals now have a care pathway or care bundle for dementia in place, or in development (see Table 9). The number of hospitals with a pathway in place has increased significantly from Round 2.

Table 9: Hospitals with a care pathway or care bundle in place or in development in Rounds 2 and 3

	Round 3: care pathway or care bundle % (n out of 199)	Round 2: care pathway % (n out of 210)
In place	61% (121)	36% (75)
In development	26% (52)	51% (106)

Of the 173 hospitals with a pathway in place or in development, nearly all had appointed a senior clinician to undertake the implementation of the care pathway across the hospital (97%, 168/173).

Integrated care pathways for people with dementia

Most people with dementia are admitted to hospital for reasons other than dementia. Common reasons include falls, broken/fractured hips or hip replacement, urinary tract infections, chest infections or stroke[3]. In this round of audit, the top four admitting conditions were respiratory related (20% of casenotes), falls related (13% of casenotes), urinary related conditions (9% of casenotes) and hip fractures/dislocations (8% of casenotes). It is therefore important when a patient with dementia is admitted to hospital to ensure they are looked after according to their admitting condition and their dementia. In Round 3 of audit, we asked about links with three key care pathways; delirium, stroke and fractured neck of femur.

Table 10 shows that in most hospitals the care pathway for dementia is linked with delirium (or this process is in development). Fewer hospitals have linked the dementia pathway with care pathways for stroke and fractured neck of femur.

Table 10: Percentage of hospitals which have integrated the dementia care pathway with the delirium, stroke and fractured neck of femur care pathways in Round 3

Care pathways	Integrated/linked with the dementia care pathway	In development:	Not integrated/linked with the dementia care pathway:
Delirium % (n out of 173)	66% (114)	27% (46)	8% (13)
Stroke % (n out of 173)	33% (57)	21% (37)	46% (79)
Fractured neck of femur % (n out of 172)	44% (75)	24% (42)	32% (55)

Involvement of the Executive Board

Results from the third round of audit show that the greatest improvement in relation to reporting to, and review by, the Executive Board has been made on information regarding hospital falls (see Figure 16).

Figure 16: Information reviewed by the Executive Board regarding re-admissions, delayed discharges and in-hospital falls (n=199)

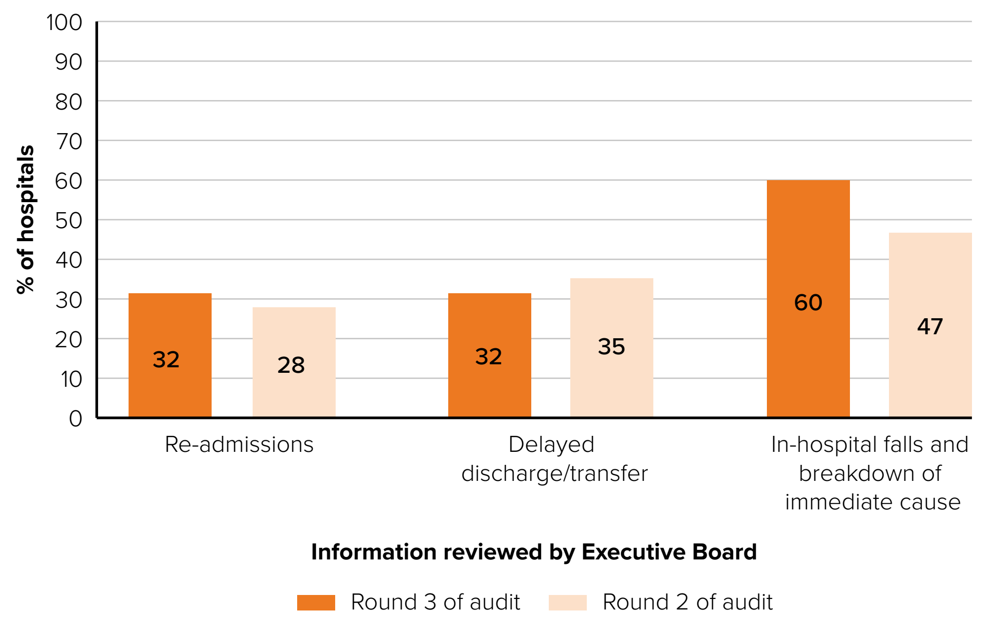


Table 11 shows that Executive Boards are more likely to review feedback from clinical leads for older people and public forums or local Healthwatch than other feedback sources.

Table 11: Feedback received and reviewed by hospital Executive Boards in Round 3

The Executive Board regularly receives feedback from the following:	% of 'yes' responses (Num/Den)
Clinical leads for older people and people with dementia	85% (169/199)
Complaints – analysed by age	52% (104/199)
Patient Advice and Liaison Services (PALS) – in relation to the services for older people and people with dementia	59% (106/181)
Patient/public forums or local Healthwatch – in relation to services for older people or people with dementia	67% (134/199)

Bed moves at night

Continuity of care is fundamental to the delivery of high quality care which is effective, safe, personalised and cost-effective[9]. Medically unnecessary moves, especially at night, can increase confusion and risk of delirium. In this round of audit, we asked hospitals whether such moves were monitored.

More than half of participating hospitals (62%, 123/199) said that they do not record or report instances of night time bed moves at Executive Board level (moves made between the evening meal and breakfast the next morning). Less than half of hospital staff surveyed (49%, 4416/9047) said that night time bed moves are avoided always or most of the time. Comments about bed moves was also the most commonly mentioned sub-theme under governance in the free text comments box on the staff questionnaire.

Staff suggestion about bed moves

"We have had patients with dementia transferred to our ward in the middle of the night. We have tried to refuse as it is unacceptable but we are always told by bed managers that we have to take them as they need the bed. This is terrible practice and despite doing incident forms each time, it still goes on. I don't think it is appropriate to be moving dementia patients, especially not at 3am!"

Registered nurse, Band 5 or 6

Dementia champions, specialist nurses and working groups

The third round of audit asked about key roles supporting people with dementia and staff in the hospital.

Dementia working group

Round 3 of the audit collected information about dementia working groups. Nearly all hospitals (94%, 186/199) reported having a dementia working group in place. Of the hospitals that had a dementia working group in place:

- Thirty-three percent (62/186) of working groups met monthly, 30% met quarterly (56/186) and 29% met bi-monthly (54/186)
- All (100%, 186/186) reported that healthcare professionals were members of the group
- Sixty-four percent (119/186) said the working group included organisations such as the Alzheimer's Society and 66% (123/186) reported having service user/carer representation.

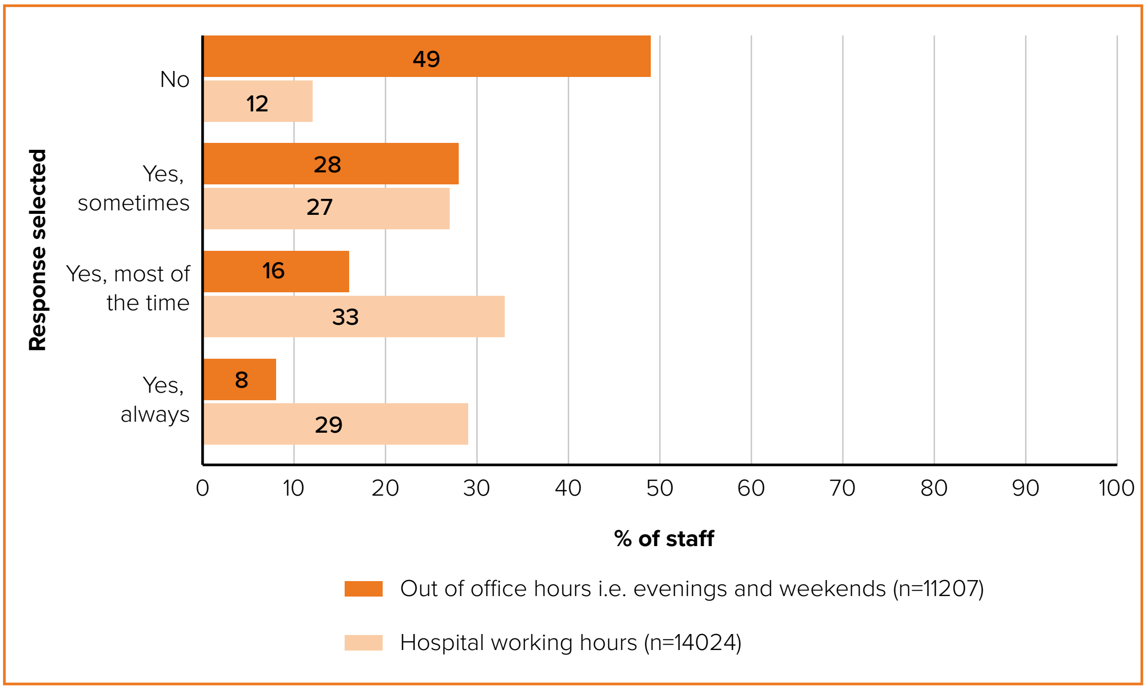
Dementia champions

More hospitals now have a dementia champion at ward level (94%, 186/199) compared to Round 2 (76%). There has been no change since the previous round of audit around dementia champions at directorate level; 82% of hospitals report having these roles (163/199).

Staff feedback

Feedback from the staff questionnaire suggests not all staff working in hospitals feel supported by specialist dementia services, especially out of office hours i.e. evenings and weekends (see Figure 17).

Figure 17: Staff responses regarding support from specialist dementia services in the hospital



Staff comments about support from dementia specialist services

"More dementia specialist nurses. This is a huge Trust and as quickly as we train dementia "champions" they leave. A "bank" of nursing assistants with skills and knowledge to perform enhanced supervision instead of being reliant on expensive agencies."

Registered nurse, Band 7 or above

"Employing more dementia specialist nurses and doctors that specialise in dementia, who can work seven days a week and can come on the ward to assist nursing staff in practical ways to help them adequately meet the needs of patients with dementia."

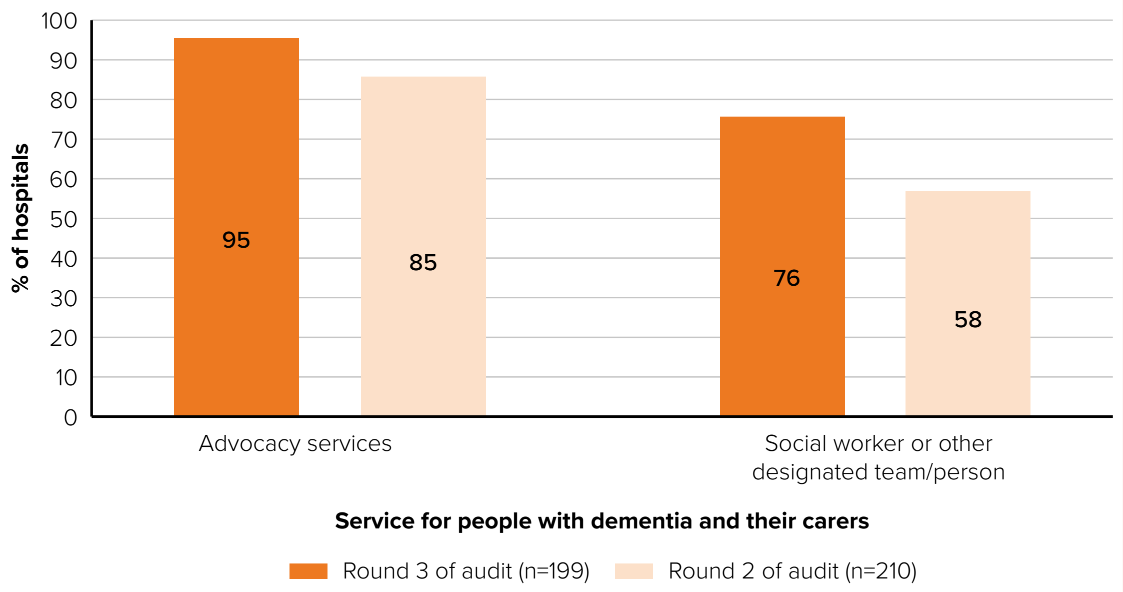
Registered nurse, Band 7 or above

Carer engagement

In this round, we asked hospitals whether they used a tool to measure carer engagement (e.g. Triangle of Care). Many hospitals (77%, 153/199) reported having a strategy or plan for carer engagement. Nearly all of those hospitals (96%, 147/153) said they have a review scheduled for their carer engagement strategy. Most hospitals also reported that they review their strategy at least once a year (76%, 116/153).

Results from Round 3 show there has been an increase in the number of hospitals with access to advocacy services. More hospitals now also have social workers responsible for working with patients with dementia and their carers (see Figure 18).

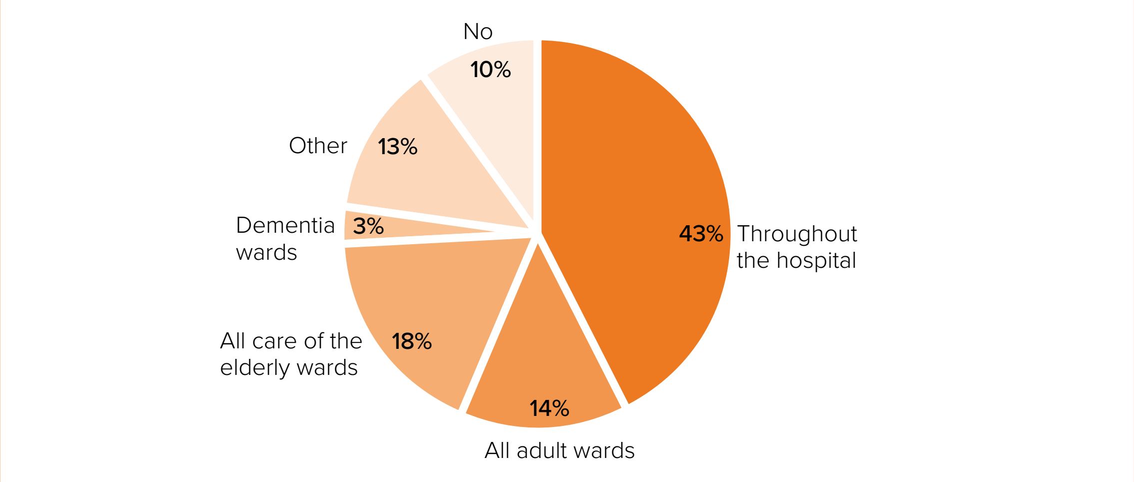
Figure 18: Access to advocacy services and social workers responsible for working with people with dementia and their carers in Rounds 2 and 3



Environment

Hospitals were asked whether the physical environment within the hospital has been reviewed using an appropriate tool (e.g. King's Fund Enhancing the Healing Environment[22]) to establish whether it is 'dementia-friendly' (see Figure 19).

Figure 19: Where hospital reviews of the physical environment have taken place in Round 3 (n=199)



Of the 180 hospitals which had carried out a review in part or all of the hospital:

- The majority (72%, 129/180) said environmental changes were completed or underway
- Most (89%, 161/180) had plans to further review the environmental changes implemented
- Seventy-eight percent (140/180) reported service users and carers were part of the team reviewing the environment.

Social environment

Hospitals were asked about opportunities for social interaction for patients with dementia. Only 15% (30/199) confirmed this was available on all adult wards. Thirty-nine percent (77/199) said opportunity for social interaction was possible on care of the elderly wards. Sixteen percent (32/199) said this was not possible anywhere in the hospital.

Summary

Hospital feedback on items related to governance shows some encouraging improvements to the implementation of care pathways and the presence of dementia champions at ward level. However, feedback from staff suggests that support from specialist services for dementia is not consistently available.

In general, the questions relating to the scrutiny of the Executive Board have seen less improvement, even though guidance was clarified to allow for reports received by sub committees reporting to the board, as well as the board itself. The number of hospitals now identifying people with dementia when reviewing falls in the hospital and their causes showed the greatest improvement.

The majority of hospitals have carried out an environmental review of the hospital for patients with dementia and many of these are following up these reviews by implementing changes and reviewing these changes. The number of hospitals which offer patients with dementia the opportunity for social interaction away from the bed space in all adult wards is low.

Recommendations for Governance

Trust Boards/Council of Governors/Board of the Health Board should:

- Request that the information they receive on delayed discharges and patient safety indicators including falls, pressure ulcers and readmissions can identify the proportion of the patient population with dementia.

The Chief Executive Officer should:

- Ensure that there is an activity program which provides opportunities for social interaction for people with dementia.
- Ensure that this report and the local audit report are disseminated to the appropriate staff members (i.e. ward managers, dementia leads etc).
- Publish progress made against these recommendations as part of an annual statement on dementia care quality, accessible via the Trust/Health Board website.
- Ensure that there is a dementia champion available to support staff 24 hrs per day, 7 days per week. This could be achieved through ensuring that people in roles such as Site Nurse Practitioners and Bed Managers have expertise in dementia care.
- Ensure that a Trust dementia lead is nominated to work with teams to:
    - Target, agree and implement local quality improvement initiatives that are aligned to areas of need as highlighted by the local and national dementia report (2017) findings.
    - Agree action plans and deadlines for implementing changes in advance of the next main round of audit in 2018.
    - Report dementia QI outputs back to the Trust Board
- (With the Directors of Medicine and Nursing) monitor support available to staff outside of weekday hours. This should be considered for inclusion in the NHS staff survey as a local question.

The Director of Nursing and Head of Therapy Directorate should:

- Work with dementia and therapy leads to create or enhance activity programs to provide opportunities for social interaction for people with dementia – especially for patients experiencing longer lengths of stay.

The Medical Director should:

- Ensure information on the dementia pathway/bundle and its links to pathways for other conditions, is available and accessible to other organisations to facilitate development and discussion.

The Medical Director and Nursing Directors should:

- Promote the attendance of key carers to support care, but ensure that this is complementary to, and not instead of, care delivered by staff. The level of input by carers, and how carers feel about the level of input they have been asked to deliver should be monitored through carer feedback, complaints and PAL enquiries. Carer satisfaction should be seen as a marker of good care. Ward managers should be supported to ensure carers supporting patients should not be asked to leave at mealtimes and/or stopped from helping with meals. (This excludes emergency and urgent care and treatment).
- Ensure that dementia champions are identified at directorate level as well as ward level.

The Director of Nursing should:

- Incorporate into existing feedback mechanisms survey information from carers on the quality of care for people with dementia, or collect this information via a biannual carer survey. The NAD tool is recommended as a validated instrument to collect anonymous feedback. The Director of Nursing should report to the Board on the feedback obtained.

The Senior Clinical Lead for Dementia should:

- Build clear links to the delirium pathway into the dementia pathway, care bundle or protocol.
- Work with clinical teams to target local Trust quality improvement initiatives aimed at improving care by developing and implementing integrated evidence-based care pathways for people with dementia and delirium. These should include:
    - Falls and fractured hips
    - UTIs
    - Chest infections
    - Stroke

The overlap and learning from other audits such as the National Audit of Inpatient Falls should be acknowledged and incorporated in this work, and highlighted within staff training.

Carer Expectations, Staff Suggestions and Recommendations

- Carer Expectations
- Staff Suggestions
- Full List of Recommendations

Carer Expectations

What should carers expect from hospitals when a person with dementia is admitted?

“Carers have a crucial role to play in the care of people with dementia. When a person with dementia develops a physical health problem and/or their behaviour changes the carer is often the first to be aware of this. If that person is admitted to hospital or a care home it is often the carer who knows the person’s history and is able to provide care staff with crucial information. Carers can also help support communication and share information with the person with dementia. This helps to ensure that the right care and treatment is provided which takes into account additional support needs and preferences.

Carers want a collaborative team approach to care, and to be seen as partners in care. Carers want to be kept involved and informed throughout assessment, treatment and discharge planning for the person they care for.

Carers of people with dementia also have their own needs, which need to be assessed and taken into account. Research shows that carers of older people with dementia experience greater strain and distress than carers of other older people. In addition, many carers of people with dementia are older people themselves, with physical frailty and health conditions of their own.

It is carers who are responsible for care when the professionals aren’t there, and as the condition progresses are commonly faced with co-ordinating and managing complex needs”.

Triangle of Care, Carers Trust and the Royal College of Nursing, 2013[19].

“Carers should be welcomed. They are an essential part of the patient’s team.”

John’s Campaign[13].

“Carers of people with dementia should be able to spend as much time as necessary with the person, whenever they need to.”

Hospital Care, Alzheimer’s Society[4].

When a person with dementia goes into hospital, a person who cares for them can expect:

1. To be able to visit at any time to provide care or support whenever this is needed, including overnight.
2. That the nature of their relationship to the person with dementia is respected: the carer's presence is welcome to support good care, but should not be depended on as necessary to provide personal care and support, unless this is their expressed wish.
3. The hospital and staff to recognise the value of carer input to the care of the person with dementia.
4. To receive clear written information from the hospital designed for carers, including:
    - Any times when carers may not be present, e.g. to protect the privacy of the person they are visiting or other patients
    - information about how to communicate with staff in the hospital and who to contact
    - information about any help provided by the hospital e.g. with refreshments, meals or parking.

With the consent of the person with dementia, or as part of a best interests decision making process:

5. To be kept clearly informed about the care and progress of the person with dementia during the hospital stay, including being involved in decisions made about care.
6. To be involved in the discussion about place of discharge and support needs of the person with dementia, including adequate notice of discharge.
7. To receive a copy of the discharge plan.

    This should be a written care plan that sets out the support that will be provided to meet the assessed needs of the carer and/or person with dementia.

8. That the hospital will seek current personal information (as distinct from medical information) to help provide the best possible care for the person with dementia.

    This will include details such as the persons preferred name, parts of their life story that they like to talk about (family, pets, work, hobbies), personal preferences (food, drink, how they like to communicate), whether they need help or support with personal care, whether there is anything that is likely to cause distress (e.g. sudden noise) and how to help them if this occurs.

9. That healthcare professionals will have awareness and understanding of the standard of care required by people with dementia, delirium and cognitive impairment admitted to hospital and of the local care pathway or other procedures in place.
10. That the person with dementia is not excluded from therapeutic interventions aimed at improving mobility or cognitive stimulation and that healthcare professionals can accommodate their needs to provide adequate support.
11. That the person with dementia receives adequate support with nutrition and hydration.

12. That appropriate food choices are available for the person with dementia, including finger food, snacks and lighter meal options. The menu should include photos to help them choose.
13. To be appropriately directed to services that can provide further advice and support, including a referral to the local authority for a carer's assessment.

    A carer's assessment from the local council (adult social services department) will determine whether carers are eligible for support. Support could include services provided directly to the carer, or services provided to the person they care for.
14. That carers are represented within the hospital/Trust Dementia Working Group, and asked regularly to provide anonymous feedback to help improve the quality of care.

Suggestions Made by Staff About Improving Care

The staff questionnaire included a question asking staff to make one suggestion on how their hospital could improve care and support provided to people with dementia. In total, 9727 staff wrote a comment in this section of the questionnaire and this amounted to a total of 16504 suggestions. Below, a breakdown of the suggestions by theme is provided.

Staffing

36% (5939/16504) of all suggestions were about staffing

Of these suggestions:

- 40% wanted more staff (general comment)
- 19% wanted more dementia specialist staff
- 10% wanted more staff to provide ‘one to one’ care
- 10% wanted more time to care
- 6% wanted more staff to help with nutritional support
- 6% related to having more volunteers
- 4% wanted more activity staff specifically
- 4% wanted more nursing staff specifically

“More staff numbers, both therapy and nursing to improve the ratio of staff to patients, to spend time with patients, to settle them, comfort them, occupy them and CARE for them.”

Environment and activities

20% (3298/16504) of all suggestions were about the physical environment and activities available in the hospital

Of these suggestions:

- 37% wanted to see better access to activities for people with dementia e.g. games, reading, music groups, pets as therapy
- 17% wanted access to a space away from the bed area e.g. day room or garden
- 15% suggested the hospital is made more dementia friendly as a general comment
- 10% specified that a separate ward for patients with dementia should be created/used more consistently
- 9% wanted to see changes to the hospital design e.g. paintwork, dementia friendly signs, adapted bathrooms
- 6% wanted to see improvements to the ward or hospital layout e.g. more or fewer single rooms
- 5% related to better access to dementia related equipment such as dementia clocks and calendars

“The hospital has recently put larger than life photographs of random members of staff on lift doors. I have knowledge of this causing confusion and distress to patients with dementia who are disorientated by seeing large and very real photos of staff on doors which then open. Carers have raised this as a concern.”

Training and information

15% (2478/16504) of all suggestions related to staff training and information

Of these suggestions:

- 44% wanted more, or more frequent, training
- 13% wanted all staff in the hospital to be trained in dementia or for training to be made mandatory
- 9% wanted there to be more awareness and knowledge of dementia among staff
- 9% wanted training on a specified subject area (e.g. challenging behaviour in people with dementia, mental capacity act)
- 9% wanted dementia training to be improved
- 9% wanted more training for a specific staffing group (e.g. nursing staff)
- 3% wanted better written information about dementia
- 3% made another suggestion about training or information

"Training – practical session on how to treat and deal with patients with difficult and challenging behaviour so the patients are always treated with dignity and respect."

Governance

7% (1134/16504) of all suggestions related to governance of the hospital or Trust

Of these suggestions:

- 40% wanted to see less bed moves or more appropriate ward placement for patients with dementia
- 16% related to better or quicker discharges (on the part of the hospital)
- 12% related to better integrated working with other services
- 11% were other suggestions related to governance
- 9% related to dementia pathways
- 7% related to management understanding that patients with dementia require more time than other patients
- 6% referred to better information systems in the hospital

"One thing I feel extremely strongly about is when they transfer patients up at 3am, and they wake up in a new room, with new faces and it scares them, causing them to become restless. I feel patients with dementia should be the final option of bed transfers in the middle of the night."

Communication of a person's dementia

7% (1112/16504) of all suggestions related to the communication of dementia in the hospital

Of these suggestions:

- 73% suggested personal information documents (e.g. This is Me) are used more often or more consistently
- 16% wanted better communication of patients' dementia between departments in the hospital
- 10% suggested better or more consistent use of visual indicators for communicating dementia (e.g. forget-me-not)

"Each patient with dementia should have a sheet with all of the key information on how the patient can be supported. E.g. their preferred name, music they enjoy, likes and dislikes, food preferences."

Patient care

5% (878/16504) of all suggestions were about improving elements of patient care

Of these suggestions:

- 54% related to improved support skills in staff such as listening and interacting at the pace of the person
- 33% related to providing for, and responding to, care needs (e.g. attending to call bells, using appropriate medication)
- 11% related to diagnoses practices (e.g. screening for dementia or delirium)
- 2% made a suggestion about another aspect of patient care

"Better focus on diagnosis in new admissions. Our diagnostic rates are poor and we tend to focus on the immediate issue (e.g. fall/infection) rather than the whole. This is a system failure due to demands on length of stay, split between hospital and community and is a national issue."

Carers and family

5% (804/16504) of all suggestions related to carers and relatives

Of these suggestions:

- 55% related to actively encouraging or involving carers in patients' care
- 17% related to consistent open visiting for carers of people with dementia
- 13% related to providing more services to carers and family
- 6% related to providing facilities for carers e.g. a place to stay overnight, free parking
- 5% related to providing written information about dementia and dementia services to carers and family
- 5% made another suggestion related to carers and family

"Encourage relatives to stay with their relative (the patient). This isn't suggested often and I don't feel relatives and patients are aware of this option. There should be plenty of information provided, visible to visitors."

Patient nutrition and hydration

5% (783/16504) of suggestions were about nutrition and hydration of patients

Of these suggestions:

- 36% wanted better access to snacks and/or finger foods
- 20% related to more appropriate food choices and portions
- 15% related to equipment to aid nutrition in patients with dementia (e.g. adapted cutlery, picture menus)
- 12% related to access to food out of hours
- 7% related to another aspect of patient nutrition
- 5% related to meal timings and 'protected mealtimes'
- 5% related to systems to show and record nutritional needs and intake e.g. system to show patients need help with eating

"Nutrition between meals and ensuring patients regularly have drinks and snacks, and during mealtimes, that patients with red trays are fully supported for the whole time."

Full List of Recommendations

National Commissioners should:

- Propose a nationally backed monitoring programme aimed at embedding the collection, sharing and use of person centred information. This should include a clear expectation that once gathered, this information will follow the patient between providers, and that this will be monitored.

Clinical Commissioning Groups/Health Boards should:

- Specify in contracts with care homes that the personal care story/information sheet that is completed for each resident should accompany them on any admission to hospital.
- Ensure that tenders let by Trusts for new catering contracts always specify provision of finger foods for main meals and access to a range of snacks 24 hours a day.

Trust Boards/Council of Governors/Board of the Health Board should:

- Request that the information they receive on delayed discharges and patient safety indicators including falls, pressure ulcers and readmissions can identify the proportion of the patient population with dementia.

The Chief Executive Officer should:

- Ensure that there is a dementia champion available to support staff 24 hrs per day, 7 days per week. This could be achieved through ensuring that people in roles such as Site Nurse Practitioners and Bed Managers have expertise in dementia care.
- Ensure that carers for people with dementia can communicate with clinicians in order to share and receive information. Carers should be given the opportunity to speak to staff privately, ensuring that their privacy and that of patients is respected.
- Ensure that there is an activity program which provides opportunities for social interaction for people with dementia.
- Ensure that this report and the local audit report are disseminated to the appropriate staff members (i.e. ward managers, dementia leads etc).
- Publish progress made against these recommendations as part of an annual statement on dementia care quality, accessible via the Trust/Health Board website.
- (With the Directors of Medicine and Nursing) monitor support available to staff outside of weekday hours. This should be considered for inclusion in the NHS staff survey as a local question.
- Ensure that a Trust dementia lead is nominated to work with teams to:
  – Target, agree and implement local quality improvement initiatives that are aligned to areas of need as highlighted by the local and national dementia report (2017) findings.

  - Agree action plans and deadlines for implementing changes in advance of the next main round of audit in 2018.
  - Report dementia QI outputs back to the Trust Board.

The Medical Director should:

- Ensure information on the dementia pathway/bundle and its links to pathways for other conditions, is available and accessible to other organisations to facilitate development and discussion.

The Medical Director and Nursing Directors should:

- Ensure that hospitals have robust mechanisms in place for assessing delirium in people with dementia including:
  - At admission, a full clinical delirium assessment, whenever indicators of delirium are identified.
  - Cognitive tests administered on admission and again before discharge.
  - Delirium screening and assessment fully documented in the patients notes (regardless of the outcome).
  - Care offered in concordance with the delirium evidence-base recommendations when the assessment indicates symptoms of delirium.
  - Results recorded on the electronic discharge summary.
- Ensure that structured pain assessments are in use and properly recorded for people with a diagnosis or current history of dementia.
- Incorporate a heading for discussions with relatives/carers within the patient notes/healthcare records, and ensure staff are aware of its purpose.
- Promote the attendance of key carers to support care, but ensure that this is complementary to, and not instead of, care delivered by staff. The level of input by carers, and how carers feel about the level of input they have been asked to deliver should be monitored through carer feedback, complaints and PAL enquiries. Carer satisfaction should be seen as a marker of good care. Ward managers should be supported to ensure carers supporting patients should not be asked to leave at mealtimes and/or stopped from helping with meals. (This excludes emergency and urgent care and treatment).
- Ensure that dementia champions are identified at directorate level as well as ward level.
- (With the Education Lead for the Trust or Health Board) ensure that training in dementia awareness is a priority for all staffing groups. eLearning should not be relied on as the sole medium for delivering training in dementia awareness.
- Ensure staff receive training in delirium and its relationship to dementia, manifestations of pain, and behavioural and psychological symptoms of dementia.

- (With the Head of Therapy Directorate) keep central training records on all staff receiving training in dementia, enabling them to be aware of the levels of awareness and expertise in the hospital.

The Director of Nursing and Head of Therapy Directorate should:

- Work with dementia and therapy leads to create or enhance activity programs to provide opportunities for social interaction for people with dementia – especially for patients experiencing longer lengths of stay.

The Director of Nursing should:

- Incorporate into existing feedback mechanisms survey information from carers on the quality of care for people with dementia, or collect this information via a biannual carer survey. The NAD tool is recommended as a validated instrument to collect anonymous feedback. The Director of Nursing should report to the Board on the feedback obtained.

The Senior Clinical Lead for Dementia should:

- Build clear links to the delirium pathway into the dementia pathway, care bundle or protocol.
- Ensure that copies of the personal information document (such as Alzheimer's Society *This is Me* or other locally developed document) are available on the ward and that the information is kept accessible to staff and visiting carers.
- Work with clinical teams to target local Trust quality improvement initiatives aimed at improving care by developing and implementing integrated evidence-based care pathways for people with dementia and delirium. These should include:
  - Falls and fractured hips
  - UTIs
  - Chest infections
  - Stroke

  The overlap and learning from other audits such as the National Audit of Inpatient Falls should be acknowledged and incorporated in this work, and highlighted within staff training.
- Target local Trust quality improvement initiatives aimed at ensuring the nutritional needs of people with dementia are met.

Safeguarding and Dignity Leads should:

- Ensure staff are properly trained and informed on the need for the appropriate presence and participation of the patient in discussions about the patient's care, treatment and discharge. Discharge discussions should include a comprehensive note of who was present and the views expressed. The appropriate presence and involvement of the carer(s), as determined by patient consent or best interest decision, should also be recorded.

- Ensure that staff are trained in the Mental Capacity Act, including consent, appropriate use of best interests decision making, the use of Lasting Power of Attorney and Advance Decision Making. Training should cover supportive communication with family members/carers on these topics. (See e.g. *NHS England's Dementia: Good Care Planning*).[k]

Ward Managers and Multidisciplinary teams should:

- Audit implementation/use of personal information collected to improve care for patients (e.g. *This is Me* or other locally developed document). The result of the audit should be fed back to the dementia champions/dementia lead and ward staff.
- Encourage carers to attend mealtimes whenever they want and ensure their input is valued.

Health Education England/Care Council for Wales should:

- Incorporate training on delirium and its presentation in people with dementia, including Behavioural and psychological symptoms of dementia, into Tier 1/"Informed" level training for healthcare staff.

National Audit of Dementia Project Team should:

- Consider developing standards on the implementation and frequency of Deprivation of Liberty Safeguarding orders within acute hospitals.

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[k] https://www.england.nhs.uk/wp-content/uploads/2017/02/dementia-good-care-planning.pdf

Appendices

Appendix A: Hospital Scores Table

The table below lists each of the seven scores for all hospitals in the audit. Hospitals are ordered alphabetically, and the colour gradient for each score reflects the rank of that hospital for each measure. To receive a full set of scores, hospitals were required to provide one complete organisational checklist, more than 19 casenotes, 20 or more staff questionnaires and 10 or more carer questionnaires. Hospitals with fewer than the required number, have not received a score for that theme. These instances are marked with a dash.

Scores are derived from separate data sources and should be viewed independently. For example, a hospital's score for Assessment should be compared to other Assessment scores, rather than the other scores for that hospital. This is because a hospital's highest score may not reflect its area of greatest achievement, if it is a theme in which all hospitals have scored highly.

Key:

Score	Highest scores			Lowest scores
Governance	100%–84.4%	81.3%–65.6%	62.5%–50%	48.4%–12.5%
Nutrition	100%	95%–87.5%	82.5%–73.8%	68.8%–36.3%
Discharge	98.5%–85.2%	84.6%–75.3%	75.2%–63.6%	63.2%–22%
Assessment	99.1%–88.9%	88.6%–85.4%	85.2%–79.9%	79.7%–48.7%
Staff rating of information & communication	82.7%–68.5%	68.4%–64.8%	64.7%–61.6%	61.5%–48.1%
Carer rating of information & communication	89.3%–71.7%	71.5%–63.4%	63.1%–57.3%	57.2%–22.2%
Carer rating of patient care	93.3%–77.9%	77.8%–72.4%	72.3%–66.1%	64.7%–21.7%

	Governance % (Rank/199)	Nutrition % (Rank/199)	Discharge % (Rank/195)	Assessment % (Rank/195)	Staff Comm % (Rank/182)	Carer Comm % (Rank/148)	Carer Rating of Pt Care % (Rank/148)
Addenbrooke's Hospital	**46.9** (158)	**100** (1)	**93.6** (9)	**93.4** (21)	**72.2** (14)	–	–
Airedale General Hospital	**68.8** (84)	**87.5** (84)	**86.6** (40)	**89.2** (44)	**65.7** (82)	**55.5** (124)	**61.7** (128)
Alexandra Hospital, Redditch	**84.4** (44)	**93.8** (70)	**69.5** (125)	**80.8** (135)	–	**53.9** (129)	**67.6** (103)
Arrowe Park Hospital	**59.4** (114)	**42.5** (193)	**80.3** (68)	**82.9** (115)	**67.8** (53)	**63.1** (75)	**67.9** (102)
Barnet Hospital	**100** (1)	**100** (1)	**81.6** (60)	**88.3** (56)	**75.9** (6)	**78.9** (16)	**78.3** (35)
Barnsley Hospital	**100** (1)	**100** (1)	**75** (100)	**84** (107)	**68.5** (43)	**81.3** (8)	**81.3** (24)
Basildon University Hospital	**68.8** (84)	**80** (112)	**88.4** (27)	**90.6** (34)	**66.9** (66)	**54.2** (127)	**63.2** (119)
Basingstoke & North Hampshire Hospital	**71.9** (73)	**67.5** (153)	**85.2** (47)	**83.8** (111)	**66.4** (73)	**54.1** (128)	**66.3** (108)
Bassetlaw Hospital	**68.8** (84)	**100** (1)	**48.8** (184)	**82.5** (119)	**62.7** (118)	–	–
Bedford Hospital	**56.3** (121)	**67.5** (153)	**49.3** (182)	**76.9** (167)	**79.3** (2)	**88** (2)	**91.1** (3)
Birmingham Heartlands Hospital	**43.8** (165)	**100** (1)	–	–	–	**54.4** (126)	**71.9** (81)
Blackpool Victoria Hospital	**50** (143)	**87.5** (84)	**59.6** (158)	**85.7** (89)	**73.6** (10)	**61.9** (84)	**76.6** (49)
Bradford Royal Infirmary	**56.3** (121)	**75** (134)	**73.7** (105)	**86.8** (71)	**71.5** (18)	**69** (47)	**75** (56)
Bristol Royal Infirmary	**71.9** (73)	**100** (1)	**88.1** (29)	**78.7** (155)	**68.9** (38)	**73.4** (33)	**81.7** (23)
Bronglais General Hospital	**19.4** (196)	**93.8** (70)	**58.9** (160)	**85.1** (99)	**57** (170)	–	–
Broomfield Hospital	**68.8** (84)	**93.8** (70)	**72.2** (112)	**86.3** (80)	**69.5** (30)	**80.7** (10)	**93.3** (1)
Calderdale Royal Hospital	**71.9** (73)	**80** (112)	**69** (128)	**87.8** (60)	**61.8** (131)	–	–
Central Middlesex Hospital	**50** (143)	**100** (1)	**75.8** (94)	**93.7** (19)	**68.4** (46)	**57.1** (113)	**77.5** (40)
Chelsea & Westminster Hospital	**87.5** (32)	**100** (1)	**72** (114)	**65.3** (189)	**68** (49)	**66.7** (58)	**83** (20)
Cheltenham General Hospital	**100** (1)	**73.8** (147)	**75.6** (95)	**91** (28)	**57.3** (169)	**52.8** (133)	**55** (143)
Chesterfield Royal Hospital	**12.5** (199)	**62.5** (180)	**56.5** (169)	**79** (153)	**68** (49)	–	–
Chorley & South Ribble Hospital	**75** (64)	**100** (1)	**92.1** (14)	**88** (58)	**68.5** (43)	–	–
City Hospital, Birmingham	**37.5** (177)	**87.5** (84)	**61.7** (151)	**82.7** (117)	**55.8** (172)	**62.5** (79)	**64.6** (113)
Colchester General Hospital	**93.8** (19)	**100** (1)	**76.3** (90)	**94.9** (11)	**59.8** (152)	**56.3** (120)	**62.5** (122)
Conquest Hospital	**84.4** (44)	**100** (1)	**54.8** (176)	**77.9** (160)	**63.8** (102)	–	–
The Countess of Chester Hospital	**56.3** (121)	**68.8** (152)	**91** (19)	**90.5** (35)	**61.2** (139)	–	–
The County Hospital, Hereford	**43.8** (165)	**67.5** (153)	**59.2** (159)	**76.5** (169)	–	–	–
County Hospital, Stafford	**62.5** (103)	**80** (112)	**67.6** (133)	**72** (179)	**65.7** (82)	**71.7** (35)	**77.5** (40)
Croydon University Hospital	**40.6** (171)	**36.3** (198)	**71.8** (115)	**84.2** (106)	**60.4** (147)	**50.9** (137)	**60.5** (133)
Cumberland Infirmary	**87.5** (32)	**75** (134)	**76.6** (88)	**98.2** (2)	**59.1** (157)	–	–
Darent Valley Hospital	**56.3** (121)	**95** (69)	**87** (36)	**95.7** (6)	**63.5** (108)	**47.6** (144)	**61.4** (130)
Darlington Memorial Hospital	**93.8** (19)	**87.5** (84)	**49** (183)	**84.3** (104)	**66** (76)	**57.3** (111)	**70** (92)
Derriford Hospital	**65.6** (92)	**80** (112)	**45.6** (187)	**81.4** (128)	**64.3** (97)	**66.7** (58)	**58.3** (136)
Dewsbury & District Hospital	**84.4** (44)	**67.5** (153)	**85.4** (45)	**85.7** (89)	**69.6** (28)	**58** (104)	**70.5** (89)
Diana Princess of Wales Hospital, Grimsby	**50** (143)	**67.5** (153)	**58.2** (163)	**81** (130)	**54.2** (175)	**77.1** (18)	**79.2** (32)
Doncaster Royal Infirmary	**81.3** (53)	**100** (1)	**56.4** (170)	**86.9** (68)	**66.5** (71)	–	–
Dorset County Hospital	**96.9** (16)	**100** (1)	**80.9** (63)	**87.1** (65)	**62.9** (116)	**57.7** (106)	**72.2** (76)
Ealing Hospital	**50** (143)	**100** (1)	**87.4** (32)	**90.2** (38)	**74.6** (9)	**75** (27)	**75** (56)
East Surrey Hospital	**56.3** (121)	**80** (112)	**24** (194)	**61.1** (191)	**63** (115)	**57.2** (112)	**66.3** (108)
Eastbourne District General Hospital	**84.4** (44)	**100** (1)	**69.7** (123)	**88.4** (54)	**69** (36)	**57.1** (113)	**77.1** (44)
Epsom General Hospital	**100** (1)	**93.8** (70)	**75.6** (95)	**92** (26)	**63.9** (100)	**56.9** (118)	**66.7** (107)

	Governance % (Rank/199)	Nutrition % (Rank/199)	Discharge % (Rank/195)	Assessment % (Rank/195)	Staff Comm % (Rank/182)	Carer Comm % (Rank/148)	Carer Rating of Pt Care % (Rank/148)
Fairfield General Hospital	**62.5** (103)	**100** (1)	**87.5** (31)	**79.7** (147)	**59.7** (153)	–	–
Freeman Hospital	**78.1** (62)	**73.8** (147)	**78.8** (72)	**82.5** (119)	**66.6** (70)	**69.8** (44)	**76.6** (49)
Friarage Hospital	**93.8** (19)	**100** (1)	**76.9** (85)	**80.6** (136)	**68.5** (43)	**60.8** (91)	**61.5** (129)
Frimley Park Hospital	**87.5** (32)	**87.5** (84)	**97.2** (3)	**93.3** (22)	**67.8** (53)	**63** (77)	**72.3** (75)
Furness General Hospital	**59.4** (114)	**100** (1)	**82.7** (54)	**83.9** (110)	**67.7** (56)	**58.8** (97)	**70.8** (85)
George Eliot NHS Hospital	**59.4** (114)	**75** (134)	**57.2** (167)	**74.6** (174)	**59.9** (151)	–	–
Glan Clwyd Hospital	**51.6** (142)	**67.5** (153)	**80.7** (64)	**90.4** (36)	**60** (150)	**67.6** (52)	**72.1** (78)
Glangwili General Hospital	**71** (82)	**55** (188)	**76.1** (92)	**80.5** (138)	**58.3** (160)	**79.2** (13)	**87.5** (8)
Gloucestershire Royal Hospital	**100** (1)	**73.8** (147)	**86** (43)	**95.8** (5)	**68.6** (41)	**51.1** (136)	**60.7** (132)
Good Hope Hospital	**43.8** (165)	**100** (1)	**82** (58)	**86** (84)	**66.4** (73)	**64.2** (70)	**75.9** (55)
Grantham & District Hospital	**65.6** (92)	**80** (112)	**78.6** (74)	**93.9** (17)	**48.1** (182)	–	–
Great Western Hospital	**90.6** (28)	**80** (112)	**64.7** (143)	**84** (107)	**61.1** (141)	**50.9** (137)	**64.3** (115)
Harrogate District Hospital	**28.1** (191)	**67.5** (153)	**74.6** (102)	**85.7** (89)	**64.4** (93)	**89.3** (1)	**83.9** (17)
The Hillingdon Hospital	**56.3** (121)	**67.5** (153)	**73.1** (108)	**77.1** (164)	**70.1** (24)	**63.4** (74)	**67.6** (103)
Hinchingbrooke Hospital	**53.1** (134)	**80** (112)	**57.4** (166)	**82** (124)	**64.8** (90)	**39.4** (147)	**54.5** (144)
Homerton University Hospital	**84.4** (44)	**100** (1)	**97.1** (4)	**95.2** (8)	**65.7** (82)	**70** (42)	**69** (98)
Horton General Hospital	**65.6** (92)	**80** (112)	**92.4** (11)	**86.6** (74)	**62.6** (120)	–	–
Hospital of St Cross, Rugby	**65.6** (92)	**100** (1)	**69.5** (125)	**88.6** (49)	**70.4** (21)	–	–
Huddersfield Royal Infirmary	**71.9** (73)	**80** (112)	**67.4** (134)	**89.4** (42)	–	–	–
Hull Royal Infirmary	**81.3** (53)	**75** (134)	**77.7** (79)	**86.9** (68)	**68.6** (41)	**57.7** (106)	**72.4** (74)
Ipswich Hospital	**65.6** (92)	**93.8** (70)	**92.2** (12)	**86.4** (79)	**67.2** (65)	**61.6** (87)	**69** (98)
The James Cook University Hospital	**93.8** (19)	**100** (1)	**76.4** (89)	**82.4** (122)	**60.1** (149)	**71.5** (38)	**76.5** (54)
James Paget Hospital	**50** (143)	**100** (1)	**78.9** (71)	**95.1** (10)	**65.9** (77)	**64.5** (69)	**71.7** (83)
John Radcliffe Hospital	**71.9** (73)	**80** (112)	**86.8** (39)	**84.9** (101)	**68.8** (39)	**55.9** (121)	**75** (56)
Kent & Canterbury Hospital	**31.3** (184)	**87.5** (84)	**61.2** (153)	**57.1** (193)	**69.3** (33)	–	–
Kettering General Hospital	**100** (1)	**87.5** (84)	**72.1** (113)	**85.7** (89)	**66.4** (73)	–	–
King George Hospital, Ilford	**53.1** (134)	**75** (134)	**89.2** (24)	**89** (47)	–	–	–
King's College Hospital	**62.5** (103)	**93.8** (70)	**98.5** (1)	**93.6** (20)	**73.5** (11)	**76** (22)	**77.9** (37)
King's Mill Hospital	**21.9** (194)	**80** (112)	**32.3** (190)	**69.3** (185)	**70** (27)	**79** (15)	**84.3** (14)
Kingston Hospital	**75** (64)	**87.5** (84)	**93** (10)	**91.6** (27)	**67.4** (62)	**59.6** (95)	**69.6** (95)
Leeds General Infirmary	**50** (143)	**87.5** (84)	**75.3** (97)	**88.6** (49)	**64.4** (93)	**55.6** (123)	**63** (120)
Leicester Royal Infirmary	**100** (1)	**48.8** (192)	**62.7** (149)	**83.5** (113)	**63.6** (105)	**67.4** (54)	**74.3** (61)
Leighton Hospital	**75** (64)	**100** (1)	**71.6** (117)	**82.5** (119)	**65.8** (80)	**58.3** (101)	**70.3** (90)
Lincoln County Hospital	**65.6** (92)	**80** (112)	**75** (100)	**87.6** (61)	**64.2** (98)	**68.5** (50)	**77.8** (38)
Lister Hospital	**46.9** (158)	**42.5** (193)	**84.6** (50)	**82** (124)	**77.1** (4)	**64.6** (68)	**73.3** (68)
Luton & Dunstable Hospital	**65.6** (92)	**75** (134)	**87.4** (32)	**83.1** (114)	**69** (36)	**57.1** (113)	**66.3** (108)
Macclesfield District General Hospital	**59.4** (114)	**87.5** (84)	**59.7** (157)	**86.3** (80)	**65.2** (89)	**59** (96)	**74** (63)
Maidstone Hospital	**34.4** (180)	**87.5** (84)	**72.9** (109)	**63.6** (190)	**60.5** (146)	**71.1** (40)	**78.3** (35)
Manchester Royal Infirmary	**65.6** (92)	**80** (112)	**58.5** (161)	**68.1** (186)	**69.2** (34)	**67.5** (53)	**73.8** (64)
Manor Hospital, Walsall	**87.5** (32)	**100** (1)	**86.9** (38)	**80.2** (143)	**67.4** (62)	–	–

	Governance % (Rank/199)	Nutrition % (Rank/199)	Discharge % (Rank/195)	Assessment % (Rank/195)	Staff Comm % (Rank/182)	Carer Comm % (Rank/148)	Carer Rating of Pt Care % (Rank/148)
Medway Maritime Hospital	**56.3** (121)	**67.5** (153)	**63.1** (148)	**72** (179)	**58.5** (159)	**46.3** (146)	**56.3** (141)
Milton Keynes Hospital	**56.3** (121)	**93.8** (70)	**76.8** (86)	**86** (84)	**61.6** (135)	**75.5** (24)	**76.7** (47)
Morriston Hospital	**12.9** (197)	**87.5** (84)	**74.1** (104)	**71.7** (181)	**69.6** (28)	–	–
Musgrove Park Hospital	**59.4** (114)	**100** (1)	**88.7** (25)	**94.4** (15)	**60.7** (144)	**79.2** (13)	**81.3** (24)
Nevill Hall Hospital	**45.2** (163)	**100** (1)	**48.8** (184)	**80.3** (140)	**59.4** (155)	**76.7** (20)	**78.8** (33)
New Cross Hospital	**53.1** (134)	**100** (1)	**55.4** (174)	**81** (130)	**68.2** (47)	–	–
Newham University Hospital	**87.5** (32)	**61.3** (185)	**91** (19)	**94.7** (13)	**71.9** (17)	**68.8** (49)	**62.5** (122)
Norfolk & Norwich University Hospital	**90.6** (28)	**100** (1)	**81.6** (60)	**86.3** (80)	**67.7** (56)	**52.2** (134)	**62.9** (121)
North Devon District Hospital	**75** (64)	**93.8** (70)	**80.7** (64)	**77.7** (161)	**67.7** (56)	**76.8** (19)	**83.3** (18)
North Manchester General Hospital	**62.5** (103)	**100** (1)	**82.4** (55)	**79.1** (152)	–	–	–
North Middlesex University Hospital	**40.6** (171)	**67.5** (153)	–	–	–	–	–
North Tyneside General Hospital	**31.3** (184)	**62.5** (180)	**82.2** (57)	**90.8** (32)	**68** (49)	**84.1** (6)	**87.5** (8)
Northampton General Hospital	**68.8** (84)	**80** (112)	**54** (177)	**85.7** (89)	**62.4** (122)	**59.9** (94)	**63.5** (117)
Northern General Hospital, Sheffield	**68.8** (84)	**100** (1)	**74.6** (102)	**77.7** (161)	**55.7** (173)	–	–
Northwick Park Hospital	**43.8** (165)	**100** (1)	**77.1** (82)	**88.4** (54)	**62.3** (125)	–	–
Nottingham City Hospital	**50** (143)	**100** (1)	**26.6** (192)	**78.9** (154)	**52.3** (180)	–	–
Peterborough City Hospital	**90.6** (28)	**100** (1)	**80.5** (66)	**78.2** (157)	**57.7** (167)	**64.7** (66)	**70.8** (85)
Pilgrim Hospital	**65.6** (92)	**80** (112)	**50.7** (180)	**87.4** (62)	**63.3** (112)	–	–
Pinderfields Hospital	**84.4** (44)	**67.5** (153)	**84.3** (51)	**88.6** (49)	**72.9** (13)	**71.2** (39)	**76.6** (49)
Poole Hospital	**96.9** (16)	**87.5** (84)	**87.2** (34)	**89.8** (39)	**59.1** (157)	**80.6** (11)	**89.6** (4)
Prince Charles Hospital, Wales	**48.4** (156)	**100** (1)	**57.1** (168)	**70** (183)	**53.5** (178)	**76.6** (21)	**72.6** (71)
Prince Philip Hospital, Wales	**32.3** (183)	**93.8** (70)	**47.9** (186)	**69.7** (184)	**62.7** (118)	**73.8** (32)	**89.3** (6)
The Princess Alexandra Hospital, Essex	**53.1** (134)	**67.5** (153)	**22** (195)	**80.1** (144)	**61.1** (141)	**61.8** (86)	**76.9** (45)
The Princess of Wales Hospital, Wales	**87.1** (43)	**100** (1)	**75.2** (98)	**88.1** (57)	**59.4** (155)	**65.7** (62)	**62.5** (122)
The Princess Royal Hospital, Haywards Heath	**81.3** (53)	**100** (1)	**78.6** (74)	**86** (84)	**72.2** (14)	**66.1** (60)	**77.4** (43)
The Princess Royal Hospital, Shrewsbury	**50** (143)	**80** (112)	**55.1** (175)	**72.9** (177)	**65.9** (77)	**58.5** (99)	**62.5** (122)
Princess Royal University Hospital, London	**25.8** (193)	**36.3** (198)	**90.7** (21)	**93** (24)	**67.6** (60)	**47** (145)	**72.7** (69)
Queen Alexandra Hospital, Portsmouth	**75** (64)	**87.5** (84)	**33.2** (189)	**80.9** (133)	**58.2** (162)	**47.7** (143)	**48.3** (147)
Queen Elizabeth Hospital Birmingham	**100** (1)	**80** (112)	**66.9** (136)	**88.5** (53)	**67.7** (56)	**63.5** (73)	**68.3** (100)
Queen Elizabeth Hospital, Gateshead	**40.6** (171)	**100** (1)	**66.8** (137)	**78.4** (156)	**64.2** (98)	**61.4** (89)	**75** (56)
The Queen Elizabeth Hospital, King's Lynn	**93.8** (19)	**67.5** (153)	**66.6** (138)	**82.6** (118)	–	–	–
Queen Elizabeth Hospital, London	**62.5** (103)	**67.5** (153)	**24.7** (193)	**57.1** (193)	**66.7** (68)	**63.1** (75)	**69.5** (96)
Queen Elizabeth The Queen Mother Hospital	**31.3** (184)	**87.5** (84)	**88.3** (28)	**82.9** (115)	**63.6** (105)	–	–
Queen's Hospital, Burton Upon Trent	**100** (1)	**93.8** (70)	**69.5** (125)	**86.8** (71)	–	**51.7** (135)	**58.3** (136)
Queen's Hospital, Romford	**53.1** (134)	**75** (134)	**68.9** (129)	**84.7** (103)	–	–	–
Queen's Medical Centre, Nottingham	**50** (143)	**100** (1)	**67.1** (135)	**89.8** (39)	**64.7** (91)	**74.5** (29)	**82.4** (21)
Rotherham General Hospital	**90.6** (28)	**100** (1)	**91.2** (17)	**86** (84)	**67.8** (53)	**53.3** (130)	**57.5** (140)
Royal Albert Edward Infirmary, Wigan	**84.4** (44)	**100** (1)	**61.2** (153)	**85.2** (98)	**61.8** (131)	**81.2** (9)	**89.5** (5)

	Governance % (Rank/199)	Nutrition % (Rank/199)	Discharge % (Rank/195)	Assessment % (Rank/195)	Staff Comm % (Rank/182)	Carer Comm % (Rank/148)	Carer Rating of Pt Care % (Rank/148)
Royal Berkshire Hospital	**68.8** (84)	**75** (134)	**91.8** (16)	**87.1** (65)	**71.4** (19)	**58** (104)	**64.7** (112)
Royal Blackburn Hospital	**46.9** (158)	**87.5** (84)	**64.1** (145)	**79.3** (149)	**63.7** (103)	**62.5** (79)	**72.1** (78)
Royal Bolton Hospital	**87.5** (32)	**87.5** (84)	**60.6** (155)	**89.5** (41)	**62.1** (127)	**57.5** (110)	**66.1** (111)
Royal Bournemouth Hospital	**100** (1)	**93.8** (70)	**85.4** (45)	**89.4** (42)	**68** (49)	–	–
Royal Cornwall Hospital	**100** (1)	**100** (1)	**72.3** (111)	**76.7** (168)	**62** (128)	**60.8** (91)	**70** (92)
Royal Derby Hospital	**56.3** (121)	**80** (112)	**57.9** (164)	**87.2** (64)	**60.9** (143)	**61.9** (84)	**76.8** (46)
Royal Devon & Exeter Hospital	**62.5** (103)	**100** (1)	**88.6** (26)	**94.9** (11)	**65.3** (88)	**62.5** (79)	**73.6** (66)
The Royal Free Hospital	**65.6** (92)	**67.5** (153)	**78.3** (78)	**94.5** (14)	**65.4** (87)	**62.9** (78)	**70.7** (87)
Royal Glamorgan Hospital	**48.4** (156)	**100** (1)	**68.6** (131)	**84.9** (101)	**61.9** (129)	**68.5** (50)	**75** (56)
Royal Gwent Hospital	**38.7** (174)	**75** (134)	**65.4** (139)	**85.5** (95)	**62.8** (117)	**71.7** (35)	**77.5** (40)
Royal Hallamshire Hospital	**68.8** (84)	**100** (1)	**69.6** (124)	**71.1** (182)	–	–	–
Royal Hampshire County Hospital	**71.9** (73)	**67.5** (153)	**75.2** (98)	**79.9** (146)	**77.3** (3)	**62.5** (79)	**71.8** (82)
Royal Lancaster Infirmary	**59.4** (114)	**100** (1)	**77.1** (82)	**79.3** (149)	–	**55.9** (121)	**61.3** (131)
Royal Liverpool University Hospital	**81.3** (53)	**67.5** (153)	**87.9** (30)	**85.4** (96)	**58.3** (160)	–	–
The Royal London Hospital	**31.3** (184)	**55** (188)	**85.9** (44)	**87.9** (59)	**71.3** (20)	**66.1** (60)	**72.6** (71)
The Royal Oldham Hospital	**62.5** (103)	**100** (1)	**82.4** (55)	**77.7** (161)	**65.7** (82)	–	–
Royal Shrewsbury Hospital	**50** (143)	**73.8** (147)	**77.6** (80)	**75.5** (173)	–	**48** (142)	**57.6** (138)
The Royal Stoke University Hospital	**62.5** (103)	**100** (1)	**69.9** (121)	**80.9** (133)	**64.5** (92)	**61** (90)	**85.7** (11)
Royal Surrey County Hospital	**81.3** (53)	**75** (134)	**95** (6)	**88.6** (49)	**70.1** (24)	**75.6** (23)	**78.8** (33)
Royal Sussex County Hospital	**81.3** (53)	**100** (1)	**92.1** (14)	**80.6** (136)	**63.3** (112)	**52.9** (132)	**83.3** (18)
Royal United Hospital Bath	**81.3** (53)	**75** (134)	**87.2** (34)	**91** (28)	**69.5** (30)	**75.4** (25)	**84.1** (15)
Royal Victoria Infirmary	**78.1** (62)	**73.8** (147)	**76.2** (91)	**85** (100)	**60.3** (148)	**75.4** (25)	**81** (27)
Russells Hall Hospital	**37.5** (177)	**82.5** (110)	**52** (178)	**81** (130)	**67.6** (60)	**85.9** (3)	**84.1** (15)
Salford Royal Hospital	**100** (1)	**80** (112)	**85.2** (47)	**82.3** (123)	**61.2** (139)	**67.4** (54)	**70.3** (90)
Salisbury District Hospital	**84.4** (44)	**100** (1)	**93.9** (8)	**92.3** (25)	**65.7** (82)	**62.5** (79)	**76.6** (49)
Sandwell General Hospital	**37.5** (177)	**87.5** (84)	**64.3** (144)	**80.3** (140)	**59.6** (154)	–	–
Scarborough Hospital	**100** (1)	**100** (1)	**62.3** (150)	**84** (107)	**58.2** (162)	–	–
Scunthorpe General Hospital	**50** (143)	**67.5** (153)	**63.2** (147)	**75.9** (172)	**54.3** (174)	**71.8** (34)	**69.2** (97)
Singleton Hospital	**54.8** (133)	**100** (1)	**55.7** (173)	**60.4** (192)	**70.4** (21)	–	–
Solihull Hospital	**43.8** (165)	**100** (1)	**56.2** (172)	**99.1** (1)	**75.4** (8)	**84.7** (5)	**88.2** (7)
South Tyneside District Hospital	**62.5** (103)	**75** (134)	**70.8** (118)	**90.9** (30)	**57.5** (168)	**74.5** (29)	**81.1** (26)
Southampton General Hospital	**87.5** (32)	**100** (1)	**70.1** (120)	**81.1** (129)	**62.4** (122)	**57** (116)	**73.8** (64)
Southend University Hospital	**28.1** (191)	**80** (112)	**50.9** (179)	**77** (165)	**64.4** (93)	**71.7** (35)	**67.5** (105)
Southmead Hospital	**71.9** (73)	**87.5** (84)	**91.1** (18)	**95.4** (7)	**62.4** (122)	**58.4** (100)	**68.3** (100)
Southport & Formby District General Hospital	**50** (143)	**67.5** (153)	**79.9** (70)	**86.6** (74)	**63.9** (100)	**57.6** (108)	**57.6** (138)
St George's Hospital, London	**46.9** (158)	**42.5** (193)	**69.9** (121)	**76.3** (171)	**70.2** (23)	**65.7** (62)	**71.6** (84)
St Helier Hospital, Epsom	**75** (64)	**55** (188)	**34.8** (188)	**76.5** (169)	**66.7** (68)	**70.3** (41)	**72** (80)
St James's University Hospital, Leeds	**50** (143)	**87.5** (84)	**72.7** (110)	**90.8** (32)	**63.6** (105)	**60.2** (93)	**54.3** (145)
St Mary's Hospital, Isle of Wight	**46.9** (158)	**67.5** (153)	–	–	**53.5** (178)	**22.2** (148)	**21.7** (148)
St Mary's Hospital, London	**59.4** (114)	**100** (1)	**94.5** (7)	**77** (165)	–	–	–

	Governance % (Rank/199)	Nutrition % (Rank/199)	Discharge % (Rank/195)	Assessment % (Rank/195)	Staff Comm % (Rank/182)	Carer Comm % (Rank/148)	Carer Rating of Pt Care % (Rank/148)
St Peter's Hospital, Chertsey	**81.3** (53)	**100** (1)	**58.3** (162)	**86** (84)	**65.8** (80)	–	–
St Richard's Hospital, Chichester	**93.8** (19)	**87.5** (84)	**63.6** (146)	**80.5** (138)	**76.2** (5)	**75** (27)	**80.6** (30)
St Thomas' Hospital, London	**96.9** (16)	**100** (1)	**86.5** (41)	**93.9** (17)	**69.1** (35)	**82** (7)	**80.8** (29)
Stepping Hill Hospital	**93.8** (19)	**61.3** (185)	**80.3** (68)	**90.9** (30)	**63.5** (108)	**50.6** (139)	**64.6** (113)
Stoke Mandeville Hospital	**31.3** (184)	**62.5** (180)	**61.3** (152)	**85.4** (96)	**63.4** (110)	**61.5** (88)	**63.6** (116)
Sunderland Royal Hospital	**75** (64)	**100** (1)	**68.3** (132)	**95.2** (8)	**62.3** (125)	**57** (116)	**63.4** (118)
Tameside General Hospital	**56.3** (121)	**100** (1)	**80.5** (66)	**86.9** (68)	**82.7** (1)	**78.1** (17)	**85.3** (13)
Torbay Hospital	**62.5** (103)	**81.3** (111)	**77.6** (80)	**87.3** (63)	**60.7** (144)	–	–
Trafford General Hospital	**65.6** (92)	**80** (112)	**73.2** (106)	**79.7** (147)	**73** (12)	**58.3** (101)	**73.4** (67)
Tunbridge Wells Hospital	**34.4** (180)	**87.5** (84)	**29.5** (191)	**48.7** (195)	**61.3** (138)	**70** (42)	**76.7** (47)
University College Hospital	**21.9** (194)	**67.5** (153)	**96.7** (5)	**86.6** (74)	**68.7** (40)	**85.3** (4)	**93** (2)
University Hospital Aintree	**87.5** (32)	**87.5** (84)	**86.5** (41)	**86.7** (73)	**66.9** (66)	**58.6** (98)	**56.3** (141)
University Hospital Lewisham	**62.5** (103)	**67.5** (153)	**76.8** (86)	**74.5** (175)	**65.9** (77)	**53** (131)	**58.5** (135)
University Hospital Llandough	**38.7** (174)	**37.5** (196)	**56.4** (170)	**81.7** (126)	**56.4** (171)	**69.1** (46)	**85.4** (12)
University Hospital North Durham	**81.3** (53)	**100** (1)	**49.4** (181)	**80** (145)	**63.7** (103)	**50.4** (140)	**51.7** (146)
University Hospital of North Tees	**100** (1)	**100** (1)	**87** (36)	**81.6** (127)	**57.8** (166)	**64.7** (66)	**70.7** (87)
University Hospital of Wales	**38.7** (174)	**37.5** (196)	**73.2** (106)	**83.7** (112)	**58** (165)	–	–
University Hospital, Coventry	**53.1** (134)	**100** (1)	**60.5** (156)	**86.3** (80)	**66.5** (71)	**68.9** (48)	**70** (92)
Wansbeck General Hospital	**31.3** (184)	**62.5** (180)	**65.3** (140)	**89.1** (45)	**68.2** (47)	–	–
Warrington Hospital	**100** (1)	**67.5** (153)	**97.5** (2)	**96.9** (3)	**70.1** (24)	**80** (12)	**87.5** (8)
Warwick Hospital	**53.1** (134)	**93.8** (70)	**78.6** (74)	**79.3** (149)	**67.4** (62)	**56.6** (119)	**67.3** (106)
Watford General Hospital	**71.9** (73)	**100** (1)	**68.9** (129)	**96.1** (4)	**72.1** (16)	**66.9** (57)	**74.2** (62)
West Cumberland Hospital	**87.5** (32)	**75** (134)	–	–	–	–	–
West Middlesex University Hospital	**56.3** (121)	**87.5** (84)	**64.8** (142)	**86.5** (78)	**54.2** (175)	–	–
West Suffolk Hospital	**87.5** (32)	**93.8(70)**	**81.8** (59)	**90.3** (37)	**61.9** (129)	**67.4** (54)	**81.8** (22)
Weston General Hospital	**53.1** (134)	**100** (1)	**57.7** (165)	**78** (158)	**61.5** (137)	–	–
Wexham Park Hospital	**75** (64)	**61.3** (185)	**83.9** (52)	**86.6** (74)	**69.5** (30)	**55.1** (125)	**58.7** (134)
Whipps Cross University Hospital	**56.3** (121)	**100** (1)	**83.3** (53)	**89.1** (45)	**75.8** (7)	**63.6** (72)	**72.2** (76)
Whiston Hospital	**71.9** (73)	**100** (1)	**78.4** (77)	**85.7** (89)	**64.4** (93)	–	–
The Whittington Hospital	**34.4** (180)	**67.5** (153)	**89.7** (23)	**93.2** (23)	**61.8** (131)	–	–
William Harvey Hospital, Ashford	**31.3** (184)	**87.5** (84)	**78.7** (73)	**84.3** (104)	**63.2** (114)	–	–
Withybush General Hospital	**12.9** (197)	**55** (188)	**65.1** (141)	**66.5** (188)	**52.2** (181)	**65.1** (64)	**77.8** (38)
Worcestershire Royal Hospital	**84.4** (44)	**93.8** (70)	**76** (93)	**88.9** (48)	–	**49** (141)	**62.5** (122)
Worthing Hospital	**93.8** (19)	**87.5** (84)	**81.4** (62)	**87.1** (65)	–	**57.6** (108)	**62.5** (122)
Wrexham Maelor Hospital	**71** (82)	**67.5** (153)	**84.9** (49)	**78** (158)	**54.1** (177)	**69.5** (45)	**72.5** (73)
Wythenshawe Hospital	**43.8** (165)	**62.5** (180)	**90.2** (22)	**66.9** (187)	**63.4** (110)	**58.3** (101)	**72.7** (69)
Yeovil District Hospital	**87.5** (32)	**67.5** (153)	**70.8** (118)	**73.7** (176)	**62.6** (120)	–	–
The York Hospital	**93.8** (19)	**100** (1)	**92.2** (12)	**94** (16)	**58.2** (162)	**63.9** (71)	**76.6** (49)
Ysbyty Gwynedd	**74.2** (72)	**67.5** (153)	**71.7** (116)	**80.3** (140)	**61.8** (131)	**74.1** (31)	**79.5** (31)
Ysbyty Ystrad Fawr	**45.2** (163)	**100** (1)	**77.1** (82)	**72.6** (178)	**61.6** (135)	**65** (65)	**80.9** (28)

Appendix B: Method for Scoring

Previous rounds of the audit have not used a scoring system. For Round 3 of the audit, a scoring system has been created. The scoring system was tested in the pilot in 2015.

This appendix lays out the question items from the four tools used in the scoring system, the reasons why these questions were chosen and an explanation of how the scores are calculated.

Selection and content of the 7 key scoring items

The 7 scoring items were selected because:

- They are identified as priority themes relating to the care of people with dementia
- Either previous audit data analysis, or analysis of the properties of the tool in pilot, suggested that they would provide a sufficiently robust basis for comparison
- They are drawn from all 4 of the main audit tools, and therefore include measures drawn from audit of casenotes, organisational response to questions relating to support for people with dementia, and the perspective of carers and of staff.

In most cases, this will produce a composite score across at least 3 items from a tool within a theme. However, we used the single question for the overall carer rating of the care delivered, as analysis of the pilot data demonstrated that responses to this overall question did correlate well to responses to other questions. The themes selected for key item scoring are as follows:

Assessment	Patients in the casenote sample – how many out of 7 comprehensive assessment items received by each
Carer rating of the quality of information and communication	Carers' responses to 3 questions on the quality of information and communication
Staff rating of the quality of information and communication	Staff responses to 3 questions on the quality of information and communication
Nutrition	Hospital responses on 4 questions: carer passport scheme, availability of finger foods, 24 hour provision and protected mealtimes
Discharge	Patients in the casenote audit receiving 4 elements of discharge planning: discussion with the person and carer, consultant and MDT
Governance	Hospital responses on 9 questions relating to leadership, support and engagement
Carer rating of patient care	How positively carers rated care provided to the person with dementia

We have been unable to develop a score based on staffing and training as the required data was not available.

Methods of scoring

Audit tools collect information in different ways, and with different response options and therefore there is not one overall method. The basic principle for each tool is outlined below, followed by examples using simulated data.

Casenote audit	• Score = % patients with positive response (i.e. Have received assessment) x total number of assessments received per patient. • Not Applicable responses are counted as positive, as N/A can only be answered where there is a recorded reason demonstrating this.	Shown as a percentage of total possible score (if all patients had received all assessments)
Organisational checklist	• Positive response receives 1 or part thereof (e.g. in a 4 part question each response receives 0.25) totalled across the theme.	Shown as a percentage of total possible for theme (if all questions had received positive response)
Carer questionnaire	• Yes, definitely = 2 • Yes, to some extent = 1 • No = 0 • Don't know = missing	Shown as percentage of total possible (if all carers had given most positive response)
Staff questionnaire	• Yes, always/frequently = 3 • Yes, most of the time/occasionally = 2 • Yes sometimes/almost never = 1 • No/never = 0 • Not Applicable = missing	Shown as percentage of total possible (if all staff had given most positive response)

Worked examples of scoring for each theme

The following tables show only how scores are calculated and not how they are presented.

Assessment (casenote audit)

Includes:

- Mobility
- Nutritional status
- Pressure ulcer
- Pain
- Continence
- Functioning
- Delirium screen.

N assessments (out of 7)	% patients receiving	Hospital score (% patients x N assessments)
Any 1	50	50
Any 2	25	50
Any 3	5	15
Any 4	10	40
Any 5	4	20
Any 6	3	18
All 7	3	21
	Total hospital score	**214**
	Total possible score	**700**
	% score	**30.6**

Information and communication (carer questionnaire and staff questionnaire)

Includes:

- CQ5. Were you (or the patient, where appropriate) kept clearly informed about their care and progress during the hospital stay? For example, about plans for treatment and discharge.
- CQ6. Were you (or the patient, where appropriate) involved as much as you wanted to be in decisions about their care?
- CQ7. Did hospital staff ask you about the needs of the person you look after to help plan their care?
- SQ3. In your current role, do you think personal information available to you to help you provide care/support to people with dementia? E.g. their likes/dislikes, preferred name, past job
- SQ4. In your current role, do you feel encouraged to accommodate the individual needs and preferences of people with dementia? E.g. taking time to speak and interact at the pace of the person with dementia, permitting them to walk around the ward
- SQ6. As a team, how often do you talk about the way you provide care/support to people with complex needs (including dementia)?

Carer rating of information and communication (based on 10 responses)

	Yes, definitely	Yes, to some extent	No	Don't Know	Total applicable N per q	Total possible score per q	Total N score
Score per response	2	1	0	N/A			
Q5	5	3	1	1	9	18	13
Q6	3	5	1	1	9	18	11
Q7	2	4	2	2	8	16	8
						Total section score	**32**
						Total possible	**52**
						% score	**61.5**

Staff rating of information and communication (based on 20 responses)

	Yes always/ frequently	Yes most of the time/ occasionally	Yes sometimes/ almost never	No/ Never	N/A	Total applicable N	Total N score
Score per response	3	2	1	0	N/A		
Q5	10	3	2	3	2	18	38
Q6	8	3	2	5	2	18	32
Q7	2	14	2	2	0	20	36
						Total section score	**106**
						Total possible	**168**
						% score	**63.1**

Nutrition provision and support for people with dementia (organisational checklist)

Includes:

- OC12. Protected mealtimes are established in all wards that admit adult with known or suspected dementia (Y/N)
- OC13. The hospital has in place a scheme/programme which allows identified carers of people with dementia to visit at any time including at mealtimes. (E.g. Carer's passport) (Y/N)
- OC35. The hospital can provide finger foods for people with dementia (patients can choose a complete meal option that can be eaten without cutlery everyday/on from four to six days per week/on two or three days per week/on only one day per week/ finger food consists of sandwiches/wraps only)

- OC36. The hospital can provide 24 hour food services for people with dementia (other food for example toast, sandwiches, cereals, soup and lighter hot dishes, are available 24 hours a day/other food for example … are available, but less than 24 hours a day/ simple food supplies for example bread, cereal, yoghurt and biscuits are available 24 hours a day/only snacks are available 24 hours a day/food is not available 24 hours a day)

	Yes/everyday	4-6 days	2-3 days	1 day	S/wich only
Score	1	0.8	0.6	0.4	0.2
	24 hr food	**Less than 24**	**Simple**	**Snacks**	**Not available**
Score	1	0.75	0.5	0.25	0
Q12	1				
Q13					0
Q35		0.8			
Q36		0.75			
				Total score	**2.55**
				Total possible	**4**
				% score	**63.8**

Discharge planning and discussion (casenote audit)

Includes:

- CA29a. Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed place of discharge and support needs with the person with dementia?
- CA29b. Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed place of discharge and support needs with the person's carer/relative?
- CA29c. Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed place of discharge and support needs with the consultant responsible for the patient's care?
- CA29d. Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed place of discharge and support needs with other members of the multidisciplinary team?

Question	% patients positive response	Hospital score
29a	50	50
29b	25	25
29c	15	15
29d	40	40
	Total hospital score	**130**
	Total possible score	**400**
	% score	**39**

Governance, leadership and support (organisational checklist)

Question number and text		Scoring per question			Response	Score
		Y	N	Other		
1	A care pathway for patients with dementia is in place (y/n/in development)*	1	0	0.5	y	1
2	The Executive Board regularly reviews information collected on:					
2a	Re-admissions, in which patients with dementia can be identified in the total number of patients readmitted (y/n)	1	0		y	1
2b	Delayed discharge/transfers, in which patients with dementia can be identified in the total number of patients with delayed discharge/ transfers (y/n)	1	0		y	1
3	The Executive Board regularly reviews the number of in-hospital falls and the breakdown of the immediate causes, in which patients with dementia can be identified (y/n)	1	0		y	1
4	The Executive Board regularly receives feedback from the following:					
4a	The Clinical Leads for older people and people with dementia including Modern Matrons/Nurse Consultants (y/n)	0.25	0		n	0
4b	Complaints – analysed by age (y/n)	0.25	0		y	0.25
4c	Patient Advice and Liaison Services (PALS) – in relation to the services for older people and people with dementia (y/n)	0.25	0		y	0.25
4d	Patient/public forums or local Healthwatch – in relation to services for older people and people with dementia (y/n)	0.25	0		y	0.25
5	There are champions for dementia at:					
5a	Directorate level (y/n)	0.5	0		n	0
5b	Ward level (y/n)	0.5	0		y	0.5
7	Has a strategy or plan for carer engagement been produced? (e.g. using Triangle of Care self assessment tool) (y/n)	1	0		n	0
9	A Dementia Working Group is in place and reviews the quality of services provided in the hospital (y/n)	1	0		y	1
Total possible			**8**		**Total score**	**6.25**
					% score	**78.1**

Carer questionnaire: overall rating of care (based on 10 responses)

Includes:

CQ8. Overall, how would you rate the care received by the person you look after during the hospital stay?

	Excellent	Very Good	Good	Fair	Poor
Score	1	0.75	0.5	0.25	0
Q8	4	1	3	2	
				Total possible	**10**
				Total score	**6.75**
				% score	**67.5**

Appendix C: Patient Demographic Information

Age range (national sample)	National (N):
34–65	2.2% (221)
66–80	24.3% (2445)
81–100	73% (7332)
101–108	0.4% (39)
Unknown	0.1% (10)

Age	National
Range	34–108
Mean	84

Gender	National (N):
Male	40.1% (4029)
Female	59.9% (6018)

Ethnicity	National (N):
White/White British	82.1% (8250)
Black/Black British	1.2% (123)
Asian/Asian British	1.9% (193)
Chinese	0.1% (10)
Mixed	0.1% (11)
Not documented	2.1% (210)
Other	12.4% (1250)

First language	National (N):
English	77.4% (7778)
Welsh	0.6% (61)
Other European language	1% (96)
Asian language	1.4% (144)
Not documented	19% (1909)
Other	0.6% (59)

Primary diagnosis/cause of admission*	National (N):
Respiratory	19.9% (1998)
Fall	13.3% (1332)
Urinary/renal	9% (901)
Hip dislocation/hip fracture	7.5% (754)
Sepsis	6.3% (633)
Delirium/confusion	6% (604)
Gastrointestinal	5.9% (595)
Cardiac/vascular	5.1% (517)
Stroke	3.8% (380)
Neurological	3.6% (364)
Skin lacerations/lesions	2% (204)
Impaired consciousness	2% (198)
Dementia**	1.9% (195)
Other	1.9% (192)
Unable to cope/frailty	1.6% (160)
Dehydration	1.4% (143)
Haematology	1.1% (115)
Endocrine/metabolic	1.1% (112)
Other fractures	1% (96)
Cancer	0.9% (94)
Surgical/non-surgical procedure	0.9% (86)
Pain/swelling	0.8% (85)
Hepatology	0.8% (84)
Oral/visual/auditory	0.4% (45)
Rheumatic	0.4% (45)
Psychiatric	0.4% (42)
Adverse reaction to medication/allergy/overdose	0.3% (28)
Injury/trauma	0.2% (24)
Not documented/unknown	0.2% (21)

*Primary cause of admission was taken as the first reason entered on the casenote audit.
**Out of 195 noted with Dementia as cause of admission, 142 of these had dementia as the only cause of admission.

Speciality of the ward patients spent the longest time in	National (N):
Care of the Elderly/Complex Care	41.1% (4125)
General Medical	23.5% (2359)
Other Medical	9.9% (999)
Orthopaedics	8.9% (892)
Surgical	6.8% (681)
Stroke	4.5% (456)
Cardiac	2.5% (248)
Other	1.4% (136)
Nephrology	0.5% (52)
Obstetrics/Gynaecology	0.4% (41)
Critical Care	0.2% (23)
Oncology	0.2% (22)
Unknown	0.1% (13)

Patients who:	National (N):
Died in hospital	12.8% (1285)
Self-discharged from hospital	0.1% (12)
Were marked ‘fast track discharge’/’discharge to assess’/’transfer to assess’/expedited with family agreement for recorded reasons	5.5% (482)
Received end of life care in hospital/was on an end of life care plan	13% (1302)

Length of stay in the hospital	National (N):
2–10 days	45.3% (4553)
11–20 days	25.5% (2559)
21–30 days	11.3% (1132)
31–40 days	6.7% (671)
41–50 days	4.2% (418)
51–60 days	2.3% (230)
61–70 days	1.7% (168)
71–80 days	1% (102)
81–90 days	0.6% (62)
More than 90 days	1.5% (152)

Length of stay in the hospital	National:
Range	2–775
Median	12

Place of residence before/after admission	National (N):	
	Before	After*
Own home	57.7% (5793)	40.2% (3519)
Respite care	0.8% (80)	1.6% (136)
Rehabilitation	0.4% (37)	2.4% (207)
Psychiatric ward	0.5% (48)	0.7% (62)
Carer's home	2.1% (212)	2.1% (181)
Intermediate care	0.3% (27)	2% (172)
Residential care	16.9% (1701)	17.7% (1551)
Nursing home	19.7% (1981)	28.7% (2511)
Palliative care	0% (5)	0.6% (54)
Transfer from another hospital	1.4% (145)	3.9% (343)
Long stay care	0.2% (18)	0.3% (26)

Change in residence*	National (N):
No change	73.4% (6428)
Own/carer's home to nursing/residential care	11.1% (972)

*These figures exclude patients who died while in hospital.

Appendix D: Carer Demographic Information

Age range	National (N):
18–24 years	1% (48)
25–34 years	2.9% (133)
35–44 years	5.6% (259)
45–54 years	16.2% (749)
55–64 years	25.8% (1193)
65–74 years	20.8% (960)
75–84 years	19.1% (885)
85 years or over	7.4% (343)
Prefer not to say	1.2% (56)

Gender	National (N):
Male	30.6% (1413)
Female	68.1% (3150)
Other	0.1% (4)
Prefer not to say	1.2% (57)

Ethnicity	National (N):
White/White British	88.4% (4079)
Black/Black British	3% (140)
Asian/Asian British	3.3% (152)
Mixed	1% (44)
Chinese	0.2% (9)
Other	1.4% (64)
Prefer not to say	2.7% (124)

Relationship to patient	National (N):
Spouse or partner	33.5% (1558)
Family member	55.9% (2597)
Friend	4.4% (203)
Professional carer (health or social care)	5.4% (249)
Other	0.9% (41)

One of main carers for patient	National (N):
Yes	77.8% (3356)

Appendix E: Staff Demographic Information

% of patients encountered in role who have dementia/possible dementia	National (N):
Up to 25%	31.9% (4559)
26–50%	25.6% (3651)
51–75%	24.4% (3489)
More than 75%	18.1% (2588)

Gender	National (N):
Male	15.7% (2260)
Female	83.2% (11954)
Other	0.2% (34)
Prefer not to say	0.8% (113)

Ethnicity	National (N):
White/White British	79.9% (11467)
Black/Black British	4.1% (594)
Asian/Asian British	8% (1150)
Mixed	1.3% (183)
Chinese	0.5% (73)
Other	4.5% (646)
Prefer not to say	1.7% (241)

Job role	National (N):
Registered nurse (Band 5 or 6)	29.9% (4300)
Registered nurse (Band 7 or above)	12.7% (1831)
Healthcare assistant	23.1% (3324)
Doctor	11.5% (1645)
Allied healthcare professional	11.9% (1713)
Allied healthcare professional assistant	2.6% (367)
Student	2.3% (332)
Ward based admin	4% (571)
Other/Unknown	1.9% (279)

Hours worked per week	National (N):
Up to 29 hours	13% (1866)
30 hours or more	87% (12458)

Time worked in the hospital	National (N):
Less than 6 months	8% (1148)
6–11 months	9.5% (1364)
1–2 years	15.6% (2242)
3–5 years	16.4% (2350)
6–10 years	15.9% (2283)
11–15 years	12.1% (1739)
More than 15 years	22.4% (3205)

Appendix F: Steering Group and Project Team Members

Steering Group

- Professor Peter Crome, Honorary Professor, UCL, Emeritus Professor, Keele University (Chair)
- Professor Dawn Brooker, Director, University of Worcester Association for Dementia
- Dr Amanda Buttery, Innovation Fellow Dementia, South London Academic Health Science Network
- Angela Connelly, Carer Representative
- Dr Oliver Corrado, Consultant Geriatrician and Leeds Teaching Hospitals' 'Dementia Champion' (NAD Clinical Lead)
- Dr Duncan Forsyth, Consultant Geriatrician, Cambridge University Hospitals/British Geriatrics Society
- Dawne Garrett, Professional Lead for Older People and Dementia Care, Royal College of Nursing
- Nicci Gerrard, Carer Representative, John's Campaign
- Professor Rowan Harwood, Professor of Geriatric Medicine, Nottingham University Hospitals
- Janet Husk, Programme Manager, Healthcare of Older People, Clinical Effectiveness and Evaluation Unit (CEEU), Royal College of Physicians
- Kelly Kaye, Partnership Manager, Dementia Action Alliance
- David McKinlay, Programme Manager, Healthcare Quality Improvement Partnership
- Dr Wendy Neil, Consultant Psychiatrist, Faculty of Old Age Psychiatry, Royal College of Psychiatrists
- Sean Page, Consultant Nurse – Dementia, Wrexham Maelor Hospital
- Sue Pierlejewski, Carer Representative
- Dr Imran Rafi, Chair of Clinical Innovation and Research, Royal College of General Practitioners
- Léa Renoux, Senior Health Influencing Manager (Policy), Age UK
- Dr Kevin Stewart, Clinical Director, Clinical Effectiveness and Evaluation Unit (CEEU), Royal College of Physicians
- Beth Swanson, Lead Nurse, South Tees Hospitals NHS Foundation Trust (Nurse Consultant to the audit)
- Gavin Terry, Policy Manager, Alzheimer's Society
- Dr Daphne Wallace, Living with Dementia Group
- Kirsten Windfuhr, Associate Director, Healthcare Quality Improvement Partnership

The National Audit of Dementia Project Team

- Professor Mike Crawford, Director of the Royal College of Psychiatrists' Centre for Quality Improvement
- Dr Alan Quirk, Senior Programme Manager (Research and Audit)
- Chloë Hood, Programme Manager
- Chloë Snowdon, Deputy Programme Manager
- Sarah Keane, Project Worker
- Simone Jayakumar, Project Worker
- Vicky Cartwright, Project Administrator
- Holly Robinson, Deputy Programme Manager (from 2015 to February 2016)
- Rahena Khatun, Project Administrator (from 2015 to June 2016)

List of Web Resources

The following documents can be downloaded on the audit website:
www.nationalauditofdementia.org.uk

- Reports from previous rounds of audit
  - Report on the second round of audit published in 2013
  - Report on the first round of audit published in 2011
- Standards documents and audit tools from all rounds of audit
- Lists of participating Trusts/Health Boards and hospitals in all rounds of audit
- Report from the pilot audit carried out in community hospitals
- Comparison between Round 2 and Round 3 audit data

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