HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 28 March 2012.

PRESENT: Councillor Dryden (Chair); Councillors Davison, Harvey and Lancaster.

OFFICERS: J Bennington and J Ord.

**** PRESENT BY INVITATION:** South Tees Hospitals NHS Foundation Trust:
B Walker, Assistant Director of Nursing and Patient Safety
R Jamieson-Gaffney, Head of Patient Relations
A Artley, Senior Nurse
J Power-Jepson, Clinical Matron.

**** APOLOGIES FOR ABSENCE** were submitted on behalf of Councillors Cole, Mawston, Mrs H Pearson and Purvis.

**** DECLARATIONS OF INTEREST-**

There were no declarations of interest made at this point of the meeting.

**** MINUTES**

The minutes of the meeting of the Health Scrutiny Panel held on 8 March 2012 were submitted and approved as a correct record.

CARE OF VULNERABLE OLDER PEOPLE – NHS TEES

The Scrutiny Support Officer submitted a report the purpose of which was to introduce senior representatives from the South Tees Hospitals NHS Foundation Trust (STHFT) to address the Panel on how vulnerable older people were protected and cared for at James Cook University Hospital.

By way of introduction statistical information was provided on overall demographics which demonstrated that there were 1.7 million more people over the age of 65 than there were 25 years ago with the number of people aged 85 and over having doubled for the same period. In terms of future predictions by 2035, 23% of the population was projected to be over 65. With specific reference to dementia there were currently 700,000 people in the UK suffering from dementia. The Alzheimer's Society predicted that this would increase to 940,000 by 2021 and 1.7 million by 2051.

In terms of the ageing population and resulting challenges statistical information was provided in respect of the STHFT which demonstrated that 51% of admitted patients were aged 65 years or older, 1.9 per 1,000 of which had dementia coded (as defined by the Information Commission) as primary diagnosis. It was noted that such information on codes would not necessarily be available to Ward staff but they would have the clinical notes. It was pointed out that 63.2 per 1,000 admissions had dementia coded as a secondary diagnosis and 7.7 per 1,000 had Alzheimer's coded as secondary diagnosis. It was acknowledged that the ageing population posed several challenges for the Trust and there was a need for ongoing examination of what was required in order to cope with such demands. The Panel sought further clarification of the breakdown on the number of patients with dementia as other mental health illnesses such as delirium may have been included in the overall figures.

Data was provided over the period January 2011 to February 2012 regarding the number of complaints from patients aged 65 and over not necessarily categorised as being vulnerable. It was confirmed that the Trust had received 223 compliant issues some of which related to alleged poor treatment of older people. Such a figure amounted to 20.8% of the Trust's total complaints. Although data collated so far did not identify the number of complaints being upheld or not substantiated the Trust intended to compile such information with effect from April 2012. On average there tended to be 25 written complaints each month which could cover more than one compliant issue. The two main codes covering the areas of complaint were Quality of Nursing

Care and Quality of Medical Care. An indication was given of a number of anonymised case studies of what was complained about and how the practice had changed as a result.
The Panel sought clarification regarding the collation of data with particular regard to the recording of cases upheld or not substantiated. It was explained that the focus of attention had been on lessons learnt and highlighting areas for subsequent improvement as such information had not previously been required by the Department of Health. The emphasis had and would continue to be on an open and transparent way or working and on shared information, identifying and responding to any recurring themes. An indication was given of the current monitoring arrangements which included monthly reports at a Divisional and Director level and to a Risk Assessment Committee and quarterly to integrated Governors. In response to a Members' question it was confirmed that further statistical information could be provided on complaints raised informally such as those by means of PALS rather than the formal written procedure.

An indication was given in the presentation of a number of national drivers for change with specific regard to caring for people with dementia on hospital wards. In caring for vulnerable older people it was recognised that such high intensity users of hospitals often incurred an overlap of physical and social vulnerabilities involving issues of ageing, acute illness, social vulnerability and chronic disease.

In terms of the arrangements for when an older person was scheduled to attend JCUH depending on their clinical condition patients may be seen at a pre-assessment clinic. It was expected that GP's would have provided on referral any information about mental health and other professionals involved in the patients care. An assurance was given that if there were concerns identified about a patient's mental health at pre-assessment then there would be the opportunity to seek further advice from the relevant clinical team. Any medication being taken by the patient relating to mental health would be considered in line with other medication with regards to pre and post operative care.

On all admissions staff completed an assessment of the patient based on the activities of daily living. In addition, a number of additional assessments were undertaken to identify risk of falls, tissue damage and nutritional status amongst other issues. A relevant social and past medical history were taken and together with any other information that staff made be made aware of, help to identify patients who may be vulnerable, their risk and actions that needed to be taken to mitigate risk. Should staff become concerned about actual or possible abuse then an alert was raised and progressed as appropriate through the multi agency safeguarding adult procedures. The Trust had a specialist nurse in post to support staff with managing concerns about vulnerable patients who had been abused. If there were concerns about a patient's mental health then advice would be sought from relevant colleagues.

In order to provide co-ordinated quality care there needed to be robust individualised patient assessment to achieve dignified, person-centred care. The key assessment areas covered cognitive ability, mobility, nutritional status, sensory impairment, continence, risk factors, vulnerability care needs, case management co-ordination and carer engagement.

In terms of aspects of quality assurance it was pointed out that visible leadership and effective teamwork were key ingredients which included such areas as:-

- Daily board rounds;
- Monthly Quality of Care Reviews by Ward Managers and Clinical Matrons;
- Trust safety walkabouts;
- Annual review of staffing levels;
- DATIX system analysis to identify concerns and any themes and lessons learnt;
- Learning from patients' experiences and sharing such information at board level every month and organising patient experience workshops to enable shared learning;
- Quarterly Governance and Safety Workshop for Ward and Departmental Managers.

Examples were provided of quality initiatives which included protected mealtimes; study days to determine staff's attitude, knowledge and beliefs surrounding patients with mental health needs and safeguarding adults; a trust-wide liaison nurse for learning disabilities; mealtime voucher scheme to help with feeding patients; the creation of a specialist nutritional nurse to visit the wards regularly and review patients with specific nutritional needs; an additional Macmillan lung cancer specialist nurse; a specialist nurse in safeguarding adults; a clinical matron in wound care; 'this is me' leaflet; 'passport' approach; intentional rounding; and driving improvement in elderly care services through FTN benchmarking.

In terms of identifying areas for development specific reference was made to the following:-

(a) increase awareness across the organisation on the needs of older people with complex requirements especially those with mental health problems;

(b) training programme for managing patients with dementia;

(c) implementation of the Dementia Strategy and identifying early detection of dementia and the different stages of dementia;

(d) service redesign involving commissioners (PCT and Clinical Commissioning Groups), local authority, mental heath, staff from acute and community care to develop pathways of care that would focus on preventing admission, supporting early discharge with rehabilitation and ongoing therapy provided in either a community setting or the patient home.

In discussing ways of obtaining patient's feedback Members referred to the benefits of 'patient's stories' and extending a scheme involving a Health Passport which was being pursued details of which had previously been reported to the Panel and to the Social Care and Adult Services Scrutiny Panel which was aimed at improving the experience of patients with learning difficulties when they were admitted to hospital for planned care and for residents when taken from a care home to visit hospital. As well as information on personal and medical details the Health Passport contained important information to the patient on such matters as to how a patient preferred to be communicated with, how they preferred to take tablets and how a patient might show they were in pain. Such information would assist in identifying what level of support they required and adjustments which were needed to improve a patient's experience.

As an alternative or in addition to the Health Passport it was suggested that the feasibility of introducing some type of comments card to be placed at the end of a patient's bed be explored. Such a card would be available to visiting family and friends of a patient upon which they could make relevant comments about a patient's care. This would avoid any confusion by deterring notes being written on a patient's medical notes form. In commenting on personal experiences Members indicated the usefulness of such a facility and felt that some patients would find it easier to communicate by this method rather than speak to staff. It was also considered that any issues could be dealt with at an earlier stage and prevent a situation escalating to a formal complaint.

Members specifically referred to the interaction of hospital staff and patients and the opportunity for patients and/or their families to raise any issues about their healthcare. The Panel was advised of current arrangements involving the Ward Managers and Clinical Sisters/Matrons on daily walkabouts (Intentional Rounding) engaging with patients.

The Panel sought information of examples where changes had been made to the environment or practices as a result of data on patient's experiences and safety. In relation to older vulnerable people Members were advised that the number of patient falls had reduced as a result of changes to bathrooms. Reference was also made to the benefits of ensuring protected meal times for patients.

Specific reference was made to positive outcomes arising from the Dementia Collaborative at Darlington Memorial Hospital the aim of which was to improve the quality of service for people with dementia and had involved a range of minor administrative, redecoration physical changes to the environment to more extensive modifications such as the removal of nurse stations to encourage staff to spend more time with patients. The Panel was advised that a similar model was being pursued with a focus on achieving improvements by a refurbishment plan.

The Panel focussed their intention on the main areas for continuing and future development. Such areas included the need to increase awareness amongst staff (total approximately 5,000) of the need of patients with mental health needs and provide staff with the most appropriate training and necessary skills which was regarded as a key element. Improved liaison with acute Teams, local authorities, Mental Health Trust to develop appropriate pathways of care including supported discharge arrangements was another important element of future working.

AGREED as follows:-

1. That the South Tees Hospitals NHS Foundation Trust representatives be thanked for the information provided which would be incorporated into the overall review.

2. That the local NHS representatives involved with the current review be invited to attend the next meeting of the Panel to be held on 19 April for a round table discussion on the evidence presented so far.

OVERVIEW AND SCRUTINY BOARD UPDATE

In a report of the Chair of the Health Scrutiny Panel, Members were advised of the key matters considered and action taken arising from the meeting of the Overview and Scrutiny Board held on 6 March 2012.

NOTED