MIDDLESBROUGH COUNCIL

AGENDA ITEM 6

OVERVIEW & SCRUTINY BOARD

21 August 2012

HEALTH SCRUTINY PANEL FINAL REPORT – THE EXPERIENCE OF VULNERABLE OLDER PEOPLE IN HEALTHCARE SETTINGS

PURPOSE OF THE REPORT

1. To introduce the Health Scrutiny Panel's final report into the Experience of Vulnerable Older People in Healthcare settings

Background

2. The topic of Older People and how they are cared for within healthcare has been a particularly high profile topic in national affairs in recent years.

3. In February 2011, the Parliamentary & Health Service Ombudsman published a report entitled *Care & Compassion?*, which centred on the experiences of older people in NHS Care in ten case studies. All of the case studies were complaints that had been submitted to, and investigated by, the Health Ombudsman's Office.

4. *Care & Compassion?* was a seminal report that attracted a great deal of interest, raised a great deal of concerns and initiated a period of debate on the NHS' care of older people that was unprecedented.

5. The Health Ombudsman said of the cases in *Care & Compassion?:*

***They illuminate the gulf between the principles and values of the NHS Constitution and the felt reality of being an older person in the care of the NHS in England. The investigations reveal an attitude – both personal and institutional – which fails to recognise the humanity and individuality of the people concerned and to respond to them with sensitivity, compassion and professionalism. The reasonable expectation that an older person or their family may have of dignified, pain free end of life care, in clean surroundings in hospital is not being fulfilled. Instead, these accounts present a picture of NHS provision that is failing to meet even the most basic standards of care*.**

6. As the Health Ombudsman says

6.1 It is incomprehensible that the Ombudsman needs to hold the NHS to account for the most fundamental aspects of care: clean and comfortable surroundings, assistance with eating if needed, drinking water available and the ability to call someone who will respond. Yet as the accounts in this report show, these most basic of human needs are too often neglected, particularly when the individual concerned is confused[1]

6.2 I continue to receive complaints in which, almost incidentally, I hear of food removed uneaten and drinks or call bells placed out of reach.

6.3 But financial resource alone will not ensure such circumstances are not repeated. An impetus towards real and urgent change, including listening to older people, taking account of feedback from families and learning from mistakes is needed. I have yet to see convincing evidence of a widespread shift in attitude towards older people across the NHS that will turn the commitments in the NHS Constitution into tangible reality.

7. The Health Ombudsman advocates that the NHS must close the gap between the promise of care and compassion outlined in its Constitution and the injustice that many older people experience. Every member of staff, no matter what their job, has a role to play in making the commitments of the Constitution a felt reality for patients

8. The Health Ombudsman makes the point that poor examples of care are not exceptional or isolated cases.

8.1 Of nearly 9000 properly made complaints to my office about the NHS in the last year, 18 per cent were about the care of older people. We accepted 226 cases for investigation, more than twice as many for all other age groups put together.[2]

9. How the NHS cares for older people and how it copes with the demands of an ageing population matters. As is point out in Care & Compassion, there are now 1.7million more people over the age of 65 than there were 25 years ago and he number of people aged 85 and over has doubled in the same period. By 2034, 23% of the population is projected to be over 65. As life expectancy increases, so does the likelihood of more years spent in ill health, with women having on average 11 years and men 6.7 years of poor health. Nearly 700,000 people in the UK suffer from dementia and the Alzheimer's Society predicts that this figure will increase to 940,000 by 2021 and 1.7million by 2051.

10. *Care & Compassion* points out that the NHS will need to spend increasing amounts of time and resource caring for people with multiple and complex issue, disabilities and long term conditions and offering palliative care to people at the end of their lives.

[1] Page 10 – Care & Compassion
[2] Page 8 on Care & Compassion

11. The Health Ombudsman points out that the failings chronicled by *Care & Compassion* suggest that extra resource alone will not help the NHS to fulfil its own standards of care. Rather, in the view of the Health Ombudsman, the actions described in *Care and Compassion*

11.1 Add up to an ignominious failure to look beyond a patient's clinical condition and respond to the social and emotional needs of the individual and their family[3].

12. Care & Compassion goes on to say:

12.1 Such circumstances should never have arisen. There are many codes of conduct and clinical guidelines that detail the way the NHS and its staff should work. The essence of such standards is captured in the opening words of the NHS Constitution: '**The NHS touches our lives at times of basic human need, when care and compassion are what matter most*****'. Adopted in England in 2009, the Constitution goes on to set out the expectations we are all entitled to have of the NHS. Its principles include a commitment to respect the human rights of those it serves; to provide high-quality care that is safe, effective and focused on patient experience, to reflect the needs and preferences of patients and their families and to involve and consult them about care and treatment. Users of NHS services should be treated with respect, dignity and compassion.***

13. The first priority for anyone with illness is high quality effective medical treatment, available quickly when needed. The outcome should be a return to health or as near as possible. If illness is terminal, the priority should be palliative care, with adequate relief of both pain and anxiety. This is not always easy or straightforward. Often, older people have multiple and complex needs that require an understanding of the interaction between a variety of different medical conditions to ensure that one is not addressed in ignorance or at the neglect of others. A person's physical illness may be compounded by a difficulty with communication or by dementia. Inattention to the suffering of older people is characteristic of the stories in this report. Inadequate medication or pain relief that is administered late or not at all, leaves patients needlessly distressed and vulnerable.

14. Alongside medical treatment, effort should be put into establishing a relationship with the individual that ensures their needs will be heard and responded to. Where older people are not able to take part in decisions about their care and treatment, families or carers must be involved. Above all, care for older people should be shaped not just by their illness, but by the wider context of their lives and relationships. Instead, our investigations reveal a bewildering disregard of the needs and wishes of patients and their families.

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[3] page 8 Care and Compassion

14.1 One family, whose story is recounted here, suffered very great distress when the gravity of their loved one's condition was not communicated to them properly or appropriately, and his life support was later turned off against their express wishes.

14.2 The theme of poor communication and thoughtless action extends to discharge arrangements, which can be shambolic and ill-prepared, with older people being moved without their family's knowledge or consent. Clothing and other possessions are often mislaid along the way. One 82year old woman recalled how, on being discharged from hospital after minor surgery, she was frightened and unsure of how to get home. She asked the nurse to phone her daughter. 'He told me this was not his job', she said.

15. Given the national focus on the treatment of older people in the NHS, the Panel felt it would be particularly beneficial to consider what happens locally, and how vulnerable older people's interests are protected at James Cook University Hospital (JCUH).

NHS Tees evidence

16. As a first source of evidence, the Panel heard from the Strategic Commissioning Manager for Mental Health from NHS Tees.

17. The Panel heard that from the outset, it was recognised that hospitals, by virtue of the constantly changing environment and busy nature of the wide range of activities carried out, was not conducive for patients with dementia. A specialist mental health provider such as the Tees, Esk and Wear Valleys NHS Foundation Trust provided a professional service across the Pathway, but in general terms other measures were being pursued to assist patients with dementia during their stay in hospital.

18. The Panel heard that in comparison to other regional and national facilities, significant resources have been invested into training at James Cook University Hospital, with particular regard to the development of a specialised vulnerable older people mental health liaison service. It was confirmed that the team currently included the services of a consultant psychologist (part), psychiatry sessions as required, services of three (and one part) nurses, specialist occupational therapist and a specialised social worker. In very general terms, and at any one time, it was indicated that 60% of patients at JCUH would be older people, 30% of whom may have dementia or other mental health illnesses. This equates to approximately 300 beds. It was acknowledged that symptoms initially presented by a patient may not necessarily be dementia, but may be as a result of other medical conditions such as delerium. The Panel heard that there was an intention to further increase the screening of appropriate patients in identifying any mental health conditions when admitted to hospital for planned care.

19. The Panel heard that one of the most effective steps that can be taken regarding the training of staff, was to increase the capability and confidence of non specialist hospital staff to identify the symptoms to look out for in terms of dementia or other conditions such as delirium. It was pointed out to the Panel that work was progressing in respect of the next financial year to support and develop the training programme further for acute trusts. Reference was made to awareness training in dementia care which had been commissioned at Middlesbrough College, at NVQ level, for non specialised staff.

20. The Panel was advised of the intention for a specific campaign to restart at JCUH around patient awareness on aspects of dignity and respect not just in respect of older vulnerable patients but several groups of people including those with learning disabilities. The Clinical Matrons had championed such a campaign, which involved clinical and ancillary staff.

21. The Panel was provided with details of a scheme devised by TEWV which had been adopted by South Tees Hospitals NHS Foundation Trust, involving a 'Health Passport'. This is aimed at improving the experience of patients with learning disabilities, when they were admitted to hospital for planned care. As well as personal and medical details, the Health Passport contained information important to the patient on such matters as to how a patient preferred to be communicated with, how they preferred to take tablets, a patient's likes and dislikes and how they may show they were in pain. It was reported that such information would assist in identifying what level of support they required and any adjustments required to achieve a better outcome for the patient. It was suggested that the use of Health Passports could be extended to vulnerable older patients with mental health concerns, including dementia, on their admission to hospitals for planned care, in order to improve communication and experience of such patients during their stay in hospital.

22. The Panel was advised of national research which demonstrated that patients with a physical condition, along with dementia, could have a lengthier stay in hospital, which could be perhaps twice as long as a patient with the same condition without dementia. It was indicated that this could be as a result of a range of factors, but mainly involved a lack of understanding of a patients needs and the inability of a patient to communicate. It was considered that with appropriate training, nursing staff would be in a better position to take on an advocacy role or patients with Mental Health concerns. This would encompass identifying more easily the symptoms of mental health illness, including dementia, and understanding a person's needs to improve the quality of care and ensure a better outcome for such patients.

23. Following positive outcomes arising from the Dementia Collaborative at Darlington Memorial Hospital, the Panel was advised of the commissioning intentions to identify investment and facilitators to extend such a scheme to JCUH. The aim of the scheme was to improve the quality of service for people with Dementia. At Darlington Memorial Hospital, it had involved a range of minor administrative,

redecoration and physical changes to the environment and equipment, to more extensive modifications such as the removal of nurses stations to encourage staff to spend more time patients. In terms of the outcome of such measures, it was pointed out that the average length of stay for such patients had reduced by a third. An indication was also given of the Rapid Process Improvement programme with the aim of improving better outcomes for patients.

24. Reference was made to an additional £300,000, which had been identified for JCUH with regard to patients with mental health issues and the proposed extension of the screening of such patients, at the point of admission to hospital.

25. The Panel discussed the areas for future consideration as part of the overall review, and paid particular attention to the areas to focus upon, with representatives of the South Tees Hospitals NHS Foundation Trust. Such areas included:-

25.1 What steps are taken to assess possible mental health issues of vulnerable older people at the point of admission at hospital for planned care.

25.2 Following such an assessment which could include a range of mental health conditions including dementia what measures are put in place to ensure the management of such problems and that appropriate care was provided to such patients on the medical wards and appropriate discharge arrangements made.

25.3 That information be sought regarding training and the Trust's policies providing hospital staff at all levels including medical, nursing and ancillary staff on guidance and responsibilities with regard to aspects of patients' dignity, privacy and well being with the aim of improving a patient's experience during their stay in hospital.

26. The Panel also considered that part of the evidence to be gained from the STHT, it would be useful if an indication was given of the overall number of complaints. The Panel also expressed a strong interest in enquiring about a examples of formal complaints received in respect of the treatment of vulnerable older patients on issues around dignity and wellbeing. Further to ascertain what any lessons were learned and subsequent changes to practice.

27. The Panel raised the issue of overall financial pressures facing the NHS. Reference was made to the Department of Health's QIPP agenda to improve the quality and delivery of NHS care whilst reducing costs. It was considered that there was potential to be more cost effective by changes in the tariff for instance regarding re-admission charges and by pursuing the measures outlined and reducing the length of stay of vulnerable older patients in hospital. It was felt that the financial constraints provided some impetus in pursuing different approaches as outlined including the development of community

services which helped to avoid unnecessary admission and lengthy stay of patients in hospital.

Evidence from South Tees Hospitals NHS Foundation Trust

28. The Panel was keen to speak with the South Tees Hospitals NHS Foundation Trust about its perspective on the experience of vulnerable older people in hospital.

29. By way of introduction, statistical information was provided on the demographic picture facing the country, 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. The Panel heard that 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.

30. The Panel heard that in respect of the STHFT, 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. The Panel heard that 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.

31. The Panel was advised that an ageing population posed several challenges for the STHFT and there was a need for ongoing consideration and examination of what was required, in order to cope with such demands.

32. The Panel was provided with data for 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 complaints, some of which related to perceived poor treatment of older people, with this amounting to 20.8% of the Trust's total complaints.

33. The Panel was surprised to learn that data collated so far, did not record the number of complaints being upheld or not substantiated. The Trust did, however, intend to compile such information with effect from April 2012. On average, there would be 25 written complaints each month, which could cover more than one complaint issue. The Panel heard that the two main codes covering the areas of complaint were around the 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.

34. 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 from complaints and highlighting areas for subsequent improvement, as data on complaints that were upheld, had not previously been required by the Department of Health. The Panel was advised that 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.

35. The Panel heard about 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.

36. The Panel was interested to ascertain what would happen in the case of a vulnerable older person and a planned visit to hospital. It was reported that when an older person was scheduled to attend JCUH, depending on their clinical condition, patients may be seen at a pre-assessment clinic. It would be expected that GPs would, on referral, provide any information about any mental health concerns and whether there are any 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.

37. It was confirmed that all admissions staff completed an assessment of the patient, based on the activities of daily living. In addition, a number of additional assessments would be undertaken to identify risk of falls, tissue damage and nutritional status amongst other issues. The panel head that a relevant social and past medical history would taken and together with any other information that staff may made aware of, help to identify patients who may be vulnerable, their risk and actions that needed to be taken to mitigate risk. It was said that should staff become concerned about actual or possible abuse, an alert would be raised and progressed as appropriate, through the multi agency safeguarding adult procedures. It was reported that 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.

38. The panel heard that 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 would cover cognitive ability, mobility, nutritional status, sensory impairment,

continence, risk factors, vulnerability care needs, case management co-ordination and carer engagement.

39. On the subject of quality assurance, it was pointed out to the Panel 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.

40. The Panel enquired about examples of the Trust's 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. It also included 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 and an additional Macmillan lung cancer specialist nurse.

41. The Panel heard that it also included 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 Foundation Trust Network benchmarking.

42. The Panel was interested to hear about what, in the view of the Trust, were the areas of practice which required development. Reference was made to the following:-

42.1 increase awareness across the organisation on the needs of older people with complex requirements, especially those with mental health problems;

42.2 training programme for managing patients with dementia;

42.3 implementation of the Dementia Strategy and identifying early detection of dementia and the different stages of dementia;

42.4 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.

43. In terms of obtaining patient's feedback, the benefit of 'patient's stories' was discussed. The Panel heard about a scheme involving a Health Passport which was being pursued, 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.

44. 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. It was felt that 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.

45. The Panel 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.

46. 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.

47. Specific reference was made to positive outcomes arising from the Dementia Collaborative at Darlington Memorial Hospital. The aim of this programme was to improve the quality of services for people with dementia. It had involved a range of minor administrative, redecoration and 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.

48. The Panel focussed their intention on the main areas for continuing and future development. It was said that 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, TEWV to develop appropriate pathways of care including supported discharge arrangements was another important element of future working.

Roundtable debate

49. The Scrutiny Panel was keen to speak to a number of key agencies working for the benefit of older people in healthcare settings. They were Dept of Social Care, NHS Middlesbrough, the South of Tees CCG, South Tees Hospitals NHS Foundation Trust, Tees, Esk & Wear Valleys NHS Foundation Trust.

50. To assist the discussion, a number of questions were set

50.1 It seems beyond doubt that there will be more older people in the future, with a greater proportion living to a very old age, with multiple health needs. How does an acute hospital, such as JCUH, need to be configured to adequately meet this demographic change, as a matter of routine?

50.2 What are the barriers to doing this?

50.3 What can commissioners do to ensure that that providers respond to such demographic developments? Do they have all of the tools necessary to 'commission-out' bad practice?

50.4 Specifically on Older People with Mental Health needs, what does JCUH need to do, that it isn't doing now, to improve the service and experience on offer?

50.5 Does JCUH have mental health support of sufficient capacity for the numbers of vulnerable older people present in JCUH at any one time?

50.6 To what extent is the improving of vulnerable older people's experience a resource issue and to what extent is it about developing appropriate working practices?

50.7 How will we know if we are meeting the needs of vulnerable older people at JCUH? What does success look like?

50.8 How can other parts of the health and social care economy play their part?

51. In response to the first question, the Panel heard that whilst the geographical circumstances differed across the areas covered by the

STHFT Community Services which included Middlesbrough, Hambleton and Richmondshire, and Redcar and Cleveland, the guiding principles of equality of access and outcome remained the same. Locality Teams were being developed together with a Rapid Response Team which was hoped would be in place by October 2012. It was said that work was progressing on a more integrated approach with the health aspects aligned to social care.

52. The Panel heard that the aim of current developments was to ensure that the most suitable use was made of acute and community hospital beds, with appropriate and effective support services being in place. Should the direction of demographic changes continue, it was considered that such services would need to be more flexible which might result in the need for more staff, rather than more community hospital beds. The Panel heard that when considering how whole system works together, it was pointed out that in terms of the area covered by the North of Tees Clinical Commissioning Group, there were no community hospitals. This supported the point that a system does not necessarily work well because there are lots of community beds.

53. In discussing how older people are dealt with in hospitals, specific reference was made to the extra investment provided in relation to training at JCUH, with particular regard to the development of a specialised vulnerable older people mental health liaison service. The Panel heard that significant extra funds had been directed into the service, which whilst not perfect, had improved the service on offer and the capacity of the service on offer.

54. The Panel was interested to discuss perceived concerns about how the system would cope with the increasing number of older vulnerable people with complex needs. The Panel was advised of systems, which were in place and/or being developed further which included specialised officers and screening for mental health issues, at the point of admission to JCUH. It was reported that the focus of systems being developed, based on measures put in place at Darlington and Birmingham, was on a whole system approach as to how people were treated. A priority for commissioning was to ensure equality of access and choice of support in community services for all.

55. In discussing changes which had previously been made, and those being developed, it was acknowledged that any change would be influenced by the political process, organisation and policy changes at a national or local level. The Panel heard that recent changes to processes had provided more of an opportunity, for a wide range of representatives to discuss overall issues and importantly consider the impact on each other and safeguarding against the dismantling of valued services. The local NHS representatives indicated that whilst there always had been partnership working, current arrangements provided this to be at a much higher organisational level.

56. It was indicated that given the financial pressures the STHFT was continuing to focus on joint working and looking at making radical changes in the ways of working in order to increase efficiency, be more creative and increase amount of productivity. The Panel heard that the financial pressures facing the public purse per se, actually presented an imperative for organisations to work together and find shared solutions to problems. Whilst the Panel was encouraged to hear that this level of joint working was now taking place, the Panel did question why such partnership hadn't been as evident when resources were more freely available. The Panel did not feel as though it got an adequate answer to this point.

57. The Panel heard that in pursuing improvements, with particular regard to community services, one of the initial actions for the Trust had been to undertake a mapping exercise of what was available and to measure effectiveness of such services. The sharing of that information across relevant organisations and the impact on each other, was considered to be an important aspect of future working.

58. In response to Members' concerns regarding the dissemination of important information, STHFT gave an indication of the various means by which information was cascaded amongst sub groups, nursing staff, training programmes. The Panel was advised that particular importance was attached to the consideration of 'patient's stories' at a ward, and Board level, on a regular basis.

59. The Panel was interested to explore what tangible impact, if any, that the public sector's financial retrenchment will have on the provision of health services. It was confirmed that there would be a closure of wards at JCUH, in the next financial year for the purpose of refurbishment. Other local representatives referred to the opportunity of assessing people over a shorter period of time, reducing the number of beds and utilising saved resources into community services. Still, any such changes would require consultation with appropriate stakeholders.

60. The Panel heard that it was anticipated that improvements which had been made to the dementia service would result in reducing the length of stay in hospital for such patients but only if appropriate and effective support mechanisms were in place to meet the demand of increasing complex needs of vulnerable older people.

Conclusions

61. The Panel has heard a great deal of how a busy acute ward can sometimes not be the best place for an older person to be, who may be easily confused and vulnerable. As such, the idea of virtual wards has gained greater traction as possible approach to keep such people under close clinical observation, whilst ensuring they are in a more familiar and perhaps less intimidating environment. The Panel considers that should virtual wards be considered to be a realistic option for the local health and social care economy, a document should

be prepared stating the case for their development, the benefits they could deliver and some detailed consideration as to what a successful virtual ward would look like.

62. The local health and social care economy arguably faces the most severe financial climate in living memory, with the paucity of fresh investment being exacerbated by a number of significant demand led pressures. The ageing population is arguably the most noteworthy of these. Bearing this in mind, the Panel does not feel as though it has been able to obtain an adequate understanding of what those budgetary pressures will mean for the care of increasing numbers of vulnerable older people. The Panel was surprised at the apparently relaxed attitude of the local health and social care economy about the scale of the challenge faced. It was expecting to be presented with more evidence that a clear plan was in place (or being developed), across all sectors, of how quality of service would be protected, whilst meeting the very stringent financial targets set by national government. This is a matter that the Panel would like to revisit in the near future.

63. The Panel heard that the challenges outlined above, could largely be addressed by improved partnership working and an improved partnership ethos. Whilst this was accepted by the Panel, it was felt that this was indirectly a criticism of the extent to which true partnership was pursued in previous years of relatively generous service funding. Still, the Panel was pleased to see that integrated working was higher on the agenda than it ever has been.

Recommendations

64. A detailed strategy should be developed by the local health and social care economy, which outlines how it will tackle the challenge of improving the quality of health outcomes of the ever increasing numbers of vulnerable older people, as well as dealing with tighter financial parameters. It should articulate how closer partnerships are being employed in practice to improve service configuration or responsiveness. This should be used as the key document in driving efforts to meet what is a significant challenge. It should also include some measures/metrics to judge how successful the local health and social care economy has been in meeting this challenge. The Panel would be happy to be involved in this document's preparation and review.

65. That a detailed document by prepared by the local health and social care economy outlining how virtual wards, and more effective community services, will reduce the number of vulnerable older people entering the acute environment, or at least reduce their length of stay. Included in that document should be reference to how virtual wards and wider community services will be developed, including reference to amount of investment and amount of staff. It should also set out when people can expect such developments to be coming on stream. The Panel is encouraged by the idea's potential, although at this stage it is not clear what it is or how its success will be judged.

66. The Panel would like to see work progressed to increase the capacity of the psychiatry liaison service, currently based at James Cook University Hospital. At the very least, the current service should be explicitly secured. The Panel considers that to reduce the services' coverage would be false economy, given the demographic pressures facing the town.

BACKGROUND PAPERS

67. Please see Care & Compassion, Report of the Parliamentary & Health Service Ombudsman.
Please see http://www.ombudsman.org.uk/care-and-compassion

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