Who Cares?
Care of Older People in Hospital Wards

Health Overview & Scrutiny Committee
Task and Finish Group Report

Chairman: Richard Pushman
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Executive Summary

Buckinghamshire County Council Health Overview and Scrutiny Committee have conducted this review on the quality of care for older people in a hospital setting. The review was in response to national concerns at the standard of care provided to older people in NHS acute hospitals, and the fact that the majority of hospital patients are older people. Evidence for the review was collected from patients, frontline staff, hospital ward site visits, performance data and inspection reports, as well as from representatives of the local NHS Trusts, Royal College of Nurses and Carers Bucks.

The review has reassured us that Buckinghamshire Healthcare Trust (BHT), which manages the acute and community NHS hospitals in the county, strives to deliver care and dignity for all patients. However, the evidence we have gathered suggests there could be inconsistent implementation of good practice across its wards, which in some cases could result in older patients not receiving the care they deserve. In light of this our report makes a number of recommendations to the BHT Board, which we consider will raise both the standard of care, and consistency of care across its wards. The report recommendations therefore apply to all wards and not just those specialising in care for older patients.

Recommendations

1. **Given the potential negative impact on patient experience arising from insufficient handover information, we recommend that BHT ensure that staff include full details in patient handover notes on needs relating to communication (including hearing aids), feeding (including dentures) and toileting assistance, on general wards as well as older people wards. [para 27]**

2. Given some patient concerns over call bell response times, we recommend that BHT monitors trends on the usage of and response rates to call bells, and, if necessary, explore ways to improve responsiveness. [para 46]

3. We have concerns that some staff will have missed out on the recently improved HCA new starter training, so recommend that BHT ensure that the improved training delivered to all new starter HCAs through induction is reflected in mandatory updates, thereby spreading this across the whole HCA workforce. [paras 49-50]

4. Appraisal is mandatory for all staff and although it is not possible to achieve 100% due to staff turnover etc, we recommend that the Trust should achieve its targets and ensure that this forms a key part of overall staff supervision. [paras 51-52]

5. **To aid patient understanding of the various ward staff we recommend that BHT adheres to a timetable for the speedy roll-out across the Trust of, visible name badges, corporate uniforms, informative staff boards and**

bedside information, including the various staff roles and responsibilities. [para 54]

6. **In the interests of patient nutritional care and to reduce the risk of malnutrition we recommend that BHT ensure that all staff on all wards (not just older people wards) are aware of the red tray initiative and that these are used consistently across BHT to ensure that patients needing help with their feeding are clearly identified. [paras 64-66]**

7. **Some patients can face difficulties obtaining information when being cared for by multiple departments, so we recommend that BHT provide, where possible and practicable to do so, a single named contact for patients with complex multiple conditions, to facilitate communication between departments and to provide signposting information for the patients. [para 73]**

8a. To ensure the receipt of timely feedback we recommend BHT and PALS ensure that routes for patient experience communications are well promoted throughout BHT, both in writing and face to face. [para 85]

8b. We also recommend that BHT and PALS monitor these communications by age as well as cause, in order to ascertain that older people are using the means available to make their voices heard. [para 85]

9. To assist in the prompt identification of a mental health history, we recommend that BHT review the plans they have to improve patient mental health information sharing with Oxford Health and GPs, including IT and their admission processes, to facilitate the quicker identification of a mental health history, thus reducing the chances of potential delays in diagnosis. [paras 92- 93]

10. To enhance staff dementia care skills we recommend that BHT ensures that all health staff, both registered and unregistered, have access to mandatory training/coaching and awareness raising on how best to support patients with dementia, including skills in communicating, managing difficult behaviour and providing dignified care. [paras 98-100]

Acronyms

BAPEN	British Association for Parenteral and Enteral Nutrition
BHT	Buckinghamshire Healthcare Trust
CQC	Care Quality Commission
GP	General Practitioner
HCA	Health Care Assistants
HOSC	Health Overview and Scrutiny Committee
LGA	Local Government Association
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
PALS	Patient Advice and Liaison Service
PEAT	Patient Environment Action Team
RCN	Royal College of Nurses

RN	Registered Nurse
SCIE	Social Care Institute for Excellence

Introduction

1. Over recent years, several high profile reports have raised concerns nationally of the standard of care experienced by older people in NHS hospitals providing acute care, including around areas of dignity, nutrition and communication. "Two thirds of NHS beds are occupied by people aged 65 years or older. Up to 60% of general hospital admissions in this age group will have or will develop a mental disorder during their admission"[1]. Older people can be found on every ward and in all clinical departments, with the exception of obstetrics (treatment of women through pregnancy, labour and childbirth) and paediatrics (treatment of children). Therefore, when we talk about quality of care in hospital for older people, we are talking about the majority of patients, not just those wards specialising in medicine for older people.

2. Older people tend to stay in hospital longer, with the average length of stay for people over 75 being more than ten days compared with just over four days for those aged 15 – 59. Over the next 10 -20 years, this number is expected to increase as the population ages[2].

3. Those who are cared for in hospitals have increasing acuity and dependency, with complex needs, including frailty, falls, multiple pathologies and dementia. To deliver safe nursing care to this group of patients demands both skill and time, with patients needing varying degrees of support with mobility, eating and drinking, and communicating. In addition, patients may have challenging behaviour and unpredictable needs.

4. For many older people, the impact of being in hospital can determine the direction their life takes once they are discharged. Their stay in hospital may have been disorientating, overwhelming and disempowering, and they may leave hospital feeling far less independent. There are pressures therefore in all hospital services to reduce admissions and length of stay.

5. Buckinghamshire County Council's Health Overview and Scrutiny Committee (HOSC) acts as a lever to improve the health of local people with a focus on health improvement and tackling health inequalities in local communities. Although its main interest is the NHS, it can also look at services provided by all organisations which have an impact on health. Elected members from both the County Council and each of the four District Councils sit on the committee. The committee meets formally each month, usually at County Hall, and the meetings are held in public.

[1] Who Cares Wins, The Royal College of Psychiatrists, 2005, paragraph 5.
http://www.rcpsych.ac.uk/PDF/WhoCaresWins.pdf
[2] Delivering Dignity – securing dignity in care for older people in hospitals and care homes, June 2012

6. As a result of national reports, the HOSC chose to look at the quality of care of older people in NHS hospitals in Buckinghamshire.

The scope

7. NHS acute and community hospitals in Buckinghamshire are managed by the Buckinghamshire Healthcare Trust (BHT). Mental health facilities in the county are managed by Oxford Health NHS Foundation Trust. BHT provides care to over half a million patients from Buckinghamshire and neighbouring counties every year. It is responsible for the majority of NHS care in the county, from community health services provided in people's homes or from local bases, to acute hospital services at Stoke Mandeville, Wycombe and Amersham.

8. At the outset of the review, members planned to look at the care of older people on BHT's acute wards and at discharge planning, including the links between Health and Social Care. It quickly became apparent that the scope was too vast and the decision was made to review the quality of care on the wards in the first instance, and to carry out a separate review of discharge planning at a later date. The final scope was planned and implemented with the full support and co-operation of BHT, which was keen to have an independent, critical friend-type approach review of how older people are cared for, what is working well on the wards and what could be improved. [3]

Methodology

9. The HOSC appointed a task and finish group to carry out the review on its behalf. The group consisted of eight members, including seven county councillors from the HOSC and one co-optee:

   Mr Bruce Allen, County Councillor
   Mr Noel Brown, County Councillor
   Mrs Avril Davies, County Councillor
   Miss Lin Hazell, County Councillor
   Mrs Wendy Mallen, County Councillor
   Mrs Jenny Puddefoot, County Councillor
   Mr Richard Pushman, County Councillor (Chairman, Task and Finish Group)
   Mrs Jennifer Woolveridge, South Bucks District Councillor, Co-opted member

10. Between June and August 2012, evidence gathering sessions were held in public and attended by a range of representatives, including from the Royal College of Nursing (RCN), Buckinghamshire Healthcare Trust (BHT), Oxford Health NHS Foundation Trust and Carers Bucks. In addition, we spoke to thirteen patients in focus groups and on the telephone, and received written feedback from a further four.[4] We also spoke informally to frontline staff,

[3] Appendix 1 Scope – Care of Older People in a Hospital Setting
[4] All of the patients were previously inpatients and now attend day hospitals as outpatients. Two came forward from a local dementia support group, with the remainder offered the chance to contribute to the review, in confidence, by BHT.

including a newly qualified registered nurse (RN) and four Healthcare Assistants. Others who contributed to the review are listed in the acknowledgements.

11. We visited Wycombe and Stoke Mandeville Hospitals, where we were shown around two Medicine for Older People's wards, one orthopaedic ward, one stroke ward and one short-stay ward. We had the opportunity to speak to ward staff, although, out of respect for privacy, we did not to speak to patients on the wards unless they approached us. The visits to the wards were scheduled to ensure that vital processes, such as ward rounds, were not interrupted.

12. The necessarily pre-planned nature of these ward visits may have limited our ability to see events as they occur naturally on a day to day basis. However, we hope that the opportunity to speak to ex-inpatients about their care and to carers, access to performance data and recent Care Quality Commission (CQC) reports have helped to give us a realistic view of ward care of older people in our acute hospitals.

Key Findings

13. During our evidence gathering, we focused on the following areas, which we consider to have an impact on the care of older people in hospital:
    1. **Dignity and privacy**
    2. **The environment**
    3. **Staffing**
    4. **Nutrition and hydration**
    5. **Involvement in decision making**
    6. **Dementia**
    7. **Communication, including patient feedback**

1. Dignity and privacy

14. 'Dignity is concerned with how people feel, think and behave in relation to the worth or value of themselves and others. To treat someone with dignity is to treat them as being of worth, in a way that is respectful of them as valued individuals.' *RCN definition.*

15. Quality of care depends not only on good health care but on respect for the older person as an individual.[5] In a 2007 RCN survey of over 2000 nurses, Healthcare Assistants and nursing students, 80% said that they always or sometimes feel upset or distressed because they are unable to give the dignified care they know they should have, 65% said they sometimes or never have enough time to devote to the dignity of their patients or clients, but more than 98% said that the dignity of their patients and clients is important to them. We were told that pressures in the workplace, rather than lack of good will or intent, can lead to lower levels of dignity in care. [6]

[5] National Service Framework – for Older People
[6] Evidence gathering session 7 June 2012

16. We learned that leadership is vital in ensuring that dignity in care is embedded in the culture of an organisation. 'Leaders must create a culture in which good care can flourish'[7]. The RCN talk of the importance of ward sisters having the time to lead and support their teams.[8]

17. BHT has demonstrated good leadership from the top, led by the Chief Nurse, with a focus on providing good, individualised patient care. Frontline staff told us of the excellent lead given by their ward sisters who are hands on and help to model good practice. [9]

18. There is a comprehensive leadership programme which includes ward manager competencies. The 'Exemplar Ward' status was introduced recently to encourage healthy competition amongst staff, and is particularly relevant in helping to ensure that older people in general wards receive the same level of care as those on medical wards for older people.[10]

19. We learned of the importance of an organisation's culture in ensuring that patients are well cared for. There are service standards in place in BHT including 'I will be compassionate'. In addition, BHT is seeking to include the need for compassionate values, alongside clinical and technical skills, in all interview and selection processes and this aspect will be monitored via staff appraisals.[11]

20. In general, patients we heard from spoke glowingly of the care they had received from staff during their stay in hospital. *'All in all, more than pleased with the care I received'.*[12]

Providing personalised care

21. The assessment of care needs takes place once a patient is admitted to a ward in order to establish their functional and social baseline. In some wards, the needs of patients with dementia are recorded in the Alzheimer's Society's 'This is Me' leaflet.[13] The leaflet provides a snapshot of the person with personal information such as needs, preferences, likes, dislikes and interests, to help staff understand the patient's condition and the best way to support them during their hospital stay. Some of the staff we spoke to had not come across this leaflet, although BHT inform us that they intend for this to be in place across all wards post reconfiguration, and is being developed in A&E and Orthopaedics currently. The leaflet does require cooperation from the patient's family in some cases to complete, and this can restrict its use if the family don't support the initiative.

[7] Dignity and nutrition inspection programme - CQC National Overview October 2011
[8] Safe Staffing for older people's wards RCN March 2012
[9] Staff meeting 8 August 2012 (closed)
[10] Evidence gathering session 7 June 2012. The Exemplar Ward is Ward 5 and sets a proven track record in audit and survey scores, as well as efficient lengths of stay. Staff report feeling valued, and there is evidence of professional development and appraisals.
[11] Delivering Dignity in Care – Gap Analysis BHT
[12] Patient focus group 9 July 2012 (closed)
[13] 'This is me' leaflet Alzheimer's Society and RCN

22. We understand that the 'This is Me' leaflet is being modified to provide a tool (known as an 'Attitude Matters' document) for patients without cognitive impairment with a view to being cascaded to all wards post reconfiguration. We would encourage this initiative, particularly in order to identify areas such as the amount and type of help needed to attend to basic needs relating to personal hygiene.

23. Patients are asked at admission how they would like to be addressed and this information is documented in the patient's profile and above their bed. Healthcare Assistants told us that they are taught how to address people in their training. This was confirmed by most patients during our discussions, although we did hear of examples of first names being used automatically and without permission.

24. Non-English speakers have access to specifically contracted translators and interpreters. Staff are not used as this would not be appropriate and, to protect patients' privacy, they try to avoid using relatives. Much of the documentation is translated into commonly used local second languages, e.g. Polish.

25. Other than on the Orthopaedic ward (for reasons relating to infection control), we observed patients wearing their own day wear to help them orientate between day and night. However, we were told that resistance to wearing their own clothes can come from patients who may not want their families to have the burden of keeping day clothes laundered.

26. During our ward visits, we observed that every attempt was made to provide privacy for patients. This was easier on some of the newer wards, but even where accommodation overall was cramped, i.e. in the Medicine for Older People's ward (ward 5B) at Wycombe Hospital, attempts were made to utilise the space effectively to ensure privacy. Curtains were around beds and if patients needed a hoist to use the toilet, then the corridor would be screened off entirely. Private meetings with families were able to take place in the staff room.

27. To ensure that staff are aware of the individual needs of patients on their wards, handovers take place between staff on the various shifts and details of incidents are noted in the nursing records. During one of our focus group discussions, we were concerned to hear of a patient's experience, which may have resulted from insufficient handover information.[14] Although he was in hospital for knee surgery, staff had not been briefed at handover about his incontinence and he was left in the toilet in an embarrassed state whilst they cleared up. We also heard anecdotally of a patient on a general ward who did not have her hearing aids or dentures put in, and as a result she was unable to communicate with staff or to eat[15].

Recommendation 1

[14] Patient focus group 9 July 2012 (closed)
[15] Member's first hand experience

Given the potential negative impact on patient experience arising from insufficient handover information, we recommend that BHT ensure that staff include full details in patient handover notes on needs relating to communication (including hearing aids), feeding (including dentures) and toileting assistance, on general wards as well as older people wards.

28. We discussed with staff the idea of having a photo of patients in their medical notes to help staff identify patients at handover time. They agreed it could be very helpful, although potentially difficult to administer. A nurse told us that seeing a photo of a patient when she was well worked as a huge incentive for the nurse to strive to restore the patient back to her former health. The 'This is Me' leaflet, as described in paragraph 21**,** includes a photo, and the RCN told us that nationally many clinical areas have adopted a version of their own. They told us that including a photo is certainly useful practice for those with dementia and their families in sharing information about the person with staff. It could also be a useful indicator of how someone looks when well, in addition to promoting individualised person centred care.

2. Environment

29. During our ward visits, we looked for ambience, space, cleanliness and privacy. We were shown around the Medicine for Older People's Ward (Ward 5B) at Wycombe Hospital, which is located in the older part of the hospital. We found accommodation to be cramped, although staff make the best use of available space. For example, a former wash room is used to store stationery and the staffroom doubles as a privacy room for families. However, the ambience on the ward is relaxed and peaceful, with low lighting, age-appropriate music playing in the background, a 'distraction table'[16] and poster-covered exit doors to distract patients with cognitive impairment from wandering out. Staff were cheerful and appeared to have a good rapport with the patients.

30. By contrast, Stoke Mandeville Hospital's Medicine for Older People's Ward (Ward 8), the Short-stay ward (Ward 10), and the Orthopaedic wards (Wards 1 and 2), and the Hyperacute Stroke Unit at Wycombe Hospital, are all new builds. Accommodation is bright and clean, with roomy wash rooms. These wards have their own gyms where physiotherapy is carried out.

31. BHT recognises that the ward environments within the older tower block are not to the standard it would like. Changes brought about through the Better Healthcare in Buckinghamshire programme will ensure that the majority of inpatient care will be provided in the most modern facilities[17]. To this end, Ward 5B will be refurbished and become a step down ward, and ultimately be relocated to another part of the hospital site (expected to be during 2013).

[16] Distraction table – includes memory cards, foods chosen specially by Speech and Language Therapists, books and pictures, all to trigger memories and conversation
[17] http://www.buckspct.nhs.uk/bhib/

The acute pathway will move from 5B to Stoke Mandeville Hospital, with the intention that most older people will be treated at Stoke Mandeville.

32. During the visits, we were told of the impracticality of nursing stations being situated centrally in corridors but away from patients. Staff told us that they hope to transfer their work from stations to trolleys to ensure greater visibility. Staff also talked of the impracticality of bed rails, designed by manufacturers without input from practitioners. One elderly patient told us, '*I pinch my fingers in them'.* [18]

33. In the Medicine for Older People's Ward 8, the 'Butterfly Scheme' is in operation, where patients with dementia are discreetly identified by a small butterfly above the bed, as needing extra support. This scheme is being trialled in a limited number of wards and will be rolled out across BHT if successful and sustainable.

3. Staffing

34. Older people in hospital have substantial needs for care, supervision and support, and often have significant medical needs. Sufficient nursing staff are needed to provide support and ensure that safety is maintained, particularly at night, when patients with dementia in particular can become confused and agitated. There is a need for enough staff to provide a good level of personalised care, rather than simply focusing on tasks.

35. According to the RCN[19], staffing levels nationally on older people's wards are too low and there is a more dilute skill mix than other types of wards:

- 9.1 – 10.3 patients per registered nurse (RN) on older people's wards
- 6.7 patients per RN on adult general/medical/surgical wards
- 4.2 patients per RN on children's wards

36. The RCN comments that the skills mix on older people's wards can potentially lead to care giving being inappropriately delegated to Healthcare Assistants, who are unregistered support workers and, because of time pressures, RNs often feel they cannot supervise Healthcare Assistants properly. In consequence, talking to patients, promoting self care, oral hygiene and falls prevention may be carried out inadequately. [19]

37. We were keen to find out how national figures compare with those to be found on BHT's Medicine for Older People's Wards. BHT told us that having the right mix of staff is cost effective as it helps to reduce the length of stay of patients and the number of falls. Staffing ratios are worked out locally, following principles set out in the RCN Guidance on Safe Staffing Levels in the UK (RCN 2010).

38. On Wycombe Hospital's Medicine for Older People's Ward 5B, the 20 beds are cared for by three RNs and two Healthcare Assistants in the daytime, and

[18] Stoke Mandeville Hospital ward visits 29 June 2012 (closed)
[19] 'Safe staffing for older people's wards' RCN, March 2012

two RNs and two Healthcare Assistants at night. The ward sister is a constant on the ward and is always visible. All nurses are made aware of all patients, however, they also each have their own patients. There are low numbers of agency staff.

39. The Care Quality Commission's (CQC) recent inspection of medicine for older people's wards at Stoke Mandeville and Wycombe Hospitals judged that the hospitals were meeting the standard that there should be enough members of staff to keep people safe and meet their health and welfare needs.

40. The table below shows how staffing levels vary across wards, reflecting the size of the ward and the conditions being treated. The mix of skills on each ward also varies reflecting the acuity of conditions being treated.

Staffing on BHT hospital wards at Stoke Mandeville (SMH) and Wycombe General Hospitals (WGH)

Ward	Beds	Staffing Level (whole time equivalents)	Skill Mix (qualified: non qualified)
8: SMH Medicine for Older People	21	25.9	60/40
9: SMH Acute Medicine	21	29.05	65/35
10: SMH Acute Assessment/Short Stay	18*	40.52	70/30
3b: WGH Respiratory	26	33.48	65/35
4a: WGH General Medicine	12**	19.68	70/30
4a: General Medicine	22	24.19	60/40
Stroke Unit/Hyper Acute Stroke Unit/Acute Stroke Unit/Rehab	30	51.8	75/25***

N.b. Above staff numbers do not include the specialist teams such as respiratory nursing, stroke nursing, nutrition specialist nurses etc, and no matron hours are included.
[*plus 7 assessment areas, **currently there are 20 beds on this ward and staffing has been increased to an appropriate level for this, ***uneven mix of skills on this ward with higher skills on the HASU/ASU and lower in rehab]

41. If there is a need, staff can be brought in from other wards, as well as agency staff, who are monitored at every shift. BHT has recently put in place an electronic roster system, which takes into account skills mix and hours of duty of staff, and has greatly facilitated this process.

42. During night shifts on older people's wards, we are told that there are lower staff numbers as the expectation is that patients will sleep. However, management are alert to staffing levels on wards where there may be repeated patterns of staff not coping. A 'twilight shift' between 6pm and midnight is also being considered.

43. During our ward visits, we learned that there are a variety of call bells available to suit different patients. One patient told us that staff were diligent in ensuring that the call bells were put back in reach once their beds were made. The CQC's inspection report commented that people they spoke to thought there was enough staff and that call bells were answered promptly. However, in our focus group discussions, patients commented that call bells were not always answered swiftly, even if the request was urgent, as staff are '*really rushed off their feet'*. The patients' perception was that there was no-one available to answer their call: '*You ring a bell and wait for ever'.*[20]

44. A newly trained nurse whose mantra is '*to treat everyone like your own and give individualised care,'* spoke movingly of the gratitude shown by a very ill patient after she spent an hour and a half giving him a much longed-for bath. She and the Healthcare Assistants we spoke to commented on time pressures on the ward preventing staff from carrying out these tasks which can make such a difference to a patient's wellbeing. *'We want to do it but can't always do it.'*[21]

45. In the Department of Health's 2011 National NHS Staff Survey, BHT was in the lowest (worst) 20% when compared to other trusts for the key finding: 'Staff feeling satisfied with the quality of work and patient care they are able to deliver'. BHT inform us that this survey was conducted in a period of change for the trust, and this is likely to have had an impact on the results. Furthermore an increase in patients with cognitive impairment has given the Trust a number of challenges including how staff perceive caring for these patients. This is a national challenge and other Trusts report the same findings. Low staff morale has been addressed by further analysis of the survey results and focus groups have been held. BHT are focussing on the staff experience and engaging staff in service changes, which is one of the areas of concern. They have worked hard at increasing the number of ward meetings and the visibility of senior staff, especially at peak times of activity. Feedback during matron rounds indicates staff have noted this and appreciate the increased support.

46. During our evidence gathering, we were never once given the impression that clinical care or safety had been compromised due to staff being busy. However, because of the patient perception we have identified that staff may be too busy to deal with basic requests, including answering call bells swiftly. During matron rounds they check that call bells are in place and observe how long people are being kept waiting. BHT would not expect patients having to wait longer than five minutes during peak times of activity, and ideally would see limited use of call bells with patient needs being met without the need to seek assistance. It would be useful for BHT to formally monitor usage and response times to call bells, to see whether action needs to be taken given what we have heard. This could be done through existing feedback methods,

[20] Patient focus group 9 July 2012 (closed)
[21] Staff discussion 8 August 2012 (closed)

such as discharge surveys or the patient experience trackers (see paragraph 80).

Recommendation 2
Given some patient concerns over call bell response times, we recommend that BHT monitors trends on the usage of and response rates to call bells, and, if necessary, explore ways to improve responsiveness.

47. BHT inform us that they do use volunteers. For example a volunteer helps deliver food, and volunteers are used for various activities at Wycombe Hospital. They are currently planning how volunteers can be used for patient feedback following reconfiguration. The trust has however chosen not to ask volunteers to help with patients nutrition due to concerns over the choking risk associated with patients with problems swallowing. Family members are permitted to assist during mealtimes.

48. We were told that Healthcare Assistants supplement the work of registered nurses by delivering a limited number of services to patients, and we were keen to find out the level of training given to these staff. [22]

49. We heard that, up until 18 months ago, there were inconsistencies in the training of Healthcare Assistants and a high turnover of staff[23]. However, we are encouraged to learn that training has improved markedly in the last twelve months, with a robust, mandatory development programme now in place. Course content includes infection control, moving and handling, food and nutrition, communication, personal hygiene, mobilisation, taking blood pressure and temperature, recording, dignity in care, and dealing with confused patients. The programme is competency-based and staff can also join an apprenticeship programme, which leads to an NVQ qualification. There are also numerous opportunities for e-learning or online training. The programme has had the added impact of boosting the retention rate of staff.

50. The programme is aimed primarily at new starters, although more experienced Healthcare Assistants can take up spare places provided they can be released from ward duties. Some of the HCA's we spoke to however had not been offered this training by their line mangers. Any gaps in the level of training received between staff that started before and after the improved starter training programme, should be addressed through mandatory updates. We also learned that staff have opportunities to learn on the ward (for example, mouth care and dementia awareness). BHT have an annual appraisal target of 90% of the workforce, which reflects a 10% turnover of staff meaning that 10% of staff will typically not have been in post for 12 months. Through the appraisal and individual staff development plans, training and development needs additional to mandatory updates can be identified.

[22] HOSC minutes, 13 April 2012
[23] Meeting with Learning and Development manager, 16 August 2012 (closed)

Recommendation 3
We have concerns that some staff will have missed out on the recently improved HCA new starter training, so recommend that BHT ensure that the improved training delivered to all new starter HCAs through induction is reflected in mandatory updates, thereby spreading this across the whole HCA workforce.

51. The Care Quality Commission (CQC), in its recent inspection on a Medicine for Older People's ward at Stoke Mandeville Hospital noted that, whilst the majority of standards inspected were fully met and BHT had a system in place to ensure that training was available, staff were not adequately supported through supervision. CQC judged this to have a minor impact on patients and it advised BHT to take action. The CQC were told that staff had an annual appraisal and that this process included identifying development needs, which include mandatory training schedules and a variety of training opportunities, including electronic. [24]

52. BHT informed CQC that staff appraisals were at 34% with a plan to meet the end of year target of 90%. The uptake of mandatory training and appraisals are key performance indicators for BHT and are reported and monitored by the Trust Board. However, it was reported that there was no formal supervision process in place, and newly qualified staff in particular, may not get supported enough. Informal supervision was available but staff felt they could be better supported.

Recommendation 4
Appraisal is mandatory for all staff and although it is not possible to achieve 100% due to staff turnover etc, we recommend that the Trust should achieve its targets and ensure that this forms a key part of overall staff supervision.

53. Agency staff may have varied levels of training and staff told us that they often spend some time on the ward bringing them up to the level required by BHT. Once a year BHT checks agencies for the standards of their Healthcare Assistants.

Identifying staff

54. We heard consistently from patients of difficulties in identifying ranks of staff and who was in charge of the ward. It was difficult to know who to speak to and patients only saw the full complement of staff at handover time. Patients commented on the inadequate size of name badges and one patient told us that he was not aware of levels of staff unless he asked. This difficulty in identifying staff is exacerbated by the fact that there is currently an array of different uniforms across the hospital sites within BHT. However, we were pleased to hear that there are plans to roll out corporate uniforms across the sites, which will help patients to identify ranks of staff. In addition, staff boards,

[24] www.cqc.org.uk

with photos and names, are planned to be in place in each ward after October 2012.

Recommendation 5
To aid patient understanding of the various ward staff we recommend that BHT adheres to a timetable for the speedy roll-out across the Trust of, visible name badges, corporate uniforms, informative staff boards and bedside information, including the various staff roles and responsibilities.

4. Nutrition and hydration

55. According to research, 1 in 4 hospital patients are admitted into British hospitals malnourished (BAPEN 2007)[25]. Good nutritional care is crucial to recovery and improved outcomes and patients at risk need to be identified early so that their nutrition can be improved.

56. We were told by the RCN that good practice in nutrition and hydration includes:
    - protected mealtimes, ensuring patients have an uninterrupted mealtime to eat their food in peace and staff are on hand to help;
    - the red tray system, which highlights those who need assistance with eating;
    - intentional rounding, where wards are toured by senior staff on a regular basis to ensure the most vulnerable patients are being well cared for;
    - specialist support through volunteers and families. [26]

57. In its 2006 campaign 'Hungry to be Heard'[27] Age UK recommended the use of red tray systems, protected meal times and the use of meal time volunteers to reduce the incidence of malnutrition on hospital wards. Many hospitals implemented these, and they are well recognised tools to address those at risk of malnutrition[28].

58. In 2010, Age UK followed this up with 'Still Hungry to Be Heard'[29], which noted that malnutrition in hospital was still a problem. The 2010 report noted that to be effective, protected meal times should allow families to visit to assist and provide company to patients during meal times, and for nurses to ensure patients are given the help they need. It also noted that to be effective the red tray system needed to implemented correctly with assistance available to those that need it.

59. BHT takes nutrition and hydration very seriously, recognising the impact it can have on a patient's recovery. All nutritional activity in BHT is overseen by a multidisciplinary team, including a consultant gastroenterologist, nutritionists, speech therapist, pharmacist and nurse.

[25] Organisation of Food and Nutritional Support in Hospital (2007) BAPEN
[26] RCN evidence 7.6.12
[27] http://www.ageuk.org.uk/get-involved/campaign/hungry-to-be-heard/
[28] The British Dietetic Association, 2012 http://www.bda.uk.com/publications/NutritionHydrationDigest.pdf
[29] http://www.ageuk.org.uk/Documents/EN-GB/ID9489%20HTBH%20Report%2028ppA4.pdf?dtrk=true

60. We were given mixed views on the quality and variety of food served, with some describing food as well presented and tasty and others being unimpressed. It should be noted that for some patients their sense of taste can be affected by the medication they are on. BHT inform us that the 2011 Patient Environment Action Team (PEAT) report rated the quality of food at Amersham, Stoke Mandeville and Wycombe Hospitals as excellent. Community hospitals at Thame and Marlow also received excellent scores. In addition BHT inform us that they have a low rate of food being returned compared to other trusts[30].

61. One patient talked of the long gap between the evening meal at 5.30pm and breakfast at 7.30am and the need for a drink and snack at 8pm.[31] We are told by BHT that snack boxes have been recently introduced onto wards for patients who may be hungry between formal meal times. Typically they contain a sandwich, yoghurt and drink, but hot meals can also be ordered. These have to be requested via the help desk, but BHT advise us that they are looking to include information on this in patient bedside leaflets. There are different snack boxes to reflect patient dietary needs, such as those with diabetes, and these are ordered via the housekeeper. Staff will also make drinks and biscuits to settle patients.

62. A new initiative on the Medicine for Older People's Wards is 'high tea', where patients are served tea and cakes on china crockery. This event not only helps with calorific intake but gives patients an opportunity for social interaction.

63. We heard that intentional rounding is in place in wards in the Trust and is viewed as a 24 hour safety check to reassure staff and patients that they are continually assessing and reviewing the patients' clinical situations, including pressure points and hydration. Rounds for individual patients vary and needs may increase or decrease at night.[32]

64. We were told that using a Red Tray system, to identify patients who need extra assistance, can improve nutritional care and reduce the risk of malnutrition and complications of a delayed hospital stay. During our visit to Ward 5B, we saw evidence of protected mealtimes and red trays in use, and a number of nursing staff helping patients with their meals, mostly sitting up to tables in the centre of bays. We heard from a Healthcare Assistant, on a Medicine for Older People's Ward, of the thorough training she received on the use of red trays.[33] We understand from the Modern Matron that ward staff are encouraged to review the need for red trays on a daily basis. [34]

65. However, Patient Survey Questionnaire results for March 2012 showed that only 43% of patients received help with their meals and this was a decrease

[30] http://www.buckshealthcare.nhs.uk/Default.aspx.LocID-03200100400g00800d.RefLocID-032001004003.Lang-EN.htm
[31] Telephone conversation with patient 15 August 2012
[32] Follow up information from BHT 2 August 2012
[33] Staff discussion 16 August 2012
[34] Visit to Stoke Mandeville Ward 16 August 2012

from the result in August 2011 (48%)[35]. Although in their recent inspection of Stoke Mandeville the CQC felt standards of staffing levels were being met, they did report that one member of staff felt they could do with more staff, and that sometimes it could be hard to support those that need assistance with their meals.

66. Carers reported to Carers Bucks that they could not recall seeing red trays in use on wards during their visits. We heard anecdotally of a patient with dementia having his meals taken away untouched with no-one there to assist with feeding.[36] It leads us to question how consistently red trays are in use across BHT.

Recommendation 6
In the interests of patient nutritional care and to reduce the risk of malnutrition we recommend that BHT ensure that all staff on all wards (not just older people wards) are aware of the red tray initiative and that these are used consistently across BHT to ensure that patients needing help with their feeding are clearly identified.

5. Involvement in decision-making

67. The government wants to place patients' needs, wishes and preferences at the heart of clinical decision-making by making shared decision-making the norm throughout the NHS. This vision is articulated in the phrase 'nothing about me, without me'.[37] CQC guidance states that people who use services should have their views and experiences taken into account in the way the service is provided and delivered. Both the patient and anyone acting on their behalf should:
    - Understand the care, treatment and support choices available to the patient;
    - Be able to express their views, and be involved in making decisions about their care, treatment and support.[38]

    It notes that people with cognitive impairment and communication difficulties, including language differences, are at particular risk of being excluded from decisions.

68. We were interested to find out how far BHT embeds this vision in the care of its inpatients, i.e. how involved and informed were patients and their families in decisions around their care.

69. We were given mixed responses from patients in our focus groups on their perceptions of the amount of information they were given and the amount of involvement in decisions around their care:
    'They told us everything we needed to know'

[35] July 2012 BHT Board Papers
[36] Evidence gathering 15 June 2012
[37] Health and Social Care Act 2012
[38] Care Quality Commission Summary of Regulations, Outcomes and Judgement Framework, March 2010.

'Not always fully explained'
'Not discussed with families fully'
'Could have been better'[39]

70. We learned that BHT places great emphasis on the role of families and the different perspective they are able to offer on patients.[40] Some patients agreed that their families were kept informed and involved and were able to make appointments to speak to staff in charge. However, one patient commented that there was no informed staff member on duty when her family came to visit and it was difficult for them to be given direct information. A relation of former patient also informed us that when a consultant spoke to their elderly family member in hospital she couldn't fully understand or hear what they said as she had partial hearing. She felt in such circumstances the consultant should be accompanied by a family member or a nurse who could feedback what was said to family members if needed. This should be a consideration with all older patients, who may be confused or disorientated in hospital.

71. Patients told us that discussions about their care were always held in private. However, there was a perception that staff did not always acknowledge that the patients might be well placed to suggest when something was wrong and what was wrong with them. *'Sometimes they don't listen to what we have to say'.*

72. Another told of a delay of up to four days to be discharged from hospital, and then it was to an empty house where no-one was expecting her. Her perception was that the delay may have been caused by lack of collaboration between the ambulance service and the hospital. Whatever the reason, the patient was not kept informed, leaving her anxious and frustrated.

73. We spoke to a patient with complex multiple conditions, where his care was being managed by several departments. On the whole, he believes he has been kept well-informed on his care and involved in decision making. However, his notes did not always follow him between departments and he has had to give the same information repeatedly. On occasions he has been left unsure as to who to approach about what. When asked what would have helped him in these circumstances, he commented that clear information provided to him when transferring between services of who can provide what, and a named contact on the ward to act as a liaison between the various departments, would be most helpful.

Recommendation 7
Some patients can face difficulties obtaining information when being cared for by multiple departments, so we recommend that BHT provide, where possible and practicable to do so, a single named contact for patients with complex multiple conditions, to facilitate communication between departments and to provide signposting information for the patients.

[39] Patient focus group 9 July 2012 and written feedback
[40] Evidence gathering session 15 June 2012

6. Patient feedback, including complaints

74. The CQC uses national surveys to find out about the experience of patients when receiving care and treatment from healthcare organisations. Between October 2011 and January 2012, a questionnaire was sent to 850 recent inpatients at each trust. Responses were received from 521 patients at BHT. For each aspect of care and treatment surveyed, each trust received a score out of 10 and a rating, based on the responses given by patients. Single overall ratings were not provided for each NHS trust, therefore it is not possible to compare the trusts overall. The CQC expects the results to be used by NHS Trusts to improve their performance and to understand their patients' experience.

75. In questions relating to 'experiences on the hospital and ward', BHT was rated 'about the same' as other trusts who took part in the survey. Areas surveyed included single sex accommodations, noise from other patients and staff, cleanliness, not feeling threatened, storing belongings, quality and choice of food and help with eating.

76. Although BHT was rated 'about the same' as other trusts for 'overall views and experiences', this included a score of 1.1/10 for whether patients were asked to give their views about the quality of the care they received during their stay in hospital, and 3.4/10 for whether patients noticed any posters or leaflets explaining how patients could complain about the care they received.

77. The survey showed BHT scoring amongst the worst performing 20% of trusts for the questions:

- 'Did your family or someone close to you have enough opportunity to speak to a doctor?' (5.6 / 10 with a higher score being better)
- 'Did you feel you were involved in decisions about your discharge from hospital?' (6.2/ 10)
- 'Were the letters (from the hospital) written in a way that you could understand?' (7.5/ 10) [41]

78. BHT advise us that there is an action plan against the National Inpatient Survey, to address the issues raised, and which is provided to the Board and regularly reviewed and updated. As part of this the Trust is working on improving bedside handover which gives patients the opportunity to meet staff.

79. We were told that BHT values feedback and recognises the need to learn more through other people's eyes. It recognises that it doesn't always get it right, but each concern or issue is investigated. We heard of the numerous opportunities, both formal and informal, provided for giving feedback. These include: matrons' rounds, the Patient Advice and Liaison Service (PALS), the

[41] Care Quality Commission 2011 Survey of Adult Inpatients

Independent Complaints Advisory Service, the Patient Experience Group, public consultations, patient satisfaction surveys and comment books. [42]

80. Patient Experience Trackers, which elicit real time feedback from patients, are currently being procured as part of an overall patient experience programme to monitor real time experience and feedback. These trackers are handheld devices which elicit responses from patients to questions relating to their care. The patient responds by pressing a button and this data is analysed and sent directly, via a telephone line, to the matron. The questions asked can vary from ward to ward depending on the needs of patients.

81. Patient feedback surveys and comment books are used to inform BHT of patients' views. In Wycombe Hospital's Ward 5B, we saw a visitor's book at the entrance to the ward and in the Orthopaedic Ward at Stoke Mandeville Hospital, we saw a comments board where a number of patients' letters and cards were displayed. *'I was particularly impressed with the gentleness, respect and love with which you cared for the two elderly ladies in my bay.'* [43]

82. We are aware that BHT has undertaken exit surveys of some patients, where they were asked at the point of discharge from hospital:
    - How was the level of care during your stay?
    - Were you included in decisions made about your care?

    We consider this to be good practice, allowing more immediate feedback of patient experiences, and better capturing the quality of some aspects of patient care and experience. Such surveys could gather information on other issues this report identifies such as call bell response times and assistance with feeding.

83. Complaints and compliments are reported to BHT Board on a monthly basis and this information is publicly available. During 2011/12 there were 553 complaints and 1298 compliments. This compared to 532 and 573 complaints in 2009/10 and 2010/11 respectively[44]. We learned that the main areas of complaints include:
    - Cancellation / delays to surgery
    - Diagnoses
    - Procedures
    - Some care on the ward e.g. nursing care, behaviour
    - Communication – i.e. patients getting the information they need

84. PALS is described as the 'one-stop-shop' for patients, carers and relatives seeking advice and support on all aspects of healthcare. The service is free and confidential and aims to support anyone with queries about health-related issues. Over the past three years, the number of issues managed by PALS in Buckinghamshire has risen year-on-year, with the number of first enquiries by

[42] Evidence gathering session 15 June 2012
[43] Written feedback from a patient, Orthopaedic ward, Stoke Mandeville Hospital
[44] Data on written complaints in the NHS 2011/12, The Information Centre for Health and Social Care: http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/complaints/data-on-written-complaints-in-the-nhs-2011-12

PALS going up and the number of first enquiries into the Complaints Team going down. Since the 1st September 2012, BHT have offered a single point of access to BHT, through PALS, for all patient experience communications.

85. We have concerns that elderly, vulnerable patients who may wish to complain about their care, and who may not have advocates such as relatives, may be unsure of the PALS route and may not wish to complain directly to staff. We understand that PALS do visit wards to proactively seek feedback from patients on their care. PALS was unable to clarify for us whether older patients are more or less likely to complain about services as this data, although collected, is not actively monitored. We believe that it would be helpful for BHT to monitor complaints received by age to find out whether the number is proportional to the population of older patients receiving care in hospitals.

Recommendations 8a and 8b
To ensure the receipt of timely feedback we recommend BHT and PALS ensure that routes for patient experience communications are well promoted throughout BHT, both in writing and face to face.

We also recommend that BHT and PALS monitor these communications by age as well as cause, in order to ascertain that older people are using the means available to make their voices heard.

86. Carers Bucks has supported carers in referring formal complaints to BHT and we were told that when things go wrong for patients, carers will often blame themselves for not doing more. Acceptance by BHT that things could have been done better can help bring closure for a carer. However, we heard of situations where complaints have not been dealt with within the target timelines set by BHT.

87. BHT sets an internal target of 25 working days within which to respond to complaints. This used to be a national target and benchmarking against other Trusts took place. However, new guidelines have provided flexibility on this, particularly as it is accepted that issues may be complex and require a number of strands of investigation. In those situations, patients have indicated to BHT that it is important for them to be kept informed of the progress of their complaint.

88. BHT Board papers (May 2012) show that the percentage of complaints responded to within 25 working days has decreased over the last two quarters. This has been explained by winter pressures and the implementation of the new complaints process in the divisions. We understand that this trend is being monitored and actions will be put in place to address the situation.[45] Given the importance for carers and patients of complaints being dealt with in a timely way in order to bring closure, we are

[45] BHT Public Board Meeting 30 May 2012

pleased to learn that the trend in the reduction of complaints responded to within 25 working days is being monitored and request that the HOSC is updated annually on the success of actions to mitigate this situation.

Percentage of complaints responded within BHT target of 25 working days [46]

	2009/10	2010/11				2011/12			
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
% achieved within 25 working days	83%	84%	86%	83%	78%	81%	78%	66%	61%

7. Caring for patients with dementia

89. Caring for people with dementia requires a trained workforce with the right knowledge, skills and understanding to offer the best quality care and support. A study carried out by the Alzheimer's Society in 2009 highlighted that the training needs of nursing staff working in hospitals with people with dementia are not being met.[47] It reported that 95% of nurses cared for someone with dementia but only 12% felt they had enough training to meet needs and challenges of working with people with dementia. Inappropriate dementia care routinely results in extended length of stay in hospital.

90. The RCN spoke to us of the 1:1 attention often required by patients with dementia, and the importance of having skilled staff who are able to give time to them. We were also informed of the need to work in partnership with carers, the need to assess and identify dementia as early as possible, preparing care plans which are person-centred and individualised, and providing safe and secure environments.[48] However, we heard of the pressures on staff on general wards dealing with a mix of patients who are medically ill and those who are confused.

91. Although Oxford Health NHS Foundation Trust has a ward based at the Stoke Mandeville Hospital site dedicated to dementia patients, and two liaison psychiatric nurses for elderly people helping to identify dementia and associated needs, we know that it is estimated that up to 25% of patients on BHT's acute wards are likely to have dementia. During the HOSC's review of dementia services in the county, the HOSC learned that there are pockets of good practice within BHT, but gaps exist in the level of skills, knowledge and empathy, and the level of priority given to dementia.[49] During the course of this review, a Healthcare Assistant commented that dementia training for all staff should be mandatory, noting: *'Some people have no idea at all about how to deal with dementia patients'.*

[47] Counting the Cost – caring for people with dementia on hospital wards, Alzheimer's Society 2009
[48] Evidence gathering session 7 June 2012
[49] ' Dementia Services in Buckinghamshire – Everyone's Responsibility' Public Health OSC review May 2011

92. The Alzheimer's Society report that carers identify that at the heart of the problem on general wards is a failure to identify dementia or understand the needs of the person with a diagnosis of dementia, with the result that the patient can be treated for the physical condition for which they were admitted, but not for the additional needs arising from their dementia. We know from evidence gathered in our recent review only 33% of those estimated to have dementia in the county are formally diagnosed. We were pleased to hear that dementia screening for all people aged 75 and over will be carried out in BHT hospitals.[50]

93. We were told that separate patient records are held by the Oxford Health NHS Foundation Trust (mental health) team, BHT and GPs. This can lead to delays in diagnosing conditions, as patient histories may not be checked, particularly of those who are admitted to general wards which aren't necessarily geared to the needs of older people. In the interests of patient care we consider it vital that the various agencies involved work closely together, and share information that will hasten the provision of appropriate care. If it is not currently possible for GPs and the two NHS trusts to share patient records, we recommend that BHT review some of its processes to facilitate the early diagnosis of mental health problems. This could include ward staff/doctors on all wards contacting a patient's GP as soon as they are admitted. Alternatively Oxford Health could be supported to provide more screening services of patients aged under 75, although this would be a contractual matter between them and the Primary Care Trust and Clinical Commissioning Groups (from April 2013).

Recommendation 9

To assist in the prompt identification of a mental health history, we recommend that BHT review the plans they have to improve patient mental health information sharing with Oxford Health and GPs, including IT and their admission processes, to facilitate the quicker identification of a mental health history, thus reducing the chances of potential delays in diagnosis.

94. We heard from Carers Bucks that carers of people with dementia have reported a reluctance to leave their loved one in hospital as they are worried that their needs will not be met. In particular, family carers often feel responsible for ensuring that their loved ones are fed during their stay, as staff are 'frantically busy'. BHT point to 'Attitude Matters' document referred to on paragraph 21, as a method for carers to highlight patient needs. BHT advise that they have always encouraged family/carer input and help with patient care, but are sensitive to some people needing to rest during the admission of a loved one.

95. Carers Bucks told us of the need for specific communication skills when dealing with a patient with dementia. Language needs to be kept

[50] HOSC minutes June 2012

straightforward and at its simplest, for example, instead of asking a patient if they would like a cup of tea, they should ask 'Cup of tea?'

96. We were pleased to hear that carers are beginning to be treated as 'expert partners' as recommended by the National Carers Strategy. This values the role that carers have, particularly in advising staff on how to help loved ones with dementia.

97. With around a quarter of people in hospital having dementia, it is important that staff at all levels, who may be involved in caring for someone with dementia, have at least a basic understanding of the condition and demonstrate the skills to maintain the individual's dignity.[51] In research referred to by the Alzheimer's Society, nursing staff listed the following areas as being the most challenging when working with people with dementia:

- Managing difficult/unpredictable behaviour – 27%
- Communicating – 23%
- Not enough time to spend with patients – 11%
- Wandering/keeping people on the ward – 8%
- Ensuring patient safety – 7%[52]

98. A member of staff told the CQC, during its recent inspection at Stoke Mandeville Hospital, that they recently had a number of patients with mental health needs and that they had not felt equipped to support them with their complex needs.

99. We understand that dementia training currently is not mandatory and can be ad hoc. We heard of good practice on Wycombe Hospital's Medicine for Older People Ward 5B, where basic training on dementia is delivered to all staff, including domestic staff, on a weekly basis by Oxford Health's Liaison Psychiatric nurses for older people. This involvement of liaison teams in a central educative role is endorsed by NICE/SCIE guidelines (2007),[53] where it is stated that local mental health and learning disability services should offer regular consultation and training for healthcare professionals in acute hospitals where care for people with dementia is provided. However, we heard that the current available resource is limited, with two liaison psychiatric nurses operating over the three acute sites. We understand that best practice is for dementia care training to be delivered by coaching in the workplace alongside patients, rather than via formal training courses. Coaching alongside patients has improved experiences in Southampton and Worcester. BHT advise us that they are looking how to bring these coaching skills in once the 'Dementia Champions for Accident and Emergency and Orthopaedics' have completed their training (by December 2012).

[51] Delivering Dignity – securing dignity in care for older people in hospitals and care homes July 2012
[52] Counting the Cost – caring for people with dementia on hospital wards, Alzheimer's Society
[53] Dementia – Supporting people with dementia and their carers in health and social care NICE/SCIE guidelines 2007

100. We are encouraged to hear that BHT is exploring how to improve dementia care skills and, given the benefits of ensuring patients can be supported well, we would ask for this to be given priority.

Recommendation 10
To enhance staff dementia care skills we recommend that BHT ensures that all health staff, both registered and unregistered, have access to mandatory training/coaching and awareness raising on how best to support patients with dementia, including skills in communicating, managing difficult behaviour and providing dignified care.

Conclusion

101. Bucks Healthcare Trust has demonstrated to us, through its strong leadership and initiatives, that its priority and aim is to deliver excellent care and dignity for all patients. Older patients we spoke to were full of praise for the staff who cared for them and we saw and heard of very good practice in place. However, we are concerned that this good practice may not be consistent across all wards and that this may result in older patients not receiving the kind of care they need and deserve.

102. We recognise the exceptional challenges BHT faces in having to reduce admissions and length of stay and to make significant savings in order to operate within a reducing financial envelope. We are also aware that acute hospitals are providing care for older people who are the frailest, most ill and have the most complex needs.

103. We have attempted through this review to portray care of older people on the wards from a patient's perspective, as well as to articulate the aspirations of the organisation and its staff. We recognise the limitations we have necessarily had to work within, including how we have been able to access wards and patients.

104. We are grateful to BHT for allowing us access to its patients, wards and staff in carrying out this review, and to the numerous contributors who helped us to form a picture of what care is like for an older patient in hospital. We hope that this honest appraisal of what we have seen and heard will be a useful document and the recommendations we have presented will help to improve the care of older people in hospital.

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Sheila Cotton

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The Buckinghamshire Older People's Partnership Board

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Appendix 1: Review Scope

Subject of the Review	**Care of older people in a hospital setting**
Chairman	Richard Pushman
Task and Finish Group members	Lin Hazell, Richard Pushman, Noel Brown, Avril Davies, Jenny Puddefoot, Wendy Mallen, Margaret Aston, Jennifer Woolveridge
Officer contact	Jane Burke / James Povey
Purpose of the Review (Reasons for undertaking the review, including where the ideas have come from)	To examine aspects of care experienced by older patients in hospitals in Buckinghamshire, including those with dementia, in view of national concerns around care of older people in hospital and at discharge.
Anticipated outcome(s)	We will work with relevant providers to: ▪ Highlight areas of best practice, not just in Buckinghamshire but in other health authorities; ▪ Identify areas for improvement and develop recommendations, which will help to drive change where it is necessary, in our areas of focus.
What is the potential impact of the review on • Residents • Equality issues, e.g. access to services, vulnerable groups • Health inequalities • Adding value to the organisation • Partners	The review will be highlighting an area which is important not only to older people but also to their families. Any recommendations resulting from the review will be aimed at improving services.
Key Issues for the review to address to be confirmed	Phase A ▪ General care of older people on the wards ▪ Recruitment and training of nursing staff ▪ Staffing levels Phase B ▪ Transition and links between Health and Social Care services at patient discharge
Methodology	• A task and finish group made up of members from the HOSC, supported by the policy officer, to carry out evidence gathering sessions, including site visits to hospitals • Consideration of use of co-optees • Evidence gathering sessions • Desktop research /visits as appropriate • Focus groups, if appropriate • Case studies, if appropriate
Key background papers and data	To include:

	▪ 'Delivering Dignity – Securing dignity in care for older people in hospitals and care homes. ' LGA, NHS Confederation, Age Uk ▪ National Service Framework ▪ Safer Staffing Tool ▪ Patients Association Report – 'We've been listening. Have you been learning?' 2011 ▪ Others to be added
Key stakeholders	Bucks Healthcare Trust (BHT) BCC Adult Social Care Oxford Health NHS Foundation Trust Patient groups Carers Bucks Care Quality Commission Royal College of Nursing Older People's Champions Forum Older People's Partnership Board Age UK LINk
Resources required	Officer and member time
Timetable	May – November 2012
Reporting mechanism	• Cabinet • NHS Buckinghamshire – recommendations and formal response to proposals