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MEETING	HEALTH SCRUTINY COMMITTEE
DATE	6 OCTOBER 2008
PRESENT	COUNCILLORS FRASER (CHAIR), ALEXANDER, AYRE (VICE-CHAIR), MORLEY, SUNDERLAND, WISEMAN AND SIMPSON-LAING (SUBSTITUTE)
APOLOGIES	COUNCILLOR DOUGLAS
IN ATTENDANCE	JOHN YATES – OLDER PEOPLE’S ASSEMBLY ANNE HARDY – ALZHEIMERS SOCIETY MIKE WRIGHT – YORKSHIRE AMBULANCE SERVICE (YAS) SUE BECKETT – YORK FOUNDATION TRUST KEVIN PRATT – NORTH YORKSHIRE & YORK PRIMARY CARE TRUST (NYYPCT) VERONICA MACKLEY – NYYPCT GRAHAM PURDY – NYYPCT DR LYNN COATES – NYYPCT MELANIE BRADBURY – NYYPCT PAT SLOSS - NYYPCT BILL HODSON - CYC

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## 17. DECLARATIONS OF INTEREST

Members were invited to declare at this point in the meeting any personal or prejudicial interests they might have in the business on the agenda.

No interests were declared further to the standing personal, non-prejudicial interests declared at previous meetings and circulated with the agenda.

## 18. MINUTES

RESOLVED: That the minute of the meeting of the Committee held on 22 September 2008 be approved and signed by the Chair as a correct record.

## 19. PUBLIC PARTICIPATION

It was reported that there had been one registration from John Yates to speak at the meeting, under the Council’s Public Participation Scheme.

John referred to the response received from the Director of YOR Local Medical Council Limited in relation to the comments he had made, at an earlier meeting, that family General Practitioners no longer existed and that GP’s were often unaware of a person’s history. He went on to clarify his comments by stating that he felt that these days GP’s were less likely to be aware of a patient’s background with only 10 minute appointment slots.

He also referred to the consultation now being undertaken on the NHS Constitution, which it was reported would cover all sections of the community. He stated that he hoped that this would be a two-way dialogue as GP's needed to be aware of what the public wanted prior to the Constitution being finalised.

The Chair confirmed that the points raised by the speaker would be noted when consideration was given to the draft final report.

## **20. DEMENTIA REVIEW – INTERIM PROGRESS REPORT**

Consideration was given to the Interim Progress Report on the Dementia Review, in particular to the information gathered at the formal meeting held on 1 September and from the informal evidence gathering session on 22 September 2008, together with the issues arising.

The Chair referred to the informal evidence gathering session when Members had identified several issues that needed further exploration. At that time it had been decided to address these by consulting and receiving evidence from the following:

- (a) Yorkshire Ambulance Service (YAS) - A representative had been invited to attend the meeting to present their experiences in relation to dementia patients accessing secondary care.

Mike Wright, the Locality Manager from YAS, thanked the Committee for the opportunity to contribute to the review. He stated that, ambulance personnel, as usually the patient's first line of contact after the GP, received very little guidance in relation to patients that were affected by dementia.

He stated that when responding to 999 ambulance calls personnel were often unaware of what type of call they were attending as only basic information had been obtained. Crews analysed each case and situation on arrival but they were trained to obtain as much information from those at the scene as possible, which included relatives and carers. He confirmed that ambulance personnel did not receive specific training on dementia but that with information received they also had to be aware of potential abuse cases. He stated that staff were trained on the requirements of the Mental Capacity Act 2005 and the new Safeguarding Adults policy, which would be ratified shortly by the Trust Board. He confirmed that crews were instructed to contact Social Services if they felt that an elderly patient was at risk and this would be done by way of a form. He stated that every situation was different and that crews learnt by experience over a period of time.

He pointed out that

- Crews were only with patients for a short period of time compared with other health professionals.
- Any training was good but that personnel had to learn a great deal of information in a very short period of time.
- Very few complaints were received in this area.

- Although staff were experienced they could miss signs if patients had trauma or were dehydrated
- Length of training for qualified paramedics: this could be undertaken in two ways the first by Technical entry which comprised an 8 week training scheme followed by 1 years probation or secondly with a 2 year study course which was equivalent to the technical entry followed by more advanced training but it was confirmed that this was still less training than that received by a nurse.
- Confirmed that relatives/carers were always encouraged to travel with patients in the ambulance and that this included staff in residential homes accompanying residents.

The representative of the Alzheimer's Society referred to the specialist training their Society provided which she felt could be useful to ambulance personnel.

Members referred to the fact that people were living longer and that with an increased elderly population and an increased incidence of dementia that there was possibly a need for more formal training for ambulance staff. Mike Wright confirmed that if funding was available and time set aside for such training that he would welcome this.

(b) York Hospital front line staff – It was reported that Members of the Committee had visited front line staff at York Hospital on 6 October 2008 when they had spoken to 3 members of staff from the Trauma and Orthopaedic Unit.

Notes of the comments made in relation to their experiences of caring for patients suffering from dementia who accessed secondary care were circulated at the meeting (copy attached to these minutes).

Arising out of consideration of this document Members made the following comments:

- Concern that those who worked on the elderly wards did not receive additional training in caring for patients with dementia;
- Unfortunate that a forum arranged on mental health issues had been cancelled at short notice due to staff unavailability. The Chair confirmed that the Matron had confirmed that she would examine issue this outside of the scrutiny review;
- Of the twelve benchmarks of 'essence of care' significant developments had been made in all areas apart from mental health. Officers confirmed that this was a national initiative and that improvements were to be made locally in this area. It was confirmed that this point would be examined further when formulating the recommendations;
- Minor text amendments would be made to the notes from the visit prior to the documents inclusion in the final report.

- (c) The North Yorkshire and York Primary Care Trust (NYYPCT) – Representatives of the PCT were in attendance to update Members on training issues and the status of the Psychiatric Liaison Service.

Members were reminded that it had been reported at the informal evidence gathering session that York Hospital together with colleagues in the PCT had investigated the possibilities of a “psychiatric liaison service” which had unfortunately been stalled due to lack of funding. A pilot of the scheme had produced some clear anecdotal evidence on the benefits of such a service.

Representatives of the PCT at the meeting reiterated the point that earlier work had shown that reductions could be made in patient’s length of stay with the use of a liaison service. They confirmed that they fully supported the scrutiny review, as they were aware of gaps in the service. They also confirmed that anecdotal evidence had provided clear evidence that there was a need for the service to be used before and after hospital admissions. They pointed out that there were also problems with the availability of resources for training. They made the final point that staff were also wary of over diagnosing or making too early a diagnosis of dementia in patients and that this was a very fine line.

Members questioned the possibility of pooling training resources with Bootham Hospital. The PCT representatives confirmed that there were no problems with staff accessing training at other venues the only issues related to the suitability of different courses for staff at different levels.

- (d) Local Medical Committee (LMC) – The LMC had been contacted to see whether it would be feasible to include in GP notes details of named carers and to flag this information up when admitting dementia sufferers to hospital for secondary care.

Details of the response received from the Director of YOR Local Medical Council Limited were circulated at the meeting. He explained that a “shared care record system” did exist but that the software used in York and Selby was unpopular with the Strategic Health Authority (SHA). He confirmed that GP’s were resisting intense pressure from the SHA to change to an alternative system. He went on to confirm that every GP had a database of patients with dementia and that GP’s should be carrying out an annual review of carer contact details.

Members expressed concern that the SHA should be attempting to change the excellent EMISWEB intranet system used by GP’s and pointed out that a compatible IT system should be used across all agencies.

- (e) National Dementia Strategy for England update September 2008

This update was circulated to Members at the meeting and informed Alzheimer’s Society staff in England about work in progress on the Dementia Strategy.

Members agreed that they now had sufficient information to produce recommendations for the draft final report and following further discussion it was

- RESOLVED:
- (i) That a further informal session of the Health Scrutiny Committee be arranged for Tuesday 21 October at 4.30pm to make appropriate recommendations to be included in the draft final report;
  - (ii) That the documents circulated at today's meeting be received for inclusion in the draft report;
  - (iii) That the Committee's thanks be conveyed to the Scrutiny Officer for the expeditious production of the notes made following the visit to York Hospital, earlier in the day.

REASON: To progress this review.

## **21. CONSULTATION ON THE NHS CONSTITUTION**

Members considered a report, which asked if they wished to take part in the national consultation on the NHS Constitution. Consideration was given to:

- A letter inviting comments;
- A copy of the consultation document and
- A copy of the constitution.

It was reported that the draft NHS Constitution now

- Recorded in one place what the NHS did, what it stood for and what it should live up to. It set out principles to guide how all parts of the NHS should act and make decisions;
- It also renewed the commitment to the enduring principles of the NHS and confirmed the commitment to a service that was for everyone, paid for out of taxes, based on clinical need rather than an individual's ability to pay, and without discrimination of any kind.
- Set out seven core principles, which aimed to empower patients, make decision-making criteria clearer and safeguard the future of the service. The draft Constitution proposed a new law to ensure that it was reviewed every ten years with its values reaffirmed every three years.

Members were informed that national consultation was underway with the public, stakeholders, patients and staff with the consultation period running to 17 October 2008.

Following discussion it was

RESOLVED: That record be made that the Committee do not wish to take part in the consultation process.

REASON: The majority of proposals in the NHS Consultation were non controversial and the Committee did not feel further comment was required.

## **22. HEALTH SCRUTINY NETWORKING**

Consideration was given to a report, which informed the Committee of recent events attended, by both Members and Officers outside the formal meeting cycle of the Health Scrutiny Committee.

Details of the following events and meetings were reported:

- Introductory meeting with North Yorkshire & York Primary Care Trust (16.06.08)
- Regional Health Scrutiny Officers Meeting (23.07.08)
- Members' visit to York Hospital (1.08.08)
- Meeting with NYYPCT (13.08.08)
- Launch of York Carer's Forum (4.09.08)
- Workshop on LINKs and Regional Specialist Commissioning
- Launch of York LINK (15.09.08)
- NYYPCT Annual General Meeting (AGM) (23.09.08)

Members agreed that the reporting of these events was very useful. The Scrutiny Officer asked for any contributions from Members for future updates to be emailed to her.

RESOLVED: (i) That the update report be noted;  
(ii) That future updates be reported to the Committee on a quarterly basis.<sup>1</sup>

REASON: To keep Members informed of events attended that are relevant to Health Scrutiny.

### Action Required

1. Health Scrutiny networking update reports to be made to Committee on a quarterly basis, the next update to be made in February 2009.

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## **23. PROTOCOL FOR THE YORKSHIRE AND HUMBER COUNCILS JOINT HEALTH SCRUTINY COMMITTEE**

Consideration was given to a report, which presented Members with the draft protocol for the Yorkshire and Humber Council's Joint Health Scrutiny Committee. Members were asked to consider whether or not to adopt this protocol.

The protocol had been developed as a framework for carrying out scrutiny of regional and specialist health services that would impact upon residents across Yorkshire and the Humber under powers for Local Authorities to scrutinise the NHS contained in the Health and Social Care Act 2001. It was reported that the protocol had been jointly drafted by scrutiny officers from across the region and that it was currently being presented for

adoption to the 15 Local Authorities that it affected. It was proposed that the regional health scrutiny protocol would replace existing sub-regional protocols.

**RESOLVED:** That the Committee adopt the protocol for the Yorkshire and Humber Council's Joint Health Scrutiny Committee.

**REASON:** To ensure that Members can fully take part in necessary health consultation.

Cllr S Fraser, Chair

[The meeting started at 5.00 pm and finished at 6.00 pm].

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### **Comments from front line staff at York Hospital**

Members of the Committee visited front line staff at the hospital on 06.10.2008. They spoke to 3 Members of staff from the Trauma and Orthopaedic Unit (a Health Care Assistant, a Staff Nurse and a Deputy Sister) and also a Matron. They made the following comments in relation to their experiences of caring for patients suffering from dementia who accessed secondary care:

#### **Training**

- There were large gaps in training provision and Members of staff on non-elderly wards did not have sufficient training in caring for patients with dementia.
- A forum had been set up for staff in relation to mental health issues but most of these had been cancelled at short notice, as staff were unavailable to attend. The Matron thought that these could possibly be revamped and was willing to explore the possibility of this.
- As part of their general nurse training qualified staff receive a 7 or 8 week placement that covers caring for people with mental health conditions. Much of the time staff were expected to learn about care for dementia sufferers 'as they went along'. The Health Care Assistant (HCA) had received no formal training in this respect other than "on the job" training/experience.
- There were link nurses for things such as manual handling and infection control. It was suggested that there could also be a link nurse for mental health.
- Staff felt that formal training in dementia care would be helpful. Discussions were had surrounding using a link nurse to do this. The link nurse would then cascade information learned down to other members of staff on the ward.
- There were twelve benchmarks of 'essence of care' and significant developments had been made in all areas apart from mental health.

#### **Communication & Provision of Information**

- Communication between the patient and members of staff could be difficult especially when a carer wasn't present.
- The information that staff had was often from a printed sheet which frequently did not indicate the social needs of a patient.
- If a patient has no carers/family then communication can be very difficult as there is very little information regarding the social

background of the patient (i.e. what they like to eat, what their usual routines are).

- If the patient is admitted from a care home the care assistant may not know them very well (especially if there has been a recent shift change). A written handover sheet is given to staff at the hospital when the patient is admitted from a care home but if there is not enough information on this then staff will ring the care home and ask for more information about the patient. This sheet would usually indicate whether the patient was suffering from dementia.
- The possibility of a checklist of standard information that staff could mark off once received was discussed.
- It was the 'little things' that could make a patient feel comfortable such as knowing what they liked to be called, what they liked to eat etc. In the case of patients with dementia there was a higher need for social care even if they were on hospital for a physical problem.
- If a patient had been referred to hospital by a GP then he/she will have some knowledge of the patient's history and this would be passed on to staff.
- Discussions were had regarding continuity and staff handovers. Communication between staff was good whilst working and when the shifts changed.
- Information was also passed on to the multi-disciplinary areas such as physiotherapists and occupational therapists.
- Staff should let the bed manager or the Matron know that they need extra staff to assist with vulnerable adults and if they want a visit from the Specialist Health Nurse.
- A safety briefing was carried out at all shift handovers. Discussion were had as to whether this could be elaborated.
- Discussions were had in relation to the 'This is me' document that the Alzheimer's Society were developing. Hospital staff thought this was a very good idea and would be a useful tool for them.

### **Hospital Environment & Patient Experience & Safety**

- The hospital environment is often alien and therefore frightening for patients suffering from dementia. It is common for dementia sufferers to feel uncomfortable outside of familiar surroundings.
- A patient will have suffered a traumatic experience (i.e. a fall) that has required admission to hospital. When a patient also suffers from dementia this can heighten the trauma.

- Patients with dementia can often be unsettled when they are unfamiliar with their surroundings and the people near them.
- If a patient presents with confusion (but has not been diagnosed with dementia) then the staff would initially look at ruling out infection as a cause. Once this had been done and if the patient was still confused then they would look at exploring whether there was an underlying mental health issue causing the problem. They were supported by the elderly medicine physicians who would come and visit the patient and advise the staff. There was also a Nurse Specialist in Mental Health.
- If a patient does not feel safe and calm then this will have a negative impact on the rest of the ward.
- To assist with patient safety patients with similar needs were often kept together in one part of the ward to allow staff to keep a closer eye on them.
- Patients with dementia often feel more at ease with some personal belongings near them. In the surgical wards this is not always possible due to the risk of infection. Infection control limited the hospital as to what personal belongings a patient could bring with them.

### **Staff Time Constraints**

- Staff on a busy ward (such as trauma and orthopaedics) can sometimes struggle to spend time with patients to reassure them that everything is okay.
- If a ward is short staffed then it was a struggle at mealtimes. It was also more difficult to watch high dependency patients and to prevent patients from falling and wandering.
- Some patients on the surgical ward require one to one care for 24 hours a day and staffing levels had been increased to cope with this and ensure patient safety. Staff would still be under pressure at busy periods of the day though.
- The Matron liaised regularly with the teams regarding staffing issues. If there were issues then, where possible, other staff were sent to assist on a ward.
- Mealtimes, drug distribution and answering patient bells often clashed. There were some very busy times of the day, especially teatime when all of the above happened and patients were still coming back to the ward post operation.
- Staff had concerns regarding patient's dignity when they were disorientated. Certain events could be upsetting for staff, patients and

visitors and needed to be avoided. It was important to make the patient feel at ease but time did not always allow for this to be as effective as it could be.

- There was only one Specialist Mental Health Nurse and if this area could be expanded it would be beneficial to all.

### **Involvement of Carers**

- Staff do, where possible, encourage carers to provide information about the patient in order to care for them in the most appropriate way.
- Carers are also encouraged to help the patient at meal times and normal routines and where possible are incorporated outside of the normal visiting times. [Not sure whether this happens on all wards due to the protected meal times scheme].
- Staff try and get patients with dementia to follow a routine that they like and this can be achieved with the support of carers and family.
- Staff felt that communication could be improved with more carer involvement.

### **General**

- People were living longer and therefore there were more instances of dementia in patients.
- Sometimes, in the early stages of dementia, the family would cover up for any problems there were.
- The introduction of a Psychiatric Liaison Service would be beneficial