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Notice of Meeting

Health Scrutiny Panel

Tuesday, 19th July, 2011 at 6.30 pm

in Committee Room 1 Council Offices
Market Street Newbury

Date of despatch of Agenda: 21 July 2011

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Rob Alexander on (01635) 503042
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West Berkshire COUNCIL

To: Councillors Howard Bairstow, Dominic Boeck, Sheila Ellison, Carol Jackson-Doerge, Tony Linden, Alan Macro, Gwen Mason (Vice-Chairman) and Quentin Webb (Chairman)

Substitutes: Councillors George Chandler, Roger Hunneman, Andrew Rowles and Julian Swift-Hook

Agenda

Part I

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1 **Apologies for Absence**

2 **Declarations of Interest**

3 **Urgent Items**
Purpose: For the Chairman to draw to the Panel's attention any urgent items for consideration.

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For Information

5 **Update on the Health Service in West Berkshire** Verbal Report

6 **Update on the Health and Wellbeing Board** Verbal Report

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Andy Day
Head of Policy and Communication

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Title of Report:	**West Berkshire LINks Annual Report**
Report to be considered by:	Healthier Scrutiny Panel
Date of Meeting:	19 July 2011

Purpose of Report: **To receive the West Berkshire LINk Annual Report**

Recommended Action: **To note the report.**

Health Scrutiny Chairman	
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Executive Report

1. Introduction

1.1 The West Berkshire LINk (Local Involvement Network) is an independent network of local people and community groups working together to influence and improve West Berkshire's health and social care services

1.2 The Annual Report details the achievements, activities and finances of the LINk of the past year.

2. Recommendations

It is recommended that:

2.1 Members are asked to note the contents of the report.

Appendices

Appendix A – West Berkshire LINk Annual Report.

West Berkshire Local Involvement Network
Annual Report 2010/11

Contents

Please address comments and queries to either :-

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Nigel Owen NOwen@westberks.gov.uk

The West Berkshire LINk has a statutory duty to

- promote and support the involvement of people in the commissioning, provision and scrutiny of local care services
- enable people to monitor and review the commissioning and provision of local care services
- obtain the views of people about their needs for, and their experiences of, local care services; and
- make such views known to commissioners and providers and regulators of local care services.

In addition we are tasked to produce reports and recommendations about how local care services could or ought to be improved.

Chairs Report

Welcome to the third Annual Report of the West Berkshire LINk

This has been an eventful year for the LINk. At the end of September 2010, West Berkshire Council terminated the contract of our Host Organisation Help and Care. This move was welcomed by the Steering Group. We have been heartened by the enlightened and constructive attitude taken by West Berkshire Council towards the LINk throughout the year but particularly since September 2010. It was noted that Bracknell terminated their contract with HAC at the same time and that Wokingham and Windsor & Maidenhead acted similarly in March 2011.

We are now faced with the implications of the Health Bill which is proposing some of the most radical reforms to the NHS since it's inception. We have been active at many levels in not only ascertaining what this bill will mean for our population but also in expressing our views to the Department of Health at both Regional and National meetings and in written submissions.

Locally, we also have two other major changes. The first of these is the merger through "clustering" of Berkshire West Primary Care Trust (PCT) and Berkshire East PCT and the second is the transfer of the management of our Community Health services to Berkshire Healthcare Foundation Trust., who have historically managed our local mental health services.

The uncertainty and discontinuity caused by these changes represents a major cause of concern for us and we will be doing our best to monitor the situation in 2011/12 on behalf of the community albeit with substantially reduced funding.

This will be our last full year of operation as a LINk as the Coalition Government has indicated that LINks will be replaced by Local Healthwatch (LHW) at some point in 2012. LHW will have the same responsibilities as LINks do presently but with the additional duty of providing an information and signposting service to the general public. LHW should, however, be an independent corporate body capable of holding it's own bank account and of employing it's own staff. We are already discussing the transition process with the local authority in order to minimise any discontinuity once the new arrangements are enacted which will probably not now occur until October 2012.

Activity this year has been inhibited by the turmoil associated with the change of host and we have had very limited support despite the costs incurred by the local authority. Certainly we have had no material support in undertaking project work though we have been supported administratively in terms of minuting meetings and in organising a major public event at Newbury Rugby Club in June 2010.

We have, however, completed a major report on Services for Neurological Conditions in the Berkshire West PCT area and have participated in the implementation of "Putting People First" and in many other activities in the local, regional and national health and social care fields.

Tony Lloyd (W Berks LINk Chair) June 2011

About our community

West Berkshire lies at the centre of the Thames Valley and is made up of 4 main centres of population ; Newbury, Thatcham, Calcot (nr Reading), Hungerford and Lambourne and a number of smaller communities, each with its own distinctive characteristics.

The population of West Berkshire is estimated at 154,000 (PANSI / POPPI information for 2010). 23.7 % of the local population are under the age of 18, 61.3% are between 20 and 64 and 15% are over 65. The number of residents aged 75 or above is projected to nearly double over the next 20 years from 10,600 in 2010 to 20,700 by 2029. It has by far the most dispersed population in Berkshire.

West Berkshire is ranked as the 24th (out of 354) least deprived area in the country (JSNA 2009). However there are some pockets of both urban (in and around Newbury) and rural deprivation. Twelve per cent of the children attending schools in West Berkshire have English as a second language.

The all age, all cause mortality rates for West Berkshire in 2007 were 511 per 100,000 compared to 528 in the SE Region and 579 in England and Wales. Life expectancy in the most deprived fifth of areas in West Berkshire is three years less than in the least deprived areas for men and 4 years for women. However West Berkshire does face some important health issues such as the under diagnosis or incomplete recording of coronary heart disease amongst our Asian Community.

Local Health Care Services

Four main NHS Trusts currently serve West Berkshire;

- Berkshire West Primary Care NHS Trust
- Royal Berkshire NHS Foundation Trust
- Berkshire Healthcare NHS Foundation Trust
- South Central NHS Ambulance Trust

However in certain areas of West Berkshire, people also access the Oxford Radcliffe Hospital, the Basingstoke and North Hampshire NHS Foundation Trust and the Swindon and Marlborough NHS Trust

West Berkshire has a community hospital in Thatcham that provides a range of services including minor injuries, palliative care and the Rainbow suite for people with long term neurological conditions. . There are 11 general practices in the West Berkshire Council Area.

Local Social Care Services

West Berkshire Council has a statutory responsibility to carry out assessments of need for care and support on behalf of any resident over the age of 18 who may be vulnerable and their family or carers and a duty to arrange support to meet assessed needs.

Levels of central funding for local services are providing a challenge to health and social care providers. The council has elected to set the eligibility for statutory social care services to “critical” need only.

West Berkshire LINk

The West Berkshire LINk is a network made up of individuals and organisations with an interest in local health and social care provision. As at September 2010 we had a database of about 600 participants. Regrettably, at the termination of their host contract in September 2010, Help and Care refused to hand over the database and we have had to rebuild the database from our own resources. As at March 2011 the list of participants totalled about 250 and at June 21st about 300.

The LINk is funded by the Department of Health through West Berkshire Council. It has a brief to

- promote and support the involvement of people in the commissioning, provision and scrutiny of local care services;
- enable people to monitor and review the commissioning and provision of local care services;
- obtain the views of people about their needs for, and their experiences of, local care services; and
- make such views known to commissioners and providers and regulators of local care services.

In addition we are tasked to produce reports and recommendations about how local care services could or ought to be improved.

People involved in the LINk Steering Group during the year

Steering Group Members

Tony Lloyd, Marika Sullivan – Jakubiszyn, Alice Gostomski, Bryan Slade, Ruwan Uduwerage-Perera, David Johnston and Jo Allen

Co-optees

John Holt (West Berkshire Neurological Alliance), John Prendergast (Bluebird Care) and Kamal Bahia (Newbury GP consortium)

Host Support – Help and Care

The LINK would like to thank Heather Wyper for attending a number of our meetings prior to September 2010 and for preparing the minutes of those meetings. Her efficiency and cheerful good humour were much appreciated.

What the West Berkshire LINk has achieved

The LINk has been involved at many levels and with many people on health and social care issues. It was however severely constrained in that, unlike most other LINks in England, we did not have the services of a development worker at any time during the year under review. We, the Steering Group have had to do nearly everything ourselves.

Our work comes under the following headings:-

Project work – mainly surveys and reports but also speaking at public meetings

Website Development – creating an independent interactive website.

Public meeting – June 25th Newbury Rugby Club

NHS Berkshire West (PCT) Meetings

PCT commissioning meetings – representing the public and patients of Berkshire West in relation to dental provision and GP services.

PCT commissioned services quality group - representing the public and patients of Berkshire West in reviewing the quality of commissioned services, mainly at NHS trusts. The group also reviews complaints, issues and enquiries raised through the PCT PALS function

PCT board meetings – generally attending these and the PCT AGM but also acting as the deputy LINk representative at a PCT Board meeting

PCT Health Network Meetings – attending these when available

Royal Berkshire Hospital Foundation Trust meetings

Clinical Governance Meetings – as LINk representative

Dementia Steering Group Meetings – as LINk representative

Medical Panel Meetings – as Panel member (including related voluntary work)

Public and Patient Involvement Steering Group Meetings – as LINk Chair

Regional work

Attending Regional meetings of LINk chairs (SELLNet)

Vascular Surgery Review (S Central SHA)

Stroke Services Review (S Central SHA)

National work

Attending Dept of Health meetings re the Health Bill

Attending CQC meetings re the Health Bill

Attending the National Association of LINk members (NALM) AGM

Other meetings

W Berks Patients Panel

W Berks Council Healthier Select Committee

Berks West 3 LINk meetings – to coordinate activities between the three LINks

W Berks Council Public Involvement Board

W Berks Independent Living Network – to discuss LHW transition issues.

Project Work

Citizens Panel Survey

Although the bulk of the work on this project had been done in 2009/10, it was not printed or despatched until 2010/11. Hard Copies, incorporating comments from the PCT, the RBH and W Berks Council were sent to all participants without e-mail. Otherwise people received e-mailed copies.

The report was referred by the PCT to the Commissioned Services Clinical Quality Group. It was stated by the deputy Chief Executive that this was “good soft intelligence” but as far as we are aware no specific action was taken as a result by the providers or commissioners though we are aware of significant improvements in maternity services that have been made over the past two years. This had been the area where we had had most adverse comments. One specific issue raised by a local GP about psychiatric care after childbirth was however dealt with after the PCT confirmed that they had no record of the original complaint.

Service Provision for ten Neurological Conditions in Wokingham, Reading and West Berkshire

West Berkshire Neurological Alliance

This is a joint project between the West Berkshire LINk and the West Berkshire Neurological Alliance (together with financial support from the Wokingham LINk) and has required an enormous amount of work from both parties. The project commenced in Feb 2010. 1332 questionnaires were sent out to patients with a range of neurological conditions and to their carers and 254 were returned from patients and 153 from carers.

The interim report was produced in Feb 2011 and circulated to the PCT, the RBH, Berkshire Healthcare Trust, the 4 GP consortia and all three local authorities.

We have still not had complete responses from two of the major players 12 weeks after they received the report.

In essence we asked patients and, separately, their carers about whether key service providers understood their conditions and needs and whether they were effective in managing their conditions.

Once we have the full set of comments back from providers and commissioners we will produce a final report that will be circulated to stakeholders throughout England. The methodology and logic of the report has been scrutinised by Professor Gillian Parker of the Social Policy Research Unit at York University and we hope that she will also write a brief foreword to the final report once we have incorporated her suggestions for improvement.

Putting People First

Marika Sullivan – Jakubiszyn, a Steering Group Member, has been working closely with West Berkshire Council and Sovereign Housing to develop the "Putting People First" agenda. Marika has spoken at Public Meetings and chairs a group organised by Sovereign. She has received many plaudits for her work

Website Development

David Johnston, another Steering Group member has developed an excellent interactive website www.westberkshirelinks.com This website, based as it is on a database system, has huge potential for communicating with patients and the public. The challenge as ever is to populate it and bring it to the attention of the local population.

Public meeting – June 25th Newbury Rugby Club

At the instigation of W Berks Council a major public meeting was arranged at the Newbury Rugby Club on June 25th. This was organised by Help and Care who brought in staff from Hampshire to manage the event. Presentations were given by the W Berks Corporate Director for Community Services , by Bluebird Housing and Marika Sullivan – Jakubiszyn and by the Berks West Improved Access to Psychological Therapies (IAPT) team. There were workshops in the afternoon.

NHS Berkshire West (PCT) Meetings

- **Dental Commissioning**. This group monitors the performance of the NHS dentistry contracts in the area and supervises the expansion of NHS dentistry capacity. Tony Lloyd attends

- **GP Commissioning**. This group monitors the performance of the local GP contracts in the area. Tony Lloyd attends from time to time as substitute for the Wokingham LINk member

- **Commissioned Services Clinical Quality**. This group monitors all aspects of the quality of clinical services commissioned by the PCT Tony Lloyd attends.

- **PCT board meetings**. Tony Lloyd attends these from time to time and has also attended the AGM. He acts as deputy for the permanent representative,

a Reading LINk member.

- **PCT Health Network Meetings**. Various members of the Steering Group have attended these meetings and participated in the discussions.

Royal Berkshire Hospital Foundation Trust meetings

- **Clinical Governance.** The RBH agreed to permit a LINk member to attend the main Clinical Governance meeting at the RBH. This gives a much broader oversight of clinical quality monitoring and reporting than would otherwise be the case. Tony Lloyd alternates with David Shepherd of the Reading LINk on this committee. We would like to commend the RBH for this concession which goes some way towards achieving full transparency at the RBH.

- **Medical Panel**. This is an RBHFT led panel involving patients and the public in developments in the medical division of the RBHFT Tony Lloyd is a member

- **Dementia Steering Group**. This is a multidisciplinary panel chaired by Dr Chatterjee covering all aspects of the care of patients at the RBH who also have dementia or delirium. It is to the RBH's credit that they encourage public and carer involvement in this influential panel Tony Lloyd is a member

- **Cross Panel Dementia Group**. This is the first RBH panel that spans more than one division. Members pursue issues associated with the main dementia support matters including nurse and care worker training, literature for relatives and carers, "Memories" books etc. Tony Lloyd is a member

- **Patient and Public Involvement Steering Group.** This panel brings together all strands of patient and public involvement in the activities of the RBH into one meeting. Tony Lloyd represents West Berkshire.

Regional work

SELLNet
Tony Lloyd has attended a series of meetings called by the Department of Health SE Regional team to engage with LINks in the Region. At the instigation of Cliff Bush of the Surrey LINk these meetings have resulted in the formation of SELLNet (South East LINks Network). With the transfer of Milton Keynes to the Northampton cluster, the chair of the network resigned and Tony Lloyd was elected Chair by the group.

Vascular Surgery Review
At the invitation of the SHA, Tony Lloyd and other LINk chairs/ members from South Central attended a high level Vascular Surgery Review to determine the location of the core Vascular Surgery unit in the Thames Valley. There were three candidates and formal presentations were given by each. The outcome was something of an anticlimax as the decision appeared to have been taken by clinicians and little account was given to the opinions of lay representatives

Stroke Services Review (S Central SHA) A similar exercise was conducted in retrospect, after legal advice, on the decision made already about the location of emergency stroke services in South Central. The meeting confirmed the original decision. Again Tony Lloyd attended together with other LINk chairs.

National work

Dept of Health
Tony Lloyd attended a National Stakeholders meeting at Richmond House (Dept of Health) on Feb 8th 2011 to discuss the Health Bill. This was addressed by Joan Saddler and Earl Howe. TL had the opportunity of referring two key points to Earl Howe as part of the consultation.

CQC
Tony Lloyd also attended a national meeting on Dec 15th 2010 organised by the Care Quality Commission (CQC) about the Health Bill, Healthwatch England and Local Healthwatch

NALM
Tony Lloyd also attended the National Association of LINk Members (NALM) AGM on July 6th 2010 in London

Other meetings

Patients Panel
A number of Steering Group members have attended meetings of the West Berkshire Patients Panel at the Community Hospital in Thatcham. The Panel brings together representatives from all of the Patient Participation Groups at the 11 surgeries in West Berkshire and is supported by the PCT.

Healthier Select Committee
Tony Lloyd has attended a few meetings of the West Berkshire Council Healthier Select Committee in Newbury. [This would be referred to as the Health Overview and Scrutiny Committee in other Councils]. On learning that this committee was to be disbanded from March 31st 2011, TL made representations to the Council and put a case for its retention. This may have contributed in some small part to the decision to continue with a Health Scrutiny Panel for 2011/12

Quality Accounts – RBH and BHCFT

NHS Trusts have a responsibility to produce a Quality Report and request comments. The LINk commented on the Royal Berkshire Hospital Foundation Trust Quality Report for 2009/10 and has done so again at length for 2010/11. A similar request has been made by Berkshire Healthcare NHS Foundation Trust for 2010/11 and we have also responded to this.

Steering Group meetings

Some effort has been made during the year to bring guest speakers to Steering Group meetings and to open the meetings to the public.

The meeting with Ed Donald, the CEO of the RBH, was very popular and packed the meeting room at the Community Hospital.

The meeting with Maureen Burton from the CQC also attracted new attendees.

The meeting with the Newbury GP consortium representatives gave us an early introduction to the thinking of the consortium that has been maintained due to the attendance at some subsequent Steering Group meetings of Kamal Bahia.

The following guest speakers attended :-

May 11th 2010	Ed Donald – recently appointed CEO of the Royal Berkshire Hospital.
July 8th 2010	Maureen Burton - CQC area manager
Aug 12th 2010	Kamal Bahia and Angus Tallini – Newbury GP consortium
Sept 9th 2010	Garry Nixon – Berkshire Healthcare
Jan 13th 2011	Janet Fitzgerald – Care for the Future
Feb 17th 2011	Jan Evans – Head of Adult Social Care West Berks Council re changes in adult care provision in W Berkshire
March 17th 2011	Andy Ferrari – Update on progress on the Summary Care Record Implementation in Berkshire West.

Membership

Participants: are groups or individuals who register their interest in the LINk

As stated earlier, we had a mailing list of participants containing about 600 names as at Sept 30th 2010. [1]

When HAC lost the contract, they refused to hand over the names of these participants on the very dubious grounds of Data Protection. We are advised that they contacted everybody on the database to permit their names to be transferred to West Berkshire Council but only succeeded in getting about 50 permissions returned.

Fortunately this had been anticipated by the Steering Group and we had already captured the names of some 250 individuals from the two main surveys that we had done. We believe that this constituted the bulk of the names of individuals who had signed up to the LINk database. We have all of their signed authorisations.

[1] As at 18 May 2010, HAC confirmed 255 individuals and 338 organisations on their database

Summary of Activity

Requests for Information in 2010-11	
How many requests for information were made by your LINk?	21
Of these, how many of the requests for information were answered within 20 working days?	19
How many related to social care?	2
Enter and View in 2010-11	
How many enter and view visits did your LINk make?	0
How many enter and view visits related to health care?	0
How many enter and view visits related to social care?	0
How many enter and view visits were announced?	0
How many enter and view visits were unannounced?	0
Reports and Recommendations in 2010-11	
How many reports and/or recommendations were made by your LINk to commissioners of health and adult social care services?	26
How many of these reports and/or recommendations have been acknowledged in the required timescale?	7
Of the reports and/or recommendations acknowledged, how many have led, or are leading to, service review?	0[2]
Of the reports and/or recommendations that led to service review, how many have led to service change?	0
How many reports/recommendations related to health services?	22
How many reports/recommendations related to social care?	4
Referrals to OSCs in 2010-11	
How many referrals were made by your LINk to an Overview & Scrutiny Committee (OSC)?	0
How many of these referrals did the OSC acknowledge?	0
How many of these referrals led to service change?	0

[2] In fairness, the bulk of these recommendations were made in mid Feb 2011 which did not leave much time for a response, let alone service review or change.

Our Finances

LINk funding allocation 2010/11

	Host	LINk	Total
	£	£	£
Expenditure			
2010/11 6m expenditure[3]	35,813	3,800	39,613
2010/11 settlement contract cancellation	26,268	0	26,268
Total expenditure via host	**62,081**	**3,800**	**65,881**
add			
Expenses paid via W Berks Council		1,340	1,340
Total expenditure	**62,081**	**5,140**	**67,221**
Analysis of Expenditure			
Host			
LINk		**in year**	**Total**
Projects		1,406	1,406
Advertising, Printing, Postage and Stationery		1,122	1,122
Expenses, training and venues		1,504	1,504
Newbury Event			
Annual Report 2010/11		1,108	1,108
Total (see above)		**5,140**	**5,140**

West Berkshire Council - grant allocation

	£	£	
Funds provided by Central Government 2010/11		95,000	
Accruals as at March 31 2010		0	
Total funds available to HAC and the LINk		**95,000**	
HAC expenditure 2010/11	62,081		
LINk expenditure 2010/11	5,140	67,221	
Admin Fee - W Berks 2010/11		5,000	
Total expenditure		**72,221**	
Surplus retained by West Berkshire Council at 31/03/2011		**22,779**	

[3] The LINk expenditure is based on the Feb 2011 accounts (p5). HAC did not provide accounts to the LINk for p6.

Cumulative Position				
	2008/09	2009/10	2010/11	Total
Funding from Dept of Health	95,000	95,000	95,000	285,000
allocated as follows				
West Berks Council Admin charge	5,000	5,000	5,000	15,000
Envolve (host organisation)	25,000			25,000
HAC (host organisation)	40,312	77369	62,081	179,762
LINk	1,993	9217	5,140	16,350
	72305	91,586	72,221	236,112
Surrendered to West Berkshire Council	**22,695**	**3,414**	**22,779**	**48,888**

Title of Report:	**Review into Dignity of Care for Older People in Hospitals**
Report to be considered by:	Health Scrutiny Panel
Date of Meeting:	19 July 2011

Purpose of Report:

a) **To inform Members of the Dignity and Nutrition for Older People in Hospitals report**
b) **To suggest a method of carrying out a local patient and carer informed review into Dignity and Nutrition for Older People in Hospitals**

Recommended Action: **To approve the proposed methodology and timescales.**

Healthier Select Committee Chairman	
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Supporting Information

1. Introduction

1.1 In 2007 the Healthcare Commission (now the Care Quality Commission) published a report called “Caring for Dignity”.

1.2 The “Caring for Dignity” report highlighted that while most people valued the services they received and felt that their dignity was respected, there were examples in acute hospitals where this was not happening, including:

- Single sex bays that accommodated both men and women
- Patients being moved frequently to release beds
- Meals being taken away uneaten with no help offered to eat them

1.3 The report also highlighted that where care did fall short, a lack of training for staff was a particular issue in dealing with people with dementia in acute care settings.

1.4 Following the healthcare commission being merged with a number of other agencies the Care Quality Commission (CQC) was established.

1.5 The CQC regulates health and adult social care services in England, whether they're provided by the NHS, local authorities, private companies or voluntary organisations.

1.6 In May 2011 the CQC published a damning report from Luton and Dunstable Hospital, which detailed their failure to adhere to a number of standards/outcomes (available in appendix A) under the title “Dignity and Nutrition for older people”.

1.7 This report was one, of the first, into a number of investigations by the CQC. By the end of the reviews the CQC hope to have investigated 100 hospitals in England. The reports are published on a rolling basis, with the most recent ones being published in June 2011.

2. Outcomes/Standards

2.1 The outcomes/standards mentioned fall into 27 different categories (Appendix A). It is these which are used as a benchmark for the CQC.

2.2 It is recommended that the Health Scrutiny Panel either use all of the standards, or select the ones they feel most important to carry out a local patient and carer informed review into Dignity and Nutrition of Older People in Hospitals.

3. Local Hospitals

3.1 At the time of writing the report, only the Great Western Hospital at Swindon has had a review conducted into it. This found 2 outcomes required work to them to bring them up to the standards that the CQC hoped for. The report is attached as Appendix B.

3.2 As of yet the main hospital which provides hospital care to West Berkshire residents, the Royal Berkshire Hospital Foundation Trust (RBHFT) has not been reviewed by CQC.

3.3 Pending further reports from CQC, Health Scrutiny Panel could consider asking the views of local people with recent experience of a hospital stay as to the standards of dignity in care they experienced.

3.4 The findings would then be shared and discussed with the relevant hospitals.

4. Proposals

4.1 It is proposed that the following partner organisations could be used to gather information about local people's experience in relation to Dignity and Nutrition in Care for Older people in Hospitals.

(i) Age UK, West Berkshire

(ii) Princess Royal Trust for Carers, Berkshire

(iii) Alzheimer's Society, West Berkshire

(iv) West Berkshire LINk

(v) Neurological Alliance, West Berkshire

4.2 The above groups could be asked if they would be interested in supporting Health Scrutiny by formulating a focus group. The standards by which the groups will be using as a benchmark will be selected by the Members of the Health Scrutiny Panel.

4.3 Should members be minded to approve the above proposal it is suggested that the following timescales be kept to.

- July to September – Consultation with groups regarding dignity and nutrition in care for older people in hospitals.
- October – Members Health Scrutiny Task Group meeting to discuss the findings and identifying key issues.
- October to January – call on Hospitals highlighted by West Berkshire groups to respond to the key issues highlighted.
- January – NHS to report back to Health Scrutiny Panel regarding dignity and nutrition of care for older people in hospitals.

5. Recommendations

5.1 It is recommended that Members decide what standards to use, as mentioned in section 2.2 and detailed in appendix a.

5.2 It is recommended that Members approve the methodology and timescales as set out in section 4.

Appendix

Appendix A – Outcomes/Standards issued by the Care Quality Commission used to review care in hospitals for older people

Appendix B – Care Quality Commission report into the Dignity and Nutrition of Care for Older People in Hospital at the Great Western Hospital, Swindon.

Outcome/Standard	Title and summary of outcome
1	**Care and welfare of people who use services** People experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.
2	**Assessing and monitoring the quality of service provision** People benefit from safe, quality care because effective decisions are made and because of the management of risks to people's health, welfare and safety.
3	**Safeguarding people who use services from abuse** People are safeguarded from abuse, or the risk of abuse, and their human rights are respected and upheld.
4	**Cleanliness and infection control** People experience care in a clean environment, and are protected from acquiring infections.
5	**Management of medicines** People have their medicines when they need them, and in a safe way. People are given information about their medicines.
6	**Meeting nutritional needs** People are encouraged and supported to have sufficient food and drink that is nutritional and balanced, and a choice of food and drink to meet their different needs.
7	**Safety and suitability of premises** People receive care in, work in or visit safe surroundings that promote their wellbeing.
8	**Safety, availability and suitability of equipment** Where equipment is used, it is safe, available, comfortable and suitable for people's needs.
9	**Respecting and involving people who use services** People understand the care and treatment choices available to them. They can express their views and are involved in making decisions about their care. They have their privacy, dignity and independence respected, and have their views and experiences taken into account in the way in which the service is delivered.

10	**Consent to care and treatment** People give consent to their care and treatment, and understand and know how to change decisions about things that have been agreed previously.
11	**Complaints** People and those acting on their behalf have their comments and complaints listened to and acted on effectively, and know that they will not be discriminated against for making a complaint.
12	**Records** People's personal records are accurate, fit for purpose, held securely and remain confidential. The same applies to other records that are needed to protect their safety and wellbeing.
13	**Requirements relating to workers** People are kept safe, and their health and welfare needs are met, by staff who are fit for the job and have the right qualifications, skills and experience.
14	**Staffing** People are kept safe, and their health and welfare needs are met, because there are sufficient numbers of the right staff.
15	**Supporting workers** People are kept safe, and their health and welfare needs are met, because staff are competent to carry out their work and are properly trained, supervised and appraised.
16	**Cooperating with other providers** People receive safe and coordinated care when they move between providers or receive care from more than one provider.
17	**Requirements where the service provider is an individual or partnership** People have their needs met because services are provided by people who are of good character, fit for their role, and have the necessary qualifications, skills and experience.
18	**Requirement where the service provider is a body other than a partnership** People have their needs met because services are managed by people who are of good character, fit for their role, and have the necessary qualifications, skills and experience.

19	**Requirements relating to registered managers** People have their needs met because services have registered managers who are of good character, fit for their role, and have the necessary qualifications, skills and experience.
20	**Registered person: training** People have their needs met because services are led by a competent person who undertakes the appropriate training.
21	**Statement of purpose** People know that the Care Quality Commission is kept informed of the services being provided.
22	**Financial position** People can be confident that the provider has the financial resources needed to provide safe and appropriate services.
23	**Notifications – notice of absence** People can be confident that, if the person in charge of the service is away, it will continue to be properly managed.
24	**Notifications – notice of changes** People can be confident that, if there are changes to the service, its quality and safety will not be affected.
25	**Notification of death of a person who uses services** People can be confident that deaths of people who use services are reported to CQC so that, if necessary, action can be taken.
26	**Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983** People who are detained under the Mental Health Act can be confident that important events that affect their health, welfare and safety are reported to CQC so that, if necessary, action can be taken.
27	**Notification of other incidents** People who use services can be confident that important events that affect their health, welfare and safety are reported to CQC so that, if necessary, action can be taken.

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Dignity and nutrition for older people

Review of compliance

Great Western Hospitals NHS Foundation Trust **Great Western Hospital**	
Region:	South West
Location address:	Marlborough Road, Swindon, Wiltshire, SN3 6BB
Type of service:	Acute Services
Publication date:	June 2011
Overview of the service:	Great Western Hospital is situated on the eastern side of Swindon, close to Junction 15 of the M4. The hospital opened in 2002 and has over 600 beds. Over 30% of the beds are provided in single rooms. A range of services are provided, including emergency care, surgery, diagnostics, paediatrics and maternity.

Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Great Western Hospital was not meeting one of the essential standards we reviewed. Improvements were needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

This review was part of a targeted inspection programme in acute NHS hospitals to assess how well older people are treated during their hospital stay. In particular, we focused on whether they were treated with dignity and respect and whether their nutritional needs were met.

How we carried out this review

We reviewed all the information that we hold about the provider. We then made an unannounced visit to the hospital. This visit took place on 12 April 2011 between 9.20am and 5.15pm. We saw two wards, called Neptune and Jupiter. Many of the patients on these wards were older people and we were told that some people had dementia. On each ward we observed how patients were being cared for, talked with people, and looked at some patient records. We spoke individually with 13 patients and six members of staff. We met with other patients, their relatives and staff during the visit.

Our inspection team was joined by a practising, experienced nurse and an 'expert by experience' - a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.

What people told us

Patients we spoke with made some very positive comments about the staff. They described staff as 'very kind', 'lovely' and as treating them 'like a friend'. We were told that staff were busy and worked hard, and some patients said that more staff were needed.

Patients told us that staff took an interest in how they were feeling. However, they had not always been asked for information which would help staff to get to know them as people, with their own likes and dislikes.

We were told about the layout of the wards, which included a number of single rooms with en-suites, and other rooms for four patients. Patients liked the privacy and the facilities that these areas provided. However, we also met patients who said that their privacy and dignity was not being respected. One person described themselves as a 'trolley patient, the fifth person in a four bedded room', as they were accommodated in an extra bed.

We heard positive comments about the choice and quality of meals. Most patients were satisfied with the meal arrangements. However, we were told about shortcomings, such as when a person got a meal that they hadn't asked for, or felt that they needed more support.

What we found about the standards we reviewed and how well Great Western Hospital was meeting them

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

- Overall, we found that improvements were needed for this essential standard.

Outcome 5: Food and drink should meet people's individual dietary needs

- Overall, we found that Great Western Hospital was meeting this essential standard but to maintain this we suggested that some improvements were made

Action we have asked the service to take

We have asked the provider to send us a report within 10 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 1:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

- Understand the care, treatment and support choices available to them.
- Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are moderate concerns

with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us

Patients made some very positive comments about how staff treated them. One person said 'staff do a wonderful job', and another told us 'the staff are marvellous, not just some, all are very good - I am happy and treated well' Patients told us that staff usually explained what they were doing; people did not always know why things were happening. One person said that things were explained to them 'up to a point' and they took a lot 'on trust'.

Patients told us how their privacy, dignity and independence were being respected, such as when staff closed the bay curtains if they were having a private conversation or receiving personal care. One patient said that they could take themselves to the toilet, but staff kept an eye on them in case they fell. We also met people who were accommodated in areas of the wards, which the trust called 'extra bed spaces'. They pointed out to us that they did not have a bay curtain and the equipment that other people had. They told us how it affected them and about the things they missed; one person said they had 'lost their dignity' and they wanted more privacy.

Patients told us that staff were good, but very busy. We heard comments from

patients such as ‘they need more staff, I need to keep waiting for help’ and ‘staff very good, attendance not – they don’t always come when you ring the bell’. Patients said that it could take a long time for staff to arrive after they used the call alarm. Not everyone knew how to operate their call alarm point, or had one for their own use.

Patients did not always know why there were in hospital, but they appreciated the attention that they received from staff. One person said staff spoke to them before assisting with washing, and asked if they wanted to get dressed and what they would like to wear. We spoke to patients who knew that staff had some information about them, but who had not been involved in the planning of their care. People said that they had not been asked about religion or their needs and preferences.

One person told us that they did not have a problem with a lack of information, and they would ask if they needed to know something. Someone else said ‘I am able to ask, so yes I am given answers. We heard from other patients that they had not been asked for feedback about the service, or been given information about the ward facilities and how to make a complaint. One person said that they were able to express concerns, but didn’t feel that these were taken on board. Some patients told us that they relied on their relatives to get them information. One relative we spoke to said that they were aware of the role of the Patient Advice and Liaison Service (PALS) in providing support and information to people.

Other evidence

The results from the Patient Environment Action Team (PEAT) assessment in 2010 showed that Great Western Hospital scored well in relation to privacy and dignity and was rated as Excellent overall. PEAT is a self-assessment that healthcare organisations use to demonstrate how well they are performing in some key areas. A survey of in-patients at the hospital in 2010 showed that performance was about the same as similar trusts. The survey results for call buttons being responded to quickly when used by patients were worse than expected.

We observed staff supporting people in both wards. The wards were busy, but the approach of staff when speaking with patients was generally respectful in tone and volume. Patients were usually addressed by their first names, with the occasional use of informal terms such as ‘my love’. We heard patients being asked by staff if they were happy for certain tasks to be carried out, such as taking a blood sample. Entries on patients’ records showed when a person had refused their medicines.

We saw that the trust’s policy on same-sex accommodation was being adhered to. This meant that men and women were accommodated separately and they had separate bathrooms. Staff closed the curtains around beds when personal care was provided. Doctors drew the curtains when they were speaking to patients. Patients had told us about the use of the ‘extra bed spaces’ and staff acknowledged that these compromised people’s privacy and dignity, particularly as there were no curtains around the beds. These patients were also being treated differently, as they did not have the use of their own televisions and patient monitoring equipment.

Patients did not have the same level of facilities and one person described their bed as being ‘at the end of the aisle’. There was a board above their bed, although this

did not show the person's name. They had a call alarm point, although one had not been provided for a patient who occupied an 'extra bed space' in another ward. One of the ward managers told us that complaints had been received from patients who occupied these spaces within the wards because they did not feel they were getting 'the whole package'.

A patient had died while we were visiting one of the wards. This ward had one patient who was accommodated in an 'extra bed space' without a curtain around it. This was significant at the time, as staff had closed the curtains around the other beds for privacy and as a mark of respect. A relatives' room was available to help people at this time.

One of the ward managers told us that they were a member of the hospital's privacy and dignity group, and the nutrition group. They told us that all staff had received training in diversity, which was mandatory and refreshed every year.
Staff had also received training in caring for people with dementia and palliative care. Jupiter ward had won the palliative care team of the year award.

We looked at a sample of patients' records. A lot of the records were kept in open trolleys in the ward corridors, which we did not think were properly secure to ensure confidentiality. We will be looking at record keeping at another review. There was little evidence of patients having contributed to their records, for example, by having a care plan which included their views. One of the staff said that they would like to have a record of people's choices and preferences, but they felt that there was no space to document this in the current paperwork. Some personal details were being recorded on a card file system; there was a space for 'religion', although this was blank on several people's records.

Staff told us about new developments on the wards. On Jupiter ward we were told about initiatives, such as 'This is Me' documentation. This was being piloted to provide a profile of patients with dementia who may not be able to communicate their views. There was also a 'productive ward' project, which was designed to increase the time that nurses spent on direct patient care.

Staff on one ward told us that they were fully staffed with good staff morale, and that temporary staff were rarely used. On the other ward, staff spoke about staff shortages and being 'very pushed for time', which they felt affected the quality of support provided to patients and how long they could spend with them. One of the staff said that it was also a cause of stress.

There were information leaflets in the ward reception areas, which covered topics such as the role of the Patient Advice and Liaison Service (PALS). There were also posters which had information about the ward managers, and people were encouraged to speak to them if they had any concerns. A patient information booklet described the hospital facilities, but the details were not specific to the wards. We were told that the booklet was to be withdrawn soon because it was out of date. It included a complaints procedure and indicated that PALS comment cards could be posted in boxes on the ward, but we did not come across these. We were also told that the patient information booklets were at people's bedsides, although we did not see any. A patient said that they were not aware of the booklet.

Our judgement
Many patients appreciate the way in which they are treated by staff and they feel that they are being respected. Staff are aware of the importance of maintaining people's privacy and dignity. However some people are being treated differently to others, and the trust is not making suitable arrangements to ensure the dignity and privacy of all patients.

Patients benefit from staff who aim to provide a service that meets people's individual and diverse needs. Systems are being developed to help with this, however a lack of information and staff time make it difficult to ensure that all patients experience this.

Patients mostly have the information that they need and there are ways in which people can comment on the hospital and the service they receive. Some patients however do not feel well informed about their individual circumstances.

Outcome 5:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

There are minor concerns
with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
Patients told us that they were usually satisfied with the meals. Some people were very positive, saying for example that the food was 'smashing', 'always hot and nicely presented', and that they were 'well catered for'. People on both wards said that they had enjoyed their lunch. We heard about some difficulties with the food generally, such as when a person found it difficult to digest. Another person said they didn't like gravy, but it always came with some dishes and was hard to remove.

We spoke to patients who said that they managed to eat their meals independently and knew what to eat and what not to eat. Some people said that they hadn't been asked about their likes and dislikes but they were usually happy with the choices on the menu cards. One person said that if they didn't like anything on the menu then staff would get them a sandwich. A number of people mentioned that they always had enough to eat and drink and that staff checked if they had had sufficient. One person told us 'I can ask for food in the night and it's not a problem for staff'. In contrast, another patient commented 'the food never fills me up' and two people said that relatives brought in the extras that they needed.

Patients chose their meals from menu cards, which included the option of having a large or small portion. We observed staff and volunteers helping people to select their choices on the menu cards for the next day's meals. One patient said that if you moved to a new ward you would be given the meal that somebody else had ordered on the day before. Staff read a list of meal choices to two people and then asked what they would like. A relative commented that this was unusual as staff

usually choose for the patients. The menu cards did not have pictures of the dishes, which could have helped some patients to make their choices.

People had the choice of a vegetarian option and we were told that all the dishes were suitable for diabetic diets. One person commented 'I am diabetic and am catered for well. I am able to ask for and will receive snacks if I need them'. Someone else said that they did not require assistance, but staff monitored them because they were diabetic. We observed one patient being asked if they would like help with completing their menu card. They replied that they would like to do this in their own time, which they were able to do. The patient pointed out that their card did not have a 'diabetic' sticker, and was told that it did not need one as all the dishes were suitable for a diabetic diet. The patient told us that the sticker was needed, as it showed that they were to be brought a sandwich later in the evening. We spoke to staff, who confirmed this to be the case, and the matter was resolved.

Patients were being helped by relatives with their lunch meals. One relative said that they had sometimes seen lunch being left on a tray away from the patient, where it could not be easily reached. Before our visit, another relative had told us about a concern that they had raised with the hospital. This involved a lack of support for a patient, and wards having poor information about the person's needs. We spoke to one person on Neptune ward who told us that information about their diet had not transferred across from the previous ward that they had been on.

Staff told us about the action that had been taken as a result of complaints and feedback from people. This had included making changes to help ensure that the meals would be hotter when they were given to patients. Staff on one ward told us that sometimes the people at the end of the wards got food that was not as hot as it could be.

Other evidence

The results from the PEAT assessment in 2010 showed that Great Western Hospital scored well for food and was rated as Excellent overall. The hospital did particularly well in relation to areas such as the choice and quality of food, but performed less well in its operation of a protected mealtime policy. This policy seeks to ensure that mealtimes are uninterrupted by things such as doctors' ward rounds, tests or visiting. While observing lunch on one ward we saw that this policy was still not being adhered to, and doctors were doing their rounds and talking to patients. Staff told us that some doctors did not respect the policy. We also saw a nurse being distracted while carrying out a medicines round and they left the medicines trolley unattended for a few minutes when helping a patient with their meal.

The survey of in-patients at the hospital in 2010 had not identified any particular concerns about the food. We saw that there were plenty of staff available at lunchtime to serve the meals, which were taken to people individually on trays. Some people had chosen to have three courses. During lunch we saw examples of staff being attentive to patients' needs and encouraging people to eat. Staff talked to patients about the food and explained what they were doing. Staff were mainly well positioned to assist people with eating. However, we did see a volunteer sitting on a patient's bed whilst helping them with eating their meal. Some patients ate

independently, but had help from staff to open packets.

A ‘red tray’ system was being used to identify people who needed support with eating. Staff told us that a ‘red jug’ system was being used to assist with fluid intake, but we did not see evidence of this. We heard about other initiatives, such as ‘comfort procedures’, which involved staff checking that all patients were well positioned and ready to have their meal served. Place mats with printed information were being used on Jupiter ward, which helped patients to prepare for their meals.

Staff said that a screening tool was being used to identify patients who were at risk of malnutrition, and we saw evidence of this on patients’ records. The trust told us that, although the tool was being increasingly used, this was inconsistent across the hospital. We will be looking at the assessment of people’s needs at another review. The trust told us that as the use of the tool had increased, more people were being referred to the dietitian, which had had an impact on resources.

Basic information about patients’ needs was being written on handover sheets and on white boards in the wards. We saw that some people’s food and fluid intake was being recorded each day. The trust has produced a lot of information about nutrition, diet, menus, and the support that patients can expect to receive. However, this information, together with information from the screening tool, and from patients themselves, had not been used to develop nutritional care plans for people. This meant that there was a lack of clear guidance about patients’ individual requirements and how staff were to assist people.

The trust told us that an increasing number of complaints were being received with a nutrition component, including a lack of support with meals. The trust had identified a number of actions that needed to be taken to improve outcomes for people. This included, for example, further training for staff and better nutritional screening.

Our judgement
People at risk of poor nutrition are more likely to be identified as the use of a screening tool has increased. However this is inconsistent across the hospital. Staff focus their support on people who are believed to be at risk, and monitor their food and fluid intake. Nutritional care plans are not being developed, and there are shortcomings which affect the quality of service that patients receive. The trust is looking at its own performance and has identified areas that need to be addressed.

Feedback from patients’ surveys has been positive overall. There are aspects of the meal arrangements that are not always to patients’ liking, but most people are satisfied with the choice and quality of meals.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury	14	5
	Why we have concerns: People at risk of poor nutrition are more likely to be identified as the use of a screening tool has increased. However this is inconsistent across the hospital. Staff focus their support on people who are believed to be at risk, and monitor their food and fluid intake. Nutritional care plans are not being developed, and there are shortcomings which affect the quality of service that patients receive. The trust is looking at its own performance and has identified areas that need to be addressed. Feedback from patients' surveys has been positive overall. There are aspects of the meal arrangements that are not always to patients' liking, but most people are satisfied with the choice and quality of meals.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent within ten days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury	17	1
	How the regulation is not being met: Many patients appreciate the way in which they are treated by staff and they feel that they are being respected. Staff are aware of the importance of maintaining people's privacy and dignity. However some people are being treated differently to others, and the trust is not making suitable arrangements to ensure the dignity and privacy of all patients. Patients benefit from staff who aim to provide a service that meets people's individual and diverse needs. Systems are being developed to help with this, however a lack of information and staff time make it difficult to ensure that all patients experience this. Patients mostly have the information that they need and there are ways in which people can comment on the hospital and the service they receive. Some patients however do not feel well informed about their individual circumstances.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within ten days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Dignity and nutrition reviews of compliance

The Secretary of State for Health proposed a review of the quality of care for older people in the NHS, to be delivered by CQC. A targeted inspection programme has been developed to take place in acute NHS hospitals, assessing how well older people are treated during their hospital stay. In particular, we focus on whether they are treated with dignity and respect and whether their nutritional needs are met. The inspection teams are led by CQC inspectors joined by a practising, experienced nurse. The inspection team also includes an 'expert by experience' – a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.

This review involves the inspection of selected wards in 100 acute NHS hospitals. We have chosen the hospitals to visit partly on a risk assessment using the information we already hold on organisations. Some trusts have also been selected at random.

The inspection programme follows the existing CQC methods and systems for compliance reviews of organisations using specific interview and observation tools. These have been developed to gain an in-depth understanding of how care is delivered to patients during their hospital stay. The reviews focus on two main outcomes of the essential standards of quality and safety:

- Outcome 1 - Respecting and involving people who use the services
- Outcome 5 - Meeting nutritional needs.

Information for the reader

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Work Programme and Future Agendas

At each Health Scrutiny Panel the work programme for the Panel will be updated and included on the agenda. It will include schemes and executive reports that the Health Scrutiny Panel have decided to scrutinise.

The table below sets out the items likely to be on the future agendas for the Scrutiny Panel in 2011 (as known at present). The following page gives the Work Programme, as carried over from last year.

Proposed items for future agendas
• Review into the Care Quality Commission report on Dignity and Nutrition – Hospitals • Update on the Health and Wellbeing Board • Update on the Health Service in West Berkshire • Progress post Six Lives report • Protection, Safety & Welfare of people who use West Berkshire Council services

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Subject/purpose (b)	Methodology (c)	Expected outcome (d)	Dates (f)	Lead Officer(s)/ Service Area (g)	Portfolio Holder(s) (h)	Comments (h)
Delayed discharges from hospital To determine the causes of delayed discharges from hospitals affecting West	In meeting review with information supplied by, and questioning of, lead officers.	Investigate ways to improve the current system, and improve patient experience.	Start: TBC End:	Chief Executive of the Royal Berkshire NHS Trust & Bev Searle - NHS Berkshire West. Royal Berkshire NHS Trust & NHS Berkshire West	Cllr Joe Mooney	
Anti-Child Poverty Strategy	To monitor the strategy	This item is to be monitored, and reviewed when necessary	Start: Ongoing End: April 2012	Julia Waldman	Cllr Joe Mooney	

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