Inquiry into clinical governance

Age Scotland welcomes the Health and Sport Committee's call for views on clinical governance and the opportunity to respond. We are content for this submission to be published.

Introduction

Age Scotland supports the underlying principles of clinical governance, that professionals recognise not only the importance of delivering quality services but also their personal responsibility and joint ownership for making it happen. In a vast organisation like the NHS, it can be susceptible to operational inefficiencies which obstruct effective care. Evidence suggests that older patients in particular can be exposed to sub-optimal levels of care.\(^1\) There are also – thankfully rare – cases of egregious failures leading to crises of poor quality care, such as in Mid Staffordshire NHS Trust\(^2\) and at Winterbourne View hospital.\(^3\)

Age Scotland’s direct involvement in this field has focused on highlighting the particular needs of older patients to inform quality improvement, and helping to inform sufficiently robust standards and improved quality of care. We do not provide services within or related to the NHS; we are therefore able to address some of the Committee’s questions more fully than others.

Older people are the **most frequent users** of health and care services,\(^1\) and this factor is likely to intensify. Older patients also deserve special consideration for two broad reasons. Firstly, the **physiology** of ageing imposes some physical limitations on us and deprives us of certain resources which are helpful for keeping us healthy. Older people are more susceptible to falls, immobility, incontinence, frailty, cerebrovascular conditions such as stroke, and cognitive impairments. They are more likely to have multiple pathologies which interact in complex ways, and are more prone to adverse drug reactions. Ageing bodies are less resilient and slower to recover, partly because the immune system becomes weaker and slower. Accordingly, geriatrics has become not only a speciality in medicine but one of the most sophisticated.

There are also important **demographic** impacts. The NHS has played a significant role in extending longevity. Effective treatments and the availability of new technologies and medicines have reduced the incidence, severity and lethality of acute conditions and potentially fatal diseases. People are living longer on average; this also means far more older people exist in our society. Chronic and degenerative conditions, more common in later life, have become more common than diseases of infancy and childhood. These are also more complex, require more prolonged treatment, and are more likely to deteriorate than improve. This trend is a symptom of the NHS’s earlier successes but complicates the provision of timely and effective care.
However, many people respond positively to the changes of ageing and do not consider themselves to be either sick or vulnerable. Ageing may be inevitable but declining health is not. We must also avoid demographic alarmism. Most people aged over 65 are not only fit and healthy, they are notably fitter and healthier than 65-year olds were a generation ago, and they in turn were fitter and healthier than the generation before at the same age. Serious disease and intensive treatment remain compressed into a relatively short period towards the end of life: this remains true whenever it occurs. To assume, therefore, that health costs will rise proportionately with greater numbers of older people, as many do, is simplistic, misleading and plainly wrong. Moreover, repeated discussion of the “burden” which older people impose on others and society at large does little to dispel the risks of age discrimination or to maintain the sense of self-worth which plays a vital role in maintaining good mental health.

1. **Are services safe, effective, and evidence-based?**

There seems little doubt that initiatives within the Scottish Patient Safety Programme have caused significant improvements in the NHS’s record on reducing patient mortality and harm. For older patients, large parts of this will focus on reducing incidences of falls, pressure ulcers, sepsis and UTIs, reducing HAIs, safe use of medicines and preventing and managing depression.

For older people, safety and effectiveness depends upon a sufficiently broad understanding of their needs. There is now widespread recognition that multi-disciplinary teams with specialist knowledge are needed so older people can obtain the best possible treatment. The specialisms which need to be addressed include recognising the occurrence and implications of frailty, delirium, falls and fractures, incontinence, immobility, dementia, depression, and the need for effective nutrition and hydration. These affect both medical and nursing care disciplines.

Addressing all of these issues requires many factors, including a culture of improvement, strong leadership, robust and clear standards, professional qualities in sufficient measure, appropriate planning and delivery of services and an organisation which enables this, systematic monitoring, inspection and audit, and a sound change management approach. It touches practices such as workforce development, information flow and, most importantly, patient-centred care.

Because of the health risks commonly associated with age, especially among frail older people, older patients in appropriate circumstances or with sufficiently complex presenting needs should now be offered a Comprehensive Geriatric Assessment (CGA). This should offer a rounded plan for not only hospital treatment but also rehabilitation, discharge, and follow-up support.

Progress has especially been made on both the frailty and delirium fronts by the National Workstream on Improving Older Persons’ Acute Care (OPAC) and the team leading this work, who are based within Healthcare Improvement Scotland. They have developed toolkits on frailty and delirium which promote good practice in recognising and responding to these factors.

Age Scotland was pleased to be part of the project group which produced revised Standards of Care for Older People in Hospital in July 2015. These placed much greater prominence than their previous iteration on patient-centred care, including personalisation, dignity and privacy, and involvement in decision-making about care. We welcomed this change and are seeking to ensure that these factors receive similar acknowledgement and protection in other settings.
2. Are patient and service users’ perspectives taken into account in the planning and delivery of services?

The perspectives of patients and service users certainly should be taken into account, but there remains little evidence that it is routinely and systematically happening at the planning level.

Most fundamentally, Age Scotland is concerned that individuals must be involved in decisions about their own care and treatment. Valid and relevant consent to treatment is the starting point, though the law allows some treatments without consent (e.g. emergency life-saving interventions, or where the patient is unconscious, perhaps while under anaesthetic) where it is in the patient’s best interests. The need for consent also depends upon the patient’s capacity to understand the benefits, risks and alternatives and can both make and communicate a decision. However, we are concerned that there may be instances where a patient’s capacity is impaired but not completely absent, yet consent decisions are removed from them. Impaired capacity may be a consequence of many conditions which are age-related or more prevalent in later life, including mental illness, shock, panic, severe fatigue, reactions to medication, delirium, mild cognitive impairment, or a transient ischaemic attack (TIA). In practice, the views of family members especially next-of-kin can be sought. But determining whether a patient has full capacity can be a complex and finely balanced process requiring specialist psychological skills. If these are not readily available, medical staff on a busy ward may look for consent from the nearest competent relative as a path of least resistance. This is why we welcome this principle featuring prominently in the revised Standards for Care of Older People in Hospital.

Similarly, we hope the Committee’s inquiry will address advance decision-making, including end-of-life care. Patients should be asked in advance about their wishes for further treatment if they may be unable to respond to consent-to-treatment requests. This would include willingness to undergo cardio-pulmonary resuscitation (CPR), assisted ventilation, artificial feeding, dialysis, and other support necessary to sustain life. This may be especially relevant in situations of heightened risk of adverse reactions to surgery or difficulties in recovering. Clearly broaching these subjects is highly sensitive, and dignity and respect matter.

3. Do services treat people with dignity and respect?

Older people have told us that, after safe, effective and timely care, being treated with respect and dignity is their chief concern in relation to hospital treatment. Members of the public have a significant disadvantage compared to professionals in understanding the diagnoses of and prognoses for medical complaints and conditions. However, they are – and should be acknowledged as – experts in how they feel, in terms of their symptoms, their reaction to treatments, but also crucially their experience of care.

Although there appears to be broad recognition among professionals that respect and dignity are important aspects of healthcare, there is sometimes less certainty about what it means in practice, and particularly how it might be monitored, inspected and evaluated. To this end, Professor Mike Nolan and colleagues developed what has become known as the Nolan Senses Framework, which identifies six aspects of personal worth which can be secured and enhanced by relationship-based medicine. These are:
• **security** – feeling safe
• **belonging** – feeling part of things
• **continuity** – experiencing links and connection
• **purpose** – having a goal(s) to aspire to
• **achievement** – making progress towards these goals; and
• **significance** – feeling that you matter as a person

Notably, the Senses Framework does not specifically link personal worth to **autonomy or independence**, although this has been repeatedly identified as a policy goal in relation to older people and an intended outcome of health services. Professor Nolan has written that this may not be a possible or even a desirable outcome for some patients. Indeed, to the extent that this glorifies self-reliance, such an explicit goal might dishearten people for whom a cure is not possible and worsen their mood and outlook. For such people, especially those with terminal or degenerative conditions which cannot be managed at home, appropriate medical goals include the alleviation of symptoms (especially pain), and the maintenance of quality of life, so far as is possible. However, recognition that the patient is the expert in terms of how they feel has led to growing understanding that positive outcomes will be personal to the individual. Medical professionals must therefore seek to understand “what matters to me” (i.e. the patient), and strive to accord with those wishes and preferences. We recommend wider use of the Framework.

These aspects, together with the examples of Mid-Staffordshire and Winterbourne View noted above, encouraged the Care Quality Commission (CQC) in England and Wales to begin thematic inspections of hospitals which specifically covered dignity and privacy. Examples of the issues identified include whether older patients were able to reach food and fluids and emergency call buttons without assistance (especially overnight for inpatients), whether adequate protection of privacy is in place (e.g. by use of curtains around ward beds, adequate body covering when being moved or using the toilet), whether confidential patient information is shared or discussed by staff where others could hear it, and even the forms of address and tone and language used by nursing staff.

### 4. Are staff and the public confident about the safety and quality of NHS services?

The 33rd British Social Attitudes survey concluded that older people have higher levels of confidence in the NHS than those aged in their 40s and 50s. The most commonly cited reason for a positive view of the NHS is the quality of care that is offered, closely followed by the fact that NHS services are available according to need and care is free at the point of use. We can surmise that, since older people are in more frequent receipt of NHS services, the quality of care they receive is likely to be a key driver of their opinion of it.

Nonetheless, the numbers of older people receiving NHS treatment, the complexity of older people's physiology, and the stronger likelihood of their experiencing comorbidities means that ensuring an appropriate standard of care for older patients has a disproportionate impact on overall performance and yet is more difficult to achieve than for many other patients.
5. **Do quality of care, effectiveness and efficiency drive decision making in the NHS?**

Age Scotland is less well-equipped to answer this question, since it depends on a greater level of inside knowledge. However, we would query whether this is precisely the right question to ask. Efficiency is a legitimate and necessary ambition, but in our view the most effective approach would be for the NHS (together with other health and care services) to prioritise the overall wellbeing of the individual, and not simply treating ailments and conditions. Such an approach would encompass aspects of wellness such as the lifestyle factors which most influence wellbeing, namely a balanced diet, limiting alcohol intake, refraining from smoking and (most importantly for older people) regular exercise and an active life. It would also promote self-management of conditions, and robust social health – i.e. having a sense of belonging and connectedness, and avoiding loneliness and isolation which are devastating for good health. These should be key tests of the success of integrated services.

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2. See the 2013 final report of the public inquiry (the “Francis Report”) at [www.midstaffspublicinquiry.com](http://www.midstaffspublicinquiry.com).
4. See, for example, Chapter 6, “The Health Time Bomb”, in *The Imaginary Time Bomb: why an ageing population is not a social problem*, Phil Mullan (2000).
7. BEd, MA, MSc, PhD RGN, RMN, Professor of Gerontological Nursing, The School of Nursing & Midwifery, University of Sheffield. See [www.sheffield.ac.uk/snm/staff/1.231866](http://www.sheffield.ac.uk/snm/staff/1.231866).
10. See [www.bsa.natcen.ac.uk/media/39062/bsa33_nhs.pdf](http://www.bsa.natcen.ac.uk/media/39062/bsa33_nhs.pdf).