ADULT SERVICES COMMITTEE AGENDA

HARTLEPOOL BOROUGH COUNCIL

Monday 9 March 2015

at 10.00 am

in Committee Room B, Civic Centre, Hartlepool

MEMBERS: ADULT SERVICES COMMITTEE

Councillors Beck, Lilley, Loynes, Richardson, Sirs, Springer and Thomas

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 To receive the Minutes and Decision Record in respect of the meeting held on 9 February 2015 *(for information as previously circulated)*.

4. **BUDGET AND POLICY FRAMEWORK ITEMS**

   4.1 Council Plan 2015/16 – Child and Adult Department Proposals – *Director of Child and Adult Services*

5. **KEY DECISIONS**

   No items.

6. **OTHER ITEMS REQUIRING DECISION**

6.1 Joint Mental Health Implementation Plan and Mental Health Update – *Director of Child and Adult Services*

7. **ITEMS FOR INFORMATION**

7.1 Hartlepool Local Executive Group – Adult Safeguarding Statistics and Progress Report for the period April-December 2014 – *Director of Child and Adult Services*

7.2 Implementation of the Care Act – *Director of Child and Adult Services*

7.3 Moving Forward Together – The Vision for Adult Services in Hartlepool 2014-17 – *Director of Child and Adult Services*

7.4 Support for People with Dementia in Hartlepool – *Director of Child and Adult Services*

7.5 Update on Domiciliary Care Services in Response to Recommendations by Healthwatch Hartlepool – *Director of Child and Adult Services*

7.6 Winter Update – *Director of Child and Adult Services*

8. **ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT**

ITEMS FOR INFORMATION

Date of next meeting – to be arranged.

ADULT SERVICES COMMITTEE

MINUTES AND DECISION RECORD

9 FEBRUARY 2015

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool.

Present:

Councillor: Carl Richardson (In the Chair)

Councillors: Paul Beck, Geoff Lilley, Brenda Loynes, George Springer and Stephen Thomas.

Frank Harrison, Years Ahead Forum.
Maureen Lockwood, Hartlepool HealthWatch
Public: E Leck and S Little.

Officers: Jill Harrison, Assistant Director, Adult Services
David Ward, Head of Finance (Child, Adult Services and Public Health)
David Cosgrove, Democratic Services Team

56. Apologies for Absence

Councillor Sirs.

57. Declarations of Interest

Councillor Thomas declared a prejudicial interest in Minute No. 59 and left the meeting during consideration of the Capital Budget element of the report.
Councillor Thomas declared a personal interest in Minute No. 60.

58. Minutes of the meeting held on 5 January, 2015

Confirmed.

59. Strategic Financial Management Report – As at 31st December 2014 (*Director of Child and Adult Services & Chief Finance Officer*)

Type of decision

None – for information only.

Purpose of report

The purpose of the report is to inform Members of the 2014/15 Forecast General Fund Outturn, 2014/15 Capital Programme Monitoring and provide details for the specific budget areas that this Committee is responsible for.

Issue(s) for consideration

The Head of Finance reported that the latest report showing the overall Council position submitted to the Finance and Policy Committee on 30th January 2015 advised Members that there would be an overall underspend in the current year. The report on the position at 31st December 2014 advised Members that there is currently a net forecast budget under spend at the year-end of £188,000, which equated to 0.2% of the net annual budget. This position is still dependant on the outturn for seasonal budgets, such as winter maintenance and elderly care services.

The position in relation to Adult Services was also reported. The unbudgeted costs relating to Deprivation of Liberty Safeguards (DoLS) remain a budget pressure. These costs would be funded from a combination of the 2014/15 Adult Services managed budget underspend and the use of departmental reserves. Three specific Adult Services reserves were being created. Two related to specific grants received from the CCG (towards winter pressures) and the Department of Health (remaining balance of the Care Act Implementation Grant) and the other related to the creation of a 'contingency' reserve for Direct Payments that were monitored and managed on behalf of relevant clients by an external provider. This funding had been returned following a change in provider and would be retained by the authority to fund costs arising in addition to these clients regular Direct Payment provision such as redundancy and sickness cover.

(Councillor Thomas left the meeting at this point.)

Expenditure against the Capital Budget to the 30th November 2014 was also reported. Projected spend mainly related to the development of the Centre for Independent Living in 2015/16. It was highlighted that the capital programme reflected a new Department of Health grant called 'Autism Innovation Capital Grant'. This was a one-off, non-recurring grant allocation of £18,500 which had been received during this financial year. Although the grant was technically not ring-fenced there were a number of grant conditions which needed to be complied with including the grant needing to be spent before the end of March 2015. The grant would be awarded to 'Incontrol-able', a disabled persons user-led organisation based in Hartlepool. It would be spent against the principles

of the Autism Act 2009 and would be used to purchase ICT equipment including tablets and laptops for use at the Centre for Independent Living which would be pre-loaded with autism related information, advice and guidance.

The Head of Finance highlighted that at present the budget for the commissioning of services for older people was significantly over-spent. This is partly offset in the current financial year by one-off funding (such as Care Act implementation funding and the Better Care Fund) but it's expected to be a significant pressure in future years.

Members were concerned that this winter had not, to date, been particularly hard and therefore services may come under greater pressure in future years. Members questioned if specific reserves were being created now to address this issue. The Assistant Director stated that measures were being put in place as far as was possible.

Decision

That the report be noted.

60. Independent Living Fund – Transfer of Funding 2015/16 (*Director of Child and Adult Services*)

Type of decision

None – for information only.

Purpose of report

The purpose of the report was to provide the Adult Services Committee with information regarding the transfer of funding and responsibilities relating to the Independent Living Fund (ILF).

Issue(s) for consideration

The Assistant Director reported that the Independent Living Fund (ILF) had originally been established in 1988 and provided financial support to disabled people so they could choose to live in their communities rather than in residential care. It was a directly funded government scheme which provided discretionary cash payments directly to disabled people to allow them to purchase care from an agency or pay the wages of a privately employed personal assistant.

To qualify for help from the ILF an individual would normally have to continue to fulfill a series of conditions, to which an additional eligibility

criteria was introduced from May 2010 restricting applications to those in work. The Assistant Director reported that currently there were 42 individuals in Hartlepool receiving ILF. All had been met by officers and the changes to the fund explained to them.

From 1 July 2015, all local authorities would receive a Section 31 non-ringfenced grant (pro-rata for 9 months of the financial year) which would be paid as one lump-sum by the Department for Communities and Local Government (DCLG) in June / July 2015. The amount to be transferred would be calculated by the DCLG based on the number of users as at 30 June 2015 and the amount of ILF funding they received as at that date. The 42 people currently in receipt of ILF in Hartlepool received a total of approximately £0.67m of funding (net of any contributions).

As the ILF was no longer open to new users this number cannot increase and would reduce over time owing to mortality, people requiring residential care or their needs changing so that they become eligible for fully funded NHS Continuing Health Care. No additional funding would be received for administration costs and there would be no claw back of unspent funds, nor would any additional funding be allocated for any overspends.

Members sought assurance that the best value for money was being obtained by the 42 recipients of the fund for the services they purchased. The Assistant Director stated that as a minimum there was an annual review of care and support packages. All of the individuals were known to the authority and received regular reviews of the other support they received.

Members expressed their concern at the changes made to the ILF, particularly as highlighted by the Assistant Director, if the fund was 'mainstreamed'. This was a further change in funding for services for the most vulnerable that was pushing services back decades to the detriment of those service users and their communities.

Decision

(i) That the Committee notes that ILF grant funding received in 2015/16 will be used to maintain the level of funding provided to individuals on 30 June 2015.

(ii) That the Committee notes that ILF contributions will remain unchanged for 2015/16 whilst a review is undertaken.

(iii) That the Committee notes the uncertainty in relation to funding in 2016/17 and beyond.

61. Hear My Voice – Inclusion North Event, 27 March 2015 – Verbal Update (*Head of Service, Child and Adult Services*)

Type of decision

None – for information only.

Purpose of report

To inform the Committee of the Hear My Voice event on 27 March, 2015.

Issue(s) for consideration

The Assistant Director, Adult Services reported that the Houses of Parliament Parliamentary Outreach Team was holding an event in Hartlepool at the Civic Centre on 27 March 2015 to encourage people with a learning disability to vote in the forthcoming election through an explanation of what parliament does and assisting in the process to register to vote.

Members commented that circulation of the details of the event should be undertaken to all relevant groups to ensure as good a response to the event as possible. The Assistant Director indicated that details had already been shared with the Learning Disabilities Board and would be circulated to all relevant groups as suggested.

Decision

That the report be noted.

62. Any Other Items which the Chairman Considers are Urgent

None.

The meeting concluded at 10.35 am

P J DEVLIN

CHIEF SOLICITOR

PUBLICATION DATE: 13 FEBRUARY 2015

ADULT SERVICES COMMITTEE

9th March 2015

Report of: Director of Child and Adult Services

Subject: COUNCIL PLAN 2015/16 – CHILD AND ADULT DEPARTMENT PROPOSALS

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 Budget and Policy Framework

2. PURPOSE OF REPORT

2.1 To provide an opportunity for the Adult Services Committee to consider the Child and Adult Services Department's proposals for inclusion in the 2015/16 Council Plan that fall under the remit of the Committee.

3. BACKGROUND

3.1 A review of the Outcome Framework was undertaken as part of the 2014/15 service planning process. Some minor changes have been made to the Framework for 2015/16 which were reported and agreed by Finance and Policy Committee on 13 October 2014.

3.2 As in previous years, detailed proposals are being considered by each of the Policy Committees throughout February and March in respect of their areas of responsibility. A further report will be prepared for Finance and Policy Committee on 23 March detailing the comments/observations of each of the Committees along with a full draft of the 2015/16 Council Plan.

3.3 The Council Plan will then be presented to Council for agreement on 26 March. It is proposed that any additional updates or changes agreed by the Finance and Policy Committee on 23 of March will be noted when the report is presented to Full Council.

4. PROPOSALS

4.1 The Director of Child and Adult Services will deliver a short presentation at the meeting detailing the key challenges that the Council faces over the next few years and setting out the proposals from the Child and Adult Services Department for how these will be addressed.

4.2 The main focus of the presentation will be on the outcomes that have been included in the Outcome Framework within the Child and Adult Services Department and how these will be delivered in 2015/16.

4.3 The Outcome within the Child and Adult Services department that falls under the remit of the Adult Services Committee is:

- Vulnerable adults are supported and safeguarded and people are able to maintain maximum independence while exercising choice and control about how their outcomes are achieved.

4.5 **Appendix A** provides detail on the proposed actions identified by the Child and Adult Services Department to deliver the outcome that falls under the remit of the Adult Services Committee. Performance Indicators (PIs) that will be monitored throughout the year in order to measure progress are also included in the appendix alongside a number of key risks.

5. NEXT STEPS

5.1 The remainder of the Council Plan proposals will have already been discussed at the relevant Committees. Comments and observations from those Committees will be added to those received at today's meeting and included in the overall presentation of the final draft of the Council Plan to Finance and Policy Committee on 23 March 2015, before being taken for formal agreement by Council at its meeting on 26 March 2015.

5.2 Progress towards achieving the actions and targets included in the Council Plan will be monitored throughout 2015/16 by officers across the Council and progress reported quarterly to Elected Members through reports to Finance & Policy Committee.

6. RECOMMENDATIONS

6.1 It is recommended that the Adult Services Committee: -

- considers the proposed outcome template (Appendix A) for inclusion in the 2015/16 Council Plan;

- formulates any comments and observations to be included in the overall presentation to the meeting of the Finance and Policy Committee on 23 March 2014.

7. REASONS FOR RECOMMENDATIONS

7.1 The Adult Services Committee has responsibility for Performance Management of issues within the Child and Adult Services Department in the Council Plan.

8. CONTACT OFFICER

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Appendix A - 2015-16 Service Planning for Adult Social Care

SECTION 1 OUTCOME DETAILS			
Outcome:	12. Vulnerable adults are supported and safeguarded and people are able to maintain maximum independence while exercising choice and control about how their outcomes are achieved.	**Theme:**	Health and Wellbeing

Lead Dept:	Child and Adult Services	**Other Contributors:**	

SECTION 2 ACTIONS			
Action		**Due Date**	**Assignee**
CAD 2015-16 HW XX (was HW11)	Establish integrated health and social care pathways / services that facilitate people living in their own homes, avoid unnecessary admissions to hospital and enable timely and safe hospital discharges, through implementation of the Better Care Fund (BCF) plan.	March 2016	Jill Harrison
CAD 2015-16 HW12	Deliver reablement services that enable people to maximise their abilities and develop the skills and capacity to retain their independence for as long as possible.	March 2016	John Lovatt
CAD 2015-16 HW XX (was HW13)	Implement the 2015-16 requirements of the Care Act and prepare for the 2016-17 requirements.	March 2016	Jill Harrison
CAD 2015-16 HWXX (was HW14)	Implement 'Making Safeguarding Personal' and ensure that local arrangements for safeguarding are compliant with the Care Act.	March 2016	John Lovatt
CAD 2015-16 HW New1	Implement the actions identified by the Mental Health Peer Review to improve Mental Health services for the people of Hartlepool.	March 2016	Neil Harrison
CAD 2015-16 HW New2	Build community capacity and low level support services that increase choice and reduce social isolation.	March 2016	Jeanette Willis
CAD 2015-16 HW New3	Improve pathways and services to meet the needs of individuals with dementia and their families / carers.	March 2016	Jeanette Willis
CAD 2015-16 HW New4	Develop an independent living centre that improves outcomes for adults with a disability and / or long term condition.	March 2016	Neil Harrison
CAD 2015-16 HW New5	Ensure that people with learning disabilities receive good quality, outcome focused care and support, including those covered under the Winterbourne View Concordat recommendations.	March 2016	Neil Harrison
CAD 2015-16 HW New6	Review systems, learn lessons from surveys and complaints and develop the workforce to ensure that staff are supported and working safely and effectively.	March 2016	Sarah Ward

SECTION 3 PERFORMANCE INDICATORS & TARGETS								
Code	**Performance Indicator**	**Assignee**	**Targeted or Monitor**	**Collection Period (e.g. Fin/Acd)**	**Freq**	**Targets**		
						14/15	**15/16**	**16/17**
ASCOF 1C-1 (Was NI 130b)	Social care clients receiving Self Directed Support	Sarah Ward	Targeted	Financial Year	Qtr	90%	95%	95%
ASCOF 2C-2 (Was NI 131)	Delayed Transfers of Care (attributable to social care)	John Lovatt	Targeted	Financial Year	Qtr	0	0	0
NI 135	Carers receiving needs assessment or review and a specific carer's service, or advice and information	Jeanette Willis	Targeted	Financial Year	Qtr	40%	40%	40%
P051	Access to equipment and telecare: users with telecare equipment	Neil Harrison	Targeted	Financial Year	Qtr	1500	1600	1650
ASCOF 2A-2 (was P066)	Permanent Admissions to residential care – age 65+	John Lovatt	Targeted	Financial Year	Qtr	900.0	823.9	807.8
P072	Clients receiving a review	John Lovatt	Targeted	Financial Year	Qtr	75%	75%	75%
P087	% of reablement goals (user perspective) met by the end of a reablement package/episode (in the period)	John Lovatt	Targeted	Financial Year	Qtr	70%	70%	70%
ASCOF 2B-1 (was NI 125)	Achieving independence for older people through rehabilitation/intermediate care (at home after 91 days))	John Lovatt	Targeted	Financial Year	Qtr	87.7%	89.2%	N/A

SECTION 4 RISKS		
Code	**Risk**	**Assignee**
CAD R034	Insufficient capacity in the independent sector to meet placement demand within adult social care (particularly in relation to nursing provision) which could lead to an increase in out of borough placements. (Actively Managed)	Jeanette Willis
CAD R035	Increased demand on adult social care services due to demographic and financial pressures, and changes within partner organisations. (Actively Managed)	Jill Harrison
CAD R038	Failure to provide statutory services to safeguard vulnerable adults. (Actively Managed)	John Lovatt
CAD R043	Delayed transfers of care from hospital due to reduced capacity and changing working arrangements for hospital discharge. (Actively Managed)	John Lovatt
CAD R060	Failure to work effectively with partners to deliver integrated health and social care services through the Better Care Fund. (Actively Managed)	Jill Harrison
CAD R061	Increased demand on Adult Social Care Deprivation of Liberty Safeguards (DOLS) due to the national implications of the Cheshire West ruling and subsequent increased activity, expenditure & risk. (Actively Managed)	John Lovatt

ADULT SERVICES COMMITTEE

9 March 2015

Report of: Director of Child & Adult Services

Subject: JOINT MENTAL HEALTH IMPLEMENTATION PLAN & MENTAL HEALTH UPDATE

1. TYPE OF DECISION/APPLICABLE CATEGORY

Non key decision.

2. PURPOSE OF REPORT

2.1 To seek approval from the Adult Services Committee for the Joint Mental Health Implementation Plan.

2.2 To request that the Adult Services Committee refers the Joint Mental Health Implementation Plan to the Hartlepool Health and Wellbeing Board and Hartlepool and Stockton on Tees Clinical Commissioning Group (CCG) for approval and monitoring of the action plan.

2.3 To provide an update on a number of key reviews of mental health services.

3. BACKGROUND

3.1 A number of key framework documents have been produced in recent years that relate to mental health services. These documents aim to support improvements in mental health across all sectors and are heavily influenced by social inclusion perspectives.

3.2 Key documents include (but are not limited to) the following:-

NHS Outcomes Framework - Improving experience of healthcare for people with mental illness

Adult Social Care Outcomes Framework – people who use services are satisfied with their care

Public Health Outcomes Framework 2013/16 – Suicide rates

No Health without Mental Health 2011 – most people will have good mental health

Closing the Gap – improved access to psychological therapies

Crisis Care Concordat 2014 – Access to support before crisis point

4. SCOPE

4.1 The Hartlepool Mental Health Forum, chaired by Hartlepool Healthwatch, aims to promote collaborative working across statutory, private and voluntary sector organisations in partnership with people who use mental health services, their carers and families

4.2 The Forum set up a task and finish group led by representatives from Hartlepool Borough Council and the CCG to support the development of a local Mental Health implementation plan.

4.3 During the summer of 2014 a Working Together for Change public engagement event was held which sought views from key organisations, people who use services, carers and commissioners.

4.4 The attached Joint Mental Health Implementation Plan for 2015-18 (see **Appendix 1**) was co-produced with the CCG. The plan incorporates the key national and local mental health outcomes and the action plan will be refreshed annually to demonstrate progress and reflect any changing national and local priorities.

5. METHODOLOGY

5.1

July 2014	Formulation of a Task & Finish Group
Sep 2014	Engagement and co-production of local plan
Oct 2014	Draft plan produced for consideration
Feb 2014	Agreement by Clinical Commissioning Group (CCG)
Mar 2015	Approval by Adult Services Committee Referral to Health & Wellbeing Board for approval and monitoring

6. PUBLIC ENGAGEMENT

6.1 As previously reported the plan was co-produced using feedback from the Working Together for Change Event in September 2014 and core members of the Hartlepool Mental Health Forum.

6.2 The Plan describes the national drivers, key deliverables and demographic pressures on the local community and uses the outcomes of the public engagement event as the basis to formulate an action plan.

7. SECTOR LED IMPROVEMENT

7.1 As part of Sector Led Improvement within the North East ADASS Region all Councils agreed to the Local Government Association (LGA) undertaking a Peer Challenge within adult social care over a three year period.

7.2 Hartlepool Borough Council's Peer Challenge took place in November 2014 and was focused on mental health services.

7.3 The Peer Challenge took place over a three day period and considered the following:

- the delivery of mental health social care services by the Council within the current partnership arrangement, to ensure that people utilising mental health services are in receipt of high quality, timely, and accessible social care.
- current achievements and any opportunities to improve the design and / or delivery of these services.
- helping the Council ensure that, wherever Social Workers are managed, the optimum infra-structure is in place to ensure that their role achieves the best possible social care outcomes for people with mental health problems.

7.4 Hartlepool Borough Council operate their adult mental health social care services under a s75 partnership agreement with Tees Esk and Wear Valleys NHS Foundation Trust (TEWV). TEWV is a large provider of acute, community and specialist mental health and learning disability services, operating over several local authority areas. In Hartlepool, social care staff have worked for 10 years in Integrated Community Mental Health Teams, managed and located within the Trust.

7.5 As part of the Peer Challenge, a team of experts from other areas of the country (including an Elected Member Peer, a Health Peer and a number of Senior Officer Peers from other local authorities) met with a range of stakeholders to discuss their experiences of services. Those interviewed included managers, frontline staff, people who user services and carers, service providers, commissioners and representatives from HealthWatch and the voluntary and community sector.

7.5 Recommendations from the review team were based on a triangulation of what they had read, seen and heard. Using existing materials, interviewing staff and using feedback from focus groups, they were able to scrutinise the delivery of mental health services focusing on the current partnership arrangements with Tees Esk & Wear Valley NHS Foundation Trust.

7.6 The review focused on 3 key themes; service delivery, working together and vision, strategy and leadership and for each area the team identified key strengths and areas for consideration as summarised below:

	Service Delivery	**Working Together**	**Vision, Strategy and Leadership**
Key Strengths	Benefits of integration recognised and supported at all levels	The importance of the HWB was recognised as a lever for change	The Mental Health Champion is passionate about improving services
	Strong performance in number of people using Direct Payments	The MH Forum and MH plan were good examples of interagency working.	The Council's committee structure allows all members to be involved in a proactive manner
	Evidence of different disciplines sharing tasks	Good multi agency development of a Mental Health Crisis Concordat Plan	There is a willingness to ensure a clear strategic direction of travel for mental health
Areas for consideration	Capacity within the teams with pressures on AMHP rotas	Ensure date is pooled to assist with planning, using data to better inform planning	Ensure mental health is woven into wider corporate and financial planning and given higher priority by HWB
	Availability of professional leadership and supervision needs to be consistent across teams	Council to consider closer working relationships across Tees to effect strategic commissioning	Recent changes in personnel represents an opportunity to clarify and streamline roles and responsibilities
	Informal communication across teams could be improved	Further work to reduce high levels of placements in long-term care	Clarify the implications of the Care Act in relation to mental health

7.6 Key recommendations include:-

- Supporting the development of the Health & Wellbeing Board and Joint Commissioning Executive as key routes for strategic and operational decision making.
- A review of existing governance and quality assurance frameworks with Tees Esk & Wear Valley NHS Foundation Trust.
- An early audit of cases and a review of compliance with the Care Act requirements.
- Reviewing the demand and capacity with the mental health teams, in particular the Approved Mental Health Practitioner (AMHP) role.

7.7 An action plan is being developed with TEWV to address the recommendations. Progress has already been made in the following areas:

- Development of the Joint Mental Health Implementation Plan to provide clear strategic direction and raise the profile of mental health issues through the Health & Wellbeing Board.
- Review of capacity within the mental health teams resulting in two additional posts being funded (one by TEWV and one by Hartlepool Borough Council using additional resources identified through the Care Act allocation to undertake additional assessments).
- An assessment of workforce development needs in relation to the Care Act being undertaken across all teams (including mental health teams).

8. CQC MENTAL HEALTH ACT MONITORIING VISIT

8.1 In December 2014 the Care Quality Commission undertook an announced visit to Tees Esk & Wear Valley NHS FT. By law, the Care Quality Commission (CQC) is required to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act. Mental Health Act Reviewers do this on behalf of CQC by interviewing detained patients or those who have their rights restricted under the Act and discussing their experience. They also talk to relatives, carers, staff, advocates and managers and review records and documents.

8.2 This visit looked at how Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) worked with other agencies, including local authorities, police and ambulance services to ensure that the right people were involved in the process; showed evidence of assessment outcome and why detention under the MHA was necessary; demonstrated adherence to the guiding principles of the MHA Code of Practice and complied with the requirements of law.

8.3 The key developments that were reviewed included:

- The closure of the section 136 suite at Sandwell Park Hospital, Hartlepool and centralisation of section 136 provision at Roseberry Park Hospital, Middleborough, where the police could take people who appeared to have mental health problems.
- The street triage team (STT) pilot in the Middlesbrough area in conjunction with Cleveland Police
- The improved working arrangements between AMHPs of all four local authorities (Hartlepool, Middlesbrough, Stockton and Redcar and Cleveland) and improved effectiveness of the emergency duty team that covers all four boroughs outside of core working times

8.4 CQC fed back that ‘the patients and carers we spoke with said that the staff had treated them with respect and courtesy. When one nearest relative recounted the circumstances of her daughter's MHA assessment to us she said that the people attending in her home “were all respectful". She also said that "the community psychiatric nurse was outstanding" in the way she had responded to her request for help by visiting them four times in the week of her daughter's admission and by visiting within an hour of her call on the day of the assessment’.

8.5 In each report CQC reviewed they saw that the AMHP had made a full record of the patient's own views and those of their nearest relative. Evidence was present of interpreters being provided when needed. While some AMHPs reported that they were concerned by the closure of some community resources, it was confirmed to CQC that a review had been undertaken which showed that none of the patients who had formerly used the services had since been admitted to hospital and no evidence was found that the hospital was being used because there were insufficient community alternatives.

8.6 Key areas for improvement for the Tees area were identified as follows:

- AMHPs were spending long periods of time attempting to locate section 12 approved doctors
- AMHPs and trust staff reported that at times they experienced long delays in accessing transportation via the ambulance service to convey the assessed service user to hospital.
- An increase in the number of service users self-presenting at the reception of Roseberry Park Hospital at night was identified as a risk.

8.7 In response to the recommendations:

- actions are already being put in place to rectify the issue regarding availability of Section 12 doctors
- additional funding has been allocated by the CCG to reduce conveyance times with the ambulance service; and
- funding has been agreed to develop additional resources to support people self-presenting at Roseberry Park.

9. CRISIS CARE CONCORDAT

9.1 The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

9.2 In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat. It focuses on four main areas:

- **Access to support before crisis point** – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- **Quality of treatment and care when in crisis** – making sure that people are treated with dignity and respect, in a therapeutic environment.
- **Recovery and staying well** – preventing future crises by making sure people are referred to appropriate services.

9.3 The Mental Health Forum and key strategic partners (including the Tees Local Authorities, Cleveland Police, Cleveland Fire Brigade, North East Ambulance Service, TEWV NHS FT and the two acute Foundation Trusts) have signed up to the principles of the Crisis Care Concordat. An action plan is being developed by March 2015 through the Tees Crisis Concordat Working Group, which will also monitor progress against the agreed actions.

10. MENTAL HEALTH ACT – REVISED CODE OF PRACTICE

10.1 A national consultation exercise has taken place on a revised Code of Practice for Mental Health.The main changes include:

- 5 new guiding principles
- new chapters on care planning, human rights, equality and health inequalities
- consideration of when to use the Mental Health Act and when to use to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and information to support victims
- new sections on physical healthcare, blanket restrictions, duties to support patients with dementia and immigration detainees
- significantly updated chapters on the appropriate use of restrictive interventions, particularly seclusion and long-term segregation, police powers and places of safety
- further guidance on how to support children and young people, those with a learning disability or autism

10.2 Work will be required to ensure professionals working under the revised Code of Practice for Mental Health are aware of the changes and remain confident practitioners. Senior managers will ensure that workforce plans are updated to reflect changes to key legislation and will monitor uptake through Continuous Professional Development.

11. RECOMMENDATIONS

11.1 It is recommended that the Adult Services Committee:

- approves the Joint Mental Health Implementation Plan.
- refers the Joint Mental Health Implementation Plan to the Health & Wellbeing Board for approval and monitoring.
- notes the outcomes of recent reviews and the actions being taken to address the recommendations.
- notes the revised Code of Practice for Mental Health.

12. REASONS FOR RECOMMENDATIONS

12.1 The Joint Mental Health Implementation Plan demonstrates joint working with strategic partners and provides evidence of local involvement, engagement and consultation in developing and shaping future service provision.

12.2 The Joint Mental Health Implementation Plan sets out shared commitment to mental health services over the next three years with clear milestones that allow progress to be monitored.

12.3 Recent reviews have identified some areas where further work is required in relation to mental health services. These recommendations will be addressed through the Joint Mental Health Implementation Plan and individual action plans linked to those reviews.

13. BACKGROUND PAPERS

https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

https://www.gov.uk/.../281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014

http://www.phoutcomes.info/

https://www.gov.uk/government/publications/the-adult-social-care-outcomes-framework-2013-to-2014

https://www.gov.uk/government/news/better-care-for-mental-health-crisis

https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice

14. CONTACT OFFICER

Neil Harrison
Head of Service
Child & Adult Services
Neil.harrison_1@hartlepool.gov.uk

Adults Services Committee – 9 March 2015

2015 - 2018

Hartlepool

Implementation Plan of the 'No Health without Mental Health' National Strategy

Developed on behalf of the Hartlepool Mental Health Forum

Draft version 6

Contents

Welcome

Acknowledgements

This plan was produced by the Mental Health Task & Finish Group which was made up of members from the Hartlepool Mental Health Forum.

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Tees, Esk & Wear Valley NHS FT
CIC
DISC
Incontrol-able
Creative Support
Connected Communities
Healthy Communities & Independent Living for Life
Hartlepool & Stockton CCG
Community Integrated Care
Hartlepool Voluntary Development Agency
MAIN
CAMHS
Hartlepool Carers
Hartlepool MIND
Lloyds Pharmacy
Hartlepool Shopmobility
Healthwatch
Services Users
North of England Commissioning Support
Hartlepool Borough Council
Space for Thinking

Foreword

'We all have a part to play to meet the social and economic challenge posed by mental ill health, and to improve the wellbeing of the population. Their needs to be a shift, whereby citizens take more control over their lives and build more capable communities.

This Joint mental health plan aims to put people who use services at the heart of decision making and will be our governing principle. Care should be personalised to reflect people's needs, People should have access to the information and support they need to exercise informed choice.

This plan is aimed at empowering local organisations and practitioners to have the freedom to innovate and to drive improvements in services that deliver support of the highest quality for people of all ages, and all backgrounds and cultures.

This plan builds on the commitment of all stakeholders knowledge, sets out the ambitions the Government shares with its partners and against which it will be judged, and invites others to join us in making better mental health for all a reality'

Chair of the Hartlepool Health & Wellbeing Board - Cllr Christopher J Akers-Belcher

Summary of the Implementation Plan

The focus of this plan is to ensure Hartlepool & Stockton-on-Tees Clinical Commissioning Group and Hartlepool Borough Council work together as commissioners to effectively deploy their resources to support people with Mental Health needs

Whilst 'No Health without Mental Health' is the key driver and identifies several key ambitions, it is envisaged this report will take a holistic approach to mental wellbeing, adopting the recommendations from several national & local reports. This will ensure Hartlepool Citizens are at the centre of a co-produced action plan.

In addition to the 'working together for change' recommendations the report addresses the findings of the Local Government Agency, Sector Led Improvement Peer review, a Care Quality Commission Mental Health Act review and a strategic review of the Integrated Mental Health Service.

The recommendations form the basis of a robust action plan; the plan will be monitored by the Hartlepool Mental Health Forum, Hartlepool & Stockton-on-Tees CCG, with sign off by the Hartlepool Health & Wellbeing Board.

Introduction

A Collaborative Approach

A Task & Finish Group was established to lead on the development of this plan. This had representation from the following organisations:

The Task & Finish Group will become the Strategy Implementation Group and be responsible for overseeing the priorities set out in this plan (Table 1). The membership of the group will include key agencies, service user and carer representatives as well as a wide range of stakeholders. The group will produce and be responsible for the delivery of the detailed action plan and will report directly to the Hartlepool Mental Health Forum.

FACT

People with mental illness are at increased risk of the top five health killers, including heart disease, stroke, liver and respiratory diseases.

If you have a mental health problem you are four times more likely to die of a respiratory disease

Smoking Cessation is a real problem for our patients as the programmes only seem to have an impact on people without mental health problems

Gastrointestinal disease is raised at least four times and most of that are liver issues to do with alcohol

Co-Production

The term “co-production” is increasingly being applied to new types of public service delivery in the UK. It refers to active input by the people who use all services, as well as, or instead of, those who have traditionally provided them. It emphasises that the people who use services have assets which can help to improve those services, rather than simply needs which must be met. These assets are not usually financial, but rather are the skills, expertise and mutual support that service users can contribute to effective public services.[1]

The Hartlepool Mental Health Forum agreed to use a method of co-production to gather the evidence from Hartlepool citizens. The Working Together for Change methodology is a process that uses person centred information and themes it to inform strategic change. The person centred information may come from person centred reviews, person centred plans, questionnaires or support plans.

This collaborative approach has allowed the Task & Finish Group to be well informed and equipped with the knowledge and understanding of what is working well, what needs to be improved and where the gaps are. This has enabled us to develop our key priorities.

The Implementation Plan covers ‘all ages’, is far reaching and aims to cover services for individuals with mild to moderate mental wellbeing needs as well as those with severe and enduring mental health conditions.

[1] Co-production: an emerging evidence base for adult social care transformation (2012) Social Care Institute for Excellence

There are a number of facts and figures[2] along with the priorities that feature throughout the document and are linked to relevant areas; these are also listed in full in Table 1.

Thanks go to all those individuals and organisations who contributed.

National Directives

There are a number of national directives and strategies that are relevant to the development of this implementation plan.

No Health without Mental Health[3]

FACT

No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact.

The publication of No Health without Mental Health: A cross government mental health strategy for people of all ages published in February 2011 drew together the wider principles that the government has laid down for its health reforms, including patient-centred care and locally determined priorities and delivery. At a national level, the strategy sets out the 'high level' objectives to improve the mental health and wellbeing of the population. These are:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

Resulting from this an implementation framework has been developed and sets out how progress will be monitored through the outcomes frameworks and made a series of recommendations for local and regional organisations to take forward.

These included providers and commissioners of mental health services, primary, acute and community health providers, the new health and wellbeing boards, social services, children`s services, public health services, housing organisations, schools and colleges.

The position statement of the Royal College of Psychiatrists states:

- No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact
- Mental illness is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour

[2] No Health without Public Mental Health, (2010) Royal College of Psychiatrists
[3] No Health without Mental Health(2011) HM Government

- Mental illness has not only a human and social cost, but also an economic one, with wider costs in England amounting to £105 billion a year

Mental health practice should aim to put the person's needs at the centre of care planning and service delivery. No Health without Mental Health encourages recovery based approaches; this is further reinforced in the NHS Outcomes Framework as well as the Social Care Outcomes Framework.

No Health without Mental Health states that a good start in life and positive parenting promotes good mental health, wellbeing, self-esteem and resilience to adversity throughout life. Parental mental health is an important factor in determining the child's mental health and secure attachments with parent or care-givers are associated with better outcomes for the child, including improved learning and academic achievement. As adults, those who are securely attached tend to have trusting, long-term relationships, higher self-esteem and supportive social networks.

A mental health dashboard[4] was then developed which brings together relevant measures from a wide range of sources to show us the progress being made against these objectives and to give a clear, concise picture of mental health outcomes as a whole. The dashboard draws only on existing, publicly available sources of information and is not intended to hold individual organisations to account.

The dashboard covers the full, wide scope of the strategy and aims to provide a balanced picture across all six of the strategy's objectives. It therefore focuses not only on mental health services, but also on the mental wellbeing of the whole population, the physical health of people with mental health problems, people's experience of care and experience of stigma and discrimination.

FACT

Circulatory, respiratory & digestive diseases are all raised in our population.

Then we've got diseases of the nervous system then mental & behavioural disorders

We have potentially got a minimum of 700 un-necessary deaths per year, that's 700 more deaths than to be expected on top of the poor lifestyle mortality

One in six of all deaths is attributed to smoking

On average mental health patients have twice the rate of smoking and this is not changing

The measures which make up the dashboard have been chosen for their relevance to these objectives and include those measures which are most relevant or important for mental health outcomes as a whole, not necessarily those which will be easiest, or even possible, for specific organisations (public services or other organisations) to affect. It focuses primarily on the outcomes we want to achieve, rather than how they will be achieved, or by whom.

The main purpose of the dashboard is to bring the best information we have about mental health outcomes together in one place, as a resource for everyone with an interest in improving these outcomes.

[4] No Health without Mental Health, mental health dashboard, (2013) HM Government

NHS England- Five Year Forward View[5]

The National Forward View acknowledges that physical and mental health are closely linked – people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people. The NHS ambition over the next five years is to drive towards an equal response to mental and physical health, and towards the two being treated together. Next year, for the first time, there will be waiting standards for mental health.

The Care Act 2014[6]

The new Care Act consolidates much of existing social care law along with best practise and creates a new obligation on local authorities to deliver the personalised agenda.

Many duties and requirements will be introduced particularly around assessments for carers and self-funders which will require a full care and support plan with Independent Personal Budgets for all adults who have eligible social care needs irrespective of whether they choose to have these met by the local authority.

The Act will also for the first time set out a clear legal framework for how local authorities and other parts of the health and care system should protect adults at risk of abuse or neglect.

Priority

Ensure that local people get the best possible start in life, including mental health support for expectant and new mothers

Children & Families Act 2014[7]

The Children & Families Act will mean changes in law to give greater protection to vulnerable children and young people, a new system for under 25s who have special education needs and disabilities to provide great choice and control and help for parents to balance work and family life. It underpins wider reforms to ensure that all children and young people can succeed, no matter what their background.

Closing the Gap: Priorities for essential change in mental health[8]

Closing the Gap supports the measures in the national mental health strategy No Health without Mental Health, the Mental Health Implementation Framework and the Suicide Prevention Strategy. It is intended to bridge the gap between long term strategic ambitions and short term actions through the 25 priorities for action –

[5] NHS England Five Year Forward View
[6] The Care Act (2014) HM Government
[7] Children & Families Act (2014) HM Government
[8] Closing the Gap: Priorities for essential change in mental health (2014) HM Government

issues that current programmes are starting to address and where 'strategy is coming to life'. The government will report on progress on these priorities next year.

The document is a useful update on significant developments such as the Crisis Care Concordat[9], which is a commitment from organisations to prevent crises through prevention and early intervention, and is a mechanism to promote partnership working. It emphasises the government's intention for parity between mental and physical healthcare as set out in the NHS Mandate.

Achieving parity of esteem between mental and physical health

In our society mental health does not receive the same attention as physical health. People with mental health problems frequently experience stigma and discrimination, not only in the wider community but also from services. This is exemplified in part by lower treatment rates for mental health conditions and an underfunding of mental healthcare relative to the scale and impact of mental health problems.

FACTS

Annual homicides in England and Wales: 550.

Annual fatal road traffic accidents: 1850.

Total military casualties that have occurred in Afghanistan from the very beginning of the conflict to the present day: 446. (www.bbc.co.uk/news/uk-10629358)

How many people with a mental health condition die early every year of preventable conditions? 18,000 - and that is only ages 19–74.

There is an ambition for the NHS to put mental health on a par with physical health. However, the concept of parity in this context is not always well understood. In this report[10] an expert working group defines 'parity of esteem' in detail and examines why parity between mental and physical health does not currently exist and how it might be achieved in practice.

A Call to Action: Achieving Parity of Esteem

In July 2013, NHS England launched A Call to Action, which began a programme of engagement and evidence collection that encourages everyone to contribute to the debate about the future of health and care provision in England. It also signalled the beginning of a process to develop a new strategy for the health service.

A discussion paper was developed[11] which focuses on valuing mental and physical health equally. This resource focuses on one of the outcome ambitions set out in the strategic planning framework: to achieve 'parity of esteem' and is intended to

[9] Mental Health Crisis Care Concordat: Improving Outcomes for people experiencing mental health crisis (2014) HM Government
[10] Whole person care: from rhetoric to reality (Achieving parity of esteem between mental and physical health) (2013) RCP
[11] A Call to Action: Achieving parity of Esteem; Transformative ideas for commissioners (2013) NHS England

stimulate debate between Clinical Commissioning Groups and local partners to think about changes that can be made.

What do we mean by parity of esteem? It's about equality in how we think about mental health and physical health care – it's about how they're valued. We need to 'close the gap' between mental and physical health services – whether that's a gap in access, in quality, in research, or even in the aspirations we have for people. As the report makes clear so powerfully, the current state of disparity is obvious.

It is astonishing that in the 21st Century NHS, 3 in 4 people with common mental health problems receive no treatment, and even for psychotic disorders this figure is nearly 1 in 3. It is equally astonishing that people with severe mental illness are, in some cases 3 or 4 times more likely to die prematurely from the 'big killer' diseases, when compared to the population as a whole. This says something, of course, not only about mental health services, but also how we treat people with mental illness, something which must change (Norman Lamb MP, 2013).

Priority
To ensure physical health needs are met

The following 10 Facts are taken directly from A Call to Action: Achieving Parity of Esteem and are reasons why we should strive to achieve parity between physical and mental health.

1. Mental health problems develop at a young age. 1 in 5 children have a mental health problem in any given year. First experience of mental health in those suffering lifetime mental health problems: 50% by 14 years old and 75% by 25 years old

2. Mental health is widespread and common. Every year 1 in 4 adults experience at least one mental disorder

3. Mental health is a significant burden. Mental illness is the single largest cause of disability in the UK

4. Mental health impacts on life expectancy. Average life expectancy in England and Wales for people with mental health problems is behind the national average. 68 years for males and 73 years for females for people with mental health problems. 79 years for males and 83 years for females for everyone else.

5. People with mental health problems have worse physical outcomes. People with mental illness are at increased risk of the top five health killers, including heart disease, stroke, liver and respiratory diseases and some cancers. People with Schizophrenia are twice more likely to die from cardiovascular disease and three times more likely to die from respiratory disease.

6. When people with long term conditions also have mental health issues the cost of treatment can rise significantly. 1/3 of people with long term conditions also experience mental health problems increasing treatment costs by around £8–13 billion a year.

7. The mental health of people with serious physical health problems is often overlooked. ½ of terminally ill or advanced cancer patients suffer from depression, anxiety and/or an adjustment disorder, yet less than half receive treatment for their mental health

8. Mental health problems affect the likelihood that people will be compliant with their treatment. Depression co-morbid patients are three times more likely to be non-compliant with treatment recommendations than non-depressed patients.

9. There are often long waits for mental health services. 1 in 10 people wait over a year for access to talking therapies.

10. There is a wider economic impact of mental health. The full costs of mental illness in England have been estimated to be £105.2 billion a year

Crisis Care Concordat: Improving Outcomes for people experiencing mental health crisis

The Concordat is a shared agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental health crisis need help – in policy making and spending decisions, in anticipating and preventing mental health crises wherever possible, and in making sure effective emergency response systems operate in localities when a crisis does occur. The Concordat is arranged around:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

The Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations. These will consist of commitments and actions at a local level that will deliver services that meet the principles of the national concordat.

Priority

Support the recommendations and actions from the Tees Multi Agency Crisis Care Concordat. Reporting improvements through the Mental Health Crisis Concordat Steering Group

Transforming Rehabilitation

The Ministry of Justice 'Transforming Rehabilitation' programme of Probation reforms sets out proposals for reforming the delivery of offender services. On the 1st of June 2014 the Government split probation services into two new organisations: A new public sector National Probation Service (NPS) dealing with all those who pose

the highest risk of serious harm to the public and twenty one regional Community Rehabilitation Companies (CRCs) managing all other offenders.

Recognised, valued & supported: next steps for the Carers Strategy[12]

It is important that the role of unpaid carers of those with mental health problems is recognised. We know that caring for someone with a mental health problem can be emotionally and often financially draining. In 2014, National Institute for Health and Care Excellence (NICE) issued clinical guidelines for 'Psychosis and Schizophrenia in adults: treatment and management'.

These introduced new requirements in respect of identifying and supporting carers, including the following:

- Mental health services to offer and provide carers with an assessment of their own needs; develop a care plan to address any needs identified; review this annually and advise carers of their statutory right to a formal carer's assessment by social care services
- Give carers written and verbal information about diagnosis and management of psychosis and schizophrenia; positive outcomes and recovery; types of support for carers; role of teams and services; getting help in a crisis
- Negotiate with service users and carers about how information will be shared and review regularly
- Involve carers in decision making if the service user agrees
- Offer a carer focused education and support programme

There are a number of services commissioned to provide a free high quality service to support unpaid carers; this includes Young Carers, Adult Carers and Parent Carers who care for someone living in Hartlepool. These services provide confidential, non-judgmental and impartial one to one support, advice and information.

Better Care Fund

In June 2013, the government announced that it would be allocating £3.8 billion to a pooled budget called the Better Care Fund.

In Hartlepool, joint plans have been developed between the Local Authority and Clinical Commissioning Groups locally on health and social care initiatives

The aim of the Better Care Fund is to improve the health and wellbeing of the people of Hartlepool by innovating and transforming services, with a focus on reducing reliance on long term health and social care, providing more preventative services, helping people to stay independent in their own homes, and improving care in community settings.

[12] Recognised, valued & supported: next steps for the Carers Strategy (2010) HM Government

Priority
To improve access to psychological therapies

Transforming Care: A national response to Winterbourne View Hospital Department of Health Review*:* Final Report[13]

Following the BBC Panorama Programme on the abuse at Winterbourne View Hospital, The Department of Health set out a transformation programme that looks to ensure people with complex support needs due to a learning disability, mental health problem and/or autism are supported closer to home and where possible within their local communities. Each area is required to develop a local plan that sets out how people with complex needs will be supported in the future.

Welfare Reform

The Welfare Reform Act[14] legislates for a range of changes to the welfare system some of which will have a direct effect on people with mental health problems. It introduces a wide range of reforms including the introduction of Universal Credit and changes to housing benefit. There has been concern amongst a range of mental health stakeholders nationally about the impact of welfare reform on people with mental health problems.

FACT

Mental illness is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour.

Employment

Many people who experience mental health problems face difficulties in gaining and maintaining employment. They often face stigma and discrimination that sometimes results in losing their job or cause challenges in getting a job. People who experience severe and enduring mental health problems have one of the lowest employment rates. Only one user in five of specialist mental health services either has paid work or is in full-time education[15]

A specialist Employment Link team is based within the Economic and Regeneration team within Hartlepool Borough Council. The staff team are equipped with the skills competence and knowledge to support people of working age with additional needs. The National Indicator (NI 150) percentage of adults receiving secondary mental health services in Hartlepool known to be in employment as of July 2014 was 11.4%.

Lesbian, Gay, Bisexual & Transgender

Lesbian, Gay, Bisexual and Transgender (LGBT) people are a minority community who often suffer from widespread harassment, discrimination and at times violence.

[13] Transforming care: A national response to Winterbourne View Hospital (2012) HM Government
[14] Welfare Reform Act 2012
[15] Removing barriers: the facts about mental health and employment Centre for Mental Health (2009)

The high levels of stigmatisation often lead to higher rates of mental health issues within the community with much higher instances of self-harm and attempted suicide.

The problems of discrimination are especially prevalent in the case of transgender individuals who have very little in the way of support and are often isolated within their communities.

53% of transgender individuals have carried out some form of self-harm in their lives, while 48% have attempted suicide at some point in their lives, with 33% more than once.[16] These statistics seem alarming, however when put into context of a small isolated community with little or no support and a lack of community understanding they begin to make more sense.

Homelessness

Homelessness easily descends into a destructive cycle of hopelessness and mental distress. It has been described as "a dire condition and if protracted highly damaging to an individual's identity, self-worth, morale and physical and mental health"[17].

There is a strong body of evidence[18] that points to markedly higher rates of mental health problems in populations of homeless adults than among the securely domiciled.

Most studies support the finding that unusually high rates of psychosis and substance misuse are a common feature of homeless populations. The difficulties of addressing combined substance misuse and mental illness (dual diagnosis), which exists in this group, has long been acknowledged. Nationally, the prevalence of substance misuse dependency among the homeless mentally ill can be as high as 50-60 percent and is up to five times higher than that for the general population.

Homeless people experience twice the rate of neurotic disorder than that of the general population, including anxiety, depression and mental distress. They are also more likely to become hospital in-patients than to be treated on an out-patient basis for their mental health problems.

Transition[19]

The ages 16–18 are a particularly vulnerable time when there is increased susceptibility to mental illness, as well as major physiological, emotional, educational and social change. It is also the age at which the young person already in contact with mental health services will move from child and adolescent services (CAMHS) to adult services (AMHS).

[16] Trans Mental Health Study (2012)
[17] Building Homelessness Prevention Practice: Combining Research Evidence and Professional Knowledge, University of Sheffield
[18] Melvin P (2004) A Nursing Service for homeless people with Mental Health Problems. Mental Health Practice, vol 7 no 8
[19] Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services (2012)

Transitions can be problematic if there are gaps in service provision and different structures and systems to navigate.

Local Context

It is well recognised that social and health inequalities can both result in and be caused by mental ill health. Many of the acknowledged risk factors for mental illness are linked to deprivation. Measures of deprivation can help to identify geographical areas where the need for mental health services is likely to be the greatest. Hartlepool has some of the most deprived areas in the country.

- Mental health needs in Hartlepool are higher than the national average.
- Hartlepool has 40% greater need in relation to mental illness compared to England and 14% higher need in relation to common mental health problems.
- Employment opportunities for people with mental health problems in Hartlepool are very limited and of those long-term unemployed people claiming incapacity benefit, two-thirds have a mental health problem.
- Incapacity benefit levels for mental health in Hartlepool are more than 70% higher than the English average and above the North East Average
- Hartlepool is an area of high deprivation.

In order to be able to plan effective mental health services it is important that we understand the mental and emotional wellbeing needs of the population.

The collation of current information in relation to mental wellbeing needs to be co-ordinated better. Assessing need in relation to mental health and wellbeing is complex and there are a number of ways in which this challenging problem may be tackled.

It is essential to consider sources of information which tell us who and where in our communities are receiving support for mental health issues alongside the range of wider determinants which impact on mental health and wellbeing and cause individuals to be more vulnerable to poor mental health.

There are many factors that may increase the likelihood of becoming unwell, such as:

- poor housing
- homelessness
- financial poverty
- unemployment
- drug and/or alcohol dependency
- being a carer
- poor physical health
- having a learning disability
- lesbian, gay, bisexual and transgendered people
- people that have committed criminal offences
- black, minority & ethnic people
- gypsies, roma & travellers

FACT

Women are more likely to have been treated for a mental health problem than men.

The North East Public Health Observatory published a Community Mental Health Profile for Hartlepool[20] which is designed to give an overview of mental health risks, prevalence and services at a local level.

Hartlepool Joint Health and Wellbeing Strategy

The Hartlepool Joint Health and Wellbeing Strategy[21] is a strategic document outlining how Hartlepool Borough Council, Hartlepool and Stockton on Tees Clinical Commissioning Group and other key organisations, through the Health and Wellbeing Board, will address the health and wellbeing needs of Hartlepool and help reduce health inequalities.

The Health and Social Care Act (2012) establishes Health and Wellbeing Boards as statutory bodies responsible for encouraging integrated working and developing a Joint Strategic Needs Assessment and Health and Wellbeing Strategy for their area. The Strategy is underpinned by the Joint Strategic Needs Assessment (JSNA) and together they will provide a foundation for strategic, evidence-based, outcomes-focused commissioning and planning for Hartlepool.

Strategic Outcome 7 of this strategy is to strengthen the role and impact of ill health prevention and improve the mental and physical wellbeing of the population by:

- Reducing the numbers of people living with preventable ill health and people dying prematurely
- Narrowing the gap of health inequalities between communities in Hartlepool

Delivery on the objectives will be ensured through an annual action plan which supports the Health & Wellbeing Strategy and specifies the detailed initiatives to deliver on the objectives.

Hartlepool Public Mental Health

The health of Hartlepool residents is improving; on average they are living healthier and longer lives. However, they still suffer more ill health and disability, higher death rates from diseases such as cancer, heart disease and respiratory disease and live shorter lives than in most other parts of the country.

There is evidence to indicate that this ‘health gap’ is widening. There are also inequalities in the ‘health experience’ of communities within Hartlepool; the most deprived communities suffering significantly poorer health than the more affluent areas.

Department of Health sets out a programme of action to support people in making healthy choices. It identifies the following priorities:

[20] Hartlepool & Stockton on Tees Community Mental Health Programme 2014
[21] Hartlepool Health & Wellbeing Strategy (2013-2018)

- Reducing the numbers of people who smoke
- Reducing obesity and improving diet and nutrition
- Increasing exercise
- Encouraging and supporting sensible alcohol consumption
- Improving sexual health
- Improving mental health

Public Health in Hartlepool is involved in a regional work, steered through Northern England Clinical Networks to address the physical health of patients with mental health problems. The first topic being tackled is tobacco.

Public Health Hartlepool is part of a Teeswide Suicide Prevention Task Force which has developed a Tees Suicide Prevention Implementation Plan with a local action plan for delivery.

Priority
Support regional work through Northern England Strategic Clinical Networks to bring about healthier lifestyles

Supporting People with Hearing Loss[22]

Hearing loss can have a significant impact on an individual's health and wellbeing. For children who are born with a hearing impairment, their language development, educational attainment and life chances can be affected. For adults with sudden or age acquired hearing loss, there is the risk of loss of employment, social isolation, depression and mental health problems.

Just over 16% of the population suffer a hearing loss. This amounts to 1 in 6 people or around 14,700 of the Hartlepool population.

In 2011 the Strategic Health Authority and Hartlepool Borough Council commissioned a review of services for deaf people in Hartlepool, and as a result, identified a number of recommendations on how services could be improved. The recommendations were grouped into 4 main categories:

1. Greater engagement of deaf people with the council
2. Improving the support that is offered to people (from children to adults)
3. Improving communication support
4. Prevention – early identification of issues

These recommendations were considered by Hartlepool Borough Council's Cabinet in November 2011 who wholeheartedly supported each one. In addition, the Cabinet made a commitment to develop the hearing loss strategy which looks at how we could offer longer term support to the 1 in 6 people, or 14,700 people who were thought to have a hearing loss in Hartlepool.

[22] Supporting People with Hearing Loss, Hartlepool Borough Council (March 2013)

The strategy has been developed around the four key recommendations outlined above and the priorities for actions identified in the consultation. The strategy is structured to outline the policy objectives and what actions will be taken to support each main recommendation.

Whilst the development of this strategy has been led by Hartlepool Borough Council, its aim is to work with partners including the Clinical Commissioning Group and the Voluntary and Community Sector to build on the services that are currently provided. It will not be achieved in isolation and will work alongside other strategies and policies such as:

- The Joint Strategic Needs Assessment
- Moving Forward Together – the vision for adult social care in Hartlepool

The strategy is linked to and will be monitored by the Health and Wellbeing Board and will help support the board's key aim:

"To work in partnership with the people of Hartlepool to promote and ensure the best possible health and wellbeing."

Hartlepool Parent Led Forum

Hartlepool Parent Carer Forum: a parent carer forum of parents and carers of disabled children who work with the local authority, education, health and other providers to make sure the services they plan and deliver meet the needs of disabled children and families.

A steering group of parents lead this work and listen to the views of other parents in the local area to make sure they know what is important to them. The forum is keen to hear from as many parent carers as possible, and supports the ambition to develop a radically different system that:

Supports better life outcomes for young people

- a new approach to identifying Special Educational Needs (SEN)
- a joint assessment process and a single Education, Health and Care Plan (EHCP)

Gives parents more confidence by giving them control

- a local offer of all services available
- parents to have the option of a personal budget by 2014

Transfers power to front-line professionals and to local communities

- giving parents a real choice of school
- greater independence to the assessment of children's needs

Children, Young People and Families Plan 2012– 2015

The Children, Young People and Families Plan outlines:

"In Hartlepool we will work together through the Hartlepool Children's partnership to keep children and young people and their families at the centre of services that we provide."

The plan details a number of priority areas, including:

- safeguarding children
- youth offending
- early intervention
- child poverty
- education
- young carers
- transitions
- health
- children with additional needs / disabled children
- looked after children

Priority *Ensure high quality of care through the implementation of the newly developed evidence based service specification for CAMHS and associated pathways*
Priority *Ensure that children with complex needs including mental health issues are given full and equal access whilst being assessed under the new Children's and families Act: Part 3 SEND reform responsibilities and where appropriate are able to take advantages of opportunities offered by personal health budgets including those children in special schools*
Priority *To develop a multi-agency pathway for children with sensory process disorder*
Priority *Continue to improve the local pathway of care for children and young people with Autism Spectrum Disorder*
Priority *Providing equality of access to equipment for children with mental health needs*

Tees Interim Children and Adolescent Mental Health Strategy 2015 – 17

The Joint Strategy for Tees is currently being developed by the Clinical Commissioning Groups and the local Borough Council in order to provide strategic direction across the locality.

This strategy has been developed to:

- Provide a cohesive approach across partner agencies, in regard to improving the mental health and wellbeing of children and young people in Hartlepool
- Ensure any work taken forward is centred on the child and family and is outcome focused

The strategic work plan within the document captures priority areas of focus related to children and young people's mental health and emotional wellbeing and is further developed in to the individual Hartlepool locality plan.

Priority *Improve transition arrangements between CAMHS and adult mental health services to ensure that there is no risk of untreated illness at this critical time*
Priority *To undertake a review of the mental health gateway service model*

Hartlepool Strategy for Assistive Technology 2010-15

Assistive technology' is a collective term used to describe a variety of services that use information and communication technology (ICT) and are linked to response services to support people to live in their own homes.

In Hartlepool, our vision of personal support is to enable the majority of people needing support to live as independently as possible in their own homes, for as long as they are able and wish to do so. This includes older people, people with disabilities or mental health problems and other vulnerable people.

Hartlepool Carers

The carer's service exists to improve the quality of lives of carers throughout Hartlepool and the surrounding villages, by providing bespoke advice, information and support services, as well as also raising awareness of carer's issues locally, regionally and nationally. Carers can be of any age and come from any social, ethnic or cultural background and will be treated with respect and dignity at all times.

A Mental Health project involves carers in local service development initiatives to promote carer awareness and improvements in local services. The project promotes the leadership training through the local NHS Foundation Trust Patient and Public Involvement, in order to help carers develop their confidence and skills in participating in service development.

Carers are involved through the Mental Health project with:

- Dementia Collaborative via the Dementia Advisory group
- Dementia Friendly Hartlepool
- Mental Health Forum
- Awareness raising through partnership working and promoting the directory of services and wellbeing

The Triangle of Care is led nationally by The Carers Trust. Tees Esk & Wear Valley NHS Foundation Trust has signed up to the group and are working with Carers and the Patient and Public Involvement Team to implement carer awareness training with the Trust staff.

The carers service support carers into work through Job club's and one to one support with Employment Support Officer's. The service provides access to courses through partnership working with Adult Education to provide Personal Development courses bespoke to Carers. Carer's can access services to meet their needs, advocating them when necessary. Tailored services help the individual and those they care for by providing a Carers assessment of needs. Benefit support is also available for carers through links with Citizens Advice Bureau to maximise carer's income.

The Mental Health project offers training and emotional support for carers through one to one support, in house counselling, or referral to other counselling services. The service seeks to reduce isolation through peer and social support groups and access to other local groups.

Young people undertake inappropriate levels of care due to a variety of reasons and complex circumstances. The young carer provider supports to up to 90 young carers living in Hartlepool and promotes identification, recognition and early help.

Veterans[23]

FACT

Self-harm statistics for the UK show one of the highest rates in Europe: 400 per 100,000 population.

A Veteran is defined as anyone who has been a member of the serving Armed Forces for a day or more. There are approximately 4.8 million veterans in the UK (just under 4 million in England). All should be registered with a NHS GP Practice.

The Department of Health (DoH) and the Ministry of Defence (MOD) have launched the first of a number of pilots designed to ensure that NHS health professionals have appropriate support and available expertise they may need to treat veterans with mental health problems. The four UK health departments, the Ministry of Defence, and the charity Combat Stress, have been working together closely to develop and pilot a new model of community based mental health care.

Centred on the client and GP, these arrangements will make it easier for veterans with concerns about their mental health to seek and access help. The pilot will provide veterans with a service, led by a Community Veterans' Mental Health Therapist that will offer understanding of the particular issues for those who have served in the Armed Forces.

Learning Disabilities

It is estimated that there are approximately 1.2 million people in England who have some form of learning disability. It is well documented that for many people with a

[23] Veterans UK, Ministry of Defence Announcement

learning disability this means significantly poorer health and the risk of dying younger. Access to healthcare through the use of reasonable adjustments and the delivery of annual health checks can identify early indications of illness, many of which risk going undetected, often due to the lack of understanding of many of the issues faced by people with a learning disability.

In Hartlepool people are working together to improve access to healthcare, this includes; accessing the annual health check, hospitals, and other community services such as opticians, dentists and pharmacies.

Tees Esk & Wear Valley NHS Foundation Trust (TEWV) provide community and inpatient specialist assessment and treatment services to people with learning disabilities and mental health problems, autism, epilepsy and challenging behaviour. Tees Esk & Wear Valley NHS Foundation Trust, in partnership with Hartlepool Borough Council provides integrated social care and health teams. These teams offer care co-ordination for people with Mental Health and/or Learning Disability needs.

People with learning disabilities demonstrate the complete spectrum of mental health problems, with higher prevalence found in those without learning disabilities. The percentage of adults aged 18 years and over with learning disabilities (2011/12) within Hartlepool is 0.57% which is higher than the England average of 0.45%.

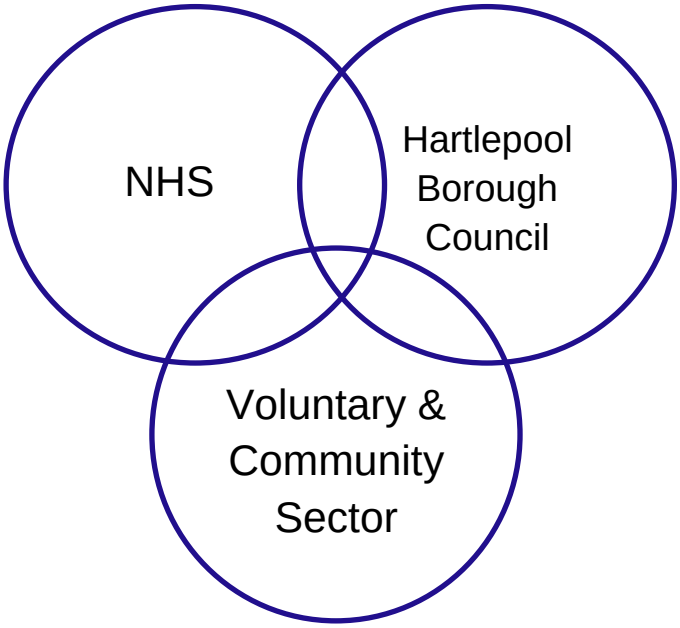
The incidence of children with mild to severe learning disabilities is expected to rise by 1% year on year for the next 15 years due to a number of factors and 40% of these children have a diagnosable mental health problem. Across Hartlepool there are approximately 1000 children and young people with a learning disability and of these 390 will have mental ill-health, rising to 450 over the next 5 years.

A growth in the size of the population aged 65 years and over is expected which will increase the numbers of adults with a learning disability. As adults with a learning disability grow older, their carers will also grow older and will therefore be more likely to need services themselves. There is evidence that adults with a learning disability are more likely to be affected by dementia than people without a learning disability.

The current range of Service Provision

This section explains the range of services commissioned and provided by NHS England, Clinical Commissioning Groups and Hartlepool Borough Council.

Although the NHS has traditionally been the predominant provider of local mental health services, a number of independent and voluntary sector organisations have played a key part in delivering specific services to complement those in the statutory sector. This was highlighted in the scoping exercise the Task & Finish Group undertook and demonstrated that there is a range of services currently available from numerous service providers.



Local Authority

Hartlepool Borough Council has developed a number of Mental Health services in the community. Others are provided by a number of Voluntary Community Sector services and Independent Sector Organisations across Hartlepool, who may be funded by both the Local Authority and the NHS.

The types of service provided include the following;

- Integrated mental health Social Work/Care Co-ordination teams covering each locality area
- Specialist residential care
- Supported living
- Outreach and Community-based floating support
- Domiciliary Care
- Post Diagnosis support for people with autism
- Services for Older People with mental health/Dementia issues
- Service-user led groups including Cree or Men's Sheds/Dementia Cafes & My Space
- Day care & drop in/Social access groups
- Volunteering and peer support
- Education/Employment/Training Support
- Specialist Advocacy
- Community Wellbeing Support Service
- Social Prescribing
- Looked after children service including Full Circle
- Generic and post-vention bereavement support
- Mental Health awareness and specific sefl-harm training

In addition the council is promoting the development of an increasing number of personalised, individual service options which are funded thought direct payments.

Clinical Commissioning Groups & NHS Foundation Trust

The Clinical Commissioning Group's commission the majority of mental health services from Tees, Esk & Wear Valleys NHS Foundation Trust.

The Trust provide community and inpatient mental health services for adults of working age in partnership with social care and a wide range of voluntary and independent service providers. The Trust treats patients with psychotic illnesses and also those with affective illnesses, such as depression, anxiety and compulsive disorders.

Primary and secondary care is often referred to within mental health services. Below is a brief explanation of what is meant by each term:

- Primary mental health services mainly provide support for people with mild to moderate mental health conditions, such as depression and anxiety. However, these services can also support people with some of the more severe mental health conditions if they are not at risk of harming themselves or others. GPs are usually the first point of contact for people with mild to moderate mental health conditions.

- Secondary (or specialist) mental health services provide support for people with severe and complex mental health conditions, such as schizophrenia and bi-polar. They also support people with other mental health conditions if they are at risk of harming themselves or others.

Common mental health problems such as depression and anxiety related conditions are generally treated in a primary care setting. NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group commission a range of services in the area. For people aged 16 and over there is a primary care psychological therapy service which provides all National Institute of Care and Excellence (NICE) accredited psychological therapies for people with common mental health problems.

Additionally for adults who have a long term mental health problem which is currently stable there is a commissioned primary care mental health service to support General Practice with the management of these patients.
More complex mental health conditions are managed in secondary care by specialist mental health providers.

The services we currently commission, as of January 2015, include:

Community

- Specialist Community Mental Health Teams for Affective disorders (multi-disciplinary service for people with severe and complex mood related mental health problems)

- Specialist Community Mental Health Teams for Psychosis (multi-disciplinary service for people with severe and complex psychotic mental health problems)
- Mental Health Access service (first point of contact for referrers)
- Mental Health Crisis Team (multi-disciplinary service for people with complex mental health conditions who are in crisis requiring an urgent response)
- Mental Health Home Treatment service (multi-disciplinary service to support people in their own home as an alternative to hospital admission)
- Intensive Home Support Service (psychologically led service for Older People in mental health crisis who exhibit complex and high risk behaviours)
- Older peoples Community Mental Health Team (for assessment and treatment of older adults with complex mental health conditions)
- Assertive Outreach service (to offer more intensive ongoing support for people with severe and enduring mental health problems who are vulnerable or prone to rapid relapse)
- Early Intervention in Psychosis service (multi-disciplinary service aimed at people aged between 14 and 35 years who experience a first episode of psychosis, specialising in focussed family work and psycho-education alongside judicial use of antipsychotic medication)
- Acute Hospital Liaison Service (specialist multi-disciplinary mental health service operating 24/7 within the acute trust to assess, treat, and help manage people with mental health conditions who present at the acute hospital, offering signposting to specialist mental health services or other provision where appropriate)
- Stepping forwards – an assertive community based service which aims to target those vulnerable individuals who have frequent contact with services through A&E, Police, MH Crisis teams but who struggle to engage with appointments and follow up.
- Hartlepool Carers – a service which offers support, advice and guidance to carers of people with mental health problems
- Baby bereavement – emotional support for bereaved parents
- Recovery College[24] - A local recovery college has been commissioned to support the recovery approach.
- Community eating disorders service, specialist community team providing treatment and support for people with eating disorders (primarily anorexia nervosa and bulimia nervosa

Inpatient Services

- Adult acute mental health wards for assessment and treatment of complex mental health problems.
- Psychiatric Intensive Care ward for people in an acute phase of mental illness with very high risk behaviours

[24] Recovery College

- Male Locked Rehabilitation for men who exhibit high risk behaviours relating to their mental health problems and require inpatient care for a longer period of time
- Female locked rehabilitation for women who exhibit high risk behaviours relating to their mental health problems and require inpatient care for a longer period of time
- Specialist mental health rehabilitation for people who require longer periods of mental health treatment, up to 18 months.
- Specialist mental health rehabilitation for people who require longer term in-patient treatment, 18 months plus

It should be noted that in-patient services for adult eating disorders and all secure services are now commissioned by NHS England rather than through local Clinical Commissioning Groups.

There are contracts in place for people whose needs require specialist input which isn't effectively provided through the other commissioned services.

Priority *Reduce the rate of admissions of children and young people for self-harm*
Priority *Work to encourage General Practices to appoint a Mental Health Champion to drive forward implementation*
Priority *To consider the findings of the CQC – Mental Health Act Inspection*

Voluntary and Community Sector

There are many voluntary and community organisations within Hartlepool providing treatment and support for people with mental health issues. Some people prefer to seek help from an organisation separate from the NHS and the voluntary sector provides many alternative options. Most, but not all, voluntary sector services work on a self-referral basis, so that individuals can approach the organisation themselves without the need for a referral from a GP or other worker.

Voluntary and Community Sector organisations operate in diverse and wide-ranging fields including many that work in health and social care, community leisure and recreation activities, environmental work, arts, sport, education, campaigning and advocacy and many are faith based organisations.

Many voluntary sector organisations are more specialised in what they provide, such as advocacy and supported accommodation, as well as help for carers, minority ethnic communities and women. Others are focused around a particular activity, such as gardening or employment.

Some community led organisations have a good understanding of local need and as a result they are better placed or more able than the larger statutory agencies to engage with communities. Many organisations have developed innovative ways of

working to help people, such as through peer support or providing wellbeing activities within the community.

Recovery

FACT

1 in 4 people will experience some kind of mental health problem in the course of a year.

Recovery in this instance equates to personal recovery and is a different concept to clinical recovery, which is focused on the absence of symptoms and 'returning to normal'. Personal recovery is considered to be individually defined and is about living a satisfying and meaningful life, with or without symptoms.

A recent review of the recovery literature identified five components that have a significant role in most people's recovery, namely:

- Connectedness (relationships)
- Hope
- Identity (beyond a diagnosis or service user)
- Meaning and purpose to life
- Empowerment

These five factors are known collectively as the CHIME framework.

Services that are recovery orientated focus on the individual goals of individuals, recognising and building on their personal strengths, foster self-management and offer a range of opportunities for individuals to find meaning in their lives. Co-production, learning from and working with people with lived experience of mental health to develop and deliver services should be at the heart of genuine recovery focused approach.

Priority *To evaluate the Recovery College*
Priority *To maintain a focus on a recovery approach*
Priority *Implement the recommendations of the Local Government Association (LGA) and Directors of Adult Social Services (ADASS) Mental health peer challenge*

Recovery has been described as:

"...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond catastrophic effects of mental illness". [25]

[25] Anthony WA (1993). *Recovery from mental illness: the guiding vision of the mental health service system in the 1990s*. Psychosocial Rehabilitation Journal 16(4): 11-23.

Recovery challenges conventional approaches to treating mental ill health. It is consistent with the government's vision and takes a more holistic approach to mental wellbeing and health improvement, rather than addressing mental illness in isolation from other important factors in people's lives.

We know that current and former service users can help to support people who experience problems with their mental health. Peer Support is one way of helping people recover from mental distress and its impact on their lives. It enables people to provide knowledge, experience, and emotional, social or practical help to each other.

Peer support relies on the assets, skills and knowledge in the community, and the recognition that local people can offer help in ways that are sometimes more effective than professional help.

Child & Adolescent Mental Health Service (CAMHS)

The term CAMHS is used as a broad concept embracing all services that contribute to the mental health and emotional wellbeing and care of children and young people, whether provided by health, education, social services or other agencies. The structure of CAMHS is often explained in terms of how a child or young person accesses the service, with four 'tiers' of service provision.

Tier 1 Universal Services

Universal services are accessible by all children and young people; and include general practitioners, primary care services, health visitors, schools and early year's provision. The mental health role of universal services is to promote positive mental health and wellbeing and to help identify, refer on and support those children who may require input from targeted or specialist services.

FACT

About 10% of children have a mental health problem at any one time.

Tier 2 Targeted Services

Targeted services are for children and young people who may be considered to have specific identified mental health needs and/or to be vulnerable, where some low intensity monitoring/interventions may be required. Service settings include universal settings, but the provision is aimed at identified groups, not the whole population.

Tier 3 - Specialist Services

Specialist CAMHS services are for children and young people with identified complex and/or high levels of need or mental health problems. These services are provided by multi-disciplinary teams of child and adolescent mental health professionals providing a range of interventions.

Tier 4 – Highly Specialist Services

Tier 4 services are the most specialised elements of CAMHS provision and are commissioned by NHS England. Services are part of a highly specialist pathway and provide for a level of complexity that cannot be provided for by comprehensive

secondary, Tier 3 community services. It is generally the complexity and severity rather than the nature of the disorder that determines the need for specialist care.

Tier 4 services include inpatient services for children and adolescents and specialist services that are provided at a regional rather than local level. Inpatient assessment and treatment and low secure services being provided at West Lane Hospital in Middlesbrough. West Lane Hospital is also the base for the specialist regional North East and North Cumbria eating disorder inpatient service for children and young people.

Although the four tier model provides a useful framework for understanding comprehensive CAMHS it is important to recognise that children and services rarely fall neatly into one tier. Children and young people may enter the system at any point and do not necessarily move up the tiers. Therefore, two services may span multiple tiers.

Health & Justice, North East & Cumbria

Forensic services are specialist services which treat patients referred by the criminal justice system because of mental health or learning disabilities conditions which have been a factor driving their offending. Tees, Esk & Wear Valley NHS Foundation Trust provide community, inpatient and rehabilitation forensic services for people with mental health problems and/or learning disabilities.

Inpatient services, including medium and low secure environments are based at Roseberry Park. Community forensic services including criminal justice liaison services that work across the whole offending behaviour pathway, for example street triage in Middlesbrough and the mental health service within all seven North East prisons are also provided.

The Clinical Commissioning Group's also have contracts with independent hospitals both in and out of the area. These provisions are utilised to support the most complex cases and offer a range of interventions.

Offenders are more likely to smoke, misuse drugs and/or alcohol, and/or suffer mental health problems, report having a disability, self-harm, attempt suicide and die prematurely compared to the general population. Nearly half of all prisoners have anxiety or depression and nearly a third of all 13 to 18 year olds who offend have a mental health issue. For many offenders who have a mental health issue or vulnerability, prison can make their situation worse.

A high proportion of both boys and girls in secure settings have mental health needs and substance misuse issues. Approximately half of all deaths in or following police custody involve detainees with some form of mental health problem. 72% of male and 70% of female sentenced prisoners suffer from two or more mental health disorders.

Section 15 of the Health and Social Care Act 2012 gives the Secretary of State the power to require NHS England to commission certain services instead of Clinical

Commissioning Groups. These include "services or facilities for persons who are detained in a prison or in other accommodation of a prescribed description".

It is NHS England's responsibility to directly commission health services or facilities for persons who are detained in prison or in other secure accommodation and for victims of sexual assault. NHS England carries out this function through 10 Health and Justice host area teams on behalf of the 27 area teams across England.

NHS England is responsible for planning, securing and monitoring an agreed set of services for:

- Prisons
- Young Offender Institutions (YOIs)
- Immigration Removal Centres
- Secure Training Centres
- Secure Children's Homes
- Police Custody Suites
- Court Liaison and Diversion Services
- Sexual Assault Services

FACT

Only 1 in 10 prisoners has no mental disorder.

NHS England is also responsible for specialised commissioning, for people who require a secure setting within a hospital. This is hosted by Cumbria, Northumberland and Tyne & Wear area team.

Research

There is an underpinning principle to the implementation plan of using evidence based practice to information interventions and programmes.

Mental health research is becoming increasingly enshrined in care delivery of Tees, Esk and Wear Valleys NHS Foundation Trust. The growth of research within the Trust is underpinned by collaborative partnership with Durham University, where strategic research priorities of primary care, youth mental health and drug safety are supported.

Mental health research has added complexity to that of other disease areas due to associated consenting and retention issues. This makes robust links between primary and secondary care all the more necessary in order to deliver quality research as integral to the best patient experience. Working across care sectors through robust research partnerships is the aim of the new Clinical Research Network structures of the National Institute of Healthcare Research.

The outcome of the review is to ensure that social workers and social care staff are enabled to add maximum value and provide optimum professional expertise within the mental health system in respect of the social determinants of mental ill-health.

Local Government Association (Sector Led Improvement) Mental Health Peer Review

A Mental Health Peer Review took place in November 2014; this challenged Hartlepool Integrated Mental Health Services in a constructive and supportive process and identified achievements, opportunities to improve the design and delivery of these services.

The overall aim of the Peer Review will be to contribute to ensuring that wherever social workers are managed, the infra-structure has to be in place to ensure that their role is maintained to achieve the best possible social care services for people with mental health problems in Hartlepool.

Summary of findings November 2014

LGA – Peer Challenge	Service Delivery	Working together	Vision, strategy and Leadership
Key Strengths	Benefits of integration recognised and supported at all levels	The importance of the HWBB was recognised as a lever for change	The MH Champion is passionate about improving services
	Strong performance in number of people using Direct Payments	The MH Forum and MH plan was a good example of interagency working.	The councils committee structure allows all members to be involved in a proactive manner
	Evidence of different disciplines sharing tasks	Good multi agency development of a Mental Health Crisis Concordat	There is a willingness to ensure a clear strategic direction of travel for mental health
Areas for consideration	Capacity within the teams with pressures on AMHP Rota's	Ensure date is pooled to assist with planning, using data to better inform planning	Ensure MH is woven into the wider councils corporate and financial planning and given higher priority by HWBB
	Availability of professional leadership and supervision needs to be consistent across teams	Council to consider closer working relationships across Tees to effect strategic commissioning	Recent changes in personnel represents an opportunity to clarify and streamline roles and responsibilities
	Informal communication	Further work to reduce high levels of	Implications and consideration in relation to

	across teams could be improved	placements in long-term care	the care act and mental health

Funding

No other health condition matches mental ill health in the combined extent of prevalence, persistence and breadth of impact[26]. The annual cost of mental ill-health in England is estimated at £105 billion[27]. By comparison, the total costs of obesity to the UK economy is £16 billion a year[28] and cardiovascular disease £31 billion[29].

NHS Hartlepool and Stockton on Tees Clinical Commissioning Group are actively involved in the development of a Clinical Quality and Innovation Scheme (CQUIN) which operates across the wider Tees Esk and Wear Valley area. Nationally mandated schemes are supplemented by local incentives which are jointly developed by Providers and Commissioners. CQUIN is used to continuously improve and drive the quality or services though financial incentives which, in total amount to 2.5% of the contractual value.

FACT

There is a wider economic impact of mental health; full costs in England have been estimated to be £105.2 billion a year.

During 2014/15 the scheme has ten indicators, three of which are nationally defined and seven that have been developed locally. These cover a diverse range of services and in most cases are closely linked to the No Health without Mental Health strategy. The schemes are developed on an annual basis with indicators from the previous year moving into the generic requirements of the contract and others being further developed in the following year's scheme.
The Implementation Plan sets out to ensure that we are using existing funding efficiently and effectively to commission quality mental health services which meet the needs of our communities. Ensuring we achieve value for money is vital because of the constraints on available funding in future years.

Implementation & Governance

The Implementation Plan will be led by the Mental Health Forum which is a sub group of the Health and Wellbeing Board and is a mechanism for engagement, consultation and involvement with service users and carers to support the work of the Health and Wellbeing Board.

The Task & Finish Group will become the Strategy Implementation Group and be responsible for overseeing the priorities set out in this plan (Table 1). The

[26] Promoting mental health & preventing mental illness, Freidli, L & Parsonage, M (2009)
[27] The Economic and Social Costs of Mental Health Problems in 2009/10 (2010) Centre for Mental Health
[28] Tackling obesities: future choices (2007) Project report Government Office for Science Foresight
[29] Prevention of cardiovascular disease at population level (2010) NICE

membership of the group will include key agencies, service user and carer representatives as well as a wide range of stakeholders.

The group will produce and be responsible for the delivery of the detailed action plan and will report directly to the Hartlepool Mental Health Forum.

The final document will be agreed by the Health & Wellbeing Board. There will be a number of actions underpinning each priority which will be developed by the Implementation Plan Steering Group as soon as this plan is agreed. The Implementation Plan will then be reviewed and revised on an annual basis.

Table 1 – Local Priorities

NHWMH Objective	Local Priorities	Lead Organisation(s)
1. More people will have good mental health *More people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well*	Ensure that local people get the best possible start in life, including mental health support for expectant and new mothers	CCG
	Improve the uptake and awareness of good mental health resilience – mental health first aid	HBC
2. More people with mental health problems will recover *More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live*	To evaluate the Recovery College	CCG
	To maintain a focus on a recovery approach	CCG
	Support a multi-agency Skills Funding Agency community learning pathway bid	HBC
	Implement the recommendations of the Local Government Association (LGA) and Directors of Adult Social Services (ADASS) Mental health peer challenge: • Refresh the Joint Strategic needs Assessment (JSNA) for Mental health ensuring data is aligned to better inform planning • Explore the potential to use the existing Tees Integrated Commissioning Group forum to extend its remit to include Mental	HBC / CCG

	Health • Appoint to a new Locality Manager for the Integrated Mental Health Service • Refresh the existing service directory and develop Information, Advice and Guidance that is Care Act compliant. • Create a review function in the affective disorders team to support additional capacity and reduce pressures on AMHP's	
3. More people with mental health problems will have good physical health *Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health*	To ensure Physical health needs are met	CCG
	Support a positive approach to mental health through the community activities network	HBC
	Support regional work through North England Strategic Clinical Networks to bring about healthier lifestyles.	HBC Public Health
4. More people will have a positive experience of care and support *Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected*	Ensure high quality of care through the implementation of the newly developed evidence based service specification for the CAMHS service and associated pathways	CCG
	Ensure that children with complex needs including mental health issues are given full and equal access whilst being assessed under the new Children and Families Act: Part 3 SEND reform responsibilities and where appropriate are able to take advantages of opportunities offered by personal health budgets including those children in special schools	CCG
	Improve transition arrangements between CAMHS and adult mental health services to ensure that there is no risk of untreated illness at this critical time	CCG

	To develop a multi-agency pathway for children with sensory process disorder	CCG
	Continuing to improve the local pathway of care for children and young people with Autism Spectrum Disorder	CCG
	Providing equality of access to equipment for children with mental health needs	CCG
	To improve Access to Psychological Therapies	CCG
	To undertake a review of the mental health gateway service model	CCG
	To consider the findings of the CQC – Mental Health Act Inspection: • Approved Mental Health Practitioners (AMHP's)are spending long periods of time locating section 12 approved doctors - Support AMHP's trough the regional forum to ensure timeliness of assessments are improved • Approved Mental Health Practitioners (AMHP's)and trust staff reported delays in accessing transportation to convey a person to Hospital - Evaluate the additional resources deployed to support a Mental Health Patient Transport Service (NEAS) • *An increased number of people were self-presenting at the reception of Roseberry Park Hospital at night* - Evaluate the impact of the new 136 assessment suite at Roseberry Park	HBC / CCG / TEWV
	Ensure that staff is aware of changes in the revised Code of Practice, including the 5 new guiding principles, the appropriate use of particular interventions and further guidance to support vulnerable groups. Equip staff with the Skills, Competence and Knowledge to ensure they are best supported to improve the lives of people with a mental health need.	HBC / TEWV

5. Fewer people will suffer avoidable harm *People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service*	Reduce the rate of admissions of children and young people for self-harm	CCG
	Implement the recommendations within the Care Act in respect to adult safeguarding and protecting people from harm	HBC
	Support the recommendations and actions from the Tees Multi Agency Crisis Care Concordat. Reporting improvements through the Mental Health Crisis Concordat Steering Group: • *Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.* • *Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.* • *Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.* • *Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.*	CCG / HBC
6. Fewer people will experience stigma and discrimination *Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease*	Work to encourage General Practices to appoint a Mental Health Champion to drive forward implementation	CCG
	Work with the mental health forum to ensure a coordinated approach to tackle discrimination - promoting an event for worls mental health day	HBC

Glossary

Our glossary lists some website links which may be useful to explain some of the terminology used within the document and to seek further information about the documents we have referred to.

Useful Websites

Mental Health A to Z
http://www.mind.org.uk/information-support/mental-health-a-z/

Types of Mental Health Problems
http://www.mind.org.uk/information-support/types-of-mental-health-problems/?gclid=CPmEn8yN6rwCFfLHtAod130Atg

A guide to Mental Health terminology
http://www.health.vic.gov.au/mentalhealth/termnlgy.htm

Mental Health: The Facts
http://www.health.vic.gov.au/mentalhealth/termnlgy.htm

NHS Hartlepool and Stockton on Tees Clinical Commissioning Group
http://www.hartlepoolandstocktonccg.nhs.uk/

North of England Commissioning Support (NECS)
http://www.necsu.nhs.uk/

Hartlepool Borough Council
http://www.hartlepool.gov.uk/

NHS England
http://www.england.nhs.uk/

Footnotes

1. Co-production: an emerging evidence base for adult social care transformation (2012) Social Care Institute for Excellence
www.scie.org.uk/publications

2. No Health without Public Mental Health, (2010) Royal College of Psychiatrists
http://www.rcpsych.ac.uk/PDF/Position%20Statement%204%20website.pdf

3. No Health without Mental Health (2011) HM Government
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ADULT SERVICES COMMITTEE

9 March 2015

Report of: Director of Child and Adult Services

Subject: HARTLEPOOL LOCAL EXECUTIVE GROUP - ADULT SAFEGUARDING STATISTICS AND PROGRESS REPORT FOR THE PERIOD APRIL – DECEMBER 2014

1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required, for information.

2. PURPOSE OF REPORT

2.1 The purpose of this report is to present the Hartlepool Local Executive Group (LEG) statistics covering the period from 1 April 2014 – 31 December 2014 and to share a summary of the progress made with the implementation of the Teeswide Safeguarding Adults Board (TSAB) strategic aims and objectives for the same period.

3. BACKGROUND - SAFEGUARDING

3.1 The current guidance that underpins adult protection arrangements is called No Secrets and within this guidance it is recognised that protecting vulnerable adults from the various forms of abuse (physical, sexual, psychological or financial) or material neglect, discrimination and institutional harm is 'Everybody's Business'.

3.2 The lead agency for the co-ordination of the arrangements regarding protecting vulnerable adults from abuse is the Local Authority and, where necessary, this includes coordinating the actions of other key local agencies including the NHS, the police, housing providers and the voluntary sector.

3.3 From April 2015 there are significant changes enshrined in the Care Act 2014 which will affect the protection of vulnerable adults and, like other Local Authorities, Hartlepool is assessing readiness for the implementation of the Care Act.

3.4 One of the key changes is that there will be a statutory requirement to have a Safeguarding Adults Board and in preparation for this it has already been agreed that this statutory function will be achieved by delegating this accountability to the TSAB which involves representatives from Stockton, Middlesbrough, Redcar & Cleveland and Hartlepool Councils, as well as strategic partners, notably from the police and NHS organisations.

3.5 To support the work of the TSAB, Hartlepool, like the other Local Authorities, has established a Local Executive Group (LEG), which was formerly the Hartlepool Safeguarding Adults Board (HSAB) and this body has the responsibility for co-ordinating and providing effective inter-agency working to safeguard local people whose circumstances make them vulnerable, and who may be at risk of abuse and neglect. The LEG will support the strategic aims and objectives of the TSAB by providing operational leadership at a local level and by embedding the Tees-wide Policy, Procedures and Practice Guidance in front line practice.

4. TRENDS IN SAFEGUARDING ADULTS

4.1 In the reporting period 1 April 2014 – 31 December 2014 there were 310 alerts identifying possible cases of abuse of adults brought to the attention of the Child and Adult Services Department's Duty Team. Following initial discussion and wider debate 86 of these alerts met the Safeguarding Adults threshold guide and therefore led to actual referrals requiring further investigation and action specifically under safeguarding adult procedures.

4.2 In the same reporting period last year there were 247 alerts identifying possible cases of abuse and 103 of these met the Safeguarding Adults threshold guide and therefore led to actual referrals under safeguarding adult procedures.

4.3 In relation to the current reporting period, it is important to highlight that although 224 alerts or 72% of the alerts required no specific further action in terms of actual safeguarding procedures, these alerts were genuine concerns reported into the Department's Duty point, therefore it is important to note that each alert was examined and appropriately risk managed via interventions by social work and care management teams; the Complaint(s) Team or the Commissioned Services Team with some referrals managed by providing more detailed information, advice or guidance at the Duty point, usually in relation to sign-posting people to relevant health professionals.

4.4 Within the current reporting period, 47% of referrals related to people aged 65 and over with a physical disability. Whilst in the reporting period 2013/14 people aged 65 and over with a physical disability were also the client group with the largest number of safeguarding referrals accounting for 41% of the activity.

4.5 As in previous reporting periods, care homes continue to be the most common location of reported abuse. 50 of the 86 referrals in this reporting period (58%) related to care homes, which is an increase on the 2013/14 reporting period by 8%.

4.6 In the 2014/15 reporting period, neglect was the most frequently identified cause of abuse, which is the same as the reporting period last year and the alleged perpetrators of abuse have been for the most part paid workers; this is followed by relatives or other family members.

5. BACKGROUND - DEPRIVATION OF LIBERTY SAFEGUARDS

5.1 Inextricably linked to safeguarding and protecting adults from abuse or significant harm are Deprivation of Liberty Safeguards. This development, which falls under the auspices of the Mental Capacity Act 2005, is a very serious matter and the Local Authority are the lead agency and Supervisory Body for ensuring that people who, for their own safety and in their own best interests, need to be accommodated under care and treatment regimes that may have the effect of depriving them of their liberty, but who lack capacity to consent, are only 'deprived' following due process, lawfully and properly.

5.2 These safeguards have been in place since April 2009 but a judgement in the Supreme Court case of Cheshire West and Chester Council and P and Surrey CC and P&Q in March 2014 has had a major impact on the way Deprivation of Liberty Safeguards (DOLS) are interpreted and applied, as has been reported to the Committee previously.

5.3 Previously Managing Authorities such as residential and nursing homes and hospital wards, would have considered applying to Hartlepool Borough Council as Supervisory Body for a DOLS authourisation only in circumstances where a person who lacked capacity was actively being prevented from leaving or perceived as being restricted in other ways, in their best interest. Usually, the application would have been reactive, in response to the person who lacked capacity actively attempting to leave, or demonstrating resistance to comply with care and treatment in other ways.

5.4 The Cheshire West judgement indicates that Managing Authorities must now consider applications of DOLS authourisation if a person is objectively being deprived of their liberty. To this end, the judgement introduces a two part 'acid test' that should be applied to determine whether an application should be made.

The 'acid test' that should be applied is:

1. Is the person subject to continuous supervision and control?
2. Is the person free to leave?

The focus therefore is not on a person's ability to express a desire to leave but what those with control over their care arrangements would do if they sought to leave.

6. TRENDS IN DEPRIVATION OF LIBERTY SAFEGUARDS

6.1 In relation to Deprivation of Liberty Safeguards (DoLS) between April 2013 – March 2014 there were 49 requests for authourisation.

6.2 Between April and December 2014 (nine months) there were 441 requests for authourisation.

6.3 There have been significant implications for Local Authorities throughout the country as a result of this judgement in terms of workload / staffing capacity and costs. The Child and Adult Services Department has had to re-model the operating framework and increase the number of those qualified workers (Best Interest Assessors - BIA's) who can legally carry out this function.

6.4 The financial cost for the additional capacity within the BIA function, legal advice, additional applications to the Court of Protection and access to Section 12 Mental Health Assessments are all borne by the Local Authority.

7. DEVELOPMENTS IN 2014/ 15

7.1 In relation to safeguarding vulnerable adults there have been a number of developments in the first nine months of this reporting period and the most significant issues are as follows: -

7.1.1 An Independent Chair has been appointed for the TSAB and a new Business Unit established to support safeguarding work across Tees.

7.1.2 The TSAB has established sub-groups to take specific projects forward in the coming months and these are Learning, Training and Development; Policy, Procedures and Practice; Performance, Audit & Quality; Communication & Engagement; Case Review.

7.1.3 The Local Safeguarding Adults Boards across Tees have all had their remit amended to reflect the revised direction of travel and Local Executive Groups have been established instead in each area with an identified Chair.

7.1.3 In accordance with the Care Act we have a Designated Safeguarding Manager.

7.1.4 An induction programme for new TSAB members has been developed and is currently being implemented.

7.1.5 A Serious Case Review was instigated under the terms of the HSAB prior to the introduction of the LEG following the tragic death of a vulnerable person as a result of an arson attack on a property and this investigation has been completed. An action plan has now been developed regarding implementing lessons learnt and an executive summary will be published shortly.

7.1.6 Discussions are currently taking place regarding a potential Case Review under the revised procedures concerning the murder of a vulnerable female in Hartlepool. Further information will be reported in due course.

8. RECOMMENDATIONS

8.1 It is recommended that the Adult Services Committee note the contents of this report.

9. REASONS FOR RECOMMENDATIONS

9.1 The Local Authority has the lead responsibility for the co-ordination of adult protection arrangements and the implementation of Deprivation of Liberty Safeguards.

10. CONTACT OFFICER

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ADULT SERVICES COMMITTEE

9 March 2015

Report of: Director of Child & Adult Services

Subject: IMPLEMENTATION OF THE CARE ACT

1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required; for information.

2. PURPOSE OF REPORT

2.1 The purpose of this report is to provide the Adult Services Committee with an update on progress regarding implementation of the Care Act and the financial implications in 2015/16.

3. BACKGROUND

3.1 The Care Act is a significant stepping stone to wider reform of care and support, and underlines the importance for councils to promote wellbeing, prevention and independence. It also introduces a new national eligibility threshold and new rights for carers and children in transition to adult services, and from April 2016 will introduce significant reforms to how people contribute towards the cost of their care.

3.2 The Care Act draws together a range of health and social care legislation built-up over seventy years and aims to create a single, modern law that clarifies and simplifies what kind of care and support people can expect.

3.3 From April 2015 local authorities will have:

- New wellbeing and prevention duties;
- New duties regarding provision of information and advice (including advice on paying for care);
- New market shaping duties;
- A national eligibility criteria;
- New duties regarding assessments for carers and self-funders;
- Statutory requirements in respect of Personal Budgets and Support Plans;
- Statutory requirements to offer deferred payment agreements.

3.4 From April 2016 the revised funding / charging reforms will be introduced which will include:

- A capped charging system;
- Introduction of Care Accounts to include self- funders;
- An extended means test.

3.5 Consultation in respect of draft regulations and statutory guidance has been undertaken over the summer and final guidance and statutory regulations were published in October 2014.

3.6 Changes to care funding, most notably the introduction of a 'cap' on liability for care costs, are not covered. The financial elements of the Care Act will be introduced from April 2016 and draft guidance and regulations on these elements are expected to be issued for consultation in February 2015.

4. IMPACT FOR LOCAL AUTHORITIES

4.1 There are some key areas within the Care Act that are expected to have a major impact on Local Authorities in terms of how they currently assess needs and deliver care and support, as well as funding implications. The areas where there is expected to be the greatest impact are as follows:

4.1.2 Preventing Needs for Care & Support

The Care Act makes clear in law that, from April 2015, councils must provide or arrange the provision of preventative services which help prevent or delay the development of care and support needs for individuals and carers, or help to reduce existing care and support needs.

4.1.3 Provision of Information, Advice and Advocacy

From April 2015, councils will be required to ensure that there is comprehensive information and advice about care and support services in their area and guarantee the provision of independent advocates to support people to be involved in key processes, such as assessment and care planning, where the person would otherwise be unable to be involved. Good information and advice services are critical to managing demand, meeting people's needs and joining up the range of services available locally.

4.1.4 Meeting Duties for Carers' Assessments

Under the Care Act, carers will be recognised in law in the same way as those for whom they care, regardless of whether that person has eligible care needs, or not. From April 2015, councils will have a new duty to carry out assessments for all carers. Carers will no longer have to be providing substantial care on a regular basis to be eligible for an assessment and, as such, more carers will qualify for an assessment and for more support than at present.

4.1.5 Impact of Funding Reforms for Self Funders
From April 2016, the Care Act will introduce a cap on the costs an individual will need to pay towards meeting their eligible needs for care and support. This means that those who are currently fully-funding their own care, and therefore have no contact with the council, may start to get in touch so that the costs of their eligible care and support can begin to count towards the cap. In these circumstances the authority can charge an 'arrangement fee' that must only cover the costs actually incurred in arranging care.

4.2 In order to successfully implement the Care Act, there are a number of areas that are priorities for Local Authorities to address:

4.2.1 Quality & Safeguarding
The Care Act sets out the council's responsibility for adult safeguarding, including responding to safeguarding enquiries, setting up a Safeguarding Adults Board, undertaking safeguarding reviews and sharing information relating to safeguarding issues amongst key partners.

4.2.2 Workforce
The introduction of the Care Act will have a number of implications for the workforce in order to meet new practice and legal expectations, from April 2015. Councils will need to ensure the whole social care workforce – including those not directly employed by the council – has the capacity, skills and knowledge to implement the Care Act effectively.

4.2.3 IT & Financial Systems
Every council with a responsibility for social care has IT systems in place to manage their case and financial records. The Care Act will necessitate a reconfiguration of these systems. Having in place the right information systems to support the reforms is critical to successful implementation and, as there is no intention for central government to develop centralised national IT systems for case records, it is each council's responsibility to work with their suppliers to ensure their systems will meet the requirements of the care and support reforms.

4.2.4 Commissioning
Councils have a critical role in developing the quality and range of services that local people want and need, including by integrating care and support with health and housing where this delivers better care and promotes well-being. Integrated commissioning is essential not only for improving user outcomes but also to ensure quality and value for money. Councils will want to work closely through their local Health and Wellbeing Boards to ensure plans across the system are aligned, including through the Better Care Fund.

4.2.5 Communications
Communication plays a crucial role in supporting the implementation of the Care Act, in ensuring that service users, carers, the general public and the council workforce understand what is changing, why and what action needs to be taken and by when. It is crucial that health and care providers, local politicians and NHS partners are fully engaged and understand the

implications of the Care Act. While not an explicit duty within the Act, councils will want to assure themselves that partners are fully engaged and have a plan in place to meet these communication requirements locally, complemented by national communications to key stakeholders.

5. UPDATE ON PREPARATIONS FOR IMPLEMENTING THE CARE ACT IN HARTLEPOOL

5.1 The Implementation Steering Group continues to meet, supported by three sub groups focused on:

- Operational and Workforce Issues including review of the operational pathways, updating policies and procedures and assessing workforce training needs and capacity against the Care Act requirements for additional assessments and the associated work;

- Advice and Information Issues including developing / commissioning a public facing advice / information suite of tools / resources and procuring a web based IT solution, developing a communication plan and refreshing the adult social care strategy documents;

- Finance, Commissioning and Performance Issues including reviewing the Resource Allocation System (RAS), developing a market position statement and analysing data to estimate the increased numbers of assessments that will be required.

5.2 Following approval by the Adult Services Committee in September 2014 of the planned use of the £125,000 Care Act Implementation Grant, work is progressing in relation to the agreed priorities. Progress to date includes:

- Appointment of additional staff to provide project management capacity, which will support the development of public information and the review of policies and procedures to accommodate the new requirements of the Care Act; and
- procurement of a service specification for a new IT solution for adult services, to replace the current Hartlepool Now website and provide a more interactive means of people accessing the information and advice that they need.

5.3 Staff briefings have been held for all adult services staff in January / February 2015 and further information is being shared through newsletters and brief guides.

5.4 Me Learning has been procured regionally to provide an e-learning platform based on the Skills for Care materials that will allow for large numbers of the social care workforce to demonstrate understanding and compliance with the Care Act. Hartlepool Borough Council will be contributing to the cost from a regional allocation for Care Act training, so will be able to provide access for our staff and the wider workforce. Funding has been agreed initially for one year.

5.4 A review of how carers are supported through Direct Payments is underway and a new approach will be implemented from 1 April 2015 which makes the system more transparent and equitable. Following a Carers Assessment it will be determined whether caring is having a low, medium or high impact on the carer and this will determine the level of funding available to meet their assessed needs. This may mean a change to the current allocations received by some carers but will be managed through the annual review process.

5.5 Local Authorities have the power to charge carers for support that is not provided directly to the person they care for but are not required to do so as in many cases it would be a false economy given the significant contribution carers make to support independence and enable people to stay in their own homes for longer. It is not proposed to introduce a charge to carers in Hartlepool.

6. REGIONAL AND NATIONAL SUPPORT TO IMPLEMENT THE CARE ACT

6.1 Care Act leads continue to meet across the region to share good practice and work collaboratively on areas where a shared approach is practical.

6.2 There are a range of groups established regionally focusing on key areas of work including:

- Market Shaping & Development
- Carers
- Workforce
- Information & Advice
- Communications
- Advocacy
- Eligibility & Assessment
- Financial Reforms
- Legal Challenges
- Systems & Informatics

6.3 The Department of Health have started their communication campaign to the public about the Care Act. Postcodes were identified nationally to be targeted with a leaflet drop. For Hartlepool this involved 3,808 households in post code TS25 2** receiving a leaflet in February. Whilst the leaflet signposts people to the Gov.uk website, it also says that people can contact their local authority for more information. As a result, frontline staff were provided with information in order to respond to any queries received as a result of the leaflet drop and information was sent to Ward Councillors for the area that was targeted.

6.4 A national radio advertising campaign is also taking place as part of the national activity to raise broad levels of awareness of the reforms. Two 30 second adverts will run – one focused on care users and one focused on informal carers. Locally, the adverts have been running on Smooth, Heart FM and Magic since 2 February.

7. NATIONAL CARE ACT IMPLEMENTATION STOCKTAKE

7.1 The national Care Act implementation stocktake has been developed by the DH, ADASS and LGA to support councils by providing information to facilitate local strategic discussions, map progress and identify opportunities for shared learning.

7.2 There have been three stocktakes across the year in May 2014, September 2014 and February 2015. Returns from Hartlepool Borough Council indicate that progress is being made toward implementation and demonstrate a significant level of confidence that the care reforms will be delivered within timescales.

7.3 The main risks identified for Hartlepool Borough Council in association with delivering the Care Act are:

- Unknown levels of additional demand from 'self funders' (people who currently purchase their own care and support but may come to the council for an assessment and a Care Account once the new legislation is in place after 2016);
- Unknown levels of additional demand from carers;
- Unknown additional workforce capacity required to manage the raised numbers of additional assessments as a result of additional demand; and
- Unknown total implementation costs.

8. FINANCIAL IMPLICATIONS

8.1 The Council received a one off allocation of £125,000 in 2014/15 to support implementation of the Care Act, which is being used as agreed by Adult Services Committee in September 2014:

Priority Area	**Spend**
Project Management Capacity	£60,000
Training & Awareness Raising	£25,000
Information & Advice	£40,000

The balance remaining on this grant will be carried forward as a specific reserve to continue to support implementing the Act in 2015/16.

8.2 Nationally, revenue funding of £420m will be provided for implementing the Care Act in 2015/16. This will be paid through a combination of funding within the Better Care Fund (£135m) and separate specific grants (£285m). Funding allocations were confirmed in December as part of the Local Government 2015/16 Funding Settlement with allocations forming part of a New Burdens allocation.

8.3 The confirmed revenue allocations for Hartlepool Borough Council are as follows:

Allocation	**Funding for 2015/16**
Better Care Fund	£266,000
New Burdens: Additional Assessments	£217,000
New Burdens: Deferred Payments	£155,000
New Burdens: Additional Support for Carers	£116,000
Total	**£754,000**

8.4 In addition, as part of the Social Care Capital Grant allocation (£134m nationally) which is included within the Better Care Fund, £50m of this funding has been earmarked for capital costs (including IT) associated with the transition to the capped cost system, which will be implemented in April 2016.

8.5 The total Social Care Capital Grant allocation for Hartlepool in 2015/16 is £279,000.

8.6 This remains an extremely complex area and it is not yet possible to give an indication as to whether the additional funding allocated will meet the anticipated additional demand and costs. For 2015/16 planning purposes it is currently anticipated that the changes will be budget neutral. The service and financial impacts will need to be closely monitored on an ongoing basis as the Care Act changes are implemented in 2015/16.

8.7 The position in 2016/17 and future years will need to be assessed when funding allocations for these years are known. This will include assessing the impact of the baseline funding for 2015/16 being mainstreamed, which is a potential risk for Hartlepool.

8.8 The funding in relation to a Universal Deferred Payment scheme needs to be considered in the context of the impact on the annual departmental budget from any increase in deferred payments. This includes the increased risk that deferred payments are not fully recovered at a future date when an individual's property is sold. Any increase in deferred payments also has potential to impact on cash flows due to unbudgeted interest costs.

8.9 However, from 1 April 2015 the Council will be able to recoup the costs associated with deferring fees by charging interest and an administration charge associated with legal and ongoing running costs. Where local authorities charge interest this must not exceed the maximum amount specified in regulations. A local authority may (but is not required to) charge the nationally-set maximum interest rate and the same rate must be charged on all deferred payments with a local authority.

8.10 The national maximum interest rate will change every six months on 1 January and 1 June in line with the most recently published report by the Office of Budget Responsibility. If the scheme started today the interest rate applied would be 2.65% for the period 1 April 2015 to 30 June 2015 with future rates depending on the published figures.

8.11 It is proposed to apply the national maximum interest rate to all new deferred payments made from 1 April 2015.

9. RECOMMENDATIONS

9.1 It is recommended that the Adult Services Committee:

a) Note progress to date in relation to implementation of the Care Act from April 2015;

b) Note the funding allocations to support Care Act implementation

c) Receive further reports throughout 2015/16.

10. REASONS FOR RECOMMENDATIONS

10.1 To provide the Committee with assurance that work is underway to implement the Care Act within the national timescales.

10.2 To make the Committee aware of the funding allocations received, and the need to monitor the financial impact throughout the coming financial year.

11. CONTACT OFFICER

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ADULT SERVICES COMMITTEE
9th March 2015

Report of: Director of Child & Adult Services

Subject: MOVING FORWARD TOGETHER – THE VISION FOR ADULT SERVICES IN HARTLEPOOL 2014-17

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 No decision required; for information.

2. PURPOSE OF REPORT

2.1 To provide the Adult Services Committee with an update on implementation of 'Moving Forward Together – The Vision for Adult Services in Hartlepool 2014-17'.

3. BACKGROUND

3.1 Moving Forward Together – The Vision for Adult Services in Hartlepool 2014-17 was approved by the Adult Services Committee in July 2014.

3.2 The document outlined what had been achieved in recent years and set out the vision for adult services. The annual action plan outlined priorities for 2014/15 and the actions required to move forward with implementation.

4. THE HARTLEPOOL VISION FOR ADULT SERVICES 2014-17

4.1 The vision for adult services in Hartlepool reflects the direction of travel set out in the national policies over the last few years together with the Health and Social Care Act 2012 due to be implemented from 2015.

4.2 The principles underpinning the national strategy for adult social care are; personalised services and increased integration between health and social care, with a leaner, more outcomes-focused role for the public sector. The overall aim is for people to stay healthy and actively involved in their communities for longer thereby delaying or avoiding the need for targeted services.

4.3 Public Health, now located within local authorities, will play a significant role in this preventative agenda. People who require services should be encouraged to remain as independent as possible and retain maximum control over the process.

4.4 The transformational change of adult social care began in 2006 and will continue to be driven forward by three key component principles:

- Preventing ill-health and intervening early to keep people well;
- Focusing on community-based approaches and public health initiatives to encourage people to take care of their own health and well-being;
- Delivering personalised care and support through personal budgets.

4.5 Local authorities will continue to work with other statutory, independent, voluntary and third sector provides, people who use services and their carers to shape provision and increase the number of people determining how they are supported or commissioning their own services.

5. PROGRESS AGAINST PRIORITIES

5.1 The action plan that is attached as **Appendix 1** provides the framework for the detailed work required to deliver the vision.

5.2 A progress update is provided for each of the agreed priorities.

6. NEXT STEPS

6.1 An action plan for 2015/16 will be developed following approved of the Departmental Plan. This will be based on the priorities identified in **Appendix 2**. This will be monitored through the Child & Adult Services Departmental Management Team throughout the year with progress reported to the Adult Services Committee in March 2016.

7. RECOMMENDATIONS

7.1 It is recommended that the Adult Services Committee notes progress made to implement the vision for adult services and receives a further updates in March 2016.

8. REASONS FOR RECOMMENDATIONS

8.1 Adult services continue to undergo significant changes in the way services are designed, developed and delivered to reflect a modern system of social care that is built on personalisation, partnerships and increasingly integrated services across organizations, where relevant and appropriate, as well as keeping people safe and enabling them to retain maximum choice and independence.

8.2 Moving Forward Together – The Vision for Adult Services in Hartlepool 2014-17 reflects these aspirations. The high level action plan aims to translate this vision into reality.

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7.3 APPENDIX 1

MOVING FORWARD TOGETHER: ACTION PLAN 2014/15

Objective	Activities/Milestones	Progress Update
Establish integrated health and social care pathways / services that facilitate people living in their own homes, avoid unnecessary admissions to hospital and enable timely and safe hospital discharges.	• Increase the number of people using assistive technology as a means to remain independent.	• The number of telecare users continues to increase on a monthly basis. The target for 2014/15 was 1,500 users. As at end of November 2014, there were over 1,860 users.
	• Increase capacity in the early intervention service to facilitate hospital discharge.	• Additional social work and Occupational Therapy capacity has been funded through the NHS transfer to social care.
	• Integrate first points of contact between adult social care and health.	• A model for integration of first points of contact has been agreed and options co-location will take place in 2015/16.
	• Develop step up / step down provision	• Audits and analysis are being undertaken to assess the need for step up and step down provision, which will be implemented as part of the Better Care Fund plan for Hartlepool.
Deliver reablement services that enable people to maximise their abilities and develop the skills and capacity to retain their independence for as long as possible.	• Increase the rate of referrals for reablement services.	• The proportion of people accessing reablement services has increased from 3.29% in 2013/14 to 5.62% at the end of November 2014.
	• Maximise the effectiveness of reablement services in reducing ongoing care needs.	• 80% of people who receive a reablement package have non ongoing care needs following the period of reablement.
	• Review reablement capacity, model and	• Model currently under review linked to the

	training requirements.	Better Care Fund plan.
Build community capacity and low level support services that increase choice and reduce social isolation.	• Award, implementation and ongoing monitoring of the low level support tender. • Review voluntary sector provision for people with long term conditions / disabilities and agree commissioning priorities.	• Contract awarded, new service due to commence early in 2015/16. • Review completed and priorities identified for 2015/16, which will be supported by the Better Care Fund.
Develop an independent living centre that improves outcomes for adults with a disability and / or long term condition.	• Finalise the business case for a new independent living centre. • Explore options for integration and links to the BCF plan re: condition management and support for people with long term conditions.	• Development has been approved. New independent living centre expected to be operational from April 2016. • Options are being explored in relation to condition management and expert carer programmes through the Better Care Fund plan.
Improve pathways and services to meet the needs of individuals with dementia and their families / carers.	• Continued engagement with the Dementia Collaborative. • Proactive work with providers to drive improvements in care home provision for people with dementia. • Create dementia advisor roles that support people with dementia and their families / carers. • Develop alternatives to residential care for people with dementia. • Increase capacity to support the assessment	• Engagement continues. all partners have agreed funding for a further year. • Support for care homes is being enhanced through the Better Care Fund plan. • A Dementia Advisor service will be commissioned through the Better Care Fund. • Some alternatives are in place (extra care housing and support at home). Potential to develop group living for people with dementia is being explored. • Two additional social work posts have been

	and care management of people with dementia including young onset dementia. • Create dementia friendly intermediate care provision.	supported from the Better Care Fund to increase capacity. • Intermediate care services developed through the Better Care Fund will take into account the needs of people with dementia. There is also work underway to have Hartlepool accredited as a Dementia Friendly Community.
Prepare for the implementation of the Care Bill.	• Financial impact modelling. • Analysis of self funders and requirement for additional assessments. • Identify implications of changes to assessment and support for carers. • Review / redesign of care management & IT systems. • Understand workforce implications and develop a training programme to meet identified needs. • Agree HBC approach to public information and advice linked to the development of the Advice & Guidance service and website review.	• Financial modelling work has been undertaken including analysis of numbers of self funders and carers requiring assessment and support. This work fed in to the national work and informed funding allocations for 2015/16. • Changes to care management and IT systems will be required from April 2016 when funding reforms are introduced. Work is underway to prepare for this. • Workforce implications have been assessed and a training programme developed. • A new online Information and Advice resource has been procured and will be in place from April 2015 with a post established to support this work.
Improve the transitions process to ensure every child and young person in transition (aged 14-25) with a disability	• Multi agency review of transitions process. • Integrate assessment, planning and resource allocation for young people with SEND to support good transitions into adulthood.	• A project is in place (led by Children's Services) to review the transitions process and explore potential integration of SEND within the 0-25 model.

has a person centred outcome focused plan for adulthood.	• Review current 0-25 model and commissioning implications for adult services.	• A review of the current 0-25 model will take place in March 2015.
Ensure that people with learning disabilities receive good quality, outcome focused care and support, including those covered under the Winterbourne View Concordat.	• Review residential respite provision and agree future commissioning model. • Support the delivery of the high level action plan for Winterbourne View and map implications for social care. • Continue to develop employment opportunities for people with disabilities.	• Current residential respite provision meets local needs. Review will take place in 15/16. • Adult services continue to support the NHS led work in relation to the Winterbourne View implementation plan. • 15% of adults with learning disabilities are in employment (compared to a national average of 6.8%).
Strengthen local arrangements for Safeguarding Adults.	• Clarify governance arrangements between HSAC and TSVAB. • Actively promote ongoing commitment of all strategic partners. • Strengthen work with CQC and health partners through use of the Serious Concerns Protocol. • Implementation of the revised QSF approach to assure quality of care in care home settings. • Use learning from user surveys, complaints and safeguarding to improve practice and inform workforce development.	• Tees Safeguarding Adults Board is now the statutory Board for the four Tees Local Authorities. A new Safeguarding Adults Local Executive Group for Hartlepool was established in January 2015 with all partners encouraged to attend. • Regular meetings are now in place involving HBC, the CCG and CQC to share information and concerns. • Revised QSF approach has been implemented and is working well. • Learning from surveys, complaints and safeguarding is regularly shared to improve practice and informs workforce development

		priorities. 'Our Voice, Our Choice' DVD developed by people who use services to inform staff training and further develop understanding of the user perspective.
Review spend on community based packages of support and identify options to improve cost effectiveness.	• Identify current spend and trends since 2007.	• Current spend and trends have been identified along with benchmarking to compare spend against other Local Authorities.
	• Develop options to review RAS.	• Options to review the resource Allocation System will be developed in 2015/16.
	• Review of high cost placements.	• High cost placements are regularly reviewed and work is undertaken to ensure that other funding sources are maximised.
	• Map implications of ILF changes and agree approach to reviews and future use of this resource.	• Changes to the Independent Living Fund have been mapped and a proposal developed for use of the resource in 2015/16.

7.3 APPENDIX 2

MOVING FORWARD TOGETHER: PRIORITIES FOR 2015/16

	Objective
1	Establish integrated health and social care pathways / services that facilitate people living in their own homes, avoid unnecessary admissions to hospital and enable timely and safe hospital discharges, through implementation of the Better Care Fund (BCF) plan.
2	Deliver reablement services that enable people to maximise their abilities and develop the skills and capacity to retain their independence for as long as possible.
3	Implement the 2015/16 requirements of the Care Act and prepare for the 2016/17 requirements.
4	Implement 'Making Safeguarding Personal' and ensure that local arrangements for safeguarding are compliant with the Care Act.
5	Implement the actions identified by the Mental Health Implementation Plan to improve mental health services for the people of Hartlepool.
6	Build community capacity and low level support services that increase choice and reduce social isolation.
7	Improve pathways and services to meet the needs of individuals with dementia and their families / carers.
8	Develop an independent living centre that improves outcomes for adults with a disability and / or long term condition
9	Ensure that people with learning disabilities receive good quality, outcome focused care and support, including those covered under the Winterbourne View Concordat recommendations.
10	Review systems, learn lessons from surveys and complaints and develop the workforce to ensure that staff are supported and working safely and effectively.

ADULT SERVICES COMMITTEE
9th March 2015

Report of: Director of Child and Adult Services

Subject: SUPPORT FOR PEOPLE WITH DEMENTIA IN HARTLEPOOL

1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required – for information.

2. PURPOSE OF REPORT

2.1 This report provides the Adult Services Committee with a further update regarding support for people with dementia in Hartlepool, following a report in August 2014.

3. BACKGROUND

3.1 Dementia is one of the most pressing issues relating to older people. It is a range of symptoms including memory loss, mood change and problems with communication and reasoning that are brought about by diseases that damage the brain, such as Alzheimer's disease. It is progressive and at present there are no cures, although there are evolving treatments that can slow the progress of the disease and sustain people for longer.

3.2 The National Dementia Strategy: Living Well with Dementia was launched in 2009 and highlighted the need for early diagnosis and treatment as it was estimated that only a third of people with dementia received an accurate and timely diagnosis.

3.3 This issue was reviewed in 'Dementia 2014 - A North East Perspective: The Regional Report and Implications for Personalisation' which identified that appropriate diagnosis remains a significant issue in the North East. The issue is also highlighted in the Alzheimer's Society's Right to Know campaign and in their publicity campaign entitled 'I get by with a little help from my friends!'.

3.4 The underlying reasons for this lack of early identification of people with dementia and formal diagnosis remain the same with reasons including:

- lack of information
- lack of awareness and confidence in dealing with people with dementia by both the general public and medical and support staff,
- The taboo, that dementia remains a subject that many people find hard to talk about, much like cancer was 15 – 20 years ago. Everyone knows someone who has it or is affected by it but doesn't talk about it.

3.5 Restrictions on health budgets and reductions in Council budgets across the country, together with the rising number of people who have or will have dementia mean that the current ways of providing and resourcing services for older people, and particularly those who have dementia, are already under severe strain and in the longer term are considered unviable if they stay the same.

4. NATIONAL DEVELOPMENTS

4.1 The National Dementia Strategy - Living Well with Dementia, continues to ensure significant improvements are made to dementia services across three key areas:

- improved awareness;
- earlier diagnosis and intervention; and
- higher quality of care.

Implementation of the Strategy's key objectives requires activity at a local level. The objectives are set out below:

Objective	
1	Improving public and professional awareness and understanding of dementia.
2	Good-quality early diagnosis and intervention for all
3	Good-quality information for those with diagnosed dementia and their carers
4	Enabling easy access to care, support and advice following diagnosis
5	Development of structured peer support and learning networks
6	Improved community personal support services
7	Implementing the Carers' Strategy
8	Improved quality of care for people with dementia in general hospitals
9	Improved intermediate care for people with dementia
10	Considering the potential for housing support, housing-related services and Telecare to support people with dementia and their carers
11	Living well with dementia in care homes
12	Improved end of life care for people with dementia
13	An informed and effective workforce for people with dementia
14	A joint commissioning strategy for dementia
15	Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers
16	A clear picture of research evidence and needs
17	Effective national and regional support for implementation of the Strategy

4.2 The Prime Minister's Call to Action in March 2012 was designed to make a real difference to the lives of people with dementia and their families and carers by 2015. One of its 3 key objectives was creation of Dementia Friendly Communities.

4.4 Dementia Action Alliance: Carers Call to Action in 2013 establishes several milestones to be achieved by March 2015:

- 2/3 of Health and Wellbeing Boards, Clinical Commissioning Groups and Local Authorities in England will be expected to recognise the importance of support for carers of people with dementia

- Local areas will be awarded star ratings based on demonstrating measurable actions in line with the five aims of the Call to Action.

4.5 It is currently not clear when the star rating system will be instigated.

5. HARTLEPOOL POSITION

5.1 As reported in August 2014 the work of the North of Tees Dementia Collaborative continues to focus on improving the care of people with dementia. The Collaborative is now in its third year and all partners including Hartlepool Borough Council have agreed funding for a further year. A list of members of the collaborative is listed in **Appendix 1**.

5.2 In its third year, the plan of work of the Collaborative has moved away from multi agency Rapid Process Improvement Workshops towards more share and spread of the learning and maximising the unique mix of Collaborative members knowledge and skills. The proposed areas of work are given below

- Continuing to extend the membership to new organisations,
- Promoting a change agent culture within organisations, with identified improvement leads
- Embedding and sustaining the changes agreed to date.
- Supporting change in new areas identified by one or more partners
- Linking with the Better Care Fund work strands
- Spreading elements of the work that would benefit other areas
- Collating knowledge on good practice in other areas.
- Maximise joint working by establishing links with the South of Tees Dementia Collaborative, North East Dementia Alliance, Clinical Network Northern England and North East Dementia Hub.

5.3 The ongoing focus on dementia created by the Collaborative means that there is now a common understanding of the issue and need for change regarding support for people with dementia and their carers. This means that the initial steps in making Hartlepool more dementia friendly are continuing.

6. RAISING AWARENESS OF DEMENTIA IN HARTLEPOOL

6.1 As reported previously there was strong interest in exploring how best to raise awareness of dementia in Hartlepool

6.2 Dementia Friends Information Sessions have proved a very effective means of assisting interested individuals, and particularly customer-facing staff, to become more aware of the issues faced by people with dementia and their carers. This method of raising awareness has become a basic foundation of what has become the Working to Build a Dementia Friendly Hartlepool project

6.3 Seven members of the project steering group have undergone Dementia Friend Champion training. This has enabled them to deliver Dementia Friends Information Session across a broad range of staff and to Elected Members. Sessions have been rolled out across the Council and to organisations such as Healthwatch Hartlepool and the 50+ Forum. There have been 70 staff members who have been trained within the Council and at least a further 50 people trained in other organisations and this number is growing. The intention is now to roll out this awareness raising to the community at large

7 HARTLEPOOL AS A DEMENTIA FRIENDLY COMMUNITY

7.1 A Steering Group has been established to deliver the Working to Build a Dementia Friendly Hartlepool project, bringing together a large range of local organisations, reflecting the community wide approach (see **Appendix 1**).

7.2 Consultation has been undertaken with people with dementia and their carers and the information gained from this will be used to establish the local priorities in Hartlepool. The immediate aim is to gain accreditation as a Dementia Friendly Community through the national scheme. This will require the project to meet the requirements of the Dementia Friendly Communities Foundation Criteria, which are shown in **Appendix 2**.

7.3 A Dementia Friendly Community has high levels of public awareness and understanding of dementia. People with dementia and their carers are encouraged to seek help and are supported by their community who are able to offer that support. People with dementia are included and their ability to remain independent and have choice and control over their lives is improved.

7.4 The Working to Build a Dementia Friendly Hartlepool project has an action plan (see **Appendix 3**) that is regularly updated. The key focus of the plan over the last year has been:

- establishing the project and the Steering Group;
- consulting with people with dementia and their carers;
- encouraging organisations to participate in the project and agreeing what actions they will take; and
- gaining accreditation as a Dementia Friendly Community.

8. ENGAGING THE WIDER COMMUNITY

8.1 Going forward, developing a greater public awareness of the Working to Build a Dementia Friendly Hartlepool project and the reasons why Hartlepool needs to become more dementia friendly will be vital.

8.2 Nationally, support has come from the Government, political parties, the business and commercial communities as well as from the charitable and voluntary sector. Employers have committed to create over 190,000 Dementia Friends in shops and banks across the UK. Organisations that have signed up at a corporate / national level are potentially key players in any local plans.

8.2 This level of sign up is gradually being replicated at a local Hartlepool level. All organisations that come into contact with people who have dementia are being encouraged to work to become Dementia Friendly. People with dementia, particularly those in the earlier stages, continue to be customers and users just as any other citizen. Where an organisation can make reasonable adjustments, customers can continue to use the facilities on offer. Friendly approachable staff, clear signage and an easily navigated environment will benefit not just people with dementia but all other users.

8.3 The local response from the organisations, people and businesses of Hartlepool to the idea of being a dementia friendly community has been remarkable and very positive. The project will seek to maintain this level of enthusiasm and build on it for the future. Once accreditation is achieved, the steering group will be able to award the Dementia Friendly Community symbol to all organisations that have committed to the project and can evidence that they are making progress. Progress will be reviewed after 6 months initially and then annually and reported to the national organisation that will re-accredit the project each year.

9. RECOMMENDATIONS

9.1 It is recommended that the Adult Services Committee note the developments in relation to support for people with dementia and their carers and receive further progress reports as appropriate.

9.2 All Council members are invited to pledge their support for the Working to Build a Dementia Friendly Hartlepool project.

10. REASONS FOR RECOMMENDATIONS

10.1 The growing number of people with dementia and society's ability to support them is one of the biggest issues facing the developed world in the 21st century. This is set against a sustained period of reducing resources available within health and social care.

10.2 The development of a Dementia Friendly Hartlepool that will improve local services and support for people with dementia and their carers requires sign up from all key partners.

11. CONTACT OFFICER

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Appendix 1

Members of the North of Tees Dementia Collaborative

The Formal Partners in the Collaborative are:-

- Hartlepool Borough Council
- Stockton Borough Council
- Hartlepool and Stockton on Tees Clinical Commissioning Group
- North Tees and Hartlepool NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- North East Commissioned Support (NECS)

In addition, a number of organisations, including those from the independent and voluntary sector have been involved including:

- Hartlepool Healthwatch
- Hartlepool Carers
- Hospital of God at Greatham
- Stockton Healthwatch
- Sanctuary (carer organisations in Stockton)
- Alzheimers Society,
- CleveARC
- Age UK

Appendix 2

Dementia Friendly Communities Foundation Criteria

Criteria 1
Make sure you have the right local structure in place to maintain a sustainable dementia friendly community

Criteria 2
Identify a person or people to take responsibility for driving forward the work to support your community to become dementia friendly and ensure that individuals, organisations and businesses are meeting their stated commitments

Criteria 3
Have a plan to raise awareness about dementia in key organisations and businesses within the community that support people with dementia

Criteria 4
Develop a strong voice for people with dementia living in your communities. This will give your plan credibility and will make sure it focuses on areas people with dementia feel are most important

Criteria 5
Raise the profile of your work to increase reach and awareness to different groups in the community

7.4 Appendix 3

Working to Build a Dementia Friendly Hartlepool Action plan

No	Foundation Criteria	Action	When	By Whom	Comments
1	Make sure you have the right local structure in place to maintain a sustainable dementia friendly community	Working to Build a Dementia Friendly Hartlepool was established in Aug 2014 A revised terms of reference and nominations for officers was discussed Revised Terms of Reference and officers confirmed	Aug 2014 Nov 2014 Jan 2015	Steering group Steering group Steering group	Actions complete
2	Identify a person or people to take responsibility for driving forward the work to support your community to become dementia friendly and ensure that individuals, organisations and businesses are meeting their stated commitments	Chair, Vice Chair and secretaries appointed Subgroup arranged to organise accreditation to dementia friendly communities organisation Pledges and statements of current and/or intended actions being confirmed with participants	Jan 2015 Feb 2015 Feb 2015 April 2015	Steering group Caroline Ryder-Jones, Steve Thomas, Gail Defty Steve Thomas Steering group	These pledges and statements of action will form the basis of the ongoing action plan that will then be used to monitor progress. Action need to identify who will monitor this post March 2015
3	Have a plan to raise awareness about dementia in key organisations and businesses within the community that support people with dementia	Sequence of Dementia Friends Information sessions is ongoing. Programme of sessions open to the wider community now required	Commenced June 2014 March 2015 onwards	Steve Thomas, Phyl Rafferty Caroline Ryder-Jones, Awareness sub group	To date these have mostly been closed groups within organisations working closely with the project. Seven Dementia Friends Champions now trained and are able to deliver session. Awareness raising sub group to coordinate planned sessions

		Programme of contacting business community and colleges to be developed to raise awareness and gain participation of the wider commercial and business community	March 2015 onwards	Steve Carter, Lisa Thompson, Caroline Ryder-Jones	*S Carter from Public Health to contact organisations involved in NE Better Health at Work award – all Dir of Pub Health are signed up to this several local firms and organisations involved inc. 13, Tata Steel, EDF energy, Herema, Northgate and Cleveland Fire. This to take place in conjunction with Business in the community Connect project [development worker Lisa Thompson has agreed to promote WTBDFH]*
4	Develop a strong voice for people with dementia living in your communities. This will give your plan credibility and will make sure it focuses on areas people with dementia feel are most important	Consultation to take place with people who have dementia and their carers.	August to October 2014	Working group	Consultation included a questionnaire and a focus group event. Both were carried out so that significant support was available so that the views of people with dementia who might find it difficult to take part could be included.
		Analysis of the views of people with dementia will be used to determine the priority areas for action locally	Nov 2014	Steve Thomas	A combined analysis report of both consultation methods has been completed as well as individual analysis report
			Feb 2015	Steve Thomas, Jeanette Willis, Laura Stone	Subsequently the HBC's Audit and Scrutiny Committee has also held a dementia focus group as part of their investigation into dementia and the support available.
			March 2015	Laura Stone	A formal report will go to Full council in March 2015.
			March 2015	Steve Thomas	The information collected from this focus group will also be included in the WTBDFH needs analysis.
5	Raise the profile of your work to increase reach and awareness to different groups in the community	Offer Presentation to • 50+ Forum • Healthwatch members	Ongoing updates	Phyl Rafferty Steve Thomas	Both organisations are aware of the programme and have now pledged their support for the project Jan 2015

		Presentation - Dementia Friends Information Session to Elected members	Nov 2014	Steve Thomas	Members who attended very supportive of the project. As a result invitations were received to address the Neighbourhood Forums and Headland Parish Council
		Presentation to South and Central Neighbourhood Forum	Jan 2015	Steve Thomas	
		Presentation to Headland Parish Council	Jan 2015		
		Project to attend promotional forum as part of "Transforming Care" event to raise awareness and ask individuals to sign up to support the project	Feb 2015	Steve Thomas, Kate Hogan, Caroline Ryder -Jones	
		Programme of presentations to Residents associations planned	March 2015	Awareness sub-group	Steve Thomas to produce initial introductory material about the importance of the project that will be disseminated by democratic services to all Hartlepool residents associations
		Contact to be made with Middleton Grange Shopping Centre to promote dementia friendly working	27th Feb 2015	Steve Thomas	Contact with the shopping centre as an organisation in its own right was seen by the steering group as key to raising the project profile within the retail sector and possible use or the centre for future promotional work.
		Explore contacts with social groups such as Rotary, Round Table, 41 club etc. to raise awareness and promote activity	April 2015	Awareness raising group	
		Agree publicity arrangements and process for formal launch once accreditation has been achieved. Plan campaign Time scale • Accreditation Feb 2015 • Publicity campaign to raise awareness of accreditation and invitation to participate • Formal Launch May 2015	Feb 2015	Steering group	HBC press office strongly recommended that 1 agency or organisation is responsible for organising publicity to avoid confusion and duplication. Colleagues in HBC public health have agreed to take on this role. Role to be agreed at next Steering group. Feb 2015

6	Focus your plans on a number of key areas that have been identified locally	Analysis from consultations and use of existing contacts to be used to prioritise actions going forward. This includes looking for easy wins where participants are in a position to make progress related to their existing activity	April 2015	Steering group	Key role of the steering group is to coordinate the actions of people carrying out activity and maintain a clear overview of what is happening and what needs to happen next
	Other areas of activity				
	Resource sub group	Bid submitted to the HaST CCG "Ideas Cave" for a part time development worker is still pending with no decision yet.	Feb 2015		Hartlepool and Stockton CCG are now considering the bid against their commissioning intentions for 2015/16
	Information sub group				
	Develop progressive information giving strategy for people with dementia and their carers	Initial actions have been completed Help for cares factsheet available via HBC web site Independent advice leaflet for cares Draft directory of support from organisations involved and the information they provide has been developed but now need to be formalised and publicised Information being available in the right place and the right time remains a key issue as evidenced by the feedback from the consultations and still needs to be addressed	March 2015	Leigh Keeble	Leigh Keeble who initiated the original group has been asked to call a meeting with the original members of the group to take this forward Link to revised 'Hartlepool Now' web site
	Coordination of activity	Roles or working sub groups needs to be reconsidered with possible revision of their membership as several new participants have joined the project Work plans for each group need to be developed Arrangements for coordination of activity through the Steering group need to be confirmed and delegated action for the Chair of the steering group need to be established to allow progress between Steering group meetings		Steering Group Caroline Ryder -Jones	

ADULT SERVICES COMMITTEE
9th March 2015

Report of: Director of Child and Adult Services

Subject: UPDATE ON DOMICILIARY CARE SERVICES IN RESPONSE TO RECOMMENDATIONS BY HEALTHWATCH HARTLEPOOL

1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required – for information.

2. PURPOSE OF REPORT

2.1 The Healthwatch Hartlepool investigation into domiciliary care services made several recommendations. This report provides the Adult Services Committee with an update regarding how the recommendations are being addressed.

3. BACKGROUND

3.1 In May 2013 Healthwatch Hartlepool commenced an examination of the provision of domiciliary care. The investigation arose from issues raised with Hartlepool LINk and later Healthwatch Hartlepool by users of domiciliary care services and their family members.

3.2 The investigation looked at the three main providers of domiciliary care in the town; Careline and Carewatch who provide general support in the south and north part of the town respectively and the HBC in-house team who provide more specialised support in areas such as Intermediate Care, Re-ablement, Telecare and Carers Emergency Respite Care Service.

3.3 The Healthwatch report was completed in December 2013 and was presented to the Adult Services Committee on 7 February 2014. The report was largely positive but made six key recommendations

3.4 A report detailing the response from Adult Services was presented to Adult Services Committee on 7 April 2014. This outlined the planned action by the department to address the report's recommendations.

4. PROGRESS

4.1 This report describes the progress that has been made on implementing these recommendations

4.2 Recommendation 1

Care time allocations should be regularly checked to ensure that the allocated time is spent fully with service users in order to ensure that individual care plan specifications are properly delivered.

Adequate travelling time must be provided to ensure that care workers can get from job to job without eating in to allocated care time.

4.2.1 HBC Response in April 2014

Within the HBC contract arrangements there is an expectation that the allocated amount of time will be used to support the service user. Case files, which are left in each service user's home have an entry for each care visit made by the care worker and include arrival and departure times. Those clients who are able to are also asked to sign the workers timesheets. This means that a record of the time spent is available for checking but this would need to be a manual process. Service users, family members and carers have access to this information.

The annual care review structure provides the opportunity for service users and carers to raise these sorts of matters. Alternatively service users have access to a care manager at any time if they have concerns or wish to discuss their care plan

4.2.2 Actions Identified in April 2014:

- Review officers to be asked to check timeliness and length of visit during reviews

- Care providers to be asked to monitor time sheets and provide quarterly audit reports based on a sample of customers

- HBC has successfully implemented its new system for care planning, called Caretime. This system is linked to the department's Carefirst system. Currently the system maps planned time and further development is being undertaken to record actual time using mobile telephone technology. An update will be provided when the system is fully implemented.

- In the future it is the intention to discuss with current providers the use of the same (or similar) system and it may be possible to build this requirement into future contractual arrangements.

4.2.3 Current Position

Arrival and departure times at client's homes are noted in the care file in each person's home. This allows reviewing officers to monitor timelines and length of visits at review. It is also monitored internally by the agencies via time sheets which are signed by the service user where this is appropriate. Providers also provide the Council with information about timeliness and adherence to agreed timing of visits from a sample of packages.

A sample of time sheets from the care agencies demonstrates that timeliness of visits is largely good. Both organisations operate a 15 minute window where agreeable to the client. In some instances this is not possible due to other circumstances such as medical conditions where support is needed or medication reminders are required.

Discussions with social work locality managers indicate that timeliness of care delivery is not generally being flagged as being an issue. Both social care locality teams have problem solving mechanisms where they are in regular discussion with the care providers and resolve issues where needed.

4.3 Recommendation 2

Mandatory training programmes across all three service providers should include Dementia Awareness, Disability Awareness and Equality and Diversity. Key modules such Adult Safeguarding and Manual Handling should be the subject of mandatory refresher programmes across all three service providers to ensure skills and understanding are up to date

4.3.1 HBC Response in April 2014

All 3 providers have dementia awareness and equality and diversity training as mandatory training. Manual handling and safeguarding training is also updated annually for all staff.

Disability awareness training is not specific training provided by Careline or HBC's workforce development programmes as this form of awareness is an underpinning of the personalisation approach taken in their delivery of care and involved in other training material.

4.3.2 Action Identified in April 2014:

- Care providers to keep training programmes under review to ensure that these goals are met

4.3.3 Current Position

All organisations continue to have robust training schemes in place including induction and refresher training for mandatory training. Both include dementia awareness training which is seen as vital to provide effective support for service users.

4.4 Recommendation 3

Every effort should be made to ensure continuity of care provision should occur as far as is practicably possible and that robust communication systems

are in place to ensure that service users are always informed when changes to care workers and routines take place.

4.4.1 HBC Response in April 2014

There is no standard measure of what is an appropriate number of carers to be involved in an individual's care. Numbers are dependent on the quantity of calls per day / week and the number of carers needed for each visit.

Section 13.7 of the HBC contract specification states that:
"Service users, their relatives and/or representatives should be kept fully informed on issues relating to their care, at all times. Service User should be provided with a weekly timetable identifying which care and support workers will be providing care and support to the Service User and the times the care and support will take place."

All care providers state that they give the service user or their representative a copy of the rota in advanced for each week, stating who should be calling and when. However in-week changes will occur due to illness etc.

All care agencies state that they make every effort to inform the service user of carers of any changes in the rota

4.4.2 Actions Identified in April 2014

- Each provider to be requested to develop a range of appropriate standards about the number of carers who would be visiting each service user and monitor performance against that standard on a 1/4rly basis based on a sample of service users.

- Each provider to be requested to monitor in-week changes to the rota and their success in notifying the service user or their representatives in advance of any changes prior to the care being provided on a quarterly basis, also based on a sample of service users.

- Both the above issues to be consider during social care reviews and contract monitoring visits

4.4.3 Current Position

Best practice standards have been developed by both providers. These are linked to the size of the care package. Every effort is made by both providers to minimise the number of workers visiting a service user's home. The table below is an approximate guide:

Calls per week	Maximum number of workers
7	3
14	4
21	5
28	6

The level of dependency of many people supported by domiciliary care in the community means that several care visits require 2 or more workers to attend (e.g. for safe moving and handling), which increases the number of people involved in the care package but does not mean a doubling of the number of people involved. An example would be that a person who received 30 calls per week had an average of 5 workers involved over a 3 week period

The providers try and match workers to clients and focus the majority of contacts on one or two main workers. This allows for better building of trust between service user and carer. This issue is monitored internally by both providers. Information provided to HBC from of a sample of care packages demonstrates that this does occur in practice in the majority of instances.

Wherever possible, a core of known workers is linked to each person requiring support. Within this core group the majority of visits are by a small; number of workers. An example from the sample provided showed that in a package where someone received 56 visits (multiple double visits) in a week 85% of those were by just 5 workers. Viewing of rotas and time sheets indicate that travel time is taken into account so workers have time to travel between calls.

Discussions with social work locality managers indicate that continuity of care is not generally seen as being an issue. There can be problems when new packages of care are needed to facilitate rapid discharge from hospital when, due to the requirement for the package to commence at short notice, continuity of care workers can suffer initially until a stable regime is established and regular staff are identified. As stated previously, both social care locality teams have mechanisms where they are in regular discussion with the care providers and problem solve issues where needed.

If problems were to persist there is an ongoing dialogue to resolve issues involving the persons care manager and the care agency. Service users are also always offered the option of having a direct payment if they wish to employ their own personal assistants, with the support from a brokerage organisation if needed.

4.5 Recommendation 4

Consideration should be given to ensuring that care staff service conditions such as payment of DBS fees are unified in line with HBC provisions

4.5.1 <u>HBC Response in April 2014</u>

There are currently marked differences between the terms and conditions offered to their staff by the all 3 providers. These differences include:

- Paying for uniforms,
- payment of mileage,
- payment for travel,
- DBS
- Use of zero hour contracts

4.5.2 Actions Identified in April 2014

- The Council will work with providers to understand the terms and conditions they employ. There may be issues such as turnover of staff relating to DBS and uniforms. With regard to mileage, an understanding of the areas covered by staff would be necessary to fully appreciate the impact. Both independent sector agencies work on a geographical basis whereas the Council provides a town wide service.

- With regard to zero hours contracts, what domiciliary care workers are paid is being investigated by H.M Revenue and Customs. Nationally, some domiciliary care workers, particularly those on zero-hour guaranteed contracts are, in some circumstances effectively being paid below the national minimum wage when travelling is not taken into account. The department would want to understand fully if this was occurring before formulating a plan of action with providers.

- Once investigation had been undertaken to understand the terms and conditions, the department can take a view on how best to address any issues that might be raised. This work can be undertaken during routine contract monitoring processes.

4.5.3 Current Position

Work has been done with both external providers to understand their terms and conditions.

4.5.4 Zero Guaranteed Hours Contracts

Nominally, Carewatch do use zero guaranteed hour contracts but state that their workers are offered as many hours as they wish and accrue entitlement for paid leave in line with the working time regulations 1998, which give workers the right to 5.6 weeks (28 days) inclusive of bank holidays. For part time workers with variable hours this is calculated on an average of the previous 12 weeks work. The contracts used allow workers the option of having more than 1 job as they are not employer exclusive. Careline operate flexible working contracts and workers accrue holiday entitlement in a similar way. Both utilise statutory sick pay.

4.5.5 DBS

Neither of the providers pay for DBS clearance for new staff. The stated reason for this is that the highest turnover of staff is those new starters that find they are not suited to the work. However both use recruitment agencies that are able to access funding for most new workers to gain DBS clearance. Turnover of staff is particularly high in these new starters. However, there is also competition now for more experienced staff from care homes looking for people who already know the caring role. This is particularly prevalent in the winter months.

Turnover rates are therefore varied – Carewatch turnover is between 5% and 10%, Careline's staff turnover averaged 6% in the 3 months to January 2015. Both agencies are recruiting regularly.

4.5.6 Payment of Mileage for Car Users
Both agencies have concentrated workers on small local patches wherever possible to enable easy access by walking. Where long distances are required for out of area packages mileage is paid. Careline pay a slightly enhanced wage to staff who are designated as car users

4.5.7 Rates of pay
Careline's basic level of pay is minimum wage for one hour. However, most calls are of a shorter duration and attract a higher pro rata pay level:

		Pro rata full hour
1 hour	£6.50	
45 mins	£4.88	£6.50
½ hour	£3.38	£6.76
15 mins	£2.39	£9.56

Weekend and bank holiday pay rates are higher and a travel allowance is paid to staff for attending calls that are not within the normal operational area.

Carewatch's basic pay rate is £6.88 per hour and is paid on a pro rata basis for short periods:

		Pro rata full hour
1 hour	£6.88	
45 mins	£5.18	£6.91
½ hour	£3.44	£6.88
15 mins	£2.15	£8.60

Small patch-based operation allows for short walking distance to cover patch. If longer trips are needed, mileage is paid.

4.6 Recommendation 5
Consideration should be given as to how opportunities can be maximised for carers and family members to input into ongoing monitoring and future service user survey processes

4.6.1 HBC Response in April 2014
The current social care review process has user and carer involvement at its core. This allows for individual issues / concerns to be raised and dealt with and where necessary fed into the care management, contracting and commissioning process. However aggregation of this information relies on analysing individual records.

There are a number of ways individuals and their carers can give their views about our services as set out below:

- The Annual Social Care Survey. This is a statutory survey that is sent to a randomly selected sample of people who use our services and asks questions about their quality of life and how the services we deliver and / or commission help them remain independent. The survey is now in its

third year and allows us to track the results to ensure our services are improving.

- The bi-annual Social Services Survey of Adult Carers in England was developed by the Department of Health and is used to find out whether or not services received by carers are helping them in their caring role and their life outside of caring, and also their perception of services provided to the cared for person.

The results from both surveys are used to influence service design and delivery.

- The department holds a quarterly service user focus group with service users and carers. The group meets to discuss issues raised by the members and has also been involved in a number of consultations as well as acting as a reading group for public information. The group was instrumental introducing factsheets that explain the roles and responsibilities of different workers in the department.

- The department consults with a number of groups such as the Carers Strategy Group, Mental Health Forum, Voice for You, 50+ Forum and Learning Disability Partnership Board. In addition, the department arranges ad-hoc consultations as required. For example, a range of consultation events were held in 2013 to discuss proposed changes to the Fairer Charging Policy.

- The department has held a number of Family Leadership Courses with In-Control. This has led to a group of service users and carers becoming members of the national organisation Partners in Policymaking. This group are now involved in a number of initiatives including the development of training materials for staff. In addition, members of the group have taken part in interview panels for the commissioning of services and we are exploring with the group opportunities for some members to become involved with monitoring contracts

4.6.2 Current Position
The annual social care survey is currently being undertaken and results will be published by September 2015.

4.6.6 In addition to ongoing consultations and engagement, the views of people with dementia and their carers were canvassed as part of the Working to Build a Dementia Friendly Hartlepool project.

4.7 Recommendation 6
Minimum supervision and support provision for care workers should be no less than four formal supervisions and one appraisal meeting each year across all three service providers. In addition to this staff meetings and briefings should be held regularly in order to keep workers briefed and up to date with developments, changes etc. Direct observations should also be carried out regularly as part of ongoing service quality assurance

4.7.1 HBC Response in April 2014
All 3 providers state that they comply with the recommendation re staff meetings and briefings. There is variation across the 3 providers about how when and if direct observation of practice occurs.

4.7.2 Action Identified in April 2014
- All 3 providers to be asked to develop a standard for direct observation of practice that reflects the experience and tenure of the different members of their workforce

4.7.3 Current Position
All agencies continue to comply with the recommendation about staff meetings and briefings are adhered to. All have policies relating to direct supervision and support that reflect experience and tenure of the different members of their workforce. All have 1:1 sessions, team meetings and each supervisor is regularly in contact with their team. All operate an open door policy for all staff. Shadowing and monitored working are also used, particularly with new staff or where issues are identified. Many of the more complex calls require 2 workers who can assist one another and feed back any concerns. A manager can be contacted by phone throughout the working day. Outside normal office hours a mobile phone is staffed by duty supervisors and managers on a rota basis.

5. Unison Ethical Care Charter

5.1 As part of the review of domiciliary care services, a desktop review of the requirements of the Unison Ethical Care Charter has been undertaken. This has not been a formal review; this will form part of the renegotiation of contracts which will take place in spring of 2016.

5.2 The Charter looks to ensure that employees of organisations are properly remunerated and protected whilst carrying out their employment and is focused on a number of areas covering payment, wellbeing and training as well as measures to ensure the individual being cared for is treated with respect and dignity.

5.3 The desktop review has indicated that both providers are already meeting some of the requirements of the Charter.

- Both agencies are contracted to provide domiciliary care on an outcome focussed basis, this involves some planning around particular tasks, and this is carried out in conjunction with the individual receiving care.

- There are some 15 minute calls used but these are restricted in the main for medication and welfare/safety checks.

- Both agencies pay statutory sick pay, travel time is paid for distances above the norm and different rates of pay are paid for shorter calls to incorporate travel time.

- Individuals are allocated the same homecare workers where possible as referenced 4.4.9 taking into account the complexity and practicalities of the package.

- Zero hour/flexible contracts are used by both agencies; currently this does not seem to impact on workers who are able to work sufficient hours regularly to be able to accrue holidays and statutory sick pay. A review of this practise will take place during the contract review.

- Training is carried out in accordance with the contract.

5.4 Two areas where the Charter requirements are not currently relate to occupational sick pay and the Living Wage.

6. RECOMMENDATIONS

6.1 It is recommended that the Adult Service Committee note the current position in relation to domiciliary care and note that domiciliary care contracts are due to be renegotiated in spring 2016.

7. REASONS FOR RECOMMENDATIONS

7.1 To make members aware of work that has been undertaken to address the recommendations in the Healthwatch Hartlepool Domiciliary Care report.

8. CONTACT OFFICER

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ADULT SERVICES COMMITTEE

9 March 2015

Report of: Director of Child & Adult Services

Subject: WINTER UPDATE

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 No decision required; for information.

2. PURPOSE OF REPORT

2.1 To provide the Adult Services Committee with an update on the management of winter pressures.

3. BACKGROUND

3.1 For a number of years, health and social care agencies have worked together to plan for increased activity and pressure over the winter months. This is currently undertaken through a Systems Resilience Group that operates across Hartlepool and Stockton and involves a range of health providers (including Foundation Trusts, the North East Ambulance Service and the Local Medical Committee representing GPs).

3.2 Clinical Commissioning Groups (CCGs) receive funding to support System Resilience over the winter that is allocated through the Systems Resilience Group, which also has a role in terms of monitoring spend and the success of resilience plans.

3.3 It has been well publicised in the national media that health providers have experienced unprecedented levels of pressure over the winter months in 2014/15. This has been replicated in the North East with all acute Foundation Trusts across the region reporting increased A&E attendances, longer waits in A&E, increased bed occupancy and more delayed discharges.

3.4 In North Tees & Hartlepool Foundation Trust, there have been up to 52 additional beds open over the winter months to manage the additional demand, and bed occupancy has consistently been above the recommended national average of 85%.

4. HARTLEPOOL BOROUGH COUNCIL POSITION

4.1 The Council is represented on the Systems Resilience Group and received additional funding of £70,000 linked to the Systems Resilience Plan to fund additional rehabilitation beds at West View Lodge and to commission additional domiciliary care capacity over weekends.

4.2 There has been a 40% increase in hospital discharge referrals compared to the same period last winter, which has created significant pressures for the social care staff that manage the hospital discharge process.

4.3 Throughout the winter period to date, despite the huge increase in hospital discharge referrals, there has not been a delayed discharge that is due to a delay in a social care assessment or a social care package being in place.

4.4 Activity in relation to care home admissions for the winter months is currently being analysed. It is normal for there to be an increase in admissions over winter, but an initial review of the data indicates that care home admissions for 2014/15 will be lower than in previous years, which is a significant achievement in the context of both the winter and the wider demographic pressures.

4.5 There was an announcement at the end of January 2015 that all Local Authorities would receive a one off ring-fenced 'Helping People Home' grant from the Department of Health to help management of delayed hospital discharges. This followed allocations earlier in January 2015 to the Councils identified nationally as having the greatest number of delayed discharges.

4.6 The Helping People Home grant was awarded based on the number of people aged over 65 in each area and then towards authorities where there were more delayed discharges because of a delay in providing home care packages and equipment. The allocation for Hartlepool was £75,000.

4.7 There is a requirement that the Helping People Home grant is used by 31 March 2015 and in Hartlepool it will be used to fund additional capacity within care management teams (Social Workers and Occupational Therapists) as well as additional domiciliary care support in the community.

5. NEXT STEPS

5.1 Work will begin shortly to review the system resilience plans for 2014/15 and to identify those interventions that were successful and could potentially continue on an ongoing basis. This information will be used to inform system resilience plans for 2015/16 and also to inform the CCG's commissioning intentions.

6. RECOMMENDATIONS

6.1 It is recommended that the Adult Services Committee note the current position in relation to management of winter pressures.

7. REASONS FOR RECOMMENDATIONS

7.1 To ensure that Adult Services Committee members are aware of the current pressures being experienced and the work that is being undertaken to manage those pressures.

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