ADULT SERVICES COMMITTEE AGENDA

HARTLEPOOL BOROUGH COUNCIL

Monday 9 November 2015

at 10.00 am

in Committee Room B, Civic Centre, Hartlepool

MEMBERS: ADULT SERVICES COMMITTEE

Councillors Atkinson, Beck, Belcher, Loynes, Richardson, Tempest 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 12 October 2015 *(for information as previously circulated)*.

4. **BUDGET AND POLICY FRAMEWORK ITEMS**

   No items

5. **KEY DECISIONS**

   5.1 Promoting Change, Transforming Lives Project – *Director of Child and Adult Services*

6. **OTHER ITEMS REQUIRING DECISION**

6.1 Teeswide Safeguarding Adults Board Annual Report 2014/2015 and Strategic Business Plan 2015/16 – *Director of Child and Adult Services*

7. **ITEMS FOR INFORMATION**

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

7.2 Response to the Law Commission's Consultation on Mental Capacity and Deprivation of Liberty Safeguards – *Director of Child and Adult Services*

7.3 Response to Healthwatch Investigation into Good Practice in Care and Support of Residents with Dementia in Care Homes in Hartlepool – *Director of Child and Adult Services*

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

ITEMS FOR INFORMATION

Date of next meeting – Monday 14 December 2015 at 10.00 am in Committee Room B, Civic Centre

ADULT SERVICES COMMITTEE

MINUTES AND DECISION RECORD

12 OCTOBER 2015

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

Present:

Councillor Carl Richardson (In the Chair)

Councillors: Paul Beck, Sandra Belcher, Brenda Loynes and Stephen Thomas.

Also Present: Karen Hawkins, Associate Director of Commissioning and Delivery, Hartlepool and Stockton on Tees Clinical Commissioning Group
Jean Golightly, Executive Nurse, Hartlepool and Stockton on Tees Clinical Commissioning Group
Stephanie Tarrant, Inspection Manager (North Region), Care Quality Commission

Officers: Sally Robinson, Director of Child and Adult Services
Jill Harrison, Assistant Director, Adult Services
Jeanette Willis, Head of Strategic Commissioning (Adult Services)
Alastair Rae, Public Relations Manager
David Cosgrove, Democratic Services Team

34. Apologies for Absence

Councillor Tempest.

35. Declarations of Interest

Councillor Thomas declared a personal interest as an employee of Hartlepool HealthWatch.

36. Minutes of the meeting held on 14 September 2015

Confirmed.

37. Care Home Provision for Older People - Presentation (*Director of Child and Adult Services*)

Type of decision

For information / discussion.

Purpose of report

The Assistant Director, Adult Services, the Head of Strategic Commissioning (Adult Services) and the representatives from the CCG and CQC gave a presentation to the Committee setting out the situation relating to care home provision for older people in Hartlepool and the monitoring regimes that applied to the sector.

Issue(s) for consideration

The presentation outlined the following key points and facts: -

- There are 16,650 people in Hartlepool aged 65 and over with 1,641 of those supported by HBC Adult Services. 945 are supported in their own homes and 696 are supported in residential care (this equates to 4% of older people in the town)
- There are 18 care homes in Hartlepool for older people; 13 provide only residential care, 2 provide only nursing care and 3 provide both (dual registered).
- The average age on admission to residential care is 86.4 years with the average length of stay 2.4 years. The average age on admission to nursing care is 82.9 years with the average length of stay in nursing care: 1.7 years.
- There had been a reduction in vacancies due to home closures and moratoriums. Admiral Court had closed losing 50 nursing beds and 15 vacancies; and Gardner House had closed losing 29 residential beds and 15 vacancies.
- Vacancy figures can change daily and are recorded weekly. On the day of the meeting there were 64 residential vacancies and 4 nursing vacancies.
- There were a small number (23) of out of borough residential placements. 6 of the 23 were within 20 miles of Hartlepool. 2 of the out of borough placements had been made since April 2015. These numbers had remained steady for last three years.
- There were 16 out of borough nursing placements with 13 of the 16 within 20 miles of Hartlepool. 9 placements had been made since April 2015. This was a significant increase over last three years.
- In the case of residential care, out of borough placements were due to client choice; they may wish to be closer to family or wished to be in a specific home setting whereas out of borough nursing

placements decreased due to lack of availability within the town.

- A range of services had been developed or commissioned by Adult Services to provide alternatives to residential care. These included 450 extra care housing units in Hartlepool, packages of support in people's own homes, increased use of tele-care (from 450 users to 2,000 users over the last 4 years), and provision of support to carers
- All elderly people placed had a designated social worker and had a minimum of a yearly review.
- The role of the Council in relation to care management, safeguarding, the serious concerns protocol and the proactive work undertaken with care homes was briefly outlined.
- How the local authority contracted with care homes and how fees were negotiated was explained including the Provider Forum and the work undertaken by Link Workers.
- HBC's Quality Standards Framework was outlined. The QSF was linked to the CQC Essential Standards (pre October 2015) and homes received one of four grades, with Grade 1 being the highest.
- In 2014/15 there had been 14 Grade 1 homes and 6 Grade 2 homes. This year, there were 8 Grade 1, 8 Grade 2, 1 Grade 3 and 1 Grade four homes. Officers were working with the two homes at Grade 3 and 4 to bring them back up to Grade 1 or 2.
- The aim was to maintain all homes at Grade 1 or 2. It was highlighted that some of the differences between the grades may not necessarily be due to the care residents received and may be influenced to the constraints of the building.
- Agreement had been reached with homes on a 'Fair Cost of Care' methodology which involves an annual review of fees to take into account inflation and factors such as minimum wage increases, fuel prices and running costs. A reasonable profit margin was essential to ensure that the homes remained healthy businesses. This process had recently been undertaken for care home fees and an increase in per bed costs of £10 per week was to be implemented from October 2015 with a further increase to be confirmed from April 2016 linked to the increasing National Minimum Wage.
- The representative from CQC outlined the purpose and role of the Care Quality Commission, how their inspections were undertaken and the issues that inspectors looked at when visiting residential settings.
- CQC inspectors used 'the mum's test'; was the care provided good enough for their loved ones.
- The CQC rating system was explained which classified homes as Outstanding, Good, Requires Improvement or Inadequate. Inspections tended to be undertaken by teams of CQC staff, though if the home was very small, a single lead inspector may undertake the inspection. As far as was possible, all inspections included an 'expert by experience' in the sector being inspected. There were also specialist advisors available to provide assistance on very more specialist care areas, such as dementia care.
- It was highlighted that a home classified as 'requiring improvement' may be meeting all minimum care benchmarks but there may be an

inconsistent approach across the home. It was also noted that if a home received two consecutive 'inadequate' assessments, then it would be placed in special measures which would require the home management to have a detailed action plan for improvement that would be continually monitored for up to 6 months.

- The CQC representative provided some national statistics which showed that of all services inspected to date (not just residential homes) less than 1% were outstanding, 58% were good, 34% required improvement and 7% were inadequate. The current figures for care homes for older people in Hartlepool showed that 17% were good, 28% required improvement, 17% were inadequate with 38% yet to be rated.
- The CCG representatives outlined the role of the Clinical Commissioning Group in monitoring residential homes. The CCG worked closely with the Council and the CQC on monitoring the progress made by providers when remedial actions were required.
- The CCG had commissioned an enhanced service in Hartlepool linking specific GP Surgeries with residential homes so that a home had a specific surgery contact that would undertake weekly visits ensuring appropriate care plans were in place and residents received their flu jabs for example. The link also gave the home direct urgent access to GPs where necessary.
- The CCG representatives outlined other services that linked into residential homes such as pharmacists, community nurses and the enhanced support that worked closely with homes that required improvement.
- The presentation went on to highlight some of the challenges currently facing the residential homes sector in the town which included; nurse recruitment, quality standards, increasing expectations, people with increasingly complex needs, home closures, the reduction in the availability of nursing beds, homes with waiting lists, homes with moratoriums, and the implementation of the National Minimum Wage increases.
- There was some work underway looking at the sustainability of the current numbers of nursing beds in the town. There were to be further meetings with providers on the potential remodelling of fees for nursing care.
- 6 additional nursing care beds had been commissioned at the Hartlepool Hospice for people receiving fully funded NHS continuing health care. Work was ongoing with potential new providers of nursing care and the assistance/support they may require to come forward.

The Chair then opened the meeting for comments and questions. Below is an outline of the issues raised and any responses given at the meeting:

- 'The Mum's test' was okay but perhaps inspectors should look at homes as being good enough for them were they in the situation of needing care. This was an issue with many older people not having extended family support.

- There was concern at the high level of services that were listed as 'requiring improvement' or 'inadequate' by the CQC. The CQC representative highlighted that the national figures shown in the presentation reflected the full range of services inspected by the CQC.
  The CQC recognised public concerns. There was an 18 month programme to inspect all services under the new regime, which included the care homes in Hartlepool and the CQC had prioritised those where there were, or had been past, concerns. Any service that was considered inadequate would be monitored closely with a return inspection after no more than 6 months but improvements would be expected before then. If it was an enforcement situation, then the CQC would state very clearly what had to be done. If it was a 'lower' level of enforcement, then the provider would be asked to give a realistic time-scaled action plan. When an action plan was 'accepted' then essentially, the CQC was accepting that those actions wouldn't be up to standard for that time, so long timescales would not be accepted. Expectations were based on weeks rather than months. The CQC was issuing guidance to providers on what was expected through its inspections. It had to be highlighted that not all the standards related to people's care; they may relate to the building.
- The Chair questioned what excuses for not meeting standards were given. The CQC representative commented that the majority of providers took on board any inspections recommendations or feedback. If they didn't, they understood it could be come and enforcement issue.
- A member of the public commented that much was down to individual perception. He had heard one resident's family member praise unreservedly the care their family member had received but his own experience was very different. It was felt that the 'Mums test' was very subjective. There were also issues around of the lack of nurses in residential homes and the use of agency nurses who didn't provide residents with continuity. The CQC and CCG representatives commented that staffing issues were a key part of the inspection and the use of agency staff was looked at. It was acknowledged that there were issues in recruiting nursing staff not only in the residential care sector but also in the NHS generally. Continuity was one of the reasons behind the GP surgery links. The CQC representative commented that their inspections looked at staffing and also took into account experience as well as qualifications. If different members of staff were coming in every day then that would be an issue.
- 79 beds had been lost through the closure of two homes; a Member asked if these were to be replaced or the homes re-opened. The Assistant Director commented that the operators of Gardner House had closed the home as it only had 50% occupancy and was unsustainable. The building was also an older building that couldn't be brought up to current standards; if it was re-opened it would have the same issues. The closure of Admiral Court was well documented.
- A Member asked how often homes were inspected. The Assistant Director stated that local authority link officers visited regularly and

were in contact with homes on a weekly basis. Different agencies had different approaches. CQC will have inspected all homes by September next year and then subsequent inspections would depend on the rating of the home. The CCG Clinical Quality Assessment is an annual process which is currently being revised. All the representatives stressed to the Committee that they did communicate with each other regularly both formally and informally and shared information on trigger points such as safeguarding issues.

- A Member asked what action was taken if a serious concern about a home was raised. The Assistant Director indicated that there was a Serious Concerns Protocol that would bring together all the regulatory bodies and the provider. Much would depend on how the home itself reacted to the issue. The CCG representative commented that inspectors did pick up on 'soft intelligence' and issues that may occur within national providers.
- A member of the public asked how quickly reviews would occur if a family member raised concerns in relation to a home. The Assistant Director indicated that individual residents would receive a review at least once a year, but a review could be requested at any point if needs changed or a family member had a concern. A member of the public asked who, through the GP surgery links was visiting homes and the CCG representative confirmed that was a GP that undertook the weekly visits.
- A question was asked regarding whether a home's accident book and records of things such as bed sores were reviewed as part of the inspection process. The Assistant Director confirmed that records were examined and any trends investigated.
- There was a question about how many people were 'bed blocking' in local hospitals due to the shortage of beds in the town. The CCG representatives stated that there was coordinated work ongoing on discharge procedures and the figures on the number of people awaiting discharge could be shared with the Committee.
- A Member raised serious concerns with the whole issue of care of the elderly nationally. The Member was concerned that the care system was at 'tipping point' through lack of national decision making on funding for the future. Locally there had been home closures and a number of homes either requiring improvement or inadequate and there was a shortage of nursing care beds. There were to be 6 extra nursing beds but there was concern on the moratoriums that two homes were under.

  The Member also referred to the Vanguard sites and the different methods of working they were trialling and how the best practice and lessons learned from those areas would be shared with other authorities.

  There were a number of bodies all with an input on these matters, the CQC, CCG, the local authority, HealthWatch, residents and family and despite what was being said there were still communication issues. The Member was keen to explore better working between HealthWatch and the CQC as he considered there was scope for relationships to be improved. The Member stated that he was

attending a national HealthWatch event in the next few days which was centred on these matters.
The Member considered that all involved had to remember these were people's homes and the quality of their lives that were being discussed.
The CCG representatives commented that they were constrained nationally but were renegotiating costs on nursing care locally and looking at wrap around care to help people return to their own homes. There was an issue around the moratoriums and the beds lost due to home closures but agencies were working as a community on that and were looking at maintain the situation through the winter. Agencies had looked at the vanguard site in Newcastle and the model they were using was very similar to that already being developed locally through the Better Care Fund. Other vanguard sites had only just started on this project. Some of the issues they had were around financing. Local agencies were well linked up and worked closely and there is excellent communication on this locality. The representatives stated that they were not waiting for any national push and communication between agencies was very good with regular meetings and the sharing of information and concerns. It would be unusual for any of the bodies not to be aware of any safeguarding issues and early warning signs.

- The Councillor requested that any available feedback from the Vanguard areas be shared with the Committee. There were also concerns with people being maintained in their own homes as the finance to support such people needed to be identified across all the relevant agencies; it could not be left solely to the local authority to pick up these costs in a time of continued austerity cuts.
- A representative from the Hospital of God at Greatham commented that there was a lot of excellent work being undertaken in care homes around the town and this must not be forgotten within this debate. Social care staff were very committed and hard working and displayed excellent person centred approaches. Having moratoriums on a number of homes was not helping the general situation in Hartlepool. There was a shortage of nurses in the home care sector but much of that was due to the differential in terms and conditions between the private sector and the NHS. There were often differences of opinion around friends and families views of a home and an inspection report and the question that arose was whose opinion counts most.
  The Hospital of God was in the process of expanding one service to provide four additional nursing beds.
- A Member of the public questioned if the financial standing of operators was checked during registration. The Head of Strategic Commissioning stated that once an operator was registered with the CQC and before they were used by the authority there was an accreditation process that involved such checks.
- A member of the public sought publication of clearer statistics on the percentages of homes in each registration section. It was good to hear that there were to be new nursing beds to be opened but assurance was sought that they would be available to Hartlepool

residents. The CQC representative stated that the statistics on the website were updated on a weekly basis and each individual element of the inspection was rated. The member of the public commented that many people did not have internet access and sought others ways of the information being published, such as The Hartlepool Mail and Hartbeat. The Head of Strategic Commissioning commented that there was a lot of information available which could be accessed by phoning the Council. The CQC representative also commented that their information was available by phone. The Public Relations Manager indicated that he would look to working with the agencies on the potential of including information in Hartbeat.

- In relation to the moratoriums, the CCG representative commented that it was an issue but it was being addressed. The availability of nursing staff was a consistent issue across the country. The availability of beds, particularly nursing beds, was one that impacted upon the CCG on a daily basis.
- In response to a question from the public, the Head of Strategic Commissioning stated that discussions were ongoing with a number of homes on the potential of them becoming dual registered to provide residential and nursing beds but much depended on the availability of nursing staff. The member of the public also questioned the numbers of nursing graduates and which sectors they were going to work in and if further consideration had been given to recruiting more nurses from abroad. The CCG representative stated that all the nurses expected to graduate next year already had job offers. All NHS Trusts were short of nursing staff.
- A Member referred to some of the press issues around people being maintained within their own homes only receiving 10 or 15 minute calls from home care staff. The Assistant Director stated that HealthWatch had undertaken a valuable piece of work on domiciliary care and following this, Adult Services were able to confirm that the proportion of people in Hartlepool receiving 15 minute calls was very low and such calls were always part of a wider package of care. Further work was to ne undertaken on this issue following the recent publication of best practice guidance.
- A HealthWatch visitor stated that leadership was the most important issue in any home. People did need to listen to the family more as this was where you were more likely to get the truth. The residents that were of concern were those that don't get regular visitors. Listen to the residents by all means but listen to the family as they don't have the fear of comeback after the inspectors have left. The CQC representative stated that whenever they were inspecting a home there would be an information poster prominently displayed that would inform visitors that an inspection was underway and how to contact the lead inspector if they wished to make comment. Inspections also observed the interactions between staff and residents.
- The Chair questioned the staffing of the CQC in this area. The CQC representative stated that there were 8 full time inspectors in the northern region. Inspection teams would include a lead inspector and depending on the size of the home being inspected, additional

inspectors, an expert by experience and specialist advisors as appropriate. Depending on the outcome of the inspection further re-inspections may be triggered and there were also random spot checks to avoid complacency within homes . Once reports were prepared, the home operators had 10 days to challenge factual inaccuracies before the report was published on the CQC website. Two versions of the report were produced, a full report and a summary document, both of which would state if any breaches of regulations had been found and both of which should be made available to residents and family members.

- The Chair questioned the ratio of nursing staff to residents in a nursing home. The CQC representative stated that there was no minimum ratio but inspectors would look to see evidence that the operator had reviewed the needs of the residents in reaching their staffing levels.
- A Councillor commented that it would be valuable to have regular updates to the Committee regarding issues relating to nursing homes and new developments. Ongoing feedback from the vanguard sites would also be valuable. There was a lot of good work going on in homes in the town and it would be valuable to have an action plan arising from the meeting to address some of the concerns highlighted.
- A member of the public questioned what inspections/ monitoring of domiciliary care was undertaken. The CQC representative stated that the same inspection regime applied and records were checked, visits with carers were undertaken and service users were also contacted directly to gain their feedback.
- The difference between what was being done in Hartlepool on social care and the Vanguard sites was questioned. The CCG representatives commented that they had met with representatives from the Newcastle and Gateshead Vanguard site and much of what they were doing was not dissimilar to what was already been done here. Other areas were looking into 'tele-medicine' services to a greater level than was done here, however, these vanguard sites were in their very early days and they needed time to establish before any lessons could be learned.

In closing the meeting, the Chair thanked everyone in attendance for their contributions to an excellent debate on the issues. The Chair stated that he would look to the development of an action plan to take forward some of the issues raised in the meeting.

Decision

That an action plan be developed from the discussions recorded above for future consideration by the Committee.

38. Date and Time of next meeting

The Committee noted that the next meeting would be held on Monday

9 November, 2015 commencing at 10.00 am in the Civic Centre.

The meeting concluded at 12.15 pm

P J DEVLIN

CHIEF SOLICITOR

PUBLICATION DATE: 22 OCTOBER 2015

ADULT SERVICES COMMITTEE

9 November 2015

Report of: Director of Child & Adult Services

Subject: PROMOTING CHANGE, TRANSFORMING LIVES PROJECT

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 Key Test i and ii – CAS 037/15

2. PURPOSE OF REPORT

2.1 The purpose of this report is to update members on behalf of the Waverley Allotment Group (WAG) Promoting Change, Transforming Lives Project

3. BACKGROUND

3.1 The Waverley Terrace Allotment Project was set up in 2007 by the WAG: a group of adults with a range of support needs, including mental health issue, learning disabilities and physical disabilities. The project was originally developed by the Council's Adult Services Team and people who use services, with support from a range of local partners including Hartlepool MIND, DISC, Nacro, Kirklevington HMP and Hartlepool College of Further Education.

3.2 The Waverley Terrace Allotment offers 3.5 acres of arable land in the Rift House area of Hartlepool for the cultivation of fruit and vegetables, refurbishment of furniture and creation of a range of seasonal items including Christmas wreaths. The allotment offers a venue for therapeutic and employment support to disabled adults and / or mental health needs.

3.3 There has been considerable progress since the site opened due to the efforts of people using services, staff members and partners, culminating in the project being praised by Disability Rights UK. However, there is still work to do, with staffing and infrastructure improvements needed to further develop the site.

3.4 Over the past 12 months, the Council's Adult Services, Economic Regeneration and Building Control Teams have been working closely together to consider how the Waverley Allotment site can be transformed into a financially sustainable enterprise.

4. BIG LOTTERY FUND APPLICATION

4.1 On behalf of the WAG, the Council submitted a Big Lottery Fund: Reaching Communities Application to support the development of the Promoting Change, Transforming Lives Project.

4.2 The bid incorporated three key elements: -

- **Therapeutic Services:** The project will build on the current offer and provide a safe environment where service users who are unlikely or unable to engage in employment can still lead positive lives and be involved in horticulture which will help them with lifeskills, raise their aspirations and prevent social isolation. At present, a number of service users from disability day services access the site as part of their therapeutic support.

- **Employment and Training Services:** The site will provide work experience, placements and high quality training for service users to develop relevant employability skills to assist them to progress into sustained employment. The site will be used as a pathway for individuals to build their confidence and when they are ready for progressing into mainstream employment, they will be supported by dedicated Employment Link Workers who will help users to identify their chosen career options and link them to local employers. In addition, local training providers are keen to use the facilities for delivery of horticultural Apprenticeships and Traineeships and a test pilot is currently underway with Springboard to assist young people with emotional and social problems to learn key employability skills.

- **Commercial Services:** The development of a commercial facility is critical in supporting the overall project objectives. The commercial aspect of the project will be non-profit based and all income generated will be used to expand the services provided. A business plan and feasibility study have already been produced which show how the project can realistically be self-sustainable within five years subject to Big Lottery funding being secured to fund a Business Co-ordinator and Volunteer Co-ordinator within this timeframe.

4.3 The Council received confirmation in September 2015 that the Big Lottery application had been successful and the full amount of £400,000 has been awarded.

5. PROGRESS AND NEXT STEPS

5.1 A Steering Group has been established to oversee the implementation of the Promoting Change, Transforming Lives Project with Terms of Reference agreed.

5.2 A new organisation will be established and a project plan developed linked to the existing business case.

5.3 A Project Co-ordinator has been appointed and a Volunteer Co-ordinator will be recruited to take up post in January 2016. The Project Co-ordinator will be responsible for the day to day management of the site as well as monitoring of project milestones and completion of returns to the Big Lottery.

5.4 Work will commence as soon as possible on the capital works to improve the Site, at a total cost of approximately £100k (£81k from the Big Lottery Grant plus match funding from the Learning Disabilities Development Fund).

5.5 Links have been established with other projects focused on the Rift House area and ward members have been briefed regarding the planned developments.

5.6 Potential links to some additional European funding are being explored.

6. RISK IMPLICATIONS

6.1 Any risks identified will be monitored by the Steering Group for the project, with mitigating actions implemented to reduce those risks.

7. FINANCIAL CONSIDERATIONS

7.1 The allocation of £400k is made up of £319k for staffing costs over five years and £81k for capital costs to further develop the site, and will be managed within Regeneration and Neighbourhood Services.

7.2 Match funding of £75k was identified within the application, which relates to existing staffing and running costs and a contribution to the capital works from the Learning Disabilities Development Fund.

8. LEGAL CONSIDERATIONS

8.1 There are currently no legal implications identified. Outline planning consent was sought as part of the Big Lottery bid process and the Council will adhere to the conditions of the grant allocation.

9. CHILD AND FAMILY POVERTY

9.1 There are no direct links to child and family poverty but the project will contribute to increased employment opportunities, particularly for vulnerable groups.

10. EQUALITY AND DIVERSITY CONSIDERATIONS

10.1 This project will support vulnerable groups of people, regardless of their background, to achieve their aspirational goals. There will be a particular focus on some priority groups including:

- Adults with learning disabilities;
- Adults with autism;
- Adults with mental health problems;
- Elderly people at risk of social isolation;
- Young people with specific learning difficulties and/or disabilities, and;
- Young people with mental health issues.

11. STAFF CONSIDERATIONS

11.1 This project will create two new posts within the Council - a project Co-ordinator post which has been filled and a Volunteer Co-ordinator post which is being recruited to.

11.2 Both posts have been through the Job Evaluation process and made available to any staff on the redeployment register as part of normal HR practice.

12. ASSET MANAGEMENT CONSIDERATIONS

12.1 No asset management considerations have been identified. Outline planning consent was sought as part of the Big Lottery bid process

13. RECOMMENDATIONS

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

13.2 Members are also asked to note that the actions from the Adult Services Committee on 8 June 2015 (arrangement of a site visit and a further update report) have been completed.

14. REASONS FOR RECOMMENDATIONS

14.1 This funding provides an opportunity to: -

- Develop additional resources to support adults with a physical disability, learning disability, autism or mental health problem;
- Improve the employability skills and employment opportunities of vulnerable adults, and;
- Transform the Waverley Terrace Allotment Project into a sustainable community enterprise.

15. CONTACT OFFICER

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ADULT SERVICES COMMITTEE

9 November 2015

Report of: Director of Child & Adult Services

Subject: TEESWIDE SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2014/2015 AND STRATEGIC BUSINESS PLAN 2015/2016

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1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 Decision required.

2. PURPOSE OF REPORT

2.1 To present to the Adult Services Committee the Teeswide Safeguarding Adults Board Annual Report 2014/15 and Strategic Business Plan 2015/16.

3. BACKGROUND

3.1 The Teeswide Safeguarding Adults Board (TSAB) was established in order to meet the requirements of the Care Act 2014, which created a legal framework for adult safeguarding, requiring all Local Authorities to set up Safeguarding Adults Boards (SABs) for their areas.

3.2 The four Tees Local Authorities have worked together for a number of years along with strategic partners to promote cooperation and consistency in relation to safeguarding adults work, and this collaborative working has continued, with the statutory responsibility now resting with the TSAB.

4. PROPOSALS

4.1 It is a requirement of the Care Act 2014 that SABs publish an annual report that sets out:

- what it has done during that year to achieve its objective,
- what it has done during that year to implement its strategy,

- what each member has done during that year to implement the strategy,
- the findings of any safeguarding adults reviews which have concluded in that year,
- any reviews which are ongoing at the end of that year,
- what it has done during that year to implement findings of reviews; and
- where it decides during that year not to implement a finding of a review, the reasons for its decision.

4.2 The Teeswide Safeguarding Adults Board Annual Report for 2014/15 is attached as **Appendix 1**.

4.3 It is also required under the Care Act 2014 that SABs publish an annual strategic plan setting out its strategy for achieving its objective and what members will do implement the strategy.

4.4 The Teeswide Safeguarding Adults Board Strategic Business Plan for 2015/16 is attached as **Appendix 2**.

5. RISK IMPLICATIONS

5.1 No risks identified.

6. FINANCIAL CONSIDERATIONS

6.1 Statutory partners (Local Authorities, Clinical Commissioning Groups and Cleveland Police) make an annual contribution to the running costs of the Teeswide Safeguarding Adults Board and the associated Business Unit.

6.2 There are no additional financial considerations associated with this report.

7. LEGAL CONSIDERATIONS

7.1 None identified.

8. CHILD AND FAMILY POVERTY

8.1 No implications identified.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 None identified.

10. STAFF CONSIDERATIONS

10.1 No staff considerations identified. The Teeswide Safeguarding Adults Board Business Unit staff are employed by Stockton Borough Council on behalf of the strategic partners.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 No asset management considerations identified. The Teeswide Safeguarding Adults Board Business Unit staff are hosted by Stockton Borough Council on behalf of the strategic partners and based at Kingsway House in Billingham.

12. RECOMMENDATIONS

12.1 It is recommended that the Adult Services Committee notes and endorses the Teeswide Safeguarding Adults Board Annual Report 2014/15 and Strategic Business Plan 2015/16.

13. REASONS FOR RECOMMENDATIONS

13.1 Safeguarding vulnerable adults is everybody's business and all partners have been involved in developing the Annual Report and Strategic Business Plan

14. BACKGROUND PAPERS

14.1 No background papers.

15. CONTACT OFFICER

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Teeswide Safeguarding Adults Board

ANNUAL REPORT

Ensuring our safeguarding arrangements act to help and protect adults

2014-15

Are you concerned about an adult who is being harmed?

Contact one of the following:

Hartlepool Borough Council	Cleveland Police	Redcar & Cleveland Borough Council
01429 266 522	01642 326 326	01642 771 500

Stockton-on-Tees Borough Council	Middlesbrough moving forward
01642 527 764	01642 726 004

Out of Hours

08702 402 994

Contents

Executive Summary from Ann Baxter

I am very pleased to introduce the 2014-15 Annual Report of the Teeswide Safeguarding Adults Board in my second year as Independent Chair.

This has been a significant year. The Care Act 2014 moved the Safeguarding Board onto a statutory footing. The decision to establish the Board across the four local authorities builds on positive collaboration, and I am encouraged by the ongoing commitment of all the partners. These innovative arrangements are beginning to work well, and there has been significant investment of resources in the Board, reflecting the priority given to safeguarding across Tees.

The Business Unit is now fully staffed, supporting and linking the four Local Executive Groups to the Teeswide Board. This enables strong local operational partnerships and ensures that the voice of those who receive services informs both the strategic and operational agendas.

At a time of major organisational and legislative change the safeguarding adults agenda has never been more important. Nationally there has been a focus on the quality of services, particularly for those adults who rely on others to help them in their day to day lives. Protecting adults at risk will always be the main priority, but the Board will also concentrate on developing ways of raising awareness and preventing harm.

In this report you will find information about what happened last year and our plans for the future. The Board has an ambitious work plan and is responding to the challenges of the year ahead.

I am confident that the Board can build on the good work to date to ensure that together we support adults to live with their rights protected, in safety, free from abuse, and make a difference to the lives of vulnerable people. I am conscious that a report such as this can only summarise the work going on every day. I would like to take the opportunity to thank everyone working with dedication and vigilance across the partnership and our communities for their continuing support in making Tees a safer place to live.

Ann Baxter
Independent Chair

Introduction to the Teeswide Safeguarding Adults Board

The Teeswide Safeguarding Adults Board was established in order to meet the requirements of the Care Act 2014. This created a legal framework for adult safeguarding, requiring that Local Authorities set up a Safeguarding Adults Board (SAB) in their area. Historically across the Tees the four Local Authorities and partners have worked together to promote cooperation and consistency in relation to adult safeguarding work. This collaborative working practice has continued and statutory responsibility now rests with the Teeswide Safeguarding Adults Board.

In order to meet these new requirements, the governance arrangements and structure of the Board were revised (as shown below) and will continue to be reviewed in line with strategic planning activities and consultation with stakeholders.

The Local Executive Groups (LEGs) and Sub-Groups play an important role in delivering the operational activities linked to the Board's Strategic Plan, and also enable a wider range of organisations to engage with, and inform the work of the Board. The work of these groups is outlined on pages seven to nine.

The Structure of the Board and Sub Groups

Key:

HBC	Hartlepool Borough Council
MBC	Middlesbrough Borough Council
RCBC	Redcar & Cleveland Borough Council
SBC	Stockton -on-Tees Borough Council
CE	Communication & Engagement
LTD	Learning, Training & Development
PAQ	Performance, Audit & Quality
PPP	Policies, Procedures & Practice
CR	Case Review
LEG	Local Executive Group

Membership of the Board

The following organisations are represented on the Board:

Statutory Partners	
Hartlepool Borough Council	Director of Children & Adults Services (7)
Middlesbrough Borough Council	Executive Director of Wellbeing, Care & Learning (5)
Redcar and Cleveland Borough Council	Corporate Director of People Services (7)
Stockton-on-Tees Borough Council	Director of Children, Education and Social Care (7)
Hartlepool and Stockton on Tees CCG	Executive Nurse (7)
South Tees CCG	(Clinical Commissioning Group)
Cleveland Police	Detective Superintendent Specialist Crime (7)
Non Statutory Partners	
NHS England Durham, Darlington and Tees	Deputy Director of Nursing (6)
Tees, Esk and Wear Valley NHS Trust	Director of Nursing and Governance (6)
South Tees NHS Foundation Trust	Head of Nursing (Safeguarding) (7)
North Tees and Hartlepool NHS Trust	Deputy Director of Nursing (7)
Public Health	Director of Public Health (5)
National Probation Service: Cleveland	Head of Area (4)
Care Quality Commission	Inspection Manager (1)
Holme House Prison	Head of Residence & Services (4)
Healthwatch Hartlepool	Development Officer (0) Active LEG member
Healthwatch Tees	Manager (3)
Cleveland Fire Brigade	Director of Community Protection (7)

Lead members for Local Authorities sit on the Board as non-voting participant observers.

The Board met on seven occasions in 2014-15 and in brackets is the number each organisation was represented.

A Review of the Work of the Board 2014-15

Overview

Last year the work programme of the Board focussed on enabling us to meet the requirements of the Care Act 2014, making us 'fit for purpose' and ensuring a smooth transition to our statutory footing from April 2015.

The underpinning issues were carefully considered at the Board's Annual Development Day in July 2014, where the wider impact of the changing environment was considered and the key themes for the future agreed.

This included a robust review and revision of our governance arrangements (as illustrated on page three), and the creation of a new Sub-Group and LEG structure. We also completed the recruitment process during the year to establish a new Business Unit to support the work of the Board.

Work commenced on the development of a new longer term Strategic Plan, which was informed by a comprehensive Consultation and Engagement exercise with a wide range of stakeholders including people that use social care services, their carers and members of the general public.

Our Inter-Agency Safeguarding Adults Policy was revised and a range of policies and procedures were reviewed and further developed including the completion of an Induction Pack for new Board members.

As members of the Tees Commissioning Group, we contributed to the response to 'Transforming Care: A National Response to Winterbourne Hospital*' and also considered other national safeguarding adults issues providing informed responses throughout e.g. the 'Supreme Court judgement in relation to the Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DoLS*).*Definitions in Glossary page 25

We continued to assess the needs of vulnerable individuals moving through and beyond the criminal justice system, and a protocol to support such people was launched. This approach is currently under review with other similar protocols in order to find the most effective method of communication, support and co-ordination for the future.

As a Board, we continued to promote awareness of Adult Safeguarding issues, including the delivery of a Financial Abuse Workshop and through support of the region wide radio campaign 'See it - Report it.'

Performance, Audit and Quality Assurance (PAQ) Sub-Group
The PAQ Sub-Group's remit is to provide assurance in relation to the safeguarding practice of the Board's partners. In order to achieve this the Sub-Group has identified two work streams; the development of a Quality Assurance/Self-Audit Framework, and a Performance Management Framework, thereby reflecting the inter-agency nature of Adult Safeguarding work. During 2015-16 the Sub-Group will continue to provide the Board with the required performance information through the evaluation of best practice. This will provide a clearer emphasis on assessing the desired outcomes of adults entering the formal safeguarding process (Making Safeguarding Personal*). *Definition in Glossary page 26

Communication and Engagement (CE) Sub-Group
The CE Sub-Group was reformed under the new Board structure with refreshed membership and revised terms of reference aligned to the strategic aims of the Board. The group developed, produced and published the Annual Report for 2013-14, and created branding guidelines and a new logo for the Board. A key component of the remaining work plan is to complete the new Communication and Engagement Strategy, which will ensure that work is underpinned by the outcome of consultation with a wide range of stakeholders including safeguarding service users and their families, carers and advocate groups. A new website for the Board is currently in development, which will provide a valuable resource for service users, the general public and practitioners.

Learning, Training and Development (LTD) Sub-Group
The LTD Sub-Group was re-established in September 2014 and identified a number of key partners to join the group, including the Police; the Fire Service; the NHS (across Tees), and Healthwatch. The group now has a clearer understanding of the resources and training programmes in place across the four Local Authorities and a Training Needs Analysis has been undertaken. This identified that there is limited inter-agency training taking place although single agency training, albeit at different levels, is being delivered within most agencies. The Sub-Group is now working to develop a training strategy with a focus on e-learning. The group is also considering how appropriate assurance around the quality of training delivered by service providers, such as Care Home and Care at Home providers, can be achieved.

A Review of the Work of the Board 2014-15

Policy, Procedures and Practice (PPP) Sub-Group
The PPP Sub-Group strengthened its membership during the year and implemented its work programme in accordance with the strategic priorities of the Board. The work included producing and agreeing an 'Inter-Agency Mental Capacity Act, Section 44 Protocol' and responding to the impact of the Supreme Court judgement in relation to the 'Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DoLS*).

The Sub-Group also considered the Government's response to the Lords Committee Review of the Mental Capacity Act 2005, and the Serious Concerns Protocol was monitored with updates being provided to the Board. The Boards Inter-Agency Safeguarding Adults Policy and Procedures are currently under review and a revised policy with associated procedures will be fully implemented across Tees in September following a trial period. *Definition in Glossary page 25

Case Review (CR) Sub-Group
The CR Sub-Group fulfils the duty of the Board in respect of Serious Case Reviews (Safeguarding Adults Reviews from April 2015) and ensures that they are completed in line with national and regional guidance.

The Sub-Group's purpose is to decide the appropriate type of case review and then to determine where responsibility rests for leadership, oversight and co-ordination of the chosen review process. The CR Sub-Group promotes a culture of continuous learning and improvement across organisations and identifies opportunities for the promotion of good practice. It is committed to adhering to the North East Regional Guidance regarding any Safeguarding Adult Reviews and to ensuring that relevant cases are considered through an integrated model of review.

The CR Sub-Group considered three individual cases during 2014-15:

Case 1
This case was previously discussed by the Hartlepool Safeguarding Vulnerable Adult Committee in October 2012. It was agreed at the time that the case met the requirements for a Serious Case Review (SCR), but that this should be delayed due to other proceedings. It has subsequently been confirmed that an SCR should now proceed and that this be managed by Hartlepool Borough Council.

Case 2
This matter was considered by the CR Sub-Group at a series of meetings and it was ultimately agreed that the criteria for an SCR was not met and that a Lessons Learned Review would be the most appropriate course of action. This recommendation was accepted by the Board's Independent Chair and a Lessons Learned Review was progressed under the Leadership of Middlesbrough Borough Council.

Case 3
This was a complex matter regarding the death of a vulnerable adult and also involving two young people. Decisions were made in respect of the three individuals concerned and agreement reached that they all met the requirements for a SCR. A combined meeting of representatives of both the relevant Safeguarding Children Board and Safeguarding Adult Board considered all of the key information and confirmed that a combined process for all three reviews should be progressed. This process is ongoing with two independent reviewers commissioned to lead the process utilising a systems methodology. A report in respect of the vulnerable adult will ultimately be published and shared with the Teeswide Safeguarding Adults Board.

In addition a further Serious Case Review, **Case 4** was commenced by Hartlepool Safeguarding Vulnerable Adults Committee in June 2013 and concluded in November 2014. This related to a vulnerable adult with mental and physical health needs, who was also alcohol dependent. The outcome of the review was presented to the Teeswide Safeguarding Adults Board within the 2014-15 reporting period. A number of recommendations were made as part of the review and an action plan has now been developed with progress reported through the Teeswide Board.

A Review of the Work of the Board 2014-15

The following is a summary of some of the main recommendations/lessons learned from the Case Reviews held in 2014-15:

- That the effectiveness of the systems in place for sharing information should be reviewed to inform risk assessment and decision making processes
- That all Health and Social Care Professionals should be reminded of accessing all available information about a person in order to inform assessments and decision making
- That all Practitioners should be reminded that 'specialist' services should be considered as part of the initial assessment process
- That all Practitioners should be reminded that an Independent Advocate should always be offered to a person where there is any indication that they need assistance to make their views known and to protect their rights
- That all Health and Social Care Professionals who take on the role of Care Co-ordinator should be reminded of their responsibilities in co-ordinating the care process
- That all staff should be reminded that people should not be discharged into the community until the necessary support is in place to secure a safe environment
- That multi-agency safeguarding training opportunities should be reviewed and refreshed.

The CR Sub-Group will continue to meet in the future as required and will ensure that reports are provided to the Independent Chair and the Board as appropriate.

Local Executive Groups (LEGs)

In **Hartlepool** the newly formed LEG focused on involving individuals in the safeguarding process through the 'Expert by Experience*' and 'Making Safeguarding Personal*' programmes and by lessons learned from case reviews. The LEG is committed to sharing information and good practice, learning lessons and most importantly on improving outcomes for vulnerable adults. It is confident that in the future it will continue to develop as a valuable forum for addressing local issues, improving practice, and ensuring that Hartlepool priorities inform and are reflected in Teeswide plans.

In **Middlesbrough**, a workforce restructure led to the recruitment of Safeguarding Adults Officers and a review of Wellbeing, Care and Learning. Adult Social Care also underwent a Peer Review/Review of Service Delivery by 'Peopletoo.' The LEG is now chaired by the Assistant Director for Safeguarding and Children's Services. The work has focussed on preparing for the implementation of the Care Act 2014 in conjunction with the Teeswide Safeguarding Adults Board; and on the 'Making Safeguarding Personal*' programme. Work has also included the development of a comprehensive training plan for staff.

In **Redcar and Cleveland** some of the issues considered during the year included the agreement of action plans arising from two Serious Case Reviews initiated in 2013-14, the implementation of the requirements of the Care Act 2014, the Cheshire West judgement and the 'Transforming Care: A National Response to Winterbourne Hospital*' Report. In addition the LEG has recently expanded its membership to include representatives from the Care at Home and Care Home Sectors, which have already proved to be valuable additions to the group.

In **Stockton-on-Tees** the commitment to adult safeguarding continued by building on previous work to develop a performance framework, completing work through the Learning Disability Partnership Board and increasing the number of Safe Place venues. The LEG worked with partners to prepare for the implementation of the Care Act 2014, led work in response to the Supreme Court Judgement relating to DoLS* and supported Children's Services colleagues to ensure that these statutory duties were addressed for people aged between 16 and18 years old. The Transforming Care work stream was considered with NHS partners and in particular those issues in relation to information sharing were discussed.

*Definitions in Glossary pages 25-26

A Review of the Work of the Board 2014-15

Safeguarding Activity

The Teeswide Safeguarding Adults Board receives data collected by the Local Authority and other Partner's Performance Teams via the Performance, Audit and Quality (PAQ) Sub-Group.

The following is a summary of some of the data collected for 2014-15.

Teeswide Safeguarding Adults alerts* have risen by **40%** since 2011-12, but referrals* have decreased by **5%** during the same time period.
*Definitions in Glossary page 25-26

97% of safeguarding referrals related to white British adults, **2%** to ethnicity unknown, and a demographically disproportionate **1%** from Black, Asian and Minority Ethnic Groups (BAME).

56% of the allegations linked to the abuse and neglect of adults were committed by 'Other-Known to Individual' and **34%** by 'Social Care Support.'

Care Homes (**45%**) and Own Home (**39%**) accounted for most of the 'Location of Abuse and Neglect,' with the remainder being Hospitals/Health (**5%**); Supported Living (**3%**); Other (**5%**); Day Centre/Service (**1%**); and Alleged Perpetrators Home (**2%**).

The two biggest categories of abuse within the safeguarding referrals were 'Neglect and Acts of Omission' **44%,** and Physical Abuse **22%**. Sexual Abuse increased from **2.8%** in 2013-14 to **4%** and was more prevalent in NHS Trusts where this accounted for **10%** of all safeguarding reports.
(Full tables can be seen on page 19).

The rise in the number of Safeguarding Adults alerts appears not only to indicate the positive and increased awareness of Safeguarding Adults issues and concerns, but also highlights that some alerts did not meet the threshold criteria for further investigation. Although as a consequence of this the 'no further action' outcome decreased by **7%** from the 2013-14 figure**,** there were more substantive outcomes for the referrals that were investigated.

Demographics

37% of the population aged 64+
(208,900)
ONS Census 2011

62% of all safeguarding referrals are for women but for people aged 18-24
61% are for men

5-6% population
Black, Asian & Minority Ethnic (BAME)
2.5% Hartlepool
12% Middlesbrough
1.5% Redcar & Cleveland
5.5% Stockton on Tees
ONS Census 2011 - estimated

54% of all safeguarding referrals are for people aged 75 or over

Teeswide

Context of Safeguarding Adults Work

Abuse and Neglect

	Alerts		Referrals	
	2013-14	2014-15	2013-14	2014-15
Hartlepool	305	415	146	113
Middlesbrough	1059	1163	401	354
Redcar & Cleveland	879	1034	518	510
Stockton on Tees	1127	1280	325	315
Teeswide	**3370**	**3892**	**1390**	**1292**

64% of abuse and neglect in 'own home' is carried out by 'other known to Individual'

20% increase in neglect referrals in 12 months

16% of referrals are for financial abuse
See page 23: 'Under the Radar'

Protection

1000% increase in DoLS activity
See page 25: Cheshire West Ruling

718 Advocacy referrals
12.9.14 to 31.3.15

109 Safe Place venues
See page 16

ONS - Office for National Statistics

What You told Us

31% said the public are safe from being victims of abuse and neglect
Board Survey March 2015

59% said promoting awareness of how people can protect themselves from abuse and neglect was the top priority
Board Survey March 2015

Case Study

A safeguarding alert was raised by the physiotherapist working with Mr. A who lived with his brothers and who had a diagnosis of Multiple Sclerosis.

He disclosed that following the death of his mother, he had started to notice money going missing from his wallet, and stated that he was not allowed to use the washing machine or the fridge freezer.

The situation was having a negative impact on his health and well-being. Mr. A consented to a safeguarding alert being raised.

Mr A was visited by a social worker. He stated that he had not reported any of the alleged thefts to police. Further more he felt that mediation with his family was not possible.

Mr. A attended the subsequent strategy meeting, which was co-ordinated by the social worker to decide what actions were needed and to enable the development of a Protection Plan.

Information was shared with the Police who conducted an investigation of the alleged financial abuse.

Given the identified risks it was agreed that Mr. A would remain at risk living with his brothers and therefore emergency accommodation was arranged. Mr. A was then supported to find suitable accommodation where his independence could be sustained into the future.

This case is a good example of 'Making Safeguarding Personal' with Mr. A involved from the start and with the adoption of an outcome focused approach concentrating on Mr. A's independence and well-being.

Mr. A was restored to a position of control and the risk of further abuse was prevented.

Provided by Stockton-on-Tees Borough Council

A Review of the Work of the Board 2014-15

Cleveland Police

Protecting vulnerable people is a key priority for Cleveland Police, with the Chief Constable and the Police and Crime Commissioner (PCC) committed to improving policing services to victims and witnesses. We have focused on a number of areas:

- Domestic Abuse: the Force has worked with partners to research ways in which we can best support victims of domestic abuse and reduce repeat victimisation
- Mental Health: the street triage scheme allows mental health professionals to work alongside police colleagues to provide improved outcomes for those with mental health illness
- Hate Crime: our focus has seen a welcome increase in reporting
- The Safe Place Scheme: ensures that staff in identified public places are aware of vulnerability issues and can help someone they come into contact with
- Modern Day Slavery: the PCC co-hosted a regional seminar for Safeguarding professionals in September 2014, to raise awareness of Human Trafficking and Modern Day Slavery. We are building upon this with training for 250 staff provided by the charity, Hope for Justice
- Safeguarding vulnerable adults: the Force has well established mechanisms to refer concerns about vulnerable people through to health and social care teams. A dedicated team of detectives continues to work closely with partners to safeguard victims and to investigate crimes committed by those who have responsibility for caring for vulnerable adults.

Safe Place Scheme Contacts

There is a Local Authority lead in each of the local Policing areas:

Hartlepool: Jayne Brown Tel: 01429 523526
Email: Jayne.Brown@hartlepool.gov.uk
Middlesbrough: Jane Hill Tel: 01642728112
Email: Jane_Hill@middlesbrough.gov.uk
Redcar & Cleveland: Derek Birtwhistle Tel: 01642 776931
Email: Derek.Birtwhistle@redcar-cleveland.gov.uk
Stockton on Tees: Sarah Allen Tel: 01642 528458
Email: SarahJane.Allen@stockton.gov.uk

If you are a venue who would like to become a Safe Place, or you support a vulnerable person who would benefit from being a member of the scheme please contact your area lead.

A Review of the Work of the Board 2014-15

Clinical Commissioning Groups
As commissioners of local Health Services the Clinical Commissioning Groups (CCGs) continued to work with providers and partners to further raise the profile and impact of Safeguarding Adults across the health and social care economy. This included the sharing of intelligence, information and actions in relation to safeguarding concerns for the shared populations across Tees. The CCG's refreshed Quality Assurance Framework outlines the approach to the monitoring, reviewing and challenging of commissioned health services and is supported by both Governing Bodies.

Cleveland Fire Brigade
Cleveland Fire Brigade undertook a significant restructure in 2014-15, which brought about a change in the designation of lead responsibility for safeguarding within the organisation. This resulted in a review of Safeguarding Procedures, and the Brigade becoming more active partners in the work of the Teeswide Safeguarding Adults Board through the provision of the chair for the Communication and Engagement Sub-Group. The principal safeguarding activity across the service remains the provision of Home Fire Safety visits and in particular those associated with the 'Stay Safe and Warm' campaign. A total of 325 urgent referrals were received in 2014-15, which is the highest number of referrals to date. This was in addition to the thousands of Warmth Assessments undertaken Teeswide.

National Probation Service
On 1st June 2014 Probation Trusts were replaced by the National Probation Service (NPS) and Community Rehabilitation Companies. From 1st April 2015 and the implementation of Part 1 of the Care Act 2014 NPS Cleveland has acknowledged the importance of our responsibilities regarding safeguarding adults. Whilst NPS is not one of the named statutory partners, locally it is important for us to engage with our Board which we have already started to do through attendance at meetings. Over the next twelve months NPS Cleveland will continue to prioritise public protection and continue to deliver a service that is further underpinned by strong partnership working with a range of agencies.

Consultation and Engagement

During the early part of 2015 we facilitated a series of engagement activities, which involved 515 people from a wide range of stakeholder groups, of which 53% were members of the general public. The analysis and evaluation of this work will assist with the development of a Communication and Engagement Strategy, as well as informing other parts of our work. As highlighted on pages 13-14 there were several themes to the feedback received and this combined with the outcomes from comments illustrated below will provide valuable insight into our strategic priorities.

"Isolation is a huge problem. Sometimes services are on the doorstep of people but these are not being accessed due to lack of awareness and knowledge".

"Find ways to improve current low levels of reporting, and simplify reporting processes to improve reporting".

"Because of culture and language barriers, there is unawareness in the Asian community".

"There needs to be better signposting of services and communication between different services".

"I know of carers who have abused a vulnerable adult and are still working within the industry. This is a major issue as trust is a key issue for the adults I work with".

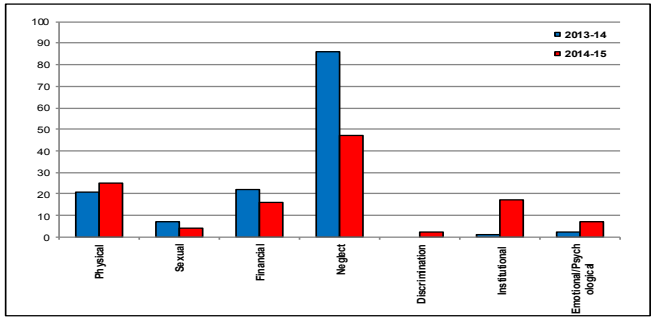
"The general public do not know how to report abuse, and there is a huge amount of work to be done in better promoting this subject".

Strategic Plan 2015-18

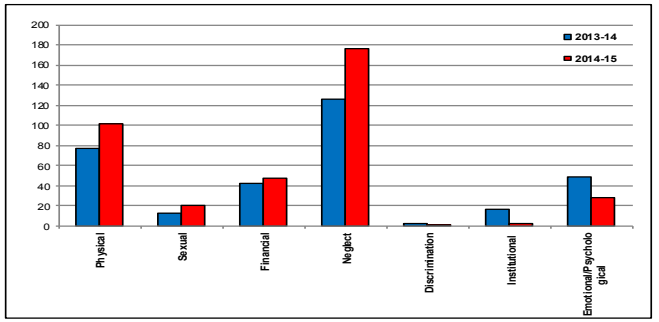
This is our first Strategic Plan since the Teeswide Safeguarding Adults Board moved onto a statutory footing in April 2015. The Plan has been developed following several months of extensive consultation and is underpinned by the feedback provided by the general public, safeguarding adults service users, their families and carers; and advocates and professionals working across a range of sectors. The Plan outlines our five longer-term Strategic Aims for 2015-18 together with our ten Business Plan objectives for 2015-16.

Vision: Ensuring our safeguarding arrangements act to help and protect adults	
Strategic Aims 2015-18	**Strategic Objectives 2015-16**
Strategic Aim One: Personalisation We will take account of the views of adults at risk in developing policies and procedures, and support the wider principles of personalisation.	Take into account the views of key stakeholders. Measure and evaluate what adults experiencing the safeguarding process say.
Strategic Aim Two: Prevention We will develop preventative strategies that aim to reduce the risk of abuse or neglect of adults.	Better promote and connect existing preventative strategies. Reduce barriers to reporting abuse and neglect.
Strategic Aim Three: Protection We will work together to ensure the protection of adults experiencing, or at risk of abuse or neglect.	Provide effective responses to reported abuse and neglect. Monitor complaints, grievances and professional/administrative malpractice.
Strategic Aim Four: Partnership We will work together to ensure that adult safeguarding links to other parts of the health and social care system to protect adults at risk of abuse or neglect.	Develop assurances for effectively linking with other strategic bodies. Evaluate how well each member agency is co-operating and collaborating.
Strategic Aim Five: Professional Accountability We will work to ensure the accountability of all partners in protecting adults experiencing, or at risk of abuse or neglect.	Take timely and appropriate action in relation to safeguarding adults. Challenge one another and hold other Boards to account.

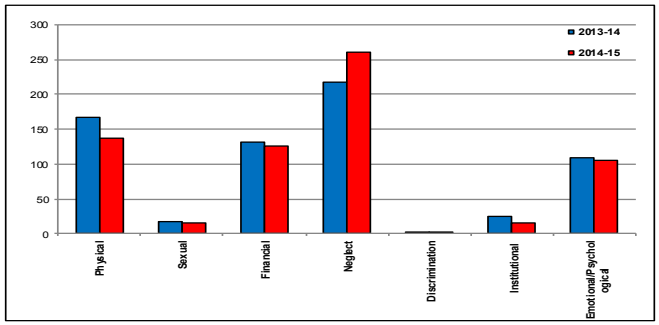
Annex A: Referrals - Types of Abuse and Neglect



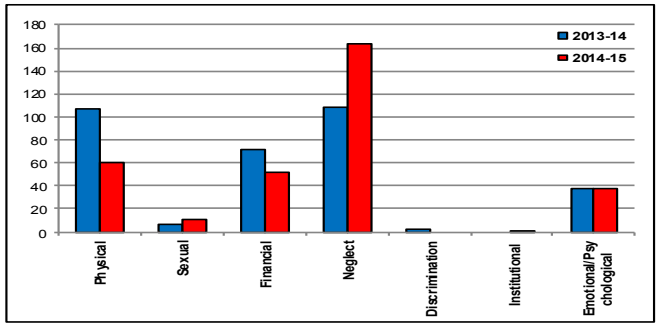
Hartlepool



Middlesbrough



Redcar & Cleveland



Stockton on Tees

Annex B: Care Act 2014 Overview

The Care Act 2014 sets out a clear legal framework for how Local Authorities and other parts of the system should protect adults at risk of abuse or neglect. Local Authorities have new safeguarding duties.
They must:

- **Lead a multi-agency local adult safeguarding system** that seeks to prevent abuse and neglect and stop it quickly when it happens
- **Make enquiries, or request others to make them,** when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed
- **Establish Safeguarding Adults Boards (SABs)**, to include the Local Authority, NHS and Police, to develop, share and implement a joint safeguarding strategy
- **Carry out Safeguarding Adults Reviews (SARs)** when someone with care and support needs dies or suffers serious harm as a result of neglect or abuse, and there is a concern that the Local Authority or its partners could have done more to protect them
- **Arrange for an independent advocate** to represent and support a person who is the subject of a safeguarding enquiry or review, if required.

The Care Act also places **duties to co-operate** on relevant agencies over the supply of information.

The broader definitions of abuse and neglect have also been amended, and these are outlined overleaf on page 21. Further detailed guidance on the whole of the Care Act can be accessed using the links highlighted on page 23.

Teeswide this means that the implementation plan has focussed on:

- Reviewing and refreshing the information provided for the general public about safeguarding adults
- Reviewing policies, procedures and practice guidance
- Reviewing systems and processes
- Delivering Care Act specific training for staff.

The Care Act 2014 Implementation Plan also acknowledged the need for greater consistency across agencies in relation to Adult Safeguarding work.

Annex C: Definitions of Abuse and Neglect

The Care Act 2014 provides ten definitions of abuse and neglect. This includes three new definitions (shaded). In addition, the term 'Organisational Abuse' is now used as an alternative to that of 'Institutional Abuse'.

Types	Definitions
Discriminatory Abuse	Including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion
Domestic Violence	Including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence
Financial or Material Abuse	Including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including wills, property, inheritance or financial transactions
Modern Slavery	Encompasses slavery, human trafficking, forced labour and domestic servitude
Neglect & Acts of Omission	Including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services
Organisational Abuse	Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to ongoing ill treatment
Physical Abuse	Including assault, hitting, slapping, pushing, misuse of medication or restraint
Psychological Abuse	Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber - bullying
Self-Neglect	This covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding
Sexual Abuse	Including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts.

Annex D: Useful Links

Teeswide Safeguarding Adults Board Strategic Business Plan 2015-16
https://www.stockton.gov.uk/adult-services/safeguarding- adults/
Care Act 2014
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
Making sure the Care Act works
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365345/Making_Sure_the_Care_Act_Works_EASY_READ.pdf
Care Act fact sheet: Safeguarding
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366087/Factsheet_7_-_Safeguarding.pdf
What the Care Act will mean for safeguarding: A legal view – Community Care
http://www.communitycare.co.uk/2014/03/03/care-act-2014-will-mean-safeguarding-legal-view/
Financial abuse 'Under the Radar'
https://www.citizensadvice.org.uk/about-us/how-citizens-advice-works/media/press-releases/financial-abuse-going-under-the-radar/
Age UK fact sheet: Safeguarding Older People from Abuse
http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/FS78_Safeguarding_older_people_from_abuse_fcs.pdf?dtrk=true
Mental Health Act: Revised Code of Practice 2015
https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983
Mental Health Act: Section 44
http://www.legislation.gov.uk/ukpga/1983/20/section/44
Mental Capacity Act 2005 (DoLS)
https://www.gov.uk/government/publications/mental-capacity-act-deprivation-of-liberty-safeguards
Social Care Institute of Excellence (SCIE)
https://www.scie.org.uk
Association of Directors of Adult Social Services (ADASS)
https://www.adass.org.uk
Health and Social Care Information Centre (HSCIC)
https://www.hscic.gov.uk
Care Quality Commission (CQC)
https://www.cqc.org.uk
Office for National Statistics (ONS)
https://www.ons.gov.uk
A range of relevant services signposted by Cleveland Police
http://www.cleveland.police.uk/advice-information/17786.aspx
All age liaison and diversion service – NHS England
http://www.tewv.nhs.uk/Trust-News/Archive-News/Working-with-police-to-support vulnerable-people-/
Sexual Assault Referral Centre (SARC)
http://www.sarcteesside.co.uk/ProInfo.htm
Teeswide Advocacy Hub
http://www.middlesbroughcab.org.uk/

Annex E: Contact Details

Name	Organisation	Telephone	Email
Business Unit	Teeswide Safeguarding Adults Board	01642 527263	tsab.businessunit@stockton.gov.uk
First Contact and Support Hub	Hartlepool Borough Council	01429 284284	fcsh@hartlepool.gcsx.gov.uk
First Contact Team	Middlesbrough Borough Council	01642 726004	adultsafeguarding alert@middlesbrough.gov.uk
Access Team	Redcar & Cleveland Borough Council	01642 771500	contactus@redcar-cleveland.gov.uk
First Contact Team	Stockton -on-Tees Borough Council	01642 527764	firstcontactadults@stockton.gov.uk
Protecting Vulnerable People Unit	Cleveland Police	999 Emergency or 101	
	Tees Esk & Wear Valley (TEWV) NHS Trust	01325 552000	tewv.enquiries@nhs.net
	South Tees Hospitals NHS Trust	01642 850850	
Patient Experience Team	North Tees and Hartlepool NHS Trust	01642 624719	patientexperience@nth.nhs.uk
General enquiries	Care Quality Commission	03000 616161	enquiries@cqc.org.uk
General enquiries	Healthwatch Hartlepool		www.healthwatchhartlepool.co.uk
General enquiries	Healthwatch Tees		www.healthwatchstockton@pcp.uk.net

Annex F: Glossary of Terms

Adult with care and support needs
(previously described as a vulnerable adult)
An adult receiving a care and support service, or an adult requesting an assessment. This maybe a mixture of practical, financial and emotional support for adults who need extra help to manage their lives and remain independent.

Alerts
Raising an alert means passing on a concern. An alert may be made by an adult at risk, their family or friends, care workers, volunteers or other professionals. Concerns should be passed immediately to the person responsible for dealing with safeguarding alerts, or Adult Social Care directly. They must decide without delay on the most appropriate course of action.

Capacity
Someone who lacks capacity cannot, due to an illness or disability such as a mental health problem, dementia or a learning disability, do the following:
· understand information given to them to make a particular decision
· retain that information long enough to be able to make the decision
· use or weigh up the information to make the decision
· communicate their decision.

Cheshire West Ruling
The Supreme Court handed down this judgment on 19 March 2014, which determined that there is a Deprivation of Liberty (DoL) when a person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements. This has resulted in a ten fold increase in DoLS assessments Teeswide in the last twelve months (total of 2185 for 2014-15).

Deprivation of Liberty Safeguards (DoLS)
Part of the Mental Capacity Act 2005 is to ensure that a care home, hospital or supported living arrangement only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person.

Annex F: Glossary of Terms

Direct Payment and Personal Budgets
Payments made directly to someone in need of care and support by their Local Authority to allow the person greater choice and flexibility about how their care is delivered. It includes the amount that the adult must pay towards that cost themselves (on the basis of their financial assessment), as well as any amount that the Local Authority must pay.

Expert by Experience
People who have experience of the safeguarding process either personally or as a carer.

Independent Advocacy
(the process of actively supporting and representing a person)
Local Authorities must arrange the use of an Advocate during: the assessment process; in the preparation and review of their care and support plan; during safeguarding enquiries and SARs, if two conditions are met: the person would have substantial difficulty in being fully involved in these processes if an Advocate was not involved, and if there is no other person to support and represent the adult who is not a paid professional or carer.

Making Safeguarding Personal (MSP)
Person-centred responses to safeguarding circumstances, creating a range of responses for people who have experienced harm and abuse, so that they are more empowered and their lives improved.

Referral
Refers to an adult safeguarding issue (alert) that meets the local safeguarding threshold and invokes a full investigation.

6.1 Appendix 2

Teeswide Safeguarding Adults Board

STRATEGIC BUSINESS PLAN

Ensuring our safeguarding arrangements act to help and protect adults

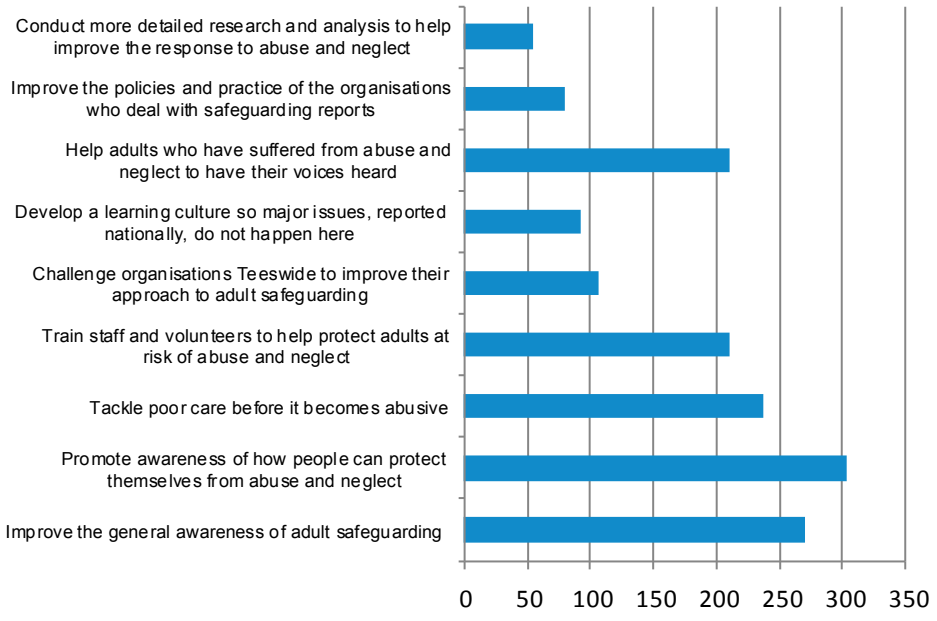
2015-16

Introduction

This is the first Strategic Plan for the now statutory Teeswide Safeguarding Adults Board following the implementation of the Care Act 2014 on April 1 2015. The Plan has been developed following several months of extensive consultation, and underpinned by the feedback provided by the general public, safeguarding adults service users, their families, carers, advocates and professionals working across a range of sectors. The table below illustrates the priorities which these groups of people have identified Teeswide, providing the framework for our five longer-term Strategic Aims for 2015-18, ten Business Plan objectives, and actions for 2015-16 which are all outlined in this Plan. We look forward to working with our current partners, and developing new relationships to implement our Vision:

"Ensuring our safeguarding arrangements act to help and protect adults"

Teeswide priorities for 2015-16



Ann Baxter
Independent Chair

Teeswide Safeguarding Adults Board

Partner Agencies

Listed below are the current partners of the Board as of July 2015.The Local Executive Groups (LEGs) also have additional organisations represented, including Housing and Care providers, Voluntary Sector Development Agencies, and other internal stakeholders from within the Board's main partner organisations. The main Board meets bi-monthly and the Sub-Groups and LEGs meet quarterly.

Statutory Partners	
Hartlepool Borough Council	Director of Child and Adult Services
Middlesbrough Borough Council	Executive Director of Wellbeing, Care and Learning
Redcar & Cleveland Borough Council	Corporate Director of People Services
Stockton -on-Tees Borough Council	Director of Children, Education and Social Care
Cleveland Police	Head of Protecting Vulnerable People Unit
Hartlepool and Stockton-on-Tees CCG	Executive Nurse
South Tees CCG	
Non Statutory Partners	
Care Quality Commission	Inspection Manager
Cleveland Fire Brigade	Director of Community Protection
Community Rehabilitation Company	Lead Manager Durham Tees Valley
Healthwatch Hartlepool	Healthwatch Development Officer
Healthwatch Tees	Healthwatch Manager
HM Prison Service: Holme House Prison	Safeguarding Lead HMP Holme House
National Probation Service: Cleveland	Head of Area (MAPPA Board)
NHS England: Cumbria and the North East	Deputy Director of Nursing
North Tees and Hartlepool NHS Foundation Trust	Deputy Director of Nursing
Public Health	Director of Public Health
South Tees Hospitals NHS Foundation Trust	Head of Nursing (Safeguarding and Vulnerable Groups)
Tees, Esk and Wear Valley NHS Foundation Trust	Director of Nursing and Governance
Lead Members for Local Authorities sit on the Board as non-voting participant observers	

Teeswide Safeguarding Adults Board Structure

Key:

HBC Hartlepool Borough Council
MBC Middlesbrough Borough Council
RCBC Redcar & Cleveland Borough Council
SBC Stockton -on-Tees Borough Council

CE Communication & Engagement
LTD Learning, Training & Development
PAQ Performance, Audit & Quality
PPP Policies, Procedures & Practice
SAR Safeguarding Adults Review

Definitions of Abuse and Neglect

The Care Act provides ten definitions of abuse and neglect. This includes three new definitions (shaded). In addition, the term 'Organisational Abuse' is now used as an alternative to that of 'Institutional Abuse'. Highlighted in red are the most common forms of abuse and neglect recorded Teeswide in 2014-15.

Types	Definitions
Discriminatory Abuse	Includes forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion
Domestic Violence	Including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence
Financial or Material Abuse (16%)	Including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including wills, property, inheritance or financial transactions
Modern Slavery	Encompasses slavery, human trafficking, forced labour and domestic servitude
Neglect & Acts of Omission (44%)	Including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services
Organisational Abuse	Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill treatment
Physical Abuse (22%)	Including assault, hitting, slapping, pushing, misuse of medication or restraint
Psychological Abuse (12%)	Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber - bullying
Self-Neglect	This covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding
Sexual Abuse	Including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts.

Vision:	
Strategic Aims 2015-18	**Strategic Objectives 2015-16** Elements have transferred from the Strategic Plan 2014-16
Strategic Aim One: Personalisation We will take account of the views of adults at risk in developing policies and procedures, and support the wider principles of personalisation.	Take into account the views of key stakeholders. Measure and evaluate what adults experiencing the safeguarding process say.
Strategic Aim Two: Prevention We will develop preventative strategies that aim to reduce the risk of abuse or neglect of adults.	Better promote and connect existing preventative strategies. Reduce barriers to reporting abuse and neglect.
Strategic Aim Three: Protection We will work together to ensure the protection of adults experiencing, or at risk of abuse or neglect.	Provide effective responses to reported abuse and neglect. Monitor complaints, grievances and professional/administrative malpractice.
Strategic Aim Four: Partnership We will work together to ensure that adult safeguarding links to other parts of the health and social care system to protect adults at risk of abuse or neglect.	Develop assurances for effectively linking with other strategic bodies. Evaluate how well each member agency is co-operating and collaborating.
Strategic Aim Five: Professional Accountability We will work to ensure the accountability of all partners in protecting adults experiencing, or at risk of abuse or neglect.	Take timely and appropriate action in relation to safeguarding adults. Challenge one another and hold other Boards to account.

Ensuring our safeguarding arrangements act to help and protect adults
People Outcome Measure: How this will make a difference
The voices of key stakeholders will be incorporated into all planning and policy decision making/documents. There will be an increase in the volume of outcomes, views and wishes realised by participants in safeguarding.
We will have helped to connect and evidence more people accessing preventative support services. We will better understand why people feel they cannot report abuse and neglect.
People Teeswide will receive a more consistent response to safeguarding adult reports. Anyone that is unhappy about a safeguarding adults issue will have an appropriate method of recourse.
We will better co-ordinate and prioritise safeguarding adults work. We will be more effective in ensuring our safeguarding arrangements help and protect adults.
We will provide effective assurances about services being delivered to adults. We will ensure the experiences of adults help to hold the wider health and social care sector to account.

Strategic Aim One: Personalisation

Objectives Reference material/Source	Action
1.1. Take into account the views of key stakeholders. Care Act 2014: 14.110 Care Act: Care and Support Statutory Guidance Board: Engagement and Consultation report May 2015 Local Government Association (LGA)/ Association of Directors of Adult Social Services (ADASS): Standards March 2015 Local Authority Surveys: Care Homes Clinical Quality Audits Tees Advocacy Hub Care Quality Commission: Inspections Local Safeguarding Childrens Boards (LSCBs) Community Safety Partnerships (CSPs) Health and Wellbeing Boards Overview and Scrutiny Boards	Develop a Communications & Engagement Strategy (C&E) including processes to create the necessary ongoing consultation with: adults and families; carers; advocates; Healthwatch; practitioners; partner agencies and other strategic bodies. (Links to Objective 4.2)
	C&E outcomes will be used to inform all of the Boards strategic and policy developments, ensuring Making Safeguarding Personal (MSP) principles are embedded.
1.2. Measure and evaluate what adults experiencing the safeguarding process say. Care Act 2014: 14.110 LGA: Making Safeguarding Personal (MSP) guide November 2014 Mental Capacity Act 2005 Board: Engagement and Consultation report May 2015	Develop a Teeswide MSP evaluation process for use by operational safeguarding teams.
	Develop practice guidance designed to provide Teeswide consistency and to help improve/increase the involvement of participants, their families, carers and advocates in the operational safeguarding and evaluation process. This to include additional supportive measures for those who lack capacity.

People being supported and encouraged to make their own decisions and informed consent

People Outcome Measure: How this will make a difference	Timeline	Lead Group	Contributors
By March 2016 the voices of key stakeholders will be incorporated into all Board planning and policy decision making/documents.	Sept 2015 & ongoing	CE	Board LEGs
	Sept 2015 to March 2016	Board	PPP CE LTD PAQ LEGs
By March 2016 there will be an increase in the volume of outcomes, views and wishes realised by participants in safeguarding.	Sept 2015	PAQ	CE LEGs
	Dec 2015 & ongoing	PPP	LEGs LTD

Strategic Aim Two: Prevention

Objectives Reference material/Source	Action	People Outcome Measure: How this will make a difference	Timeline	Lead Group	Contributors
		It is better to take action before harm occurs			
2.1. Better promote and connect existing preventative strategies. Care Act 2014: 14.110; 14.196; 14.197; 14.198 & Chapter two Board: Engagement and Consultation report May 2015 LGA/ADASS: Standards March 2015 Community Safety Partnerships	The C&E strategy will collate and bring together existing preventative work and highlight ways to better promote and connect existing services. This research will underpin the development of a website and linked publicity campaigns.	By March 2016 we will have helped to connect and evidence more people accessing preventative support services.	Dec 2015 & ongoing	CE	LTD LEGs (CSPs)
	Create a portfolio of evidence linked to community awareness of adult abuse and neglect, and how people can prevent and respond to this.		Dec 2015 & ongoing	CE	PAQ LTD LEGs (CSPs)
2.2 Reduce barriers to reporting abuse and neglect. Care Act 2014: 14.110 Equality Act 2010 (Public Sector Equality Duty) Joint Strategic Needs Assessment (JSNA) Joint Health and Wellbeing Strategies (JHWS)	Collate and cross-reference existing data and research into Teeswide population demographics and safeguarding reporting patterns.	By March 2016 we will better understand why people feel they cannot report abuse and neglect.	March 2016	PAQ	Board Possible academic researcher
	This research will then be transferred into an action plan in 2016 and filtered into the main Strategic Business Plan for 2016-17. This will include responses to disability 'Hate' and 'Mate' crimes, highlighted under-reporting within specific community and harder to reach or marginalised groups.		April 2016 to July 2016	PAQ	Board

Strategic Aim Three: Protection	
Objectives Reference material/Source	Action
3.1. Provide effective responses to reported abuse and neglect. Board: Strategic Plan 2014-16 Care Act 2014: 14.128 Board: Inter-Agency Policy May 2015 Board: Engagement and Consultation report May 2015 LGA/ADASS: Standards March 2015 National Prevent Strategy	Effective and consistent delivery of Teeswide Inter-Agency Policy and Procedures.
	Analyse safeguarding data to better understand the reasons that lie behind local data returns and use the information to improve the Strategic Plan and operational arrangements.
3.2. Monitor complaints, grievances and professional/ administrative malpractice. Care Act 2014: 14.110 Board: Inter-Agency Policy May 2015 Board: Serious Concerns Protocol	The Inter-Agency Policy 2015 will be linked to updated practice and guidance, which will include distinct and separate sections on dealing with: complaints; grievances and malpractice.
	All partners will alert the Board as soon as the Serious Concerns Protocol has been activated.

Support and representation for those in greatest need			
People Outcome Measure: How this will make a difference	Timeline	Lead Group	Contributors
By March 2016 people Teeswide will receive a more consistent response to safeguarding adult reports.	Sept 2015	PPP	PAQ LEGs
	Sept 2015 & ongoing	PAQ	Board PPP CE LEGs LTD
By March 2016 anyone that is unhappy about a safeguarding adults issue will have an appropriate method of recourse.	Dec 2015	PPP	PAQ
	Sept 2015 & ongoing	Board	PAQ LEGs

Strategic Aim Four: Partnership	
Objectives Reference material/Source	Action
4.1. Develop assurances for effectively linking with other strategic bodies. Care Act 2014: 14.128 Local Safeguarding Childrens Boards Community Safety Partnerships Health and Wellbeing Boards Overview and Scrutiny Boards LGA/ADASS: Standards March 2015 National Prevent Strategy	Each member agency will ensure the Strategic Aims of the Board are effectively represented within the wider health and social care strategic framework. This will allow higher level and joint strategic priorities to be developed.
	Create a learning culture by considering recommendations from Safeguarding Adults Reviews (SAR) and other national and local reviews.
4.2. Evaluate how well each member agency is co-operating and collaborating. Care Act 2014: 14.128 Care Act 2014: 14.110 Board: Strategic Plan 2014-16 Care Act: Care and Support Statutory Guidance Mental Capacity Act 2005 (including Deprivation of Liberty Safeguards) Equality Act 2010 Mental Health Act 1983 and the New Code of Practice 2015 Mental Health Crisis Care Concordat Feb 2014	Routinely evaluate Board attendance, membership, effective participation and active leadership, including the implementation of a multi-agency Information Sharing Agreement.
	The strategic plan and other policy developments are cascaded, and risks escalated via the Boards sub-structure. Further develop and review the Sub-Group and LEG membership to provide local innovation and solutions. (Links to Objective1.1)

Local solutions through services working with their communities			
People Outcome Measure: How this will make a difference	Timeline	Lead Group	Contributors
By March 2016 we will better co-ordinate and prioritise safeguarding adults work.	Sept 2015 & ongoing	PPP	Board
	Sept 2015 & ongoing	Board	SAR LTD LEGs
By March 2016 we will be more effective in ensuring our safeguarding arrangements help and protect adults.	Sept 2015 & ongoing	Chair	PAQ
	April 2015 to March 2016	Board	Sub Groups LEGs

Strategic Aim Five: Professional Accountability		Transparency in delivering safeguarding			
Objectives Reference material/Source	Action	People Outcome Measure: How this will make a difference	Timeline	Lead Group	Contributors
5.1. Take timely and appropriate action in relation to safeguarding adults. Care Act 2014: 14.110; 14.196; 14.197; 14.198 & Chapter two LGA/ADASS: Standards March 2015 Better Care Fund	Member agencies will complete a Professional Quality Assurance Framework (QAF) annually, and provide assurances for the quality of safeguarding adults work within their own organisations. The framework will be linked to MSP outcomes. (Objective 1.2)	By March 2016 we will provide effective assurances about services being delivered to adults.	Dec 2015 & ongoing	PAQ	Board LEGs
	Non-member agencies maybe requested to complete a QAF if there are grounds for concern, or if they deliver a contracted service.		Dec 2015 & ongoing	PAQ	SAR LEGs
5.2. Challenge one another and hold other Boards to account. Care Act 2014: 14.110 Board: Strategic Plan 2014-16 Local Safeguarding Childrens Boards Community Safety Partnerships Health and Wellbeing Boards Overview and Scrutiny Boards LGA/ADASS: Standards March 2015 Care Quality Commission: Inspections Board: Engagement and Consultation report May 2015 Organisational Change Programmes	Member agencies will recognise and deliver their individual and organisational duty to proactively support and challenge the work of the Board and its partner agencies, whilst helping to ensure other strategic bodies constructively support the Strategic Aims of the Teeswide Safeguarding Adults Board.	By March 2016 we will ensure the experiences of adults help to hold the wider health and social care sector to account.	April 2015 & ongoing	Board	PAQ PPP LEGs (CQC)
	Develop an annual 360 degree appraisal for the Board chair.		March 2016	Board Local Authority CEOs	Sub Groups & LEG Chairs

Work programme for the Board and Sub Group structure			
Action Points	**Board**	**CE Sub Group**	**LTD Sub Group**
1.1.1	Contributor	**Lead Group**	
1.1.2	**Lead Group**	Contributor	Contributor
1.2.1		Contributor	
1.2.2			Contributor
2.1.1		**Lead Group**	Contributor
2.1.2		**Lead Group**	Contributor
2.2.1	Contributor		
2.2.2	Contributor		
3.1.1			
3.1.2	Contributor	Contributor	Contributor
3.2.1			
3.2.2	**Lead Group**		
4.1.1	Contributor		
4.1.2	**Lead Group**		Contributor
4.2.1	**Lead Group**		
4.2.2	**Lead Group**	Contributor	Contributor
5.1.1	Contributor		
5.1.2			
5.2.1	**Lead Group**		
5.2.2	**Lead Group**	Contributor	Contributor

Work programme for the Board and Sub Group structure			
PAQ Sub Group	**PPP Sub Group**	**SAR Sub Group**	**LEGs**
			Contributor
Contributor	Contributor		Contributor
Lead Group			Contributor
	Lead Group		Contributor
			Contributor
Contributor			Contributor
Lead Group			
Lead Group			
Contributor	**Lead Group**		Contributor
Lead Group	Contributor		Contributor
Contributor	**Lead Group**		
Contributor			Contributor
	Lead Group		
		Contributor	Contributor
Contributor			
Contributor	Contributor	Contributor	Contributor
Lead Group			Contributor
Lead Group		Contributor	Contributor
Contributor	Contributor		Contributor
Contributor	Contributor	Contributor	Contributor

ADULT SERVICES COMMITTEE

9 November 2015

Report of: Director of Child and Adult Services

Subject: SUPPORT FOR PEOPLE WITH DEMENTIA IN HARTLEPOOL

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 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 March 2015.

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.

3.6 The number of those anticipated to be living with dementia by 2030 is significant; the table below shows the steady anticipated increase with an estimated 54% total increase by 2030.

Hartlepool - Dementia - all people	**2014**	**2015**	**2020**	**2025**	**2030**
People aged 65-69 predicted to have dementia	66	69	64	71	81
People aged 70-74 predicted to have dementia	101	104	137	131	145
People aged 75-79 predicted to have dementia	200	200	194	263	252
People aged 80-84 predicted to have dementia	312	312	335	322	439
People aged 85-89 predicted to have dementia	283	300	361	400	417
People aged 90 and over predicted to have dementia	209	209	268	388	477
Total population aged 65 and over predicted to have dementia	**1,171**	**1,193**	**1,358**	**1,575**	**1,811**

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.

4.3 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.

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

5. HARTLEPOOL POSITION

5.1 As reported in March 2015, 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 attached as **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.

5.4 Since April the collaborative have projects in the following areas:-

1. Pooling of Direct Payments including review of what those living with Dementia want to be able to continue to do.
2. DVD for Carers – work underway awaiting some funding
3. Children's Dementia awareness – education sessions being rolled out in Hartlepool schools
4. Book launch – Julia Jarman's "Lovely Lion" – a book designed to help younger children understand the impact of dementia. Successfully delivered to 8 primary schools.
5. Teeswide Dementia Friendly Railway Stations project – a group of individuals took a supported rail journey from Middlesbrough to Saltburn.
6. Input to the Hartlepool & Stockton Frail Elderly and Care Home group.
7. Gap analysis of National Dementia Strategy – 3 years on.
8. QIS leaders course – Quality Improvement Systems – key personnel from Adult Services, Hospital of God and other partners. Undertaking training to improve projects currently underway rather than whole system change.

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.

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.

6.4 There have been a significant number of sessions delivered since the last update including sessions designed and delivered for children. There are over 430 adults that have become new dementia friends and over 560 children.

6.5 There are currently 35 Dementia Champions within the town; these individuals are trained to be able to deliver Dementia Friends sessions. Champions work to raise the awareness within their own organisations and circles within the community.

6.6 Earlier this year The Bridge was opened at Villiers Street in the town centre. The centre is a drop in and information centre for those living with dementia and their carers. The centre hosts the Dementia Advisory Service commissioned by Adult Services to ensure that anyone needing advice and support to navigate through previously unknown territory can do so in a positive and supportive place. The Bridge and advisory service is provided by Hospital of God.

6.7 Alzheimer's Road Show bus – attendance of the Road show bus was secured for Waldon Street car park in the town centre on 25 August, the Society were particularly pleased with the turnout – they record any meaningful contact with interested people. They have said that they received higher than expected interest in Hartlepool.

6.8 They held 52 interviews with individuals and covered topics such as:-

- Types of dementia
- Symptoms of dementia
- Support for Carers
- Managing Behaviours
- Diagnosis/Visiting GP
- Legal/Financial Issues

6.9 The majority of the people spoken to were under the age of 65, The Bridge also attended and people were able to be signposted to the facility either that day or for a future visit.

7 HARTLEPOOL AS A DEMENTIA FRIENDLY COMMUNITY

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

7.2 Following consultation with people with dementia and their carers and the information gained from this the local priorities for Hartlepool were established. The immediate aim being to gain accreditation as a Dementia Friendly Community through the national scheme. This required 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 been successful in gaining the first level of accreditation which enables all interested parties that pledge their support and to be able to register as part of our Dementia Friendly Community. This enables the wider community to have confidence that they will meet individuals and staff that are sensitive to the issues facing those living with dementia.

7.5 Following the success of gaining Dementia Friendly Community accreditation the official launch was celebrated by holding a Memory Walk, this was held on 26 September at Ward Jackson Park. The walk was opened by Councillor Jim Ainslie. Over 100 people attended the event from the very young to residents of local residential homes. There was some fundraising carried out on the day which collected £226 donated to Alzheimer's Society. The event showed how successful the awareness raising has been in the town – it is hoped this will become an annual event.

7.6 There have also been significant levels of work carried out within the residential homes within the town to ensure that those living with dementia are cared for in the most appropriate way. This has built on the Care Homes project carried out through the Dementia Collaborative which delivered specific training to care home staff. Individuals now have an 'All About Me' yellow folder which can be taken with them should they need to be admitted to hospital. This folder contains key information which enable those who do not know the individual to gain an insight to how dementia affects them and how best to manage the impact.

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.

8.3 This level of sign up is gradually being replicated at a local 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.

8.4 The local response from the organisations, people and businesses of Hartlepool to the idea of being a dementia friendly community has been very positive. The project will seek to maintain this level of enthusiasm and build on it for the future. Now accreditation has been 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. RISK IMPLICATIONS

9.1 There are no risk implications associated with this report.

10. FINANCIAL CONSIDERATIONS

10.1 There are no financial considerations associated with this support. The North of Tees Dementia Collaborative is supported financially by the Council and other new developments such as the Dementia Advisory Service are supported through the Better Care Fund pooled budget.

11. LEGAL CONSIDERATIONS

11.1 There are no legal considerations associated with this report.

12. CHILD AND FAMILY POVERTY CONSIDERATIONS

12.1 There are no child and family poverty considerations associated with this report.

13. EQUALITY AND DIVERSITY CONSIDERATIONS

13.1 The development of support for people with dementia and their carers, and the Dementia Friendly Hartlepool initiative aim to ensure that people with dementia are treated equitably.

14. STAFF CONSIDERATIONS

14.1 There are no staff considerations associated with this report.

15. ASSET MANAGEMENT CONSIDERATIONS

15.1 There are no asset management considerations associated with this report.

16. RECOMMENDATIONS

16.1 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.

17. REASONS FOR RECOMMENDATIONS

17.1 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.

17.2 The creation 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.

18. 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

ADULT SERVICES COMMITTEE

9 November 2015

Report of: Director of Child & Adult Services

Subject: RESPONSE TO THE LAW COMMISSION'S CONSULTATION ON MENTAL CAPACITY AND DEPRIVATION OF LIBERTY SAFEGUARDS

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1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required, for information.

2. PURPOSE OF REPORT

2.1 The purpose of the report is to provide members of the Adult Services Committee with an overview of the Law Commission's consultation on Mental Capacity and Deprivation of Liberty Safeguards and the response that has been submitted by the Council.

3. BACKGROUND

3.1 The Mental Capacity Act was introduced in 2005 and in 2007 an amendment to the Act introduced the concept of Deprivation of Liberty Safeguards (DoLS).

3.2 The introduction of DoLS established an administrative process for authorising deprivations of liberty in hospitals or care homes and introduced the practice of using a professional assessment to determine whether a person lacks the mental capacity to decide whether to be accommodated in a hospital or care home for the purpose of care or treatment; and whether or not it is in their best interest to be deprived of their liberty in order to facilitate their care and treatment.

3.3 For a number of years there were low levels of referrals for DoLS assessments with Hartlepool Borough Council (HBC) receiving approximately 46 referrals per year in 2012/13 and 2013/14.

3.4 In March 2014 the Supreme Court handed down a judgement relating to a specific case and as a result the concept of the 'Acid Test' was introduced. The 'Acid Test' focuses upon the questions:

- *Is the person subject to continuous supervision and control?*
- *Is the person free to leave?*

3.5 For a significant number of people residing in residential care or nursing care the response to the 'Acid Test' is 'Yes' the person is subject to continuous supervision and control and 'No' the person is not free to leave, as the risks of leaving without support are too high. If this is the case, the 'Acid Test' is proven and a referral for a DoLs is required. For the most part this is authorised following a detailed assessment. This has led to a massive change in the number of people who now require an assessment and subsequent DoL authorisation and the challenge for every Local Authority across England has multiplied.

3.6 Once HBC became aware of the legal implications of the ruling a predicative modelling exercise was completed and it was identified that the number of assessments per annum could increase to 750, which also brings the additional requirement for ongoing reviews. In 2014/15 HBC completed 648 assessments. This was less than anticipated as there was work required initially to inform professionals of the new legislative requirements and to provide subsequent training. However the requirements are more familiar to professionals now and as a result in the first quarter of 2015/16, 209 assessments were completed.

4. CURRENT POSITION AND PROPOSALS

4.1 The briefing paper attached as **Appendix 1** sets out:

- The current position in Hartlepool (post Cheshire West Judgement);
- Current issues and concerns within the DoLS System;
- A summary of the Law Commission proposals;
- HBC analysis of the Law Commission proposals; and
- HBC conclusions regarding the proposals.

4.2 This paper represents the Hartlepool contribution to the consultation, and has also been used to inform a response on behalf of the Teeswide Safeguarding Adults Board and a regional response.

5. RISK IMPLICATIONS

5.1 It is not possible to identify risks at this stage, as the proposals are subject to consultation. If current legislation changes, a risk assessment will be undertaken to identify the impact for the Council.

6. FINANCIAL CONSIDERATIONS - FINAL

6.1 As the Supreme Court judgement was not made until March 2014 the financial impact was not known and therefore not reflected in the 2014/15 budget. Instead, it was determined that all additional costs would be funded from a combination of in-year departmental underspend and departmental reserves.

6.2 The additional costs in 2014/15 (£0.217m) and 2015/16 (est £0.250m – net of a one-off DoLS government grant of £0.053m) will be funded from within the overall departmental outturn. A DoLS reserve of £0.448m was created in 2014/15 from existing departmental reserves to fund these unbudgeted costs and this will now be carried forward to meet the unbudgeted costs in 2016/17.

6.3 Funding has been included in the Medium Term Financial Strategy from 2017/18 for the Child and Adult Services Department towards a range of a range of legislative and other requirements, including DoLS. Given the uncertainty around future proposals and changes to current legislation this strategy enables a longer lead in time to determine the likely on-going cost pressure and whether this funding will be sufficient to fully meet these pressures in 2017/18.

7. LEGAL CONSIDERATIONS

7.1 There is potential for significant changes to current legislation to be implemented following the consultation, but it is not possible to quantity the impact at this stage.

7.2 Adult Services currently work closely with the Council's legal team in relation to issues concerning Mental Capacity and Deprivation of Liberty Safeguards and will continue to do so.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 No issues identified in relation to child and family poverty.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 Legislation regarding Mental Capacity and Deprivation of Liberty Safeguards has a positive impact on equality and diversity, as it ensures that people who lack mental capacity are appropriately safeguarded, and can only be deprived of their liberty under a robust legal framework.

10. STAFF CONSIDERATIONS

10.1 If changes to current legislation are agreed there may be staffing implications, as highlighted in **Appendix 1**, both in terms of training and a potential requirement to review grades.

10.2 Staff considerations will be reviewed in following the outcome of the consultation.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1. There are no asset management considerations associated with this issue.

12. RECOMMENDATIONS

12.1 It is recommended that Members:

- note the proposals made by the Law Commission in relation to Mental Capacity and Deprivation of Liberty Safeguards;
- note the response provided by the Council; and
- receive a further report outlining the implications for the Council if changes to the current legislation are implemented following the consultation.

13. REASONS FOR RECOMMENDATIONS

13.1 The Council currently has legislative responsibility as Supervisory Body for the assessment, authorisation and review of all Deprivations of Liberty Safeguards in Hartlepool and for out of area placements for care homes.

13.2 Any change to current legislation is likely to have significant financial, legal and staffing implications for the Council.

14. BACKGROUND PAPERS

14.1 Law Commission Consultation Document:
http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty

15. CONTACT OFFICER

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The Law Commission: Mental Capacity Act and Deprivation of Liberty Safeguards Consultation

Briefing Paper

1. HBC Position - Post Cheshire West Judgement

1.1 As a result of the Cheshire West judgement HBC has redesigned the adult social care staffing and management infrastructure to address the legal requirements of the ruling, and to ensure compliance with the Mental Capacity Act / Deprivation of Liberty Safeguards legislative framework.

1.2 HBC now has a dedicated team to focus on the requirements, consisting of a Team Manager, 3 whole time Best Interest Assessors (BIAs) and one part time BIA. There is also one full time clerk who deals with the paperwork element of the process, which is considerable.

1.3 HBC has invested in the training of new BIAs, as well as ensuring that existing qualified BIAs have regular legal updates in order for them to practice safely within the complex legal framework.

1.4 A rolling process is in place to recruit Independent BIAs because the timescales and the volume of activity is such that additional input is sometimes required, to supplement the dedicated DoLS Team.

1.5 As required by the legislation, a system has been established for paid Relevant Person Representatives as well as an Advocacy Service.

1.6 The Cheshire West Judgment has had a significant impact on HBC and every other Council in England due to the financial implications associated with the huge increase in activity. Although a one off grant was allocated in 2015/16 by the Department of Health (DoH), it is not sufficient to cover even 50% of the costs that have been accrued since the ruling and there are no options available currently to reduce expenditure.

1.7 In response to the ruling, HBC developed a strategic approach to managing the requirements by working with service providers to manage the influx of referrals and to avoid any legal complications for HBC as a Supervisory Body and for the providers as Managing Authorities. In doing so, the priority was to ensure that each person was safeguarded and legally deprived of their liberty (if necessary) in accordance with the law.

1.8 HBC developed and followed an action plan for 2014/15 to identify and manage the legal risks, and has continued with this approach for 2015/16.

1.9 Overall in response to the Cheshire West Judgement the HBC approach worked well and continues to work well. All referrals are managed within the legal time scales and there are no waiting lists for assessments.

1.10 As part of the process HBC, like all Local Authorities has had to commission the services of Mental Capacity Act Mental Health Assessors, known as Section 12 Doctors, and thus far has been able to develop excellent relationships with these professionals and secure their services for certain days of the week when all assessments are completed. A DoL cannot be authorised without the involvement of a Section 12 Doctor.

1.11 HBC assessments are completed with all relevant parties present which include a BIA, Section 12 Doctor and a family member, friend or the most appropriate person to represent a service user. This has meant that any potential legal challenges or issues can be addressed in the first instance as the reason for the DoLS assessment is explained at the time of the assessment and any potential objections discussed quickly.

1.12 HBC has also re-visited previous DoLS cases and cases requiring a referral to the Court of Protection and again can confirm that this work has all been completed within the legal time scales, with the only cases outside the time frames being those awaiting a Court date which is beyond the control of HBC. The delays in relation to the Court of Protection (CoP) are because the judgement has had a significant impact on the CoP which has meant that there is a waiting list (although delays have now been reduced as a revised stream-lined process has been introduced). HBC has dealt with these cases by ensuring that in the interim period prior to the Court decision the person is safeguarded and clear action plans and risk assessments have been completed and implemented.

2. Current Issues and Concerns within the DoLS System.

2.1 Now, over a year after the Cheshire West ruling, there are still clearly identifiable issues and concerns in the current system that need to be addressed and some of the key issues and concerns are as follows: -.

2.1.1 The term ‘Deprivation of Liberty Safeguards’ is now deemed to be inappropriate and it is considered that this terminology does not adequately reflect or emphasise the adult protection element of the work.

2.1.2 There are tensions in the care management system and perceived conflicts of interest between the Local Authority role as the adult safeguarding lead organisation and as a Supervisory Body under MCA / DoLS and the Local Authority role as a commissioner of services from providers. This is the rationale for introducing a dedicated team to lead on the DoLS processes and these BIAs do not commission services on behalf of service users from any provider organisation.

2.1.3 The DoLS processes promote the idea of a one size fits all approach irrespective of setting and the current process considers an intensive care hospital ward in the same way as a long stay residential care home but

these settings serve different purposes and therefore the issues arising are very different.

2.1.4 In relation to referrals involving the hospice and end of life patients or palliative care patients residing elsewhere, the question arises as to whether it is appropriate for families and patients to go through this cumbersome and bureaucratic process at such a difficult time? The law as it stands states that this must happen, but this is at odds with a person centred and holistic approach to care management practice.

2.1.5 There is still a lack of referrals from some hospitals as well as a number of inappropriate referrals from hospitals, and HBC BIAs face weekly issues due to patients being discharged without the Council being notified or being moved to different sites prior to the assessment being carried out. This has a significant financial impact as Section 12 Doctors still require a payment for their time and operational time is wasted in 'tracking' patients.

2.1.6 Although HBC works closely with Managing Authorities, they do require on-going support to ensure they always consider the 'Acid Test' and to ensure that conditions of the DoLS for service users are adhered to. Nationally this has been identified as a major problem. In relation to this issue in Hartlepool, HBC Social Workers or Social Care Officers currently provide support in this area. This is time consuming but does help to promote compliance. However it should be noted that there is still no clear guidance or monitoring process for those service users who are in receipt of NHS Continuing Healthcare funding.

2.1.7 For those Hartlepool people who are residing Out of Borough, DoLS referrals are problematic because despite the Association of Directors of Adult Social Services (ADASS) agreement for the 'host' authority to undertake the assessments on behalf of the placing authority for a small payment or for a reciprocal arrangement, this is not being adhered to simply because of the lack of capacity in most of the 'host' authorities and the backlog of work for what see as 'their' service users.

2.1.8 There is still a gap in the system where people held under a DoL are transported to and from hospital, and uncertainty about 'best interest' decisions and a person's capacity to make any decision whilst in transit.

2.1.9 If an individual dies whilst being subject to a DoL, the Coroner's Office must be informed and due to the volume of referrals and authorised DoLS the Coroner's Office has experienced delays and this causes problems for some people when trying to arrange a person's funeral.

2.1.10 The financial consequences of Cheshire West are immense. The additional, unbudgeted, costs to HBC in 2014/15 totalled £217k and are forecast to be £250k in the current year, even after accounting for the one-off government grant funding of £53k. These additional costs include the

staffing team, section 12 doctors, relevant person representatives and advocates.

	2014/15 £'000	2015/16 *Est* £'000
Staffing	**136**	**180**
Mental Health & Capacity Assessments	**105**	**120**
Other Expenditure inc BIA's & IMCA	**27**	**54**
Total Expenditure	**268**	**354**
HBC Existing Budget	**(42)**	**(51)**
Government Grant	**(9)**	**(53)**
Unbudgeted Cost	**217**	**250**

2.1.11 All assessments and authorisations need approving by a senior representative of the Local Authority known as a 'signatory', this is an additional accountability and training has been provided, and will need to continue, to ensure HBC comply with the legislation.

2.1.12 Due to the nature of those service users who are subject to requests for a DoL and their fluctuating health needs, their circumstances are subject to change as people regularly go into hospital, then return back to residential and / or nursing care; move to another home; or their mental capacity and or decision fluctuates as it is affected by illness including infection. This causes changes to arrangements which are beyond the Local Authority's control but impacts on workload and capacity.

2.1.13 Currently the interface between the use of the Mental Health Act 1983 and the Mental Capacity / DoLS legislative framework is highly complex, even for specially trained health and social care professionals to fully understand. This is especially so when a patient is admitted for their own well being to an inpatient mental health assessment ward. The outcome for each inpatient is currently very much dealt with on a case by case basis and rightly so, however this too absorbs operational capacity and places a strain on the health and social care system.

2.1.14 Fundamentally the most significant issue is the sheer scale of the work required. The DoLS system and processes were designed for a relatively small number of cases and were never intended to deal with the number of cases that have arisen since the Cheshire West Judgement. This has led to the Law Commission proposal for reforming the system.

3 Summary of The Law Commission Proposals

3.1 In response to the shortfalls highlighted thus far the Law Commission's proposal is to replace the current Deprivation of Liberty Safeguards with a new scheme called 'Protective Care' as part of a new code of practice. It is also recommended that the UK and Welsh Governments review the existing Mental Capacity Act Code of Practice.

3.2 The principles of the new 'Protective Care' scheme are that it should: -

- deliver improved outcomes and deliver tangible benefits to disabled people, their family or carers.
- be in keeping with the approach, language and empowering ethos of the MCA.
- remove unnecessary bureaucracy, whilst also protecting legal rights and providing meaningful procedural safeguards.
- be compatible with the European Convention on Human Rights (ECHR) and the UN Disability Convention.
- be tailored and flexible to ensure different approaches can be used in particular settings.

- be imputable to the state in order to engage article 5 (right to liberty) of the ECHR.
- apply to hospitals and care homes, albeit that the nature of the safeguards provided should differ according to the setting.
- include other forms of accommodation namely supported living; shared lives accommodation; family and other domestic settings as the Law Commission consider that it is unacceptable to require that every case of deprivation of liberty in a domestic setting be taken to a Court, which is recognised to be unnecessarily onerous and expensive for public authorities and potentially distressing for the individual and family concerned.

3.3 Taking into account the principles as outlined, in broad terms the consultation paper focuses upon the following issues: -.

3.3.1 **'Supportive Care'** – is one element of the wider scheme of protective care. It applies where a person is living in care home, supported living or shared lives accommodation, or if a move into such accommodation is being considered. 'Supportive care' is intended to provide suitable protection for people who are in a vulnerable position, but not yet subject to restrictive forms of care and treatment (including deprivation of liberty). In other words, it is intended to establish a preventative set of safeguards that reduce the need for intrusive interventions in the longer term.

'Supportive care' covers people who may lack capacity as a result of an impairment of, or a disturbance in the functioning of, the mind or brain, in relation to the question of whether or not they should be accommodated in a particular care home, supported living or shared lives accommodation for the purpose of being given particular care or treatment.

With regards to the assessment process for those people who are in need of 'supportive care', where it appears to a local authority that a person may be eligible for 'supportive care', the local authority would be required to arrange an assessment, or to ensure that an appropriate assessment has taken place. This assessment would focus on the person's capacity to determine whether they should be living in the relevant accommodation.

The professional who undertakes this assessment would be required to establish whether the person lacks capacity in relation to the question of whether or not they should be accommodated in the relevant care home, supported living or shared lives accommodation for the purpose of being given the relevant care and treatment. If it is established that the person lacks capacity, further safeguards would apply however in most cases the Law Commission do not think that the capacity assessment will require a fresh process to be initiated. Where it is proposed that a person who may lack capacity be moved into the relevant accommodation, the Law Commission would expect that an assessment process would already have been carried out, for instance under the Care Act 2014 or NHS Continuing Healthcare regulations. So it should be just a matter of making

sure these additional capacity considerations form part of the existing assessments. Although for some self-funders, this may be the first independent check of their capacity, and care and treatment arrangements, and therefore resource implications will arise.

If a person has been assessed as being eligible for 'supportive care', the consultation paper proposes that a number of further and ongoing safeguards should be made available to that person. These safeguards are as follows:

- the Local Authority would be required to keep under review the person's health and care arrangements and whether a referral to the 'restrictive care and treatment' part of protective care is needed;
- care plans must include a record of capacity and best interests assessments and any restrictions imposed (including confirmation that the restrictions are in the person's best interests);
- the Local Authority would have discretion to appoint an "Approved Mental Capacity Professional" (formerly known as a BIA) to oversee the case;
- an advocate or appropriate person must be appointed (if not already appointed);
- the appointed advocate and appropriate person would be responsible for ensuring that the person has access to the relevant review or appeals process.

3.3.2 **Public Law and the Mental Capacity Act –** In relation to the interface between public law and the MCA, the Law Commission have highlighted that the Courts have already warned of the danger of blurring the distinction between statutory duties in a private law context (namely considering the best interests of a person lacking capacity under the Mental Capacity Act), and public law decisions (such as the provision of services and care planning). The consultation paper proposes that under 'supportive care', public bodies must be much clearer in future about the basis on which decisions are being made. For example if an NHS body or Local Authority is considering a placement on the basis of the person's best interests, it will need to record what choices have been considered, and confirm that the principles and best interests checklist in the Mental Capacity Act have been applied. Alternatively, if the NHS body or Local Authority is making a public law decision, it must demonstrate that the accommodation meets the needs of the person, taking into account all relevant considerations including the views of the person and their family, resources, and the likely benefits for the person.

3.3.3 **Mental Capacity and Tenancies -** The consultation paper considers the tenancy arrangements that apply when people who lack capacity are moving into care home, supported living or shared lives arrangements. The current framework includes the Mental Capacity Act and various common law provisions. It is argued that the current law offers a number of legally based (as well as some more informal) mechanisms to ensure,

in practice, that people who lack capacity and their carers and landlords are protected. It is emphasised that decision-makers should be clearer about the basis on which accommodation is being arranged. The consultation paper therefore proposes that, as a requirement of 'supportive care', Local Authorities must ensure that this is stated clearly in the person's care plan.

3.3.4 **Safeguards When a Placement is being Considered** - The decision to move into care home, supported living or shared lives accommodation can have significant consequences and will frequently engage ECHR Article 8 rights. Under the Law Commission scheme, the main form of protection for the person, and their families and carers, when a move into accommodation is being considered consists of greater access to advocacy both under the Care Act and under the Law Commission proposals. However the Law Commission also suggest that they are interested in exploring the possibility of additional safeguards for the person, and their family and carers, when a move into accommodation is being considered. The detail is not outlined within this proposal and the Law Commission are seeking views from others about this issue as part of the consultation exercise.

3.3.5 **Referrals** - The consultation paper provisionally proposes that all registered care providers should be required to refer an individual for an assessment under the relevant protective care scheme if that person appears to meet the relevant criteria. It also asks if the duty to make referrals for protective care should be a regulatory requirement which is enforced by the Care Quality Commission, Care and Social Services Inspectorate Wales, or Healthcare Inspectorate Wales.

3.3.6 **Restrictive Care and Treatment** – Following on from the 'supportive care' element the second tier of the proposed revised system is 'restrictive care and treatment' and it is highlighted that this provides the direct replacement for the DoLS but, importantly, it is not organised around the concept of deprivation of liberty. Instead it provides safeguards for those whose care and treatment arrangements are becoming sufficiently restrictive or intrusive to warrant this. This will include individuals deprived of their liberty, but also some whose arrangements fall short of this.

3.3.7 **Qualifying Requirements** - The 'restrictive care and treatment' scheme would apply in respect of a person who is moving into, or living in, care home, supported living or shared lives accommodation and some form of 'restrictive care and treatment' is being proposed. In addition, the person must lack capacity to consent to the care and treatment, and the lack of capacity must be the result of an impairment of, or a disturbance in the functioning of, the mind or brain. The meaning of 'restrictive care and treatment' would be determined by reference to a non-exhaustive list. This is intended to be a more straightforward approach which makes sense to practitioners, and is easier to explain to the relevant person and their

families and carers. The consultation provisionally proposes that restrictive care and treatment would include any one of the following:

- continuous or complete supervision and control;
- the person is not free to leave;
- the person either is not allowed, unaccompanied, to leave the premises in which placed (including only being allowed to leave with permission), or is unable, by reason of physical impairment, to leave those premises unassisted;
- barriers are used to limit the person to particular areas of the premises;
- the person's actions are controlled, whether or not within the premises, by the application of physical force, the use of restraints or (for the purpose of such control) the administering of medication – other than in emergency situations;
- any care and treatment that the person objects to (verbally or physically); and
- significant restrictions over the person's diet, clothing, or contact with and access to the community and individual relatives, carers or friends (including having to ask permission from staff to visit – other than generally applied rules on matters such as visiting hours).

The proposal outlines that cases involving 'serious medical treatment' would continue to be decided directly by the Court of Protection, and would not be authorised through the 'restrictive care and treatment' scheme.

3.3.8 **The Approved Mental Capacity Professional** - The role and expertise of the BIA is a highly regarded aspect of the DoLS, and would continue to be central to the new system of restrictive care and treatment. The consultation paper proposes that in order to reflect its status, the title should be changed to 'Approved Mental Capacity Professional' (AMCP).

All restrictive care and treatment assessments would be referred to an AMCP and the AMCP would retain overarching responsibility for ensuring that the assessment is carried out, however they would be given wide discretion over how this is achieved. In some cases the AMCP might decide that the assessment should be carried out by the professional already working with the person. The AMCP might also act as a general source of advice for the assessor – to assist them to apply the principles of the MCA and share good practice. In other cases, the AMCP could take charge of the restrictive care and treatment assessment themselves and thereby ensure that an independent assessment takes place. This would depend on the circumstances of the case.

The Law Commission proposal suggests that AMCPs would be in the same position legally as Approved Mental Health Professionals. In other

words, they will be acting as independent decision-makers on behalf of the Local Authority. The Local Authority would be required to ensure that applications for protective care appear to be "duly made" and founded on the necessary assessments.

In order to further reflect the importance of the AMCP the consultation paper provisionally proposes that the Health and Care Professions Council and Care Council for Wales would be required to set the standards for, and approve, the education, training and experience of AMCPs. The ability to practise as an AMCP would be indicated on the relevant register for the health or social care professional.

3.3.9 **Conditions** - Under 'restrictive care and treatment', the responsibility for imposing conditions would rest directly with the AMCP. In other words, they would not make recommendations to the Supervisory Body; they would issue the conditions directly. In addition, AMCPs would be given powers to make "recommendations" to public authorities about the care plan. The AMCP would be given responsibility for monitoring compliance with conditions. This could be delegated to health and social care professionals who are allocated to the case, and advocates and the appropriate person would be required to report any concerns about noncompliance with conditions.

3.3.10 **On-going oversight and reviews** - Where a person becomes subject to 'restrictive care and treatment', an AMCP would be allocated to their case. The AMCP would be required to ensure that care arrangements continue to comply with the relevant legal requirements (for example, under the Care Act and Mental Capacity Act). Moreover the AMCP would be required to keep under review generally the 'restrictive care and treatment' that has been authorised, and have a general discretion to discharge the person from the 'restrictive care and treatment' scheme. The AMCP would need to ensure that reviews take place at the most appropriate time for the individual. There would also be a duty to review the care and treatment following a reasonable request by the person (including someone making the request on their behalf) such as a family member or carer, the care provider, and the advocate or the appropriate person.

The Local Authority would also be given general discretion to discharge the person from the 'restrictive care and treatment' scheme. Local Authorities could consider discharge themselves, or arrange for their power to be exercised by a panel or other person.

3.3.11 **Deprivations of Liberty** - Under 'restrictive care and treatment', some people may need to be deprived of their liberty. In such cases the deprivation of liberty must be expressly authorised in the care plan. The AMCP would need to certify in the care plan that objective medical expertise had been provided and that the deprivation of liberty was in the person's best interests.

3.3.12 **Domestic Settings** - The consultation paper argues that where a deprivation of liberty is proposed as a part of care or treatment offered in a domestic setting, the safeguards of the restrictive care and treatment scheme should apply. An AMCP would be required to authorise the deprivation of liberty, or seek alternative solutions (such as the provision of services by a public authority to end the deprivation of liberty). In some cases the matter may need to be settled by the Court. If the deprivation of liberty is authorised, the person would be subject to the same safeguards as those provided under the 'restrictive care and treatment' scheme.

3.3.13 **Urgent Authorisations –** The Law Commission consider it important that 'restrictive care and treatment' enables professionals to respond in cases of emergency. However, enabling self-authorisation by care providers is considered to be one of the least satisfactory elements of the DoLS. The consultation paper therefore proposes that, in emergencies, the first recourse of the care provider should be an AMCP who would be able to give temporary authority (of up to 7 days and to extend this period once for a further 7 days) for the care and treatment pending a full assessment.

3.3.14 **Protective care in hospital settings and palliative care** - The consultation paper proposes a separate bespoke system for hospitals and palliative care. This would enable the authorisation of deprivations of liberty in NHS, independent and private hospitals where care and treatment is being provided for physical disorders, and in hospices. The hospital scheme would apply when the following conditions are met:

- the patient lacks capacity to consent to the proposed care or treatment; and
- there is a real risk that at some time within the next 28 days the patient will require care or treatment in his or her best interests that amounts to a deprivation of liberty; or
- the patient requires care or treatment in their best interests that amounts to a deprivation of liberty; and
- deprivation of liberty is the most proportionate response to the likelihood of the person suffering harm, and the likely seriousness of that harm.

The consultation paper also asks whether the "acid test" may need to be elaborated in order to make it more relevant to hospitals. This could include clarifying that assessors – when considering the "not free to leave" limb of the test – will often need to focus on what actions the staff would take if, for instance, family members or carers sought to remove them.

If the criteria are met, the patient may be deprived of their liberty for up to 28 days once a registered medical practitioner has examined them and certified in writing to the managers of the hospital that the conditions above are met. The hospital managers would then be required to appoint a responsible clinician in charge of the care and treatment of the patient.

The responsible clinician would be responsible for preparing a written care plan for the patient. Before preparing the care plan the responsible clinician would be expected to consult the patient, any carer, and any other person interested in the person's care. Copies of the plan should be given to these people following the authorisation of a deprivation of liberty. Also, an advocate or an appropriate person must be appointed for the patient.

The Law Commission suggest that a deprivation of liberty may only extend beyond 28 days if an AMCP has also assessed the person and confirmed that the conditions are met, whereupon a deprivation of liberty may be authorised for up to 12 months.

3.3.15 **Advocacy and the Relevant Person's Representative -** The consultation paper argues that it is vital that independent advocacy continues to play a central role in the proposed new scheme. It is provisionally proposed that, in all cases, an advocate should be instructed for those subject to 'protective care'. It is also considered that there may be benefits in streamlining and consolidating advocacy provision across the Care Act and Mental Capacity Act, and that Independent Mental Capacity Advocates should be replaced with a single system of Care Act advocates and appropriate persons.

The consultation paper also provisionally proposes to maintain the role of the relevant person's representative for people subject to 'restrictive care and treatment'. In cases where an advocate has been appointed, this will help to ensure that the important role of the family, friends or carers is recognised. However, the Law Commission do not propose to maintain the paid representative role. In cases where there is no person suitable to act as the representative, the Law Commission consider that an advocate should be appointed.

In cases where an appropriate person has been appointed the Law Commission also do not propose that a representative should always be appointed. This is because otherwise it is likely that in many cases the same person would be appointed to both roles, which are very similar. However, the AMCP would have discretion to appoint a representative where this would improve the person's outcomes.

3.3.16 **The Mental Health Act Interface** The consultation paper provisionally proposes to extend the Mental Health Act to enable all necessary deprivations of liberty for mental health patients for the purposes of mental health treatment. This would mean that the new scheme could not be used to authorise the detention in hospital of incapacitated people who require treatment for a mental disorder. Instead, there would be a new mechanism under the Mental Health Act to enable the admission to hospital of compliant incapacitated patients in circumstances that amount to deprivation of liberty, while those who are objecting could be detained under the existing provisions of the Mental Health Act.

The safeguards would be similar to those provided to incapacitated but compliant supervised community treatment patients who have not been recalled to hospital (Part 4A of the Mental Health Act), and would consist of:

- the right to a Mental Health Act Advocate;
- a power to provide treatment if a donee of a lasting power of attorney, a deputy, or the Court of Protection consents to the treatment on the person's behalf;
- a requirement that treatment cannot be given under this power if it is contrary to a valid advance decision or if force is needed to administer it;
- a requirement that a second medical opinion is needed for certain treatments including medication;
- rights for the patient and the nearest relative to seek a review of the treatment plan; and
- rights to apply to the mental health tribunal for an order to discharge the patient.

3.3.17 **Right to Appeal** - People subject to the proposed 'restrictive care and treatment' scheme (and the hospital scheme) would have the right to challenge their care and treatment arrangements before a judicial body. The consultation paper considers whether the Court of Protection should perform this role, or whether a tribunal system should be established.

It is argued that the key advantages of the tribunal system are the diversity of training of its members, its ability to bring about the patient's participation, the flexibility and informality of its processes, and the capacity to deliver cost savings from these characteristics. However, the advantages need to be balanced against the considerable expertise that has been developed amongst Court of Protection Judges, and the need for complex determinations under the new scheme.

On balance, the consultation paper provisionally proposes that a First-tier tribunal should be established to review cases under the 'restrictive care and treatment' scheme (and in respect of the hospital scheme). It is also provisionally proposed that there should be a right to appeal against a tribunal decision, either to the Court of Protection or to a Chamber of the Upper Tribunal. Local Authorities would be required to refer people subject to the 'restrictive care and treatment' scheme (or the hospital scheme) to the First-tier Tribunal if there has been no application made to the tribunal within a specified period of time.

3.3.18 **Supported decision-making and best interests -** Supported decision-making refers to the process of providing support to people whose decision-making ability is impaired, to enable them to make their own decisions wherever possible. The consultation paper argues that there are a number of clear benefits in introducing a formal legal process in which a

person (known as a "supporter") is appointed to assist with decision-making. In particular, it would give greater certainty and transparency for individuals, families, carers, professionals and service providers, and could help to ensure that the Mental Capacity Act works as intended. It is therefore provisional proposed that a new legal process should be established under which a person can appoint a 'supporter' in order to assist them with decision-making. The 'supporter' must be able, willing and suitable to perform this role. The AMCP would be given the power to displace the 'supporter' if necessary (subject to a right of appeal).

The consultation paper also argues that the law fails to give sufficient certainty for best interest decision-makers on how much emphasis should be given to the person's wishes and feelings, and that greater priority should be given to a person's wishes and feelings. This is something that would be consistent with the aims and aspirations of the UN Disability Convention. It is therefore provisionally proposed that Section 4 of the Mental Capacity Act should be amended to establish that decision-makers should begin with the assumption that the person's past and present wishes and feelings should be determinative of the best interest decision.

3.3.19 **Advance decision-making** - The consultation paper considers the existing legal framework for advance decision-making and how it might be reflected under the new scheme. It is argued that advance decision making can have a number of important benefits, for instance it gives a person greater control over his or her circumstances and so reduces the chances of potentially distressing situations, and it gives health and social care professionals greater clarity over treatment options.

It is provisionally proposed that the ability to consent to a future deprivation of liberty should be given statutory recognition. The advance consent would apply as long as the person has made an informed decision and the circumstances do not then change materially. It is also proposed that the 'restrictive care and treatment' scheme and the hospital scheme would not apply in cases where they would conflict with a valid decision of a donee or an advanced decision. Views are also sought on the ways in which advanced decision-making, in general, could become more central to health and social care.

3.3.20 **Regulation and monitoring** - Currently, the DoLS are monitored by the Care Quality Commission, Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales. The consultation paper argues that the existing regulatory scheme complies at a national level with the Optional Protocol to the Convention against Torture, and it is provisionally proposed that the DoLS regulators should be required to monitor and report on compliance with the 'restrictive care and treatment' scheme and the hospital scheme. The consultation paper also asks for further views on how the new legal framework might encourage greater joint working between the various health and social care bodies and regulatory schemes, the practicality of alternative forms of regulation, and whether

greater regulatory oversight is needed of individual decision-makers and Local Authorities and the NHS for the purposes of 'protective care'.

3.3.21 **Other issues** - The consultation paper also considers other matters which are relevant to the proposed protective care scheme as listed below.

- Protective care would apply to **16 and 17 year olds**, as well as those aged 18 and over. Views are also sought on whether the zone of parental responsibility is appropriate in practice.
- The consultation paper seeks further views on the operation of the **ordinary residence** rules in respect of the DoLS and whether there are any current areas that could be usefully clarified under the new scheme. It also asks whether a fast track determination scheme is needed for cases where a person is deprived of liberty and there is a dispute over the person's ordinary residence.
- The consultation paper asks whether a new **criminal offence** of unlawful deprivation of liberty be introduced.
- It is provisionally proposed that the Criminal Justice Act 2009 should be amended to provide that C**oroner's inquests** are only necessary into deaths of people subject to the 'restrictive care and treatment' scheme where the Coroner is satisfied that they were deprived of their liberty at the time of their death and that there is a duty under ECHR Article 2 to investigate the circumstances of that individual's death. The consultation paper also asks if Coroners should have a power to release the deceased's body for burial or cremation before the conclusion of an investigation or inquest.
- Views are sought on whether people should be **charged for their accommodation** when they are being deprived of liberty in their best interests – and whether there are any realistic ways of dealing with the resource consequences if they are not charged.
- The consultation paper asks whether the law concerning **foreign detention orders** causes difficulties in practice, and whether difficulties arise when a person needs to be deprived of liberty and has been placed by a local authority in England or Wales into residential care in a different UK country.

3.3.22 **Conclusion -** The consultation paper makes a number of provisional proposals for law reform. Some, but not all, have been highlighted in this summary. In doing so, the Law Commission emphasise that these represent their initial view about how the law should be reformed and that they will be reviewing these proposals on the basis of the responses to the consultation paper.

4. HBC Analysis of the Law Commission Proposals

4.1 In response to the Law Commission's proposal to replace the current Deprivation of Liberty Safeguards with a new scheme called 'Protective Care' HBC would agree that, should the proposal be accepted there should

be, or rather there must be a new code of practice developed and the UK and Welsh Governments should also rewrite the existing Mental Capacity Act Code of Practice.

4.2 The overall principles of 'Protective Care' are ambitious and HBC consider that these give a solid foundation to facilitate best practice.

4.3 The 'Supportive Care' aspect of the proposal has a number of elements, however HBC consider that fundamentally the recommendations focus upon the promotion of least restrictive practice and good social work practice, which is what the Council strives to achieve in all cases. In principle, there is very little change for HBC in terms of operational practice because, in order to be accommodated into a care facility and if the person wishes to be supported by HBC, an individual has to be assessed under the Care Act 2014 and in doing so issues such as assessing a person's mental capacity are very much standard practice. It is also already routine practice for consultation to take place with both the service user and / or their family with an advocate appointed where necessary to ensure that the decision making process is transparent and fair. The Social Worker or Care Manager already gathers relevant information and ensures that the person's best interests are considered and that their needs are met in the least restrictive way. Moreover a comprehensive care plan and risk assessment is already completed to cover any potential safeguarding issues that may arise. Following on from this assessment process, HBC already has systems and processes in place to monitor and review the person's needs on a regular basis with the frequency determined by the complexity of the situation. The only difference would seem to be with regards to those people who are self funding as these people currently may not be known to the Local Authority until there is an application from a Managing Authority for a Standard Authorisation or a safeguarding investigation. However once someone is known to the Council, the DoLS processes are completed. If there is requirement for Councils to more actively manage such situations this would have resource implications.

4.4 Regarding the issue of 'Public Law and the Mental Capacity Act', HBC already ensure when considering a placement in a registered facility that this is in the person's best interests, however some practitioners would require additional training to strengthen their approach to recording, to provide a more robust evidence base regarding what choices have been considered, and to demonstrate that the 'Protective Care' principles have been adhered to and the best interest's checklist in relation to capacity has been applied.

4.5 Likewise regarding the Mental Capacity Act and Tenancies, HBC consider that the current practice in place meets with the requirements, and the person's care plan would clearly include the necessary information.

4.6 Referrals – HBC agree that it is the care provider's responsibility to submit the referral. However clear guidelines for each tier would need to be

introduced for providers to follow. There would also need to be an agreed process for them to follow when submitting the referral which clarifies how the referral should be made. The proposal seems to make no recommendations as to the paperwork or timescales in relation to this aspect or who would be the responsible supervisory body for the authorisation. The new system follows a completely different approach meaning that the current six elements of the DoLS are no longer required. This change would result in significant changes to current internal recording systems, and again re-training of staff. HBC has recently invested time and money in implementing the new Association of Directors of Adult Social Services (ADASS) paperwork which will represent an unnecessary waste of time and financial resources if these proposed changes are agreed.

4.7 The Restrictive Care and Treatment element of the proposal is intended to replace the current Deprivation of Liberty Safeguards (DoLS). The proposal states that it should instead provide safeguards for the person. HBC's approach ensures that, within the current system, the main focus is always on safeguarding the person as outlined in the conditions of the DoL. On this basis, HBC can see no benefits to this part of the proposed system.

4.8 Qualifying Requirements – The restrictive care and treatment scheme would apply to those persons moving into or living in, a care home, supported living or shared lives accommodation where some form of 'restrictive care and treatment' is being proposed. They must lack capacity as a result of an impairment of, or a disturbance in the functioning of the mind or brain. It is proposed within the new scheme that a reference or list should be used in order to provide an easier explanation to families etc. HBC has concerns about this aspect of the proposal as, under the Cheshire West Judgement Councils are told only to apply the 'Acid Test'. On the presenting information it appears that the proposed approach could be more intrusive and complex and potentially could lead to more CoP applications.

4.9 With regards to the introduction of the Approved Mental Capacity Professional (AMCP) role to replace the current Best Interest Assessor (BIA) role, HBC currently has 20-30 BIAs and, should this change occur, each BIA would have to be retrained, which has cost and time implications. The fact that the new AMCP role is deemed to be equivalent to the current Approved Mental Health Professional role would also have significant financial implications, as the AMHP role is currently evaluated at a higher pay scale than the BIA role, and a re-evaluation of role to reflect this equivalence would be essential to avoid any potential equal pay claim.

The main advantages to the introduction of this role would be a reduction in the need to use Section 12 Mental Health Assessors (and the associated cost) and the elimination of the current signatory role, as the AMCP would carry this responsibility. The proposal also mentions the introduction of a Mental Capacity Professional which would be known as an MCP. It states that this professional would accompany the AMCP throughout the

assessment process and possibly cover the monitoring and conditions. HBC cannot see the added value of this role. It is also unclear regarding the work of the AMCP as to what the 'checks and balances' will be in relation to the monitoring of their practice and safe decision making.

4.10 Conditions – this is a key change and reinforces the power of an AMCP who, if the proposal is accepted, would have the authority to issue conditions directly and make recommendations to a Public Body about the content of care plans. Moreover the AMCP would have the responsibility for monitoring compliance with conditions, which could be delegated to health and social care professionals who are allocated the case. HBC consider that the volume of people likely to fall into the restrictive care and treatment category will be such that the AMCP caseloads will be too large to effectively manage and therefore it will be inevitable that after a period of time they will delegate the monitoring to other health and social care professionals, without necessarily knowing the volume or complexity of work that the worker has already been allocated, or without any real understanding of the allocated worker's knowledge and skill set. HBC has concerns that this development will lead to tension in the system and affect other aspects of social work or other health and social care functions. The system that is currently utilised to monitor conditions is similar in that the conditions are identified by the BIA and subsequently the Care Manager monitors these conditions, however the key difference is that the Council as a Supervisory Body allocate the Care Manager and therefore understand what is achievable within the wider context of activity and workload, and has the authority to make changes as necessary to meet operational challenges. The AMCP role as described does not necessarily allow this and the proposals show a lack of understanding of the whole remit of a Local Authority and its accountabilities in relation to the delivery of services for vulnerable adults.

4.11 On-going oversight and reviews – HBC consider that this aspect of the proposal is satisfactory because on-going oversight and reviews are already provided, so there is little change. This issue is already well managed in the current system via the use of Social Workers and Social Care Officers with a robust administrative process that tracks and monitors the conditions of the DoL as well as ensuring a review is completed as and when the current DoL is due to lapse or should a request be made by either the person, their representative or the care provider. When this occurs a further assessment is completed and should the DoL no longer be required the authorisation is terminated or the conditions altered accordingly.

4.12 Deprivation of Liberty – Currently any DoLS authorisation is included within the person's care plan as well as the accompanying standard authorisation paperwork which provides the reason for the authorisation and the conditions relating to the DoL. HBC ensure that as part of the DoLS process the person's care plan is updated and a copy of all 6 assessments and the authorisation are kept on the person's file. Again this is standard practice for HBC. Under the new proposal there is no mention of any

paperwork only that a comprehensive care plan must be completed, however it is not clear as what would constitute a comprehensive care plan. The guidance needs to be much clearer.

4.13 Domestic Settings – In these cases HBC would ensure that the person in question has the appropriate safeguards and risk assessments in place and an application to the CoP would be made. This is already standard practice, so no benefit can be seen from the proposed changes.

4.14 Urgent authorisations – HBC provide advice and guidance to all care providers upon request and fail to see how this would improve current practice, other than the AMCP carrying the risk instead of the Managing Authority (who in reality should have better knowledge of the individual and their specific circumstances). Potentially this proposal would require an AMCP being available 7 days per week, which may an expensive requirement. Depending upon the number of referrals being requested this could become unmanageable due to the timescales involved, as the proposal states that an assessment would need to take place (although there is no indication as to the level of assessment that would be required and what, if any paperwork would be used or the timescales for responding).

4.15 Protective care in hospital setting and palliative care – HBC would welcome this part of the proposal as it quite rightly acknowledges that hospitals and hospices are very different settings to residential care or domestic settings, however HBC would seek clarification as to who would be the authorising body under the new proposal. HBC would also ask the question as to how and who would ensure these applications are made and followed. HBC would suggest that each setting has its own named person or team of responsible AMCPs or clinicians to carry out these assessments and prepare the written care plans. HBC would request clarification regarding the statement that a Responsible Clinician will carry out their own assessments, specifically on the issue of whether there would be an independent scrutiny of doctors applying the 28 days powers in hospitals and if so which professional would undertake this role. Clear indications would be needed as to who this would be and what is meant by this –n whether it includes General Practitioners, Hospital consultants and / or Mental Health Consultant. HBC faces daily challenges in relation to hospital applications so this aspect of the proposal would potentially reduce workload and costs.

4.16 Advocacy and the Relevant Person's Representative – The information outlined in the proposal appears to be the same as the current system. HBC ensures that upon a referral being received a form of consultation takes place with the relevant family member(s) or friend(s) of the person in question. Should the person not have a family member / friend etc HBC ensures that a paid representative is appointed. Securing a paid representative is not a problem as contracts are in place to ensure sufficient capacity is available. The individual chosen to represent the person is

involved and invited to each meeting and is given a copy of all paperwork and information booklets to ensure they have all the information necessary to carry out the role and any issues arising are addressed immediately. However the proposal does look at a change taking place within this role which HBC fails to see the benefits of, as it would appear that again the role would require a process in order to re-train those currently carrying out this role. HBC cannot see how this change would be of any benefit to the family or the person in question. This could result in challenges if a current Paid RPR could no longer represent this person, and this could have significant repercussions for not only the Council but the person themselves.

4.17 The Mental Health Act interface – HBC feel that if any change is made to the MCA / DoLS current system it is essential that there is a review of the Mental Health Act.

4.18 Right to appeal – HBC understand the rationale for considering a change to the right to appeal system but advise caution on this issue as the right to appeal is a fundamental right in this country and any 'watering down' of the Judicial system needs to be considered carefully. Further details regarding the 'terms of reference' of a tribunal system are required in order to allow further consideration of this proposal.

4.19 Supported decision-making and best interests – Currently HBC in the consultation and the assessment stages of the DoLS process do engage with the person and make sure that the person's feelings and wishes are taken into consideration. An authorisation is only granted if it is in the person's best interests and the rationale for the decision is highlighted within the assessments. On this basis, the introduction of a 'Supporter' is not felt to be necessary.

4.20 Advance decision making – HBC fully supports this aspect of the proposal. HBC already try to address this issue in current practice and in the initial consulting stages of the DoLS process evidence of any advance decisions is requested so that this can be included in the assessment process. In addition, any person who has made an advance decision or has been given lasting power of attorney for health and finance is asked to provide evidence of this. Moreover since the Cheshire West ruling and the implementation of the Care Act 2014 HBC has incorporated this in to care planning assessments and when engaging with service users and the family members or advocates, future planning for a person's care needs etc is encouraged. It should however be reinforced that this is a difficult area and sensitivity is understandably necessary.

4.21 Regulation and monitoring – In relation to this aspect of the proposal there is only a limited amount of information outlined and the Law Commission seem to be seeking the views of others prior to providing any further detail. HBC believe that communication between all public authorities will need to improve if positive change is to happen, and each public authority will need to acknowledge and better understand one another's key deliverables and statutory responsibilities beyond this very specific issue.

4.22 Other issues - Regarding the plethora of issues identified in this paragraph of the proposal (which surely demonstrates what a complex task any change will be), HBC consider that:

- protective care should apply to 16 and 17 years old;
- ordinary residence rules need to be reviewed;
- establishing a new criminal offence of unlawful deprivation of liberty needs further consideration, particularly as one of the drivers of the

proposal is to 'free' up the Courts, not to subject the Judicial system to even more pressure and further expense to any Public Authority;

- the guidance regarding Coroner's inquests does need re-examining to avoid unnecessary stress to the loved one's of the departed;
- the charging debate is highly complex and the Law Commission will need to be careful about the pressures any significant change would put on the 'public purse'.

5. HBC Conclusion

5.1 The Law Commission are making a valiant and commendable attempt to address challenges that have been identified in a highly complex and significant area of law that impacts upon the most vulnerable people in our society.

5.2 In trying to address the sheer complexities of the arising issues, which are often inextricably interlinked, the proposal itself is difficult to read and interpret and at times ties itself into legal knots that are difficult to unpick. HBC is of the view that the Law Commission has not clearly identified how exactly the system will work and, on reflection, it could in fact be a more complex approach than the current Deprivation of Liberty Safeguards.

5.3 If the proposal is implemented as it is presented each LA will need to re-invest significantly in the re-training of staff and the realignment of operational teams. HBC has previously and more recently invested a huge amount of time and money into the training of new BIAs and also the current practicing BIAs, which may now be wasted.

5.4 HBC believe that the introduction of the AMCP role and the associated new powers is fundamentally flawed from a financial and operational perspective, and at a time of austerity this additional role makes little sense and adds limited value.

5.5 On a positive note the Law Commission should be applauded for recognising that Hospitals and Hospices serve different purposes and using a different approach here is necessary in comparison to a person who is to be accommodated in what is essentially 'long stay' accommodation and in this regard perhaps a 'lighter touch'. The 'Acid Test' should be considered but realistically whether or not the Judiciary will accept this concept is quite a different matter.

5.6 The principle of making changes to the current bureaucratic and paper driven system is welcomed, but HBC has concerns that the Law Commission proposal is a 'step too far' with an over reliance on the care planning function. Further discussion is required regarding this matter, especially in the context of a 'litigation society' where defensible evidence is required to support decision making of this significance.

5.7 Finally, over the past year and a half since the introduction of Cheshire West, the HBC DoLS Team has undertaken a huge amount of work to ensure that all services users are appropriately assessed according to the 'Acid Test'. The introduction of the new Protective Care Proposal could mean revisiting the 650+ cases again and assessing them against the new Scheme, following further investment in re-training and updating electronic systems. HBC is not opposed to change, but has concerns that the proposal as it stands is not addressing all of the current failing parts of the process. The proposal is in fact trying to invent a whole new concept which would place the LA in a more financially difficult position.

ADULT SERVICES COMMITTEE

9 November 2015

Report of: Director of Child and Adult Services

Subject: RESPONSE TO HEALTHWATCH INVESTIGATION INTO GOOD PRACTICE IN CARE & SUPPORT OF RESIDENTS WITH DEMENTIA IN CARE HOMES IN HARTLEPOOL

1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required – for information.

2. PURPOSE OF REPORT

2.1 The Healthwatch Hartlepool investigation into good practise examples in the care and support of residents with dementia in Hartlepool care homes made several recommendations. This report provides the Adult Services Committee with an update regarding how the recommendations are to be addressed.

3. BACKGROUND

3.1 In September 2014 a core group of Healthwatch members and staff undertook a project to formulate a comprehensive picture of dementia across the town. As part of this work they undertook to 'enter and view' each of the 20 care homes in Hartlepool.

3.2 The group developed a series of questions which were used during visits. The visits began in September 2014 and concluded early in 2015.

3.3 The Healthwatch report was completed in May 2015 and was presented to the Health & Wellbeing Board on 11 September 2015. The report identified many examples of good practice and made a number of recommendations. A copy of the Healthwatch report is attached at **Appendix 1.**

4. ACTION PLAN

4.1 This report describes how Adult Services plans to address the recommendations.

4.2 **Recommendation 1**
The good practise areas identified are acknowledged and recognised.

Adult Services Response
The overall Healthwatch report will be shared at a specific forum with a focus on dementia. Current good practise has been summarised in **Appendix 2**, the forum will be an opportunity for managers in particular to understand what good practise looks like in homes other than their own.

4.3 **Recommendation 2**
That opportunity is actively sought to share and promote these areas of good practise between care homes within the town.

Adult Services Response
On a regular basis there are specific meetings held with the managers of residential homes. It is the intention to use this forum to discuss the good practise in the specific 9 areas identified in the report:

- Environment
- Privacy, Dignity and Respect
- Promotion of Independence
- Interaction between residents & staff
- Residents views
- Food
- Recreational Activities
- Involvement in key decisions
- Visitors & relatives

The link officers for each home attend the forums and will be able to participate in the discussions around what good practise looks like. It is the intention to incorporate these types of good practise as evidence within the Quality Standards Framework (QSF).

Link officers will review through routine visits to identify if share and spread of good practise becomes evident.

4.4 **Recommendation 3**
That further visits are undertaken over a period of 6-12 months by the Local Authority in order to:

(i) Check training levels of staff

Adult Services Response – dementia training is not mandatory as part of the contract. Staff training is tailored by each provider to meet the requirements of the individuals they support. The Quality Standards Framework (QSF) operated by the Council reviews the type of training undertaken to ensure it fits with statement of purpose of each individual home.

(ii) Check progress in adapting homes to meet the needs of residents with dementia.

Adult Services Response – Findings are detailed in **Appendix 3**. Checks will be made to ensure that, where providers are registered to provide support for dementia, their premises are fit for purpose. All other homes will be checked to ensure they follow the principles of dementia friendly surroundings.

(iii) Feedback should be provided by Hartlepool Borough Council as to visit outcomes and progress through Adult Services Committee.

Adult Services Response – an interim report will be provided in 6 months with a further follow up report in November 2016.

5. RISK IMPLICATIONS

5.1 There are no risk implications associated with this report.

6. FINANCIAL CONSIDERATIONS

6.1 There are no financial considerations associated with this report.

7. LEGAL CONSIDERATIONS

7.1 There are no legal considerations associated with this report.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 There are no child and family poverty considerations associated with this report.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 This report promoted fair and equitable treatment for people with dementia in care homes.

10. STAFF CONSIDERATIONS

10.1 There are no staff considerations associated with this report.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 There are no asset management considerations with this report.

12. RECOMMENDATIONS

12.1 It is recommended that the Adult Service Committee note the current position in relation to provision of care and support for peopel with dementia in care homes in Hartlepool.

13. REASONS FOR RECOMMENDATIONS

13.1 To assure members that work that is being undertaken to address the recommendations in the Healthwatch Hartlepool Dementia Care & Support in Care Homes report.

14. CONTACT OFFICER

Jeanette Willis
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Tel: 01429 523744

Healthwatch Hartlepool Investigation into Good Practice in the Care and Support of Residents with Dementia in Hartlepool Care Homes

May 2015

MISSION STATEMENT

"Healthwatch Hartlepool has been established in a way that is inclusive and enables involvement from all areas of the local community. We wish to involve those who are seldom heard."

Contents of the Report

1. Background

1.1 Over recent years at both national and regional levels, there are very few issues and conditions that have attracted as much interest and coverage as dementia. It is estimated that around 850,000 people in the UK are living with dementia and that a further 700,000 are providing care and support to people with the condition.

1.2 Dementia is an umbrella term for a range of conditions which impact upon the functioning of the brain. The most common types are Alzheimer's disease and vascular dementia; less common forms include Lewy bodies and frontotemporal dementia.

1.3 Dementia is not a normal part of aging and will affect people differently. Symptoms can include problems with memory, thinking, concentration and language. One may become confused, have changes in mood, behaviour and emotion.

1.4 Most people with dementia are aged over 65 years of age, but dementia can also affect younger people. It is a progressive condition which means that symptoms will get worse over time but this does not mean that people with dementia cannot lead full and active lives, particularly if they are receiving appropriate care, support and stimulation. Some symptoms are treatable, but as yet no cure has been found.

1.5 In recent years there has been an increasing awareness of the needs of those with dementia and their carers. This has led to Department of Health publications such as the 2009 document "Living Well with Dementia" and the "Prime Ministers Challenge on Dementia" which was published in 2012. Both documents recognise

the importance of challenging the stigma of dementia and of the individual nature of the condition.

1.6 The "Prime Ministers Challenge on Dementia" has assisted in raising the profile and understanding of the condition and over 1,000,000 people have now become dementia champions.

1.7 It is therefore inevitable that there will be increasing numbers of people in residential care who have various forms and degrees of dementia. It is vitally important that the needs and individual support requirements of such residents are always acknowledged and that every effort is always made to ensure they enjoy the best quality of life possible.

1.8 Healthwatch Hartlepool members firmly believe that the care provided in care homes across the town, must focus primarily on the person rather than the condition. The environment, communication, appropriate activities, family involvement and suitably trained and managed staff, are all of paramount importance if this is to be achieved.

1.9 This "person centred" approach is shared both by the project "Working to Build a Dementia Friendly Hartlepool" and by our wish to identify and share, examples of good practice in residential care homes.

2. Methodology

2.1 In September 2014 a small group of Healthwatch members and Healthwatch staff formed a core group. It was decided that in order to formulate a comprehensive picture of dementia care across the town, there would be a need to undertake Enter and View visits to all 20 care homes. Care homes such as Gretton Court provide care specifically for those with dementia, but it was recognised that all care homes within Hartlepool, would have some residents with some level of dementia and it was important that the needs of such residents were also being acknowledged and met.

2.2 The group then developed a series of questions which were used during visits.
A copy of the questionnaire can be found at Appendix 1.

2.3 All visits were conducted in line the Healthwatch Hartlepool code of practice regarding Enter and View visits. All homes were given advanced notice that the visit would be taking place, details of the members of the visiting team and information regarding the reason for the visits.

2.4 The visits began in September 2014 and concluded in early 2015. After each visit a draft copy of the report was made available to the individual Care Home Managers, enabling them to make comments. Any factual inaccuracies were amended but comments received from residents or family members were never changed.
All twenty reports from the visits can be found in Appendix 2.

2.5 The final report summarises findings from these visits. It particularly focuses on identified areas of good practice which we believe should be shared across all homes in the town.

3. Findings

3.1 There was a total of 718 residents within the 20 Care Homes visited. The number of residents with loss of capacity was 345 (48%). It was noted that much good practice and awareness was already in place.

3.2 The Individual

(i) Some homes have instigated a "Life History" of the resident. Family members share photographs, information about past jobs, interests, achievements, family details and other important information. It is placed within the Individual care Plan and acts as a source of reference, ensuring person centred care and can assist in the building of relationships between staff and residents.

(ii) In many Homes, residents are encouraged to become involved in routine tasks such as assisting with folding laundry, washing-up in

the kitchen and gardening. Such activities re-enforce skills learned in their past.

(iii) Staff were aware of personal care needs of individual residents; assisting where necessary with appropriate dressing and ensuring that each person was happy with their appearance.

3.3 Involving Family

(i) Family members are encouraged to share information and advice about the best ways to engage and support their relative. Giving suggestions as to how to make the environment more familiar and comfortable.

(ii) Homes hold regular family forum events. Giving opportunities for exchange of ideas and providing a way for visitors to be informed of any changes within the Home.

(iii) Visitors Boards have been introduced, which allow family/friends the opportunity to write down any issues, concerns, compliments etc. This provides an immediate route through which small changes and concerns can be identified and dealt with quickly, resulting in enhanced care.

(iv) All Homes have adopted an "open door" policy ensuring relatives and family are welcome at any time.

3.4 Personal Information and Confidentiality

(i) Considerable thought has been given to developing systems which will ensure that personal information is used with discretion. Only relevant sections of care Plans are sent with those residents attending hospital appointments. Awareness of stigma attached to identifiable folders was demonstrated.

3.5 Recreational Activities

(i) A variety of recreational and social activities has been developed. These include –

- Music
- Memory/reminiscence rooms

- Photo albums
- Hartlepool in the past
- Singers and entertainers
- Parties and celebration events
- Chair exercise classes
- Excursions
- Helping with gardening and some domestic tasks

Both salaried staff and volunteers may assist in such activities and relatives and friends are also encouraged to be involved. Excursions can however, prove to be difficult with transport arrangements and staffing being problematic.

(ii) Arrangements have been put in place for residents to have "pampering" sessions, hand massage is very popular! Other homes allow family pets to visit, sometimes even tame snakes, spiders and rats!!

(iii) "High Streets" have been introduced. Pubs, sweet shops, and fruit barrows permit residents to make a choice and in some instances, the residents are responsible for the finance involved.

3.6 Staff Attitude and Training

(i) Good staff attitude toward residents was often observed. Residents were spoken to in a dignified and caring manner, which demonstrated awareness of the resident as an individual.

(ii) Staff are now expected to undertake specific dementia training modules. Some Homes have instigated an "In House" programme, which all employees are required to attend.

(iii) The importance of activities and stimulation is recognised.

(iv) A "Key-Worker" system ensures continuity and uniformity of care.

3.7 Leadership and Management

(i) Continuity of management is of paramount importance.
Continuity of key worker provides opportunity for early identification of any change and affords a sense of security for the resident.

(ii) Several care homes have worked towards the Gold Standard Framework for end of life care and support for people with dementia. Other qualifications have also assisted in providing person centred end of life care.

3.8 The Environment

(i) Many homes have now giving consideration to decoration, ensuring that rooms and corridors are using "dementia friendly" design, that corridors are obstruction free and signage is clear, easy to read and in diagrammatic form.

3.9 G.P Visits and Hospital

(i) Several homes now have weekly GP visits. This can assist in early identification of problems thus preventing crisis situations and unnecessary hospital visits.
(ii) Some staff visit residents who have been admitted to hospital. They assist at meal times to ensure that the resident is feeling more comfortable. Consequently, there is a reduction in hospital falls which often occur when the patient is agitated, upset or confused.

4. Conclusions

4.1 Overall, members felt that the care and support of residents with dementia varied from home to home.

4.2 There was a willingness and desire amongst managers and staff to provide the best possible standard of care.

4.3 It was clear that finance was a big factor in the speed of change.

4.4 A purpose built establishment is better able to provide the specific needs of those with dementia.

4.5 Our findings during these and previous Enter and View visits, confirm the importance of effective management. Strong leadership is necessary to ensure consistently high standards of care.

5. Recommendations

5.1 The good practice areas identified during the series of visits are acknowledged and recognised.

5.2 That opportunities are actively sort to share and promote these areas of good practice between care homes within the town.

5.3 That further visits are undertaken over a period of 6-12 months by the Local Authority in order to –
(i) Check training levels of staff.
(ii) Check progress in adapting Homes to meet the needs of residents with dementia.
(iii) Feedback should be provided by Hartlepool Borough Council as to visit outcomes and progress through its Adult Services Committee.

6. Acknowledgements

Healthwatch Hartlepool would like to thank all organisations and individuals who have provided our members with information and hospitality during the course of this investigation; their help has been invaluable.

7. References

(i) Alzheimer's and dementia: your questions answered (Alzheimer Society)
(ii) The dementia guide – Living well after diagnosis (Alzheimer Society)
(iii) Living well with dementia: A National Dementia Strategy (Department of Health)
(iv) Continuous improvement in dementia care homes (East Sussex County Council)(v) The Prime Minister's challenge on dementia 2020 (Department of Health)
(vi) Caring for people with dementia – (E A Fletcher)

Appendix 1 – Outline Questionnaire

Healthwatch Hartlepool Care Home
Enter and View Group

Organisation	Healthwatch Hartlepool
Site Visited	
Contact Name	
Group Members	
Date/Time of Visit	

Managers Questionnaire

1.	The number of staff (qualified)?		
2.	The number of staff (unqualified)?		
3.	The number of beds in total?		
4.	The number of single rooms?		
5.	The number of rooms with en suite facilities?		
		YES	**NO**
6.	Will the person with dementia have a particular person responsible for their care?		
7.	Does each resident have a care plan? How regularly are their needs reviewed? Does the Care Plan, go with the resident on hospital admission? Do the documents sent into hospital go in a yellow folder to increase visibility?		
8.	A. Does each resident have an “All about Me” or equivalent documentation? B. Does the home provide personalised activities that are suitable and engaging for residents with dementia?		
9.	Do staff have any training in Dementia Care? Have staff attended “Monitoring Health in Care Homes training?		
10.	A. What safety and security measures are in place to keep the residents with dementia safe? B. Do staff do DoLS Training (Deprivation of Liberty		

	Safeguards)?		
11.	Can residents eat in their rooms or eat at different times if they prefer?		
12.	Are special diets catered for and resident's likes and dislikes taken into account?		
13.	Are staff trained sensitively to help people eat their food if needs be?		
14.	Are there rooms for couples who wish to remain together?		
15.	Are there opportunities for residents to help staff with small tasks if they wish?		
16.	Are residents encouraged to exercise?		
17.	Are visitors welcome anytime? Are visitors encouraged to take residents out or join them for a meal?		
18.	Is information readily shared with families and carers and how is this done?		
19.	Is there suitably adapted equipment for people with dementia?		
20.	What happens if residents are unwell or need medication or help with taking medication?		
21.	Can residents see their own GP?		
22.	A. What options are available for end of life care? B. Do staff fill in the "Deciding Rights" documents for each resident? C. Is the home accredited with the Gold Standard Framework?		
23.	A. If a person with dementia comes from a different culture or background from most other residents, how would their needs be catered for in a sensitive way? B. Where would you go for information?		

Healthwatch Hartlepool Care Home
Enter and View Group

Organisation	Healthwatch Hartlepool
Site Visited	
Contact Name	
Group Members	
Date/Time of Visit	

Resident's Questionnaire

	Independence & activities	
1.	When you are out in your local area – What sort of things do you do?	
2.	Are there any things you used to do but now you cannot?	
3.	Do you have a choice in daily routine?	

4.	Do you have support with moving about and getting out and about if required?		
5.	Can friends and relatives visit at any time?		
	Dignity and Privacy	**YES**	**NO**
6.	Do staff always knock before entering your room?		
7.	Do you need assistance with dressing and bathing?		
8.	Is the food good quality and have you access to snacks?		
9.	Do you need assistance with feeding and drinking?		
10.	Are staff respectful and polite?		
11.	Are things explained in a way you understand?		
12.	Do staff take time to talk about things you like and listen to you?		
13.	Does the staff make adjustments in the home to help you?		
14.	Does the home provide activities for you to join in?		
15.	Are their opportunities for residents to help staff with small tasks if they wish?		

Appendix 2 –Individual Enter & View visits Report

Healthwatch Hartlepool – Admiral Court Care Home
Enter and View 2pm 20th February 2015

Organisation Four Winds
Site Visited Admiral Court Care Home
Contact Name Geraldine Narciso
Group Members Phyl Rafferty & Zoe Sherry

Acknowledgements:
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer:
Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the visit:
This visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life of people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. During the visit the facilities and stimulus offered to residents with dementia will be assessed. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic Drivers:
- CQC dignity and Wellbeing strategy
- Care homes are a local Healthwatch priority

Methodology:
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.
Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.
Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate,

other topics such as accessing health care services from the care home. Family members were also spoken to. They explained to everyone they spoke to why they were there and took minimal notes.

Summary of findings:
At the time of the visit, the evidence was that the home was operating to an acceptable standard of care with regard to dignity and respect with residents who have dementia.
The personal care appeared good, with resident's clothes clean and tidy. We saw no evidence of dignity not being respected.

- Regular visits from nominated GP's was proving a success
- Residents told us they were happy with the food and menus.
- The nurse on duty on the unit upstairs informed representatives that the home was under new ownership. All staff had either received Dementia Training or were to complete it in the near future.

Results of visit

Environment:
Admiral Court is a Care Home with nursing. It is privately owned with 50 residents. It is a registered home for people with dementia, mental health conditions and old age. Residents are often escorted to the shops or the local pub by taxi or by public transport. There was a secure enclosed garden for people to use in the summer which is in the process of being updated. There were plenty of tactile objects on the walls for residents to touch/experience including a lounge with memorabilia. Signage was good throughout the home especially for those with dementia. The Care Home has two different units with the upstairs having seventeen bedrooms catering for males with mental health conditions. There are smoking rooms attached to both units. There is a 7 bedded unit in the process of re furbishing upstairs and the rest of the home should be completed later in the year. The downstairs was for females only, the representatives visited both units. The ages of the residents are from late 40's to one resident who is 94 years of age. Each resident had their name and photograph on their doors and a short resume about them. On the day of the visit the staff were not aware we were attending as it had not been written into the diary but the senior staff on duty gave us facts and figures and were well informed about the residents and the care provided.

Promotion of Privacy, Dignity and Respect:
The Senior Care Assistant told us that staff worked in teams and all staff were either dementia trained or would be in the future. Each person had a Care Plan that was reviewed once per month and more often if required. The Care Plan did not go into the hospital if the resident was admitted. All residents will have an "All About Me" document . However, the documents do not go into a yellow folder to increase visibility. There are key pads on all doors and window locks for safety.

Promotion of Independence:
Residents helped staff with the laying of tables, dusting and washing up. There were no coloured doors and toilet seats but these would be put in eventually. All residents could see their own GPs and a named GP visited weekly.

Interaction between residents and staff:
The staff appeared to be on good terms with the residents and when asked how much time they spent talking with residents they said whenever they could. It was a warm friendly atmosphere.

Residents:
Both representatives talked to residents and families who seemed happy with the care.

Food:
Residents we spoke to seemed happy with the food and menus. Residents could eat in their own rooms and whenever they wanted to. Special diets were catered for and menus were regularly changed. There were 3 choices of meals each day. Liquids were available on a regular basis and there were water glasses available on the tables downstairs for the ladies. There are blue plates and cups for people with dementia.

Recreational Activities:
Two activities co-ordinators were employed to work with the residents. There was a list of activities on display. Entertainment is provided for residents and a singer was due into the home on March 12th. Families and carers are also invited to these events which provide drink and snacks for everyone. Staff and the Activity Co-ordinators take residents out to shops and for meals etc.

Involvement in key decisions:
Families and carers were involved in every stage where possible with the residents with decision making. Family, carers and residents if possible were involved with decisions on end of life care. However, the staff did not fill in the "Deciding Rights" documents for each resident and the home is not accredited with the Gold Standard Framework. Their G P completes the necessary paperwork

Visitors and relatives:
Visitors were welcomed at any time and could eat with residents

Good Practice:

- Regular visits from nominated GP's –created confidence and early detection of illness
- The staff are aware of and manage the needs of each individual resident.

Recommendations:

- Building in need of refurbishment
- Training requirements of staff to be a high priority
- Due to the recent change of ownership there are many things to be addressed but the staff are aware of these needs for change and a programme of work is ongoing.
- A re visit in 6 month time to check progress of the work.

Healthwatch Hartlepool Brierton Lodge Care Home 3rd February 2pm

Organisation: BUPA
Site Visited: Brierton Lodge Care Home 3 February 2015 at 2pm
Contact Name: Carol Barnard
Visiting Members: Ruby Marshall, Zoe Sherry

Acknowledgements

Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer

Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the visit

This visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life of people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic Drivers

- CQC dignity and wellbeing strategy
- Care homes are a Local Healthwatch priority

Methodology

This was an announced Enter and View Visit

We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.

Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.

Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate, other topics such as accessing health care services from the care home. They explained to everyone they spoke to why they were there and took minimal notes.

A large portion of the visit was also observational, involving the authorised representatives walking around the public/communal areas and observing the surroundings to gain an understanding of how the home actually works with residents with dementia and how the service receivers engaged with staff members and the facilities. There was an observation checklist prepared for this purpose.

Summary of findings:

At the time of the visit, the evidence is that the home was operating to a very good standard of care with regard to Dignity and Respect

- There was a warm, happy evironment
- Staff were kind and compassionate
- A busy interactive home were staff understood and acted on people's individual preferences and respected their dignity.
- The home is accredited with the Gold Standard Framework

Environment:
The Manager was available also two senior nursing staff. One had recently had comprehensive training on dementia. The home has a capacity of 58 beds and at present they have 38 patients with dementia. There was an escorted tour and free access to all areas of the home. There were very few residents well enough to talk to but the home was busy with people coming and going. Some staff and relatives were spoken to.
The home provided a corridor (street) of shops etc. like going outside there is a reminiscence room, a pub, a sweet shop, a hairdressers, residents can purchase goods from these. A corridor is being converted into an indoor garden with fresh and artificial flowers that will change with the seasons. There are two activity co-ordinators. There is an enclosed garden when weather permits.
The dining tables are set to each individuals as some residents do not cope with clutter, flowers napkins etc. So each has their own style.

Promotion of Privacy, Dignity and Respect:
All residents have named key workers who are aware of each individual's needs and personal care. They all have care plans and there is ongoing work to complete the yellow folders for hospital admissions. The care plans are reviewed at least once a month more frequent if changes occur. Each resident has a 'Who I Am' map of life.
Staff have Dementia and DOL's training, this is ongoing as new staff are employed. The TEWV Mental Health service has given a series of training sessions under the Monitoring Health in Care Homes. The safety of residents is

a priority. Risk assessment, door key pad locks window locks and adhering to care plans. Residents have the freedom of the home. They eat where they wish, lounge, dining room, where they are comfortable, staff are aware of the need to treat each individual according to their wishes within the safety limits.

Promotion of Independence:
There are arm-chair exercise classes. The home is laid out with attractive stopping points that catch attention and this has proved to reduce accidents and falls. Families and Carers are kept informed individually also at residents meetings and an occasional newsletter. Staff also encourage residents to help around the home, the tea trolley is a popular task.

The home has equipment to meet the specialist needs but admits to not having everything in place. This is an ongoing project and has to be tempered by finance and that some furnishings still have some useful life.
Though the essential hoists, baths memory boxes in rooms and pictures on doors are in place. All trained staff are trained to administer medication and can refer to a G.P if necessary. Residents retain their own GP though the home has an allocated GP Dr Maserari (McGowan surgery) who calls weekly. The home is accredited with the Gold Standard Framework.
For those residents on 'End of life' pathway there is a colour code scheme coded to approaching time of death to assist with appropriate care. There is no 'Deciding Right' this has been superseded by an emergency plan. GP's must have an emergency plan in place to include DNR and preferred place of care.
The home has yet to have a resident with cultural differences but they would gather all relevant information, Internet, Carer, church to meet their needs.

Residents:
All residents and carers interviewed were happy with the standards of care and had no concerns.

Staff:
The staff knew all residents and their needs. They worked pleasantly and calmly in what at time is a difficult environment

Food:
They eat where they wish, lounge, dining room, where every they are comfortable, staff are aware of the need to treat each individual according to their wishes within the safety limits.

Summary:
A warm happy environment, both residents and staff. A busy interactive home. All residents and carers interviewed were happy with the standards of care and had no concerns. The staff knew all residents, their needs they worked pleasantly and calmly in what at time is a difficult environment.

Good Practice:
There is a colour code system for end of life care to ensure appropriate levels of care at the right time.

There is a row of shops that resembles a high street to promote social interaction and memory recall.

Recommendations:
Continue refurbishment to meet the needs of people with dementia

Healthwatch Hartlepool –Charlotte Grange Care home
Enter and View 20/02/2015

Organisation Community Integrated Care
Site Visited Charlotte Grange Residential Care Home
Contact Name Margaret Spence
Group Members Zoe Sherry & Maureen Lockwood

Acknowledgements
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer
Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the visit
This visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life of people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. During the visit the facilities and stimulus offered to residents with dementia will be assessed. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic Drivers
- CQC dignity and Wellbeing strategy
- Care homes are a local Healthwatch priority

Methodology
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.
Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.
Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate, other topics such as accessing health care services from the care home. Family

members were also spoken to. They explained to everyone they spoke to why they were there and took minimal notes.

Summary of Findings:
At the time of the visit it was evident that the Home was operating to a high standard of care.

- Staff are trained to a very high standard of Dementia Care.
- Home has been recently been re-accredited with the Gold Standard award.
- Regular visits from named GP, gives confidence and early detection of illness.
- Positive interaction with staff and residents.

Results of Visit:

Environment:
The home is light and airy and is divided into units onto a main corridor with access onto a main communal area. The 'EMI' – dementia unit has open door policy and residents can access all areas of the home. There are 12 dementia patients on unit and 15 people with vascular dementia. The Manager has NVQ 4 and has registered Manager Qualification. Senior car staff, NVQ level 3. Support staff, NVQ level 2. All new staff have a foundation induction. Also other theory and practice training in various care areas and progress to NVQ training. There are 46 beds and are all single rooms. The Unit is purpose built – small areas of 3 bedrooms to 1 bathroom and toilet. Small private areas for dignity and where personal care can be carried out. In the past staff have converted two rooms into a lounge and bedroom.

Promotion of Privacy, Dignity and Respect:
All have named key workers but staff work across all the units and know all residents so there are never strange faces. Same bank staff always used for continuing of care. Night staff are bases in the dementia unit. All have care plans – updated monthly or whenever changed to care needs happen. They have Health Information passports to be used for hospital admission. The home liaises directly with the hospital manager Lyn Tolputt and notifies her of the admission. A member of staff escorts the resident, no discharges accepted after 6pm. Home staff re-access to ensure that the person is suitable to return to the home. Not aware of yellow folder, thinks it a good idea and will arrange to obtain some. Each resident has 'My Life in Focus' document. There are communal activities, bingo, singing, concerts. There is one to one sessions often hand massage and talking to promote memory pamper sessions, outings to shops, pubs, armchair exercise. All staff have dementia awareness. The manager had not heard of "Monitoring Health in Care". There are security – key code door locks and window restrictions. All 12 residents on EMI unit on DOLS also 14 other residents on DOLS. Residents can retain their own GP and a named GP

visits the home weekly. The residents own G.P does the emergency plan with DNAR and preferred priorities.

Problem – if DOL'S resident admitted to hospital – DOLS cancelled – has to be reinstated on discharge – at a cost of around £300 so some homes use "Route to good care".

Promotion of Independence:
Resident eat where they wish. Resident are encouraged to do small tasks. This promotes continuity from home life to care home life i.e. washing up, setting tables, trolleys and laundry (folding clothes). There is open visiting – but protected meal times – to allow residents to eat without an audience – problems of large families visiting especially school holidays. Families are allowed to use a lounge not to disturb other residents. Visitors can eat with family if circumstances allow, i.e. travel long distance to visit. There is some equipment for people with dementia, toilet seat and bath edge and rails – bright blue. Toilet signs were not very obvious. Carpet and flooring was appropriate though no special crockery. Medication is administered by Senior Support workers. All residents have medication support.

Food:
The likes, dislikes, allergies and other dieting needs are logged in the care plan and kitchen on a white board. Staff are taught feeding methods to respond to individual needs. There is open visiting – but protected meal times – to allow residents to eat without an audience – problems of large families visiting especially school holidays. Families are allowed to use a lounge not to disturb other residents. Visitors can eat with family if circumstances allow, for example travelling long distance to visit.

Recreational Activities:
Armchair exercise takes place within the home. Residents have access to secure enclosed gardens which are dis ability friendly.
Involvement in key decisions:
Information- There is a pack for residents and families on admission. This contains a brochure and general information. There is a newsletter, notice board and resident meetings to keep families informed at all times.

Staff:
Staff are trained to a high standard and the staff and manager are friendly and helpful.

Visitor and relatives:
Visitors and relatives are welcome at any time. Relatives are kept informed at all times. At present no residents from different cultures. To give appropriate care if they would speak to relatives, carers and research using Internet etc. to give personalised care.

Additional information:
When a resident is admitted to hospital there is a cost of returning staff to the care home @ £15 per trip which has to be paid by the resident. Staff can be missing up to 6/7 hours (The cost is in the information brochure)
The manager felt It was important to get to know the residents with dementia before the illness progressed – personal traits, habits – to deal with these as the illness progresses.
Also to understand how to react to moods, facial expressions from non- verbal residents.
There is access to tea making facilities. They have a good reputation – and a waiting list.
We won 'Putting People First' the best of 500 homes.

Good Practice:
Rotation of staff so that all staff are known to all residents
Home always uses the same bank staff.
One page resumes of all staff including the manager,

Recommendations:
Improve signage to toilets and bathrooms doors.

Healthwatch Hartlepool Clifton House Enter and View 11th February 2015

Organisation	Mr Gill
Site Visited	Clifton House
Contact Name	Sue Heel
Group Members	Ruby Marshall & Phyl Rafferty

Acknowledgements
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer
Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the visit
This visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life for people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic Drivers
- CQC dignity and Wellbeing strategy
- Care homes are a local Healthwatch priority

Methodology
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.
Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.
Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate, other topics such as accessing health care services from the care home. Family members were also spoken to. They explained to everyone they spoke to why they were there and took minimal notes.

Summary of findings

At the time of the visit, the evidence is that the home was operating to a very good standard of care with regard to residents with dementia.

- The home was odour free and safety and security measures were in place
- The personal care was excellent. We saw no evidence of dignity not being respected.
- We saw evidence of staff interacting with residents positively and regularly.
- Staff were trained to a high standard and all staff completed Dementia training.
- Residents were happy with the food and menus.
- We saw evidence of social activities within the home.

Results of visit:

Environment:
There are 28 rooms in total but at the time of the visit thirteen beds were empty. Some adjoining rooms were utilised for couples. Six members of staff were trained to level 2, twelve had level 3 and one member of staff had level 4. An enclosed garden was available for residents to enjoy in the warmer months. The home was pleasantly and homely decorated but needed some updating for people with dementia. Some of the residents were in the early stages of dementia.

Promotion of Privacy, Dignity and Respect:
Residents had key workers and each resident had a care plan that was reviewed monthly or whenever it was needed. Each resident had a Passport with all their information within it. Documents do not go in a yellow envelope when the resident goes into hospital. All staff are trained in “Dementia Care”. Senior members of staff had attended the Monitoring Health in Care Homes training. Members of staff had completed DoLs training. Residents could see their own GP. A named GP visited the home weekly. The district nurses along with the residents, family and staff complete an Advanced Care Plan for each resident for end of life care. The manager explained that they had worked towards accreditation for the Gold Standard Framework but due to lack of funding they could not complete it.

Promotion of Independence:
Residents were encouraged to help staff with small tasks such as folding the laundry. Outings were arranged by the activity coordinator

Interaction between residents and staff:
There was a good staff/resident ratio. Staff interacted with residents at all times and on the day of the visit an entertainer was on site. Both representatives talked to several residents and their relatives who were happy with the care they were receiving. All staff seemed to be aware of the resident’s individual preferences and capabilities.

Residents:
Both representatives spoke to residents who were happy and content and delighted with the care they were receiving.

Food:
The residents were happy with the choice and variety of food on offer. The daily menu was displayed. Residents were free to choose were they ate and when they ate.

Recreational activities:
The home provided a varied programme of activities delivered by a skilled activities co-ordinator. On the day of the visit an entertainer was on site. If people had a diagnosis of dementia the co-ordinator would tailor sessions to their needs. Reminiscence sessions, old photographs etc. were used to stimulate conversation.

Involvement in key decisions:
Meeting with residents and families were held regularly and any information shared with relatives at all times.

Visitors and relatives:
Visitors were welcome at any time. There were several relatives there on the day of the visit who were pleased with the care there relatives received.

Recommendations:

- When planning refurbishments make sure they meet the needs of residents with dementia.

Healthwatch Hartlepool Dinsdale Lodge Nursing and Residential Home 18/02/15

Organisation: Four Winds Group
Site Visited: Dinsdale Lodge – Seaton Carew
Contact Name: Cynthia Myers
Group Members: Phyl Rafferty and Liz Fletcher
Date of visit: 2pm Wednesday February 18th 2015

Acknowledgements
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer
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Purpose of the visit
This visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life for people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic Drivers
- CQC dignity and Wellbeing strategy
- Care homes are a local Healthwatch priority

Methodology
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.
Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.
Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate, other topics such as accessing health care services from the care home. Family

members were also spoken to. They explained to everyone they spoke to why they were there and took minimal notes.

Summary of Findings:
At the time of the visit, it was felt that the home was acceptable affording a good standard of care with regard to dignity and respect for those suffering from dementia.

1. Personal care appeared satisfactory. We saw no evidence of disregard for dignity.
2. There is a good working relationship with local G.P. who will attend if needed.
3. Residents told us they were very happy with variety and standard of food.
4. Manager informed us that staff receive Dementia Training and some training in DOL's.

Result of Visit:

Environment:
Dinsdale Lodge is a 25 single bed Care Home, 17 occupied, two rooms have en-suite facilities and there are 4 rooms large enough to be converted to doubles. A secure garden is easily accessed. There are a variety of needs presented by the residents, some of which are complex. Although 'tired' the premises were clean and free from offensive odours.
Residents were seated in two large lounges and in the main hall. Some residents were too ill to leave their rooms. Unfortunately, there was a lack of pictures, tactical objects and suitably adapted equipment e.g. crockery, toilet seats, which could be of use for those with dementia.
Signage appeared poor, although the manager assured us that this matter was being dealt with. The manager had not been in post long enough to implement her ideas.

Promotion of Privacy, Dignity and Respect:
Staff work in teams and some were dementia trained. All staff to complete DoLS training in the coming weeks. Each residents has a Care Plan, which is reviewed on a monthly basis or as and when needed e.g. a resident who is not eating properly. A Cultural Policy would be incorporated into Care Plan were there to be a need.
If a resident has to be admitted to hospital – a Hospital Sheet (not Care Plan) is sent with him/her. Staff do not use yellow folders to send the documentation into hospital.
The manager is working to complete "All About Me" documents, but some residents have no family and thus is proving difficult. There is an effort being made to ensure that staff are aware of basic respect e.g. knocking on residents' door.

Promotion of Independence:

Residents like to help staff with small domestic tasks – dusting, setting up tables, folding napkins.
One gentleman happily makes a cup of tea, enjoys his newspapers and seems to take responsibility for the welfare of others.

Interaction between residents and staff:
Because of the complex needs of some residents, there is a high number of nursing staff as well as general carers.
There appeared to be a relaxed, easy rapport between carers and cared for.
Only one concern was raised by a gentleman who felt that there was a difference in the way he was treated by certain staff.
We raised the issue with the manager, she gave a plausible reason but remarked that she intended to mention it to the staff concerned.

Residents:
Both representatives talked to residents and relatives. There was very positive feedback from relatives who had a member of family on 'end of life care' – they felt that she "was comfortable and looked after – she still knows Dad – he sings to her and she tries to sing with him!"
Their only concern was a lack of promised facilities e.g. "fridge to keep her drinks cool".
One gentleman in the lounge remarked "aye we're all right here – have you seen the size of that TV. – it must be 52 inches!"

Food:
Residents appeared to be very happy with the food offered. There is a picture menu on display which is of assistance to those with dementia.
A "special needs" list is kept up to date in the kitchen. Liquid e.g. juice constantly available with tea/coffee offered 2 hourly.

Recreational activities:
There is a full time Activities Co-ordinator who appears to have a definite, positive impact on the general day to day living experiences of the residents. A list of activities was on a board in the main foyer. Apart from the in-house activities; games, chair exercises; dominoes; visiting the Belle Vue Centre for lunch as well as a visits to the Marine Hotel (staff from Hotel help collect residents in wheelchairs). One gentleman is a keen Car Boot visitor – and the Co-ordinator ensures he is taken to a local venue.
Others enjoy computer games (2 computers), crossword puzzles and just reading the papers.
Wheelchair taxis are used where possible.

Involvement in Key Decisions:

Families and carers are involved, where possible. There is an alternate monthly meeting which family members are invited – if they are unable to attend – they are advised of any concerns/changes etc.
The staff do not complete a "Deciding Rights" document for each resident and the Care Home is not accredited with the Gold Standard Framework.

Visitors and Relatives:
Welcome at any time but if they wish to dine with a relative, they are asked to give 24 hours' notice.

Good Practice:

- Manager re-enforces daily, the need to respect residents.

Recommendations:

- Décor to be more "dementia friendly".

Healthwatch Hartlepool – Elwick Grange Care Home Enter and View 21st August 2014

Organisation Care UK
Site Visited Elwick Grange Care Home
Contact Name Shamalia Seabrooke
Group Members Phyl Rafferty and Ruby Marshall

Acknowledgements
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer
Please note that this report relates to the findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the Visit
The visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life for people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic drivers
- CQC dignity and wellbeing Strategy
- Care homes are a Local Healthwatch Priority

Methodology
This was an announced Enter and View Visit
We approached a member of management in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent, or due to safety or medical reasons.
Authorised representatives conducted short interviews with the manager of the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training in dementia care were explored.
Authorised representatives also approached three residents at the care home to informally ask them about their experiences of the home and where appropriate other topics such as accessing health care services. They explained to everyone they spoke to why they were there and took minimal notes.

A large proportion of the visit was also was also observational, involving the authorised representatives walking around the public/communal areas and observing the surroundings to understand how things work for people with dementia. There was an observation checklist prepared for this purpose.

Summary of findings
At the time of our visit, the evidence is that the home was operating to a good standard of care with regard to people with dementia.

- Residents looked tidy and clean, we saw no evidence on dignity not being respected.
- We saw evidence of staff interacting with patients positively and regularly
- Residents told us they were happy with the food menus.
- The manager informed us that all staff received Dementia Training.
- Residents have their own named GP but sometimes Out of Hour Services have to be used and these doctors do not know the residents
- The manager raised concerns about transport

Results of Visit:

Environment
The unit was colourful and busy with lounges and hallways filled with familiar everyday objects. There were no obstructions along the corridors. The home was really clean and free from any unpleasant smell. The overall impression of the building is one of being fit for purpose. Adaptions had been made for a couple who wanted to stay together within the home. One room was used as a bedroom and the other as a living room. There are a lot of adaptions for residents in the Care Home which include blue crockery, adapted cutlery and plate guards.

Promotion of Privacy, Dignity and Respect
Residents in the home have a named key worker who liaise with the family. The manager informed us that the resident's needs and requests concerning end of life care are recorded in their care plan. This is constantly reviewed. Macmillan nurses and district nurses work alongside staff in the home to give residents the best possible care at the end of their lives. Every member of staff has received Dementia Training. There are also Dementia Specialists in the home. There are key pads on all doors to keep residents safe and risk assessments are in place to keep people safe and secure. Signage is good in the home with individual room indicators to assist people to their rooms. There are signs on toilets and bathrooms.

Interaction between residents and staff
Staff engaged with the residents throughout the visit. People's past lives and memories seem to really matter to the team as they chatted to the residents. One lady said she was happy, content and comfortable. She mentioned that she was a Catholic and receives Holy Communion each week.

Promotion of Independence
There were opportunities for residents to work alongside staff if they wanted to. Residents wash up, dust and lay tables. We did speak to one relative who loved doing her “little jobs”. All residents had their own named GP. The manager said that the “Out of Hour Services” were the most difficult to access.

Residents
We spoke to residents – one of which said that she loved living there and the staff were lovely. Residents told us that everyone in the home was nice and friendly..

Food
Residents were happy with the choice of menus. Specialist diets were catered for and all care plans include the resident’s likes and dislikes. Residents can eat in their own rooms and can eat at different times if they prefer. Staff were trained to help residents with feeding if required.

Recreational activities
There were activities to stimulate residents. Three part time event co-ordinators were employed to engage with residents. The manager informed us that they worked one to one with dementia residents. They delivered Reminiscence Sessions and regularly took residents on outings. Residents were encouraged to take exercise.

Involvement in key decisions
Information was shared with relatives and residents. Relatives were always informed of any changes, concerns and needs of residents.

Visitors and relatives
The manager informed us that visitors were welcome any time.

Recommendations:
The report highlights the good practice that was observed.

- The findings did indicate that there were sometimes difficulties with Out of Hours Services.

Healthwatch Hartlepool – Four Winds Care Home
Enter and View 11th December 2014

Organisation Matt Matharu
Site Visited Four Winds Care Home
Contact Name Nicole Noble
Group Members Phyl Rafferty & Liz Fletcher

Acknowledgements
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer
Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the visit
This visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life of people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. During the visit the facilities and stimulus offered to residents with dementia will be assessed. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic Drivers
- CQC dignity and Wellbeing strategy
- Care homes are a local Healthwatch priority

Methodology
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.
Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.
Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate, other topics such as accessing health care services from the care home. Family

members were also spoken to. They explained to everyone they spoke to why they were there and took minimal notes.

Summary of findings
At the time of the visit, the evidence was that the home was operating to an acceptable standard of care with regard to dignity and respect with residents who have dementia. However, there was a marked lack of variety and stimuli.

- The personal care appeared good, with resident's clothes clean and tidy. We saw no evidence of dignity not being respected.
- Regular visits from nominated GP's created confidence and early detection of illness.
- Residents told us they were happy with the food and menus.
- The Senior Care Assistant told us that staff received Dementia Training. Senior staff had also received "Monitoring Health in Care Homes" training. All staff received DoLs training

Results of visit
Environment
Four Winds is a Care Home adapted from a large residence. The home is primarily geared towards residential clients. Early stage dementia residents are accommodated but later stage dementia is felt to be too disruptive for other residents – the group has a specified unit which caters for the more challenging issues. The premises were clean and free from offensive smells. Residents were seated in a large room with conservatory attached. The dining room area led off from the main room. Although there were corridors which could be used for residents with dementia to walk along there was nothing tactile for residents to touch/experience. Signage was poor throughout the home especially for those with dementia.

Promotion of Privacy, Dignity and Respect
The Senior Care Assistant told us that staff worked in teams and all staff were dementia trained. Each person had a Care Plan that was reviewed once per month and more often if required. The Care Plan did not go into the hospital if the resident was admitted. Residents do have an "All About Me" document. However, the documents do not go into a yellow folder to increase visibility.

Promotion of Independence
Residents helped staff with the laying of tables, dusting and washing up. One person likes to deliver the post to residents. Craft sessions, flower arranging and knitting sessions were organised by an activities co-ordinator. There appeared to be no list of activities on display this was due to the fact that at the time there was no co-ordinator in place. Two new co-ordinators have since been appointed. There is a room designated as a Memory Room with reminiscence materials.

Interaction between residents and staff

The staff appeared to be on good terms with the residents and when asked how much time they spent talking with residents were told 5-10 minutes when staff are available. On the day of the visit a hairdresser was on site who chatted to residents.

Residents
Both representatives talked to residents and families. After talking to several residents, representatives had the distinct impression that they did not want to appear "to be a nuisance". An overall impression would indicate that there was very little thought given to the specific needs of those with dementia. However, one lady said she was very happy in the home and well cared for.

Food
Residents we spoke to seemed happy with the food and menus. Residents could eat in their own rooms and whenever they wanted to. Special diets were catered for and picture cards were used with residents with dementia to help them identify different foods. Menus were regularly changed. Liquids were available on a regular basis and water jugs were filled twice daily.

Recreational Activities
The Senior Care Assisant informed us that the activities coordinator visited three times per week and there were opportunities for interaction. Residents did go out shopping and to the park with staff. On the day of the visit residents were in one room with little stimulation and covered with blankets as it was quite cold in the room. One man commented that he was freezing. Blankets were eventually brought from the laundry.

Involvement in key decisions
Families and carers were involved in every stage and where possible the residents with decision making. Family, carers and residents were involved with decisions on end of life care. However, the staff did not fill in the "Deciding Rights" documents for each resident and the home is not accredited with the Gold Standard Framework.

Visitors and relatives
Visitors were welcomed at any time and could eat with residents

Good Practice

- Regular visits from nominated GP's –created confidence and early detection of illness
- It is intended to co-op residents onto interview panels for perspective members of staff.

Recommendations

- Building appeared to be in need of refurbishment
- More stimulation and involvement with residents

- Supply a variety of tactile objects, photographs of local area, war years etc.

Healthwatch Hartlepool –Gardner House Enter and View 19th February 2015

Organisation Community Integrated Care
Site Visited Gardner House
Contact Name Sharon Harland
Group Members Phyl Rafferty & Liz Fletcher

Acknowledgements
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

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Purpose of the visit
This visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life of people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic Drivers
- CQC dignity and wellbeing strategy
- Care homes are a Local Healthwatch priority

Methodology
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.
Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.
Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate, other topics such as accessing health care services from the care home. They explained to everyone they spoke to why they were there and took minimal notes.

A large portion of the visit was also observational, involving the authorised representatives walking around the public/communal areas and observing the surroundings to gain an understanding of how the home actually works with residents with dementia and how the service receivers engaged with staff members and the facilities. There was an observation checklist prepared for this purpose.

Summary of findings
At the time of the visit it was evident that the Home was operating to a high standard of care.

- Personal care was good, with resident's clothes clean and tidy. Dignity and privacy was obviously respected.
- Regular visits from named GP, gives confidence and early detection of illness.
- Residents appeared happy with the variety and standard of food offered.
- There was positive interaction between residents and staff
- The Senior Care Assistant told us that the staff have training in Dementia Care, with updating in process. The need for "Monitoring Health in Care Home" training is negated by the use of District Nurses and Community Matrons. All staff complete DoLS training.

Results of visit:
Environment:
This is a 29 room, purpose built establishment. Upon entering the home, there is a warm, cosy atmosphere, corridors with handrails are designed around a secure garden. Apart from two lounges, a bar and a smoking room, there are convenient "resting points". These have comfortable high seated chairs, books and some games e.g. large piece jig-saw puzzles. On the walls of the corridor we remarked on photographs of the town on a by-gone era and pictures relevant to the residents. Signage was poor on bathroom doors especially for those with dementia – other residents used bathrooms nearest to their rooms, so had no trouble.

Promotion of Privacy, Dignity and Respect:
Staff work in teams and all were dementia trained. Each person had a Care Plan which was reviewed on a monthly basis. Were the resident to need medical assistance this review would be completed daily. An Information Pack would accompany residents on hospital admission and each resident has an "Information Passport" which is gradually being replaced by the "About Me" document. Yellow folders are used for DNR.

Promotion of Independence:
Residents help staff with small domestic tasks – assisting in the dining room, folding napkins, accompanying staff with the tea trolley twice a day, planting in the garden when weather permits. One gentleman was used to vacuuming his

home and is very particular about standards – so a carpet sweeper had been provided as a necessary part of his comfort.

Interaction between residents and staff:
The staff appeared to be on very good terms with the residents. We observed the knowledge and mutual respect offered to several residents. Residents felt confident to approach staff who were doing clerical work (care plans), then sit with them. As there are few residents (approx. 17) the staff have the opportunity and inclination to spend time with them all. If a resident has to spend time in hospital the staff make it a priority to visit.

Residents:
Both representatives spoke to residents and received the impression that they were very happy with individual needs being catered for as a priority. One lady who has a 90th birthday due soon – chooses to spend most of her time in her own room. Everything around her has been tailored to her needs- including a fridge for her "cans of coke". Her laundry is done by her family by their choice – she has regular visits from a caring family but appreciates the care given in the Home. She stated "I want for nout". It was noted that call assist bells were situated on the arms of the chairs of those residents in their rooms.

Food:
A varied menu ensures that residents are happy with the choice and standard of food provided. Special diets are catered for with a list of residents needs posted in the kitchen (Communication Board). Liquids are available on a regular basis. It was a disappointment that there were no picture menus – some residents may find these of use.

Recreational activities:
We were informed that there was no official activities co-ordinator. Staff agree to involve themselves on a regular basis and there is an activities board listing various forms of interaction together with the name of the member of staff responsible. Apart from chair exercise these are bowls, karaoke, manicures, sing along and on the day of our visit reminiscence. In the main lounge a few residents were seated with a care assistant showing old photographs and pictures on a one to one basis. Encouraged by one of our representatives who had a knowledge of the town's history a gentleman diagnosed with dementia became very animated- the care assistant remarked that she had "never heard him talk so much!" When weather permits work is done in the garden and staff take residents on outings.

Involvement in key decisions:
Families, carers and where possible residents are involved in all decisions making including Care of Dying Patient. Staff fill in "Deciding Rights" document for each resident and the home is Gold standard Framework accredited – they are due for re-accreditation.

Staff:
The staff and management were friendly and helpful. Staff were trained in dementia care. Senior staff had attended "Monitoring Health in Care Homes" training. Staff

Visitor and relatives:
Visitors were welcome at any time and may join their relative/friend for lunch providing they telephone the Home to inform them.

Good Practice:

- Strong lead sets example for rest of staff
- Advice on making complaints on board in foyer- accessible to visitors
- Dignity Champions
- If having difficulty regarding surgeries – request a telephone consultation with GP.
- If in need of urgent medication for resident – dial 111- press option 2 and request a script for a 3 day supply of necessary medication.
- Use of red vest by staff member issuing medication – sign – do not disturb

Recommendations:

- Lack of bathroom signage – member of staff decided to utilise technology – download signs-enlarge-laminate-secure to doors!

Healthwatch Hartlepool –Gretton Court Care Home
Enter and View 15th December 2014

Organisation Hospital of God
Site Visited Gretton Court Care Home
Contact Name Andrea Atkinson
Group Members Phyl Rafferty & Liz Fletcher

Acknowledgements
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer
Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the visit
This visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life of people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. The visit was also made to assess the facilities and stimuli offered to the residents with dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic Drivers
- CQC dignity and Wellbeing strategy
- Care homes are a local Healthwatch priority

Methodology
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.
Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.
Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate,

other topics such as accessing health care services from the care home. Family members were also spoken to. They explained to everyone they spoke to why they were there and took minimal notes.

Summary of findings:
At the time of the visit, the evidence is that the home was operating to an excellent standard of care with regard to dignity and respect with residents who have dementia.

- Care is delivered with understanding, patience and kindness. We saw no evidence of dignity not being respected.
- Regular visits from nominated GP's created confidence and early detection of illness.
- Residents told us they were happy with the food and menus.
- The manager told us that staff received Dementia Training. Most staff received DoLs training.

Results of visit

Environment:
This purpose built home consisted of a variety of inter linked sitting rooms-quiet rooms and corridors with individual highlighted bedrooms leading off corridors. . The premises were clean and free from offensive smells. When representatives arrived the majority of residents were singing carols obviously enjoying themselves. There was no distress when entertainment finished residents were happy to interact with staff and visitors. Rooms and corridors were in good decorative order with pictures and tactile objects on the walls. Good clear signage and seats were strategically placed on which residents rested whilst pacing the corridors. The manager did inform the representatives that alterations are ongoing within the establishment. Rooms were available for residents to enjoy complete privacy if requested. The secure garden was accessed from most corridors- there were rabbits and hens which residents helped feed and groom. Families were encouraged to bring in pictures for reminiscence. There were key pads on all doors to keep residents safe.

Promotion of Privacy, Dignity and Respect:
The manager told us that staff worked in teams and all staff were dementia trained. Each person had a named care worker. Each resident has a personal care plan which was reviewed monthly to ensure the resident's needs are continuing to be met. Each resident had a "This is Me" document which is created with the assistance of relatives. Resident's Care Plan did not go into the hospital if the resident was admitted. The "This is Me" document did go into hospital when the resident was admitted but not in a yellow folder for increased visibility. The manager said that they offered a high quality of care and support that is personalised to match people's needs and interests. The manager remarked that the recent scheme were GPs visited the care home on a regular

basis had been of great benefit as it avoided “crisis situations”. A recent innovation “Home from Hospital” where staff from the care home visited the residents who had been admitted to hospital and helped with feeding had been successful. The continuity had resulted in residents being less confused and agitated, which resulted in fewer falls and a reduction of time spent in hospital. The manager informed us that residents are listened to and what may seem a small matter to the management of the organisation is of great importance to a resident living there. Staff do not complete the “Monitoring Health in Care Home training as they had trained nurses on site. Residents saw their own GP. The staff did not fill in the “Deciding Rights Document” and the home had not accredited with the Gold standard Framework. However residents, families and carers do discuss end of life care and their views are written in their documentation.

Promotion of Independence
All staff were sensitive to the resident’s individual preferences and capabilities. Residents helped staff with the laying of tables, dusting and washing up. The home provided a varied programme of activities delivered by the skilled activities co-ordinator. Staff supported the residents to continue their leisure activities both within the home and outside. There was suitably adapted equipment for people with dementia including coloured crockery and red toilet seats.

Interaction between residents and staff
Staff are encouraged to learn as much as possible about the resident’s lives. Staff chatted to residents and laughed along with them. The dedication and intimate bond the staff had with the residents was clear to see. An indication of a well ran establishment is the staffing turn over. Gretton Court had a very high retention of staff. The manager mentioned that staff went in on their days off.

Residents
Both representatives talked to residents who were happy with the care their loved one received. One elderly gentleman whose wife was a resident in the home said “It’s an amazing place. It’s like home from home in here. They even make me feel part of the family”.

Food
There are restricted meal times but residents we spoke to seemed happy with the food and menus. Residents could eat in their own rooms and whenever they wanted to. Special diets were catered for and picture cards were used with residents with dementia to help them identify different foods. Menus were regularly changed.

Recreational Activities
The manager informed us that the activities co-ordinators provided a varied programme of activities which included craft sessions, reminiscence sessions, singing, simple exercise etc.

Involvement in key decisions
Staff have a good relationship with families, carers and residents and they are involved in all key decisions including end of life care. However, the staff did not fill in the "Deciding Rights" documents for each resident and the home is not accredited with the Gold Standard Framework.

Visitors and relatives
Visitors were welcomed at any time and could eat with residents

Good Practice
"Home from hospital "- Carers visited residents who had been admitted to hospital even helping with feeding. Source of continuity/assurance and residents returned to care homes much quicker.
GP interaction prevents crisis situations

This report highlights the good practice that we observed. The home functioned as a true community with everyone's contribution recognised and valued.

Recommendations

- Home in need of refurbishment. Manager commented that this is ongoing.

Healthwatch Hartlepool – Highnam Hall Home Enter and View 3rd February 2015

Organisation Matt Matharu
Site Visited Highnam Hall
Contact Name Carolyn Lyth
Group Members Phyl Rafferty & Liz Fletcher

Acknowledgements
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

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Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the visit
This visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life of people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic Drivers
- CQC dignity and wellbeing strategy
- Care homes are a Local Healthwatch priority

Methodology
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.
Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.
Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate, other topics such as accessing health care services from the care home. They

explained to everyone they spoke to why they were there, and took minimal notes.
A large portion of the visit was also observational, involving the authorised representatives walking around the public/communal areas and observing the surroundings to gain an understanding of how the home actually works with residents with dementia and how the service receivers engaged with staff members and the facilities. There was an observation checklist prepared for this purpose.

Summary of findings:
At the time of the visit, the evidence is that the home was operating to a very good standard of care with regard to Dignity and Respect

- There was a warm, friendly atmosphere in the home
- Staff seemed kind and compassionate
- Staff understood and acted on people's individual preferences and respected their dignity.
- There was positive interaction between residents and staff
- The manager told us that all staff received Dementia Training

Results of visit:

Environment:
A Victorian establishment which caters for a variety of needs – EMI, dementia as well as those with physical disabilities. The home was clean and odour free. A secure garden space was available for residents to use along with a conservatory for people who smoke. Family members were encouraged to bring in resident's own furniture for resident's rooms. Representatives were visiting to look at the quality of life offered to those who had dementia. There was poor signage on bathroom doors. No coloured toilet seats, patterned carpets in corridor areas, little obvious stimulation and nothing tactile on walls. Representatives spoke to the manager about the areas of concern and she felt that if was a Care Home specifically for those with dementia then these concerns would have been factored into their plans. The manager explained that in the past signs had been taken off the bathroom doors by residents. She explained that residents who had dementia are actually taken to the bathroom by staff. However, it appeared from further discussion that the representative's concerns were recognised and that further renovations were due to take place.

Promotion of Privacy, Dignity and Respect:
On the day of the visit the manager was in a meeting so the assistant manager Michael who obviously knew and cared for the residents spoke to the representatives. A hairdresser visited weekly. Vision Call dealt with spectacles. Hearing aids and dentures were checked regularly. Fluids were offered regularly and each resident had a jug of water/ juice in their room.

Promotion of Independence:
Residents were encouraged to help staff with small tasks. Residents liked to set the tables and dust. All rooms had a photograph of the resident secured to the door and also information for staff of any problems that resident might have if they were mobile/wheelchair or sick. There were photos of the day/night key workers together with their names. Décor was to individual taste.
Representatives spoke to a couple one lived together on the upper floor one of which had dementia. They were capable of independent living and the lady was escorted to town for individual shopping needs. They felt secure in the knowledge that their "buzzer" would be answered quickly and confident in the assistance of staff.

Interaction between residents and staff:
We saw evidence of staff interacting with residents in a pleasant friendly and positive way. Residents were watching a DVD when representatives arrived everyone seemed to enjoy it. The staff supported and encouraged residents to eat. Staff seemed caring and cheerful. The representatives witnessed the ease and affection generally held towards the assistant manager and staff.
Residents:
Both representatives spoke to residents but on the day of the visit there were no family members to speak to. The residents had nothing but praise and thanks for the caring staff. The residents appeared happy and settled. Each resident had a Care Plan and all documentation was sent into hospital in a yellow folder.

Food:
Choice of menus were on display in the dining room but representatives were told by residents that they could have what they asked for as long as they gave warning.

Recreational activities:
An activities coordinator, who was new in post, was employed to organise a variety of activities. She was keen to arrange a weekly rota of activities.

Involvement in key decisions:
The assistant manager informed us that information was always shared with families and relatives. They were always encouraged to ask questions.

Staff:
The staff and management were friendly and helpful. Staff were trained in dementia care. Senior staff had attended "Monitoring Health in Care Homes" training.

Visitor and relatives:
Visitors were welcome at the home anytime. Visitors were encouraged to take residents out.

Good Practice:
Staff numbers are high
Good rapport between staff and residents
Pertinent information on resident's doors

Recommendations:

- Home required refurbishments
- More stimulation for people with dementia.
- Signage and adaptations for people with dementia

Healthwatch Hartlepool Lindisfarne Care Home Enter and View 11th February 2015

Organisation Gainford Care Homes
Site Visited Lindisfarne Care Home
Contact Name Beryl Anderson
Group Members Zoe Sherry & Jean Hatch

Acknowledgements
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer
Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the visit
This visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life for people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic Drivers
- CQC dignity and Wellbeing strategy
- Care homes are a local Healthwatch priority

Methodology
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.
Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.
Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate, other topics such as accessing health care services from the care home. Family members were also spoken to. They explained to everyone they spoke to why they were there and took minimal notes.

Summary of Findings:
At the time of the visit, the evidence is that the home was operating to an excellent standard of care with regard to dignity and respect with residents who have dementia.

- A pleasant, airy warm home with a happy environment for both residents and staff
- The manager is reviewing all staff training needs regarding dementia.
- The manager is aware of the care needs and personal needs of people with dementia.
- The manager and some staff sit in at meal times to check, assist or help with feeding if required.

Environment:
The Home is pleasant, airy and warm. The manager has only been in post for a short time and is making changes. She is aware of the care needs and personal needs of people with dementia. There are 37 members of staff which 22 are carers. This is a residential home. There are no registered nurses but staff qualifications vary from NVQ's to management level. There are thirty beds in use with a mixture of residential and EMI. Residents are not segregated there are twenty beds downstairs and ten beds upstairs. All rooms are singles and all are en suite. Plus several bathrooms and shower rooms and toilets which are well identified- green doors and stanchions to stand out. Adjacent rooms are sometimes converted into a lounge and bedroom for couples. There are remote door locks, alarmed doors, window locks and lift locks.

Promotion of Dignity and Respect:
Each resident has a Care Plan which is renewed monthly and each resident has a key worker. For hospital admissions the Home uses "transfer to hospital forms". Also height, weight, Maars chart and a member of staff goes with the resident. All "End of Life" discharges accepted at any time. Home not aware of yellow envelopes. All residents have a "This is Me" – My Life Map. If residents were from a different culture it would not affect their care as staff would ensure cultural needs were met. They would check with the resident, carers and family, church etc. on the person's needs and entered into the Care Plan.

Promotion of Independence:
Residents can assist with tasks – set tables, push trolleys and small cleaning jobs. The carpets and flooring are neutral. There is colour coding on handrails, toilet and bathroom doors. There is also light weight crockery. Residents can retain their own GP. A designated GP calls each Monday – often very little to do. For End of Life Care residents have a preferred place document. GP has Emergency Plans in place with DNAR, preferred place and medication. The Home is not accredited with the Gold Standard award. If residents become unwell medication is administered by trained team leaders or senior staff. If there are any concerns first call must be the Optim nurse then own GP if necessary.

Staff:
Information is shared with residents and family. There are notice boards for staff, residents and visitors. Staff do hand overs for continuity of care and information. Staff are on a rolling programme of DOLS training. Residents with DOLS are clearly identified on resident's list.

Residents:
Residents seemed happy with their care.

Food:
All residents likes and dislikes, allergies are logged. Pureed diets are served straight to tables if required. Residents can eat anywhere and anytime if not hungry at meal times.

Recreational Activities:
An Activities Co-ordinator has been employed who organises daily activities. The home has a mini bus for trips out.

Involvement in key Decisions:
The Manager is always available to talk to residents and families. If there is an incident carers are told immediately.

Visitors and Relatives:
The Home operates open house visiting. Visitors can join residents for snacks or meals.

Comments:
The manager suggested that there needs to be a dementia friendly secure place to take people to, but away from the locks/comments of people.

Recommendations:

- To plan any refurbishment to meet the needs of all residents including those with dementia.
- The Manager to find out about the Dementia Friendly Hartlepool Group.
- The manager to find out about the Teesside Dementia Alliance.

Healthwatch Hartlepool – Manor Park Care Home Enter and View 19th August 2014

Organisation Four Season Health Care
Site Visited Manor Park Care Home
Contact Name Jean Reaney
Group Members Phyl Rafferty & Liz Fletcher

Acknowledgements
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer
Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the visit
This visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life of people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic Drivers
- CQC dignity and wellbeing strategy
- Care homes are a Local Healthwatch priority

Methodology
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.
Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.
Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate, other topics such as accessing health care services from the care home. Family members were also spoken to. They explained to everyone they spoke to why they were there and took minimal notes.

A large portion of the visit was also observational, involving the authorised representatives walking around the public/communal areas and observing the surroundings to gain an understanding of how the home actually works for residents with dementia and how the service receivers engaged with staff members and the facilities. There was an observation checklist prepared for this purpose.

Summary of findings
At the time of the visit, the evidence is that the home was operating to a very good standard of care with regard to Dignity and Respect

- The personal care appeared good, with resident's clothes clean and tidy. We saw no evidence of dignity not being respected
- We saw evidence of staff interacting with residents positively and regularly, including asking them if they were okay.
- Residents told us they were happy with the food and menus
- The manager told us that all staff received Dementia Training
- We saw evidence of social activities and the residents had the option to take part
- Staff raised concern about the lack of specialised transport and taxis.

Results of Visit:
Environment
The home was pleasantly decorated and furnished, it had achieved the Pearl Specialist Award for Dementia. The visit to the care home took place when residents were being bathed/changed. There was a smell of urine, a carer said that it may be because of personal changing. When the urine smell was mentioned to the manager she dealt with it immediately.
An enclosed garden area was available for the residents to sit and enjoy the sunshine. The corridors were free of obstructions and some walls had 3D objects mounted on them. All rooms were personalised, signage was clear. Several areas were available for residents to move around in.

Promotion of Privacy, Dignity and Respect
The manager told us that members of staff worked in two teams so that all staff knew the residents. Staff always worked with families to resolve any problems. The staff appeared to be aware, caring and approachable. All the residents we saw appeared to be clean and well dressed. The hairdresser was on site the morning of the visit, opticians and podiatrists also visit regularly. The home was kept safe with key pads on doors.

Promotion of Independence
All rooms were individually furnished, residents appeared proud of environment**.** Residents were encouraged to help staff if they wanted to – one lady liked to fold the clothes in the laundry. Outings were arranged by the activities co-ordinator.

There were adaptions for residents in the care home including blue crockery, adapted cutlery and raised toilet seats.

Interaction between residents and staff
We saw evidence of staff interacting with residents in the television room. They asked residents regularly in a friendly polite way if they needed anything. One member of staff spoke in detail about the music preferences of residents and how they liked to dance.

Residents
Both representatives spoke to residents who said that everyone talked to each other. One representative observed while residents were getting their hair done. The residents laughed and joked with the hairdresser and staff. The residents said that they felt secure and settled.

Food
The daily menu was displayed on a board. Specialist diets were catered for and residents could eat at different times if they wished. Residents could eat in their own rooms and one lady liked to eat in the lounge as she did not like the noise in the dining room.

Recreational Activities
Residents were encouraged to take exercise. There were weekly classes in all three units. There was an activities co-ordinator who displayed a weekly plan on the main notice board. He was very aware of the needs of the residents with dementia- involving those who were more able bodied to assist him with those less able. He tried to incorporate “outside visits” taking residents to shops and the local park. He told us the obtaining of wheelchair access taxis was a real problem no matter what time of day or night. Transport was a big issue as hiring buses was so expensive.

Involvement in key decisions
Meetings with residents and families were held regularly. Information was shared with relatives at all times.

Visitors and relatives
Visitors were welcome anytime. A visiting relative said that his wife who had dementia had been resident for three years – he visited every day and was happy with her care.

Recommendations
The report highlights the good practice that we observed and reflects the appreciation that residents felt about the care and support provided,

- Transport - The findings did indicate that the opportunity to take residents out is sometimes a problem due to lack of suitable transport.

Good Practice
Utilised a member of staff who had worked as a ‘carer’ had him trained as Activity Co-ordinator. He knew the residents well-their abilities and interests –they felt secure with him.

Healthwatch Hartlepool – Park View Care Home 8th September 2014

Organisation Matt Matharu
Site Visited Park View Care Home
Contact Name Barbara Jacques
Group Members Phyl Rafferty & Liz Fletcher

Acknowledgements
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Strategic Drivers
- CQC dignity and Wellbeing strategy
- Care homes are a local Healthwatch priority

Methodology
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.
Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.
Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate, other topics such as accessing health care services from the care home. Family members were also spoken to. They explained to everyone they spoke to why they were there and took minimal notes.

Summary of findings
At the time of the visit, the evidence is that the home was operating to a very good standard of care with regard to Dignity and Respect.

- The personal care appeared good and resident's clothes were clean and tidy. We saw no evidence of dignity not being respected.
- We saw evidence of staff interacting with residents in a positive manner.
- Residents told us they were happy with the food.
- The manager told us that all staff received dementia training.
- We saw evidence of social activities within the home.
- Staff raised concern about transport.

Results of visit

Environment:
The home was odour free and airy with space to wander. There was clear signage on doors and access to an enclosed garden. Decoration was a bit worn and dated but some renovation work had been completed on the top floor. Flats for couples were available. Bedrooms had individual photographs and residents personal belongings. There are key pads on all doors.

Promotion of Privacy, Dignity and Respect:
Before admission information is obtained and assessments of people's individual needs were written in their Care Plan. All staff had received dementia training. Residents were asked if they needed anything at regular intervals. Signage was clear on toilets and corridors.

Promotion of Independence:
Residents are encouraged to help with tasks such as washing up and dusting. Residents we spoke to had visited the pub next door for an evening out. The home does not have coloured crockery for people with dementia. All residents use the same. Residents can see their own GP.

Interaction between residents and staff:
Staff talked to residents and the manager informed us that staff are trained to value each individual and to recognise their different preferences and needs.

Residents:
Both representatives talked to residents who said they were happy with the care they received in the home. Two residents said they were good friends and chattered together.

Food:
Residents seemed to be happy with the food and menus available. Residents could eat in their own rooms and at different times if they preferred. Special diets were catered for.

Recreational Activities:
The manager informed us that the home did not employ an activities coordinator. The staff organised the activities. Residents were encouraged to do chair exercises and ball activities. Residents were regularly taken out along the sea front.

Involvement in key decisions:
Residents and carers were always involved in any key decisions. Information was shared with residents usually one to one every week.

Staff:
The staff were all friendly to us and the residents. One residents said that the staff were “very good”.

Visitors and relatives:
Visitors were welcomed anytime day or night.

Recommendations:
Continue refurbishments

Healthwatch Hartlepool – Queen's Meadow Care Home
Enter and View 1st September 2014

Organisation Hillcare
Site Visited Queen's Meadow Care Home
Contact Name Julie Armstrong
Group Members Phyl Rafferty & Liz Fletcher

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Strategic Drivers
- CQC dignity and Wellbeing strategy
- Care homes are a local Healthwatch priority

Methodology
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.
Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.
Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate, other topics such as accessing health care services from the care home. Family members were also spoken to. They explained to everyone they spoke to why they were there and took minimal notes.

Summary of findings
At the time of the visit, the evidence is that the home was operating to a good standard of care with regard to dignity and respect with residents who have dementia.

- The personal care appeared good, with resident's clothes clean and tidy. We saw no evidence of dignity not being respected.
- Residents told us they were happy with the food and menus.
- The manager told us that staff received Dementia Training

Results of visit

Environment
The unit was colourful and pleasantly furnished. Signage was good and bedroom doors were different colours and resembled the front doors of people's homes. The corridors were free from obstructions but had different areas for residents to walk around. All rooms were personalised and signage was clear. Doors were fitted with key pads. The manager said that she was still working on the Dementia unit and was going to install a pub/snug area. Families were encouraged to bring in pictures for reminiscence.

Promotion of Privacy, Dignity and Respect
The manager told us that staff worked in teams and all staff were dementia trained. The manager informed us that the home was working on a Dementia Strategy.

Promotion of Independence
Residents helped staff with the laying of tables and washing up. There was different coloured crockery available for people with dementia. There was pictures on doors as well as signage. Toilets and bathrooms had signs. Outing were organised by the activities coordinator.

Interaction between residents and staff

Residents
Both representatives talked to residents. One gentleman said he was very happy in the home and well cared for.

Food
Residents we spoke to seemed happy with the food and menus. Residents can eat in their own rooms and whenever they wanted to. Special diets are catered for and picture cards were used with residents with dementia to help them identify different foods.

Recreational Activities
The manager informed us that the Activities Coordinator visited each day and there are opportunities for interaction e.g. Laughing Yoga. Unfortunately at the time of our visit, the Activities Coordinator had left, there was little evidence of activity or enthusiasm in the main lounge.

Involvement in key decisions
Families and carers were involved in every stage and where possible the residents.

Visitors and relatives
Visitors were welcomed at any time. We spoke to several family members and on the whole they appeared to be content with the care given to their relatives. There did appear to be a lack of opportunities for varied interests. The manager was aware of the lack of stimulation and variety of special areas and intends to carry out refurbishments.

Recommendations
This report highlights the good practice that we observed.

- The findings did indicate that there was a lack of opportunities for varied interests.

Healthwatch Hartlepool – Seaton Hall Care Home Enter and View 4th February 2015

Organisation A Wilks
Site Visited Seaton Hall
Contact Name Nicola McGurry
Group Members Phyl Rafferty and Jean Hatch

Acknowledgements
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer
Please note that this report relates to the findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the Visit
The visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life for people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic drivers
- CQC dignity and wellbeing Strategy
- Care homes are a Local Healthwatch Priority

Methodology
This was an announced Enter and View Visit
We approached a member of management in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent, or due to safety or medical reasons.
Authorised representatives conducted short interviews with the manager of the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training in dementia care were explored.
Authorised representatives also approached three residents at the care home to informally ask them about their experiences of the home and where appropriate other topics such as accessing health care services. They explained to everyone they spoke to why they were there and took minimal notes.

A large proportion of the visit was also observational, involving the authorised representatives walking around the public/communal areas and observing the surroundings to understand how things work for people with dementia. There was an observation checklist prepared for this purpose.

Summary of findings:
At the time of our visit, the evidence is that the home was operating to a good standard of care with regard to people with dementia.

- Residents looked tidy and clean, we saw no evidence on dignity not being respected.
- The manager informed us that all staff received the relevant Dementia Training to support their role.
- There was positive interaction between residents and staff

Results of Visit:

Environment:
Seaton Hall is a residential home on the sea front in Seaton Carew. The sea views were stunning from the lounge. It is within walking distance of a number of local amenities, such as cafes, restaurants and beaches. Individuals are supported to use the services and actively engage in community life if they wanted to. Most of the residents were over 90 years of age. However, the home had started to take in people with alcohol problems.

Promotion of Privacy, Dignity and Respect:
The manager informed us that staff understood and acted on people's individual needs and respected their dignity. Each resident had an "All About Me" document and Care Plan that was reviewed monthly. All staff had completed Dementia training. Four members of staff had completed the Monitoring Heath in Care Homes training. All staff complete the DOLS training. Residents in the home had a named key worker who liaise with the family. The manager informed us that the resident's needs and requests concerning end of life care are recorded in their Care Plan. This was constantly reviewed. Macmillan nurses and district nurses worked alongside staff in the home to give residents the best possible care at the end of their lives. The home is not accredited with the Gold Standard Framework. There were key pads on all doors to keep residents safe. Most of the residents were over 90 years old but the manager informed representatives that the establishment has a few younger residents with alcohol abuse related problems.

Interaction between residents and staff:
Staff engaged with the residents throughout the visit.

Promotion of Independence:
There were opportunities for residents to work alongside staff if they wanted to. All residents had their own named GP. There is a named GP who visited weekly.
.

Residents:
Residents were positive about the service they received.

Food:
Residents were happy with the choice of menus. Menus were displayed on the notice boards. Staff were trained to help residents with feeding if required.

Recreational activities:
There were daily activities to stimulate residents which were written up on a board. The staff delivered the activities as there was no Activities Co-ordinator.

Involvement in key decisions:
Information was shared with relatives and residents. Relatives were always informed of any changes, concerns and needs of residents.

Visitors and relatives:
The manager informed us that visitors were welcome any time. One relative who visited her mother daily informed us that she felt her mother was well cared for in the home

Recommendations:

- Develop a more “Dementia Friendly” environment
- Make small scale improvements e.g. purchase coloured crockery
- Improve signage, flooring and colour schemes as part of the maintenance programme.
- Employ an Activities Co-ordinator

Healthwatch Hartlepool – Sheraton Court 2015 Enter and View 2pm 16/02/15

Organisation	Helen McCardle
Site Visited	Sheraton Court
Contact Name	Shirley Delal (Assistant Manager**)**
	Julie Weldrake (Senior Care Assistant)
Group Members	Phyl Rafferty Liz Fletcher, Marjorie Marley, Ruby Marshall, Maureen Lockwood

Acknowledgements:
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer:
Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the visit:
This visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life of people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic Drivers:

- CQC dignity and wellbeing strategy
- Care homes are a Local Healthwatch priority

Methodology:
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.
Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.

Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate, other topics such as accessing health care services from the care home. They explained to everyone they spoke to why they were there and took minimal notes .

A large portion of the visit was also observational, involving the authorised representatives walking around the public/communal areas and observing the surroundings to gain an understanding of how the home actually works with residents with dementia and how the service receivers engaged with staff members and the facilities. There was an observation checklist prepared for this purpose.

Summary of findings:

Sheraton Court is an eighty, single room all en-suite care establishment, catering for a variety of needs. At the time of the visit, representatives were impressed by the high standard of care and awareness being shown to the residents. There was an obvious understanding of those with Dementia, a good variety of stimulus was evident.

1. Personal Care appeared very good
2. Regular weekly visits from nominated G.P
3. Residents felt secure
4. Senior Care Assistant advised that all staff receive Dementia Care training and attend courses on D.O.L.'s
5. Monitoring Health in Care Homes is replaced by use of District Nurses, Community Matrons and Mental Health Team.

Results of Visit:

Environment:

The premises were light, airy, well decorated and free from any offensive odour. Carpeting was plain. The doors of individual rooms were painted in a variety of pastel colours and to the right was a frame containing a photo of the resident and family. A large mural on the wall near the lift and a "mood enhancer" afforded residents stimulus as did pictures on the walls, a market trolley containing 'vegetables' together with photographs and music. Some residents stayed in the lounge whilst other moved easily around the facility. Signage was good and applicable to those with dementia. There is coded number for visitor access.

Promotion of Privacy, Dignity and Respect:

We were told that staff work in teams and all were dementia trained. Each resident has a Care Plan which is evaluated on a monthly basis. Family/Carers/Residents complete a Life Story Portfolio stimulated by a synopsis supplied by a Social Worker. Care Plans are reviewed more regularly should the need arise.

If a resident has to be admitted into hospital he/she is accompanied by the front cover of the Care Plan, together with relevant information about admission; yellow folders are used if there is a DNR in place.

Promotion of Independence:
Residents enjoy helping staff to dust, make beds, clean/set dining room tables. There is a 'sweet' trolley overseen by staff, which the resident likes to distribute to others remembering who enjoys what! A hairdresser visits three times each week and residents take the opportunity to "pop in for a chat"

Interaction between resident and staff:
There appeared to be a lively, natural and easy relationship between the staff and the residents. There is a system in place which seemed to work very well - "Hourly /comfort checks", which entails staff asking if residents are comfortable/have everything they need/checks residents fluids/and access to the nurse call.
One of the representatives remarked "Interaction-constant" A 3 day induction trainer for all staff, is held in an Academy in Newcastle. It was noted that as some residents were wanting to dance/sing-members of staff joined them.

Residents:
Several representatives talked to residents and formed the impression that people were very happy. One gentleman who was singing to himself-welcomed a representative "I'm pleased to see you again" – others felt they were well looked after, happily talked about their family when stimulated by a photograph; although one preferred to stay in her room as she felt intimidated by another resident-staff were aware. An overall impression would be that that there was a great deal of thought given to the specific needs of those with dementia. There is a wall board in each room, which is specifically for the use of anyone who visits that resident. If there were a person with dementia from a different culture/background-we were informed that there needs would be catered for by reference to their family/community. It was remarked that the chef would have to play a strong part in the team.

Food:
Residents are allowed to eat "anywhere-anytime"; special diets are catered for and resident's likes and dislikes are taken into account – with chef informed and details keep on a board in the kitchen. The dining room is pleasant with the menu displayed on the door, cream linen and green crockery are used which gives necessary contrast.
If a resident need assistance, staff are trained to perform this with awareness and sensitivity. There is a flip chart with photographs for use in the dementia unit. Liquids are available constantly and the "hourly checks" ensures that all residents have access to a drink.

Recreational Activities:
There are two part time activity co-ordinators employed and staff work with them. An activities board is on prominent display apart from music, dvd's, bowls, darts, dominoes and karaoke-the staff ensure that residents are taken out into town via public transport. One resident remarked "I go shopping but I don't have a lot of money so I don't do a lot of shopping"- I've written 3 books about Sheraton Court!"
There is a weekly bus trip to Seaton for fish and chips plus visits to the Headlands-time for reminiscing. Activities unite all abilities but are modified where there is a lack of capacity.

Involvement in key decisions
Where possible, residents as well as family and carers are involved in decision making. A Multi-discipline Report is utilized when needed, and this is shared with family/carers. If a resident is unwell, or needs medication-the first point of contact is to advise the Community Matrons or GP. Implementation of "Care of the Dying" has to be on the direction of the GP; then a chart is used detailing, food and liquids-together with an adapted Care Plan for individual needs. District nurses oversee. The Home is accredited with the Gold Standard Framework.

Visitors & Relatives
Visitors are welcome anytime. A wall board in each resident's room affords relatives/friends to record their visit and gives an opportunity to pass on information/observation to staff. There is a prominent "Complaints Procedure" guide in the lift used by visitors.

Good Practice
1. Hourly check "Comfort Call" chart kept in red folders in each resident's room.
2. Visitors Board-on wall in resident room-opportunity for comments, observations etc.
3. Pro-Active Unit in Dementia Community - awareness of need for stimulation

Healthwatch Hartlepool Stichel House - Hospital of God Report

Organisation Hospital of God
Site Visited– Stichell House
Contact Name Linda Unthank
Group members Ruby Marshall and Liz Fletcher
Date/Time of Visit 5 February 2015 at 2pm

Acknowledgements:
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer:
Please note that this report relates to the findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the Visit:
The visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life for people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic drivers:

- CQC dignity and wellbeing Strategy
- Care homes are a Local Healthwatch Priority

Methodology:
This was an announced Enter and View Visit
We approached a member of management in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent, or due to safety or medical reasons.

Authorised representatives conducted short interviews with the manager of the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training in dementia care were explored.

Authorised representatives also approached three residents at the care home to informally ask them about their experiences of the home and where appropriate other topics such as accessing health care services. They explained to everyone they spoke to why they were there and took minimal notes.
A large proportion of the visit was also observational, involving the authorised representatives walking around the public/communal areas and observing the surroundings to understand how things work for people with dementia. There was an observation checklist prepared for this purpose.

Summary of findings:
At the time of the visit, the evidence was that the purpose built 35 bed home, was operating to an exceptionally high standard of care throughout.

a) Personal Care was superb
b) Home was odour free, well decorated with floor covering appropriate to needs.
c) In total there are 56 staff. All care staff are trained to level 2 NVQ. 12 trained to level 3 with 4 members working towards level 3. All staff receive DOL's training.
d) Residents told us they were very happy
e) Safety and security measures are in place and have recently been overhauled.

Results of Visit:
Environment – All rooms are single, en suite, but there is the possibility of utilizing adjoining rooms for a couple.
There are a variety of public areas which residents may use at any time.
An enclosed garden is accessed from several locations.

Promotion of Privacy, Dignity and Respect:
Residents suffering from Dementia have two named key workers and any concerns are prompted in resident's files on a daily basis. All residents have a Care Plan and their needs are reviewed monthly. The Manager conducts an over-view on a 3-6 months basis.

A Summary of the Care Plan goes with the resident on hospital admission (see enclosed) Documents are not sent in a yellow folder, as Manager has concerns about possible stigma for those with limited capacity. Each resident has a document entitled "This is me"

If a resident is unwell or in need of medication, there is a team of 4 medically trained staff who will assist. There is access to individual GP's of choice. A 'Priorities of Care' enclosed in Care Plans; several residents have requested they return to Stichell House rather than remain in the local Hospital/Hospice. The Manager expressed appreciation of the local District Nurse. "Very supportive, excellent." Should a resident, suffering from dementia, be from a different

culture/background; then the family/local community/Religious Community-would be consulted-all needs would be dealt with in a sensitive manner.

Promotion of Independence:
Opportunities for residents to be happily occupied are encouraged by the staff. If they so wish
residents can "assist" with the laundry (folding clothes and delivering items to other residents). Helping to set and clean the dining room –taking crockery from tables to kitchen 'hatch' very much "home from home"

There is a Sweet Shop manned by residents each have their own role, from stock taking, selling and finance.

Interaction between residents and staff:
As there is an excellent staff/residents ratio, there is the opportunity for easy and regular communication. It was noted that staff are very aware of the needs of each resident and all effort made to ensure that that resident was comfortable/secure. – when a resident appeared upset, a member of staff sourced that the lady was remembering her own mother – (stimulated by music) We were aware that staff visit the residents rooms just to "chat".

Resident:
Both representatives had the opportunity to talk to visitors and residents. All of whom were very positive about care and staff ("wonderful, - so caring and they have a sense of humour") One lady remarked "I was only 5 stone when I came here – could only walk with assistance – now look at me – I'm a new woman – I'll show you I can walk-I'll escort you downstairs".

Food:
All very happy with choice, food and kitchen staff! Residents are free to choose where, what and when they eat. For those with difficulties – members of staff deal gently and sensitively with the issue. All rooms have jugs containing fluid of choice-juice/water; fruit is available in the dining room and a drinks trolley was noted-some people enjoy a glass of wine with their meal (obviously dependent upon medication).

Recreational Activities:
A full-time, activities co-ordinator, has a very strong part to play in the lives of the residents. All activities are pitched for the needs of the individual; skills and interests are identified, exercise is encouraged. Visits to places of interest e.g. Beamish, are organised by the co-ordinator as is involvement with the village community-visits to hotels/sojourns for fish and chip etc. Visitors are welcome anytime and take an active part in events e.g Burns Night (complete with a Piper and Haggis-cooked by Chef!) A Scots resident who suffers from dementia-recited the "Ode to the Haggis!"

Involvement in Key Decisions:
Families/carers are involved in every stage of decision making and where possible, so is the resident. The Manager holds a quarterly "Family Forum" which is held over 2 session's am/pm. It offers the opportunity for families to attend and express any concerns. On an annual basis, the residents and their family/carers are asked to complete anonymously, a 'Quality of Life Form'. The responses and ideas gleaned are always implemented. The Home is accredited with the Gold Standard Framework.

Visitors and relatives:
Visitors are welcome anytime and may eat with residents.

Good Practice:

- Manager sensitive to stigma surrounding those with limited capacity e.g. Yellow Folder
- Quality Family Forum held over two sessions i.e. morning/afternoon. Allows time for all family members to attend.
- Priorities of Care-compiled by residents, family carers and staff-enclosed in Care Plans.
- Annual Quality of Life Form – completed and any valid suggestions are implemented

- An uplifting Visit

Healthwatch Hartlepool – Warrior Park Care Home Enter and View 20th August 2014

Organisation Four Season Health Care
Site Visited Warrior Park Care Home
Contact Name Sue Farnsworth
Group Members Phyl Rafferty & Liz Fletcher

Acknowledgements
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer
Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff.

Purpose of the visit
This visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life of people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic Drivers
- CQC dignity and wellbeing strategy
- Care homes are a Local Healthwatch priority

Methodology
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.
Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.
Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate, other topics such as accessing health care services from the care home. Family members were also spoken to. They explained to everyone they spoke to why they were there and took minimal notes.

A large portion of the visit was also observational, involving the authorised representatives walking around the public/communal areas and observing the surroundings to gain an understanding of how the home actually works with residents with dementia and how the service receivers engaged with staff members and the facilities. There was an observation checklist prepared for this purpose.

Summary of findings
At the time of the visit, the evidence is that the home was operating to a very good standard of care with regard to Dignity and Respect

- The personal care appeared good. We saw no evidence of dignity not being respected
- We saw evidence of staff interacting with residents positively and regularly, including laughing and joking.
- Residents told us they were happy with the food and menus
- The manager told us that all staff received Dementia Training
- We saw evidence of social activities.
- Staff raised concern about transport.

Results of visit:

Environment
The home was clean and odour free. It was pleasantly decorated and furnished. The dementia unit was accommodated on the upper floor. There were wide corridors with tactile objects on the walls and pictures of by-gone eras: seating areas were varied and ran effortlessly into one another so that walking was easy and safe. There was a bar area where events were held/ residents had tea and coffee if they wish. Key pads were on all doors to keep residents safe. The home has the Pearl Dementia Care award.

Promotion of Privacy, Dignity and Respect
The staff got to know their residents and their backgrounds and they created genuine person centred care. It seemed to be a place where each member of the team wanted to do their best to provide excellent care on a daily basis. Staff recognised that everyone with dementia was different and residents with dementia were encouraged to lead fulfilling lives.

Promotion of Independence
Residents were encouraged to help staff with small tasks. Residents liked to set the tables, dry dishes and dust. At lunch times staff take residents to the local pub to the Luncheon Club. On warm days, people are escorted to the seafront for ice creams.

Interaction between residents and staff
We saw evidence of staff interacting with residents in a pleasant friendly and positive way. Music was playing when representatives arrived and the residents seemed to enjoy it. The staff supported and encouraged residents to eat. Staff seemed caring and cheerful, it was obvious the there was a great deal of understanding of the residents.

Residents
Both representatives spoke to residents but on the day of the visit there were no family members to speak to. The residents had nothing but praise and thanks for the caring staff.

Food
The dining room was clean, sunny and welcoming. Residents said that they liked the food. Adaptations were made for people with dementia. A variety of coloured crockery and adapted cutlery was available for ease of use for people with dementia.

Recreational activities
An activities coordinator was employed who organised a variety of activities. These took place in groups or one to one sessions. These included pampering sessions, quizzes, bingo crafts and reminiscence sessions. Recently the residents had been on an outing to Stewart's Park in Middlesbrough. Staff mentioned that it was difficult getting transport to take residents out.

Involvement in key decisions
The manager informed us that information was always shared with families and relatives. They were always encouraged to ask questions.

Staff
The staff and management were friendly and helpful and the home itself was clean and welcoming. All staff were trained in dementia care, and an observation showed an awareness and consideration of all residents.

Visitor and relatives
Visitors were welcome at the home anytime. Visitors were encouraged to take residents out. Staff listened to residents as one person liked playing dominoes and now staff play with them.

Recommendations:
Continue to utilise the knowledge offered by the 'carer'/relative of the resident, in order to offer a more "home-like" environment definite example of Good Practice.

Healthwatch Hartlepool – West View Lodge Enter and View 19th August 2014

Organisation Four Season Health Care
Site Visited West View Lodge
Contact Name Jayne Dixon
Group Members Phyl Rafferty & Liz Fletcher

Acknowledgements
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer
Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the visit
This visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life for people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic Drivers
- CQC dignity and Wellbeing strategy
- Care homes are a local Healthwatch priority

Methodology
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.
Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.
Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate, other topics such as accessing health care services from the care home. Family members were also spoken to. They explained to everyone they spoke to why they were there and took minimal notes.

Summary of findings
At the time of the visit, the evidence is that the home was operating to a very good standard of care with regard to residents with dementia.

- The personal care appeared good. Residents seemed clean, warm and comfortable. We saw no evidence of dignity not being respected.
- We saw evidence of staff interacting with residents positively and regularly.
- The manager informed us that she booked all staff on Dementia Training courses.
- Residents seemed happy with the food.
- We saw evidence of social activities within the home.
- Staff raised concern about transport

Results of visit:

Environment
We visited the dedicated, specialised dementia unit that is devoted to residents who are living with Alzheimer's or other forms of dementia. The home was clean and there were several areas for the residents to use and walk around. The corridors were free from obstruction. The manager was new to the post and was looking at the signage and carpets in the unit as they were not dementia friendly. There are key pads on all doors to keep residents safe.

Promotion of Privacy, Dignity and Respect
The manager told us that they tried to have a key worker for each resident but there had been staffing issues and sickness levels were high. Staff seemed respectful to the residents during the visit.

Promotion of Independence
There were opportunities for residents to help with small tasks – laying tables and washing up. Residents were taken out by staff and encouraged to exercise.

Interaction between residents and staff
The staff seemed dedicated, compassionate and caring. They were friendly with us and actively listened to the residents. They were calm, patient and empathetic.

Residents
Both representatives spoke to residents and families. We spoke to them in their rooms or in areas within the unit. Residents and staff laughed together and seemed to have a good rapport. Residents told us they were happy with their care. A gentleman who visited his wife daily had managed for a numbers of years to care for his wife at home. He explained that the time had come for her to go into care. He said he was really pleased with the care she had received in the home.

Food

The menus were displayed on white boards. Residents could eat in their own rooms and could eat at different times if they wanted to. Special diets were catered for and residents likes and dislikes taken into account. Staff were trained to help people who had trouble eating.

Recreational Activities
The manager informed us that that the home provides activity plans for all residents. One to one sessions were organised for people with dementia. Activity coordinators take residents out and they often visited neighbouring housing schemes. They used wheelchair taxis but these are rarely available

Involvement in key decisions
The manager said residents and families were always involved in all decisions. All residents have a Care Plan that is reviewed monthly.

Visitors and relatives
Visitors are welcomed anytime and encouraged to eat with relatives. One relative said that staff were always friendly.

Recommendations
To follow the ideas of the manager.

Healthwatch Hartlepool – Wynyard Woods Care Home 9th Feb 2015

Organisation Healthwatch Hartlepool
Site Visited Wynyard Woods (Ideal Care Homes)
Contact Name Kathleen Seigeant (Dep. Manager)
Group Members Maureen Lockwood and Elizabeth Fletcher

Date/Time of visit 2pm Monday 9th February 2015.

Acknowledgements
Healthwatch Hartlepool would like to thank the service provider, service users, visitors and staff for their contribution to the Enter and View programme.

Disclaimer
Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Purpose of the visit
This visit occurred as part of the "Dementia Friendly Communities" initiative which is a national scheme that focuses on improving social inclusion and quality of life of people with dementia in their broader community. A more Dementia Friendly Hartlepool will have improved levels of public awareness and understanding of dementia. The visit was also made to assess the facilities and stimuli offered to the residents with dementia. As part of this process Healthwatch Hartlepool is visiting all care homes in Hartlepool with a view to talking to residents who are experiencing the different stages of dementia together with family members and staff. This work will allow us to identify good practice within the care home setting and any areas in which it is felt that improvements can be made.

Strategic Drivers
- CQC dignity and Wellbeing strategy
- Care homes are a local Healthwatch priority

Methodology
This was an announced Enter and View Visit
We approached a member of management before we spoke to anyone in the care home and took their advice on whether any residents should not be approached due to their inability to give informed consent.

Authorised representatives conducted short interviews with members of staff at the care home. Topics such as quality of care, safety, dignity, respecting and acknowledging the resident's and families' wishes and staff training were explored.

Authorised representatives also approached residents at the care home to informally ask them about their experiences of the home and, where appropriate, other topics such as accessing health care services from the care home. Family members were also spoken to. They explained to everyone they spoke to why they were there and took minimal notes.

Summary of findings
At the time of the visit, the evidence is that the home was operating to an excellent standard of care with regard to dignity and respect with residents who have dementia.

- Care is delivered with understanding, patience and kindness. We saw no evidence of dignity not being respected.
- Regular visits from nominated GP's created confidence and early detection of illness.
- Residents told us they were happy with the food and menus.
- The manager told us that staff received Dementia Training. Most staff received DoLs training.

Summary of Findings:
At the time of the visit, it was evident that the Home was operating to a very high standard of care, with regard to dignity and respect offered to all residents. However, there was a noticeable lack of variety and stimuli for those suffering from dementia.

1. Personal Care appeared excellent – with residents' clothes obviously well cared for. We saw no evidence of dignity not being respected.
2. The home has good rapport with 5 doctor's surgeries and District Nurses provide a ready assistance.
3. Residents told us they were very happy with the food and menus.
4. The Deputy Manager assured us that staff receive "In House" training in Dementia Care (a week of training just completed); they have links with Alzheimers Centre and all staff are given DOL's training.

Results of Visit:

Environment:
This is a 6 year old, purpose built establishment, set in the pleasant area of Wynyard.
There are 50 single rooms, all en-suite and very well appointed. If a couple wished to live here, either 2 adjoining rooms or opposite quarters would be utilised.

The premises were clean, and free from offensive odours. Tastefully decorated lounges, 3 dining rooms and sitting areas afford a variety of space. Snacks and drinks available constantly.
It is policy of the Home to house those with dementia (13) on the upper floor, this is due to concern for safety of the residents.

Staffing levels in this unit were very high; each client has an assigned key worker. A "Restrictive Access Assessment" is kept in residents Care Plan e.g. bedrooms floor sensors etc. It was noted that staff appear to be aware of the needs of their residents and aware of the lack of opportunity to use a secure outside space – in fine weather, staff accompany residents into the grounds of the Home. An effort is made to involve clients in a variety of activities and they enjoy trips out in the mini bus.

Contrasting crockery is used and staff spend time socialising with the residents.
It was felt that clearer signage on bathroom doors together with facilities to stimulate memory, would be useful.

Promotion of Pathway, Dignity and Respect:
Each resident has a Care Plan which is renewed monthly and is part of an ongoing evaluation. Family members are asked to complete a "Life History" form; this provides background of resident and is kept with the Care Plan.
Were a resident to be admitted to hospital, a photocopy of the relevant information from Care Plan, would accompany them. Yellow folders are not used.

Promotion of Independence:
Any resident who wishes, has the opportunity to assist staff in a variety of tasks – table setting, laundry folding, dusting, gardening etc. Some residents have the capacity to go to local shops and collect newspapers.

Interaction between residents and staff:
There appeared to be a mutual respect shown between staff and residents throughout the Care Home.
Within the area for those with dementia, staff were relaxed but aware of the needs of the residents. It was remarked that there appeared to be a general division between one group and the other; coffee and tea breaks were taken with the residents; communication was gentle, firm and understanding and all residents appeared content. (One care assistant remarked that she had noticed a resident looking "a bit down" and over heard her saying to herself "would love a G&T" – after check-up about medications etc. – she had made her a small glass of G&T. – "After all –it is her home!").

Residents:

Both representatives spoke to residents, there were no family members available at the time. There did not appear to be any outstanding issues – it was felt that "staff are wonderful, nothing is a problem". One lady, remarked that she felt "Happy, secure and safe". Another had thanked the staff and been told "It's nothing – we get paid for looking after you".
One resident who has lost her sight – was somewhat agitated because her radio wasn't working too well – she was assured that "The handyman will check it tomorrow".
When enquiry was made about Talking Books, the deputy manager assured us that they were available if requested.

Food:
Residents appeared happy with the choice and standard of food. Kitchen staff produce a wide variety of dishes and this is obviously appreciated – one resident commented that her 'diabetes' was always considered.
If there is a need for residents to have meals in their room this was allowed, but there are three dining rooms which allows a wide choice of seating. Staff felt that it gave an opportunity for people to socialise/mix – and with regard to those with dementia, "I'm not about making people with dementia, feel different".
In the public lounges there were trays with juice, glasses and a bowl of crisps/biscuits.
Liquids were served regularly and jugs of fresh juice in resident's rooms.

Recreational Activities:
We were informed that the owners "Ideal Care Homes" do not employ an activities co-ordinator – however the staff take it upon themselves to create opportunities for social activities. Motivation and "06mph"; (exercise on chairs) guided by staff member; Arts and Crafts day by another member of staff. Several outside agencies visit the Home – "Songs of Praise", Zoo Lab; a quiz is held which is tailored for abilities.
The Home has its own minibus which provides opportunities for day trips. These trips are decided upon by a panel of residents who met on a monthly basis.
It was felt that those with dementia were taken on some of the outings but lost the opportunity to partake in others.

Involvement in Key Decisions:
There is a definite ethos of involvement – from individual members being present at staff interviews – to a number of written surveys, (enclosed) which afford residents and family/carers an opportunity to express their opinions.
Residents are able to see a G.P of their choice – if necessary, and all parties agree, the staff deal with Palliative Care – A designated room for the family/carer is made available.
Staff complete the Deciding Rights documents and on each resident's door, where applicable, there is placed a Red Dot (DNR order in place) or, a Blue Dot

(DOL's). This was felt by the management to be a discreet aid which would allow staff to give the best care and to carry out the wishes if the residents.
The Home is accredited with Gold Standard Framework.

Visitors and Relatives:
Visitors are welcome at any time and may dine with the residents.
Recently, a resident was approaching her 93rd birthday – the family asked whether it were possible to have a party. The family insisted on providing the food but staff decorated one of the lounges and kitchen staff baked a birthday cake. The remark from the resident "It was the best party I ever had – I couldn't sleep for nights!"

Recommendations:
1. It would be an advantage if there were access to secure outside space.
2. More inclusion/stimulation for those with dementia
3. Appointment of Activities Co-ordinator

Good Practice:
1. 'Life History' – completed by family and kept in Care Plan
2. Photocopy of relevant sections of C.P accompany residents to hospital
3. Discreet indication of DNR/DOL's (assists in care).

Home	Good Practice	Type
Brierton	There is a colour code system for end of life care to ensure appropriate levels of care at the right time.	Colours
Brierton	There is a row of shops that resembles a high street to promote social interaction and memory recall.	Stimulation
Charlotte Grange	Rotation of staff so that all staff are known to all residents.	Staff
Charlotte Grange	Home always uses the same bank staff.	Staff
Charlotte Grange	One page resumes of all staff including the manager.	Staff
Dinsdale Lodge	Manager re-enforces daily, the need to respect residents.	Management
Four Winds	Regular visits from nominated GP's – created confidence and early detection of illness.	GPs
Four Winds	It is intended to co-opt residents onto interview panels for prospective members of staff.	Resident involvement
Gretton Court	The home functioned as a true community with everyone's contribution recognised and valued.	Community
Gretton Court	GP interaction prevents crisis situations.	GPs
Gretton Court	"Home from hospital "- Carers visited residents who had been admitted to hospital even helping with feeding. Source of continuity/assurance and residents returned to care homes much quicker.	Home from hospital
Highnam Hall	Pertinent information on resident's doors.	Information
Highnam Hall	Staff numbers are high.	Staff
Highnam Hall	Good rapport between staff and residents.	Staff
Manor Park	Utilised a member of staff who had worked as a 'carer' had him trained as Activity Co-ordinator. He knew the residents well-their abilities and interests – they felt secure with him.	Staff
Sheraton Court	Visitors Board-on wall in resident room -opportunity for comments, observations etc.	Communication
Sheraton Court	Hourly check "Comfort Call" chart kept in red folders in each resident's room.	Information
Sheraton Court	Pro-Active Unit in Dementia Community - awareness of need for stimulation.	Stimulation
Stichell House	Quality Family Forum held over two sessions i.e. morning/afternoon. Allows time for all family members to attend.	Inclusion
Stichell House	Priorities of Care - compiled by residents, family carers and staff - enclosed in Care Plans.	Inclusion
Stichell House	Manager sensitive to stigma surrounding those with limited capacity e.g. Yellow Folder.	Management
Stichell House	Annual Quality of Life Form – completed and any valid suggestions are implemented.	Suggestions

Warrior Park	Continue to utilise the knowledge offered by the 'carer'/relative of the resident, in order to offer a more "home-like" environment definite example of Good Practice.	Staff
Wynyard Woods	'Life History' – completed by family and kept in Care Plan.	Care Plans
Wynyard Woods	Photocopy of relevant sections of C.P accompany residents to hospital.	Care Plans
Wynyard Woods	Discreet indication of DNR/DOL's (assists in care).	Care Plans

	Recommendation	Issue
Brierton	Continue refurbishment to meet the needs of people with dementia.	Refurbishment/Decor
Charlotte Grange	Improve signage to toilets and bathrooms doors.	Signage
Clifton Lodge	When planning refurbishments make sure they meet the needs of residents with dementia.	Refurbishment/Decor
Dinsdale Lodge	Décor to be more “dementia friendly”.	Refurbishment/Decor
Elwick Grange	The findings did indicate that there were sometimes difficulties with Out of Hours Services.	Health Services
Four Winds	Building appeared to be in need of refurbishment.	Refurbishment/Decor
Four Winds	More stimulation and involvement with residents.	Stimulation
Four Winds	Supply a variety of tactile objects, photographs of local area, war years etc.	Stimulation
Gretton Court	Home in need of refurbishment. Manager commented that this is ongoing.	Refurbishment/Decor
Highnam Hall	Home required refurbishments.	Refurbishment/Decor
Highnam Hall	More stimulation for people with dementia.	Stimulation
Highnam Hall	Signage and adaptations for people with dementia.	Signage
Lindisfarne	To plan any refurbishment to meet the needs of all residents including those with dementia.	Refurbishment/Decor
Lindisfarne	The Manager to find out about the Dementia Friendly Hartlepool Group.	Management
Lindisfarne	The manager to find out about the Teesside Dementia Alliance.	Management
Manor Park	The findings did indicate that the opportunity to take residents out is sometimes a problem due to lack of suitable transport.	Transport
Park View	Continue refurbishments.	Refurbishment/Decor
Queens Meadow	The findings did indicate that there was a lack of opportunities for varied interests.	Stimulation
Seaton Hall	Develop a more “Dementia Friendly” environment.	Refurbishment/Decor
Seaton Hall	Make small scale improvements e.g. purchase coloured crockery.	Colours
Seaton Hall	Improve signage, flooring and colour schemes as part of the maintenance programme.	Refurbishment/Decor
Seaton Hall	Employ an Activities Co-ordinator.	Stimulation
West View Lodge	To follow the ideas of the manager.	Management
Wynyard Woods	It would be an advantage if there were access to secure outside space.	Outdoor Space
Wynyard Woods	More inclusion/stimulation for those with dementia.	Stimulation
Wynyard Woods	Appointment of Activities Co-ordinator.	Stimulation