HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

Friday 11 September 2015
at 10.00 a.m.
in Committee Room 'B'
Civic Centre, Hartlepool.

MEMBERS: HEALTH AND WELLBEING BOARD

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors C Akers-Belcher, Richardson, Simmons and Thompson.
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group (2) – Dr Schock and Alison Wilson
Director of Public Health, Hartlepool Borough Council (1); - Louise Wallace
Director of Child and Adult Services, Hartlepool Borough Council (1) – Sally Robinson
Representatives of Healthwatch (2). Margaret Wrenn and Ruby Marshall

Other Members:
Chief Executive, Hartlepool Borough Council (1**)** – Gill Alexander
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council (1) – Denise Ogden
Representative of the NHS England (1) – Vacancy
Representative of Hartlepool Voluntary and Community Sector (1) – Tracy Woodhall
Representative of Tees, Esk and Wear Valley NHS Trust (1) – Martin Barkley
Representative of North Tees and Hartlepool NHS Foundation Trust – Alan Foster
Representative of Cleveland Police, ACC Simon Nickless.

Observer – Statutory Scrutiny Representative, Hartlepool Borough Council, Councillor S Akers-Belcher

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

3.1 To confirm the minutes of the meeting held on 3 August 2015

4. **ITEMS FOR DECISION**

4.1 Draft Healthy Weight Strategy for Hartlepool – *Director of Public Health*

5. **ITEMS FOR INFORMATION**

5.1 Immunisation Presentation – *Director of Public Health*
5.2 Scrutiny Investigation into Cardiovascular Disease (CVD) – Action Plan - *Director of Public Health*
5.3 HealthWatch Hartlepool Investigation of Good Practice Examples in the Care and Support of Residents with Dementia in Hartlepool Care Homes – *Healthwatch Hartlepool*

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

Date of next meeting – 5 October 2015 at 10.00 a.m. at the Civic Centre, Hartlepool.

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

3 August 2015

The meeting commenced at 2.00 pm in the Civic Centre, Hartlepool

Present:

Councillor C Akers-Belcher, Leader of Council (In the Chair)

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors Jim Ainslie (substitute for Councillor Simmons), Carl Richardson, and Paul Thompson
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group (2) – Dr Schock and Alison Wilson
Director of Public Health, Hartlepool Borough Council - Louise Wallace
Director of Child and Adult Services, Hartlepool Borough Council – Sally Robinson
Representatives of Healthwatch – Ruby Marshall and Margaret Wrenn

Other Members:
Representative of Hartlepool Voluntary and Community Sector – Tracy Woodhall (also in attendance as Chief Executive, Hartlepool and District Hospice in relation to agenda item relating to Breathlesssness Support Programme
Representative of Tees Esk and Wear Valley NHS Trust – David Brown (substitute for Martin Barkley)
Representative of North Tees and Hartlepool NHS Foundation Trust – Alan Foster
Representative of Cleveland Police – ACC Simon Nickless

Also in attendance:-
Hartlepool and District Hospice, Deputy Chief Executive, Sandra Britten
Healthwatch – L Allison, J Gray, G and S Johnson
Public – J Clayton, E Leck, S Leighton

Hartlepool Borough Council Officers:
Neil Harrison, Head of Service
Amanda Whitaker, Democratic Services Team

11. Apologies for Absence

Elected Member, Hartlepool Borough Council – Councillor Simmons
Chief Executive, Hartlepool Borough Council – Gill Alexander
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council –

Denise Ogden

12. Declarations of interest by Members

Cllr Ainslie declared a personal interest in agenda item 5.4 – Breathlessness Support Programme – as trustee of Hartlepool and District Hospice.

13. Minutes

The minutes of the meeting held on 22 June 2015 were confirmed.

Minute 9 – Community Based Urgent Care Update – the Chief Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group, advised the Board that NHS England had decided to review some standards and had asked all Clinical Commissioning Groups to pause the procurement process until the review had been completed. The Chair of the Board requested that regular updates be provided to the Board.

14. Improving Clinical Standards – Implications from the Dalton Review (*Chief Officer, NHS Hartlepool and Stockton- on- Tees Clinical Commissioning Group*)

The Board received a report which provided an appraisal on the outcome of the Dalton Review 'Examining new Options and Opportunities for the Providers of NHS Care', a copy of which was appended to the report. The report was supported by a presentation by the Chief Officer. The Board was advised of the background to the review, the conclusions of the review and the local implications in relation to improving clinical standards.

The 'Dalton Review' had included a series of recommendations to national bodies, Clinical Commissioning Groups, Trust Boards and NHS leaders. There was an expectation that leaders in the NHS with their partners would consider the review recommendations and how these might support solutions that reflected local circumstances. The Board had received previously reports on the Securing Quality in Health Services (SeQHIS) project and received an update of the progress with SeQUIS at the meeting. It was highlighted that the Dalton Review would be helpful in considering the organisational changes required to deliver robust and sustainable services in the future.

Board Members debated issues arising from the presentation. During the debate, the implications of a statement by the Secretary of State for Health were discussed with reference to the extension of cover by Consultants to provide health care 24/7, 365 days year.

Board Members acknowledged issues raised in relation to the functions of voluntary and charity organisations. The significance of public engagement was recognised also and the Chief Officer provided an assurance that genuine public engagement was pertinent.

Decision

The report was noted.

15. Local Health and Social Care Plan (*Chief Executive*)

The Board was informed that at the Council meeting held on 25th June 2015, an update had been received on the development of a plan for submission to NHS England to see the delivery of integrated health and social care services from the hospital site. In taking forward the wishes of Council, it had been proposed that a Hartlepool Local Health and Social Care Plan Working Group be established; the draft terms of reference for the working group had been circulated to the Board.

Recognising the comments made earlier in the meeting regarding the engagement process including the role of the voluntary and community sector, attention was drawn to details of the membership of the Working Group. It was highlighted that there was scope in the terms of reference to involve 'other interested parties'. There was interest expressed by the Assistant Chief Constable in representation by Cleveland Police in the Working Group. Opportunities arising from the Working Group were recognised by Board Members.

Decision

The report was noted.

16. Learning Disability Update – Tees Integrated Commissioning Group (*Director of Child and Adult Services*)

The Board was provided with an update on progress in relation to the Tees Integrated Commissioning Group action plan for adults with learning disabilities. The Board was informed of the background to the establishment of the group, details of the terms of reference for the Group. The proposed action plan for 2015/16 had been appended to the report. Progress on previous actions was presented to the report together with associated risks and details of the establishment of a regional Transformation Board to support 'fast track arrangements'.

Decision

The Board noted progress on actions to date and updates on recent developments and agreed to receive further reports in due course.

17. Breathlesssness Support Programme (*Chief Executive, Hartlepool and District Hospice*)

The Board received a report and presentation which provided an appraisal on the Breathlessness Support Programme Pilot which had comprised 9 x 6 week programmes with the final programme ending on 23 March 2015. The Board was presented with the progress and benefits that the service had brought both to the patients and the health economy. The presentation by the Chief Executive and Deputy Chief Executive of the Hospice included an evaluation of the Core Aims of the Programme.

The Chief Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group, advised the Board that the programme was one of a number of initiatives funded by the CCG. Details were provided of a number of those projects. The Breathlessness Support Programme presentation had been useful insight that the CCG would consider in conjunction with the other initiatives.

During the discussions arising from the report, a member of the public referred to her personal experience of COPD. The Chair of the Board requested that a report be submitted to a future meeting of the Board relating to respiratory disease in Hartlepool. In response to concerns expressed regarding implications of air pollution, the Director of Public confirmed this would be addressed in the report to be submitted to the Board on respiratory disease.

Decision

(i) The report and presentation were noted
(ii) It was agreed that a report be submitted to the Board relating to respiratory conditions in Hartlepool.

18. Director of Public Health Annual Report 2014/15 (*Director of Public Health*)

The Director of Public Health reported the requirement for the Director of Public Health to write an Annual Report on the health status of the town and the Local Authority duty to publish the annual report as specified in the Health and Social Care Act 2012.

The Director of Public Health Annual report 2014/15 focused on the issues relating to health and work. The report concluded that there was a positive relationship between health and work and reflected the work of Professor Sir Michael Marmot, who concluded in The Marmot Report 2010, to seek to ‘create fair employment and good work for all’.

Decision

The report was noted.

Meeting concluded at 4.00 p.m.

CHAIR

HEALTH AND WELLBEING BOARD

Friday 11 September 2015

Report of: Director of Public Health

Subject: DRAFT HEALTHY WEIGHT STRATEGY FOR HARTLEPOOL

---

1. PURPOSE OF REPORT

1.1 To present to the Health and Wellbeing Board, a proposed 10-year Healthy Weight Strategy for Hartlepool (attached at **Appendix A**), and the associated Action plan to support its implementation (attached at **B**).

2. BACKGROUND

2.1 At the Health & Wellbeing Board meeting on 11 August 2014, it was requested that a Childhood Obesity Strategy for the town be developed, to set out an approach to tackling rising levels of overweight and obesity among young people in Hartlepool. This was in response to data from the National Childhood Measurement Programme, which highlighted that 25.6% of children aged 4/5 and 38.7% of children aged 10/11 are carrying excess weight (compared to 22.5% of 4/5 year olds and 33.5% of 10/11 year olds nationally).

2.2 A town-wide obesity conference was held in February 2015, in order to bring together key stakeholders and services that have a significant role to play in the obesity agenda, including Elected Members and the wider community. The aim of the conference was to highlight areas of good practice, identify gaps in provision, establish what more key partners can do around the agenda, and highlight key actions and areas for strategic focus.

2.3 Following the conference, a steering group was established from members of the Hartlepool Healthy Weight Healthy Lives Strategic Group, to analyse the findings from the conference, consider the existing evidence and good practice, and develop a proposed healthy weight strategy and action plan for the town.

3. PROPOSALS

3.1 It is proposed that the healthy weight strategy takes a longer-term view of the obesity issue and details three key strategic themes covering primary, secondary and tertiary prevention, each with specific objectives to be tackled over a 10-year period.

3.2 It is also proposed that the strategy takes a whole-systems approach to the issue across the full life course, and as such, also addresses obesity in adults and the wider family unit, as evidence suggests children who are overweight or obese are more likely to become obese adults (National Obesity Observatory).

3.3 There is also the fact that many key decisions around nutrition, physical activity and wellbeing in early life are taken by the parents rather than young people themselves – a child with one obese parent has a 50% chance of being obese. When both parents are obese, their children have an 80% chance of obesity (Kral & Faith, 2009) – hence a life course approach is needed to tackle the issue effectively.

3.4 The overall strategy aims to "narrow the gap in child and adult obesity levels between Hartlepool and the regional and national average, and secure a sustained downward trend in levels of obesity in children and adults in Hartlepool by 2025."

4. RISK IMPLICATIONS

4.1 There is a risk that without a clear and robust strategy for tacking obesity in Hartlepool, rates may continue to rise in both children and adults, leading to a greater strain on health and social care systems within the Local Authority and the NHS.

5. FINANCIAL CONSIDERATIONS

5.1 In order to fulfil the actions and objectives within the strategy, there will be a need to identify funding sources or access existing budgets for specific projects and initiatives. Where possible, this will be sourced from existing budgets and funding streams, and achieved by more efficient and collaborative working arrangements between partners.

6. GOVERNANCE ARRANGEMENTS

6.1 Due to the strategy covering a 10-year period, there will be a need to have robust governance and regular monitoring arrangements in place. It is proposed that a 6-monthly progress report in relation to the objectives and actions within the strategy is provided to the Health & Wellbeing Board.

6.2 Once approved, further work will be undertaken with key partners and stakeholders to agree realistic timescales for completion of the actions within the strategy. Content of the 6-monthly updates will then focus on the progress of those most pertinent actions.

7. LEGAL CONSIDERATIONS

None

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

None

9. EQUALITY AND DIVERSITY CONSIDERATIONS

None

10. STAFF CONSIDERATIONS

None

11. ASSET MANAGEMENT CONSIDERATIONS

None

12. RECOMMENDATIONS

12.1 It is recommended that the Health and Wellbeing Board:

i) Consider the draft Health Weight Strategy 2015-2025 and Action Plan;
ii) Subject to any feedback or comments, agree the content of the draft Healthy Weight Strategy and Action Plan;
iii) That the Strategy and Action Plan be referred to partner governing bodies, with a view to seeking support for its adoption and implementation;
iv) That responsibility for the implementation of the Strategy be referred to the Hartlepool Healthy Weight Healthy Lives Strategic Group;
v) That the membership of the Hartlepool Healthy Weight Healthy Lives Strategic Group be reviewed/extended to ensure that those involved are in a position to take forward all required actions within their respective organisations / bodies; and
vi) That the Hartlepool Healthy Weight Healthy Lives Strategic Group report progress against implementation of the Strategy to the Health and Wellbeing Board on a 6 monthly basis.

13. BACKGROUND PAPERS

(i) National Obesity Observatory – Health risks of childhood obesity: https://www.noo.org.uk/NOO_about_obesity/obesity_and_health/health_risk_child

(ii) Influences on Child Eating and Weight Development from a Behavioral Genetics Perspective (Kral & Faith, J Pediatr. Psychol., 2009)

14. CONTACT OFFICER

Louise Wallace
Director of Public Health
Hartlepool Borough Council
louise.wallace@hartlepool.gov.uk

HEALTHY WEIGHT STRATEGY FOR HARTLEPOOL 2015-2025

Introduction

This document describes a strategy for reducing excess weight and maximising the proportion of individuals who achieve and maintain a healthy weight in Hartlepool. Excess weight has been identified as an issue both nationally and locally because it is associated with a significantly increased risk of health problems. At a population level, obesity results in a major increase in chronic diseases, leading to distress, sickness, and an unsustainable burden on health and social care systems.

We outline our strategy for Hartlepool with a social and physical environment conducive to healthy weight, together with our strategic aims and objectives around reducing excess weight.

The following healthy weight strategic themes are:

1: To transform the environment so that it supports healthy lifestyles (Primary Prevention)

2: Making healthier choices easier by providing information and practical support (Secondary Prevention)

3: Services – To secure the services needed to tackle excess weight (Tertiary Prevention)

The scale of the challenge

As a nation each generation is becoming heavier (passive obesity), with weight creeping up without us consciously realising it so that obesity is now a global epidemic[1]. Reducing obesity is a national aim[2] and a local priority. However, there needs to be a shift in focus to healthy weight in its widest sense and not solely obesity treatment, which is a symptom of the underlying factors that need addressing i.e. poor nutrition and physical inactivity.

What do we mean by healthy weight?

'Healthy weight' is the term used to describe an individual whose height and weight is proportional and falls within defined parameters where the risk of ill-health (due to weight) is at its lowest. Those individuals above (overweight or obese) or below (underweight) a healthy weight are at increased risk of adverse effects on their health and wellbeing during childhood, adulthood and later life.

Factors affecting weight

In simple terms, the balance between the food we consume (calories) and energy we use through our metabolism and physical activity (metabolic equivalent) is known as the 'energy balance'. An imbalance in this equation can cause weight gain or weight

[1] Foresight, 2007
[2] DH, 2011

loss and if balanced, weight maintenance. There are many different contributory factors contriving to affect an individual's weight, including the so-called 'obesogenic' environment.

Engagement with communities

Communities have numerous assets (people, places, insight etc.) that are crucial when addressing health inequalities and improving health. Successful engagement and empowerment of communities will ensure that the resources within them are understood and utilised, achieving maximum benefit and successes that a top down approach to tackling healthy weight would not achieve.

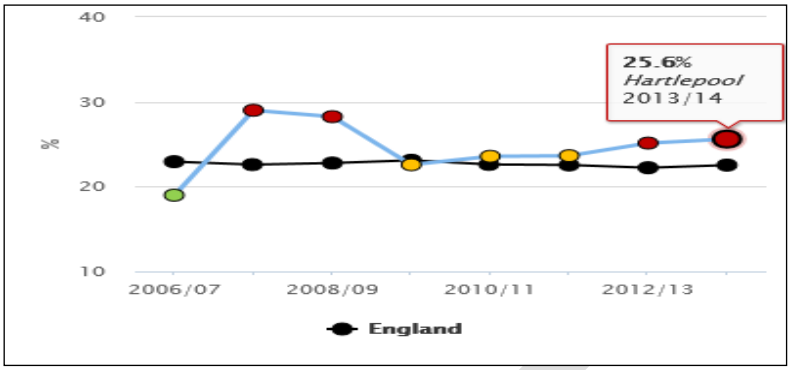
Multi-factorial strategies to create substantive changes to re-engineer the obesogenic environment and challenge and change social and cultural norms will be required to tackle excess weight effectively. This is a crucial challenge in public health and strong, resolute, resilient and sustained political support and leadership in the face of potentially challenging conflicts with existing priorities and perspectives is required to affect wide reaching and novel approaches to this major political issue in respect of its economic considerations.

Statistical Drivers

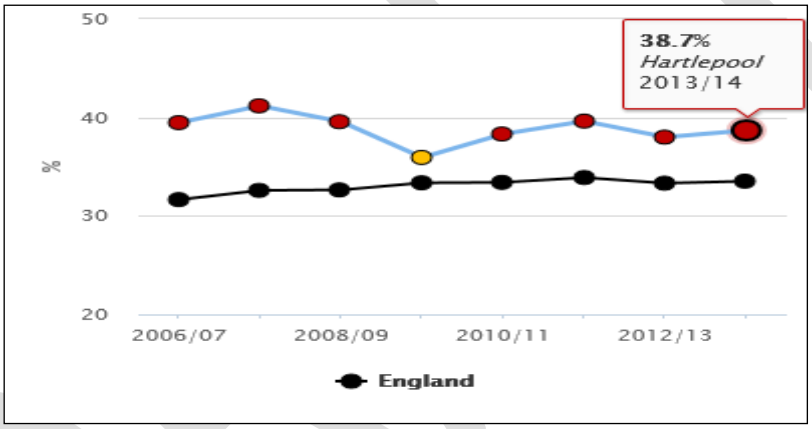
The Foresight report suggests an increase in the prevalence of obesity among people aged under 20 to around 15% by 2025. The proportion of boys having a healthy BMI will be 45% while for girls only 30% will be in the healthy weight category (Government Office for Science, 2007).

Percentage of children predicted to be obese by age and sex, England, 2004 and 2025			
Gender	**Age**	**2004**	**2025**
Boys	6-10	10%	21%
	11-15	5%	11%
	All under 20	8%	15%
Girls	6-10	10%	14%
	11-15	11%	22%
	All under 20	10%	15%

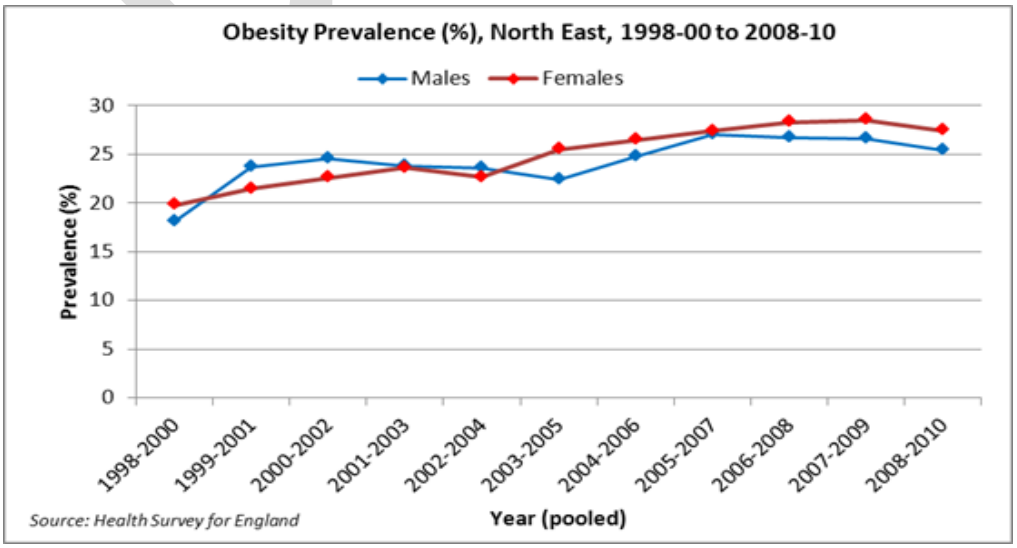
Children (Reception)	Overweight	Obese	Combined
England	13.0	9.5	22.5
North East	14.0	10.4	24.4
Hartlepool	14.4	11.2	25.6



Children (Yr6)	Overweight	Obese	Combined
England	14.4	19.1	33.5
North East	15.0	21.1	36.1
Hartlepool	14.3	24.4 (highest in region)	38.7 (highest in region)



Adults	Overweight	Obese	Combined
England	40.8	23.0	63.8
North East	42.1	25.9	68.0
Hartlepool	37.9	30.6 (highest in region)	68.5



Hartlepool Healthy Weight Conference 2015

In February 2015, a Healthy Weight, Healthy Lives – Tackling Obesity in Hartlepool Conference took place. Stakeholders including weight management services users, residents, Elected Members, young people, healthcare professionals, council officers, schools, voluntary sector agencies, community organisations and academics were invited to take part. After 'setting the scene' presentations, a 'cafe' style consultation took place and the event ended with a series of workshops covering the following themes:

- The role of clinical health services
- Raising the issue of obesity
- What more can schools do to play their part?
- Obesogenic environments
- Engaging teenagers (making it 'cool') – led by young people
- Active travel/physical activity

The outcomes of the workshop and 'cafe' consultation are included in **Appendices 1 and 2**.

A group of relevant stakeholders met in March and April to consider and develop the learning from the conference and start to develop the strategy and action plan. The agencies represented included:

Health Visiting – North Tees and Hartlepool Foundation Trust
School Nursing - North Tees and Hartlepool Foundation Trust
Public Health – Hartlepool Borough Council
Educational Psychology – Hartlepool Borough Council
Children's Centres – Hartlepool Borough Council
Youth Participation – Hartlepool Borough Council
Commissioning – Clinical Commissioning Group
Planning – Hartlepool Borough Council
Chief Executives Department
The information gathered from these meetings is included in **Appendix 3**.

Policy context and key documents

Over the last few years, the government has developed a number of policies to demonstrate its commitment to addressing the increasing population problem of obesity, and the associated risks of developing cardiovascular disease, Type 2 Diabetes, cancers, and many other health conditions which result in increased ill health and escalating costs to society if no action is taken.

NICE Guidance on each of these disease specific areas as well as Public Health guides to improving health provides direction to support this strategy.

Healthy Lives Healthy People – A call to action on obesity in England (2011) outlines National ambitions;

- A sustained downward trend in the level of excess weight in children by 2020; and
- A downward trend in the level of excess weight averaged across all adults by 2020

And overall a shift in focus;

- From Obesity to Excess Weight to highlight the health issues of overweight;
- From the focus on children to a life stage approach including adults as an influence on children as part of a family;
- From individual choice alone to prevention through a supportive environmental change; and
- A greater emphasis on the psychosocial aspects of weight management.

Marmot suggests a proportional universalism and life course approach, which will be incorporated into the action planning, as whilst excess weight is more prevalent in deprived areas it is a condition which affects all social gradients.

Hartlepool's Health and Wellbeing Strategy 2013-2018, supports the ten themes of *Better Health, Fairer Health* (2008), of which obesity is a key component. Obesity also features heavily in Hartlepool's Joint Strategic Needs Assessment and was identified as a fundamental factor in improving the health and wellbeing of Hartlepool residents by the town's Health and Wellbeing Board. This prompted the development of a Healthy Weight Strategy for Hartlepool 2015-2025, with key documents utilised in its development outlined in **Appendix 4**.

Key partners and responsibilities

Hartlepool Borough Council will take strategic leadership of the Healthy Weight Strategy, but in order to address the issue of obesity effectively, it will require all partners to pull in the same direction and work in partnership to address the challenges highlighted within. It is envisaged that a wide range of services and partners will be engaged including:

- Hartlepool Borough Council
- North Tees and Hartlepool Clinical Commissioning Group
- North Tees and Hartlepool NHS Foundation Trust
- Public Health England
- Schools and school governors
- General Practices
- Pharmacies
- Young people
- Community and Voluntary Sector
- Providers of weight management services
- Retailers
- Employers
- Sports and leisure providers and clubs

Overall aim/vision:
To narrow the gap in child and adult obesity levels between Hartlepool and the regional and national average, and secure a sustained downward trend in levels of obesity in children and adults in Hartlepool by 2025.

Key themes:

Strategic Theme 1: Universal – To transform the environment so that it supports healthy lifestyles (Primary Prevention)

a. Planning and retail: Work with partners to improve access to healthy food options and remove barriers to adopting a healthy diet (incorporating takeaway licensing, access to healthy food outlets and facilitating cooking on a budget)
b. Physical activity: improve access to green spaces for health and exercise reasons (removing the traditional barriers to physical activity)
c. Travel and infrastructure: create a more supportive environment for cycling and walking to improve rates of active travel in schools, workplaces and communities (including reduced car use, school parking restrictions and 20mph zones)

Strategic Theme 2: Preventative – Making Healthier Choices Easier by providing information and practical support (Secondary Prevention)

a. Develop a social marketing and communications plan for Hartlepool to promote and facilitate a healthy weight and lifestyle (incorporating social media, wellness campaigns, supporting national and regional communications and improving promotion and awareness of new technologies for health)
b. Ensure obesity is tackled by early intervention through improved training and awareness for front line staff and in communities (incorporating Making Every Contact Count, brief intervention skills and better signposting to services)
c. Ensure that tackling obesity is a key priority as part of the planning and implementation process for the Hartlepool Vision (including Health Impact Assessment of new developments, creating healthier communities and removing barriers to health)

Strategic Theme 3: Services – To secure the services needed to tackle excess weight (Tertiary Prevention)

a. Create an integrated pathway of support, driven by GPs and Primary Care, to improve accessibility into healthy weight services (creating a clear obesity pathway, more joined up services and referrals and better links with clinical services)
b. Support schools and children's centres to develop a 'Curriculum for Life' which promotes a healthy weight and lifestyle from an early age (targeting breakfast and after school clubs, support for school governors, education around life skills, cooking for families and school meals provision)
c. Ensure healthy weight services are part of the vision for the provision of a Hartlepool 'Health and Social Care Plan' (embracing the Better Care Fund, holiday hunger, better childhood programme and more integrated models of community support hubs with a whole-family approach)

Appendix A(1)

OUTCOME OF THE CONFERENCE WORKSHOPS

Workshop 1 - Role of clinical health services

- How well connected are the correct services and the overall pathway? How will/do people access?
- Explore wellness model – how can GPs play a part/role?
- Specialist W.M. Service – surgery
- Lack of dietary/emotional support pre and post surgery
- Bariatric surgery as a last resort
- Lack of communication around negative aspects to tier 4 and ongoing support needed

Connectivity – We have been through huge change in the last two years which is why this conference is timely. Connectivity is not there at present and we need to understand how we get hold of the right people at the right time and what they have to offer. We have new capacity in the system and it is important people are aware of this.
Services – If you feel that you are seeing people that are inappropriately coming into your service and another service would have been the right one that is a really important thing to feed back. Probably feeding it back directly to the referrer is the correct thing to do. This is a difficult one and relates back to connectivity.
Clinicians – Commissioning is very complicated but one of the really positive things is that we do have more clinicians involved in all the discussions around services and they can and do influence how investment is made in resources.
Shared records – It might not be possible to always join up services but shared records, which don't really exist across the system, would help people work off the same record and help people doing interventions to see what had happened previously. (I think this was raised in relation to a point that had been made earlier about the loss of contact between Health Visitors, School Nurses etc.)

Points raised:

i) For the Childhood Obesity Strategy to be a key element of an overarching wellness model;
ii) To consider the interface between Tier 3 and 4 interventions in the development of a long term service specification;
iii) To examine of the role of GP's as part of primary care interventions;
iv) To recognise the breadth of activities already in place when looking at what more can be done to provide improved and sustainable outcomes, for service users in Hartlepool.

Workshop 2 - Raising the issue of obesity

Issues raised:
- Is there a sensitive way to raise the issue?
- Often the issue is an ultimatum and can either put people off or scare them into change
- Cycle of change and behaviour
- Social stigma of slim vs obese is a barrier

- Needs more emphasis on positive aspects of weight loss and individual gains rather than negatives
- Need to ensure people are in the right frame of mind
- Emotional support often needed
- More opportunities with H.T. clinics in GP surgeries
- Could cooking skills be incorporated?

Issues:

- Confidence in raising the issue with others
- Often dependant on role or client as to approach taken
- Good and bad experiences
- Stigma, offence, criticism
- Empathy needed
- What are the underlying issues – time, finances
- Need for planning and appreciation of wider factors and influences
- Need to work with grandparents as well as parents
- Brief intervention skills – as little as 30 seconds (to plant seed)
- Assessing readiness for change – clients need to make own choices
- Ask/advise/act/always – brief intervention model

Other issues:

- Health Trainer service not always signposted to from other services
- HT service offer family sessions? Keeping the weight off – FAMILY PROVISION
- Cost of council gym an issue – car parking expensive
- Lack in provision for teenagers – need something similar to health trainer programme
- Schools – food education around where certain foods come from
- HT takeaway resources mentioned – would be useful to educate children about fats in school dinners
- Social media apps – pregnancy, birth and beyond, 4 week parent craft, early intervention

Workshop 3 - What more can schools do?

- Free breakfast provision evaluation (Blackpool)
- Interventions with combined approaches – integration – sustainable change
- Techniques for children to choose healthier options – branding
- How can academic research and understanding be duplicated locally?
- School readiness and transition – impact and educational achievement
- Food banks and influence on children

Points raised:

- Visual resources (such as test tubes with sugar, fat, salt in etc) good use for school children and adults to get an idea of what is in the food)
- If this is discussed in schools then children can pass on the information to parents at home
- Visual resources are also used in training packages to train teachers
- School dinners in Hartlepool are now colour coded but it would also be interesting to look at nutritional value

- One of the problems we have (society as a whole) is that devise tools to help solve problems but then they just sit on a shelf and people don't use them.
- Look at ways to embed messages into school day, integrate initiatives into day
- Draw on practice across Hartlepool to look to see what is working
- If had an unlimited pot of money then would not put all money into one provision but a range of provisions / spread the money out
- Breakfast Clubs – just feeding people does not change anything, need to look at types of breakfast clubs i.e incorporated into reading clubs for example, start of school day etc
- Hartlepool has a 'kick start' breakfast provision, which forms part of the socialism of the school day, which does not take up curriculum time. A trolley is provided for children to pick their breakfast. The introduction of breakfast provision has increased children's punctuality at school on a morning. Good idea to introduce colour coding on breakfast also.
- Generally find with breakfast provision that educational attainment and achievement does increase. Working on report around breakfast clubs, will share with Council in April, which looks at key things that are working
- Not every model fits all i.e. not everyone eats at a table, some people eat breakfast later
- If children have breakfast at 6.30am, they peak at 8.30am, which is not good when school starts at 9am
- Breakfast clubs can become a learning model also
- School dinners will not conquer obesity alone, you need a holistic approach for example, active travel, physical activity.
- In Redcar tokens are provided free to go swimming but only 20 families took part. It was discovered that take up was low because people had to arrange transport. If going to put on a provision then it needs to be easy for people to access
- Departments across the Council are working in silos, needs to be a joined up approach
- Need to look at area and the problems and look how to embed activities into learning i.e using fruit to measure in maths, walking around the classroom, look to learn information in a better way
- It is about changing attitudes, for example, some children do not know how to hold a knife and fork
- HBC introduced colour coding because children were not choosing the correct food groups and HBC received criticism for not educating school children on what to eat
- It is also about changing mind set of staff. Starting to get positive feedback from schools on the colour coding.
- Businesses starting to sponsor breakfast clubs. It is about empowering communities to make informed choices.
- Breakfast provision is not just about tackling inequalities, for example, working parents rely on breakfast clubs to drop children off before they go to work.
- There are examples of excellent pockets of work across the Council but it needs to be joined up. All services doing individual things to tackle obesity but people need to discuss with each other. This was also what was found in Blackpool, lots of provision but not joined up.
- You can teach children a huge amount but the parents buy the food/do the shopping, therefore it is important that the message is communicated home.
- When the services / activities / messages are joined up that's when you will see a cumulative impact.

- Not about banning pack lunches but it is about making people want to have school dinners
- Every child/family is different it is about looking at bets initiatives and putting them in a coherent plan to drive forward, then adapt and tweak as necessary.
- Concern around 'holiday hunger' – what do children do in school holidays (white paper to be published soon on the issue). Throston once ran a holiday club which provided food over the holiday.
- HBC are introducing interactive whiteboards in order for the children to choose what they want for lunch each day. This cuts down waste and 'end of queue disappointment'. It could also be used as a learning tool, i'e use of different languages.
- Concern over children spending their free school meal entitlement at the break time service? Unsure what can be done about this?
- Need to be aware of what is happening in the community and not to give out mixed messages through summer holidays, need a coherent message across community.
- Need a holistic approach, can't just focus on food, have to focus on physical activity etc. You need different initiatives to scaffold onto each other.
- HBC trying to get schools to use pupil premium to fund breakfast provision.
- Need to educate - children can make individual choices. i.e 'grab a bag' lunch if children do not want to wait in a queue.
- Concern that the introduction of Universal Credit will make things worse.
- Carry out a Social Return on Investment (SROI) for breakfast provision to find out value, you know if something is working, if the class is engaged and can get evidence from SROI.
- Breakfast clubs can reduce family stress, increase punctuality; energy levels are reduced because children are not having fizzy drinks before school.
- Nursery staff can give out information.
- Look in Hartlepool at LEP funding, tie in up skilling of the work force (i.e secondary school children) – if eat healthy you will have better outcomes.
- Use the colour coding system right across the school day and the next step is to disseminate information home to parents.
- If breakfast club is not introduced right, it will have a stigma attached.

Workshop 4 - Obesogenic Environments

- Barriers to P.A. and build environment
- Public Protection – take away and catering providers – how to influence
- Need for small changes to make healthier takeaway / fast food
- Tax subsidies on healthier ingredients?
- Small unnoticeable changes to allow healthier cooking practices
- Ratios on takeaways in certain areas – over concentration in some areas
- Implement planning conditions on healthy options? Providing healthier options as an incentive

Points raised:

- Can we control opening hours especially around school so that children do not have as many opportunities to access unhealthy establishments.
- We should not allow takeaways near schools, too much temptation for children going too and from school. Shops selling unhealthy food such as pastries were also frowned upon as it was recognised that children often attend them. Success

has been seen when children attend breakfast clubs as they no longer visit a shop before school.

- Would it be possible to only allow healthy food shops close to schools (comment by a primary school pupil)
- Could we allow takeaways if they followed certain rules i.e had day time opening and healthy menus. Discussed that this is not in policy at the moment and is not something we can do but it will be looked at further to see if there is anything along these lines that can be done.
- The mid range age group of children are disadvantaged, there is very little for them to do, spaces are locked up early but children can still play out until around 9pm in summer yet where can they go?
- There are not enough cycle ways in the borough, they should be part of planning applications and the cycle parking facilities are poor so it`s not an enjoyable experience.
- No space on footpaths for buggies as cars park all over pavements, this makes walking undesirable as it can be difficult and this off putting
- We should not allow catering vans outside school – discussed that they may operate for 15 minutes and then must move on, if they are there longer than 15 minutes they need a licence. Attendees were advised to report any catering vans, however there was a slight hesitation as one particular resident did not want to be the person to report a catering van and in a sense spoil others fun. Discussed that, what do people think is acceptable and if they disagree will they act upon it?
- Could businesses work together to buy healthier options i.e low fat cheese in bulk (an economies of scale approach) this could reduce bills and ensure that lots of establishments are providing healthier options. Is this something HBC could help facilitate?
- Could we have traffic lights system on takeaways so people know what options are healthier – discussed that at this time funding is not available to test all the food on a menu as it can cost £100 per food item test and some menus have over 100 items. The traffic lights system may be something for the future.
- How can we get businesses on board, why would they improve recipes if they are already making a profit and doing well, what is in it for them? Discussed that it is likely to be a cost factor, businesses will want to see some cost benefit. So if they reduce salt in meals, they use less so spend less. But some better oils can be more expensive so it's not an easy task.
- Are we tackling HBC businesses i.e Inspirations coffee shop? Discussed that Inspirations is not being looked at this point in time, but maybe in the future. Discussed that a lot of work has been done in the schools

Workshop 6 - Active Travel / Physical Activity

- How can people be influenced to choose active journeys?
- Support to meet physical activity recommendations
- Promotion of walking for health programme and Summerhill
- Education around cycle journeys and routes
- Walk about in Hartlepool: 500 walkers/week – 8 groups (5 community based)
- Progressive for different abilities/families
- Possible links to other groups and promotion e.g. Unison
- Street Life app – links to Facebook – getting walkers together – use social media to bring community together – via Big League website etc – bringing people together and setting up new groups

Points Raised:

- Some cyclists are irresponsible. They ignore road signs and the Highway Code.
- No cycle lane visible at Seaton promenade (no definite lines) and lots of groups riding fast. (don't walk on prom any more)
- Need safe links to cycle paths to create a network of safe routes
- Dimmed LED lights make cycling dangerous after dark
- Is there room for more involvement from Sustrans?
- Links between transport and cycle routes.
- Have we asked children and young people what activities they would like to take part in? Could there be consultations with the primary schools
- Free exercise opportunities
- 'Streetlife' – people want walking
- Something in Hartlepool for everyone (50% of ward has long term conditions)
- Swimming – entice people into swimming – manage need – GP referral scheme
- Long term issues
- 2 year old – me time and parent academy Rossmere and Hindpool

Healthy Weight Strategy for Hartlepool

Strategic Theme 1: Universal – To transform the environment so that it supports healthy lifestyles (Primary Prevention)

Outcomes from the Obesity Conference:

Connectivity – How we get hold of the right person at the right time and what they can offer. We have the capacity in the system and people need to be aware of it.

GP's – Examine the role of GP's as part of the primary care interventions and how they can be part of the overall wellness model.

Childhood obesity strategy – A key element of an overarching wellness model.

Obesogenic environments – Control of opening hours / licensing takeaways / locations / max number of takeaways – planning issues.

Retail – Need to involve and work with to promote healthy eating.

Active travel – Increase / promote cycling and walking in the town.

Schools – Prevention and treatment (i.e. breakfast clubs, school meals).

Strategic Theme 2: Preventative – Making Healthier Choices Easier by providing information and practical support (Secondary Prevention)

Outcomes from the Obesity Conference:

Connectivity – as above.

Recognising the breadth of activities – Need to recognise what is already in place when looking at what more can be done.

Sharing of records – Need for joined up services and sharing of information is essential.

Equipping – Need to equip people to make the right decisions.

Retail – as above.

Lobbying – Licensing / Sugar Tax?

Other facilities outside schools – Healthy eating food vans.

Food banks – promote Healthy eating or wider support services?

Education – Schools do a lot but can have significant role in education parents through children – influencing whole family change.

Stigma – reducing stigma to enable people to make better decisions and ask for help earlier.

Danish Model – How it might fit in.

Schools – as above.

Strategic Theme 3: Treatment – To secure the services needed to tackle excess weight (Tertiary Prevention)

Outcomes from the Obesity Conference:

Connectivity – as above.

Interface between Tier 3/4 – Need to consider the interface in the development of primary interventions.

Sharing of records – as above.

Clinicians – Need for more clinicians to be involved in discussions as they can influence how investment is made.

Services – Need to ensure that people are receiving appropriate services and redirected. Need for correct referrals.

Danish Model – as above.

Environment

What are we doing?

- Working with takeaways to:
  - Influence recipes to reduce salt & fat;
  - Limit portion size and reduced salt /fat/sugar intake (i.e. shakers that deliver less);
  - Prevent extra food items
  - Encourage the provision of water in takeaways and as part of meal deals;
  - E-post health meal deals
- Hartlepool vision

- Planning - Restricting number and location of takeaways.
  etc
- Takeaway meals
- Taking forward as next steps

What is working?

- Recipes – salt levels are reducing

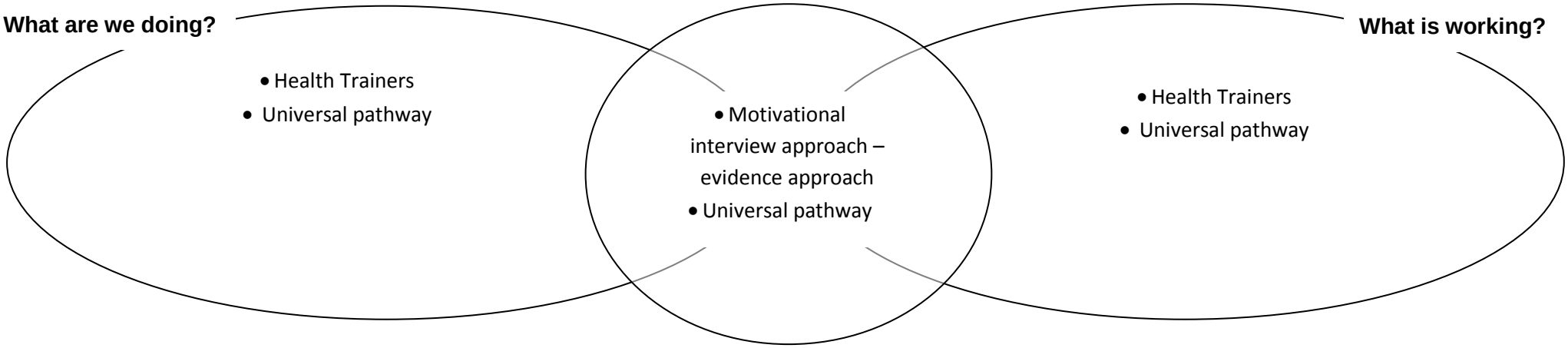
What could we do – Something new?

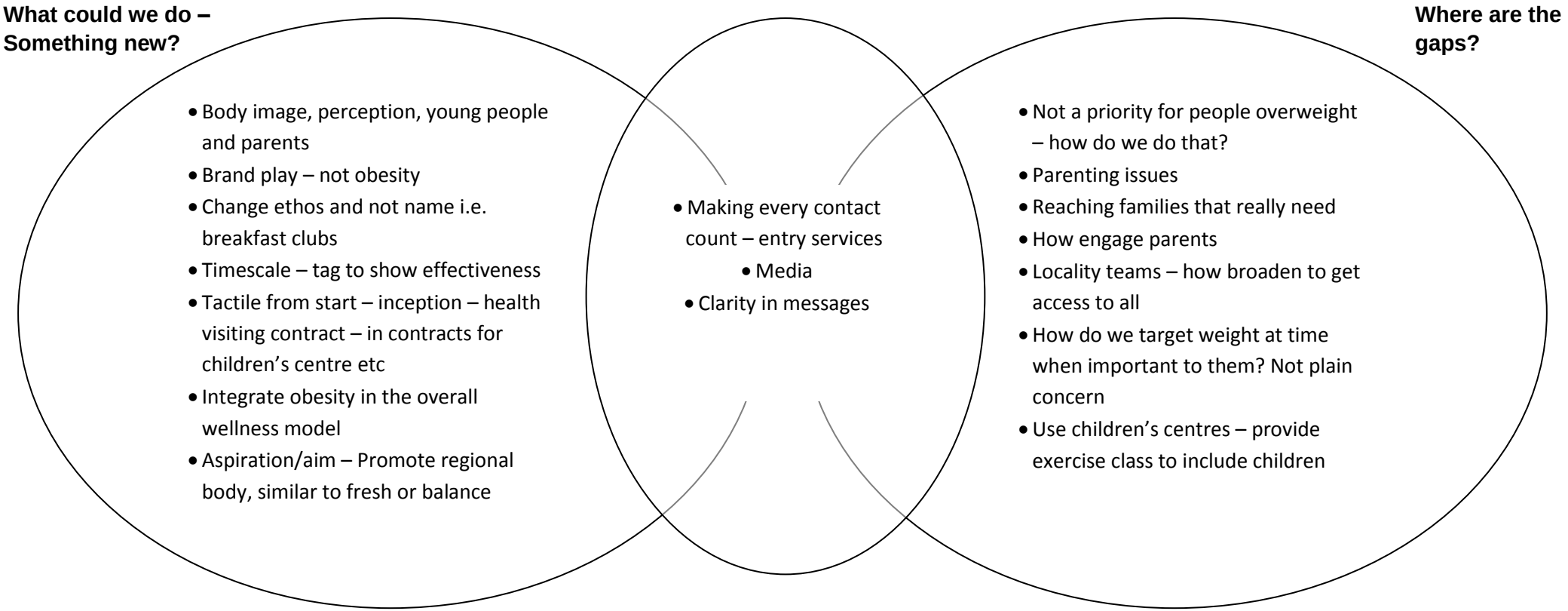
- Food festival
- Should it be stealth or purchased?
- Use of green space, improve organised activities inc football etc
- Accessible school fields to give somewhere safe to play (not remove fence)
- New schools – standing environments
- Fund the provision of smaller containers to get them to use same size/ smaller containers
- Take orders, good practice, re recipes in takeaway to other providers
- Active travel / Sustran officers
- Approach specific healthy eating as part of vision
- Retro/vintage play

Where are the gaps?

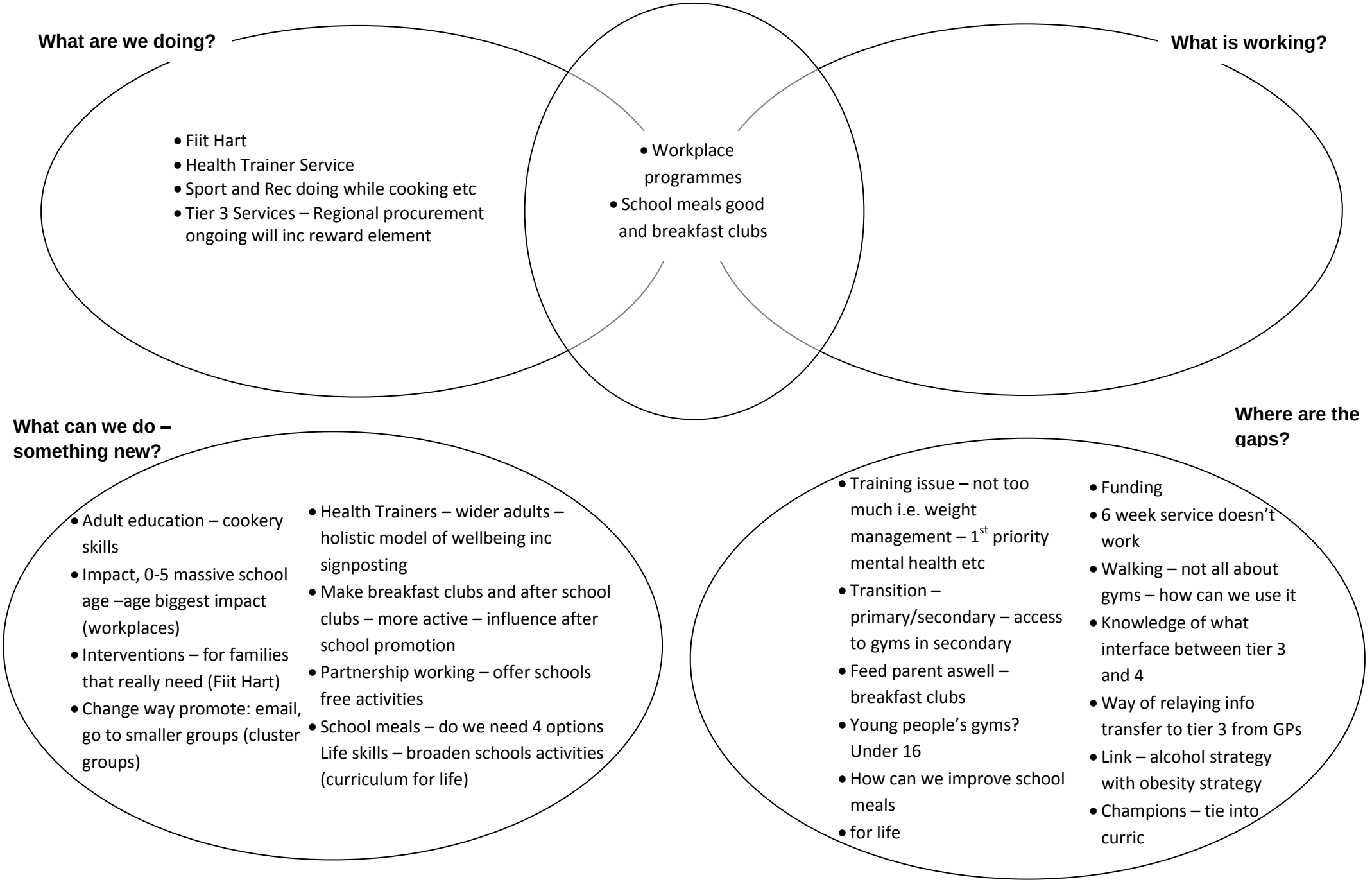
- Need different activities - something new
- Monthly taster sessions on school fields
- Cycle routes, poor – develop by new officer
- Flex – to encourage healthy eating – robust policy – on locality of takeaways – John Wilcox Waterfield
- Breakfast clubs – taster schools – get kids involved in making breakfast – teach life skills – will target vulnerable areas to meet goals

Influencing Behaviour





Services


What are we doing?
• Fiit Hart
• Health Trainer Service
• Sport and Rec doing while cooking etc
• Tier 3 Services – Regional procurement ongoing will inc reward element
• Workplace programmes
• School meals good and breakfast clubs
What is working?
What can we do – something new?
• Adult education – cookery skills
• Impact, 0-5 massive school age –age biggest impact (workplaces)
• Interventions – for families that really need (Fiit Hart)
• Change way promote: email, go to smaller groups (cluster groups)
• Health Trainers – wider adults – holistic model of wellbeing inc signposting
• Make breakfast clubs and after school clubs – more active – influence after school promotion
• Partnership working – offer schools free activities
• School meals – do we need 4 options Life skills – broaden schools activities (curriculum for life)
Where are the gaps?
• Training issue – not too much i.e. weight management – 1st priority mental health etc
• Transition – primary/secondary – access to gyms in secondary
• Feed parent aswell – breakfast clubs
• Young people's gyms? Under 16
• How can we improve school meals
• for life
• Funding
• 6 week service doesn't work
• Walking – not all about gyms – how can we use it
• Knowledge of what interface between tier 3 and 4
• Way of relaying info transfer to tier 3 from GPs
• Link – alcohol strategy with obesity strategy
• Champions – tie into curric

Appendix A(4)

References

Local strategies and plans

NHS Tees Integrated Strategic and Operational Plan 2011-2014
NHS Tees Weight Management Services Strategic Review and Development Plan 2010
Hartlepool Health and Wellbeing Strategy 2013-2018

National strategies and plans

Department of Health (Childhood Obesity National Support Team, 2011). Strategic high impact changes: childhood obesity.
Department of Health (2011). Healthy Lives, Healthy People: A call to action on obesity in England.
Strategic high impact changes: childhood obesity (PDF, 719K)
Healthy Lives, Healthy People: A call to action - Department of Health
Foresight (2007) Tackling Obesities: Future choices
National Obesity Observatory – for a wide variety of publications and information related to obesity
NHS Hartlepool & Stockton-on-Tees Clinical Commissioning Group A Clear and Credible Plan for Commissioning Health Services 2012-2017
Director of Public Health Report 2013: Public health then & now 1973-2013
Health profiles (Public Health England)

Other references

Centre for Maternal and Child Enquiries (CMACE, 2010). Maternal Obesity in the UK: Findings from a National Project.
Child and Maternal Health Observatory (2011). Disability and Obesity: The Prevalence of Obesity in Disabled Children.
Department of Health (2005). Health Survey for England 2004.
Department of Health (2008). Healthy Weight, Healthy Lives: A cross-government strategy for England.
Department of Health (2010). Supporting of Commissioning of Adult Weight Management Services Tool – Prioritising Investment
Disability Rights Commission (2005). Equal Treatment: Closing the Gap Interim Report.
Government Office for Science (2007). Tackling Obesities: Future Choices – Project Report (2nd Edition).
Health Survey for England (2009) Health Survey for England - 2009: Health and lifestyles
Heslehurst, N., Rankin, J., Wilkinson, J. & Summerbell, C.D. (2010). A nationally representative study of maternal obesity in England, UK: trends in incidence and demographic inequalities in 619,323 births, 1989-2007. *International Journal of Obesity*, 34 (3), 420 – 428
Mcpherson, K., Marsh, T. And Brown, M. (2011). Is the rise in obesity prevalence in England and Wales flattening?
National Obesity Observatory (2010). Epidemiology of childhood obesity
National Obesity Observatory (2011). NCMP: Changes in children's BMI between 2006/07 and 2009/10.
National Obesity Observatory (2012) Factsheets

National Obesity Observatory (2009). Body mass index as a measure of obesity.
National Obesity Observatory (2011b). Obesity and Ethnicity.
National Obesity Observatory (2010). NOO Data Briefing: Adult Weight.
NHS Information Centre, National Child Measurement Programme
NHS Information Centre (2012) Statistics on obesity, physical activity and diet: England 2012.
World Health Organisation (2012). BMI Classification.
Foresight (2007) Tackling Obesities: Future choices
National Obesity Observatory – for a wide variety of publications and information related to obesity
Centre for Maternal and Child Enquiries (2010). Maternal obesity in the UK: findings from a national project.
Summerbell , C.D et al (2009) Interventions for preventing obesity in children

NICE Guidelines
CG43 Obesity: full guideline sections
PH6 Behaviour change: guidance
Weight management before, during and after pregnancy

Healthy Weight Strategy for Hartlepool
Proposed Action Plan

Strategic Theme 1: Universal – To transform the environment so that it supports healthy lifestyles (Primary Prevention)			
Key Objective	**Areas of action**	**Desired Outputs**	**Expected Outcomes**
(a) Planning and retail: Work with partners to improve access to healthy food options and remove barriers to adopting a healthy diet.	Restrictions on advertising of high fat, sugar and salt foods to children	Develop a policy for organisations to follow Restrict food adverts on bus shelters locally and any advertising space within statutory authority control	Reduced exposure to advertising reducing demand from parents
	Develop Healthy Catering Guidelines linked with the Breastfeeding and Better Health at Work Award	Work with businesses to alter the menus offered to become healthier options, actively support breastfeeding and create a healthier staff working environment Ensure the Healthier Catering guidelines are promoted and followed	Catering premises will have low fat, sugar fat and salt content menu items across a minimum of 30% of their menus Corporate catering will comply with the guidelines 90% of occasions
	Develop licensing conditions to reduce the number of fast food catering establishments in areas of high density, including near schools	Audit through food mapping Approved licence conditions	Prevent an increase in the number of fast food outlets in the town
(b) Physical activity: improve access to green spaces for health and exercise reasons.	Increase the capacity of buildings to support physical activity	Cycle parking Showers Drying areas Stairs and lifts policy	All new buildings and alterations are compliant with NICE guidance
	Increase the availability of green space across Hartlepool for play and recreational use	Identify existing green space Identify existing plans to improve Community involvement in where, what, when and how Add outdoor/green gyms to existing spaces	Increased green space Better utilisation of existing provision

	Support charities and projects which improve aspects of the obesogenic environment such as Living Streets and Sustrans	Work with partners to remove barriers to physical activity Improve confidence around walking and cycling	Aspects of the obesogenic environment are addressed to make walking and cycling easier
(c) Travel and infrastructure: create a more supportive environment for cycling and walking to improve rates of active travel in schools, workplaces and communities.	Reducing the proportion of Hartlepool adults and children who are sedentary	Work with businesses through the Better Health at Work Award Cycle Repair and training (Bikeability) Scheme	Offer sedentary workers physical activity options Increased cycle users
	Utilise LSTF funds to improve cycle route infrastructure and encourage active travel in workplaces and schools	Target business enterprise zones Develop travel plans for workplaces and schools	Improved cycle provision and links across town Reduced car use
	Develop no parking zones around schools in favour of park and stride sites	Extend parking exclusion zones around schools Extend 20mph zones	Improved road safety Increased walking levels in children and parents

Strategic Theme 2: Preventative – Making Healthier Choices Easier by providing information and practical support (Secondary Prevention)			
Key Objective	**Areas of action**	**Desired Outputs**	**Expected Outcomes**
(a) Develop a social marketing and communications plan for Hartlepool to promote and facilitate a healthy weight and lifestyle.	Develop a public opinion which supports the key actions of strategy	Work with media to create a public opinion shift Work through social media to create a new normal of behaviours	Public will support the actions predominantly rather than oppose them
	Undertake further insight work with young people on fast food and sugar sweetened beverages	Work with Youth Parliament and Young People's Participation Team to produce relevant insight	Insight to enable appropriate alternative marketing
	Using the Change 4 Life and Health Trainers to engage and mobilise citizens to make healthier choices.	Develop an agreement to ensure any public body led campaigns and incentives to take part in them, would be compliant with <u>all</u> principles of healthier choices within the Change4Life campaign. Embed agreement across all directorates and other organisations	Consistent messages promoting healthier choices across all media from all directorates within the Council and all organisations in Hartlepool
	Embrace new technologies to engage and support individuals with health & wellbeing activities and services	Explore potential of health-related mobile apps and online activity tracking programs for leisure facilities and healthy weight services	Improved monitoring of adult and young people's physical activity Increased motivation for service users
(b) Ensure obesity is tackled by early intervention through improved training and awareness for front line staff and in communities.	Promote healthy lifestyles within the Hartlepool workforce	Train and support council staff to provide information to customers Better Health at Work Award promotion	Healthier, more empowered staff Improved signposting via 'Making every contact count'
	Support individual behaviour change around diet, physical activity and breastfeeding	Individual behaviour change will be supported by Health Trainers and Health Buddies Front line practitioners and volunteers will be trained in MECC	Individuals will receive support to change health behaviours in conjunction with higher tier services

	Fiit Hart will continue to provide education to children and families on healthy eating and physical activity	All children and their families who a identified as overweight or very overweight will be offered support from the FiiT Hart team	Childhood Obesity prevalence will reduce
	Training of front line staff on Healthy Weight Management	Number of staff trained	Staff knowledge & confidence on WM improves
(c) Ensure that tackling obesity is a key priority as part of the planning and implementation process for the Hartlepool Vision.	Implement the PH Responsibility Deal with respect to labelling of nutritional information on menu's	70% of all menu's to be compliant with nutritional information as outlined in the PH Responsibility deal	Healthy options will be obvious and priced accordingly
	Strengthen the role of health impact assessments in planning applications to ensure the physical environment supports physical activity	Potential health impacts to be assessed on all new developments and projects	New developments to consider impact on obesity and physical activity

Strategic Theme 3: Services – To secure the services needed to tackle excess weight (Tertiary Prevention)			
Key Objective	**Areas of action**	**Desired Outputs**	**Expected Outcomes**
(a) Create an integrated pathway of support. Referrals to be driven by GPs and Primary Care to improve accessibility into healthy weight services.	Ensure the care pathways adequately meet the needs of those carrying excess weight	Ensure there is a smooth transition and good links between all obesity service pathways	Service provision will be appropriate to meet the needs of the client group
	Monitor the efficacy of Family Healthy Weight Programmes for children and adults	Successful programme will be recorded Future of service will be secured	Service provision will be appropriate to meet the needs of the client group
	Ensure appropriate Early Years interventions for those with excess weight are in place	Evaluate the needs of this age group Ensure services are in place	Funding and services will be in place as required. Care pathways will be complete and adequate
	Secure long term funding for a Tier 3 Weight Management Service	Support the commissioning process to ensure strong links with tier 2 community weight management services	Clear and robust obesity pathway for the client group
	Produce guidance for primary care regarding National Child Measurement (NCMP) and adult obesity pathways	G.P's and primary care staff are aware of the NCMP & adult obesity pathways	An increase in referrals from Primary care into children's and adult weight management services
(b) Support schools and children's centres to develop a 'Curriculum for Life' which promotes a healthy weight and lifestyle from an early	Promote Healthier Weaning	Continuation of weaning programme for Children's Centres and early year's providers.	Reduce the proportion of 12 – 18 month olds who exceed the Estimated Average Requirement for Energy intake
	Increase rates of Breast Feeding	Offer support to mothers who are excess weight to improve post-partum weight management	Increase proportion of excess weight mothers who breastfeed.

age	All families with children under 5, who are most at risk of becoming overweight or obese, are identified through key contacts with professionals working with this age group and are referred to appropriate services	Engage family support workers, health visitors and housing staff working with the most at risk families	Increase numbers of the most at risk families and young people who are identified and supported
	Jacqui Braithwaite to include action around emotional wellbeing in schools		
(c) Ensure healthy weight services are part of the vision for the provision of a Hartlepool 'Health and Social Care Plan'	Develop an integrated model of 'community wellness hubs', bringing together a public health offer alongside health and social care services with a whole-family approach	Develop public health 'offer' Identify community hub sites	More integrated and accessible services Improved signposting and referrals Improved care and support to those in need
	Address the issue of 'holiday hunger' for the most at risk families over school holiday periods	Assess need Develop cost-effective model and pilot project	Reduced levels of young people suffering under nourishment in school holidays
	Embed healthy weight in the Better Childhood Programme delivery model	Healthy weight will be considered as part of the Better Childhood Programme	Children's workforce enabled to raise the issue of healthy weight Children's workforce enabled to provide families with advice, information and support to maintain a healthy weight

HEALTH AND WELLBEING BOARD

Friday 11th September 2015

Report of: Director of Public Health

Subject: IMMUNISATION PRESENTATION

1. PURPOSE OF REPORT

1.1 The purpose of the report is to introduce the immunisation presentation by the Director of Public Health and Immunisation and Screening Manager from NHS England.

2. BACKGROUND

2.1 NHS England (Cumbria and North East) is responsible for commissioning immunisation programmes, monitoring providers' performance and for supporting providers in delivering programme changes and improvements in quality when required.

2.2 Hartlepool Borough Council has a duty, under regulation 8 of the Local Authorities Regulations 2013 (Health and Social Care Act 2012), to scrutinise immunisation rates in Hartlepool to assure that there is sufficient uptake of vaccinations across all age groups. Local authorities also provide independent scrutiny and challenge of the arrangements of commissioners to ensure all parties discharge their roles effectively for the protection of the local population.

3. PRESENTATION

3.1 The purpose of the presentation is to provide the Health and Wellbeing Board with:

- assurance that appropriate governance arrangements are in place within NHS England in relation to immunisations for the population, in order to protect the health of people in Hartlepool.
- an update on the local picture of Immunisations in Hartlepool and;
- NHS England's plans to improve uptake and local actions being undertaken to address these.

4. RECOMMENDATIONS

4.1 Members note and comment on the content of the presentation.

5. CONTACT OFFICER

5.1 Louise Wallace
Director of Public Health
Hartlepool Borough Council
4th Floor Civic Centre
Victoria Road
Hartlepool
louise.wallace@hartlepool.gov.uk

(01429 266522)

HEALTH AND WELLBEING BOARD

11 September 2015

Report of: Director of Public Health

Subject: SCRUTINY INVESTIGATION INTO CARDIOVASCULAR DISEASE (CVD) – ACTION PLAN

---

1. PURPOSE OF REPORT

1.1 To agree the Action Plan in response to the findings and subsequent recommendations of Council's investigation into Cardiovascular Disease (CVD).

2. BACKGROUND

2.1 As a result of the Scrutiny investigation into CVD, a series of recommendations have been made. To assist the Health and Wellbeing Board in its determination of either approving or rejecting the proposed recommendations an action plan has been produced, (attached as **Appendix A**) and is detailed along with the Final Report and recommendations of Council attached as **Appendix B.**

3. PROPOSALS

3.1 No options submitted for consideration other than the recommendation(s).

4. RISK IMPLICATIONS

4.1 Details of any financial or other considerations / implications are included in the action plan.

5. FINANCIAL CONSIDERATIONS

5.1 Details of any financial or other considerations / implications are included in the action plan.

6. LEGAL CONSIDERATIONS

6.1 Details of any financial or other considerations / implications are included in the action plan.

7. CHILD AND FAMILY POVERTY CONSIDERATIONS

7.1 Details of any financial or other considerations / implications are included in the action plan.

8. EQUALITY AND DIVERSITY CONSIDERATIONS

8.1 Details of any financial or other considerations / implications are included in the action plan.

9. STAFF CONSIDERATIONS

9.1 Details of any financial or other considerations / implications are included in the action plan.

10. ASSET MANAGEMENT CONSIDERATIONS

10.1 Details of any financial or other considerations / implications are included in the action plan.

11. RECOMMENDATIONS

11.1 The Health and Wellbeing Board is requested to approve the proposed recommendations and to approve the action plan in response to the recommendations of Council's investigation into CVD.

12. REASONS FOR RECOMMENDATIONS

12.1 The aim of the investigation was to consider the approaches being taken to prevent and treat CVD, to ensure longer term reduction in incidence and prevalence, and improve quality of life and health outcomes for those individuals who already have the disease.

13. BACKGROUND PAPERS

The following background paper was used in the preparation of this report:-

Final Report of Council into Cardiovascular Disease (CVD) – March 2015

14. CONTACT OFFICER

Laura Stones – Scrutiny Support Officer
Chief Executive's Department – Legal Services
Hartlepool Borough Council
Tel: 01429 523087
e-mail: laura.stones@hartlepool.gov.uk

COUNCIL SCRUTINY ENQUIRY ACTION PLAN

NAME OF COMMITTEE: Council

NAME OF SCRUTINY ENQUIRY: Cardiovascular Disease (CVD)

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION+	FINANCIAL / OTHER IMPLICATIONS	LEAD OFFICER	COMPLETION DATE*
Provision of Services (a) That following the transfer of Public Health responsibilities to the Local Authority and the inclusion of sports and recreation services within the Public Health Department, CVD provision commissioned by the Council be reviewed to ensure that:-				
(i) It is effectively joined up and integrated to take advantage of the opportunities across service areas, with due regard to the wider piece of work being undertaken in relation to the Better Care Fund;	Ensure future CVD provision is considered as part of future developments across all service areas, including BCF.	By aligning CVD provision with existing services, it is hoped efficiencies can be found.	Louise Wallace	Ongoing
(ii) Community provision for the	Ensure Health Check delivery is	Dependent upon	Louise	March 2017

delivery of Healthy Heart Checks is developed and the use of community buildings, such as community centres and libraries be explored to improve accessibility and sustainability of services and facilities; and	integrated into the proposed model for community hubs and is better aligned with existing health and social care services in the community.	the future decision around community hubs and the agreed delivery model of Health Checks moving forward.	Wallace	
(iii) There are no gaps/shortfalls in provision.	Health Check delivery will be closely monitored across all sites and among the eligible population to ensure targets are met.	Shortfalls or rises in checks will impact upon payment-by-delivery costs.	TVPHSS	Ongoing
(b) That as part of the service review of the Healthy Heart Check Programme currently being undertaken by the TVPHSS, consideration be given to:				
(i) Why the take up of Healthy Heart Checks varies across GP practices, particularly in the most disadvantaged wards, with a significant difference between the number of invitations sent and the number of checks	Issues to be explored with GP practices with a view to a more consistent approach by sharing good practice.	Shortfalls or rises in checks will impact upon payment-by-delivery costs.	TVPHSS	March 2016

carried out; (ii) How those from the most deprived communities can be better engaged, including the exploration of the most effective means of establishing initial contact; (iii) How the process for the transmission of data to GPs practices in relation to Health Checks undertaken in the community facilities could be improved to better record community checks.	Further consultation to be carried out with providers and the wider community to establish new approaches to awareness and engagement. Data transfer processes are being reviewed to ensure patient information from community checks transfers seamlessly onto the GP clinical database.	Payments for health checks higher for people from the most deprived quintile. Improved data sharing and transfer processes will lead to efficiencies.	Louise Wallace TVPHSS	March 2016 March 2016
Prevention of CVD (c) That the Health and Wellbeing Board support the approach to amend the childhood measurement letter, for use in the next roll out of measurements, in order to make it compassionate and friendly by using suitable wording;	Hartlepool is represented on the NCMP national steering group to feedback and influence decision-making around the communication of NCMP data. National letters have already been adapted locally and continue to be regularly reviewed.	A more compassionate and friendly approach when presenting NCMP data is expected to improve numbers of families accessing support.	Deborah Clark	Ongoing

(d) That an evaluation be undertaken of the work carried out in schools relating to CVD awareness, with focus on ensuring the continued provision of activities. The evaluation to include:- (i) What schools are doing well; (ii) How schools can promote CVD messages; (iii) How schools can further raise awareness of healthy eating and lifestyle choices; and (iv) How the Council can work with secondary schools to encourage schools to offer CPR training to their pupils.	Capacity within Public Health will need to be identified to carry out the CVD evaluation with schools. Initial scoping around the work in schools and 'what more schools can do' was carried out as part of the Healthy Weight Healthy Lives conference in February 2015 and a new obesity strategy for Hartlepool is currently in development. Further work will need to be aligned with the development of a 'curriculum for life' as part of the overall obesity strategy. NEAS may be able to support CPR training alongside community defibrillator provision.	Staff capacity and funding may need to be identified to carry out an evaluation of the work in schools. CPR training may come at a cost in the future.	Steven Carter	March 2016
(e) That the Council continue to raise awareness of CVD by:- (i) Continuing to offer the Healthy Heart Check to Council staff;	Further NHS Health Check opportunities to be promoted with HBC staff across all sites utilising nurse bank and mobile health improvement service.	Staff time required to attend health checks.	Steven Carter	Ongoing

(ii) Encouraging Council staff to become CPR trained; and	To be arranged with NEAS as part of Community Defibrillation programme – awaiting dates for training.	Staff time required to attend training – key staff to be identified.	Steven Carter	March 2016
(iii) Publicising the Healthy Heart Checks in all Council buildings and GP practices.	Promotional materials to be developed and circulated to all sites and key services.	Funding required to produce promotional materials.	TVPHSS	Ongoing
Treatment of CVD (f) That the Health and Wellbeing Board:-				
(i) Encourage businesses across Hartlepool to install defibrillators within their workplace and register the defibrillators with NEAS; and	Businesses involved in Better Health at Work Award to be approached initially. Several businesses already have defibs in place but exercise is needed to confirm registration with NEAS.	Businesses will be required to fund the units and training may not be free in the future.	Steven Carter	Ongoing
(ii) Explore the installation of defibrillators in venues for community provision usage, including the Health Bus.	Units in place in HBC sites and Parish Councils – further locations have been identified for phase 2.	Funding has been identified for provision and installation of additional units.	Steven Carter	March 2016

[+] please detail any risk implications, financial / legal / equality & diversity / staff / asset management considerations
* please note that for monitoring purposes a date is required rather than using phrases such as ‘on-going’

HARTLEPOOL
BOROUGH COUNCIL

FULL COUNCIL

FINAL REPORT

CARDIOVASCULAR DISEASE (CVD)

MARCH 2015

HEALTH AND WELLBEING BOARD

June 2015

Report of: Full Council

Subject: FINAL REPORT – INVESTIGATION INTO CARDIOVASCULAR DISEASE (CVD)

---

1. PURPOSE OF REPORT

1.1 To present the findings of Full Council following its investigation into Cardiovascular Disease (CVD).

2. BACKGROUND

2.1 The Audit and Governance Committee met on the 7 August 2014 to consider their Work Programme and agreed that the Committee would in 2014/15 focus on CVD as the health topic for investigation. In scoping the investigation task and finish groups were established to undertake specific areas of work, with the outcome of the task and finish groups to inform the CVD Final report. With effect from 24 November 2014, the Council's Statutory Health Scrutiny responsibilities were transferred from the Audit and Governance Committee to Full Council. From this date the conduct of the investigation continued through the agreed task and finish groups, with all Members of Council invited to participate, with the Final Report to be from Full Council as the body responsible for Statutory Health Scrutiny.

2.2 Circulatory and heart disease, also known as cardiovascular disease (CVD), refers to a group of related conditions of the heart and blood vessels. These conditions include:

- Coronary heart disease (CHD): a disease of the blood vessels supplying the heart muscle which can lead to angina, heart attack and heart muscle damage;
- Cerebrovascular disease: a disease of the blood vessels supplying the brain which leads to transient ischaemic attacks (TIA) and strokes;
- Peripheral vascular disease (PVD): a disease of blood vessels supplying the arms and legs that can lead to claudication;

- Atrial fibrillation (AF) and arrhythmias: abnormal pulse rhythm which can be a major cause of strokes; and
- Other conditions such as vascular dementia, chronic kidney disease, cardiac arrhythmias, sudden cardiac death, and heart failure are related because they either share common risk factors or have an impact on the prognosis and outcome of CVD.

2.3 CVD is the main cause of death in the UK and accounts for almost 191,000 deaths each year (one-third of all deaths). Almost half of deaths (46%) are from CHD and nearly one quarter (23%) from stroke. CVD-related conditions are estimated to cost the economy £25.8 billion annually. The health of people in Hartlepool is generally worse than the England average. Deprivation is higher than the England average and life expectancy for both men and women is lower than the England average. Mortality rates from CVD are significantly higher than the national rate. Mortality rates have decreased by 55.6% since 1995-97.

2.4 Non-modifiable and non-behavioural risk factors including age, sex, family history/genetic factors, ethnicity and deprivation are considered to estimate the overall risk of CVD for an individual. Modifiable and behavioural risk factors such as smoking, physical inactivity, poor diet and obesity reflecting individual circumstances and choices can be prevented or changed by lifestyle changes. Conditions associated with an increased risk, hypertension, raised cholesterol, diabetes and chronic kidney disease, can be prevented or reversed in their early stages but usually need medical treatment.

2.5 Factors accounting for the large majority (86%) of risk of CVD (and therefore inequalities in life expectancy) are potentially reversible, and appropriate services to address CVD within Hartlepool reflect this.

2.6 Quality and outcomes framework (QOF) data shows a considerable gap between observed and estimated prevalence on a number of CVD measures. This is acknowledged in efforts to find the 'missing thousands'.

2.7 Prevention of CVD is a high priority. A comprehensive CVD risk screening programme (NHS Health Checks/ Healthy Heart Check), aims to identify and manage people with undiagnosed CVD. There continues to be an issue in uptake of the screening programme by people in deprived groups and by men.

2.8 With trends in obesity levels rising, it is anticipated that there will be a significant increase in the number of people with diabetes and pre-diabetes which is likely to have an impact on the incidence of CVD[1]

[1] [1] Hartlepool JSNA - http://www.teesjsna.org.uk/hartlepool-circulatory-diseases

3. OVERALL AIM OF THE SCRUTINY INVESTIGATION

3.1 To consider the approaches being taken to prevent and treat CVD, to ensure longer term reduction in incidence and prevalence, and improve quality of life and health outcomes for those individuals who already have the disease.

4. TERMS OF REFERENCE FOR THE SCRUTINY INVESTIGATION

4.1 The Terms of Reference for the Scrutiny investigation were as outlined below:-

(a) To gain an understanding of CVD and the pathways available to people diagnosed with CVD (including the causes; signs and symptoms; prevention; and treatment);

(b) To examine the incidence and prevalence of CVD across Hartlepool, and how this compares to regional and national levels, and in doing so, consider why Hartlepool has a particularly high rate of CVD;

(c) To explore the risk factors that contribute to the development of CVD including the impact of lifestyle choices;

(d) To explore and examine the CVD services provided in:-

(i) Primary Care;
(ii) Secondary Care;
(iii) Tertiary Care; and
(iv) A pulmonary and rehabilitation setting.

(e) To seek the views of CVD patients and their families and carers; and groups / bodies who provide services for people diagnosed with CVD

5. MEMBERSHIP OF THE CARDIOVASCULAR DISEASE TASK AND FINISH GROUP

5.1 The membership of the Task and Finish Groups are as detailed below:-

Group 1 - Councillors S Akers-Belcher, R Martin-Wells, Lynn Allison (HealthWatch) and N Rollo (Independent Person)
Group 2 – Councillors J Ainslie, R Cook
Group 3 – Councillors S Akers-Belcher, K Sirs and Lynn Allison (HealthWatch)

The membership of Full Council is as detailed below:-

Councillors Ainslie, C Akers-Belcher, S Akers-Belcher, Atkinson, Barclay, Beck, Brash, Clark, Cook, Cranney, Dawkins, Fleet, Gibbon, Griffin, Hall, Hargreaves, Hind, Jackson, James, Lauderdale, Lilley, Loynes, Martin-Wells,

Morris, Payne, Richardson, Riddle, Robinson, Simmons, Sirs, Springer, Thomas and Thompson.

6. METHODS OF INVESTIGATION

6.1 Members of the CVD Task and Finish Groups met formally from 21 August 2014 to 2 March 2015 to discuss and receive evidence relating to this investigation. A record of the issues raised during these meetings is available on request.

6.2 A brief summary of the methods of investigation are outlined below:-

(a) Setting the Scene presentation from the Public Health Team and the Tees Valley Public Health Shared Service;

(b) Presentation and verbal evidence received from North Tees and Hartlepool NHS Foundation Trust, Cardiology Department;

(c) Presentation and verbal evidence received from South Tees NHS Foundation Trust, Cardiology Department;

(d) Presentation and verbal evidence received from the Tees Valley Public Health Shared Service;

(e) Presentation and verbal evidence received from the North East Ambulance Service; and

(f) Visits to a Stop Smoking Clinic, a rehabilitation exercise class and the Health Bus.

7. FINDINGS

WHAT IS CVD AND THE PATHWAYS AVAILABLE TO PEOPLE DIAGNOSED WITH CVD (INCLUDING THE CAUSES; SIGNS AND SYMPTOMS; PREVENTION; AND TREATMENT)

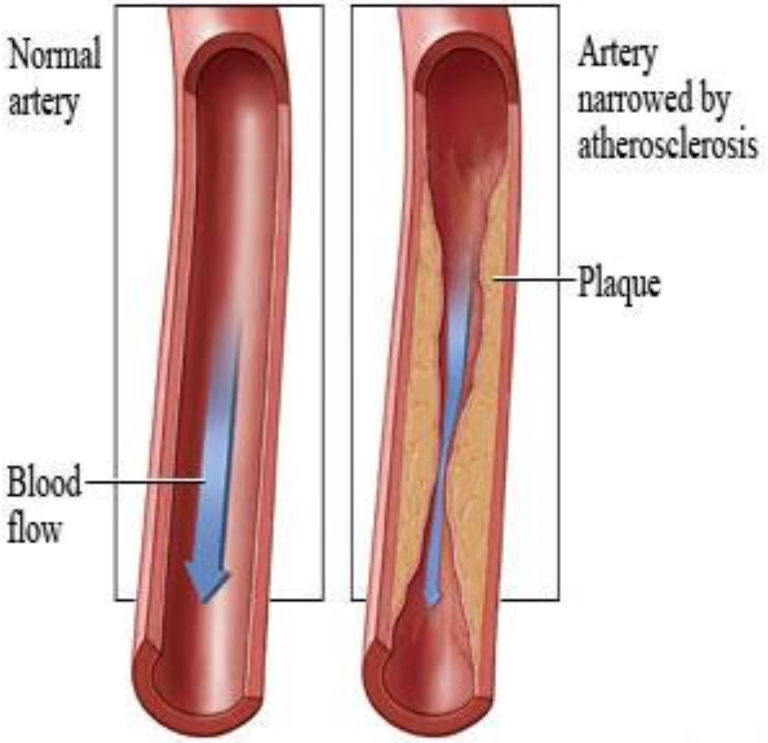
7.1 Members at their meeting of 16 October 2014 received a setting the scene presentation from the Tees Valley Public Health Shared Service and Hartlepool Council's Public Health Department to gain an understanding of CVD and the pathways available to people who have been found at risk of CVD through the Healthy Heart Check (NHS Health Check) including the causes; signs and symptoms; prevention; and treatment.

Causes, signs, symptoms

7.2 CVD is defined as a disease of the heart and circulatory system predominantly caused by the process of atherosclerosis. Atherosclerosis is the gradual build-up of fatty plaques within the walls of the arteries called atheroma. As atheromatous plaques develop and increase in size, they

narrow the lumen of the artery and reduce blood flow to the tissues. Plaques may be small or extend several centimetres along the length of the artery.

7.3 Atherosclerosis can affect any artery in the body. The process of atheroma is triggered off by an initial injury to the lining of the artery. This can be caused by the effects, for example, of high blood pressure or smoking. Cholesterol is absorbed into the injury and forms a fatty streak; this in turn develops into a fibrous atheromatous plaque, as illustrated in the diagram below. The artery may slowly obliterate or plaque can rupture at any time.



7.4 Members were informed that deaths from CVD have fallen by over a third between 2001 and 2010, but CVD is still one of the main causes of death in the UK and accounts for about one-third of all deaths. In 2011, almost 160,000 people in the UK died from CVD. 74,000 of these deaths were caused by coronary heart disease which is the UK's single biggest killer.

7.5 The most prevalent CVD diseases are outlined below:-

Coronary Heart Disease (CHD) – a disease of the blood vessels supplying the heart muscle which can lead to angina, heart attack and heart failure.

Cerebrovascular Disease – a disease of the blood vessels supplying the brain which leads to stroke and TIA's (transient ischaemic attack).

Peripheral Vascular Disease (PVD) – a disease of the blood vessels supplying the arms and legs which can lead to claudication (pain), ulcers, gangrene etc.

Atrial Fibrillation (AF) – abnormal heart rate and rhythm which can be a major cause of stroke.
Prevention

7.6 Members welcomed evidence from the Public Health team who outlined the methods of prevention.

- **Stopping smoking is a preventative measure.** There is an effective evidence-based model of smoking cessation delivered by a Specialist Service in 8 different community venues and 5 community pharmacies across the town. There is an active local Smoke Free Alliance made up of a range of partners supporting and advocating for all tobacco control issues not just smoking cessation. There is also a vibrant Regional Office – FRESH – to inform and support local delivery of International, National and Regional activity on tobacco control.
- **NHS Health Check (branded locally as Healthy Heart Checks)** - A mandated function for Local Authorities to offer a check to the population aged between 40 – 74 not already diagnosed with CVD. There is also a mini-health check available for people aged 25 – 39. NHS Health Checks are currently provided mainly in Primary Care through GP practices, but also workplaces and in other community venues through a nurse bank located at South Tees Trust. There is mobile outreach through the Health Bus which includes opportunities for Healthy Heart Checks.
- **Weight Management** – The Health Trainer Service currently provided by North Tees and Hartlepool NHS Foundation Trust (which will move into the Local Authority in April 2015) provides free weight management support (healthy eating, behaviour change support and access to physical activity) to adults in a range of community venues and GP practices in Hartlepool. The Families in it Together Hartlepool ('FiiT Hart') provides one-to-one support to families around nutrition and group-based physical activity opportunities.
- **Physical Activity** - Hartlepool Exercise for Life Programme (HELP) – GP Exercise on Referral scheme provides specific cardiac-rehab and heart failure sessions for CVD and heart disease patients. This is Community-based Phase IV Cardiac rehabilitation. Patients have the opportunity to continue with supervised exercise when referred to the service by the Specialist Coronary Care Nurse team. The HELP service also operates as a preventative intervention encouraging a more active lifestyle for those patients identified through the CVD screening as at risk of developing coronary heart disease.

8. THE INCIDENCE AND PREVALENCE OF CVD ACROSS HARTLEPOOL, AND HOW THIS COMPARES TO REGIONAL AND NATIONAL LEVELS

8.1 Members welcomed evidence from the Public Health Intelligence Specialist. Members were informed that heart and circulatory disorders are one of the leading causes of death in the country; ischemic heart disease and strokes

being the two leading causes. The disorders account for 8,730 deaths out of a total 24,400 of those in the North East area.

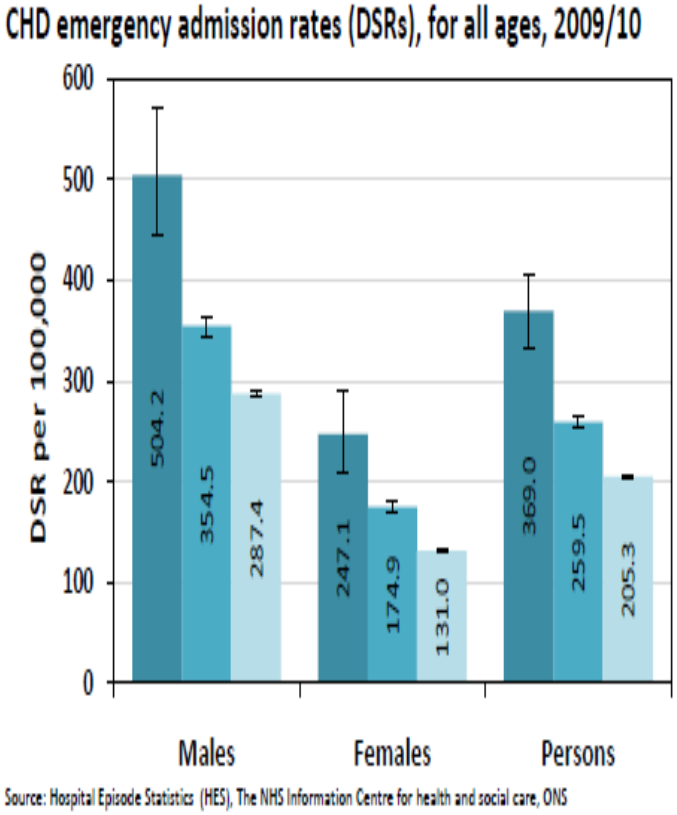
8.2 In Hartlepool, deprivation indicators are high with more than 50% of electoral wards in the bottom 20% in the country. Since 1993, the prevalence of obesity in adults has increased significantly across the country and there is a correlation between obesity rates and diabetes. Other risk factors for CVD such as smoking, excessive alcohol intake, inactivity are all significantly higher than the England average, as shown on the chart below.

Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	England Range	Eng best
	1	Deprivation	44,474	48.2	20.4	83.8		0.0
Our communities	2	Children in poverty (under 16s)	5,480	30.6	20.6	43.6		6.4
	3	Statutory homelessness	0	0.0	2.4	33.2		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	688	59.0	60.8	38.1		81.9
	5	Violent crime (violence offences)	1,256	13.6	10.6	27.1		3.3
	6	Long term unemployment	1,746	30.0	9.9	32.6		1.3
Children's and young people's health	7	Smoking status at time of delivery	234	21.7	12.7	30.8		2.3
	8	Breastfeeding initiation	473	43.9	73.9	40.8		94.7
	9	Obese children (Year 6)	212	21.2	18.9	27.3		10.1
	10	Alcohol-specific hospital stays (under 18)	16	78.5	44.9	126.7		11.9
	11	Under 18 conceptions	66	36.3	27.7	52.0		8.8
Adults' health and lifestyle	12	Smoking prevalence	n/a	28.2	19.5	30.1		8.4
	13	Percentage of physically active adults	n/a	49.7	56.0	43.8		68.5
	14	Obese adults	n/a	30.6	23.0	35.2		11.2
	15	Excess weight in adults	164	68.5	63.8	75.9		45.9
Disease and poor health	16	Incidence of malignant melanoma	10	10.5	14.8	31.8		3.6
	17	Hospital stays for self-harm	330	357.6	188.0	596.0		50.4
	18	Hospital stays for alcohol related harm	694	783	637	1,121		365
	19	Drug misuse	1,101	18.4	8.6	26.3		0.8
	20	Recorded diabetes	4,588	6.0	6.0	8.7		3.5
	21	Incidence of TB	2	4.3	15.1	112.3		0.0
	22	Acute sexually transmitted infections	799	868	804	3,210		162
	23	Hip fractures in people aged 65 and over	110	642	568	828		403
Life expectancy and causes of death	24	Excess winter deaths (three year)	32	11.0	16.5	32.1		-3.0
	25	Life expectancy at birth (Male)	n/a	77.4	79.2	74.0		82.9
	26	Life expectancy at birth (Female)	n/a	81.5	83.0	79.5		86.6
	27	Infant mortality	4	3.8	4.1	7.5		0.7
	28	Smoking related deaths	201	403	292	480		172
	29	Suicide rate	10	11.4	8.5			
	30	Under 75 mortality rate: cardiovascular	74	97.1	81.1	144.7		37.4
	31	Under 75 mortality rate: cancer	115	188	146	213		106
	32	Killed and seriously injured on roads	29	31.9	40.5	116.3		11.3

8.3 Members questioned the obesity statistics and commented that if they were based on Body Mass Index (BMI) then often this was not a true reflection. For example, rugby players were often classed as obese when their BMI was calculated yet they were very fit and active men. BMI is evidence based and for the vast majority of people it is the best indicator currently available. In people of South Asian ethnicity the additional measurement of waist circumference is advised. The problem with BMI measurements in rugby players is due to their relatively high proportion of muscle tissue which is usually not a problem of the general population. The Director of Public Health indicated that there are a range of data sources and measures and whichever measure was used, specialists are sure that the problem is as significant as it is portrayed. Members raised concerns regarding the letter that is sent out to families following a child's BMI measurement at school and thought that the wording of the letter was not particularly compassionate or friendly. Members were informed that this was a national programme with national guidance but the Council did have an officer on the national team managing the project.

The Group requested that an approach be made to change the letter. Hartlepool's Health and Wellbeing Board is focussing on childhood obesity and a strategy is currently in development.

8.4 The emergency admission rates for 2009/10 for Hartlepool are significantly higher than the North East and England averages, as shown in the graph below. The emergency admission rate for people from the most deprived wards in Hartlepool is 2.6 times higher than for people from the least deprived wards.



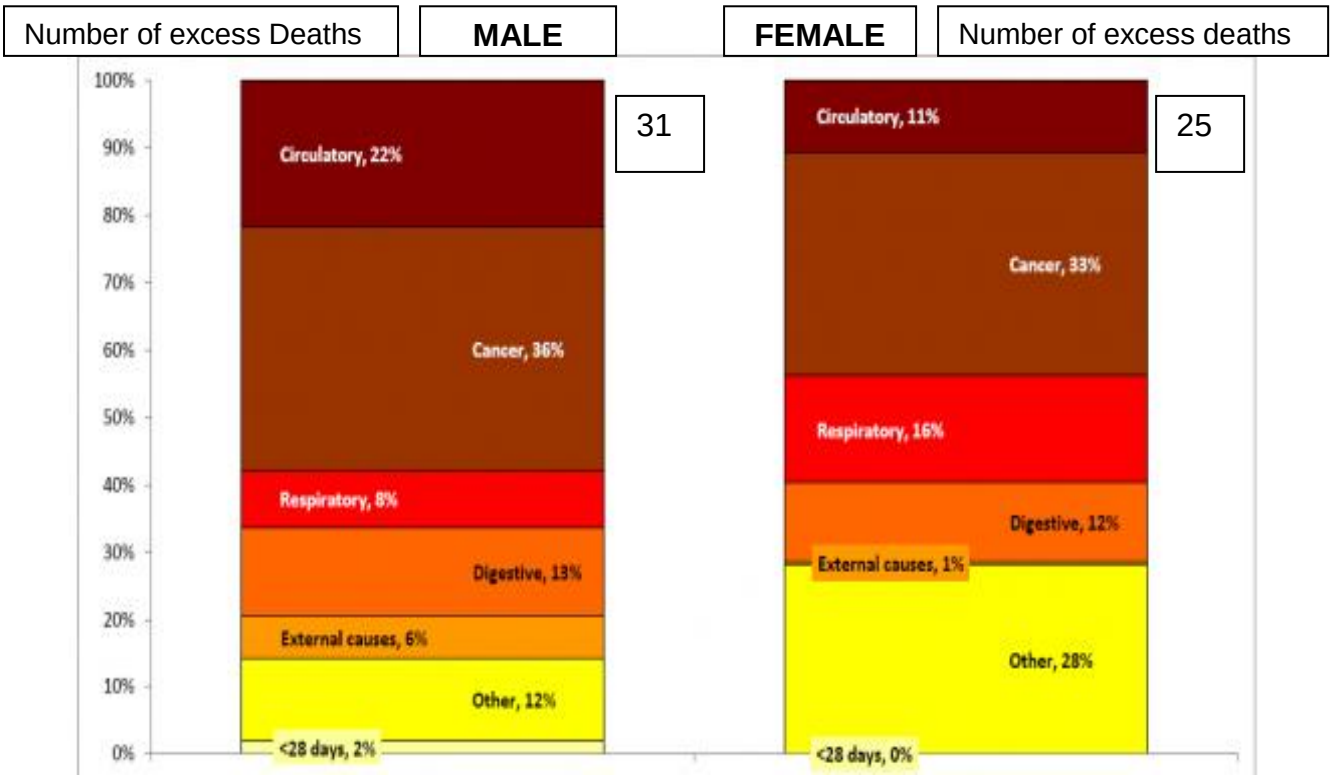
In 2009/10 the emergency admission rate for CHD, all persons, in Hartlepool was 369.0 per 100,000 (428 admissions). This is significantly higher than England (205.3 per 100,000) and significantly higher than North East (259.5 per 100,000).

Male CHD emergency admission rates are significantly higher than female CHD emergency admission rates.

8.5 Members were interested to hear about the costs of emergency and elective admissions to the NHS for CVD. These figures are based on Hartlepool and Stockton Clinical Commissioning Group's area. Male CVD elective admissions cost £783k and male emergency admissions £274K. Female costs are lower, as admissions are not as high.

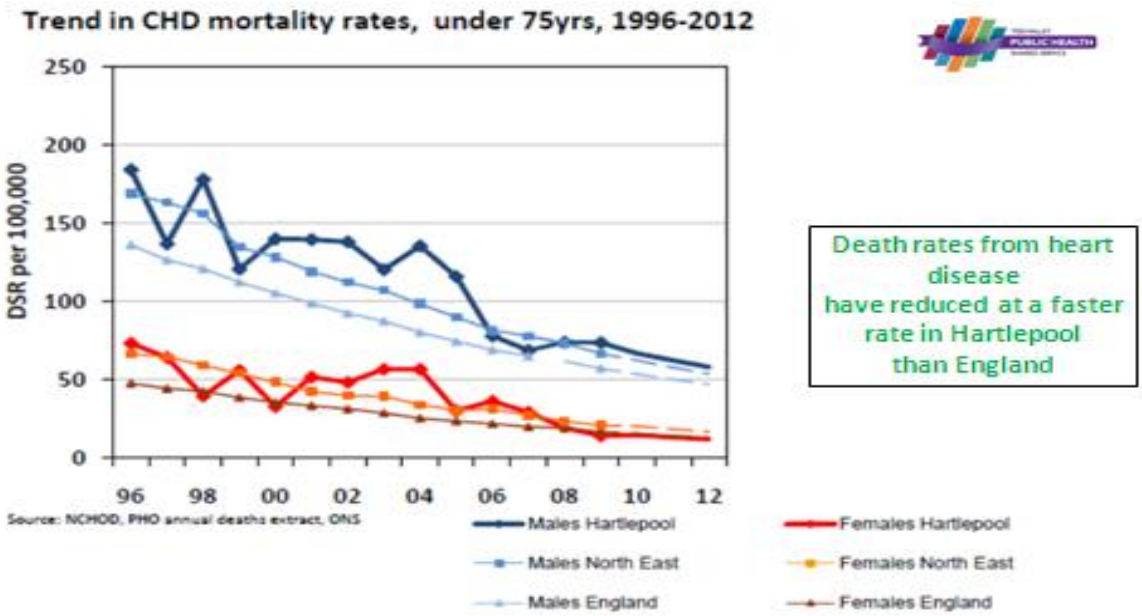
8.6 Circulatory diseases and cancer are the most significant contributors to the gap in life expectancy between Hartlepool and the England average. Essentially, there are 31 male and 25 female unnecessary deaths each year in Hartlepool caused by factors that are avoidable. The Public Health Intelligence Specialist indicated that in Hartlepool people tended to live two years fewer than the national average; if those 31 deaths did not occur, then Hartlepool would meet the national average. The chart overleaf indicates the contributors to the gap in life expectancy between Hartlepool and England.

Contributors to the gap in life expectancy between Hartlepool and England



8.7 The statistics show that people in Hartlepool experience illness earlier, for longer and die early because of it. Life expectancy in Hartlepool is two years less than the national average and Members were of the view that the life expectancy gap needs to be addressed.

8.8 Death rates from heart disease have reduced at a faster rate in Hartlepool than England, as shown in the graph over the page.



9. THE RISK FACTORS THAT CONTRIBUTE TO THE DEVELOPMENT OF CVD INCLUDING THE IMPACT OF LIFESTYLE CHOICES

9.1 The CVD risk factors are identified below. A risk factor is something that increases your likelihood of getting a disease. It was noted that non-modifiable risk factors need to be accepted and that focus has to be on the modifiable risk factors.

Modifiable risk factors: smoking, excessive alcohol consumption, physical inactivity, poor diet and obesity. Conditions associated with an increased risk are high blood pressure (hypertension), raised cholesterol, diabetes and chronic kidney disease.

Non-modifiable risk factors: family history of CVD, ethnic background (South Asian origin), gender (men are more likely to develop CVD at an earlier age than women), age (the older you are the more likely you are to develop CVD).

Other: socio-economic status – people living in more deprived areas are more exposed to the risk factors of CVD and are less likely to make healthy lifestyle choices.

9.2 In terms of prevention there are several actions which can be taken, including:-

Surveillance – analysing and monitoring incidence, prevalence and mortality

Primary prevention – Healthy Heart Check (NHS Health Check) to identify risk factors of CVD, lifestyle interventions, medication (statins).

Early diagnosis – Treating diseases earlier can slow down or halt progression.

Secondary prevention/care – Events (i.e. heart attacks) can be prevented from happening again.

Tertiary care – Support and rehabilitation for patients.

10. NHS HEALTH CHECK PERFORMED IN PRIMARY CARE

10.1 Members welcomed information from the Tees Valley Public Health Shared Service regarding the NHS Health Check, also known as the Healthy Heart Check. The check is a mandated programme introduced by the Government in 2009 and it started locally in Hartlepool in October 2008. The Check is performed locally in GP surgeries and workplace/community venues. The responsibility for the delivery of the check is now within the remit of the Local Authority, since Public Health was transferred to the Local Authority in 2013.

10.2 The NHS Health Check is offered to people in England who are aged between 40 and 74, and have not already been diagnosed with cardiovascular disease, not on a statin or not had a check within the last 5 years.

10.3 The check includes:-

- Blood test to measure cholesterol
- Pulse and blood pressure
- Height, weight and waist circumference measurement
- Lifestyle advice about diet, alcohol, exercise and smoking
- Family history
- Ethnicity/age/gender

10.4 The check takes account all the risk factors that may affect the person, rather than focusing on just one thing, such as, cholesterol level. Dementia awareness is now included in the check for the older age group because risk factors that increase the chance of developing cardiovascular disease also increase the chance of developing dementia.

10.5 The check is face to face with a trained nurse or health care assistant, who will advise the patient about their risk score. The risk is calculated as a percentage and if the risk is less than 20%, lifestyle advice is given and a review is scheduled for 5 years time. If the person's risk is 20% or higher, they are recommended to take a statin, given lifestyle advice and referred into lifestyle services such as stop smoking services. Further blood tests and a yearly review are carried out until a disease develops. If the check is carried out in a location other than the GP surgery, then the agreed practice is for a record of the check to be sent to the GP for follow up and documentation in their records. However, indications were that there is the potential for a discrepancy between the number of community checks actually undertaken and the numbers recorded by GPs.

10.6 A team of nurse facilitators located at the Tees Valley Public Health Shared Service (TVPHSS) support GP practices to improve uptake and quality of the NHS health check. An example of the support provided for practices is highlighted below:-

- Quarterly visits are offered to all GP practices to improve the administration and delivery of the check;
- Underperforming practices are contacted by the TVPHSS GP Clinical Lead to discuss opportunities to improve performance and reach targets;
- Educational resources are provided for practices to enhance the quality of the check;
- 1:1 training for new staff and update in practices;
- Joint visits to practices are undertaken by the Public Health Nurse Facilitator and Primary Care Intelligence if the practice has recurring issues with templates and reports;
- Information on available lifestyle services;
- Sharing of good practice e.g. successful processes in other practices; and
- Further training sessions on CVD care are being designed at present by the TVPHSS

10.7 The Healthy Heart Check has a good track record across the Tees Valley. However, continuous improvement is always a priority and a service review of the Healthy Heart Check Programme is currently being undertaken by the TVPHSS. This will identify strengths and weaknesses of the current service model and delivery and the scope of the review is as follows:-

(i) Review the evidence base and best practice;
(ii) Review the national programme objectives and quality requirement;
(iii) Review population need;
(iv) Evaluate how effective the current service models are and how effective current providers are in engagement and delivery (strengths and weaknesses) including but not limited to:

a) Provider variation
b) Quality of delivery
c) Inequalities and access
d) Capacity to deliver
e) Joint commissioning arrangements
f) Integration with lifestyle / behaviour change providers
g) Payment mechanisms

(v) Scope/test alternative commissioning models, this will include:

- Single provider;
- Multiple provider; and
- Any qualified provider.

(vi) Consult, engage and market test; and

(vii) Recommend models of delivery; define the quality of delivery; suggest payment models; model programme costs; and explore commissioning options.

10.8 A final report is expected in August 2015 and the outcome of this investigation is to be fed into the service review.

10.9 The table below illustrates in Quarters 1 to 3 in 2014/15 that in Hartlepool 22,934 were eligible for a healthy heart check, the total invitations at Quarter 3 were 3,882 and the total assessments at Quarter 3 were 1515, which equates to 39% of people responding and having the check. The NHS health check guidance recommends to invite a maximum of 20% of the eligible population per year. The average national response rate to the invitation is 48.6%. Members acknowledged that awareness of the Healthy Heart Check does need to be raised and people need to know and understand the importance of the check. Public Health England is encouraging people to find out the age of their heart by using a new tool called 'My Heart Age'. By using the tool people can find out the age of their heart by inputting simple lifestyle information, such as their weight and whether they smoke, and see how this compares to their actual age. They can then take action to improve their health. The personalised results, combined with the NHS Health Check, give an opportunity for people to take action to reduce their risk of developing serious but preventable conditions. The tool is available on the NHS Health Check website and also includes information about what happens at the NHS Health Check.

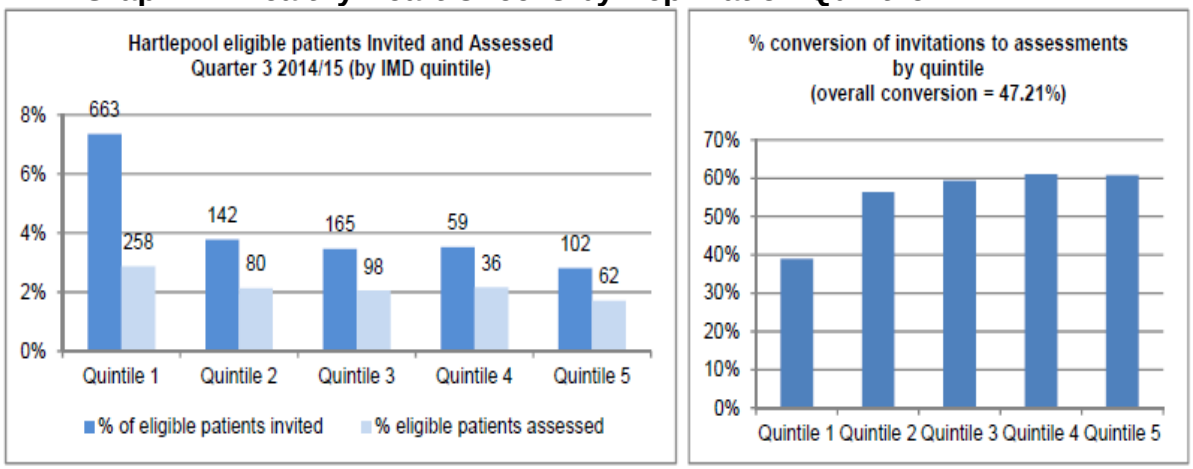
Table 1 – Healthy Heart Check Q1-3 2014/15

	Eligible patients	Total invitations at Quarter 3 2014/15	Total assessments at Quarter 3 2014/15
Middlesbrough	36266	6906	3273
Redcar & Cleveland	35463	6996	2489
Stockton	50070	10381	3588
Hartlepool	22934	3882	1515
Totals	144733	28165	10865

10.10 The data in relation to the eligible patients invited and assessed in each deprivation quintile is shown overleaf. Eligible patients from quintile 1 (most deprived) are prioritised. GP practices receive lists of eligible patients to be invited to health checks from Public Health. Patients from quintile 1 are less likely to respond to the invitation for a health check. This could be due to a number of reasons such as not wanting to visit the GP practice, maybe a lack of understanding / benefits of the check, not reading the invitation, not

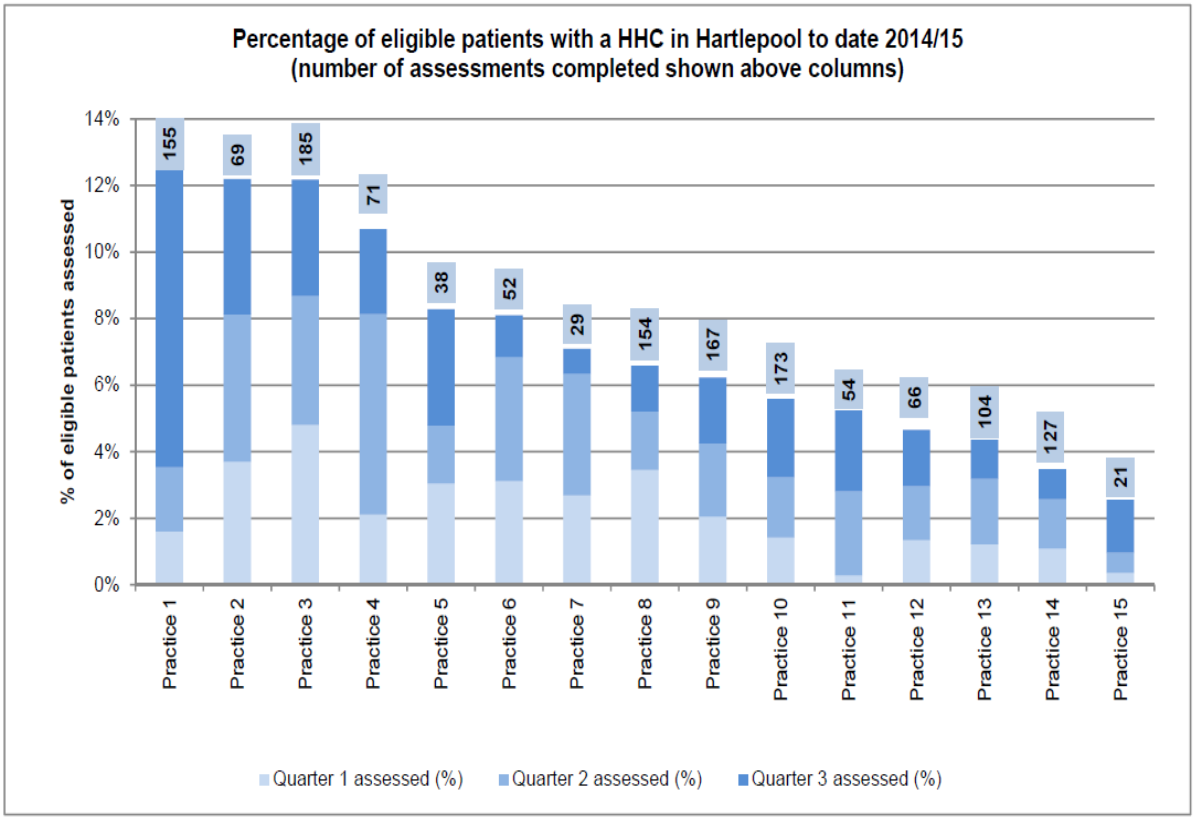
responding to postal invitations, not having time to respond or not wanting to attend a pre-booked meeting. It is known that people in quintile 1 respond better to telephone invitations and when offered walk in facilities in community venues.

Graph 2 – Healthy Heart Checks by Deprivation Quintile



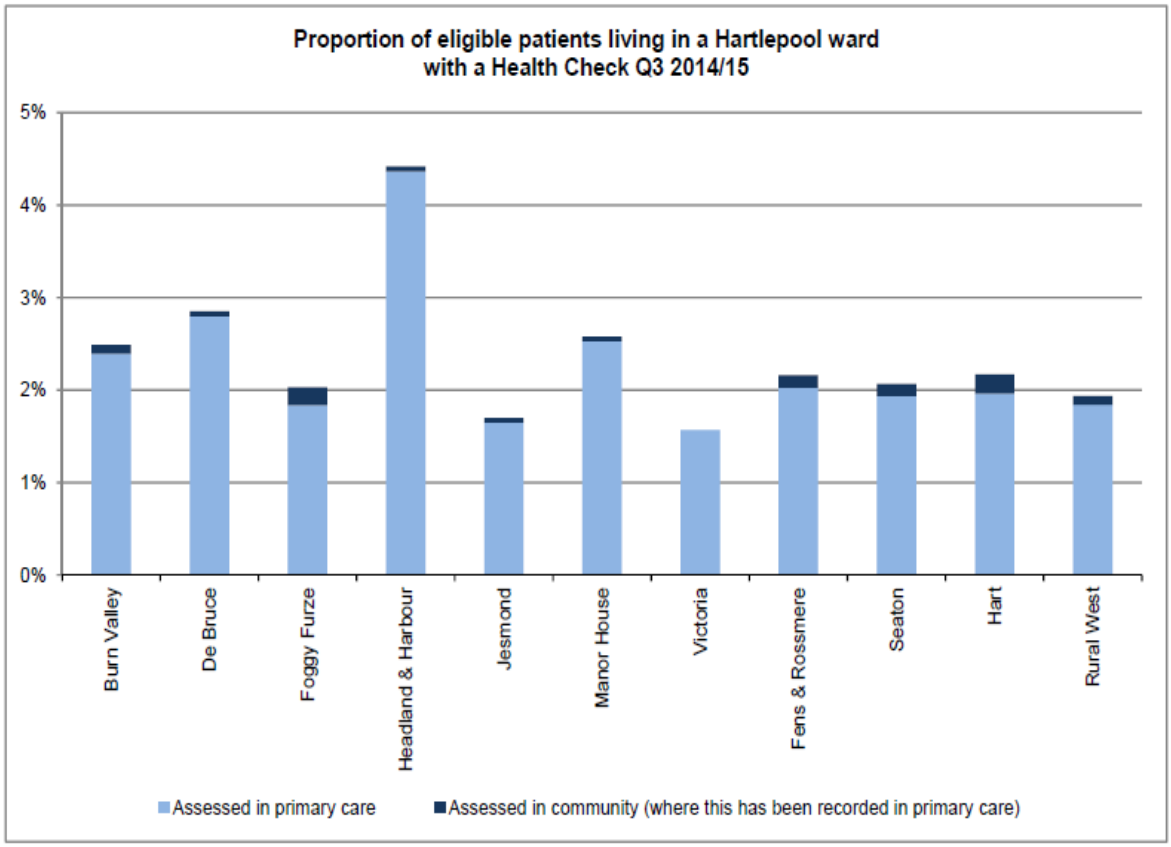
10.11 Graph 3 shows significant variation between GP practices across Hartlepool. However, figures need to be looked at with caution, as bigger practices will obviously have a higher number of eligible patients. Practice names are anonymised but practices are currently being approached to allow benchmarking information to be shared in the future. Members noted that it would be beneficial to know the practice names. Once the practice names are released it may increase the competition amongst practices and perhaps increase attendance at Healthy Heart Checks. The Council has developed a directory of services which is hoped that GPs will use to refer practices onto other services if needed, for example, the Stop Smoking Service. The HealthWatch representatives commented that while there were many GPs in the town taking proactive measures, some were not.

Graph 3 – Healthy Heart Checks in GP Practices April – December 2014



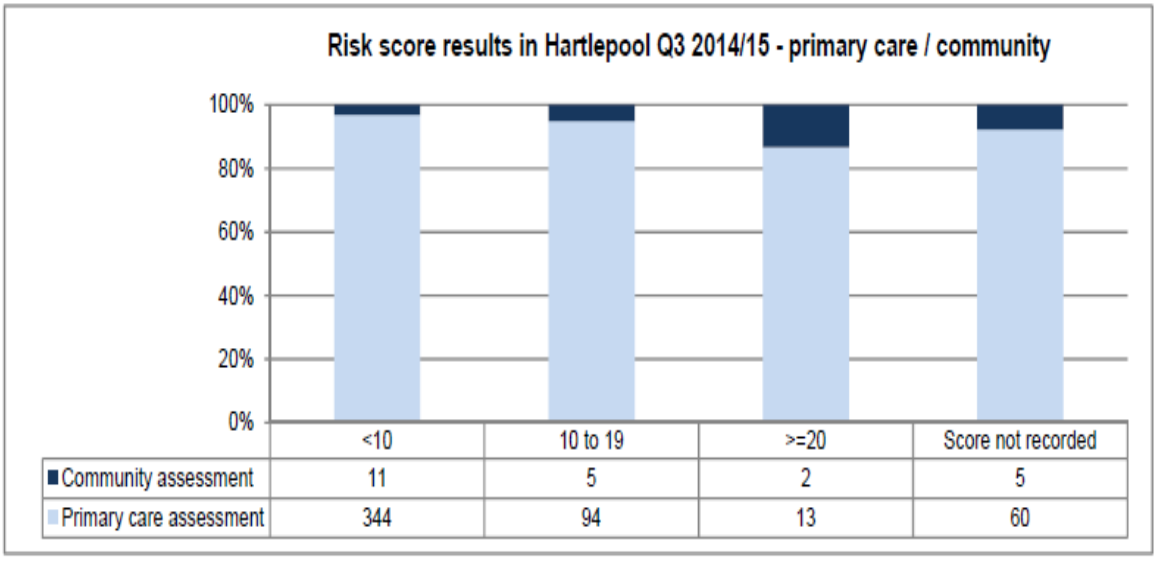
10.12 Graph 4 illustrates the number of Healthy Heart Checks undertaken in each ward in quarter 3, and indicates those assessed at a GP practice and those assessed in the community (where this has been recorded in primary care). Data has to be interpreted with caution as uptake and numbers of assessments vary considerable between quarters.

Graph 4 – Healthy Heart Checks by Ward



10.13 Table 5 illustrates the Healthy Heart Check outcomes. This data is for quarter 3 of 2014/15, therefore should be interpreted with caution as data varies considerably between quarters. From the collated information 15 (3%) patients were diagnosed with high risk for CVD (with nearly half of these receiving a statin), 99 (19%) patients with moderate risk and 355 (66%) patients with low risk.

Table 5 Healthy Heart Check Outcomes



	<10	10 to 19	>=20	Score not recorded
Community assessment	11	5	2	5
Primary care assessment	344	94	13	60

10.14 Members requested details about the Lifestore in Middlesbrough. The Lifestore is based in the Cleveland Centre and was established in 2006 by the former Primary Care Trust with the intention of providing information and advice about health and health services to the local population. The intention was also to offer health services/clinic from the unit. However, this has been limited due to the scope of the lease. The service is currently provided by the Pioneering Care Partnership and commissioning responsibility has transferred to the CCG. It is understood that the service is currently under review. Members suggested the possibility of a similar model in Hartlepool in the Middleton Grange Shopping Centre.

10.15 Members questioned what work was ongoing in Redcar relating to Healthy Heart Checks. The work in Redcar uses GP records and demographic data to identify areas/population groups where Primary Care provision of health checks is not reaching. A Nurse Facilitator within the Tees Valley Public Health Shared Service has been working with Redcar Council to identify appropriate sites to extend the reach of the service and establish partnerships with organisations who engage with the target group to increase awareness and proactively signpost. Health Checks have been delivered on a trailer on the high street and in other settings such as libraries. The checks have been delivered by a Healthy Heart Check Nurse Bank located at South Tees Trust who is commissioned to provide Health Checks. This 'outreach' approach is currently being evaluated. The outcomes of the pilot project will be shared with the other Tees authorities.

Work in Schools

10.16 Members were interested to hear about the work in schools relating to cardiovascular disease. Between April 2012 and end of March 2015, the British Heart Foundation (BHF) funded a project to raise awareness among school children between the ages of 7 and 14 of the risk factors that contribute to coronary heart disease. Every school, bar one, in Hartlepool participated. It became apparent that many schools were already doing a lot of health-related work but the project provided a focus and offered support, resources, publicity, motivation and ideas to school staff in delivering CVD prevention messages mainly around healthy eating, being more active, not smoking and overall heart health and how the heart works. The idea was that after the 3 years of the project, the good practice embedded would be sustainable through delivery by staff in school.

10.17 Both public health staff members employed in the project left in August 2014 to take up other posts, but the Health Improvement Team has been able to sustain some of the work. The HBC Community Nutritionist in the Team continues to work with schools on healthy eating including looking at school meals provision and delivery to support the children to make healthier choices at lunchtime. For example, using colour coded menus for children to pick foods from particular food groups. In addition, the remaining money left in the BHF grant has been used to provide a Healthy Cooking in the Community programme aimed at children and parents and carers. This follows on from a

series of successful cooking in schools sessions where it was recognised that parents would benefit from a community programme.

10.18 BHF money has also been used to continue to commission a theatre in education group called 'Gibber' that provides a drama performance workshop called 'The Truth for Year 7' pupils in all secondary schools to raise awareness of the consequences of smoking and the tactics of the tobacco industry to recruit young smokers. These have been running for 5 years and prove very popular with pupils and staff.

10.19 With regard to physical activity in schools, the BHF project enabled the introduction of a range of physical activity opportunities and challenges for children in schools and provided opportunities for the Council's own Sport and Recreation staff to get into schools and develop work, which will be ongoing. To date, there has been no central call to lobby for increasing physical activity time within the curriculum. Members were concerned that only 1 lesson a week was dedicated to PE.

10.20 Through the mainstream Public Health budget, a tobacco intervention is currently being developed for delivery in the school and youth setting to provide opportunities for young people who want to quit to access appropriate help and support linking with the Specialist Stop Smoking Service. This is based on insight work carried out with young people in Hartlepool identifying their preferred means of support. The intervention will also encourage all young people, whether they smoke or not, to be involved in the tobacco agenda aiming to make smoking 'not cool' in their school / youth club. As part of this intervention 'Gibber' has been commissioned to produce a drama and workshop for Year 10 pupils. Members reiterated that CVD messages needed to be continued to be reiterated through schools in a language that school children would understand. Members questioned if the Council could influence Headteachers to encourage healthy eating, for example, only allowing children to eat on the school premises rather than at food outlets outside of the school.

11. **BUDGET**

11.1 Members questioned the Council's budget provision for CVD services. The Director of Public Health provided the following information. The total budget for the provision of NHS Checks and Health Improvement interventions for 2014/15 is as follows:-

- £88k for GP surgeries NHS Health Checks (General Prevention Health Checks)
- £40k for Cardio Vascular Disease Bank Nurse (Community and Workplace Health Checks)
- £58k for Mobile Health Improvement Service (which provide Healthy Heart Checks as part of an integrated Health Improvement Service). This budget is not exclusively for Healthy Heart Checks as these are delivered within a package of Health Improvement Services, not in isolation.

11.2 The Director of Public Health advised that the budgets / resources allocated to CVD are sufficient and all partners are fulfilling their statutory roles.

11.3 The Council commission a Mobile Health Improvement Service which is known as the 'Health Bus' to deliver a broad spectrum of health improvement services, not exclusively for Healthy Heart Checks. The total cost of this service is £57,680. It has engaged with 2308 individuals, in the community, in the first 9 months of service and significantly through the screening programmes it delivers; 2 of which identifying life threatening conditions, which led to immediate response referrals, potentially saving the lives of those individuals concerned.

11.4 Members visited the Health Bus on 2nd March 2015 and were impressed with the overall service being provided. Members received anecdotal evidence from the nurse practitioner to demonstrate the value of the service and levels of patient support. Examples included the success of the service in identifying a gentleman who had been found to have extremely high blood pressure, resulting in a referral to his GP for further investigations and subsequent admittance to hospital. Also, the treatment of a man walking past the bus with chest pain that was looked at by the nurse and an ambulance was called due to a suspected heart attack.

11.5 Following discussions regarding the ability of the nurse on the bus to deal with heart attacks, Members questioned whether a defibrillator was installed on the vehicle. Members noted that at the present time a defibrillator was not placed on the bus and that a request had been submitted as part of the programme for the installation of devices in community settings across the town. Members expressed their support for the installation of a defibrillator on the bus as part of the programme across the town.

12. SECONDARY AND TERTIARY CARE SERVICES

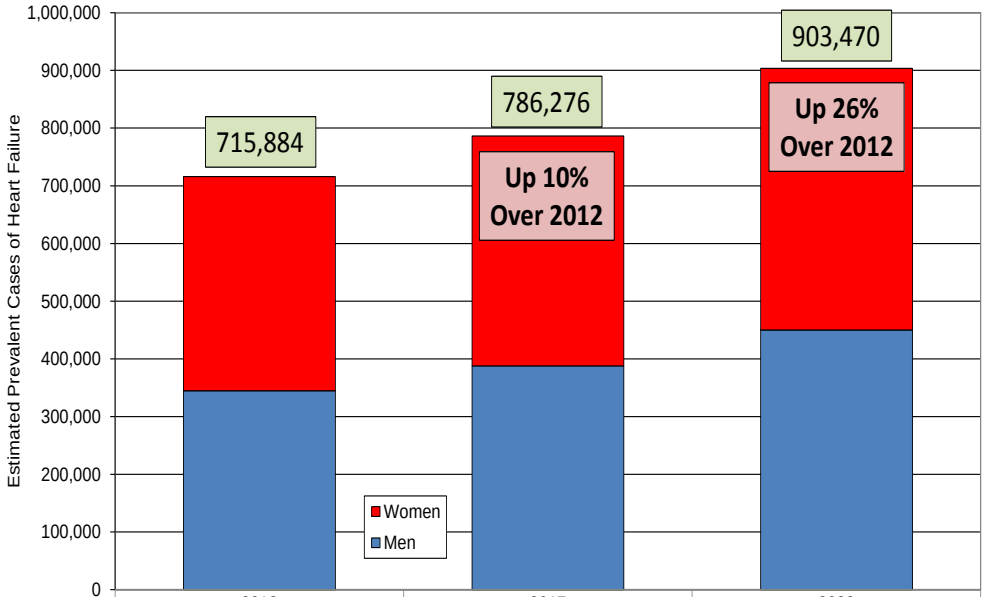
12.1 Members received evidence regarding secondary and tertiary care services from South Tees NHS Foundation Trust, North Tees and Hartlepool NHS Foundation Trust and the North East Ambulance Service.

South Tees NHS Foundation Trust – Cardiology Department

12.2 Members received a presentation from the Consultant Cardiologist and Chief of Cardiothoracic Services at South Tees Hospital. Members were informed that CVD causes 200 thousand deaths per annum and 4.9m adults have CVD, which is 11.7% of the population. There was 1.4m hospital admissions in 2010/11 and 65% were patients under 75 years with more than 50% being emergencies. CVD costs the NHS and UK economy £30billion per annum. Prevalence of CVD increases with deprivation and due to lifestyle, i.e. diet / obesity, CVD is starting to become more prevalent. Children are now being diagnosed with diabetes, which a major concern. The future prevalence of heart disease is shown over the page.

Long Term Conditions: Heart Failure - Future Prevalence

England – Heart Failure – Prevalence Cases – Projected Numbers to 2022 – Based on General Practice Research Database 2010



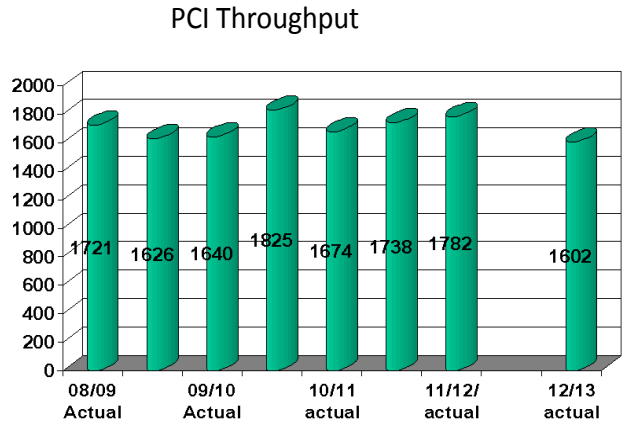
	45 Plus		
Women	371,156	398,461	453,129
Men	344,728	387,815	450,342

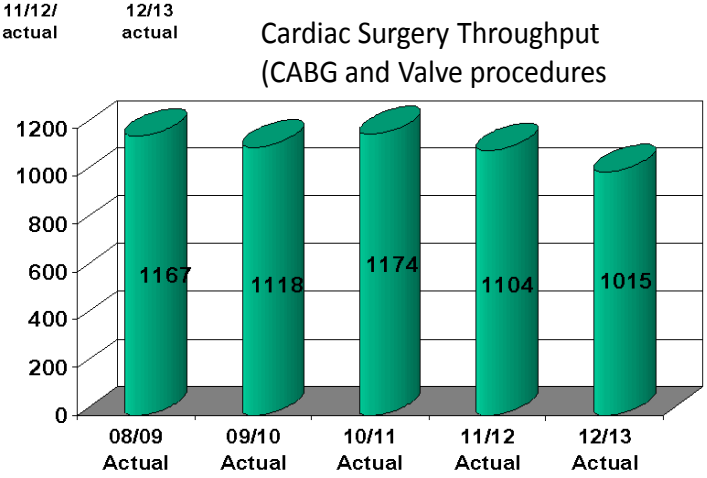
Source: General Practice Research Database 2010, reported in British Heart Foundation Coronary Heart Disease Statistics . 2010 Edition Heart Failure rates by Age/Sex applied to ONS Population Projections.

12.3 There are a range of services offered at the Cardiothoracic Division at James Cook University Hospital, which include:-

- Cath Lab
- CT surgery / ITU
- Electrophysiology
- Rehabilitation
- Heart failure
- Cardiac imaging
- Valve Surgery
- Arrhythmias/AF Pacing / Device
- Prevention
- Heart failure
- Diagnosis and monitoring
- Chest pain
- Acute coronary syndromes

The throughput of the services is shown in the graphs below.





12.4 Members were informed that there have been major improvements in cardiac services since 2000. The National Service Framework for Coronary Heart Disease – National Service Framework (2000) states that "this framework will transform the prevention, diagnosis and treatment of coronary heart disease. It will help professionals to give better, fairer and faster care everywhere, to everyone who needs it. We want a service that is amongst the best in the world. Our people deserve nothing less" (Alan Milburn, Secretary of State for Health).

12.5 In 2000, the UK did not have high rates of diagnostic catheterisation compared to the rest of Europe. Since 2000, there has been significant financial investment in the coronary heart disease infrastructure, clinical pathways, cardiac networks and commissioning of services. Mortality rates have halved from 1970 to 2009. Members commented that early diagnosis was essential.

Cardiovascular Disease Pathways

The Cardiology division provides the following services:-

12.6 **Acute chest pain management**. Patients who call 999 with suspected cardiac chest pain will have an electrocardiograph performed by the

paramedic and this will be faxed directly to the coronary care unit (CCU). The paramedic will then contact the CCU senior sister providing details about the patient and their symptoms. The CCU senior sister will decide on the most appropriate department for admission based on the information provided. The patients with heart attacks and unstable angina or unstable heart rhythms will be admitted directly to CCU. The patients with other types of chest pain will be admitted to the acute admissions unit (AAU) or accident and emergency (A&E) and investigated appropriately. Patients suffering from a particular type of heart attack known as a STEMI (ST-Segment Elevation Myocardial Infarction) will usually be offered angioplasty treatment immediately regardless of time of day. Those patients who self present in A&E with STEMI will also be offered immediate angioplasty.

12.7 **Cardiac rehabilitation**. The team is a multi-disciplinary team which includes nurses, physiotherapists, clinical exercise physiologists, health care assistants and clerical staff. The aim is to help people who have suffered a heart-related illness work towards healthier lifestyles.

12.8 **Cardiology**. There is a full and comprehensive range of modern, diagnostic and therapeutic techniques at The James Cook University Hospital for a large population. These include facilities for, echocardiography, exercise stress testing, ECG and BP monitoring, angiography and percutaneous coronary Interventions, insertion and follow-up of pacemakers electrophysiology including radiofrequency, ablations and implantable defibrillators. There are also specialist clinics for chest pain, arrhythmia, heart failure, cardiac genetics and adults with congenital heart disease. On average the team perform 3,000 cardiac catheters, 1,700 angioplasties (using a balloon to unblock the arteries) and fit 350 pacemakers a year. The team also help the care of patients with chronic heart disease that develop other major illnesses and are supported by the cardiac rehabilitation department that provides a seven-week programme for patients recovering from heart conditions or surgery.

12.9 **Cardiothoracic surgery – cardiac intensive care**. A full range of cardiac surgical interventions, including coronary bypass, arrhythmia and valve operations are offered, with the current exception of heart transplantation. Surgical intervention is also provided as emergency care to patients who suffer traumatic chest injuries. Patients who are referred for surgery will meet members of the team before their operation and receive plenty of information and advice. Pre-admission clinics are regularly held for surgical patients, at which relatives are also welcome.

12.10 **Rapid access chest pain clinic**. There is a rapid access chest pain clinic that is run on a daily basis and appointments will be offered within 2 weeks of referral. The rapid access chest pain clinic (RACPC) at The James Cook University Hospital has a daily service dedicated to patients with recent onset chest pain (within 12 weeks) where cardiac origin is likely or suspected. Patients can be referred to the service by their GP or occasionally via the A&E department or AAU. During clinic attendance, which lasts for 40-60 minutes, patients will be seen by the nurse/doctor, a history will be taken of their

symptoms of chest pain, physical examination and exercise tolerance test will be performed. Following this a treatment plan will be formulated in conjunction with the patient. Prescribing will be performed as necessary, but this will mainly be the remit of the GP. Treatment plans will be faxed to the GP within one working day of clinic attendance. Patients requiring angiogram/angiography will be listed and pre-admitted during their attendance at RACPC to ensure waiting times for procedures are kept to a minimum.

12.11 **Cardiac function clinics.** The clinics offer heart failure diagnostics including community clinics and immediate echocardiology.

12.12 Members questioned why many services were being concentrated in one locality, for example, heart attack services. This is because concentrated services are proven to have better outcomes and if surgeons treat less than 500 patients then the service is not as good. It is costly to deliver services in a range of localities and as IT systems are now better advanced, it is possible to diagnose people in community settings. The direction of travel has to be in a community setting, not in a hospital. Better treatment and better outcomes come with centralised services. It is about getting more diagnostic services, initial assessments and treatment out into the community, as close to patients as possible.

12.13 The Joint Strategic Needs Assessment is used to help tackle inequalities and working with health services to help shape the JSNA will help tackle health inequalities at a strategic level.

12.14 On 5 March 2013, the Department of Health published a CVD Outcomes Strategy[2] which recommended a number of measures:-

- Manage CVD as a single family of diseases
- Improve prevention and risk management
- Improving and enhancing case finding in primary care
- Better identification of very high risk families/individuals
- Better early management and secondary prevention in the community
- Improve acute care
- Improve care for patients living with CVD
- Improve intelligence, monitoring and research and support commissioning

12.15 Some of the actions to address these measures include:-

- Integration of services
- Raising awareness
- Improve survival from out of hospital cardiac arrest
- 24x7 cardio vascular services

[2] Department of Health – Cardiovascular Disease Outcomes Strategy, Improving outcomes for people with or at risk of cardiovascular disease

12.16 The Cardiologist concluded:-

- There is falling CVD mortality but this may reverse due to an increase in obesity, diabetes
- Important to have an integrated approach to prevention and care and the importance of data
- The future challenges are as follows:-
  - Medical inflation and healthcare funding
  - Ageing population and lifestyles
  - Integration of services
- The 5 Year Forward Plan stresses prevention, models of care and use of information/data
- Local services have started journey towards:-
  - Specialist care
  - Community clinics for diagnostics, initial assessment and treatment
  - Look at the next steps
- Success will require collaboration:-
  - Primary, secondary and tertiary care
  - Local authorities
  - Charities
  - Specialist societies and Royal Colleges
  - NHS England
  - Health Education England
  - Commissioners

North Tees and Hartlepool NHS Foundation Trust – Cardiology Department

12.17 Members received evidence from the Consultant Cardiologist at North Tees and Hartlepool NHS Foundation Trust. Members were informed that coronary heart disease is the most common cause of death in the UK and the UK underperforms most of Europe. There are high rates of Coronary Heart Disease in Scotland and North East England.

Cardiovascular Disease in Hartlepool

12.18 Compared to the England average in Hartlepool there is a 55% increase in admission to hospital and 57% more heart attacks (there are similar levels for cancer and respiratory illnesses). In Hartlepool there is a 10% increase in CVD death and a 16% increase in premature CVD deaths.

12.19 Members questioned the causes of CVD and why they were highest in the North East of England. It was confirmed that it was a combination of many factors including smoking and poverty.

12.20 Members were informed that there has been significant investment in the cardiology department at North Tees and Hartlepool NHS Foundation Trust (NTHFT) including:

- increased numbers of cardiologists
- improved diagnostics
- local services
- enhanced community services
- streamlined pathways
- Investment in new equipment – for example, a new CT scanner

12.21 There is a cardiology outpatient service based at the University Hospital of Hartlepool with Consultant led clinics that look into general cardiology, heart failure, arrhythmia (pacemakers) and structural heart disease. The clinics have approximately 800 new patients a year and over the past two years the clinics have started to expand. There are also nurse led clinics, which are the rapid access chest pain clinic (which has 600 patients per year and GPs can refer to the service and patients will usually be seen within 2 or 3 days and guaranteed to be seen within two weeks), the Community Heart Failure Liaison Clinic, the Valve Clinic and the Arrhythmia Clinic.

12.22 In 2010, NTHFT had one cardiologist, no speciality clinics and limited urgent capacity. Now, in 2015 there are 4 cardiologists with speciality clinics and increased urgent capacity.

12.23 Diagnostic testing services are offered at the University Hospital of Hartlepool in the Cardiac Investigations Unit which offers a full range of non-invasive testing, which includes a ECG reporting service for local GPs, echocardiography, heart monitors and BP monitors, exercise testing and pacemaker follow-up.

12.24 The cardiac services offered at North Tees Hospital are the same as those offered at Hartlepool but at the North Tees site they carry out complex imaging and the cardiology day unit and catheter lab offers diagnostic angiography (800 patients a year) and pacemaker implants (200 patients a year). There is an acute cardiology ward at North Tees hospital, with up to 6 high monitored beds. There are daily consultant led ward rounds on a weekday, which has improved care (quality and safety) and shorter admissions. The aim of the cardiology unit is to provide 7 day cardiologist cover.

Community Based Services

12.25 Members were informed that CVD patients are well served by community CVD services and the Cardiology Team are trying to expand local services further / enhance community programmes. The data collected from GP's shows that there is an increase from 30% to 70% of referrals to the clinics, therefore the demand is there and the expectation is to expand services to

meet demand. The community heart failure clinic is a service for severe heart failure, 200 patients in Hartlepool use the service and home visits are undertaken where needed. The service offers supported discharge from hospital and has links to palliative care services. Most patients are seen in local clinics where the investigations are undertaken. Offering services to patients earlier in their pathways will help to prevent people being admitted to hospital. Cardiac rehabilitation is offered to all patients following a heart attack, which provides patients with lifestyle advice, point of contact and a graded exercise program. When measuring cardiac rehabilitation on improved medical outcomes, the data shows that it does not have a great impact, but patients enjoy the rehabilitation as it contributes to improved quality of life. One of the roles of the Cardiology Team is to educate GP's about services available to CVD patients.

12.26 Members questioned whether care offered at GP surgeries is helping to detect heart disease. In response to the question, the Cardiologist said that care delivered in primary care is valued, although care provided by some GP's is better than others. There was a discussion about GPs carrying out / reading ECG's, and in Stockton nearly all GP's have access to ECG's and can read them, whereas in Hartlepool patients are referred to the hospital for an ECG and then back to the GP with the results. Members asked if the Cardiology Team could influence GPs about the use of ECGs in their surgeries, and the Cardiologist confirmed that he had made suggestions to GPs about this but he was not aware of any GPs who were offering ECGs.

12.27 The group discussed targeting primary prevention and trying to get all GPs to recognise that prevention does work i.e. the Healthy Heart Checks.

Tertiary Services

12.28 The North East has a strong cardiac network, who meets three times a year, topics discussed include collaborative working, agreed pathways of care, managed expansion and devolution. NTHFT has close links to James Cook University Hospital with cross site posts, participation in education program and multi-disciplinary meetings between James Cook and NTHFT.

12.29 Members were informed that people are living longer in 2014 even though they are travelling further for treatment.

13. THE ROLE OF AMBULANCES IN RELATION TO CARDIOVASCULAR DISEASE

13.1 Members received evidence from a Consultant Paramedic at the North East Ambulance Service. In relation to CVD the ambulance service treats the following conditions:-

- ***Acute Coronary Syndrome*** **(angina, myocardial infarction (MI))**
  Angina is a narrowing of the coronary arteries which can be relieved by rest but may need drugs to widen the arteries.
  MI is captured by the ECG and requires primary percutaneous coronary intervention (PPCI) and drug therapy on route to hospital

- ***Stroke***
  The FAST (Face, arms, speech, time) is used and if positive then the patient is transported to a hyperacute stroke unit and given oxygen on route, the hospital is alerted of the emergency.

- ***Cardiac Arrest***
  This is a complete stop of the heart and the most important action is for the patient to receive CPR immediately and this is normally by a bystander, although the North East is one of the worst areas for bystander CPR. Treatment for a cardiac arrest can include defibrillator and drug treatment and 70 to 80% are treated at the scene. The drug that is used to treat a cardiac arrest is adrenaline, although there is no evidence to suggest that this is the most effective drug to use. Therefore, NEAS, along with 4 other ambulance services in the country are trialling a new drug.

13.2 The Consultant Paramedic is currently developing a Cardiac Arrest Strategy and within this he intends to include how to increase bystander CPR along with more public access to defibrillators. Members discussed CPR training and the lack of people trained in CPR and suggested that secondary school children would be appropriate people to be trained in CPR. Also, members suggested that it would be beneficial if more staff within the local authority were CPR trained.

13.3 Members supported the use / access of defibrillators in public places but stressed the need for defibrillators in the workplace, which was supported by the Consultant Paramedic. Members supported Public Health's approach to encourage employers to place defibrillators in the workplace and also to provide training for Council staff and Councillors on the use of defibrillators. Members stressed the importance of not only having a defibrillator in the workplace but also to register it with NEAS, as this will then make paramedics aware of when it is in use. In keeping with this, Community Defibrillators are currently in the process of being placed in Council-owned buildings and Parish Council locations with training for the staff and community to follow.

13.4 Members were informed that NEAS staff in their own time were piloting the use of a cardiac arrest car. The car is being piloted at Newcastle and the paramedic indicated that if the patient is treated by the cardiac arrest car then the patient has a 3 times higher chance of being discharged from hospital following the cardiac arrest. It is hoped that further cars can be made available across the North East, although this will be subject to funding. It was anticipated that 3 to 4 cars would be needed to cover the North East, which would cost on average 1.5 to 2 million pounds. It was recognised that the car was a success because of its specialism in treating certain conditions;

it was about getting the best responder in place. In general paramedics do not attend many cardiac arrests but the paramedics on the car, only attend cardiac arrests therefore they build up their knowledge and learn each time from their experience.

13.5 Members questioned the use of the Fire Brigade as first responders to cardiac arrests, as concern was raised about the resource implications and funding issues. This method of using the Fire Brigade as first responders has proven successful in America but Members were concerned that often a 'mix and match' service fails to deliver.

NEAS Performance

13.6 The ambulance service quality indicators collate data from a variety of incidents and are categorised as emergency service unplanned care for cardiac arrest, ST segment elevation myocardial Infarction (STEMI), and stroke. The indicators are aimed at accessing the treatment provided by ambulance clinicians, based on their initial assessment and diagnosis of the patient when attending the incident.

13.7 In relation to STEMI, the indicator measures the percentage of patients suffering a STEMI and who, following direct transfer to a PPCI centre receive primary angioplasty within 160 minutes of the emergency call. NEAS are below the national average for this indicator. The national average is 89.5% and NEAS is at 86.6%. NEAS are currently ranked 8th in the country for this indicator. The Consultant paramedic explained that NEAS are not getting patients to hospital in good time and explained that this was due to a shortage of paramedics and delayed hospital turn around times. Third party ambulance providers, such as Red Cross and St John's Ambulance were being used to transport patients to hospital when a rapid response car was on scene. The rapid response paramedic will then go with the patient in the third party ambulance to hospital.

13.8 NEAS are above the national average for the indicator which measures the percentage of patients suffering a STEMI who receive an appropriate care bundle. The national average is 80.2% and NEAS are performing at 85.1% and are ranked 3rd in the country.

13.9 In relation to stroke, the percentage of FAST positive stroke patients potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke unit within 60 minutes of emergency call is 70%, and the national average is 60%. NEAS are ranked 2nd in the country for this indicator.

13.10 98.4% of suspected stroke or unresolved transient ischaemic attack patients (assessed face to face) receive an appropriate care bundle, this compares to a national average of 97%.

13.11 Regarding cardiac arrest performance, NEAS are measured on patients who arrive at hospital with a heart beat. NEAS is performing at 35.7% and the national average is 30.1%. NEAS are ranked 3rd in the country.

13.12 NEAS are also measured on survival to discharge. This is the percentage of patients who survive after admission to hospital; this figure is very low at 4.9%, compared to 8.2% nationally. Although, if a patient receives treatment from the specialised cardiac arrest car this figure rises significantly to 12%. If the patient has a 'shockable rhythm' there is a 20% of survival to discharge. NEAS are ranked 10th in the country for this performance indicator.

14. REHABILITATION PROGRAMMES / LEISURE CENTRES

14.1 Leisure Centres in Hartlepool offer a wide range of activities, for example, free swimming for school children, GP referrals to exercise classes (detailed below), subsidised charges for activities through the use of the Active Card. Members questioned if Healthy Heart Checks could be undertaken in community venues, such as leisure centres, libraries and community centres. The Healthy Heart Checks do take place in community and workplace venues including Hartlepool Borough Council, as well as GP practices and clinical settings.

14.2 Members asked about the NHS Health Trainer Service. The NHS Health Trainer Service in Hartlepool, currently provided by North Tees and Hartlepool NHS Foundation Trust, will move into the Local Authority as of 1st April 2015. The service is the only Tier 2 (Community) Weight Management Service for adults currently operating in Hartlepool, where obesity and overweight currently affects 68.5% of adults. As such, the service forms an integral part of the Healthy Weight Healthy Lives Strategy and obesity pathway for Hartlepool. There are 5 health trainers plus one team leader, strategically placed at key areas in the community to offer free one to one and group based support around nutrition, healthy lifestyle and behaviour change. People can self refer into the service or seek a referral from other clinical services. Health Trainer-led weight management clinics are also provided in several GP practices across the town. The move into Public Health within the Local Authority will enable more flexibility and control over the future development of the service, to ensure there are closer working links with key council services such as adult social care and sport and recreation teams. There is also scope to consider how the service could support delivery of the Healthy Heart Check agenda and also support families, not just adults with nutrition and healthy lifestyle advice.

<u>Visit to the Cardiac Rehabilitation Community Exercise class</u>

14.3 Members were offered the opportunity to visit the Cardiac Rehabilitation Exercise Class at the Mill House Leisure Centre. The Exercise for Life Programme provides opportunities at weekly supervised sessions for those patients with Coronary Heart Disease (CHD) to continue exercising on completion of their Phase 3 NHS Cardiac Rehabilitation programme. This

Phase IV provision is an extension to the secondary care offered by the NHS services, offering long term maintenance of physical activity and life style change to reduce the risk of recurrent events. The HELP scheme has a good working partnership with the Community Coronary Heart Disease Specialist Nurse team who are based at the McKenzie House surgery.

14.4 The British Association for Cardiac Rehabilitation protocols are followed regarding the referral process, with the confidential exchange of the relevant patient information from the Phase 3 teams to the GP Referral Coordinator. Patients give their consent for this to happen, the patient's GP is then informed that this process has taken place. Any instructors who hold this nationally recognised advanced qualification have to revalidate their teaching certificate every three years.

14.5 Groups of patients seen are:-
- Post Heart Attack - M.I's
- Coronary arteries bypass graft and valve surgeries
- PCI's (stents or balloon insertions)
- Pacemakers and other implanted devices
- Heart Failure patients
- Stable angina

14.6 Phase IV exercise offers the opportunity for patients to maintain and increase their fitness levels. This in turn increases their confidence and supports them as individuals as well as helping their families. The sessions also offer a social element to support those who otherwise may live quite a solitary life.
GPs and CHD Nurse Practitioners also refer to the Phase IV provision direct from the surgeries. These patients may have Angina or be at risk of increasing risk of developing heart problems. The NHS - CVD Cardiovascular Disease screening programme identifies those patients who could benefit from the HELP scheme service and all referred patients are given the opportunity to engage.

14.7 People who are anxious are encouraged to observe sessions prior to participation so that they and their family members are more comfortable with the transition from the NHS clinical teams to the community exercise professionals who work in this area. On completion of an initial 10 week period of attending, allowing time for assessment on cardiovascular function patients are then sign posted to further opportunities in the councils leisure centre services offering a menu of choice. This provides more flexibility and variety to their physical activity sessions. At the present time clients do pay a small fee to attend their exercise sessions this is £1.80 per session if the patients are over 60 years of age in line with the Council's Sport and Recreation Concession Active Card scheme. If a patient does not fit this category the cost to take part is £2.70 per visit. To date, the Exercise Co-ordinator has had little feedback to suggest this is a barrier to access, but it is something that is always considered when receiving new referrals.

14.8 The benefits for patients who maintain regular cardiac rehabilitation structured exercise in the long term are:-

- Reduced hospital admissions
- Reduced Angina
- Improved Lipid Profile
- Reduced Blood Pressure
- Improved functional capacity
- Improved compliance with positive lifestyle behavioural changes
- Reduced anxiety and depression
- Increased confidence and well being
- Improved likelihood of a return to work and leisure activities
- Improved health education for families and friends

14.9 Some comments received from the patients are listed below:-

"really thorough and brilliant, trainer keeps a good check on you. Help and guidance is offered, very worthwhile class, everyone is cared for ".

Smoking Cessation Clinics

14.10 Members visited a smoking cessation clinic. North Tees and Hartlepool NHS Foundation Trust is commissioned through local authorities to provide stop smoking clinics across Teesside at a number of convenient venues in Stockton, Hartlepool, Middlesbrough and Redcar and Cleveland. There are also a number of pharmacies that can offer stop smoking treatments along with various GP practices. There is a team of specialist advisors who provide friendly and non-judgmental help to smokers. The support is tailored to each individual to provide the best possible chance of quitting.

14.11 Members were concerned that smoking among young people seemed to be on the increase and were concerned that many could be using e-cigarettes as they thought them to be less harmful. The use of flavoured e-cigarettes as well was also thought to appeal to young people. Members were informed that smoking cessation work was carried out through youth workers.

14.12 Members questioned whether all services provided to help prevent cardiovascular disease were sufficiently joined up and questioned whether smoking clinics and healthy heart checks could be offered at the same time / same place. Logistically, offering the service at the same time would not be of benefit. It was also questioned whether there is sufficient "joined up" thinking/action both within the Council and with partner agencies, for example, altering lifestyle choices through Economic Development and housing initiatives and other critical factors? It was acknowledged that there is some evidence of joined up working, however, as organisations, roles and responsibilities are now clearer and embedded post April 2013, there is scope to deepen joint working and integrate further.

15. CONCLUSIONS

15.1 Council concluded that:-

Inequalities, Access and Provider Variation

(a) CVD is one of the significant issues facing the provision of Health Services in Hartlepool and is compounded by high levels of deprivation and health inequalities;

(b) Healthy Heart Checks / NHS Health Checks are a key tool in the early identification of CVD and signposting to treatment services. However:

- Take up is low, particularly in the most disadvantaged wards, with a significant difference between the number of invitations sent and the number of checks carried out;

- Invitations are predominantly sent to people living in the most deprived communities and evidence shows that these groups are historically less likely to respond; and

- It is known that people living in deprived communities respond better to telephone invitations and when offered walk in facilities in community venues.

(c) Patient numbers at GP practices, and the take up of Healthy Heart Checks, vary across Hartlepool. On this basis, the provision of data on a practice by practice basis would the beneficial in the evaluation of service provision and the sharing of good practice in the future;

(d) The provision of services from Community locations is a valuable alternative / addition to the provision of services at GP practices and will form part of the blueprint for service provision in the future;

(e) Data in relation to the conduct and outcome of Health Checks undertaken in community facilities is relayed to GP's as a matter of course. It is imperative that this occurs across all practices if the provision of services in community locations is to be a truly effective part of Healthy Heart Checks in the prevention and early detection of CVD;

Quality of delivery

(f) Work undertaken in schools has been effective in raising awareness of CVD, and whilst this was initially supported by the British Heart Foundation Project, it will in the future be embedded into delivery by staff in schools. It is essential that this good practice continues as schools are well placed to promote and encourage healthy lifestyle choices;

(g) Focus needs to be placed on the modifiable risk factors for CVD and how to prevent the disease in order to make people aware that CVD is a serious but preventable disease;

(h) Defibrillators for use within the workplace and community venues along with trained first aiders are crucial to help save lives and Members expressed their support for the installation of a defibrillator on the Health Bus as part of the programme being implemented across the town.

Integration with lifestyle / behaviour change providers

(i) The prevalence of CVD in Hartlepool is high due to a combination of factors including deprivation and lifestyle choices;

(j) There are a wide range of very effective lifestyle services provided by the Council and its partners in terms of prevention and early detection. This includes the Stop Smoking Service which is effectively linked in with the Healthy Heart Checks.

16. RECOMMENDATIONS

16.1 The Task and Finish Groups have taken evidence from a wide variety of sources to assist in the formulation of a balanced range of recommendations. With due regard to the evidence considered by each of the Groups, Council's key recommendations to the Health and Wellbeing Board are as outlined below:-

Provision of Services

(a) That following the transfer of Public Health responsibilities to the Local Authority and the inclusion of sports and recreation services within the Public Health Department, CVD provision commissioned by the Council be reviewed to ensure that:-

(i) It is effectively joined up and integrated to take advantage of the opportunities across service areas, with due regard to the wider piece of work being undertaken in relation to the Better Care Fund;

(ii) Community provision for the delivery of Healthy Heart Checks is developed and the use of community buildings, such as community centres and libraries be explored to improve accessibility and sustainability of services and facilities; and

(iii) There are no gaps/shortfalls in provision.

(b) That as part of the service review of the Healthy Heart Check Programme currently being undertaken by the TVPHSS consideration be given to:

(i) Why the take up of Healthy Heart Checks varies across GP practices, particularly in the most disadvantaged wards, with a significant difference between the number of invitations sent and the number of checks carried out;

(ii) How those from the most deprived communities can be better engaged, including the exploration of the most effective means of establishing initial contact;

(iii) How the process for the transmission of data to GPs practices in relation to Health Checks undertaken in the community facilities could be improved to better record community checks.

Prevention of CVD

(c) That the Health and Wellbeing Board support the approach to amend the childhood measurement letter, for use in the next roll out of measurements, in order to make it compassionate and friendly by using suitable wording;

(d) That an evaluation be undertaken of the work carried out in schools relating to CVD awareness, with focus on ensuring the continued provision of activities. The evaluation to include:-

(i) What schools are doing well;
(ii) How schools can promote CVD messages;
(iii) How schools can further raise awareness of healthy eating and lifestyle choices; and
(iv) How the Council can work with secondary schools to encourage schools to offer CPR training to their pupils.

(e) That the Council continue to raise awareness of CVD by:-

(i) Continuing to offer the Healthy Heart Check to Council staff;
(ii) Encouraging Council staff to become CPR trained; and
(iii) Publicising the Healthy Heart Checks in all Council buildings and GP practices.

Treatment of CVD

(f) That the Health and Wellbeing Board:-

(i) Encourage businesses across Hartlepool to install defibrillators within their workplace and register the defibrillators with NEAS; and

(ii) Explore the installation of defibrillators in venues for community provision usage, including the Health Bus.

COUNCILLOR STEPHEN AKERS-BELCHER
CHAIR OF COUNCIL

ACKNOWLEDGEMENTS

The Task and Finish Group is grateful to all those who have presented evidence during the course of our investigation. We would like to place on record our appreciation, in particular of the willingness and co-operation we have received from the below named:-

Hartlepool Borough Council:

Louise Wallace – Director of Public Health

Carole Johnson – Head of Health Improvement

Steven Carter – Health Improvement Practitioner (Workplace, Obesity, Physical Activity)

Jennifer McDermott – Community Nutritionist

Lorraine Harrison – GP Referral Co-ordinator

External Representatives:

Hartlepool residents

Lynne Allison, Healthwatch Hartlepool

Elaine Salvati – Nurse Clinical Lead. Tees Valley Public Health Shared Service

Rachel Forgan – Nurse, Tees Valley Public Health Shared Service

Dr Tanja Braun – Consultant in Public Health Medicine

James O'Donnell – Public Health Intelligence Specialist

Dr Michael Stewart – Consultant Cardiologist and Chief of Cardiothoracic Services, South Tees Hospitals NHS Foundation Trust

Dr Vineet Wadehra – Consultant Cardiologist – North Tees and Hartlepool NHS Foundation Trust

Paul Fell – Consultant Paramedic – North East Ambulance Service

Hartlepool Families First

Evidence provided to the Task and Finish Groups

The following evidence was presented throughout the course of the investigation into CVD:-

Date of Meeting	**Evidence Received**
16 October 2014	Setting the Scene Presentation from:- - Public Health representatives - Tees Valley Public Health Shared Service
14 November 2014	Visit to a Stop Smoking Clinic venue
17 November 2014	Primary care services and the healthy lives project / work in schools - Tees Valley Public Health Shared Service - Public Health representatives
9 December 2014	Visit to Cardiac Rehabilitation Class
10 December 2014	Presentation and verbal evidence from South Tees NHS Foundation Trust
8 January 2015	Presentation and verbal evidence from North Tees and Hartlepool NHS Foundation Trust
11 February 2015	Presentation and verbal evidence from the North East Ambulance Service
2 March 2015	Visit to the Health bus

HEALTH AND WELLBEING BOARD

11th September 2015

Report of: HealthWatch Hartlepool

Subject: HealthWatch Hartlepool Investigation of Good Practice Examples in the Care and Support of Residents with Dementia in Hartlepool Care Homes

1. PURPOSE OF REPORT

1.1 To inform the Health & Wellbeing Board of the outcomes of the Healthwatch Hartlepool investigation of good practice examples in the care and support of residents with dementia in Hartlepool Care Homes.

2. BACKGROUND

2.1 HealthWatch Hartlepool is the independent consumer champion for patients and users of health & social care services in Hartlepool. To support our work we have appointed an Executive committee, which enables us to feed information collated through our communication & engagement plan to form the strategic vision. This ultimately should lead to influence of all services within the borough. Further information relating to the work of Healthwatch can be viewed via www.healthwatchhartlepool.co.uk

2.2 The Care Home Dementia Project was included in the 2014/15 work programme of Healthwatch Hartlepool as a result of some concerns raised with us about inconsistencies in the quality of care and support received by residents with varying levels of dementia in residential care homes in Hartlepool.

3. PROPOSALS

3.1 Established under the Health and Social Care Act 2012, the requirements set out in the legislation mean HealthWatch Hartlepool will be expected to:

- Obtain the views of the wider community about their needs for and experience of local health and social care services and make those views known to those involved in the commissioning, provision and scrutiny of health and social care services.
- Promote and support the involvement of a diverse range of people in the monitoring, commissioning and provision of local health and social care services through membership of local residents and service users.
- Make reports and recommendations about how those services could or should be improved.
- Provide information to the public about accessing health and social care services together with choice in relation to aspects of those services.
- Represent the views of the whole community, patients and service users on the Health & Wellbeing Board and the Hartlepool Clinical Commissioning Group (locality) Board.
- Make the views and experiences of the broad range of people and communities known to Healthwatch England helping it to carry out its role as national champion.
- Make recommendations to Healthwatch England to advise the Care Quality Commission (CQC) to carry out special reviews or investigations into areas of concern (or, if the circumstances justify it, go direct to the CQC with recommendations, if for example urgent action were required by the CQC).
- This report will be made available to all partner organisations and will be available to the wider public through the Healthwatch Hartlepool web site.

4. EQUALITY & DIVERSITY CONSIDERATIONS

4.1 HealthWatch Hartlepool is for adults, children and young people who live in or access health and/or social care services in the Borough of Hartlepool. HealthWatch Hartlepool aims to be accessible to all sections of the community. The Executive committee will review performance against the work programme on a quarterly basis and report progress to our membership through the 'Update' newsletter and an Annual Report. The full Healthwatch Hartlepool work programme will be available from www.healthwatchhartlepool.co.uk

5. RECOMMENDATIONS

5.1 That the Health and Wellbeing Board note the contents the HealthWatch Hartlepoool Investigation of Good Practice Examples in the Care and Support of Residents with Dementia in Hartlepool Care Homes and that full consideration is given to recommendations contained within.

6. REASONS FOR RECOMMENDATIONS

6.1 The recommendations are based on findings from our investigations and the feedback and comments we have received from residents, family members, carers and staff during the course of our investigation.

7. BACKGROUND PAPERS

7.1 None

8. CONTACT OFFICER

Stephen Thomas - HealthWatch Development Officer
Hartlepool Voluntary Development Agency
'Rockhaven'
36 Victoria Road
HARTLEPOOL. TS24 8DD

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
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, 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.

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 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.

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, 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
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.

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

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.

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).