ADULT SERVICES COMMITTEE

AGENDA

Thursday 2 February 2017

10.00 am

Committee Room B,
Civic Centre, Hartlepool

MEMBERS: ADULT SERVICES COMMITTEE

Councillors Hamilton, Hind, Morris, Richardson, Sirs, Tempest and Thomas.

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

   3.1 To receive the Minutes and Decision Record in respect of the meeting held on 5 January 2017 *(for information as previously circulated)*.

4. **BUDGET AND POLICY FRAMEWORK ITEMS**

   No items.

5. **KEY DECISIONS**

   No items.

6. **OTHER ITEMS REQUIRING DECISION**

   No items.

7. **ITEMS FOR INFORMATION**

7.1 Direct Care and Support Services – Update on Action Plan following CQC Inspection – *Director of Child and Adult Services*

7.2 Unison Ethical Care Charter – Implementation within Domiciliary Care Services – *Director of Child and Adult Services*

7.3 HealthWatch Hartlepool Dementia Diagnosis Consultation Report – *Director of Child and Adult Services*

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

FOR INFORMATION

Date of next meeting – Thursday 2 March 2017 at 10.00am in the Civic Centre, Hartlepool.

ADULT SERVICES COMMITTEE

MINUTES AND DECISION RECORD

5 January 2017

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

Present:

Councillor: Steve Thomas (In the Chair)

Councillors: Lesley Hamilton, Tom Hind, Carl Richardson and Sylvia Tempest

Also Present:

In accordance with Council Procedure Rule 5.2 (ii) Councillor Beck was in attendance as substitute for Councillor Sirs and Councillor Loynes was in attendance as substitute for Councillor Morris

Karen Hawkins and Jean Golightly, Hartlepool and Stockton on Tees CCG
Ann Baxter, Independent Chair, Teeswide Safeguarding Adults Board
Anne Sykes and Lee Russell, Age UK
Michael Slimings, Incontrolable CIC
Stella and Gordon Johnson - Healthwatch Representatives
Sylvia Moore, MS Support Group
David Granath, Hospital of God
Members of the Public – Sue Little and Evelyn Leck

Officers: Jill Harrison, Assistant Director, Adult Services
Jeanette Willis, Head of Strategic Commissioning
Neil Harrison, Head of Service – Adult Services
Steve Hilton, Public Relations Officers
Leigh Keeble, Development Officer
Denise Wimpenny, Principal Democratic Services Officer

53. Apologies for Absence

Apologies for absence were submitted on behalf of Councillors George Morris and Kaylee Sirs.

54. Declarations of Interest

Councillor Steve Thomas declared a personal interest as an employee of Healthwatch Hartlepool and a personal interest in relation to Minute 56 as a Member of the Teeswide Safeguarding Adults Board.

55. Minutes of the meeting held on 1 December 2016

Received

56. Teeswide Safeguarding Adults Board (*Director of Child and Adult Services and Independent Chair of Teeswide Safeguarding Adults Board*)

Type of decision

Non key

Purpose of report

To present the Adult Services Committee the Teeswide Safeguarding Adults Board (TSAB) Annual Report 2015/16 and Strategic Business Plan 2016/17.

Issue(s) for consideration

The report provided background information to the establishment of the (TSAB) and the requirements of the Care Act to publish an annual report and annual strategic plan, copies of which were attached as appendices to the report.

In support of the report, the Chair of the Teeswide Safeguarding Adults Board (TSAB), who was in attendance at the meeting, reported on the role of the board and highlighted that the purpose of the plans was to set out what the Board had done during that year to achieve its objectives and implement its strategy. The Chair set out some of the challenges that the Board had made and reported that the Board was now well established and making good progress.

In the discussion that followed, the Chair of the TSAB and Assistant Director responded to issues raised by Members in relation to the safeguarding process and how this information was publicised. The Committee welcomed the report and placed emphasis upon the importance of this information being publicised as widely as possible and in a number of formats to target individuals who may not have access to the internet. It was suggested that posters be displayed in public places to

include GP surgeries, libraries, gyms and social facilities. The Chair of the Safeguarding Adults Board provided assurances that information was circulated as widely as possible and one of the priorities of the Board was to engage with individuals in terms of raising awareness.

The various methods of accessing information and raising awareness were discussed at length including the benefits of the Hartlepool Now website. It was reported that an update report on public information and engagement would be provided under the next agenda item and would include details of the Hartlepool Now website.

Members of the public and representatives in attendance, who were invited to speak, shared various examples/experiences of vulnerability issues during which concerns were raised regarding the high turnover of staff in care agencies and the impact on the quality of care as a result. The quality of the training provided for care workers was also questioned. The Assistant Director indicated that whilst the Council did have checks and balances in place and operated a Quality Standards Framework, the challenges in this regard were acknowledged and it was noted that this issue was high on the national agenda. The representative from the CCG commented on the value of the comments raised in arenas of this type and indicated that the messages conveyed would be fed back to the Board.

A Member referred to the misconceptions that domestic abuse was mainly prevalent in younger people and was pleased to note that the report recognised that this was not the case. The need to feedback this issue to witness support as well as the police was highlighted. In response, the Chair of the Safeguarding Adults Board advised that the Board was aware of this issue and domestic abuse had been identified as the theme for a conference scheduled for April/May 2017.

The Chair referred to the recent cessation of the Local Executive Group meetings and the benefits of such forums in terms of feeding in the types of information/issues as reported at today's meeting. Whilst the rationale for removing such meetings was acknowledged in terms of duplication, and whilst it was recognised that these meetings could not be reintroduced, clarification was sought on the most appropriate mechanism of capturing information of this type within the health sector. The Assistant Director advised that following the cessation of the Local Executive Group meetings, views were sought from contributors. Given the issues raised, the feedback from this exercise would be revisited to determine a way forward with the possibility of introducing a regular newsletter.

Decision

(i) That the Teeswide Safeguarding Adults Board Annual Report 2015/16 and Strategic Business Plan 2016/17 be noted and endorsed.

(ii) That the comments of Members, be noted and actioned as necessary.

57. Tackling Social Isolation – Public Information and Engagement: Presentation (*Author*)

Type of decision

No decision required – for information

Purpose of report

To provide the Committee with an update in relation to public information and engagement and to advise on progress regarding tackling social isolation through a range of initiatives including the Befriending Network and Project 65.

Issue(s) for consideration

The Head of Strategic Commissioning referred to the Committee's interest in what was being done within Hartlepool to tackle social isolation due to the potential impact this could have on vulnerable adults. The report provided background information in relation to the Council's commitment to tackle social isolation as a priority, details of which were provided.

Officers and representatives from Age UK and Incontrol-able were in attendance at the meeting and provided a detailed and comprehensive presentation on progress made regarding public information, engagement and tackling social isolation.

The presentation included the following:-

- Update on developments on the Hartlepool Now site since this was last reported to Committee
- Demonstration of the Hartlepool Now website
- Update on the development of the Hartlepool Now App which had been downloaded 150 times
- Local Account of Adult Social Care Services in Hartlepool 2016/17
- User Engagement
- Project 65 – Social Inclusion Through Technology
- Project 65 is a twelve month project to reduce the impact of social

isolation on Hartlepool residents aged 65 and over

- Tablets loaned to 19 individuals since the project started in November 2016 - average age of users is 78

- Feedback from Project 65

- Hartlepool Befriending Network Update
  - Marketing and Promotion
  - Volunteer Recruitment
  - Referrals
  - Going Forward

In response to a query in terms of support available to accompany individuals who may be socially isolated to medical appointments, a Member commented that Care-Co-ordinators, based in GP practices, may be able to co-ordinate such arrangements. Members were advised that the ambulance service operated a volunteer driver scheme to assist in this regard, although this was focused on hospital appointments. It was highlighted that a recruitment exercise was currently underway to increase the number of volunteer drivers. Given the queries raised in relation to access to health services, the Chair requested that information in relation to the type of support available to accompany individuals to such appointments be further explored and reported back to a future meeting of this Committee.

In concluding the debate, the Chair thanked the representatives for their presentations and welcomed the progress that had been made in Hartlepool to support individuals who may be at risk of social isolation and enhance quality of life.

Decision

(i) That the information given and comments of Members be noted.

(ii) In relation to access to health services, that information in relation to the type of support available to accompany individuals to such appointments be further explored and reported back to a future meeting of this Committee.

58. Update: Care Homes for Older People (*Director of Child and Adult Services*)

Type of decision

No decision required – for information

Purpose of report

To provide the Committee with an update in relation to care home provision for older people.

Issue(s) for consideration

The Head of Strategic Commissioning reported on the background to previous updates that had been provided to Committee on this issue.

Members were referred to Appendix 1 which provided an update on the care home sector published ratings since the last update with one home being rated good, two homes being rated 'requires improvement, and two homes improving from 'inadequate' to 'requires improvement'. There were now no homes in Hartlepool rated as 'inadequate' and all embargoes on new admissions had been lifted, therefore all homes were able to take appropriate admissions. This position had increased residential care capacity and improved choice for local residents. There were still significant issues regarding nursing capacity within the town, resulting in an increase in out of borough placements.

The report included a summary of the national picture in terms of CQC ratings and the improvements that had been made in services following initial ratings. It was noted that the national direction of travel was largely reflected locally. Information was also provided on the range of initiatives in place to support existing providers and encourage new providers to the market, including provider forums and manager's meetings, training and education programmes and enhanced pharmacy support.

In the discussion that followed presentation of the report, the Head of Strategic Commissioning responded to issues raised. Clarification was provided on the current position and future proposals in relation to homes that had recently closed as well as the reasons for such closures.

Concerns were raised in relation to the lack of provision in relation to respite care for under 65's with specialist needs. Whilst details of the ranges of respite care available were provided, it was acknowledged that respite care within the town for younger people with complex physical needs was limited and there was a reliance on out of town provision to meet this need.

A Member shared with the Committee a situation whereby an elderly parent's discharge from hospital had been delayed as a result of the family being unhappy with the quality of care provided by the care home. Members were advised of the CQC framework and inspection arrangements in place to ensure standards of care were carefully monitored.

Given the queries raised in relation to respite care, the Chair requested a report exploring this issue be presented to a future meeting of this Committee in the next municipal year.

Decision

(i) That the contents of the report be noted.

(ii) That a report exploring respite care provision be provided to a future meeting of this Committee.

59. Provision of Nursing Care for Older People – Presentation from Hast CCG (*Director of Child and Adult Services*)

Type of decision

No decision required – for information

Purpose of report

To provide the Committee with an update in relation to the position of NHS Hartlepool and Stockton on Tees Clinical Commissioning Group (HAST CCG) in relation to provision and support for nursing residential care for older people.

Issue(s) for consideration

The report provided background information outlining Members' interest in understanding the CCG's position in relation to care home provision and the ongoing pressure regarding availability of nursing beds within Hartlepool.

The Chair welcomed representatives from the CCG who provided a detailed and comprehensive presentation in relation to the ongoing work of the CCG in terms of provision of nursing residential care for older people.

The presentation focussed on the following issues:-

- Details of home closures in the last 2 years;
- Continuing pressures within residential and nursing care;
- Role of the CQC;

- Increase in delayed transfers of care and measures in place to address this issue;

- Commissioning priorities;

- Sustaining the current market through engagement with providers, fee increases and introduction of a Quality Incentive Scheme;

- Developing the market through exploring options for potential new providers and also through looking at alternatives to care home provision as part of BCF ambition to reduce overall admissions into long term care.

- Risks in relation to impact of reducing capacity on ability to discharge patients in a timely fashion and schemes not delivering the required improvements in quality of care for residents. The costs associated with managing risks were also highlighted.

A service provider, who was in attendance and invited to address the Committee, commented on the difficulties around recruitment and retention of nurses and highlighted that his service was currently reviewing to explore whether some roles currently carried out by qualified nurses could be undertaken by care staff. The potential impact and risks associated with moratoriums were also discussed.

In response to concerns raised that the rigorous CQC inspections may have contributed to nursing home closures, the representative from the CCG reported on the benefits of the CQC framework and inspection process and highlighted the importance of patient safety and high quality care.

A member of the public expressed concerns regarding the increase in recruitment of nurses from overseas and the need for more apprenticeship opportunities within the NHS. The CCG representative outlined the reasons for overseas recruitment and reported on the review that was currently ongoing to reintroduce apprenticeships within the health sector, details of which were provided.

In response to clarification sought, the Assistant Director confirmed that individuals assessed as requiring nursing care required 24 hour nurse oversight and could not be supported in residential care settings with input from community nursing services. The Assistant Director also confirmed that if a care home resident was admitted to hospital, their needs would be reassessed prior to discharge to ensure that they were discharged to an appropriate care setting that could meet their needs.

The representatives and Assistant Director responded to further issues raised in relation to the arrangements in place to address the shortage of nursing care beds in Hartlepool.

The Chair welcomed the work that was underway to take this issue forward and was keen to receive feedback from the work underway to explore alternative service delivery models and services for older people. The Chair acknowledged the significant challenges in relation to this issue and commented on the excellent provision within the town and the opportunities to build upon such excellence in the future.

Decision

(i) That the contents of the presentation and comments of Members be noted.

(ii) That feedback from ongoing work in relation to care home provision and the availability of nursing beds be reported to a future meeting of this Committee.

60. Scrutiny Investigation into Access to Transport for People with a Disability (*Director of Child and Adult Services*)

Type of decision

None key

Purpose of report

To agree the action plan in response to the findings and subsequent recommendations of the Audit and Governance Committee's investigation into Access for Transport for People with a Disability.

Issue(s) for consideration

It was reported that as a result of the investigation into Access to Transport for People with a Disability a series of recommendations had been made which had been approved by the Adult Services Committee on 3 November 2016. It was agreed by the Committee that an action plan would be produced in response to the recommendations for consideration by the Committee.

Members were referred to the Action Plan, attached at Appendix 1, which set out actions being taken to address each of the recommendations. The Head of Service advised that since writing the report, the Department had been approached by two providers who were interested in providing wheelchair accessible vehicles.

In terms of patient transport, the representative from the CCG reported that outpatient and review appointments were organised differently. In

addition to patient transport, it was noted that there was the North East Ambulance Service transport provision. To ensure clarity in terms of what was available, arrangements would be made for an officer from the CCG to liaise with the Council following the meeting.

A member of the public shared a personal experience of difficulties associated with accessing the hospital transport service and raised concerns regarding the lack of support from drivers for individuals with mobility difficulties. A Member placed emphasis upon the importance of disability awareness training to ensure adequate support was provided by drivers to individuals with mobility issues.

In response to concerns raised regarding ongoing problems of access to wheelchair accessible transport, a member of the public was pleased to report that she had recently secured a licence for a wheelchair accessible vehicle which should alleviate this issue.

The Chair took the opportunity to thank the Audit and Governance Committee as well as all contributors for their input into the investigation.

Decision

(i) That the action plan in response to the recommendations of the Audit and Governance Committee's investigation into Access to Transport for People with a Disability be approved.

(ii) That the comments of Members be noted.

(iii) That an update report be received in 6 months time.

The meeting concluded at 12.45 pm

P J DEVLIN

CHIEF SOLICITOR

PUBLICATION DATE: 12 JANUARY 2017

ADULT SERVICES COMMITTEE

2 February 2017

Report of: Director of Child and Adult Services

Subject: DIRECT CARE AND SUPPORT SERVICES – UPDATE ON ACTION PLAN FOLLOWING CQC INSPECTION

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1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 No decision required; for information.

2. PURPOSE OF REPORT

2.1 To provide the Adult Services Committee with an update on the action plan developed for the Direct Care and Support Service following the inspection by the Care Quality Commission (CQC), and to provide assurance that actions have been implemented to address those areas highlighted as requiring improvement.

3. BACKGROUND

3.1 The CQC monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. The CQC make sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve.

3.2 The Direct Care and Support Service (DCSS), based at the Centre for Independent Living is registered with the CQC and regulated by the Health and Social Care Act (Regulated Activities) Regulation 2014.

3.3 The Health and Social Care Act 2008 established the CQC as the regulator of all health and adult social care services. It is a single Act of Parliament that sets out powers and duties, and represents the modernisation and integration of health and social care.

4. REPORT FINDINGS

4.1 An announced CQC inspection took place in February 2016.

4.2 The DCSS is a domiciliary care service which provides intermediate care (short term support for up to six weeks, usually following discharge from hospital), a response to 'telecare' services (technology to help people live at home independently longer) and emergency respite care for family carers. The service supports over 2,000 people in the Hartlepool area.

4.3 At the time of this inspection, 29 people were receiving personal care and reablement support.

4.4 The CQC gave the service an overall rating of 'Requires Improvement'. The findings for each of the five domains were as follows:

Ratings	
Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

4.5 The findings for each of the domains where improvements were required were summarised as follows:

4.5.1 Is the service safe?

- The registered provider did not have accurate records to support and evidence the safe administration of medicines.
- People and their relatives spoke positively about care staff.
- People said staff were on time and they didn't rush them.
- Staff had a good understanding of safeguarding adults and their role in preventing abuse.
- Safeguarding concerns, accidents and incidents were reported by staff and dealt with appropriately by the management team.

4.5.2 Is the service effective?

- Staff had not received up to date training in a number of key areas.
- Some staff had not received regular supervisions.
- Observations of care did not take place regularly.

- People told us staff sought permission before providing care.
- The service worked closely with health professionals to ensure people didn't stay in hospital longer than necessary.
- Staff completed appropriate training before working unsupervised.
- People were supported to meet their nutritional needs.
- People were supported to access other healthcare services when required.

4.5.3 Is the service well-led?

- The provider did not have systems in place to identify and investigate issues with medicines records in a timely manner.
- There was no quality system in place to check care plans.
- People told us the service was well organised and they would recommend it to others.
- The service had a registered manager. Staff told us there was a positive, open culture and they felt supported.
- Some systems were in place to assess the quality of care people received.
- Where issues had been identified, these had been acted upon.

5. IMPROVEMENT PLAN

5.1 The DCSS developed and implemented a detailed improvement plan to address the three areas identified in the CQC report as requiring improvement. A copy of the improvement plan and an update on progress is attached as **Appendix 1.**

5.2 As a result of changes to the inspection process in October 2014, frequency of inspection is based on ratings with poorer services inspected more frequently and good and outstanding services less often.

5.4 If a service is inadequate a further inspection will take place within 6 months of the first inspection. If the service is outstanding the next inspection will only take place within 2 years but there will be a number of random inspections at any time on good and outstanding providers.

5.5 Inspections will still be unannounced and will also be carried out in response to issues and concerns.

6. RISK IMPLICATIONS

6.1 The service must meet regulations made under powers set out in the Health and Social Care Act 2008.

6.2 The CQC has a wide set of powers that aim to protect the public and hold registered providers and managers to account. In addition a new

enforcement policy is in place enabling CQC to take action where poor care is identified, or where registered providers and managers do not meet the standards required in the regulations.

7. FINANCIAL CONSIDERATIONS

7.1 Additional staffing resources have been allocated to address some areas highlighted within the report, notably to create flexibility to enable staff to attend training whilst still maintaining sufficient staff levels to meet demand. This has been managed within the existing staffing budget for the service.

8. LEGAL CONSIDERATIONS

8.1 The CQC has not taken any enforcement action as a result of this inspection. The improvement plan aims to address the required improvements identified in the report.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 There are no equality and diversity considerations associated with this report.

10. STAFF CONSIDERATIONS

10.1 Additional staff have been used to ensure that refresher training can be accessed while service provision is maintained.

10.2 Audits will be monitored as part of the management supervision process.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 The registered address of the service will change when staff transfer to the new Centre for Independent Living, which may trigger a re-inspection of the service.

12. RECOMMENDATION

12.1 It is recommended that the Adult Services Committee note this report and note the steps taken to improve the areas highlighted as requiring improvement within the CQC inspection.

13. REASONS FOR RECOMMENDATION

13.1 Improvements to the Direct Care and Support Service will impact directly on the quality of care delivered to people using the service.

14. BACKGROUND PAPER

Direct Care and Support Team inspection report
http://www.cqc.org.uk/location/1-723709856

15. CONTACT OFFICER

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Hartlepool Borough Council Provider Services

Direct Care and Support Service-CQC Action Plan

Regulation	The questions asked about services	Rating for the service	How the regulation was not being met:	Additional Detail	Actions taken to meet the regulation/intend to achieve
12	Is the service safe?	Requires Improvement	The registered provider did not have accurate records to support and evidence the safe administration of medicines	During the inspection the Medicine Administration Records (MAR) for 11 people who used the service were sampled. 3 of the 11 MAR sheets were incomplete for the period Oct 2015 to Jan 2016. Staff had not signed to confirm prescribed medicines had been given. MAR did not always correspond with the daily notes. Medicines risk assessments were not always signed and dated by staff.	All MAR sheets are checked and authorised before they are scanned into the database. Recording errors or missed medication issues are clarified at and safeguarding alerts raised as required. Supervisors sign MAR sheets to confirm they are correct A sample of MAR sheets is audited by the Registered Manager.

Regulation	The questions asked about services	Overall rating for this service	How the regulation was not being met:	Additional Detail	Actions taken to meet the regulation/intend to achieve
17	Is the service well-led?	Requires Improvement	There was no documented quality assurance process in place to support the safe administration of medicines. This meant the provider had been ineffective in identifying and investigating errors on the MAR.	The service was not always well-led. The provider did not have systems in place to identify and investigate issues with medicine records in a timely manner. There was no quality system in place to check care plans.	A revised quality assurance process is now in place for the safe administration of medication. MAR and 'Care Plans' are part of the Registered Manager's monthly audit. The protocol requires supervisors to undertake regular checks and this is further audited on a monthly basis by the Registered Manager.

Regulation	The questions asked about services	Overall rating for this service	How the regulation was not being met:	Additional Detail	Actions taken to meet the regulation/intend to achieve
18	Is the service effective?	Requires Improvement	The service was not always effective. Staff had not received up to date training in a number of key areas .	Some staff had not completed up to date moving and positioning training and training on emergency aid. This meant we could not be sure staff knew how to care for people in the right way	A revised training matrix has been developed. 96% of staff completed moving and positioning refresher training. 96% of staff completed emergency aid refresher training. 93% of staff completed emergency aid refresher training. 75% of staff completed food hygiene refresher training. Further refresher courses are arranged in February 2017 for those that still require updates.

Regulation	The questions asked about services	Overall rating for this service	How the regulation was not being met:	Additional Detail	Actions taken to meet the regulation/intend to achieve
18	Is the service effective?	Requires Improvement	Some staff had not received regular supervisions.	The provider's policy stated a minimum of two supervisions were required each year. All of the 10 files we viewed had a minimum of two formal supervisions recorded each year, however the provider agreed that the policy needed to be updated to ensure ad hoc supervisions were also recorded	New audit process has been introduced to ensure that supervisions and observations of all staff are undertaken on a regular basis.
			Observations of care did not take place regularly	Records confirmed staff did not receive regular spot checks of the care they provided. There was no clear policy in place regarding the frequency of such spot checks.	A rota has been developed which ensures that an average of 3-5 observations and spot checks are carried out each week. The checks include observations for medication administration, food preparation and telecare response.

ADULT SERVICES COMMITTEE

2 February 2017

Report of: Director of Child and Adult Services

Subject: UNISON ETHICAL CARE CHARTER - IMPLEMENTATION WITHIN DOMICILIARY CARE SERVICES

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1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required - for information.

2. PURPOSE OF REPORT

2.1 To provide an update on progress in respect of the implementation of Unison's Ethical Care Charter in respect of Domiciliary Care Services.

3. BACKGROUND

3.1 A report presented to Adult Services Committee on 9 March 2015, following the Healthwatch investigation into domiciliary care services, provided an overview of the department's progress in implementing Unison's Ethical Care Charter both for internal services and services commissioned from the independent sector.

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

4. PROGRESS

4.1 At its previous meeting on 9 March 2015 Committee members noted the current position in relation to domiciliary care services and agreed to receive a further update following renegotiation of domiciliary care contracts.

4.2 As per the report presented to Adult Services Committee on 23 March 2016 the current contracts have not yet been renegotiated, and have instead been extended whilst a focussed piece of work around models of care delivery is undertaken by an independent consultancy.

4.3 This report provides a further update following the national implementation of the National Living Wage.

4.4 The Unison Ethical Care Charter is attached at **Appendix 1**. The stages set out on page 5 have been summarised and progress measured from the current two main external providers and the internal HBC service.

4.5 **Appendices 2, 3 and 4** provide a summary of progress for each organisation. Appendix 2 relates to Carewatch, Appendix 3 relates to Careline and Appendix 4 provides an update for the Council's Direct Care and Support Service.

4.6 The appendices demonstrate that all organisations are meeting the broad principles of the Ethical Care Charter, with only one slight exception in one agency. The external agencies face challenges regarding resources and, on occasion, the ability to retain staff who do not want permanent contracts. There are seasonable fluctuations around school holidays and although the relevant bank holiday pay is afforded to staff, these periods continue to be a challenge.

4.7 There are currently nineteen local authorities signed up nationally to the Ethical Care Charter. Councils are able to sign up to the Charter any point, with the intention of implementing changes when they review or renew contracts, but the most likely time for Councils to sign up to the Charter is at the point that they renew a contract with a provider, or tender a service. The information contained within the appendices clearly demonstrates that independent providers are working towards full implementation of the Charter principles where they are able to and the intention is that officers within adult services will to continue to work with providers to improve quality and outcomes for individuals who receive services and staff within the services. As and when a new contract is issued the Ethical Care Charter standards will be incorporated in the terms and conditions as part of any tendering / contracting process and the option of formally signing up to the Charter will be explored and pursued.

5. RISK IMPLICATIONS

5.1 There are risks associated with domiciliary care services not being able to meet the requirements of the Unison Ethical Care Charter owing to a number of factors including, but not limited to, resources to fund National Living Wage, availability of staff to ensure continuity of worker to each individual and to ensure that calls are covered in a timely and effective manner.

6. FINANCIAL CONSIDERATIONS

6.1 There are financial considerations associated with the National Living Wage and the impact it has had on the viability of independent domiciliary care provision owing to associated increases in overheads for supervisory and management staff. There are no financial considerations specifically linked to this report.

7. LEGAL CONSIDERATIONS

7.1 There are no legal implications associated with this report.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

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

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 There are no equality and diversity considerations associated with this report. The Unison Ethical Care Charter aims to ensure that all employees properly remunerated and protected whilst carrying out their employment regardless of any protected characteristics.

10. STAFF CONSIDERATIONS

10.1 There are no staffing implications for the Council in relation to the internal Direct Care and Support Service. The Council is compliant with the Ethical Care Charter with all staff receiving sick pay, payment for travel time and appropriate training, and there is no use of zero hours contracts.

10.2 In relation to commissioned services:

- Agencies pay statutory sick pay, travel time is paid for distances above the norm and different rates of pay are paid for shorter calls to incorporate travel time;
- Individuals receiving services are allocated the same homecare workers where possible, taking into account the complexity and practicalities of the package;
- Zero hour / flexible contracts are used by agencies; some staff employed by these organisations report that they do not want the security permanent contracts offer. Care providers advise that this is due to the perception that they will lose flexibility around the hours they choose to work. However, workers are able to accrue holiday and sickness pay whilst on zero hour contracts; and
- Training is carried out in all services.

11. ASSET MANAGEMENT CONSIDERATIONS

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

12. RECOMMENDATION

12.1 It is recommended that the Adult Services Committee note the current position in relation to progress against implementation of the Unison Ethical Care Charter.

13. REASONS FOR RECOMMENDATION

13.1 There is a commitment from all care providers to adhere to the principles and recommendations contained within Unison's Ethical Care Charter.

14. CONTACT OFFICER

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UNISON
the public service union

UNISON's ethical care charter

UNISON's ethical care charter

Contents

7.2 Appendix 1

Introduction

A number of reports from client organisations, consumer groups, and homecare providers have recently been produced which have been highly critical of the state of homecare services in the UK. Little consideration however has been given to the views of homecare workers themselves as to why there are so many problems in this sector.

UNISON, the largest public service union, conducted a survey of homecare workers entitled “Time to Care” to help address this imbalance and to illustrate the reality of homecare work. The online survey which was open to homecare workers who were either UNISON members or non-members attracted 431 responses between June and July of 2012.

The responses showed a committed but poorly paid and treated workforce which is doing its best to maintain good levels of quality care in a system that is in crisis. The report highlights how poor terms and conditions for workers can help contribute towards lower standards of care for people in receipt of homecare services.

Key findings

- 79.1% of respondents reported that their work schedule is arranged in such a way that they either have to rush their work or leave a client early to get to their next visit on time. This practice of 'call cramming', where homecare workers are routinely given too many visits too close together, means clients can find themselves not getting the service they are entitled to. Homecare workers are often forced to rush their work or leave early. Those workers who refuse to leave early and stay to provide the level of care they believe is necessary, also lose out as it means they end up working for free in their own time.
- 56% of respondents received between the national minimum wage of £6.08 an hour at the time of the survey and £8 an hour. The majority of respondents did not receive set wages making it hard to plan and budget. Very low pay means a high level of staff turnover as workers cannot afford to stay in the sector. Clients therefore have to suffer a succession of new care staff.
- 57.8% of respondents were not paid for their travelling time between visits. As well as being potentially a breach of the minimum wage law, this practice eats away at homecare workers' already low pay.
- Over half the respondents reported that their terms and conditions had worsened over the last year, providing further evidence of the race to the bottom mentality in the provision of homecare services.

  56.1% – had their pay made worse
  59.7% – had their hours adversely changed
  52.1% – had been given more duties
- 36.7% of respondents reported that they were often allocated different clients affecting care continuity and the ability of clients to form relationships with their care workers. This is crucial, especially for people with such conditions as dementia.
- Whilst the vast majority of respondents had a clearly defined way of reporting concerns about their clients' wellbeing, 52.3% reported that these concerns were only sometimes acted on, highlighting a major potential safeguarding problem.
- Only 43.7% of respondents see fellow homecare workers on a daily basis at work. This isolation is not good for morale and impacts on the ability to learn and develop in the role.
- 41.1% are not given specialist training to deal with their clients specific medical needs, such as dementia and stroke related conditions.

The written responses to our survey paint a disturbing picture of a system in which the ability to provide some companionship and conversation to often lonely and isolated clients is being stripped away. Some recounted the shame of providing rushed and insufficient levels of care because of the terms and conditions of their job, whilst many detailed insufficient levels of training that they had been given to carry out the role. Others made the point that rushed visits are a false economy leading to a greater likelihood of falls, medication errors and deterioration through loneliness.

However the survey also showed the selflessness and bravery of homecare workers who, to their own personal cost, refused to accept the imposition of outrageously short visits and worked in their own time to ensure that their clients received good levels of care. Some homecare workers were doing tasks and errands for their clients in their spare time, despite the seemingly best efforts of the current care model to strip away any sense of personal warmth or humanity.

Homecare workers are personally propping up a deteriorating system of adult social care, but they are being pushed to breaking point. That they are still willing to deliver good levels of care in spite of the system is nothing short of heroic. For the system to work it needs to be underpinned by adequate funding and a workforce whose terms and conditions reflect the respect and value they deserve. Crucially they must be given the time to care.

“ I never seem to have enough time for the human contact and care that these people deserve. ”

“ A lot of the people I care for, are old and lonely, they are not only in need of physical support, but they are also in need of company and someone to talk to. The times given to these people are the bare minimum to get the job done, no time for a chat, just in and out. ”

“ People are being failed by a system which does not recognise importance of person centred care. ”

“ We are poorly paid and undervalued except by the people we care for! ”

“ I have worked as homecare worker for 15 years. Things have to change but not at the expensive of clients. It’s appalling the care they receive now. ”

Ethical care councils

In light of UNISON's findings, we are calling for councils to commit to becoming Ethical Care Councils by commissioning homecare services which adhere our Ethical Care Charter.

The over-riding objective behind the Charter is to establish a minimum baseline for the safety, quality and dignity of care by ensuring employment conditions which a) do not routinely short-change clients and b) ensure the recruitment and retention of a more stable workforce through more sustainable pay, conditions and training levels. Rather than councils seeking to achieve savings by driving down the pay and conditions that have been the norm for council – employed staff, they should be using these as a benchmark against which to level up.

Councils will be asked to sign up to the Charter and UNISON will regularly publish the names of councils who do.

Ethical care charter for the commissioning of homecare services

Stage 1

- The starting point for commissioning of visits will be client need and not minutes or tasks. Workers will have the freedom to provide appropriate care and will be given time to talk to their clients
- The time allocated to visits will match the needs of the clients. In general, 15-minute visits will not be used as they undermine the dignity of the clients
- Homecare workers will be paid for their travel time, their travel costs and other necessary expenses such as mobile phones
- Visits will be scheduled so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time
- Those homecare workers who are eligible must be paid statutory sick pay

Stage 2

- Clients will be allocated the same homecare worker(s) wherever possible
- Zero hour contracts will not be used in place of permanent contracts
- Providers will have a clear and accountable procedure for following up staff concerns about their clients' wellbeing
- All homecare workers will be regularly trained to the necessary standard to provide a good service (at no cost to themselves and in work time)
- Homecare workers will be given the opportunity to regularly meet co-workers to share best practice and limit their isolation

Stage 3

- All homecare workers will be paid at least the Living Wage (as of November 2013 it is currently £7.65 an hour for the whole of the UK apart from London. For London it is £8.80 an hour. The Living Wage will be calculated again in November 2014 and in each subsequent November). If Council employed homecare workers paid above this rate are outsourced it should be on the basis that the provider is required, and is funded, to maintain these pay levels throughout the contract
- All homecare workers will be covered by an occupational sick pay scheme to ensure that staff do not feel pressurised to work when they are ill in order to protect the welfare of their vulnerable clients.

Guidance for councils and other providers on adopting the charter

Seeking agreements with existing providers

1. Convene a review group with representation from providers, local NHS and UNISON reps to work on a plan for adopting the charter – with an immediate commitment to stage 1 and a plan for adopting stages 2 & 3

2. Start by securing agreement for a review of all visits which are under 30 minutes. The review will include getting views of the homecare workers and client (and/or their family) on how long the client actually needs for a visit and what their care package should be

Looking for savings

3. Are providers' rostering efficiently – for example are there cases of workers travelling long distances to clients when there are more local workers who could take over these calls?

4. How much is staff turnover costing providers in recruitment and training costs?

5. How much are falls and hospital admissions amongst homecare clients costing the NHS and could some of these be prevented by longer calls and higher quality care?

6. Are there opportunities for economies of scale by providers collaborating around the delivery of training and networking/mentoring for workers?

7. Are there opportunities for collaboration between providers to achieve savings on procurement of mobile phones, uniforms and equipment for workers?

The commissioning process

1. UNISON's evidence, along with that of other bodies such as the UKHCA, shows that working conditions are intrinsically bound up with the quality of care.

2. When councils are conducting service reviews and drawing up service improvement plans, the Charter will provide a helpful benchmark for ensuring service quality – whether for an improved in-house service or in relation to externally commissioned services.

3. Where a decision has been taken to commission homecare externally, identify how the elements of the charter will be included as service delivery processes, contract conditions or corporate objectives in the invitation to tender documents. It must explain how these are material to the quality of the service and achieving best value.

Service monitoring

1. Work with providers and trade unions to agree how service quality will be monitored and compliance with the Charter assured

2. Build regular surveys of homecare workers into this process to gain their views and consider establishing a homecare workers panel from across local providers who can provide feedback and ideas on care delivery

The provisions of this charter constitute minimum and not maximum standards. This charter should not be used to prevent providers of homecare services from exceeding these standards.

UNISON has more than a million members delivering essential services to the public. Services that protect, enrich and change lives.

We want to see changes that put people before profit and public interest before private greed. Join our campaign to create a fairer society.

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Published and printed by UNISON, The UNISON Centre, 130 Euston Road London NW1 2AY unison.org.uk
CU/NOV2013/22014/stock no: 3179

Unison Ethical Care Charter - CAREWATCH

Stage 1		
The starting point for commissioning of visits will be client need and not minutes or tasks. Workers will have the freedom to provide appropriate care and will be given time to talk to their clients	Yes	Where the support planning process allows, co-ordinators will be given the opportunity to discuss the care package at the start of the commissioning process - this is person centred care. Any decision made giving the care worker freedom in providing the clients care must be based around a robust assessment / quality monitoring process. Additionally, each care worker must be qualified to support the client's care needs.
The time allocated to visits will match the needs of the clients. In general, 15-minute visits will not be used as they undermine the dignity of the clients	Yes	15 minute visits can only deliver a limited number of tasks - if requests are made to achieve tasks other than less complex medication calls or pop ins there is a referral back to the care manager to review the appropriateness of time allocated within a support plan.
Homecare workers will be paid for their travel time, their travel costs and other necessary expenses such as mobile phones	Yes	
Visits will be scheduled so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time	Yes	This is the intention, however within the care sector there are circumstances that can challenge this position. There is on occasion low commitment of some staff members and sickness is a continuous concern for all providers. If staff do call in sick the main priority to ensure that all individuals are seen, to ensure their basic care requirements are satisfied safely.
Those homecare workers who are eligible must be paid statutory sick pay	Yes	

Stage 2		
Clients will be allocated the same homecare worker(s) wherever possible	Yes	There are potential problems associated with allocating the same carers to clients. At the start of a new package an assessment is made of the staffing levels required to cover these contingencies and the relevant workers are introduced to the individual receiving care. Sickness and holidays present issues in ensuring that clients are comfortable with care staff allocated whilst the main carers are not available. Our structure of 3 teams with individual caseloads is intended to maximise the knowledge of each team member about the individuals on their patch to ensure that the relevant skills can be employed when faced with challenges around short staffing.
Zero hour contracts will not be used in place of permanent contracts	Yes	There is a major misunderstanding of zero hour contracts utilised in the care industry and in our experience staff do not wish to change to permanent contracts. The situation for our company is that we have a growing number of weekly hours for which, at times, we do not have sufficient staff. There is no such thing in our company as 'zero hours'. Staff effectively can choose the number of hours they work each week. In fact, a 'zero hour' contract is a two-way agreement and we find that care staff often decide not to work. With the 'zero hour' contract we cannot insist contractually that they accept a care rota.

		Furthermore, after 12 months of trying to have staff move over to permanent contracts, we have decided to go with staff wishes and remain with 'zero hour' contracts for the moment. Following our company change towards a more robust team-based, continuous improvement, and person-centred based structure we will look once again at introducing permanent contracts. This is anticipated to happen within the next 3 – 4 months. From a company perspective, we whole heartedly agree with the sentiments of this point.
Providers will have a clear and accountable procedure for following up staff concerns about their clients' wellbeing	Yes	Staff within the team structure understand the state of individuals wellbeing and are best placed to raise appropriate concerns. Staff will report initially to their supervisor who will escalate accordingly.
All homecare workers will be regularly trained to the necessary standard to provide a good service (at no cost to themselves and in work time)	Yes	
Homecare workers will be given the opportunity to regularly meet co-workers to share best practice and limit their isolation	Yes	The organisational structure has 3 overarching teams under individual co-ordinators each with their own caseload. These teams have regular team meetings and this method of operation encourages support alongside accountability. The premises from which the organisation operates has a common room utilised by staff which encourages stronger relationships.

Stage 3		
All homecare workers will be paid at least the Living Wage (as of November 2013 it is currently £7.65 an hour for the whole of the UK apart from London. For London it is £8.80 an hour. The Living Wage will be calculated again in November 2014 and in each subsequent November). If Council employed homecare workers paid above this rate are outsourced it should be on the basis that the provider is required, and is funded, to maintain these pay levels throughout the contract	Yes	We feel that care staff are underpaid but there are serious challenges for care organisations to remain commercially viable whilst at the same time increasing care staff pay. Our staff receive the NLW plus travelling time. Currently, care staff pay is £7.80 per hour with no differentiation due to age (ie. a 22yr old receives the same hourly rate as staff over 25). Additionally, we have a number of senior carers paid £8.05 per hour. Company overheads and operating costs need to be taken into account when making statements about care staff pay. Associated with many of the above points is a significant cost implication and when the supervisory and various management positions required for robust, quality care are taken into consideration it is easy to see why homecare companies are struggling to stay afloat. The point relates to the whole of the UK and does not include consideration of the fact that there are major discrepancies in rates paid to care companies throughout the country.
All homecare workers will be covered by an occupational sick pay scheme to ensure that staff do not feel pressurised to work when they are ill in order to protect the welfare of their vulnerable clients	Yes	

Unison Ethical Care Charter - CARELINE

		Response
Stage 1		
The starting point for commissioning of visits will be client need and not minutes or tasks. Workers will have the freedom to provide appropriate care and will be given time to talk to their clients	Yes	
The time allocated to visits will match the needs of the clients. In general, 15-minute visits will not be used as they undermine the dignity of the clients	Yes	
Homecare workers will be paid for their travel time, their travel costs and other necessary expenses such as mobile phones	Yes	
Visits will be scheduled so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time	Yes	The provider currently allocates work in zoned areas to reduce distance and time required from one call to the next.
Those homecare workers who are eligible must be paid statutory sick pay	Yes	SSP is paid were appropriate
Stage 2		
Clients will be allocated the same homecare worker(s) wherever possible	Yes	Continuity is a key priority when rostering calls. The system we use allows us to monitor continuity and match the care workers.
Zero hour contracts will not be used in place of permanent contracts	No	Zero hours contracts are offered to care staff, staff are provided with hours they require on a regular basis. Holidays and sickness is paid pro-rata in conjunction with hours provided on a 12 week average basis.
Providers will have a clear and accountable procedure for following up staff concerns about their clients' wellbeing	Yes	We have robust procedures in place for all concerns to be raised wither through safeguarding, whistleblowing through supervision.
All homecare workers will be regularly trained to the necessary standard to provide a good service (at no cost to themselves and in work time)	Yes	All staff receive a five day induction prior to commencing employment and then annual updates.
Homecare workers will be given the opportunity to regularly meet co-workers to share best practice and limit their isolation	Yes	Staff receive supervision every three months, team meetings with their colleagues every three months and appraisal yearly.

Stage 3		
All homecare workers will be paid at least the Living Wage (as of November 2013 it is currently £7.65 an hour for the whole of the UK apart from London. For London it is £8.80 an hour. The Living Wage will be calculated again in November 2014 and in each subsequent November).If Council employed homecare workerspaid above this rate are outsourced it should be on the basis that the provider is required, and is funded, to maintain these pay levels throughout the contract	Yes	Living wage is being paid
All homecare workers will be covered by an occupational sick pay scheme to ensure that staff do not feel pressurised to work when they are ill in order to protect the welfare of their vulnerable clients	Yes	We pay SSP

Unison Ethical Care Charter - HBC INTERNAL SERVICE

Stage 1		
The starting point for commissioning of visits will be client need and not minutes or tasks. Workers will have the freedom to provide appropriate care and will be given time to talk to their clients	Yes	
The time allocated to visits will match the needs of the clients. In general, 15-minute visits will not be used as they undermine the dignity of the clients	Yes	HBC's Call Confirm system monitors actual time spent in properties, we do however get examples where customer requests worker to leave early.
Homecare workers will be paid for their travel time, their travel costs and other necessary expenses such as mobile phones	Yes	
Visits will be scheduled so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time	Yes	
Those homecare workers who are eligible must be paid statutory sick pay	Yes	
Stage 2		
Clients will be allocated the same homecare worker(s) wherever possible	Yes	Direct Care & Support Service worked with Tees Esk and Wear Valleys NHS Foundation Trust using RPIW (Rapid Process Improvement Workshop) to set limit for workers linked to best practice guidance for dementia care.
Zero hour contracts will not be used in place of permanent contracts	Yes	
Providers will have a clear and accountable procedure for following up staff concerns about their clients' wellbeing	Yes	
All homecare workers will be regularly trained to the necessary standard to provide a good service (at no cost to themselves and in work time)	Yes	
Homecare workers will be given the opportunity to regularly meet co-workers to share best practice and limit their isolation	Yes	Where possible down time is maximised to give workers experience of working in other settings and time to meet with peers.
Stage 3		
All homecare workers will be paid at least the Living Wage (as of November 2013 it is currently £7.65 an hour for the whole of the UK apart from London. For London it is £8.80 an hour. The Living Wage will be calculated again in November 2014 and in each subsequent November). If Council employed homecare workers paid above this rate are outsourced it should be on the basis that the provider is required, and is funded, to maintain these pay levels throughout the contract	Yes	Band 5 homecare worker scale points 13- 15 £8-35 -£8.68
All homecare workers will be covered by an occupational sick pay scheme to ensure that staff do not feel pressurised to work when they are ill in order to protect the welfare of their vulnerable clients	Yes	

ADULT SERVICES COMMITTEE

2 February 2017

Report of: Director of Child and Adult Services

Subject: HEALTHWATCH HARTLEPOOL DEMENTIA DIAGNOSIS CONSULTATION REPORT

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1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required - for information.

2. PURPOSE OF REPORT

2.1 To inform the Adult Services Committee of the outcomes of the recent consultation regarding patient experience of dementia diagnosis in Hartlepool.

3. BACKGROUND

3.1 HealthWatch Hartlepool is the independent consumer champion for patients and users of health and social care services in Hartlepool. HealthWatch Hartlepool has an appointed Executive Committee, which enables information collated through the communication and 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.

3.2 The dementia diagnosis consultation was included in the 2016/17 work programme of Healthwatch Hartlepool as a result of concerns raised regarding access to and subsequent patient experience of dementia diagnostic processes.

3.3 The report was presented to the Health and Wellbeing Board on 16 January 2017 and it was recommended that the findings were also considered by the Adult Services Committee.

3.4 The debate at the Health and Wellbeing Board highlighted that a significant amount of progress had been made in Hartlepool in relation to dementia diagnosis and awareness, with Hartlepool and Stockton on Tees CCG

reporting one of the highest rates of dementia diagnosis in the country and new developments such as The Bridge, and the Dementia Advisory Service which is funded from the Better Care Fund.

3.5 It was noted however that there were areas where more could be done to improve awareness and reduce the stigma associated with dementia, as well as ensuring that people had access to support following a diagnosis (including the person with dementia, carers and the wider family).

3.6 The importance of access to information and advice was highlighted and the Health and Wellbeing Board were reminded that Hartlepool Now was a key resource to promote local activities and services and to signpost people to more specialist advice when needed (www.hartlepoolnow.co.uk).

3.7 It was also noted that work was underway through the North of Tees Dementia Collaborative to review information that's provided following a diagnosis to see if the consistency of the information could be improved and links to services such as The Bridge strengthened.

4. PROPOSALS

4.1 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 and 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.

5. RISK IMPLICATIONS

5.1 There are risks associated with domiciliary care services not being able to meet the requirements of the Unison Ethical Care Charter owing to a number of factors including, but not limited to, resources to fund National Living Wage, availability of staff to ensure continuity of worker to each individual and to ensure that calls are covered in a timely and effective manner.

6. FINANCIAL CONSIDERATIONS

6.1 There are no financial considerations associated with this report.

7. LEGAL CONSIDERATIONS

7.1 There are no legal implications associated with this report.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

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

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 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

10. STAFF CONSIDERATIONS

10.1 There are no staffing considerations associated with this report.

11. ASSET MANAGEMENT CONSIDERATIONS

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

12. RECOMMENDATION

12.1 That the Adult Services Committee notes the contents of the HealthWatch Hartlepool Dementia Diagnosis Report and gives consideration to the recommendations contained within.

13. REASONS FOR RECOMMENDATION

13.1 The recommendations are based on findings from the consultation events and subsequent discussions.

14. CONTACT OFFICER

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Healthwatch Hartlepool Investigation into Patient Experience of Dementia Diagnosis

Update Report

September 2016

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 have been 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 Recognition has also been given to the importance of achieving timely assessment for possible dementia. Diagnosing dementia, and the type of dementia someone has is important. It will ensure that people with dementia get the right support and treatment quickly and can plan for the future.

1.5 In most cases the person's G.P is the first person to be contacted and if dementia is suspected a referral will be made to a memory clinic or specialist. G.P's will also routinely ask certain patients who are at high risk of developing dementia whether they are concerned about their memory. This includes patients with Parkinson's disease, those who are over 60 and have diabetes or a heart condition and those with a learning disability.

1.6 However, making a diagnosis of dementia can be difficult, particularly at the early stages as there is no one simple test for the condition and symptoms can be very similar to many other common conditions.

1.7 There is also considerable evidence that despite the headway that has been in developing "dementia friendly" communities, there is still considerable fear of a diagnosis of dementia. This can have a profound effect on the willingness of individuals to acknowledge that there may be a problem and to seek help from their G.P.

1.8 As with many other conditions, early diagnosis of dementia can have a positive impact on how the progress of condition is managed and on the quality of life of the patient, their family and carers.

1.9 Recent government figures suggest that at both local and national levels there have been significant improvements in diagnosing dementia and in developing subsequent care pathways. This report looks at dementia diagnosis in Hartlepool from the perspective of both G.P practices and patients, their families and carers. A copy the NICE Dementia Pathway guidance is shown in Appendix 2.

2. Methodology

2.1 Healthwatch Hartlepool decided to look at the issue of dementia diagnosis as part of its ongoing interest in the provision of dementia care and treatment services.

2.2 Also, despite indications that diagnosis rates in the Hartlepool and Stockton Clinical Commissioning Group (HAST CCG) area were improving, concerns were identified that some patients were reluctant to acknowledge that they were experiencing memory problems due to stigma (perceived or otherwise) associated with the condition.

2.3 In November 2015 questionnaires were sent to all G.P surgeries in Hartlepool. The questionnaire asked about the process the individual practices followed with patients from a possible problem being identified through to diagnosis and ongoing treatment and support.

2.4 In total, eight practices returned the questionnaire, a copy of which, together with a summary of the responses received can be found at Appendix 1.

2.5 At the same time we also visited Caroline Ryder-Jones from TEWV who described the work which is undertaken through the Memory Clinic with patients who have been referred to them from G.P's and by other means.

2.6 Finally, a series of discussions took place with individuals and groups of patients and carers who have recent experience of dementia diagnosis. In total, we spoke to more than 30 patients and carers but encountered some difficulties finding people who were willing to talk openly about their experiences.

3. Findings

3.1 G.P Feedback

(i) Generally, we received a positive impression of the dementia diagnostic services provided by the eight practices who returned questionnaires. It must be said however, that overall, practices were slow to respond and despite several reminders only 50% of the practices in the town returned the questionnaire.

(ii) There was a clear indication that all surgeries undertake preliminary examinations and screening of patients if dementia is suspected. This includes blood and urine tests as well as basic memory tests (such as the 6 CIT test). Some Practices said that patient history and general mental health were also considered.

(iii) Several practices said that they had detailed discussions with patients/carers /family members at this stage and consent was gained to investigate further.

(iv) All practices indicated that a referral to the Memory Clinic would be made once initial tests had been concluded and results indicated that further investigation was needed.

(v) On receiving confirmation of a dementia diagnosis from the Memory Clinic, most practices indicated that the patient was added to their Dementia Register and would subsequently be called to an annual dementia review meeting. Most practices also said that they would be involved with other agencies in planning subsequent nursing and social care inputs.

(vi) Most practices said that dementia diagnosis had shown a slight increase in the previous two years. They also commented that patients were generally more aware of the condition and its symptoms and therefore more prepared to request screening at an earlier stage. Some also commented that greater awareness was also leading to relatives and carers being more likely to raise concerns.

(vii) In general, practices are promoting awareness and the importance of early diagnosis through surgery based information and discussions during consultations. It was also reported that national publicity is also helping to raise awareness levels.

(viii) Some practices said that patients were waiting slightly longer to access Memory Clinic appointments but overall, waiting times were not seen as excessive and all practices were of the opinion that diagnostic and treatment services have improved.

(ix) All practices that responded have provided staff training around dementia and in most cases this has included administrative and reception staff. Some reported using e-learning packages and others said that staff received annual dementia updates and that the issue was regularly discussed at team meetings.

(x) Some practices reported offering newly diagnosed patients care planning meetings which recognise the individual nature of each patient's dementia and seek to develop care packages which are right for that person. Patients are also encouraged to bring a relative or carer to review meetings whenever possible.

(xi) Most practices also reported that they have made attempts to make surgeries dementia friendly with examples being the use of easy read signage and introducing longer appointments.

(xii) Practices also reported that systems were in place to flag up patients who were at particularly high risk of dementia. In some practices patients with Learning Disabilities were offered dementia screening as part of their annual health check although some difficulties were reported in administering the 6 CIT test.

3.2 Patient/Carer/Family Feedback

(i) Around 30 patients, carers and family members with recent experience of the dementia diagnosis process have input into our investigation. This has been through one to one discussions and larger focus group events. We are extremely grateful to all those who have taken time to speak to us and their input is are extremely valuable.

(ii) Gathering information has proved to be quite difficult and on occasions people have been reluctant to talk about their experiences. We feel that this indicates that despite the enormous amount of excellent work that has happened over recent years aimed at raising awareness and understanding of dementia, it is still a condition which some patients are reluctant to talk about.

(iii) It is often said that each person with dementia will have their own individual experience of the condition. Our investigation indicates that this can also be said about the experiences individual patients have during the diagnostic process. The feedback we received from G.P's shows that broadly similar diagnostic processes are being followed and that pathways which leads to a referral to the Memory Clinic are fairly consistent. However, the point at which diagnosis occurs and the emotional, psychological and personal impacts on individuals vary greatly.

(iv) Some patients reported that they thought they had dementia before they spoke to their G.P –
"I know the signs and knew I had it even before I went to see my doctor"
For others it came as a complete surprise and in some cases was picked up as a result of other medical inputs.
"I went for an eye test and the optician said I should see my G.P"

(v) Some patients reported that a significant issue or event had caused them to consult their G.P -
"I was driving home from work after a training day. I got to a roundabout and could not remember what to do"
Others said that friends or relatives had noticed changes before they had themselves, and on occasions, a significant period of time could pass before they raised concerns with their G.P.

(vi) In all cases, both patients and family members reported that this was a particularly stressful time for all concerned and in most instances the referral to the Memory Clinic was triggered by the G.P although one patient said that their referral had happened via the hospital and two others said that they were referred following a stay in Sandwell Park.

(vii) Both patients and family members reported that generally once a referral to the Memory Clinic happened, the appointment came through quickly.

(viii) The diagnosis process is extremely stressful for patients and their families and carers. Concerns were raised by some patients about information and communication during the diagnosis process and in some instances poor communication had increased stress and anxiety –
"I felt that the way I was given my diagnosis was insensitive……I felt like there was no hope at all"
"I still don't know what type of dementia I have and what can be done"
"It was one of the most stressful times of my life"
However, some patients reported that communication had been good and they were kept well informed at all stages.
"My G.P was good, I was referred quickly and he kept me well informed".

(ix) Some patients reported that their individual diagnosis had taken several months to complete. This was most common among those patients who had experienced the onset of dementia in their 50's or early 60's. It was reported that in such cases G.P's had initially looked

to rule out other conditions before dementia was considered. In one instance a patient reported that their initial diagnosis had been for depression and that they had gone through a very traumatic period before their dementia was properly diagnosed.
"It took an age to get my diagnosis …….and I am still not sure what it all means"

(x) Patients and family members often reported that they had been given information verbally and in written form but had found it too much to take in and retain at the time and consequently were now unclear about their diagnosis and how the condition was likely to develop.

(xi) The impact on carers and family members can be immense both during diagnosis and subsequently. During the course of our investigation we heard many powerful accounts of the life changing impact the condition has on individuals, carers and family members.

(xii) Several patients and family members reported that their decision to see their G.P had been made following a visit to The Bridge where they were given information and advice about dementia and the importance of early diagnosis. Feedback regarding the Bridge and the work it does in supporting individuals with dementia and their families and carers, was extremely positive.

(xiii) Some patients commented that they had received very little post-diagnosis support from their G.P. Most surgeries who returned questionnaires indicated that patients with dementia will have an annual health check during which their condition is reviewed. They also reported that patients could also see their G.P at any time by appointment if needed.

4. Conclusions

4.1 Overall there was evidence that diagnosis and associated procedures have improved across the G.P practices that returned questionnaires. Awareness levels amongst all staff appear to have improved and staff training on dementia awareness now happens routinely in most Practices. This includes administrative and reception

staff as well as well as G.P's and nurses. However, service development in this area is still a "work in progress" and there is still scope for further improvement.

4.2 Diagnosis of dementia for an individual, their family and carers is still an extremely difficult and traumatic process. There was evidence that some patients and their families feel that there is still a stigma attached to the condition and this can impair their willingness to seek help and support at an early stage.

4.3 Much has been done to address some of the misconceptions and prejudice around the condition, but more is needed if the ambition of creating truly "dementia friendly communities" is to become a day to day reality.

4.4 Concerns were raised by some patients about the level of ongoing support they received once diagnosed. This suggests that improvements could be made to this aspect of ongoing care and consideration given as to how understanding can be checked at diagnosis.

4.5 Evidence was presented by those with dementia and family members and carers which showed that communication processes at all stages of diagnosis can be problematic. We acknowledge and accept that due to the nature of the condition and the stressful nature of diagnosis, communication can be difficult. However, it is not acceptable for patients to be unclear about any aspect of their diagnosis and its implications for the future. Every effort should be made to ensure that all parties are kept fully informed, and as far as is practicably possible have understood all aspects of diagnosis and ongoing implications.

4.6 Patients who had experienced the onset of dementia at an early age more frequently reported problems and delays in reaching a diagnosis of their condition, and in one instance the patient had been incorrectly treated for depression for a period of time. In some instances these patients also found it hard to accept and come to terms with the diagnosis as the condition was seen as "something that only happens to old people". We accept that our sample group is

relatively small but it does seem to indicate that some further work is needed in order to develop the support received by this age group during diagnosis and beyond.

4.7 Communication between G.P's and the Memory Clinic in most instances appear to be working reasonably well and as stated earlier the introduction of The Bridge Centre has been extremely helpful in providing additional information and support to patients and family members.

5. Recommendations

5.1 That the findings and conclusions above are noted and acted upon by all relevant parties and that Healthwatch Hartlepool continues to monitor the ongoing development of patient experience of service delivery in this area.

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.

7.3

Appendix 1

Healthwatch Hartlepool
Dementia Diagnosis and Pathways Questionnaire

1) When a patient comes for a consultation, and describes/displays symptoms which suggests dementia as a possible/probable prognosis how would you proceed?
*A template such as a G.P log is used to assess and depending on the results of this patient will be offered blood tests for dementia screening including calcium, vitamin B12 and folates. A referral to memory services would also be initiated depending on results.
*Look at patient history, duration of issues and mental state. If further examination needed, bloods and ECG.
*Do basic assessment as per Tees Dementia Screening.
Ask if patient has any concerns with memory. If yes ask patients consent to assess. Undertake GPCOG if consent given. Depending on score, bloods and urine taken and refer to Memory Clinic. Also discuss with family/carer.
*Discuss if the patient would like to proceed further. Gain consent to screen/investigate. Establish if the patient has capacity to make decision.
*GP takes a detailed patient history, particularly around symptoms associated with dementia. Clinician does CIT scoring test, if return score over 8 patient is referred to Memory Clinic.
*Check bloods/MMT screening and refer to Memory Clinic (2)
2) At what stage would a patient be referred to the Memory Clinic in order to access, diagnosis and support?
*As soon as concern is expressed or identified.
*If there is demonstrable cognitive impairment on MMT
*If score 8 or more on test will be referred.
*If the screening test showed referral appropriate and all tests have been completed.
*Once tests have been completed an assessment is done
*Following investigation and mental state examination a referral is made to Memory Clinic.
*If symptoms and or results of blood tests and GP log show possibility of diagnosis patient is referred.

3) What ongoing involvement do you have with the patient regarding their condition once they have accessed the Memory service regarding their memory condition?
*Annual review as a minimum standard or earlier if needed. Blood test also done annually or sooner if needed.
*Depends on risk factors and patients circumstances, eg living independently, in a care home etc.
*Annual review, medication request.(2)
*Would deal with any medical problems as we normally do and await feedback from Memory Clinic. Arrange any nursing or social service interventions as appropriate.
*Provision of medication under shared care guidance. All patients with dementia diagnosis has it placed on their medical record. Other primary care services as normal.
*If a patient is diagnosed they will be added to our practice dementia register. They will be invited for yearly dementia reviews and the relevant GP will create a dementia care plan. As always patients have open access to GP's.
*Followed up in routine clinics after we receive results from the Memory Clinic. Added to practice dementia register.
4a) Over the last two years has the level of dementia diagnosis at your practice changed, if so please quantify?
*Increased due to improved screening and awareness. Also patients more forthcoming.
*Yes, increased.(2)
*Unable to say for certain.
*Yes 1% more.
*2014 80.9 (Q4), 2013 83.7, National average 62.06
*Patients have requested screening more as more aware so yes.
*This has increased due to our quality improvement scheme. Patients with certain chronic diseases such as stroke/PVD or diabetes over 60 or COPD, Downs Syndrome records flagged to carry out tests if any concerns.
4b) Are patients raising memory related concerns with you at an earlier stage, and if so why?
*Yes, the subject of dementia is more frequently mentioned and patients are asked routinely whether they have any problems,

which is highlighting issues at an earlier stage
*Yes, more concern around memory, can investigate more quickly and reach diagnosis.
*Yes possibly due to TV coverage.
*Have not seen any particular increase. Practice has increased screening/prompts to patients. We have flagged patient records who have learning disabilities and other high risk groups.
*Yes carers are also raising more concerns. More awareness of the issue generally.
*Often relatives of patients raise concerns. Patients are often concerned about raising memory problems for fear of what the diagnosis may be.
Yes – More awareness
4c) Has the time it takes for patients to access the Memory clinic changed, if so please quantify?
*Waiting time increased due to volume of referrals.
*Don't know 4
*Couldn't say for certain but since start of enhanced service and quality improvement schemes relating to dementia, the number of referrals has most likely increased leading to longer waiting times.
*Patients referred are seen fairly quickly.
5) In your opinion, over the last two years, have diagnostic and subsequent treatment services for patients with dementia – • **Improved Greatly □2** • **Improved a little □6** • **Stayed the Sane □** • **Have become a little worse? □** • **Have become a lot worse? □**
6a) What steps have been taken at your Practice to improve staff awareness and understanding of dementia and challenge associated stigma?
*Included in staff training programmes
*All patients considered to be more at risk of memory problems have alerts coded to their records. This prompts clinical staff to carry out 6CIT test. All relevant staff receive required training to help keep them up to date with patient needs.
*Staff raise problems encountered. If changes in patient behaviour

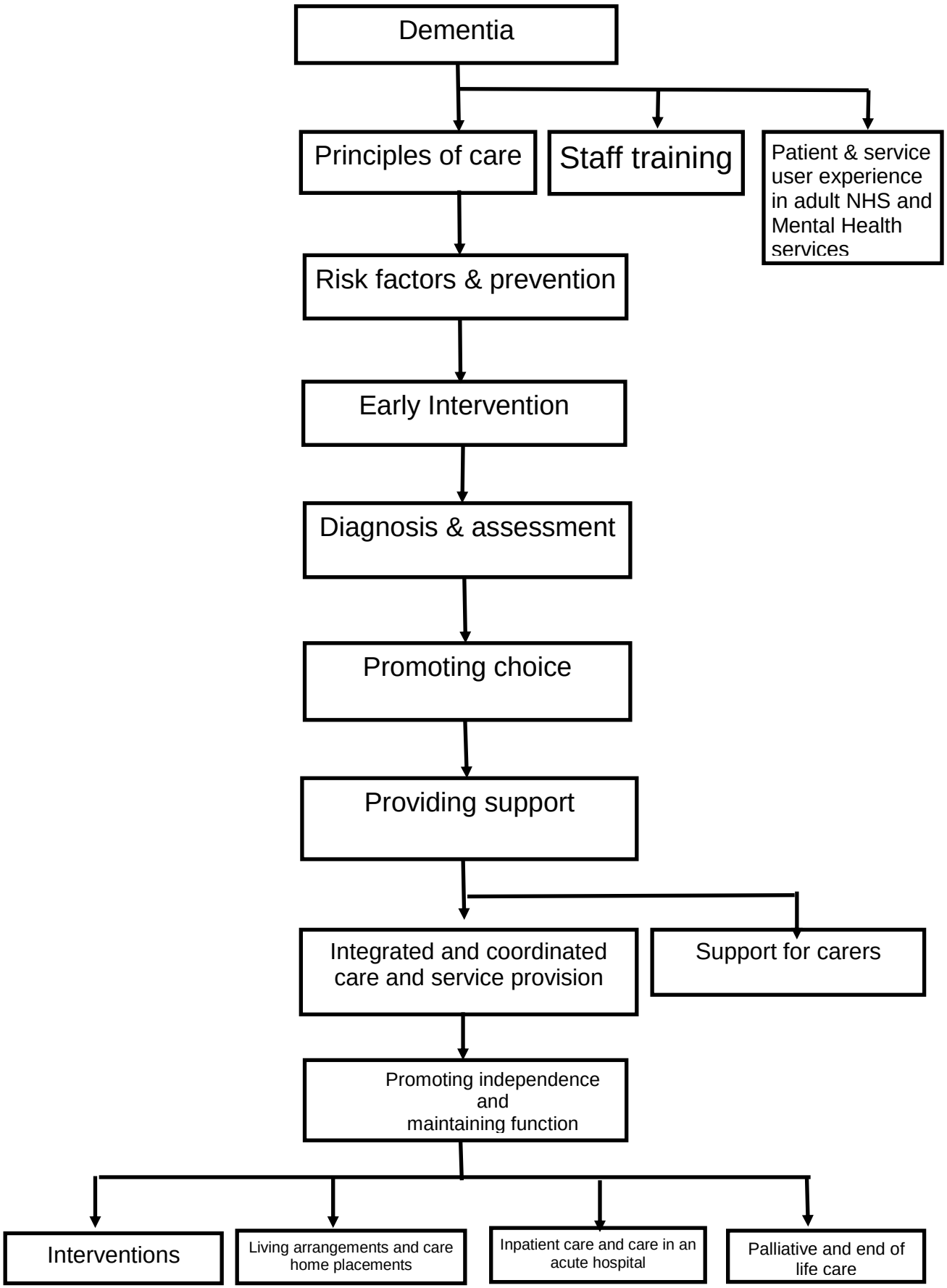
are noticed they are raised.
*Arranged training for reception and administrative staff in April 2016.
*Annual updates and regular discussion at Practice meetings.
*Using dementia e-learning package
We have recently signed up to have training for all staff to become Dementia Friends. This will run in 2016.
6b) Please give details of any mandatory training which clinical and administrative staff undertake around dementia ay your Practice?
*All practice staff undergo Adult safeguarding training. The G.P's also have training in mental health capacity each year. G.P's and Practice Nurses also attend time out sessions on dementia. (2)
*E-Learning training has been undertaken by few. Will ensure all staff (including admin) undertake dementia e-learning in coming months.
*Yearly dementia updates
*Access online training via Time Out. Attend town wide training session for GP's/Nurses
*G.P's attend regular updates as required. All nursing and admin staff have access to electronic training modules and time to complete training
*Time out sessions, lunch and learn and dementia with lewy bodies.
7) What steps have you taken to promote the importance and benefits of early diagnosis and care?
*G.P's carry out cognitive tests routinely
*Posters/leaflets are displayed.
*Undertook the 2014/15 Dementia DES. Flagged with wall charts in consultation rooms.
*Increased screening/prompts to patients and flagged patient records in high risk groups.
*Discuss any problem with patient and relatives.
*Early intervention – diagnosis – treatment – better care
*We signed upto a quality improvement scheme aimed at facilitating early diagnosis and support for dementia patient.
8) What steps do you take to ensure that patients and carers

are included in all stages of diagnostic and subsequent treatment pathways?
*Care plans are developed and carers identified
*It's been Practice policy to include patients and their carers in all stages of diagnostic and subsequent treatment pathways for better outcomes. We believe in providing a holistic outcome.
*Regularly update them with dedicated clinics at surgery
*Patients newly diagnosed are offered care planning meeting. Carer/family is offered health check if our patient to assess their needs. All patients with dementia are offered annual dementia reviews.
*Active involvement encouraged as with all conditions. Patient centred and specific to the individual.
*As part of the dementia care plan a named relative is included on plan. Patients attending for dementia review are always advised to bring a relative or friend to their appointments.
*Patients with firm diagnosis are followed up by Memory Clinic offered support.
9) How is ongoing assessment and care planning agreed and co-ordinated with patients, carers, memory clinic and other agencies?
*Emergency healthcare plans in place in home environment.
*Diagnosed patients attend yearly reviews of their care plans with named G.P. Practice has encountered some issues with secondary care agencies, often long waiting time to receive care plans from care homes etc.
*Patients are seen annually at practice or at home to review care plan along with carer or family member were appropriate.

10) What steps have been taken within your Practice to ensure your surgery is "dementia friendly" in the following areas -
Physical Environment
*We are a small surgery on one level, we use easy read signage to access clinical rooms
*New premises.2
*L.D/Dementia friendly signage
*****Physical access to surgery is easy. Open access to G.P's means

patients can be seen when needed.
Signage
*Easy read signage and leaflets are available.2
*We are working on it
*New purpose built premises2
*Posters in waiting room could be improved.
Appointment Systems
*Longer appointments if required with G.P. Also 30 minute health check with nurse for all dementia patients.
*Flexible timewise, and reminders sent.
*Extended appointments are available
*Fully triaged appointment system with phone/online access. Exceptions list for direct booking of patient appointments for those with other needs.
*Open access to G.P's
11) How do you ensure that patients with Learning Disabilities and sensory loss do not go undiagnosed and unsupported regarding the onset of dementia?
*Increased awareness, follow up complaints, clinical decisions
*Annual review for these patients with pro-active memory assessment if needed.
*G.P's have found it very difficult to conduct 6 CIT on patients with LD as they often don't understand the purpose of the test. Raising concern in next Practice meeting with LD team.
*Offered annual physical medical checks to patients with LD, opportunistic screening.
*Annual assessment3
*Patients over the age of 50 with LD have a flag on their records to show they are at risk of developing dementia. Clinicians raise this issue opportunistically and offer screening if appropriate.
12) Have you any comments or suggestions as to how diagnostic and treatment pathways could be improved in any way?
*Continue with awareness training for all.
*Early appointments at Memory Clinic.
*Improve communication and planning with other agencies, maybe get together every three months and discuss patients.

Appendix 2 (taken form NICE Dementia Pathway guidelines)


Dementia
Principles of care
Staff training
Patient & service user experience in adult NHS and Mental Health services
Risk factors & prevention
Early Intervention
Diagnosis & assessment
Promoting choice
Providing support
Integrated and coordinated care and service provision
Support for carers
Promoting independence and maintaining function
Interventions
Living arrangements and care home placements
Inpatient care and care in an acute hospital
Palliative and end of life care