CMM
CAREMANAGEMENTMATTERS
SEPTEMBER 2019 www.caremanagementmatters.co.uk

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IN THIS ISSUE

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FEATURES

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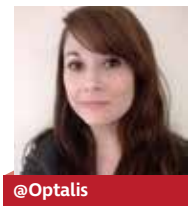
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From the Editor

Editor, Angharad Burnham shares details of the features in this month's CMM and urges readers to share their feedback.

It's been a sweltering summer break, but that hasn't stopped the cogs turning in the adult social care sector. More reports have been released, we've seen the official launch of the CARE Badge and there is a new Prime Minister.

A TIME FOR CHANGE

Whether you're a Boris fan or would rather someone else was in charge, it can't be denied that he seems aware of the current state of social care. In his first speech as Prime Minister, he committed to a 'clear plan we have prepared to give every older person the dignity and security they deserve'. We are hoping that he also has a plan for the younger adults the sector supports to live full lives too, although as far as I'm aware, he hasn't clarified this point.

The fact is, running a care business in the current climate is full of difficulties, largely financial, and sometimes this means a provider facing insolvency. If you're worried about what happens if you find yourself in that situation, the article on page 24 goes through a selection of paths you can consider. Pippa Hill and Julian Pallett from Gowling WLG take each potential route in turn to offer easy and essential information.

For those who wonder if a system overhaul might be the best option for changing the social care market, we've asked the Greater Manchester Health and Social Care Partnership to share their learning on page 20. Find out what they've been able to achieve as a devolved area and read about where they are going next, as they share the progress they've made so far.

PEOPLE FIRST

On page 35, Kate Portman-Thompson explores the concept of trauma-informed care. She asks why we haven't embedded these principles, when person-centred care is such an integral part of quality service delivery. She imparts her knowledge so you can start offering trauma-informed care in your service.

As person-centred care is so important to the way UK services operate, our Business Clinic (page 28) looks at the WHELD programme, which is finding ways to create an evidence-based person-centred care training programme. As it looks to an e-learning version, we ask our panel to share their thoughts.

NEW DEVELOPMENTS

In the CMM office, we've been coming up with new ideas to keep bringing you the latest news, opinion and best practice you need to drive your business forward. Look out for new content in the Knowledge section of the CMM website, as well as announcements from us later in the month. If you're not already a member, it's free to sign up for providers.

Lastly, we are asking for reader feedback on how you use CMM magazine, the website and Insight events. Let us know the features you'd most like to see, what you want from our website, and who you want to see at our events. Visit www.caremanagementmatters.co.uk/survey and you could win a free enhanced listing on www.carechoices.co.uk.

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Director of Quality and Innovation,
Friends of the Elderly

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Inside CQC

DEBBIE IVANOVA

Debbie Ivanova, Deputy Chief Inspector of Adult Social Care at the Care Quality Commission (CQC), updates you on phase two of the thematic review of restraint, seclusion and segregation.

We are now into phase two of our restraint, seclusion and segregation review and I want to use this column to tell you what that means.

In May, we published an interim report containing the findings of the first phase of our review of restraint, seclusion and segregation.

The interim report focused exclusively on the experiences of those people cared for in segregation on a mental health ward for children and young people or on a ward for people with a learning disability or autism.

In the interim report, you can find a number of recommendations for the health and care system, including for the CQC.

The second phase of the review is looking at restrictive interventions in adult social care services, as well as mental health rehabilitation centres, low secure hospitals, and some children's residential services.

From now until the end of October, our team will be visiting around 40 services and our findings will be in the final report to be published in March 2020.

You may have read columns elsewhere by my colleague Dr Paul Lelliot, Deputy Chief Inspector of Hospitals and lead for Mental Health at the CQC, who led phase one of the review.

As my background is in social care, I am leading on the second phase and am really pleased that we will be visiting adult social care settings, as we need to better understand how staff in social care settings use restrictive interventions and how extensively they are used.

As professionals in the sector, I hope that you would agree that adult social care is about giving people as full and independent a life as possible and it is therefore incredibly important that we understand and evaluate the use of these practices across the country.

As well as visiting 40 services during phase two of the review, we will be looking for as many opportunities as possible to speak to people who have lived experience. This could be from having experienced seclusion, segregation or restraint first-hand or from witnessing these practices being used.

We know that this is not an easy topic to talk about and it can bring up distressing memories for people, making them feel uncomfortable and emotional.

This means that we have to think hard about how we can best reach people with these experiences and we are therefore continually looking for new opportunities and ways of engaging with people who may be harder to contact.

So far in the second phase, we have held two expert advisory group meetings and two workshops to gather experiences and feedback, and we will be holding more of both over the coming months.

As well as face-to-face events, we are working with CHANGE people, a learning disability charity, and Advonet, a mental health organisation, to make sure the voice of those people with lived experience is heard at every step of the way.

This means that people's views and experience will be guiding the recommendations for changes and improvements across care services that are part of the report.

The work we do at CQC must have impact and lead to improvements in the health and social care sector. I am confident that, working with all of our partners, this really important review can do that.

"From now until the end of October, our team will be visiting around 40 services and our findings will be in the final report to be published in March 2020."

Debbie Ivanova is Deputy Chief Inspector of Adult Social Care at the Care Quality Commission. Share your thoughts and feedback on Debbie's column on the CMM website, **www.caremanagementmatters.co.uk**

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NEWS

Size of social care sector and workforce

The adult social care workforce in England is growing, according to Skills for Care's most recent report.

The *Size and structure of the adult social care sector and workforce in England, 2019* report shows that there are 1.49m people working in the adult social care sector and that there has been a 22% growth in the total number of adult social care jobs since 2009.

The sector's contribution to society and people is underlined in the report, with an estimated 18,500 organisations involved in providing or organising adult social care in England. These services are delivered across an estimated 39,000 establishments, says Skills for Care.

As well as providing evidence that the adult social care workforce is growing, the report showed that around 237,000 adults, older people and carers received direct payments from councils' social services departments in 2017/2018, and it is estimated that approximately 31% of these recipients were employing their own staff. Other key findings include:

- The number of adult social care jobs in England as at 2018 was estimated at 1.62m and was estimated to have increased by around 1.2% (19,000 jobs) between 2017 and 2018.
- The rate of increase for adult social care jobs has slowed – between 2014 and 2018 the workforce grew by around 16,000 jobs per year, compared to an average increase of 45,000 per year between 2009 and 2014.
- The number of full-time equivalent jobs was estimated at 1.13m.
- Since 2009, the workforce has continued to shift away from local authority jobs (a decrease of 37%, or 65,000 jobs) and towards independent sector jobs (an increase of 30%, or 290,000 jobs).
- The number of jobs within independent sector care homes with nursing increased between 2017 and 2018 by 2% to 295,000 jobs. This figure had, however, decreased by 5,000 jobs between 2016 and 2017.
- Registered nurses were one of the only jobs in adult social care to see a significant decrease, down 10,500 (20%) since 2012.

Read the full report on the Skills for Care website.

Prioritise social care and the NHS, says NHS Confederation

The NHS Confederation has sent a letter and briefing to the Prime Minister, asking him to prioritise social care and the NHS. The Confederation says there is much 'unfinished business' for the new government to resolve in the health and care sector.

Amongst other topics, the organisation welcomes the Prime Minister's personal commitment to finding a solution to the crisis in social care.

However, the organisation is calling on Mr Johnson to ensure that people using health and care services do not suffer as a result of Brexit. Protecting the medical supply chain, honouring reciprocal healthcare agreements and establishing workforce agreements will be key.

The letter also warns the new Prime Minister that the question of NHS funding is not yet settled, despite the £20.5bn funding settlement that kicked in from April this year. It states that the settlement excluded some vital areas of expenditure that will in part determine whether the NHS can achieve the ambitions set out in the Long Term Plan, most notably capital spending, training and education budgets, public health and social care. Failure to address these and prioritise social care and the NHS in the next spending review will put the delivery of the plan in jeopardy, the NHS Confederation warns.

The full letter can be found on the NHS Confederation website, along with a briefing for the new Prime Minister.

APPOINTMENTS

INDEPENDENT AGE

A new Chief Executive of Independent Age has been announced by the older people's charity. Deborah Alsina MBE will take on the role from October 2019, leaving her position as Chief Executive of Bowel Cancer UK after 11 years with the organisation, ten of which she has served as Chief Executive.

BOROUGH CARE

Rekha Patel-Harrison and Michael Hinett have been appointed to Borough Care's Board of Directors.

Rekha is CEO of Petrus, a homeless and community interest company based in Greater Manchester. Michael works for Fairhome Care as Group Quality and Compliance Director.

NHS CONFEDERATION

Stephen Dorrell will step down from his role as Chair of the NHS Confederation later this year, with the organisation searching for a successor. Mr Dorrell, a former Secretary of State and Chair of the Commons Health Select Committee, has been Chair of the NHS Confederation since October 2015.

NAPA

Hilary Woodhead will take over from Sylvie Silver as Executive Director of National Activity Providers Association (NAPA). Hilary will begin her new role on 1st September with overall responsibility for NAPA's work.

THE FREMANTLE TRUST

Krista Brewer has been appointed as Head of Care and Clinical Governance at The Fremantle Trust.

APPOINTMENTS

NEW CENTURY CARE

New Century Care has announced the appointment of Phil Smith as its new Managing Director. Phil's appointment comes after almost four years as New Century Care's Chief Operating Officer. Prior to joining New Century Care, Phil spent 10 years as the Senior Director of Operations at Sunrise Senior Living.

CHRISTCHURCH GROUP

Christchurch Group has promoted Ruth Smith to Chief Operations Officer. Ruth was previously Director of Operations, where she ensured that 100% of the company's ten centres across the UK achieved a Care Quality Commission rating of Good or Outstanding.

INSPIRED VILLAGES GROUP

Inspired Villages Group has announced that Stuart Garnett has been appointed Planning Director. Stuart brings a wealth of experience from the retirement living sector, joining from Savills where he was responsible for various residential projects.

READER SURVEY

Please take a few minutes to send us some feedback and influence future editions of CMM. Visit www.caremanagementmatters.co.uk/survey for the chance to win a free enhanced listing on www.carechoices.co.uk.

LAST MONTH'S SURVEY WINNER

We are pleased to announce the winner of last month's reader survey prize is Dr JS & Mr MS Lidder, Lidder Care Group.

Nominations closing: Markel 3rd Sector Care Awards

Nominations are closing soon for the Markel 3rd Sector Care Awards 2019. Now in its sixth year, these free-to-enter Awards celebrate all those working in the not-for-profit support sector, including charities, community interest companies, and informal community groups.

With 12 categories, the Awards look to celebrate as much of the hard work in the voluntary care sector as possible.

A new Dementia Care Award has been added for 2019, to find and showcase exemplary work in this area, while other categories invite people to share their innovations, reward exceptional care and appreciate outstanding leadership.

Nominees could be in any role, from a chief executive, a chef, a care worker or someone running a local club, to an entire organisation or group.

People can enter themselves or someone else and can make nominations in multiple categories.

Winners will be announced at the Awards Ceremony in London on Friday 6th December, attended by around 250 people invested in the not-for-profit care and support sector, and will receive an article in CMM Magazine to share their initiative and passions, as well as full social media coverage, an opportunity to share their stories on a national stage, and more.

Nominations must be submitted by Friday 6th September. Go to www.3rdsectorcareawards.co.uk to submit your entry today, and follow the progress of the Awards on Twitter: @3rdSectorCare #3rdSectorCareAwards

Public support tax rises for social care

GMB Union has found that almost three quarters of the general public support tax rises for social care as part of a survey conducted on its behalf.

Of the 1,024 people polled, 73% said they would be in favour of a tax increase to pay for adult social care.

There was also much support for better treatment of care workers, with 86% of people surveyed saying care workers should be well paid and trained and 83% saying that pay should be reflective of the skilled and complex work care workers carry out. 80% thought that care workers should be treated in the same way as NHS staff in terms of pay, training and working conditions.

Conducted in June 2019, the poll also asked what state people believed adult social care to be in. It found that 68% of people thought the sector was in a poor state, while just 23% of people believed it to be in a good or very good state.

The survey now being conducted by GMB can be found on the group's website.

Emergency admissions for care home residents

Analysis has found that 41% of emergency admissions to hospital involving care home residents could be avoided.

The research from the Improvement Analytics Unit, a joint initiative between NHS England and the Health Foundation, comes as the NHS rolls out the Enhanced Health in Care Homes (EHCH) initiative to improve residents' health and reduce avoidable emergency admissions.

Emergency admissions to hospital from care homes: how often and what for? includes evaluations of four local sites where the NHS worked with care homes to step-up the support they received.

Results included decreases in potentially avoidable emergency admissions to hospital of up to 27%, decreases in emergency admissions of up to 23% or reductions in A&E visits of up to 29% from care home residents. Following the early findings, it was announced in the NHS Long Term Plan that the EHCH model will be rolled out nationwide to give everyone living in a care home improved GP support and more visits from specialists like dieticians and clinical pharmacists.

Up-skilling care home staff to deliver more routine care, ensuring that residents have regular access to the same GP and encouraging better working relationships between NHS and care home staff are all things that are thought to have contributed to care home residents needing less emergency hospital care.

The analysis is the first national study of emergency hospital use by care home residents.

The research found that care home residents were being admitted to hospital with 'potentially avoidable' conditions such as chest infections, pressure sores and urinary tract infections.

It also revealed that 7.9% of emergency admissions to hospital are for people living in a care home, an estimated 192,000 emergency admissions each year.

The analysis also finds that, nationally, emergency admissions and A&E visits were particularly high in patients from care homes without nursing. There were approximately 32% more A&E attendances and 22% more emergency admissions from these care homes than from care homes with nursing.

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Research into homecare market

A report following research into the homecare market has highlighted the need for commissioners to increase average length of visits to improve standards.

Access Group's *Hidden Dynamics 2019*, produced in conjunction with United Kingdom Homecare Association (UKHCA), is based on data from more than 4,700 registered care locations in the UK which provide 64m hours of care per year.

The research found that in all regions of England excluding the South West, homecare providers were seeing extremely small margins or even losses on their services once the operating costs were taken into account. The study concludes that short lengths of visits create inefficiencies and are associated with lower ratings for quality of care.

Leading organisations have warned of the links between poor experience of care and inadequate visit lengths.

In September 2015, National Institute for Health and Care Excellence (NICE) recommended homecare visits should not normally be shorter than 30 minutes, so that workers have time to do their job without being rushed or compromising the dignity or wellbeing of the person using the services. However, Access Group found that this has become the standard, rather than a baseline. 30-minute visits were found to be the most frequent length, accounting for 65% of all state-funded visits.

Analysis of providers as a whole shows that those that deliver a greater proportion of their overall provision as 60-minute visits are more likely to be rated Outstanding by the Care Quality Commission.

The study also suggests that homecare providers which were able to increase revenue through higher fees are better placed to invest in more experienced staff and retain their workforce.

Involved & informed campaign

The National Institute for Health and Care Excellence (NICE), in collaboration with partner organisations, has launched *Involved & Informed: good community medicines support*, a new initiative to encourage better medicines support for people who are receiving care at home.

The aim of the campaign is to ensure people enjoy the best possible outcomes for them, with a reduced risk of harm, through the safe use of medicines in the community.

The *Involved & Informed* campaign encourages health commissioners and local authorities to work together, including having a written agreement setting out clear responsibilities for home-based medicines support. This should encourage better multi-disciplinary working and ensure all parties have something to refer to.

The campaign also urges homecare providers to focus on their medicines policies, so that they are as robust as possible and in line with NICE guidance.

The campaign focuses on NICE's guideline and quality standard on managing medicines in the community and is made up of action-orientated messages directed at specific audiences, including commissioners, social workers, Care Act assessors, homecare providers, people accessing medicines support (and their families and carers), CQC inspectors, GPs, pharmacists and NHS Acute Trusts.

NICE has worked with several partner organisations on this campaign. These are: Association of Directors of Adult Social Services, Local Government Association, United Kingdom Homecare Association, Care Quality Commission, Voluntary Organisations Disability Group, Think Local Act Personal, NHS England, Skills for Care, Royal Pharmaceutical Society and Royal College of General Practitioners.

Report on the future of adult social care

The All-Party Parliamentary Group on Adult Social Care (APPG) has revealed the findings of its inquiry in a report on the future of adult social care.

Of those who responded to the inquiry, 23.7% had a personal experience of receiving adult social care, either personally or through a family member; 19.8% of respondents worked for an adult social care provider, but not in a direct care or support role; and 25.7% worked as a care or support worker, such as a personal assistant. The remainder of the respondents covered other roles in the healthcare sector.

Responses showed that many people who use services continue to receive good quality care and are happy with their support.

When asked about the top three improvements needed to make a difference, increased funding was by far the most common response. This was followed by a stronger focus on supporting people to live more independently, and involving more people with experience of social care in the design of services.

Following this evidence, the report on the future of adult social care has made several recommendations, including:

- The APPG should work to facilitate a debate as to what the future of adult social care should look like.
- People with experience of using services must be fully involved in the co-design and co-production of adult social care services.
- There should be a stronger focus on supporting people to live more independently, with a more positive portrayal of the value and benefits of working in the sector, and a greater appreciation of the value and skills of the workforce.
- The Secretary of State should be encouraged to use their full title and wear a care badge alongside the NHS badge, to help raise the public profile of adult social care.

State of Caring report released

Carers UK's latest *State of Caring* report has revealed that unpaid carers can't save for their retirement, as many are using their own money to support the person they care for.

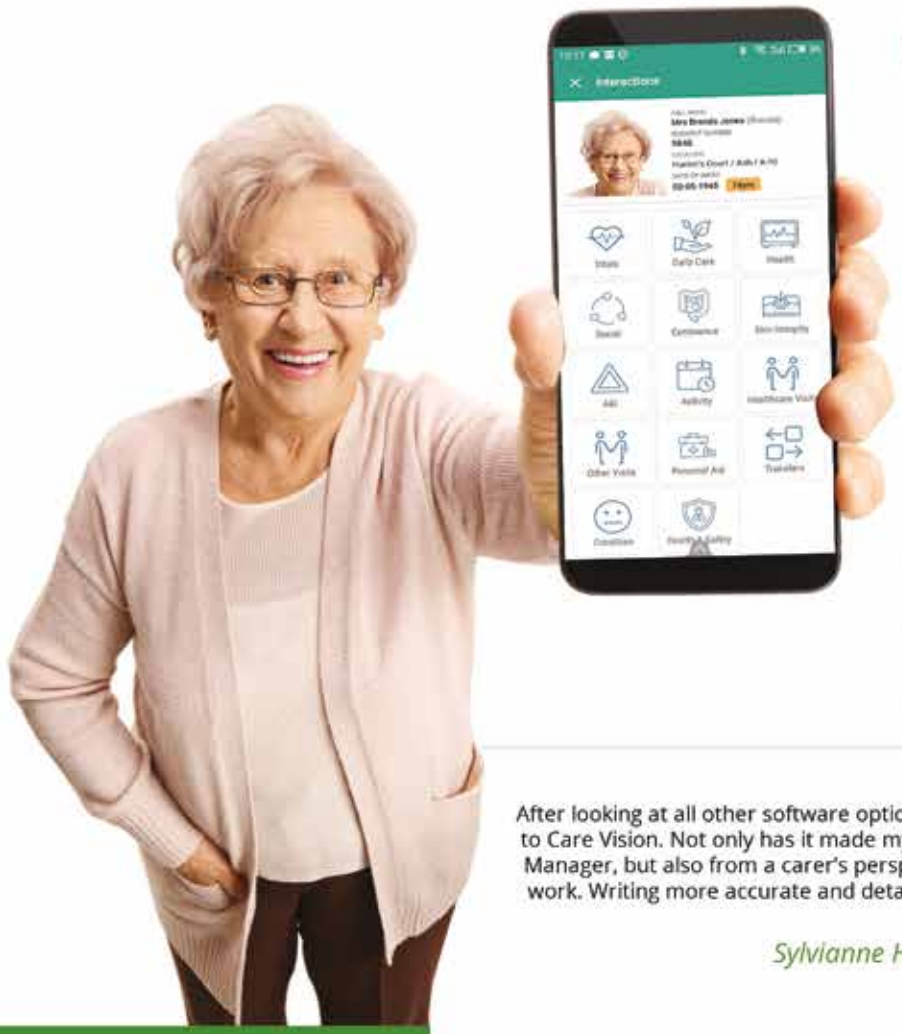
The survey suggests that two in five carers (39%) are struggling to make ends meet. Those who take on caring responsibilities also often reduce their hours at work, turn down promotions or leave work altogether, according to Carers UK.

As well as providing significant levels of care, 68% of carers are using their own income or savings to cover the cost of support, equipment or products for the person they care for. This is creating financial pressure, as over half of those in caring roles who haven't retired are left unable to prepare for the future, and 53% of all carers are unable to save for retirement.

For those on a low income or receiving Carer's Allowance it is a never-ending struggle to make ends meet, according to the report; three quarters (73%) of this group are unable to save for retirement.

Crucial support is also being cut, with 12% of carers reporting that they or their loved one received less care or support in the previous year as a result of reduced support from social services.

Carers UK is urging Government to urgently put in place the financial and practical support that carers need.



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Sylvianne Hockey - RGN, Registered Manager

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Effective	Outstanding ☆
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EAC social care funding report

The House of Lords Economic Affairs Committee (EAC) has released a report stating that Government should immediately spend £8bn to restore the quality of, and access to, adult social care in England.

Social care funding: time to end a national scandal also calls for Government to introduce free personal care, funded through general taxation, over a period of five years.

The EAC found that publicly funded social care support is shrinking, as diminishing budgets have forced local authorities to limit the numbers of people who receive public funding. Funding is £700m lower than 2010/11 in real terms, despite continuing increases in the numbers of people who need care.

More than 400,000 people have fallen out of the means test, which has not increased with inflation since 2010. The Health Foundation and The King's Fund estimate that to return quality and access to 2009/10 levels, Government would need to spend £8bn.

To address unfairness in the system, the EAC proposes introducing free personal care, saying that this is simple, fair, and not much more expensive than other proposals for reform.

Those in care homes would still pay for their accommodation and 'extras'. Those receiving care in their own homes would still pay for assistance with less critical needs like housework or shopping, but would not pay for support with personal care, which the EAC hopes may encourage care users to seek essential help early. This model would cost £7bn per year according to the Health Foundation and the King's Fund, only £2bn more than the Government's 2017 'cap and floor' proposal.

The report argues that additional funding for social care should come from national government, which should raise the money largely from general taxation and distribute it to local authorities according to a fair funding formula.

ADASS Budget Survey 2019

The Association of Directors of Adult Social Services (ADASS) has revealed that failure to properly fund adult social care is negatively affecting people who rely on services. The *ADASS Budget Survey 2019* also shows that there is a negative impact on families and those who work in social care.

Since 2010, adult social care directors in councils across England have had to make £7bn of savings, and need to find a further £700m for 2019/20, despite both the level of demand and complexity of needs increasing.

Lack of certainty from Government about continued funding for adult social care from April 2020 onwards will force directors of adult social services and their councils to make incredibly difficult decisions, says ADASS.

This is also likely to have a significant impact on the NHS, says the report, including more admissions and greater demand on hospitals due to a lack of support at home, despite the stated aims in the NHS Long Term Plan.

The survey has also found 87% of councils have continued to experience pressure from increased hospital admissions, while 60% of directors say demand for social care as a result of premature or inappropriate discharge is a cause for concern.

ADASS is calling on Government to provide:

- A long-term, sustainable funding solution for adult social care.
- Funding from the Spending Review to be for at least two years and to continue until whatever is in the promised green paper can be produced and implemented.
- Adequate funding to meet an increasing number of people's needs in the ways they want.
- A proper debate with the public about the priority of social care.
- Investment in new, asset-based approaches and prevention.

IN FOCUS

Survey of Adult Carers

WHAT'S THE STORY?

NHS Digital has conducted research to discover how informal carers are coping with their roles. The report, *Personal Social Services Survey of Adult Carers in England 2018-19* found that more informal carers are stressed or depressed than in previous years.

The survey asked 50,800 adult carers in England about their stress levels and mental health. The national survey is conducted every other year by Councils with adult social services responsibilities. The survey seeks the opinions of carers aged 18 or over who are caring for an adult, on topics that reflect a balanced life alongside their unpaid caring role.

WHAT DID IT FIND?

The survey revealed that 60.6% of carers reported feeling stressed in 2018-19, up from 58.7% in 2016-17. The percentage of carers who reported feeling depressed also increased, from 43.4% in 2016-17 to 45.1% in 2018-19.

Of all the carers surveyed, 77.8% reported feeling tired (an increase from 76% in 2016-17) and 66% said that they experienced 'disturbed sleep' (an increase from 64% in 2016-17).

In terms of the amount of care being provided, more than three quarters (76.0%) of respondents to the survey of adult carers in England said that they spend over 20 hours per week looking after the cared-for person, and 38.7% said they spend over 100 hours per week on their caring duties.

The survey also showed a rise in the percentage of carers who were not in paid work as a result of their caring responsibilities, from 21% in 2016-17 to 22.6% in 2018-19.

Financial difficulties for carers are also increasing, as 10.6% of respondents reported that caring had caused them a lot of issues in this area in the past 12 months, compared to 9.6% of respondents in 2016-17.

The report also provides information relating to the carer and their wider experiences of providing care. The majority of carers were female (67.8%) and the largest age band of carers was 55-64 years. The smallest group was 18-24 years.

WHAT DOES THE SECTOR SAY?

Responding to these figures, Helen Walker, Chief Executive at Carers UK, said, 'The findings... again underline the need for Government to urgently come forward with significant and effective proposals for reforming adult social care funding, to ensure unpaid carers – and the family members and friends that they care for – get the support and services they need.

'The results show that one in ten carers are experiencing significant financial difficulties as a direct result of caring, a substantial 1.9% rise since 2016/17. The survey also makes clear that caring is having an increasingly negative impact on carers own health and wellbeing. In response to every health metric reported on in the survey, from 'feeling tired' or 'depressed', to having 'disturbed sleep' or 'experiencing physical strain', more carers report that their own health is suffering.

'...It couldn't be clearer; carers, who provide so much support and value to society, are being massively short-changed.'

Digital Social Care website launched

A new website, Digital Social Care, has been launched to support providers in all aspects of adopting and maintaining technology in their services.

www.digitalsocialcare.co.uk is a dedicated space to provide advice and support to the adult social care sector on technology and data protection. Run by social care providers for social care providers, the project is a partnership project between members of the Care Provider Alliance, Skills for Care and NHS Digital.

The website is funded until March 2021 and aims to support social care providers with technology, data protection and appropriate information sharing with health and local authority partners.

CQC research into complaints

Research undertaken for the Care Quality Commission (CQC) as part of its year-long *Declare Your Care* campaign has revealed racial disparity in people raising concerns about their care.

CQC found that those from a black and minority ethnic (BME) background are less likely than those from a non-BME background to raise concerns about the standard of care they receive, particularly in relation to mental health.

Almost half (48%) of BME people with a previous mental health issue who took part in the research said they had wanted to raise concerns about mental health services but did not do so. This is compared to just 13% of non-BME people with a mental health issue.

Additionally, 84% of BME people with a mental health issue have wanted to raise concerns or make complaints about the standard of their care more generally, compared to 63% of non-BME people with a mental health issue.

Reasons as to why people don't feed back on their standard of care include not knowing who to raise it with (33%) and not wanting to be a 'troublemaker' (33%). A third of people asked (37%) felt that nothing would be changed by speaking up.

However, when people did raise a concern or complaint, the majority (66%) found that their issue was resolved quickly, it helped the service to improve or they were happy with the outcome.

Most people who provided feedback on their care were motivated by a desire to make sure that care improved for others. This included wanting to improve the care they, or a loved one, had received (61%) and improve care for everyone using the service (55%) with a smaller number also hoping for an apology or explanation (26%).

Further information on the data can be found on the CQC website.

Attitudes towards co-production

Social Care Institute for Excellence (SCIE) has released *Attitudes towards co-production*, revealing that almost two-thirds of people using social care feel they don't get a say in how services work.

The survey showed that just 11% of those asked positively, strongly or completely agreed that they have a say in how their services are designed and delivered.

The survey also brings together responses from those working in social care. Overall, 96% of surveyed professionals in the sector said that they would prefer to work in services that are designed and delivered in equal partnership between themselves, carers and people who use services. 95% of people who use services and their carers said they would prefer to use services that have been co-produced.

Sleeping in, losing out report from UNISON

A new report from UNISON, *Sleeping in, losing out* reveals a picture of sleep-in conditions for care staff, saying that some are abused physically and verbally, punched and threatened with knives.

Based on a survey of more than 3,000 care workers who work overnight, including in care homes and in people's own homes, the report reveals the extent of overnight staff's heavy workloads, and that the vast majority are not allowed to leave their place of work while on a shift.

Of those who responded to the survey, more than one in ten (13%) said their sleeping facilities were unsuitable where they worked.

Some had to make do with make-shift beds in staff offices, with ripped mattresses, and 2% had nowhere to sleep at all.

Some respondents also reported there was no bathroom to wash in, despite having to work another shift the next day, and lack of privacy was an issue too.

More than seven in ten (72%) respondents were so busy they only got a couple of hours' sleep a night, with the same number left feeling exhausted.

The duties respondents assumed responsibility for overnight included; calming people with learning disabilities or mental health issues when distressed (81%), assisting vulnerable people to go to the toilet (43%), and giving medication (59%).

Nearly a third (31%) who responded to the survey had experienced personal threats or even been attacked.

Some had been bitten, punched, kicked, spat at, had people try to strangle them, been threatened with knives, and boiling water, or even told they would be killed. However, more than two thirds (67%) say they are the only member of staff on site during their sleep-in shift.

UNISON is calling on employers to improve sleep-in working conditions, recommending providing somewhere safe and clean to sleep and carrying out proper risk assessments.

It is also asking Government to fund the back-pay owed to sleep-in shift workers who have not received the national minimum wage.

Manifesto for Better Mental Health

The Mental Health Policy Group has launched a *Manifesto for Better Mental Health* as the new Prime Minister takes up post. The group is made up of colleagues from the Mental Health Network, Mind, Rethink Mental Illness, Royal College of Psychiatrists, Mental Health Foundation and the Centre for Mental Health.

It says it's vitally important Mr Johnson establishes a clear direction for mental health policy. Whilst Brexit still dominates much of the wider political debate, the group wants to make sure that mental health remains high on the agenda. The *Manifesto for Better Mental Health* therefore focuses on five key asks of the new Prime Minister. These are: take action to prevent mental illness; create a cross-government plan for mental health and establish a 'mental health in all policies' approach; reform the Mental Health Act; ensure everyone can access the right mental health support, in the right place, at the right time; and build a mental health workforce fit for the future.

The group also wants to see the new Government re-commit to the ambitions of the NHS Long Term Plan as well as a funding settlement post 2020 to provide vital increases in investment for mental health services.

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Rural areas face lower funding rates

The International Longevity Centre UK (ILC UK) and The Salvation Army have found that rural areas have less money to care for older people.

Adult social care is largely funded by local business rates, Council Tax and other local charges, but areas with lower house prices and fewer businesses cannot raise as much money as more urban areas, says the report.

Care in Places – Inequalities in local authority adult social care spending power states that this has resulted in severe funding inequality across the country and prevents most local authorities from providing adequate social care for older residents.

ILC UK states that as the Government develops policy for the future of social care, it will be vital to discuss how social care will be delivered in place. The report showed that:

- Some areas can raise up to five times more revenue than others.
- The idea that areas with lower populations don't need to raise as much money is false. Their funding streams are so depleted they cannot raise sufficient funds.
- While rural areas are the worst hit, the funding disparity does affect urban areas too, especially those that have been hit by years of economic decline.
- Inequalities in the ability to meet the need for social care are systemic.
- Local leadership alone cannot overturn the current inequalities.

The Salvation Army is asking Government to prioritise properly funding adult social care and to consider funding most of it centrally. This is the only way to ensure that money is distributed fairly and all older people get the help they need, says the charity.

Vibrance and HAIL merger

Vibrance and HAIL (Haringey Association for Independent Living) have formally merged to provide a wider range of services, as one organisation across London and the South East.

Although they will continue to operate under their own names, together they will now support a total of more than 4,000 people with a range of learning disabilities and mental health issues through a wide variety of services.

Vibrance offers day services, housing, short breaks, supported employment and self-directed services. HAIL supports people with learning disabilities, mental health issues and autism to lead independent lives.

Learning disability sector deal

A new report is proposing a sector deal for the learning disability sector, focusing on the potential of technology to boost investment and transform the way care is delivered.

Hft, supported by Tunstall Healthcare, produced the paper outlining the key arguments for an economic partnership with Government as part of the UK Industrial Strategy.

The report highlights the challenges faced by a social care sector in financial crisis with increasing demand.

Hft and Tunstall believe the successful negotiation of a learning disability sector deal would enable effective investment that could unlock the potential of assistive technologies.

In turn, the organisations suggest, this would stimulate innovation and investment in future services, bring financial sustainability to providers within the sector, and ultimately deliver enhanced outcomes for people with learning disabilities.

Call for better carers' breaks

New guidance from the Social Care Institute for Excellence (SCIE), in partnership with Carers UK, is calling for better breaks for carers, outlining how health and social care commissioners and providers can improve regular breaks for families and friends who care for other adults.

Research by Carers UK shows 46% of unpaid carers have not been able to access a break in the last five years, despite wanting one.

Carers' breaks: guidance for commissioners and providers calls for a whole-family approach to ensure that breaks are accessible, personalised and enjoyable for both the carer and the person they care for.

Evidence and current practice indicate that there needs to be a wider choice of carers' breaks available to suit the varying needs of unpaid carers, says SCIE.

The improvement agency, along with Carers UK and the Department of Health and Social Care, suggests that commissioners should be playing a role in shaping the market, and providers should take innovative approaches to developing a range of breaks, available at different times to suit carers. You can read the guidance in full on the SCIE website.

Support for housing-with-care

A high-profile group of MPs, Lords, charity leaders and business leaders have publicly declared their support for the UK's fast-growing retirement community sector.

The group, which includes MPs and Peers from five political parties and groups has publicly backed calls for the UK retirement community sector to nearly quadruple in size by 2030 to offer homes for 250,000 people.

The sector already accounts for 75% of all projected growth in the UK's supply of specialist housing for older people from 2024 onwards.

It is now aiming to double this projected output during the course of the next decade, to help tackle the housing shortage and the challenges facing the health and social care systems in the UK.

High profile political backers include former Secretary of State for Work and Pensions, the Rt Hon Damian Green MP (Conservative), Co-Chair of the All-Party Parliamentary Group on Adult Social Care, Eleanor Smith MP (Labour), Liberal Democrat Spokesperson for Housing, Lord Shipley (LD), respected cross-bench peer Baroness Sally Greengross (CB) and Jim Shannon MP (DUP).

Anchor Hanover

Anchor Hanover has taken on five homes previously owned and run by Hadrian Healthcare Group.

The homes provide a total of 382 en-suite rooms for older people, including older people with dementia. The deal brings the total number of care homes operated by Anchor Hanover to 114. The five homes are The Manor House, Barnard Castle; Wetherby Manor, Wetherby; The Manor House, Knaresborough; Oulton Manor, Leeds; and The Manor House, Harrogate. Four of the care homes are rated good by the Care Quality Commission with The Manor House in Harrogate awaiting inspection by the regulator.

In conjunction with the acquisition of the business by Anchor Hanover, the properties were acquired by the Lime Property Fund managed by Aviva Investors.

PAVING A NEW PATH

LESSONS FROM DEVOLUTION IN GREATER MANCHESTER

Since 2016, Greater Manchester has been responsible for its own health and social care budget, organising services and support in the best way for the area. But is devolution in Greater Manchester effective? How has it changed ways of working? Stuart Cowley from Wigan Council, and Jo Chilton from the Greater Manchester Health and Social Care Partnership share their learning here.

In Greater Manchester, the number of care homes rated Good or Outstanding by the Care Quality Commission (CQC) has risen from 54% in April 2016 to 77% in June this year. Homecare agencies have improved from 62% Good or Outstanding to 88% and, at the same time, the number of homecare agencies and care homes rated Inadequate has also fallen significantly, from 28 a year ago to five now, out of more than 900 providers.

In Wigan, early deaths from cardiovascular disease and cancer have fallen faster than in England as a whole, with fewer people smoking and lower rates of physical inactivity.

The King's Fund recently studied how this had been achieved through the 'Wigan Deal' and noted that the council had succeeded in controlling the growth in demand for social care, despite saving more than 40% of its budget since 2011.

We are often asked whether devolution in Greater Manchester is working. Put simply, yes, devolution is 'working'. You can see this when you look at what it has enabled us to do. But the reason it is bringing success across a range of measures is the fundamental change we have made in the way we work.

COMING TOGETHER TO SUCCEED

Greater Manchester has a long tradition of collaboration that stems from the 10 boroughs having worked together for decades to pool policy-making in areas such as planning, transport, skills and the economy.

The NHS in Greater Manchester also has almost two decades' experience of joint working, developing new models of hospital care, joint commissioning and population health innovations. However, we recognised that the way services were provided through NHS trusts, primary care and social care was often fragmented and of inconsistent quality.

Bringing the NHS and local government elements together through the devolution agreement felt like a natural extension of a long-standing way of working, based around place and communities. We brought together clinical commissioning groups, local authority social care and public health functions into a single commissioning organisation in each of our 10 local authority areas. The budget is pooled, risk is shared, the staff work together and, in many cases, they are led by one chief officer.

Health and social care to support people to live well at home is provided through integrated local care organisations. Teams based in neighbourhoods of between 30,000 and 50,000 people – which we find is the natural size of people's communities – are led by GPs, and include community health, mental health, social workers, independent providers and the voluntary and community sector.

>

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> Commissioners have developed partnerships with neighbourhood-based health, care and support providers and have established a Greater Manchester independent care sector network. This gives providers a stronger voice and the ability to shape policy, strategy and delivery. This in turn has improved outcomes for people.

This is an area where working together will bring innovation. For example, we are developing new 'blended' neighbourhood-based care roles which will support and enable care staff to undertake low-level healthcare tasks – providing better career opportunities and job enrichment for the workforce, as well as better support for the individual.

Providers are creating apprenticeship roles and are offering leadership development for existing registered care managers and those who want to develop into management roles; local authorities have established ethical commissioning frameworks to ensure a fair deal for the workforce and to prove their commitment to high-quality support.

As a result of these initiatives, wages are starting to rise, skills levels are improving and turnover in some areas is starting to fall. In terms of care given, the focus is on outcomes, rather than the time spent in a person's home or a tick list of tasks.

Through this collaborative approach, we are also working to shape the market – understanding and researching demand, how costs can be met and the need for new models of health, care and supported housing.

WHAT PEOPLE WANT

Another area of focus has been on ensuring we are offering the best care for that person at that time. Too often in the past, social care and NHS staff have started with the question, 'What's the matter with you?'. We have turned that around to ask, 'What matters to you?'

We ask staff to have a different conversation with people, about what people want to do and achieve and about their community.

We have numerous examples of the difference this has made, for example:

- A man with dementia who is living in a care home is now taken to watch his football team by a volunteer from the team's supporters' club.
- A woman with dementia who loved to iron before moving into a care home now irons clothes from a local charity shop and enjoys visiting her local tea room with the shop's volunteers.
- A man with little sight who lives in his own home and used to enjoy going to the bookmakers is now taken there by volunteers from his local veterans' association. He says, 'With someone on my arm I can stride out again.'
- A woman with Chronic Obstructive Pulmonary Disease (COPD) who loved to sing has joined a community choir, which has led to new friendships and is good for her lungs too.

We find that when we turn around the conversation with people, listen to them, work out together how we can offer the best support and personalise the care based on what matters to them, we see better outcomes and better manage demand.

This actually means fewer people in social care, so we can focus on the people with the most complex needs.

THE PREVENTION GOAL

Prevention is often talked about in terms of avoiding illness or disease, but for us it's also about avoiding or minimising the need for social care or NHS care by intervening early to enable people to continue living independently in their own homes.

This might be by finding suitable housing options, helping someone to become independent again following a stay in hospital, or supporting people to stay active and take part in the local community.

As part of our work on prevention, we have analysed future need for supported housing and we know we currently do not have enough. Having this knowledge means we have been able to begin working with planning and housing colleagues to achieve our ambition of providing a further 15,000 supported housing units by 2035. This will help us to meet future demand.

HAVING A CLEAR STRATEGY

Devolution has also enabled us to develop targeted strategies to ensure we are helping people as best we can. Working with self-advocates, families and specialist organisations, we have listened to people to understand what they want to see. Through this, we have co-produced a learning disability strategy with 10 areas identified, such as belonging, health and justice, employment, advocacy and workforce.

We have also developed an autism strategy that focuses on making sure public services are accessible and improving employment opportunities.

For informal carers, we have worked with partners to develop a model of best practice in how to support them. We know there are at least 280,000 unpaid carers in Greater Manchester and that without their contribution the health and care system would collapse.

We have therefore co-produced a carers' charter and a commitment to carers which very clearly sets out their rights. It focuses on identification, an improved annual health and wellbeing check, support in employment and opportunities for young carers. A carers' partnership ensures carers' voices are heard and they influence policy and development.

As well as this, we have co-produced a working carers' toolkit for employers that has been endorsed and adopted by all of Greater Manchester's key public sector organisations as well as in the private sector. This helps organisations to identify carers and put structures and policies in place to support them, helping to ensure their wellbeing and minimising the risk of them leaving their job.

As with other policies in Greater Manchester this approach has been agreed by listening to local views, defining a standard that we all aspire to and then handing over responsibility for delivery to local areas.

WORK IN PROGRESS

To return to the original questions, we ask ourselves if our strategies are working by asking if our local population is being served well.

Using Wigan as an example, we have recently produced our 2030 version of the Wigan Deal, after listening to the views of more than 6,000 local residents. Healthy life expectancy has improved, 3,000 people are using community-based alternatives to traditional social care and we are best in the North West for getting people home quickly from hospital. Each Greater Manchester borough could also point to their own successes.

We are making good progress, but it takes time. However, we have glimpsed what is possible and we are determined to continue because we know it is the right thing to do.

When we have turned around the historic inequality in health and care outcomes in Greater Manchester, then we will be able to say that devolution has been a success. **CMM**

Stuart Cowley is Chair of the Greater Manchester and North West Association of Directors of Adult Social Services, and Director of Adult Social Services at Wigan Council. Jo Chilton is Programme Director for Adult Social Care Transformation at Greater Manchester Health and Social Care Partnership. Email: **s.cowley@wigan.gov.uk** Email: **joanne.chilton2@nhs.net**

What can be learnt from Greater Manchester's progress? Should devolution be replicated in more areas? How can it assist with the integration agenda? Share your thoughts and ask questions on the CMM website, **www.caremanagementmatters.co.uk**

Weighing up the options for **managing insolvency**

Managing a business in the current climate of social care is challenging. Despite doing everything possible to protect an organisation and make ends meet, some find that they can no longer continue to operate in the same way. Here, Julian Pallett and Pippa Hill of Gowling WLG discuss the options for those organisations that are facing solvency issues.

With Four Seasons Health Care entering administration and Allied Healthcare proposing a company voluntary arrangement (CVA) towards the end of April, the spectre of insolvency is once again haunting the care sector.

And it is a spectre that is likely to be around for some time to come, as the Local Government Association estimates that, in the current financial year, there will be a funding gap in adult social care of around £1.5bn, increasing to £3.5bn by 2024/2025. Sector specific pressures include staffing costs which continue to rise, with the introduction of the National Living Wage for workers over 25 three years ago (and its rise in April of this year by almost 5%), the exodus of cheaper labour due to Brexit, the cost of pensions auto-enrolment, and the ongoing uncertainty regarding the status of sleep-in workers.

At the same time, funding for local authorities to pay for care is not increasing at anything like a high enough rate, and

demographic pressures mean that funding has to be split between more end users.

Combined, this has created a perfect storm in the care sector, causing financial difficulties for providers of homecare and residential care alike, and on all parts of the size spectrum.

WHY DO FINANCIAL PROBLEMS MATTER?

Company directors need to be aware of their duties, and in particular how these shift where the company is experiencing financial difficulties. The directors of a company are at risk of personal liability to the company's creditors if they allow the company to trade whilst insolvent and the company ends in formal insolvency. Once a company is insolvent, the directors owe a duty to the company to take care to protect the interests of its creditors.

The two main tests of insolvency are:

- The 'cash-flow test': The company cannot pay its debts as they fall due – ie. it has a liquidity shortfall.
- The 'balance sheet test': The liabilities of the company (including contingent and prospective liabilities) are in excess of its assets.

Failing either (not necessarily both) of these tests can mean a company is insolvent, and requires a shift in the way directors consider their duties.

In addition to the directors' general duty to creditors when a company is insolvent, there are three other main areas of concern for the directors of companies in financial difficulties. These are fraudulent trading, wrongful trading and disqualification from acting as a director.

All of this should focus the minds of directors where a company is facing financial difficulties to ensure that they take appropriate advice – either legal or from an insolvency practitioner.

The Care Quality Commission (CQC) has a duty to monitor the financial stability of providers in England that >

> local authorities would find difficult to replace in the event of a failure (typically those that are particularly large in size or specialism, either nationally or regionally). This is done via a scheme called Market Oversight. Providers in the scheme are subject to increased engagement and reporting requirements when suffering financial problems. Where a provider is assessed to be at the highest level of risk (Stage 6), CQC has the power to notify local authorities of the likelihood of business failure. For providers within the scheme, it is therefore essential to factor liaising with the Market Oversight team into contingency planning.

FINDING A SOLUTION

If a company is facing insolvency, there are various options available to them. The option or process that is most appropriate in the circumstances will depend on the issues facing the company and whether these are resolvable, as well as the support any restructuring or standstill is likely to receive from creditors. Below, we discuss three possible options to achieve a rescue either of the company or the underlying business. Of course, rescue will not be possible or appropriate in all circumstances, but in businesses providing vital services it must be a first port of consideration.

Administration

Administration is primarily designed as a rescue process, with a view either to rescuing the company or the underlying business. If a company goes into administration, a licensed insolvency practitioner (most of whom are accountants) will be appointed to manage the company, with the benefit of a statutory moratorium, or ban, on enforcement by creditors (including HMRC and landlords).

Administration can be instigated in three ways:

- Notice being filed at court by the company or directors.
- Notice being filed at court by a secured creditor (which contains a 'qualifying floating charge').
- Application to court by the company or by a creditor (secured or unsecured) – although this last method of appointing an administrator is the least common.

It's relatively rare for an administrator to manage to rescue the company (and for it to exit administration back to trading solvently), although this is sometimes possible when the administrator is able to elicit new equity investment. Selling the business and assets (or sometimes just part thereof) to new ownership is far more common.

This may take place as a 'pre-packaged' administration sale (or pre-pack). This occurs where the proposed administrator, prior to their appointment, works with the company to find a buyer for the business and assets, and sells them immediately on appointment. There has, perhaps understandably, been criticism and scrutinisation of this method of sale in recent years, against a backdrop of complaints that it is detrimental to the interests of unsecured creditors – particularly if the business is ultimately sold back to the incumbent management or owners via a new vehicle.

However, depending on the circumstances of the business in question, a pre-pack may represent the best chances of a continuation of the business. This can be of particular importance in a sector such as social care, where it is important for the service provided to end-users to transition with minimal disruption.

In addition, the regulatory bodies for insolvency practitioners have provided guidance (which has been in place for around ten years now, but has developed and expanded in that time) on the key compliance standards for pre-packs, and information that must be provided to creditors following a pre-pack sale – i.e. a Statement of Insolvency Practice 16 (SIP 16). This includes the standard of marketing (for the sale of the business) expected, known as the 'marketing essentials', and a requirement to explain how any strategy that deviates from these marketing essentials has delivered the best available outcome.

The Government has also put in place a body known as the Pre-Pack Pool, which a purchaser can voluntarily approach when that purchaser has previously been connected with the company in administration (eg. where it has the same management). The job of the Pre-Pack Pool is to assess and give an opinion on whether the new entity will be viable – the idea being that this provides some degree of comfort to the insolvency practitioner in concluding the sale and also the creditors that the business is not simply going to fail again.

Together, where an insolvency practitioner provides the information required of them by SIP 16 and also requires a purchaser (if connected) to seek an opinion from the Pre-Pack Pool, concerns around pre-pack sales are significantly mitigated.

Company voluntary arrangement

A CVA is a statutory contract to enable the company to adjust its debts so as to be able to keep trading during a short-term insolvency issue. It can be particularly appropriate where liquidity issues are created by one or more particular classes of debt (e.g. rent costs or pension liabilities).

CVAs have been used to varying long-term effect where the insolvent company has a portfolio of leases, with some establishments trading more successfully than others. An example would be a company owning multiple care homes, some of which are over-rented, and some of which are underperforming. A CVA might be proposed to temporarily vary the rent on the over-rented properties, and also close down underperforming locations.

To propose a CVA, a company would approach an insolvency practitioner to act as nominee (and ultimately, if the CVA is voted through by the requisite proportion of creditors, as supervisor). This means that the CVA is prepared with the assistance of an insolvency practitioner who is, by the time the CVA is proposed, satisfied that its purposes can be achieved if it is passed.

Standstill or restructuring of debt

Sometimes, it can be possible to agree a standstill (where a creditor agrees not to push for payment or take enforcement action) or restructuring of the debt (altering terms such as a payment schedule) outside of a formal insolvency process, which of course can impact on media focus and reputation, and also credit rating. Often, this will be done with advice from and support of a relevantly qualified accountant and/or lawyer, who will be able to assist with the approach to the creditor(s).

SEEKING ADVICE

As can be seen, there are a range of options available for directors of companies facing solvency difficulties which may preserve the underlying business – particularly important where end users would be severely impacted by a disruption, such as in the care sector.

The most important point for directors to remember is to seek suitable legal advice, or advice from an insolvency practitioner, as early as possible where solvency issues are anticipated. **CMM**

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Have you experienced insolvency? How have you handled it? Share your stories on the CMM website where you can also feed-back on this article, **www.caremanagementmatters.co.uk**

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SUPPORTING PEOPLE WITH DEMENTIA: EVIDENCING PERSON-CENTRED CARE

Person-centred care is generally accepted to be good practice for supporting people as individuals, particularly when caring for people with dementia, but evidencing this can be challenging.

Many people living with dementia have complex needs which are not always fully understood by staff or properly treated. Quality of care can be compromised by staff turnover, low ratio of staff to residents and poor training provision. For researchers, this raised the question of how staff can be better supported to deliver good care that improves the lives of people with dementia.

A person-centred care approach is widely recognised as the standard for dementia care, but practice varies and very few training programmes available are evidence-based or can demonstrate improving quality of life.

The Improving Wellbeing and Health for People Living with Dementia (WHELD) study sought to address this. It consisted of five-year programme, funded by National Institute for Health Research (NIHR), aiming to develop a standardised approach to delivering evidence-based, person-centred care. The WHELD study was led by University of Exeter Medical School, Oxford Health NHS Foundation Trust and King's College London.

CREATING A CHANGE

The WHELD study followed on from the work led by Professor Clive Ballard into reducing the use of anti-psychotic drugs in care homes. Specifically, the project aimed to:

- Improve mental health and quality of life.
- Improve the quality of prescription of antipsychotic drugs.
- Reduce agitation for people with dementia in care homes.

Three systematic reviews were carried out to:

- Identify the existing evidence for effective psychosocial treatments for people with dementia.
- Understand what factors influenced care home staff in using psychological and social interventions.
- Identify training materials which were evidence-based and effective in improving outcomes.

By adapting the most effective approaches at the time, the WHELD study developed a therapist-led training programme for care home staff, aimed at increasing social interaction for residents from two minutes a day to one hour of meaningful engagement per week, combined with a programme of personalised care. This involved simple measures such as talking to residents about their interests and involving them in decisions.

The large-scale randomised controlled trials provided conclusive evidence that care and quality of life improved, and agitation and the use of antipsychotic medication was reduced, with just one hour of social interaction per week. Other elements of the programme included training on recognising and addressing unmet needs, creating opportunities for meaningful engagement, activities, and monitoring and reviewing of medication. These all contributed to the outcomes achieved.

ACCESSIBILITY

Although WHELD proved successful, the research team wanted to find a more affordable programme with a wider reach. A follow-up study explored how the training could be delivered online with therapist support provided via phone, skype and email.

The Improving Staff Attitudes and Care for People with Dementia e-Learning (tEACH) study, was conducted by the University of Exeter Medical School and King's College London in partnership with the Social Care Institute for Excellence (SCIE). It involved 280 residents and care staff in 24 care homes over nine months.

Care workers took part in an e-learning programme with key modules based on the WHELD training, with or without Skype supervision. They compared outcomes they began to see with those they experienced from usual care before the training began.

Both e-learning training with and without Skype supervision improved resident wellbeing and staff attitudes to person-centred care. The Skype-supported arm continued to deliver improved resident wellbeing four months after the trial was completed.

Although the study found successful outcomes, some clear challenges emerged, including:

- Managers agreed to provide support and time to allow staff to study, but in practice found this challenging.
- Some homes had technology difficulties (for example, restricted WiFi) to enable staff to study on the premises.
- Universally, staff responded positively to the video content and other scenario-based learning, but some found the written learning more challenging.

LOOKING FORWARD

The next step for the eWHELD project is to create an optimised, cost-effective, national training offer, which can be rapidly rolled out and meet the needs of the residential care workforce. This will be a 'blended' learning offer and is likely to comprise of the following:

- A CPD-accredited 12-module online course, mapped to the relevant topics of the Dementia Care Framework, which can be accessed any time in or away from work.
- A managers' handbook, together with a collection of resources including films, training materials and other third-party content.

The researchers are suggesting the delivery of eWHELD will involve the care home's manager attending a local half-day briefing and introduction to the programme. They will be provided with a resource pack which will help them implement the programme, and additional material that can be used to supplement individual study in group sessions.

Each staff member will also be given access to the eLearning course, which will record individual progress. Certificates will be awarded to those who complete the programme. Managers will be supported via Skype and email and regular regional events where they can share experiences and learn from each other.

Subject to funding, design and development, work is expected to start later this year, with first phase roll out in 2020. At the same time, the University of Exeter hopes to implement a large-scale evaluation of the course, as part of funded research it is carrying out with other funding partners. **CMM**

OVER TO THE EXPERTS...

Does this offer a solution to standardised training in dementia care? What might prevent care homes from using this learning method?

IT'S A GOOD START

Would any of us disagree with the objective for well-trained care workers to offer person-centred care? I think not. The organisation I chair – Think Local Act Personal – has produced statements of what good care looks like, and the one that comes to mind is the statement, 'I have considerate support delivered by competent people'.

The WHELD study has helped to reveal the stark gap between the rhetoric and reality of personalisation. Its finding that people with dementia living in a care home can expect only two minutes a day of social interaction is a reminder of the distance we still need to travel to close the gap.

I am encouraged that the evidence-backed training led to some improvements, but the barriers identified by the study must be addressed. I'm not convinced that the shift to a 'manager led' approach will be enough to overcome the problems care workers experience such as struggling with written learning or the lack of technology for online learning.

The Secretary of State, Matt Hancock has made technology his second priority, so what slice of this can be directed to small care homes? Similarly, Skills for Care produce resources that may assist and then there is support from the various trade associations.

I'm not convinced that a national training programme will fulfil the potential to spread person-centred care or create a more professionalised care workforce, but it's a good start. Ultimately, what will make the most positive difference to people's lives is the attitude and approach of the care home owners and the staff who work in them.

Clenton Farquharson MBE Chair, Think Local Act Personal

TRAINED WORKFORCE IS AN INVESTMENT

As I read this, I remain hopeful that the world has moved on since the research began. Much of the care I witness when visiting NCF members is focused on supporting people living with dementia, and the notion of two minutes' interaction a day as standard practice feels out of touch – and the target of one hour of social interaction a week seems unambitious.

However, this does not take away from the importance of creating learning and development solutions that will reinforce and strengthen the centrality of person-centred ways of working.

I recognise the challenges that the e-learning programme experienced, and again, hope that some of those core barriers relating to technology are reducing, whilst not disappearing completely.

The model suggested around train-the-trainer will appeal to some homes, but as with all training, the final version of the programme must consider and recognise the cost to homes of staff time, both to deliver and attend the session.

I am slightly concerned that the refreshed programme might be focusing on a 'workaround' to the barriers identified, rather than seeking to challenge them. We do both our workforce and those we support a disservice if we aren't clear that quality training and a quality, trained workforce is an investment that society must make. It's only through prioritising and centrally funding workforce development, based on programmes like this, that we can ensure staff can deliver the care everyone living with dementia should receive – and, importantly, where, as with WHELD, there is an evidence base to demonstrate that staff trained in this way can fundamentally improve outcomes.

Vic Rayner Executive Director, National Care Forum

ALREADY SHOWN REAL PROMISE

Dementia affects 70% of people living in care homes, so it is vital staff have the right training to provide good quality dementia care. We know that care home staff want the opportunity for dementia training and that training is crucial in order to provide the individualised care which can have a significant impact on the wellbeing of people living with dementia.

We need a sustainable and well-funded approach to providing training for our workforce. Alzheimer's Society supported the early stages of the world-leading WHELD programme, which includes an online training programme for care home staff based on person-centred care, and a range of non-drug approaches. This programme has already shown real promise in supporting staff to improve the wellbeing of residents. We need training like WHELD to help staff develop the specialist skills and roles required for delivering high-quality dementia care. This would ensure that staff feel more capable and confident in delivering complex care for people with dementia, as well as delivering other benefits such as reducing staff turnover.

Alzheimer's Society is committed to improving dementia care through research, and campaigning for evidence-based dementia training to be made more accessible. But without sufficient and sustainable Government investment in social care, to cover the costs of training and to allow protected learning time for staff, there won't be enough money to deliver the specialist care people with dementia need. We look forward to seeing further research to understand the true benefits of online training that the WHELD team have now developed, both for people living with dementia and for care home staff.

Fiona Carragher Chief Policy and Research Officer, Alzheimer's Society

NCF **RISING STARS** 2019

Charlotte Sehmi is Registered Manager for two care homes at Optalis.

CAREER HISTORY

My career didn't start off in care – I wasn't the best in school and when I left I did a lot of temping jobs.

I came into the care sector eight years ago working for a domiciliary service for elderly people. I fell in love with the job and the feeling that you can make a positive difference to people's lives.

I moved to Optalis and joined their team for domiciliary dementia support. I'm a huge people person and I'm ambitious and I felt that the higher you climb in an organisation, the more change you can make.

I spent two years in that role before becoming a senior support worker, then operational lead.

A year after that, I decided I wanted something different, and I saw an opportunity come up at Suffolk Lodge as deputy manager.

This was my first experience of working in residential care – I learnt so much there from the manager and the people I worked with and supported. I really loved it.

A year into my role at Suffolk Lodge, I became Registered Manager for two care homes Optalis runs, Homeside Close and Winston Court.

ORGANISATION

I manage two residential care homes for people with learning disabilities. They're small homes with eight people in each.

They're quite close to each other so I'm often going from one to the other, splitting my time between the two. I have a deputy manager in each home and two teams of brilliant staff.

The people we look after have varying levels of needs. Some are mobile while others need hoisting, some communicate verbally, some through Makaton (which I'm learning and think is great) and some can't communicate at all.

One of our homes is rated Good by the Care Quality Commission but the other doesn't have a Good rating and that's something we need to work on. I knew when I took the role that I would need to make changes, but I find this really motivating.

We have our next inspection in October and I'm looking forward to making sure we've got everything in place ready for it.

I know the team is amazing – they've built great relationships with the residents and the quality of care leaves nothing wanting, but we need to firm up processes and procedures so I'm working on getting that side of things done.

>

> CURRENT ROLE

I've been in my role a month, so it's not been very long! I knew to expect the challenges of being a registered manager, especially taking on a lower-rated service. But I would hate to be bored so am glad that there are challenges for me to tackle.

In my previous roles I had responsibility for paperwork so I knew that was an important part of the job, but knowing that if something goes wrong you're held responsible is a little scary.

I'm confident that we have fantastic staff who go out of their way to care for the residents – they see them more than they see their families and are so committed to them.

So far, the best part of my role is the residents. They have such big characters and it's lovely to be around them and spend time with them. The previous registered manager had been in post for a long time and was very much loved, so I did have big shoes to fill, but the residents and staff have all welcomed me and I'm starting to build those relationships. I will always see it first and foremost as the residents' home and make sure I ask for their opinions on any changes we are thinking of making.

The most difficult part at the moment is looking at how much needs to be done before our next CQC inspection, compared to how little time we have. I find that looking at it in bitesize chunks makes this easier and it feels like a more manageable task that way.

NCF RISING STARS

I didn't know what the NCF Rising Stars programme was before Jeanette Crisp, our Director of HR and Corporate Services, said they wanted to nominate me. I went away and did some research to find out more about it and it looked amazing.

I didn't comprehend how big it was until we were at the NCF annual conference and saw the quality of the speakers and the vastness of it and the fact they mentioned the programme there. We had a special lunch to meet our mentors and hear from experts in the sector about their journeys and how important the Rising Stars programme would be in helping us to develop.

I feel really honoured to be nominated and recognised in this way. Sometimes when you work in a management role you can feel a bit unnoticed and unappreciated, but things like this give you that confidence boost and show you that your work is being seen.

I'd like to get as much as I can out of the programme. I am excited about the networking opportunities and hearing about innovations – being able to bring that back to my service to make a difference. It's great to have that peer support, too; the Rising Stars have a What'sApp group which we use to check in with each other if we want advice or support.

I also think that having a mentor will be good for me. I am ambitious and I want to make sure I get the most out of my career. I'm just intending to soak up as much as I can and bring it all back to my services.

So far, meeting Caroline Dinenage and discussing social care with her has been a highlight. We were given a special tour of the Houses of Parliament and told the history behind it, which was very interesting. After the tour, we were taken to meet Caroline. She was so easy to talk to and it was clear she was passionate about what she did. We all had a chance to talk about our services, what we do and ask any questions.

After that, some of us continued to explore and went into the House of Commons and the House of Lords which I have never done before. It was an amazing day from start to finish; I did get home with rather large blisters on my feet, but it was worth it! I can't thank NCF and Caroline enough for arranging the day.

FUTURE CAREER

In terms of my career goals, I am really passionate about end of life care. It's such an important part of care to get right, but it just doesn't always go as planned.

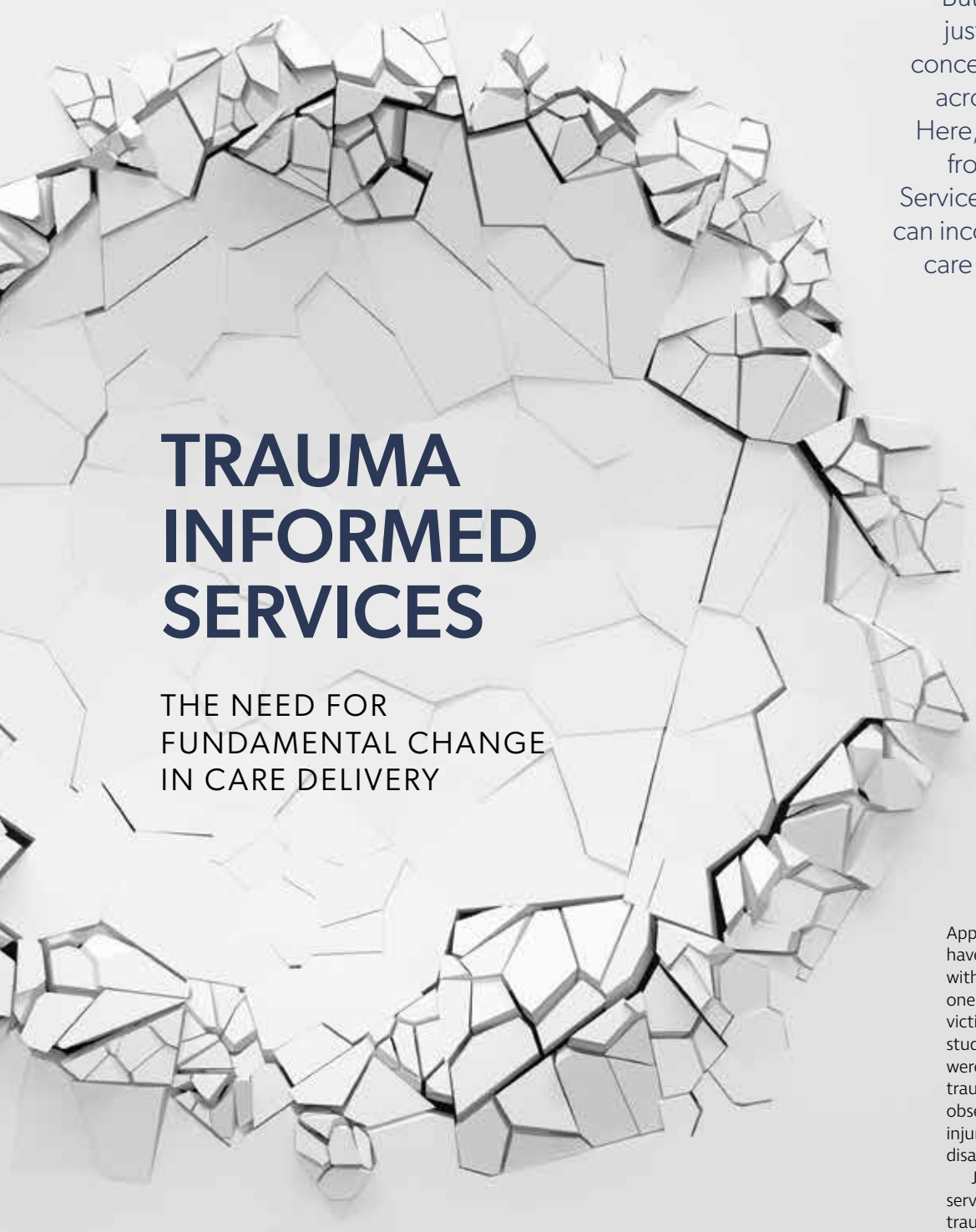
People who want to die at home end up doing so in hospices or hospitals and I want to fix this. It's also about supporting families so that they know their loved one has had the death they wanted. I'd love one day to help shape how end of life care is delivered nationally.

ADVICE

My advice to aspiring registered managers is that it can be lonely at times. Remember to reach out to other people – including peers outside of the service. There are always people who will talk to you. Also don't be afraid to change things up. I hate when people say 'this is how we've always done it' – just because it's always been a certain way, doesn't mean you can't try something new.

For senior management, I would say it's important to share your knowledge and experiences. Let registered managers know you've been there. We will make our own mistakes but allow us learn from yours too. **CMM**

Now in its third year, the NCF Rising Stars Programme addresses the need to invest in and develop the skills of the next generation of leaders in social care, with registered managers from the NCF membership selected to take part each year. For more information, contact Helen Glasspool at National Care Forum. Email: **helen.glasspool@nationalcareforum.org.uk** Twitter: **@NCFCareForum**



TRAUMA INFORMED SERVICES

THE NEED FOR FUNDAMENTAL CHANGE IN CARE DELIVERY

The emergence of trauma-informed care is widespread. But despite recent, and well-justified, popularity it is not a concept that is well-embedded across health and social care. Here, Kate Portman-Thompson from New Horizons Therapy Services explores how providers can incorporate trauma-informed care principles in their service.

Approximately one third of children have experienced some form of abuse, with around one in five boys and one in four girls experiencing sexual victimisation of some form. In a US study, 60% of men and 51% of women were found to have experienced traumatic events in the forms of observing someone being seriously injured or killed or being involved in a disaster or life-threatening incident.

Just about anyone using a care service may have been a victim of trauma – and could be suffering trauma-related difficulties. >

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> The impact of trauma on health and social care services is far-reaching and it is imperative that trauma-informed care is adopted to improve outcomes and staff wellbeing and reduce the social and economic burden associated with trauma-related difficulties.

Trauma-informed principles of care can be adopted into existing services, embedded in continuous service development or ingrained in service delivery from conception. The emphasis should be on trauma-informed ways of working becoming a part of care, not for principles to be seen as an additional task or intervention. Staff are already stretched and services are working at capacity; keeping trauma-informed principles of care simple is key to them being genuinely and routinely embedded.

IDENTIFYING TRAUMA

Delivery of trauma-informed care does not rely upon an individual holding a formal diagnosis of post-traumatic stress disorder (PTSD) or similar syndrome, it simply means considering a person's experiences when delivering services.

Individuals across the health and social care systems might be exhibiting a range of symptoms and associated coping mechanisms and we need to be able to identify these. Common symptoms of trauma include:

- Physical and/or emotional distress or hyperarousal.
- Poor sleep.
- Intrusive memories, dreams or nightmares.
- Acting or feeling as though the event were happening again.
- Feeling disconnected, numb or experiencing poverty of thought, speech or emotion.
- Loss of interest in relationships or activities.
- Reduction in positive emotions.
- Feeling constantly on edge, irritable or aggressive.
- Being easily startled or overly alert for danger.
- Problems concentrating.

Common coping mechanisms professionals might see are:

- Drug or alcohol use.
- Over reliance on medication such as pain killers or sleep medication.
- Social isolation.

- Avoidance of people, places or triggers.
- Keeping busy, exercising, being overly active.
- Self-harm.
- Trying to get away from situations experienced as upsetting.

Whilst these difficulties can be characteristic of a range of emotional and mental health difficulties, the most important issue to note is that they will be occurring in the context of a traumatic experience. Most often, this is the experiencing or witnessing of an event, or series of events, that involved a serious threat to personal safety, wellbeing or personal integrity and that has left the person involved feeling hopeless, helpless, shocked or injured.

It is also important to note that the severity of trauma response does not always match the severity of the incident, nor does the passage of time. There are many factors that affect the impact of an event on an individual. The prevailing principle of trauma-informed care is that if a person reports distress associated with an event, or series of events, then health and social care professionals should accept that as a lived experience and offer care that is appropriate to that experience.

THE IMPACT OF TRAUMA

We know that trauma underpins many common mental health issues, and there is a significant link between childhood adversity and incidences of mental health issues in adulthood.

We also know that trauma perpetuates trauma; those who have encountered traumatic experiences are more likely to encounter adversity and further trauma. They are also more likely to tolerate poorer care, opening the door for further vulnerability and poor health outcomes – this is especially true for older adults who have encountered childhood adversity.

As well as this, there is a growing body of evidence that trauma affects neurobiology, resulting in emotional and psychological difficulties, and those who have experienced traumatic events often experience generally poorer health outcomes; including higher need for medication and longer and more frequent hospital admissions.

Common physical disorders and symptoms associated with people who have encountered traumatic events include somatic complaints; sleep disturbances; gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, and dermatological disorders; urological problems; and substance use disorders.

CHANGING THE WAY WE CARE

Trauma-informed care is a shift away from 'What is wrong with you?' towards 'What has happened to you?'. It is a rapidly emerging area that, until relatively recently, has been limited to psychological therapies. It is widening across health and social care settings and is demonstrating improved experiences for people using >

> services, as well as improved working environments and increased levels of satisfaction for staff. Simply, it is holistic care, bearing witness to a person's past experiences and remaining mindful and exercising understanding of the coping mechanisms for managing distress.

It is a care delivery concept that seeks to avoid re-traumatisation. Re-traumatisation occurs when a current experience is reminiscent of past trauma, such as the inability to stop or escape a perceived or actual personal threat, or a 'matching trigger', such as a colour, taste or smell. The consequences could involve an individual remembering the event and associated emotional distress; vivid pictures in the mind or flashbacks that trigger an individual to act as if the event is happening again; to fight, try to escape, hide, defend oneself, help others; or even partial or full dissociation, where an individual appears not to be present in the current time as the brain enters a psychological shut-down to protect the individual from extreme distress.

"Person-centred care goes a long way towards mediating some of the issues but more is required from care delivery and development initiatives to make trauma-informed care part of a standard approach."

Any kind of sensory, interpersonal or practical experience can activate re-traumatisation. This might include intrusive experiences, such as seclusion, restraint, personal care, forced medication, body searches and intense observation, but might also include physical examinations, being closed in a room, wound dressings being changed, tone of voice, words that might have been spoken at the time of the trauma, physical proximity or even being fed.

Re-traumatisation is common in health and social care and can affect how people engage with services and professionals. Triggers are often not recognised by those delivering care or those designing services, resulting in the potential for unnecessary distress for people receiving support, and additional demand on services. Person-centred care goes a long way towards mediating some of the issues but more is required from care delivery and development initiatives to make trauma-informed care part of a standard approach.

ADAPTING SERVICE DELIVERY

The Institute for Health and Recovery, which has worked with a range of agencies in the US to develop women's services, believes that the ideal system for developing trauma-informed care is:

- Comprehensive, accounting for a holistic range of needs akin to Maslow's hierarchy of needs.
- Continuously caring, enabling the individual receiving care to develop relationships and access those relationships for as long as is required.
- Integrated, acknowledging interaction between mental health, trauma histories, medical conditions, substance use, disability and safety.

To achieve such a system of care delivery, liaison between agencies and involvement and collaboration of people using services is paramount. Routine screening for experiences of trauma and the impact of those experiences is helpful in developing a narrative that can inform care delivery and multi-agency working. This can be undertaken formally, using a recognised measure, or informally though conversation or activities. This narrative scaffolds the care and support that person receives, so providers can deliver flexible and responsive care that fosters people's strengths and empowers them to live in the best way possible.

Developing an informed and compassionate workforce is key. Training, reflection and supervision underpin a healthy workforce that can understand and actively support people who may be experiencing the myriad difficulties associated with traumatic events.

Creating a physically and emotionally safe environment is also essential. Policies that encourage holistic, collaborative, respectful and person-centred care and support choice, empowerment and self-care can help to create these safe environments, as the focus is on involvement and collaboration rather than more traditional professional-led care and support. Care plans that include wellness recovery action plans, statements of advance wishes, positive behaviour support and crisis and safety planning can provide frameworks for the involvement needed for trauma-informed care to become routine practice.

In addition, small changes to the physical environment can create a calm and predictable space for people to receive care; whether in outpatient settings or inpatient or residential services. For example, improving lighting, clearly signposting exits, creating designated de-stimulation areas, thinking about the impact of noise from TVs, radios or staff duties, giving consideration to colours, décor and layout, and having individualised spaces can reduce re-traumatisation and re-activation of trauma triggers.

FINDING SUPPORT

Support for providers to implement trauma-informed care principles is available from a range of agencies; for example, screening tools and trauma toolkits can be accessed on the Institute of Health and Recovery website (www.healthrecovery.org) and The Trauma Informed Care Project (www.traumainformedcareproject.org).

Individuals experiencing trauma-related difficulties are increasingly accessing health and social care systems and we must acknowledge their specific needs so that services can meet them in a co-ordinated way. **CMM**

Kate Portman-Thompson is Founder of New Horizons Therapy Services. RMN, Accredited CBT Therapist (BABCP), EMDR Practitioner, Accredited CAT Practitioner (ACAT). Email: **newhorizonstherapyservices@outlook.com**
Twitter: **@HorizonsTherapy**

What impact do you think trauma-informed care could have on the people your service supports? How can it be implemented successfully? Share your views and any questions about this article on the CMM website, **www.caremanagementmatters.co.uk**

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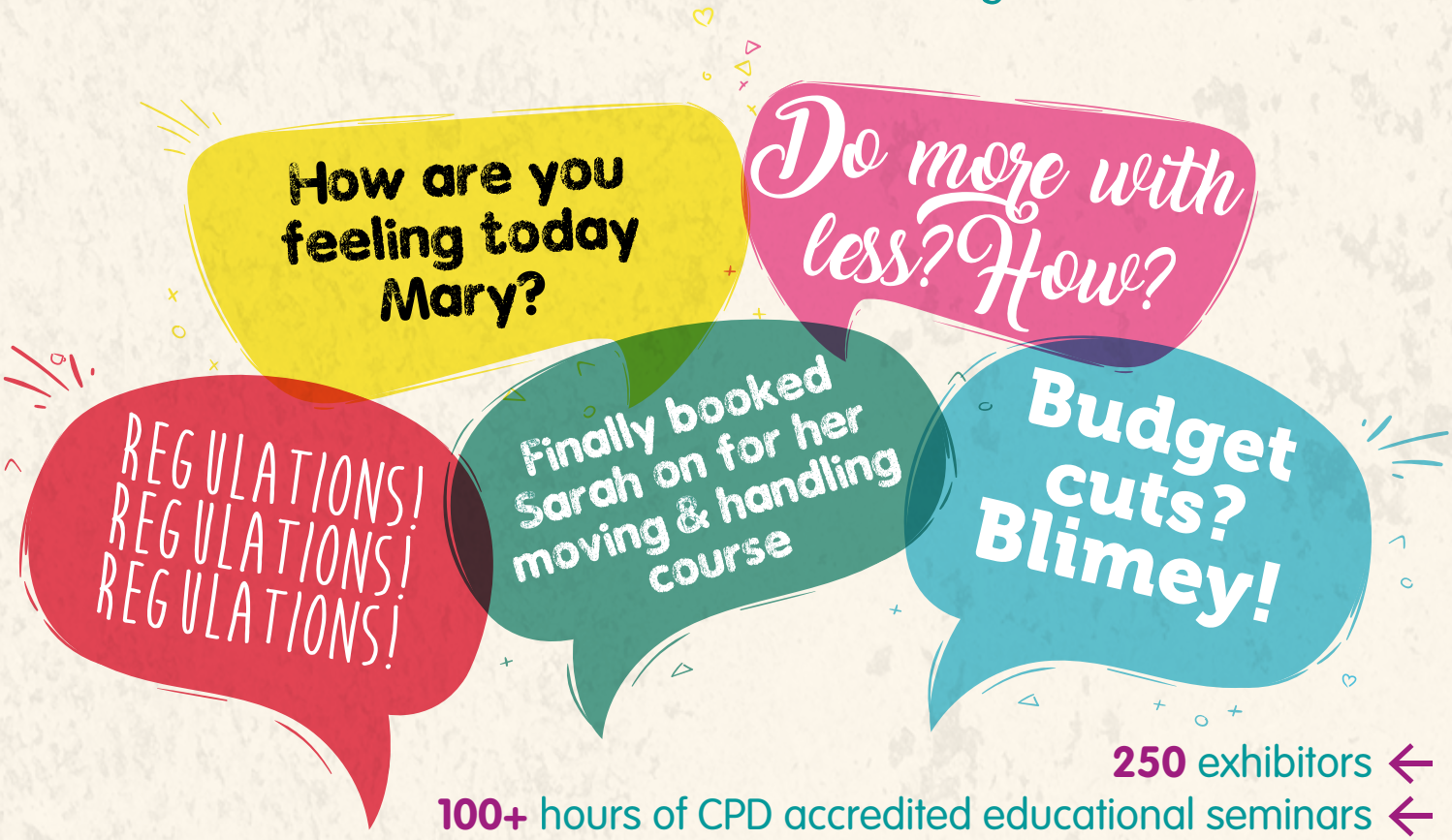

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Having run a registered homecare service for 15 years, Jo absolutely understands the compliance, inspection pressures and recruitment challenges faced by managers in social care. She frequently welcomes customers to audit AJ support worker HR files to ensure they always feel confident and trust that AJ are providing high-quality staff.

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EAST POINT CARE NURSING AGENCY

Tel: **0330 123 5399**
Email: **info@eastpointcare.com**
Website: **www.eastpointcare.com**

SECTORS

- Nursing homes.
- Residential care homes.
- Mental health hospitals.
- Learning disability hospitals/ care homes.
- General hospitals.
- Supported living.

SERVICES

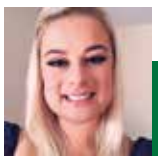
- Qualified nurses.
- Learning disability staff.
- Mental health staff.
- Health care assistants.
- Healthcare support workers.

LEAD INDIVIDUALS

Our recruitment consultants have a nursing background experience. They have enough insight to understand what happens on the floor in care settings, and this gives them an advantage to choose the right candidate for your service.

COMPANY INFORMATION

We specialise in providing staff (adults, learning disability, mental health, healthcare assistants, healthcare support workers) to established care providers. This service was established in September 2013. We're accessible 24-hours a day for you – there is always someone to talk to you. We have a 90% success rate in covering shifts last minute, and our team is dedicated and industry qualified.



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FLORENCE

Tel: **0203 911 2555**
Email: **hello@florence.co.uk**
Website: **www.florence.co.uk**

SECTORS

- Nursing homes.
- Residential homes.

SERVICES

- Temporary recruitment.

LEAD INDIVIDUAL

Bunie is Chief Marketing Officer at Florence. He joined Florence in December 2016 after spending much of his career in pharmaceutical sales and marketing. Bunie leads nurse and carer acquisition at Florence.

A passionate advocate of new technology, Bunie sees social media as the future of candidate acquisition across all industries. He enjoys the challenge of finding nurses in traditionally hard-to-find areas and welcomes the opportunity to find workers to fill your shifts.

If you would like to discuss nurse acquisition or marketing in general, feel free to reach out. He's always happy to have a chat over coffee and a biscuit.

COMPANY INFORMATION

Florence is the online marketplace for care homes to find fully-qualified registered general nurses, registered mental health nurses and health care assistants to fill temporary shifts. We offer transparency, accountability and simplicity for care home managers looking to ease the pressure of filling staffing gaps.

Since 2017, Florence has had over 20,000 nurses and 600 care homes sign up to find and post temporary shifts through Florence.

Operating across England and Wales, we match you to the most relevant nurses based on location, required skills and reliability for you to choose from.

As Florence is entirely online, you can access the platform remotely – accept nurses for shifts, sign off timesheets and post new shifts from your desk or on the go.

Concerned about continuity? You can quickly grow a bank of your favourite workers based on your home's needs using our 'favourites' feature – and directly invite them to fill your shifts.

Take the pressure off and plan your staffing in advance. In half a million shifts worked between April 2017 and March 2019, shifts posted at least a week in advance had a 94% fill rate.

Care homes rate all Florence nurses and carers after every shift. This means you can compare them based on their effectiveness and make an informed decision on who to bring into your team.

Fill your staffing gaps without compromising quality by using Florence.

Bunie Anyaegbuna *Chief Marketing Officer*
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ROOSTR TECHNOLOGIES

Tel: **01202 798745**
Email: **hello@roostr.app**
Website: **www.roostr.app**

SECTORS

- Care homes.
- Homecare.

SERVICES

- Connecting self-employed nurses and care workers with shifts.

LEAD INDIVIDUAL

Rebecca Hannam has worked in care homes for 20+ years, most recently as registered manager of a 60-bed nursing and dementia care home. Rebecca founded Roostr in 2018 with the belief that there is a more efficient way to fill the care sector staffing shortfalls. Always trying to encourage staff to reach their maximum potential, she felt that it was time to empower nurses and care workers to embrace self-employment and the worldwide trend toward the 'gig economy' – quite a scary concept for some people in the highly-regulated world of healthcare.

Rebecca is passionate about the quality of care delivered within the health and social care and, to this end, has come up with a rating system to monitor quality amongst Roostr registered professionals. Coming from a 'hands on' background in care home management and first-line care delivery, and with an excellent understanding of the overall industry structure, she is able to ensure that Roostr really delivers a service that both employers and the nurses and care workers actually want and need.

COMPANY INFORMATION

Roostr is an online platform connecting independent and experienced nurses and carers with jobs in the social care sector on a self-employed basis.

The professionals registered with Roostr are self-employed enabling the savings employers make on agency commission to be partly redistributed to the hard-working professionals. Nurses and care workers earn more and employers pay less.

When registering, care homes set the hourly rates they are prepared to pay for shift cover. Roostr's flat rate fees of £2/hr for health care assistants and £3/hr for registered nurses are welcomed by both employers and professionals for their transparency.

Roostr Care at Home connects individuals preferring to stay in their own homes with private nurses and care workers who they can call their own. This means an end to rushed visits and pressured care workers, and for less than they would often pay a homecare agency, by engaging direct.

If embracing the gig economy in the healthcare sector sounds a bit risky, be reassured that the registration, verification and vetting process exceeds industry standards and is the future of efficient staffing cover in an industry in crisis.

Rebecca Hannam *Managing Director*
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Email: rebecca@roostr.app

CELEBRATING EXCELLENCE IN **END OF LIFE CARE**

Hospiscare@Home won the End of Life Care Award in the Markel 3rd Sector Care Awards 2018.

Hospiscare is a charity that provides end of life care in Exeter, Mid and East Devon. We care for patients with any type of life-limiting illness – whether on our inpatient ward, in our three day hospices or through our community nursing teams.

We believe that dying is an important part of living, so, for us, the needs and wishes of patients and those close to them are incredibly important. We know that the majority of people, given the choice, would like to die at home. But sadly this isn't a reality for most people – whilst 81% of people in Devon say they'd like to die at home, only 24% actually do. At present, our community services enable 42% of our patients to die at home; we're proud of what we do, but we knew we could do more to help people have that all-important individual choice over the end of their lives.

That's why we launched the Hospiscare@Home service in 2015. In the last year, through the support of Hospiscare@Home, we were able to support 96% of patients to die at home. It's an achievement that we're absolutely thrilled with, made all the more meaningful by being recognised by the Markel 3rd Sector Care Awards for outstanding end of life care. The judges were particularly impressed with how we provide true individualised care for patients and their families at the end of their lives.

HOW WE DO IT

The idea behind Hospiscare@Home is to provide a complete package of end-of-life nursing expertise, advice and support 24-hours a day, 365 days a year – all in the patient's home. Our work is all the more vital because we are the only provider of 24-hour end of life care in people's homes in these areas.

The service is provided by registered nurses and healthcare assistants, with support from our clinical nurse specialists and specialist medical consultants.

Our clinical staff work closely with each patient's GP to meet medical and pain management requirements; they also consider the social, psychological and spiritual needs of each patient and that of family members. Our staff can also help with general care, including washing and dressing, plus remedial massage and other support.

We were also commended by the Markel 3rd Sector Care Awards judges for the kind manner in which we work alongside our communities, and the support we receive from them in return is brilliant. Our amazing supporters and charity partners – Seaton & District Hospital League of Friends, The League of Friends of Axminster Hospital, Exmouth & Lympstone Hospiscare, and Budleigh Salterton & District Hospiscare – raise money to fund the service in their respective areas.

MARKEL
3RD SECTOR
CARE AWARDS 3

'IT'S SO IMPORTANT TO HAVE THE CHOICE'

The founder of the hospice movement, Dame Cicely Saunders, said, 'You matter because you are you, and you matter to the last moment of your life.' It's a quote we wholeheartedly embrace. For us, Hospiscare@Home is an important way to allow people to be themselves, away from a clinical environment. In the home setting, you really get to know people. Hospiscare@Home nurse, Liz says, 'It gives you a deeper understanding of the real person, and that allows you to give complete, holistic, focused care. Wanting to give all-encompassing support is the reason many of us become nurses in the first place and I wouldn't want to do anything else.'

Gwennie's husband Keith was supported by the Hospiscare@Home service in 2017. Keith spent time on our inpatient ward in Exeter, but was keen to return home to his family as soon as possible. As Gwennie put it, 'Being home seemed to revitalise him. The Hospiscare@Home team would come in and do all the treatments. It all came to us.'

At the heart of Hospiscare@Home are the connections we make with patients and their families. Gwennie told us, 'Keith got on so well with the team. He really looked forward to the girls coming over. We had such good banter with them, we were always laughing and one of the nurses was always singing.

'When he died, I called the Hospiscare@Home team. Keith wanted to be buried in his motorbike gear, full leathers, gloves, boots and with his helmet by his feet, and the nurses helped me do this. I don't suppose I should say it, but there were comical moments. We couldn't get one of his gloves on properly, but together we did it, just as he wished.'

We do everything we can to help someone have a good death – and being part of that is always a huge privilege. In Gwennie's words, 'Enabling people to die at home, to give people that choice, is invaluable. The nurses are experts; their help and advice is second to none. Anytime I needed them 24/7 they were there, like part of the family. It's so important to have the choice to stay at home – no-one wants to be away from home.'

Nominations close 6th September. **Don't miss out.**

WHAT'S NEXT

It means a lot to us to have all the hard work, commitment and compassion that's gone into Hospiscare@Home recognised by the Markel 3rd Sector Care Awards – but we're not stopping here. We are all living longer on average, and Devon in particular has a large older, rural population and many single-person pensioner households. Combine that with the recent halving of community hospital beds throughout our focus area, and it's clear that demand for in-home end-of-life care will only continue to grow.

We know our model works, so we're hoping to roll out Hospiscare@Home throughout our focus area in coming years so we can enable everyone to have the choice to spend the end of their life as they choose. **CMM**

Ann Rhys is Assistant Director of Care (Community) at Hospiscare. Email: **info@hospiscare.co.uk** Twitter: **@hospiscare**

The Markel 3rd Sector Care Awards is run specifically for the voluntary care and support sector. Nominate today to be in with a chance of your project featuring in an issue of CMM. Visit **www.3rdsectorcareawards.co.uk** to enter for free. Sponsorship opportunities are also available.

With thanks to our supporters: National Care Forum, Learning Disability England, The Care Provider Alliance, Association of Mental Health Providers and VODG.

The End of Life Care Award was sponsored by

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CMM INSIGHT LEEDS CARE CONFERENCE 2019

CMM INSIGHT CONFERENCES · EXHIBITIONS
Leeds Care Conference • 20 June 2019

20th June 2019, Oulton Hall, Leeds

The CMM Insight conferences ventured to Leeds in June to host a day of knowledge-sharing and inspiration for local providers.

Developed and hosted alongside Leeds Care Association, the Leeds Care Conference intended to offer practical solutions to common issues faced by providers, while imparting ideas that attendees could take back to their services with them to improve their offering.

A FOCUS ON COLLABORATION

Chaired by Peter Hodkinson, Chair of Leeds Care Association, delegates heard from experts in their field, in tailored workshops on overcoming and avoiding legal issues, and how to handle inquests and inspections from the Care Quality Commission (CQC).

These interactive sessions were combined with a focus on collaboration from the main stage.

Cath Roff, Director of Adults and Health at Leeds City Council, spoke on ways the local authority and care providers can work together, suggesting that only 'relentless improvement' can ensure quality outcomes.

Deanna Westwood from CQC also made this an area of focus, discussing the importance of providers working with inspectors, to make sure they are being supported by CQC in the right ways, and on the necessity of keeping an open dialogue throughout the year, not just around inspection time.

TALKING ABOUT TECHNOLOGY

Collaboration and integration go hand-in-hand, and Professor Martin Green of Care England explored the problems the sector has in trying to become more integrated with other services, while Professor Karen Spilsbury from University of Leeds focused on NICHE Leeds, a project that is integrating the social care and academic spheres seamlessly.

We all know technology is an important part of this integration agenda, and delegates were supported with this too, with an engaging workshop on how to implement digital solutions, even when there's resistance from staff teams.

Neil Eastwood also put emphasis on the use of technology in recruiting staff, and how it can be beneficial to use digital systems. He shared details of his latest venture into employee referral schemes and encouraged the audience to apply certain techniques and standards when recruiting to ensure they retain as many staff as possible.

IMPARTING KNOWLEDGE

An inviting and popular exhibition saw delegates engaging in new conversations with local and national services, from solicitors to assist with enquiries, to entertainment ideas for care home residents. Breaks also provided opportunities to engage with other local providers, to share experiences and offer guidance to colleagues.

The packed day surpassed its aims of imparting all the latest insights to delegates, who left the venue with all they needed to continue to provide the best care possible for the people using their services. Attendees said the day was 'informative and useful', that they would return to next year's event and that the presentations were 'excellent'.

The next CMM Insight event will be held in Lancashire on 19th September. Book your place now to make sure you don't miss out. **CMM**

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WHAT'S ON?

Event: Professional Care Workers' Day
Date/Location: 4th September, London
Contact: National Association of Care & Support Workers, Web: www.nacas.org.uk/pcwd

Event: VODG Annual conference 2019
Date/Location: 9th September, London
Contact: VODG, Web: www.vodg.org.uk

Event: Care Show
Date/Location: 9th-10th October, Birmingham
Contact: Care Show, Web: www.careshow.co.uk

CMM Media Partner

Event: Future of Care
Date/Location: 15th October, Leeds
Contact: Broadway Events, Web: www.futureofcare.co.uk

Event: Change Makers: NCF Managers' Conference
Date/Location: 4th-5th November, Kenilworth
Contact: National Care Forum, Web: www.nationalcareforum.org.

Event: Care England Conference 2019
Date/Location: 13th November, London
Contact: Care England, Tel: 0207 492 4840

Event: National Children and Adult Services Conference
Date/Location: 20th-22nd November, Bournemouth
Contact: Local Government Association, Email: events@local.gov.uk

CMM EVENTS

Event: CMM Insight Lancashire Care Conference
Date/Location: 19th September, Blackburn
Contact: Care Choices, Tel: 01223 207770

Event: CMM Insight Berkshire, Buckinghamshire and Oxfordshire Care Association Conference
Date/Location: 17th October, Maidenhead
Contact: Care Choices, Tel: 01223 207770

Event: Markel 3rd Sector Care Awards
Date/Location: 6th December, London
Contact: Care Choices, Tel: 01223 207770

Event: CMM Insight Dorset Care Conference
Date/Location: 6th February, Poole
Contact: Care Choices, Tel: 01223 207770

Please mention CMM when booking your place.
Sign up online to receive discounts to CMM events.

SIR ROBERT FRANCIS QC · CHAIR · **HEALTHWATCH ENGLAND**

STRAIGHT TALK

Following the Care Quality Commission's recent report into oral health in care homes, Sir Robert Francis QC shares his views about the importance of this topic and the work Healthwatch England are doing to help put things right.

Access to good dental care is a fundamental need for everyone. However, feedback gathered by Healthwatch England has shown that access to an NHS dentist can be a real struggle for some people living in care homes. This is a cause for concern, as it can have major effects on people's oral health, their health more generally and on their quality of life.

Access to dentists, particularly in care homes, is an issue which Healthwatch England has raised many times. We published a report, *Access to NHS Dental Services: What people told local Healthwatch* in 2016. Our more recent *What's it like to live in a care home?* report reinforced our original findings. Since the original report was published, local Healthwatch have continued to monitor what is happening in their areas.

Our network looks at all services. It explores how services work together and how people experience using services. Most recently we have heard:

- In 2018, Healthwatch Dorset reported that 38% of residents in homes that responded to a survey received no dental services at all and 59% of the homes that responded said that their residents received poor or average dental services. Issues of concern included long waiting times, a lack of home visits and a lack of services supporting people with dementia.
- Healthwatch Sefton has found problems for care home residents, including availability of home visits from dentists, ability to register with an NHS dentist, and care home managers not being aware of any local dementia friendly dentists.
- Healthwatch Derby found that many care home residents they surveyed last visited a dentist more than two years ago, mainly due to local dental services not offering visits to the home.

At present, the problems facing care home residents are not always identified by the NHS or those responsible for ensuring quality, such as the Care Quality Commission (CQC).

For example, primary care dental services and care homes are regulated/inspected separately – so asking about the oral health of care home residents does not necessarily fall under the remit of either team of inspectors. In addition, domiciliary care is not covered within the standard NHS dental contract.

Healthwatch has raised this with a range of national bodies who have responsibility for commissioning and regulating dental services, and last year the CQC looked more closely at the oral health of care home residents.

Their dental inspection teams joined adult social care inspectors on routine unannounced inspections of 100 homes. The CQC report – published in June – highlighted both a lack of access to dentists and insufficient support provided by care home staff.

Around half of care homes did not provide training to their staff on oral health care, while nearly-three quarters of individual care plans did not cover oral health sufficiently. One in six care homes also said they did not assess residents' oral health on admission and one in three said they could not always access dental care.

CQC is recommending a cross-sector approach to oral health care, including sharing best practice, repeating and reinforcing the guidance, mandatory staff training, oral health check-ups for all residents moving into a care home and the creation of a multi-agency group to raise awareness. Healthwatch agrees with this. We have long argued that all care home residents should have an oral health assessment when they enter a care home, with recommendations for ongoing dental care included in their personal care plan, and that care home staff should be properly trained to look after the oral health needs of residents with confidence.

And, of course, care home residents should have access to local dental health services when needed in the same way the wider community does. We would also like to see the CQC alter its adult social care inspection framework to include looking at oral health in care homes in further detail.

This tallies with the commitment in the recently published NHS Long Term Plan to 'ensure that individuals are supported to have good oral health in care homes'. However, there was no mention of a similar commitment for older or disabled people who use domiciliary care agencies and we want this to be urgently addressed.

Our network of 152 local Healthwatch branches are able to spot these issues because they look at all services, how they work together, and people's experiences of them – rather than just looking at individual services in isolation.

There are simple things that could vastly improve the oral health and quality of life of people who are living in care homes across England. We are calling for this to be addressed as a priority and for change to be implemented at the earliest opportunity to protect the health of those living in care homes. **CMM**

Sir Robert Francis QC is Chair of Healthwatch England. Email: **enquiries@healthwatch.co.uk** Twitter: **@HealthwatchE**

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