STOCKPORT
METROPOLITAN BOROUGH COUNCIL

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Scrutiny Committee

AGENDA

HEALTH SCRUTINY COMMITTEE

Committee Rooms 1&2 Town Hall Stockport	Meeting: Tuesday 1 June 2010 Tea: 5.00 pm (Stopford House) Business: 6.00 pm

Substitutes

Councillors who require a substitute to be appointed should inform the Council Secretariat using the pro-forma by 4.00 pm on Thursday 27 May, 2010. Councillors who wish to arrange their own substitute should inform the Council Secretariat of the name of their substitute prior to the commencement of the meeting.

1. MINUTES (Enclosed)

To approve as a correct record and sign the Minutes of the meeting held on 6 April, 2010.

2. DECLARATIONS OF INTEREST

Councillors and officers to declare any interest which they may have in any of the items on the agenda for this meeting (including whipping declarations)

3. CALL-IN

To consider any call-in items.

4. DIGNITY IN CARE – THE ROLE OF SCRUTINY (Enclosed)

To consider a report on dignity in care and the role of scrutiny in engaging in issues relating to dignity in care.

Stockport has a local Dignity in Care Champions Group which aims to promote and raise awareness of dignity across all local health and social services. The Group is keen to engage with the Health Scrutiny Committees regarding the work of the Group, the dignity in care agenda in general and ways in which Scrutiny may be able to contribute to this agenda.

The Committee is invited to comment on the report and consider ways in which the Committee's work programme may contribute to the dignity in care agenda

Officer contact: Nicole Alkemade, email Nicole.Alkemade@stockport-pct.nhs.uk

5. DIRECTOR OF PUBLIC HEALTH'S ANNUAL REPORT (Enclosed)

To consider an oral overview of the key issues contained in the Director of Public Health's Annual Report.

Each year the PCT commissions the Director of Public Health to produce an independent professional report on the health of the people of Stockport, including recommendations for improvement for local service providers. The Council is invited to produce a formal response to the report and its recommendations.

The Scrutiny Committee is invited to submit comments on the report and identify any issues which the Committee wish to consider in further detail as part of the 2010/11 work programme.

Officer contact: Dr Watkins, e-mail stephen.watkins@stockport-pct.nhs.uk

6. RÉSUMÉ OF THE HEALTH AND WELLBEING PARTNERSHIP PARTNERSHIP – 22 MARCH 2010 (Enclosed)

To note the résumé of the meeting held on 22 March 2010.

Officer contact: Jonathan Vali Tel: 474 3201, email: jonathan.vali@stockport.gov.uk

7. AGENDA PLANNING (Enclosed)

To consider a report of the Assistant Chief Executive (Strategy and Democracy).

The report sets out planned agenda items for the Scrutiny Committee's next two meetings and Forward Plan items that fall within the remit of the Scrutiny Committee.

The Scrutiny Committee is invited to consider the information in the report and put forward any agenda items for future meetings of the Committee.

Officer contact: Gaynor Alexander Tel: 474 3186 email: gaynor.alexander@stockport.gov.uk

Agenda officer contact: Steve Worthington on 474 3239,
email: steve.worthington@stockport.gov.uk or Fax: 0161 474 3240

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পারে। মেহেরবানী করে স্টকপোর্ট ইন্টারপ্রিটিং ইউনিটে ফোন করুন টেলিফোন নম্বর, 0161 477 9000.

اگرآپ کوان معلومات کے بارے میں مددکی ضرورت ہے تو مفت ترجمانی کی سروس دستیاب ہے۔ براہِ مہربانی انٹرپریٹنگ یونٹ کو
0161 477 9000 پرفون کریں۔

خدمات ترجمه رایگان این اطلاعات در صورت نیاز موجود میباشد. لطفا با شماره تلفن0161 477 9000 با
واحد ترجمه(اینترپریتینگ یونیت) ما تماس بگیرید.

تنوفر خدمة ترجمة شفوية اذا تطلبت مساعدة في فهم هذا المعلومات. نرجو الاتصال اربن رينيول على رقم
الهاتف:0161 477 9000

AGENDA ITEM 1

HEALTH SCRUTINY COMMITTEE

Meeting: 6 April 2010
At: 6.00 pm

PRESENT

Councillor Tom McGee (Chair) in the chair; Councillor Hazel Lees (Vice Chair); Councillors Walter Brett, Christine Corris, Chris Gordon, Sylvia Humphreys, Bryan Leck, June Somekh and Craig Wright.

1. MINUTES

The Minutes (copies of which had been circulated) of the meeting held on 24 February 2010 were approved as a correct record and signed by the Chair.

2. DECLARATIONS OF INTEREST

No declarations of interest were made.

3. CALL-IN

There were no items to consider.

4. REPORT ON CONTROL OF HOSPITAL BASED INFECTION

At its meeting on 7th July 2009, the Committee received a presentation on the Stockport NHS Foundation Trust Annual Plan 2009/10-2011/12. Members were informed that though 2008/9 figures represented an improvement on the previous year, the Trust had fallen slightly short of its target regarding cases of MRSA. The Committee was informed that various measures had been put in place to reduce risk of hospital based infection and requested that the Trust be invited to provide a progress report in 2010 regarding the impact of infection control during the winter months.

The Stockport NHS Foundation Trust submitted a report entitled ‘Health Care Prevention Update’ (copies of which had been circulated) which detailed both the method and impact of measures introduced to reduce the risk and combat hospital based infection. In addition, the Committee received a presentation from Dr Doshi which outlined vast improvements made in reducing incidences of hospital based infection in Stockport.

Promoting awareness with both staff and members of the public and ensuring that they adopted the various hygiene measures in place was the key to keeping incidences low. In order to maintain low levels, a system of root cause analysis had been adopted which allowed constant evaluation from which policy was formulated.

Although MRSA bacteraemia rates were clearly in decline, concern was expressed with regard to incidences of Clostridium Difficile, which were below the national average. However, the Committee was informed that the figures could be distorted as higher forms of the disease were being addressed.

RESOLVED – That the report be noted and that thanks and congratulations be given to Stockport NHS Foundation Trust for the report and the improvements made.

5. HEALTH AND WELLBEING PARTNERSHIP PERFORMANCE UPDATE

The Director, Adult Social Care submitted a report (copies of which had been circulated) presenting the Health and Well Being Partnership's Performance Management Framework for quarter three of the reporting year 2009/10, (1/10/09 – 31/12/09). It also provided highlight and exception information, together with an update on the development of new measures and indicators.

It was reported that although performance had remained steady, there were several 'good news' stories with particular regard to supporting people with mental health problems to gain employment.

Councillors expressed a number of concerns with regard to failure to meet targets with particular regard to teenage pregnancy, breast cancer screening and hospital admissions for alcohol related harm. It was suggested that a seminar focussing on alcohol related issues in the borough - which would involve a wide range of groups and organisations - should be given future consideration. In addition, further information was requested with regard to future plans to increase the uptake of both breast cancer screening and chlamydia testing for younger people.

Although Stockport's figures in respect of smoking cessation were below the national average, it was recognised that these could be improved and that improved awareness measures should be considered. Further concern was given with regard to perceived slow process of referrals to treatment. In response to a Councillor's question it was agreed that the most recent information with regard to direct payment pilot schemes would be circulated to all Members.

RESOLVED – That the report be noted.

6. PARTNERSHIP REPORTING TO SCRUTINY

The Assistant Chief Executive (Strategy and Democracy) submitted a report updating the Scrutiny Committee on a review of existing governance arrangements and the relationship between the Stockport Partnership with associated thematic boards, and Scrutiny Committees. The report also contained proposed enhanced reporting arrangements between these partnerships and the associated Scrutiny Committees.

RESOLVED – That the report be noted.

7. DEMENTIA SERVICES SCRUTINY REVIEW

The Assistant Chief Executive (Strategy and Democracy) submitted a report setting out the findings of the Health Scrutiny Review on Dementia Services. It was reported that no further comments had been received on the draft report which had been circulated.

The Chair thanked all Members and officers commenting that the Panel had gained a sound knowledge of the keys issues relating to Stockport and the review had

progressed positively through a cooperative approach from all involved; particularly from the many outside organisations who had contributed.

RESOLVED – That the Executive be requested to adopt the following recommendations:

(1) That initiatives are piloted to promote positive messages regarding the support available during, and after, diagnosis of dementia. In particular, the Committee recommends that NHS Stockport commissions a mobile “memory services” vehicle in public areas such as shopping centres, designed to raise public awareness of memory conditions and the wide range of support available to people with dementia and their carers. The Committee welcomes this provision at the earliest opportunity but definitely during the 2011/12 financial year.

(2) That one GP from each of the four Practice Based Commissioning Areas is identified as a “Dementia Champion,” with responsibility for: - raising GPs’ awareness of dementia; raising awareness of the role of GPs’ in identifying symptoms of dementia and signposting patients and carers to support; promoting dementia training for GPs; and disseminating up-to-date information regarding dementia and dementia support. The Committee recommends that NHS Stockport implement this recommendation as soon as is possible.

(3) That GP training should be complemented by public information campaigns which encourage people to access their GP about concerns regarding their memory.

(4) (i) That NHS Stockport carry out a thorough analysis of diagnosis rates by individual ward area in order to identify areas with lower than expected diagnosis rates for dementia (allowing for natural variations associated with the demographic profile of individual areas); and

(ii) That NHS Stockport carry out localised targeted action based on the above analysis to improve diagnosis rates.

This work should be carried out during the 2010/11 municipal year.

(5) (i) Stockport NHS and Stockport Council (Joint Commissioning), in conjunction with the voluntary and community sector, carry out a gap analysis to identify demand for support across the borough and ensure provision is mapped to meet local demand.

(ii) Stockport NHS consult with the voluntary and community sector on an annual basis in order to carry out up-to-date audits of services and help ensure provision of dementia services continue to meet demand.

(6) (i) That further voluntary and community provision is encouraged and proactively supported by the Council as a low cost option to complement existing services and fill any gaps in provision (both in terms of location and type of service provided). In particular, the Committee recommends that the luncheon club operated in conjunction with Bramhall United Reform Church is considered as an example of good practice to be encouraged in other parts of the borough.

(ii) The specific needs of BME groups are considered and support is tailored to meet their needs.

(7) That joint working between NHS and voluntary service providers is encouraged in order to provide a more integrated and comprehensive service. In particular, the Committee welcomes the proposed community memory services “hubs” and recommends that they are introduced and monitored during the 2010/11 municipal year, with a view to further developing the service across the borough.

(8) That an arrangement for internal monitoring, by Stockport NHS Foundation Trust Board, of progress in relation to the implementation of the Trust’s dementia action plan is built into the plan. This will help to raise awareness and support for the plan at the highest strategic level.

(9) A specialist mental health liaison service, in line with national good practice, would derive substantial benefits at a relatively low cost. Such specialist mental health liaison service should be commissioned by NHS Stockport during the 2011/12 financial year.

(10) Evidence suggests there are benefits to be had from prompt hospital assessment and streamlined pathways through hospital for people with dementia. It is therefore recommended that:

(i) Measures are implemented to speed up the time taken to carry out an effective hospital assessment of patients who are in an acute hospital;

(ii) The pathway through hospital for patients with dementia is streamlined, and unnecessary transfers during hospital stay avoided. These actions should be initiated at the earliest opportunity.

(11) (i) All relevant stakeholders and dementia service providers sign up to the local dementia strategy and implement the appropriate actions in their organisations;

(ii) The Stockport Older People’s Working Group (mental health) takes a proactive role in monitoring the implementation of the Strategy; and

(iii) An annual report on performance in relation to the actions contained in the local dementia strategy is presented to the Health and Wellbeing Partnership Board.

(12) Membership of the Stockport Older People’s Working Group (mental health) should be refreshed to include representation from Stockport NHS Foundation Trust, in addition to all other relevant stakeholders from the PCT, Pennine Care, Stockport Council and voluntary and community sector.

(13) (i) A local set of targets and performance indicators focusing on specific priorities for improvement in relation to dementia services, is developed and agreed by the Health and Wellbeing Partnership Board;

(ii) All NHS and voluntary service providers are encouraged to sign up to the targets; and performance is reported to the Health and Wellbeing Partnership Board.

(iii) That the targets are renewed on an annual basis.

(14) That a further meeting is held in twelve months time, with all stakeholders, to monitor progress towards implementing the recommendations contained in this review and to evaluate early outcomes.

8. JOINT ROLE OF CHIEF EXECUTIVE NHS STOCKPORT AND CORPORATE DIRECTOR, ADULTS AND HEALTH.

(NOTE: The Chair was of the opinion that this item although not included on the agenda should be considered as a matter of urgency in accordance with section 100 B(4)(b) of the Local Government Act 1972 to avoid delay in the consideration of the item).

Richard Popplewell gave an oral explanation with regard to his duties plans and aspirations in respect of his joint role as Chief Executive, NHS Stockport and as Corporate Director, Adults and Health during the next three year period.

RESOLVED – That the position be noted.

9. AGENDA PLANNING

A representative of the Assistant Chief Executive (Strategy and Democracy) submitted a report (copies of which had been circulated) setting out the planned agenda items for the Committee's next meeting and Forward Plan items which fell within the remit of the Committee.

RESOLVED – That the report be noted.

The meeting closed at 7.40 pm

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Dignity in Care 2010

Background

In response to the DOH campaign on implementing Dignity in Care Champions Stockport Adult Social Care services took the initiative to develop an approach that would bring the principles of this work to life in the borough.

A group was constituted comprised of representatives of statutory, voluntary and private sectors that are part of the wider care economy across the borough. The group has been working over the last few months to drive this work forward and to ensure that within the borough we are able to promote the campaign for 'Dignity in Care' and to develop a partnership approach that promotes and embraces good quality care services

In support of this campaign, Stockport Council in partnership with other locally based health, voluntary and independent sectors organised an event to celebrate what is already being done across the borough and share best practice on how to further improve quality for all. Furthermore, we used this as an opportunity to consult on a draft Dignity Partnership Agreement. This agreement articulates the principles and conditions to provide dignity and quality services to people in receiving services from independent and statutory providers in Stockport

Event

The event took place at the end of January and was opened by Gordon Burns from BBC Northwest Tonight, with speakers Cllr John Pantall and Maggie Kufeldt.

The purpose of the event was:

- to encourage local people to take part in discussions and consultation on how best to deliver health and social care in Stockport
- to give local organisations the opportunity to network and share ideas
- to promote and embed dignity and respect for all.

Communication

Communication was designed to deliver maximum publicity about the event and to engage local people.

Communication tools used to do this were:

- Invitations to potential stall holders, organisations wanting to deliver workshops and dignity champions
- Poster/flyers
- Targeted press release(s)
- Email to staff
- Internet and intranet

Match funding

Stockport Council Adult Social Care has set aside £50,000 to help make a real difference to the way in which social care services deliver support to people in Stockport. Applications are welcomed from independent, voluntary and private but not from statutory organisations, delivering social care services in Stockport.

Any successful bid to the Dignity in Care fund will need to have match funding from the successful organisations. So for example if the bid is for £5,000 of funding the Council will contribute £2,500. It is expected that successful projects will start within 2 months of the funding being agreed

All successful bids will need to evidence the cost of the bid with appropriate quotations and, on completion, receipts. Appropriate documentation will be kept for audit purposes and future evaluation. In addition the successful organisations will need to provide evidence of the outcomes achieved and be willing to share their experience with others.

Feedback from the public

Over 300 people came along to the Dignity in Care event and many took part in the public consultation.

We asked people to comment about their concerns, issues and personal experiences of dignity in care in Stockport. We received over 125 comments – below is a snapshot of what was fed back:

- Good care can only happen alongside friendship/companionship
- I want to go to bed when I want to – not when someone can fit it in
- Personalised care is improving
- The point about it being down to leadership and training was well made
- Failed operation – dented confidence
- Current systems still very much one size fits all
- In principal it looks good
- Want people to talk to me, not at me
- Carers/patients are still afraid to complain.

We also asked people as they were leaving to comment about the event. It was encouraging that a lot of people were very positive - below is a small list of what people told us:

- Very interesting – will take back some ideas from conf to my work place
- I really found the real life stories and experiences of people very useful and powerful 'hear it as it is'
- Would have liked to see more emphasis on younger peoples care
- I want to ensure people in my care are always treated with dignity
- Today has given me greater understanding

- More for younger people needed e.g. teenagers
- Has helped me look at different careers I might take up in later life
- Being well prepared for disabled guests i.e. cups they can hold for their tea!!

More feedback from the public can be found on
www.stockport.gov.uk/dignityincare

Post event

To continue to raise awareness of dignity in care and to highlight this year's national Dignity Action Day, which took place on 25 February, we presented the results of our consultation to the dignity champions, and independent and private providers of care in the borough.

Our established group will continue to meet to address issues of both quality and dignity in all care environments and to embed the work of our Partnership Agreement within all sectors providing care services.

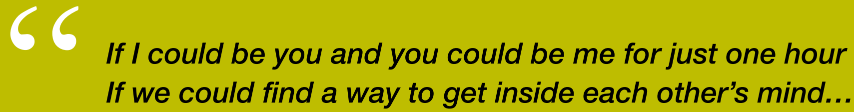
Walk a mile in my shoes

Scrutiny of dignity and respect for individuals in health and social care services: a guide

cfps the centre for public scrutiny
better scrutiny for better government

I&DeA
improvement and development agency

November 2009



> *If I could be you and you could be me for just one hour*
> *If we could find a way to get inside each other's mind…*
>
> *Walk a mile in my shoes, walk a mile in my shoes*
> *And before you abuse, criticize and accuse*
> *Walk a mile in my shoes.*

Joe South

> *Support people with the same respect you would want for yourself or a member of your family*

The Dignity Challenge: point 2

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Foreword

Like everyone else, I have experienced the health and social care system, both as a (very occasional) user of services, and more often through family and friends. I know that respect and dignity – being treated as an individual – is very important to people. And I believe that this can significantly affect their wellbeing and their recovery from illness.

I believe that elected members of local authorities, in their scrutiny role, are making a real difference to how people who use health and care service are treated, not only by exposing actions and practices that are disrespectful, but also by celebrating good practice where they find it. But I also know that there is much more that Overview and Scrutiny Committees can still do, by continuing to raise these issues in the course of their work.

This guide is designed to assist Overview and Scrutiny Committees and others in discussing what dignity is, why it matters and how to assess whether an organisation or service treats the people whom it serves with dignity and respect. The key messages that I hope will emerge from this document are that:

- being treated with dignity and respect is consistently one of the **most important issues** for people using services and lack of dignity and respect is one of the top reasons for complaints
- the NHS review, High Quality Care for All emphasises that treating people as individuals, and therefore with dignity and respect, is a key part of **quality** services; the NHS Constitution gives people the **right** to be treated in this way; and the Comprehensive Area Assessment will provide citizens and communities with a better picture of **outcomes that matter**, including dignity and respect
- issues of dignity should be embedded in the **commissioning** of health and social care and other public services and scrutiny should always take commissioning as its starting point – if dignity and respect are missing from commissioning it is unlikely that providers of services will get them right either
- care organisations and services should always have **policies** in place to promote dignity and respect but Overview and Scrutiny Committees will need to ensure they have **evidence** that these are working in practice on the “front line” and reflected in the experiences of individual service users
- equally, individual health and social care practitioners who champion dignity in care need to be supported by strong **leadership**.

I am delighted that many councillors have already pledged to become Dignity Champions. I hope that the experience of participating in scrutiny reviews which prioritise issues of dignity and respect will encourage even more to sign up as Dignity Champions for the area they represent – to ensure the issue of dignity moves to the heart of all NHS and care services.

Councillor David Rogers
Chair, Health and Wellbeing Board
Local Government Association

Preface and acknowledgements

This guide is intended to assist local authority Overview and Scrutiny Committees (OSCs) in reflecting dignity issues throughout their work.

We hope that the guide will assist them in a number of ways to help raise awareness and understanding of dignity and respect for individuals who are receiving health and social care services.

Using the guide, OSCs should be in a position to:

- review local leadership and partnerships to judge whether services respect the dignity of service users
- promote dignity and respect for individuals and the role of the OSC
- help ensure local health and care services are commissioned and delivered with dignity as a central aspect of care; and that an approach to dignity is embedded at a strategic and corporate level as well as at the frontline
- gather local intelligence and provide evidence which can be reflected in local reviews of services by the Care Quality Commission (CQC) and in the Comprehensive Area Assessment (CAA).

The intended audience for the guide is primarily Chairs and Members of OSCs and the local authority officers supporting overview and scrutiny. We hope that this will not only include OSCs with a specific health and social care remit or those scrutinising issues relating to older people. Dignity is an important issue for all users of all public services and, as such, should be part of local authority overview and scrutiny in many different areas, including housing services, transport and travel, leisure and cultural services. The intended audience therefore includes unitary, county and district councils as well as local authority and NHS staff and members of governing bodies, LINks' members and Dignity Champions.

The guide was written by Fiona Campbell with the help of a Steering Group, to whose members, listed below, we are grateful for their time and effort.

Amanda Brown, Performance and Service Development Manager and Dignity in Care Beacon Award co-ordinator, Warrington Borough Council

Ken Clemens, Head of Policy and Campaigns, Age Concern Cheshire

Caroline Coombes, Overview and Scrutiny Lead, Bradford Metropolitan District Council

Karen Dooley, Dignity in Care Campaign Manager, Department of Health

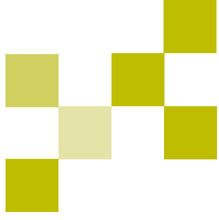
Anna Gaughan, Regional Dignity Lead, North West Improvement Partnership, chair of Steering Group

Cllr Shelagh Marshall, Yorkshire Futures and North Yorkshire County Council

Jan Potts, Dignity, Prevention and Early Intervention Lead, Yorkshire and Humber Improvement Partnership

Alison Williams, Health Policy and Scrutiny Officer, Warrington Borough Council.

A draft of the guide was tested with focus groups of overview and scrutiny councillors from Bradford Council and Warrington Council, to whom we are also grateful for their time and comments. Thanks also to Caroline Coombes, Bradford Council and Alison Williams, Warrington Council for arranging the focus groups and to Ken Clemens, Age Concern,



Cheshire for gathering feedback from local LINk members on an earlier draft of the publication.

The guide is a legacy product from the Dignity Beacon Award (2008-9). It was sponsored by the Department of Health, the Centre for Public Scrutiny, the Improvement and Development Agency for Local Government, the North West Joint Improvement Partnership and Yorkshire and Humber Improvement Partnership working with partners from Future Years, Age Concern Cheshire, Warrington Borough Council and the City of Bradford Metropolitan District Council.

The guide is supported by a presentation and set of exercises which can be used by OSCs to inform their work on dignity and respect. These can be downloaded from the Centre for Public Scrutiny website www.cfps.org.uk

A word about language

We all know it's not true that "sticks and stones may break my bones / but words will never hurt me". Words can hurt a lot and, used insensitively, can undermine people's dignity and self-respect. Even something as simple as whether a person is addressed by their first name or their title and surname can make a difference. The steering group thought long and hard about how to refer to the people who are the subject of this guide. Since dignity is very much about respecting the unique viewpoint and experience of each individual, we felt it important to emphasise the individual rather than the group they belong to. So we have generally talked about people first and groups second, for example, "people with dementia". Sometimes this would make for an artificial and cumbersome way of writing, so, for example, we talk about "older people" rather than "people who are older". Sometimes, indeed, it is membership of a group that is at the root of how people are treated, as when people are discriminated against by sex, race or age. We know also that people who belong to different groups have strong feelings about how they are described, so our use of language may not satisfy everyone. The important message for scrutiny of dignity issues, we believe, is to think about language as an aspect of dignity, to try not to label people too hastily; and to try to respect the way that people prefer to be referred to themselves.

1 Introduction

What is dignity and why does it matter?

According to dictionary definitions, dignity is the quality or state of being worthy of esteem or respect. This means that it is a quality possessed by all human beings, since all are worth respect. But dignity is also about how people are treated. If you treat someone disrespectfully, then you take away their dignity. We often talk of treating someone with dignity, as shorthand for treating them as though they are worthy of respect.

One important form of respect is self-respect. If you are not treated with respect by others, it is hard to hold onto your self-respect. It is hard to keep your sense of yourself as an autonomous person with rights to the kind of things that contribute to self-respect, like privacy. So, as the Social Care Institute for Excellence puts it,

> *"dignity consists of many overlapping aspects, involving respect, privacy, autonomy and self-worth".* *(SCIE Guide 15)*

Because all of these aspects are so important to our sense of our own and others' full humanity, the loss of dignity is a very serious thing for any human being, young or old.

The importance of dignity as a fundamental aspect of an individual's humanity is recognised in human rights legislation. The very first sentence of the Universal Declaration of Human Rights says that "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world." The UK Government's stated purpose in introducing the Human Rights Act was to promote a culture of respect for these rights, making them a feature of everyday life.

Dignity and respect in health and social care

One of the times at which people are most in danger of losing their dignity and their self-respect is when they need help with health and social care. By their nature, health and social care services are provided when people are most vulnerable – when they are feeling at their weakest, when they are afraid and when they have to expose the most intimate and personal parts of themselves (their bodies and their minds) to inspection and handling by others.

Most of the time, most of us carry round with us a kind of protective shell: we cover our bodies with clothes that indicate how we want to be perceived by others; we protect our minds and our most private inner selves by concealing many thoughts and emotions; and we are usually able to control, to a considerable extent, how much of these we reveal, depending on how close we feel to the people we are with.

When we seek or need health and social care, we have to allow some of this protective shell to be breached to enable others, often strangers, to understand and help meet our needs. We may have to remove our clothes and allow others to examine our bodies and help us with our intimate bodily functions. Or we may have to reveal feelings and experiences that we would normally keep private. In these circumstances, because we are so vulnerable to the loss of our dignity, it is all the more important that it is recognised and protected.

In this guide, we will use the definition of dignity in care given by the Social Care Institute for Excellence:

> *"Dignity in care means the kind of care, in any setting, which supports and promotes, and does not undermine, a person's self-respect, regardless of difference"*
>
> *(SCIE Guide 15)*

We take the phrase "regardless of difference" to refer to any of the ways in which individuals and the groups they belong to differ from each other. This includes age, gender and sexual orientation, race, nationality, religion and disability. Many of the policy documents written about issues of dignity in care use examples and case studies about the treatment of older people. This is partly because the majority of people using health and care services are older. Unfortunately, also, research has highlighted many instances in which older people have not been treated with the dignity and respect that is their right. But of course, it is not only older people who are entitled to dignity. Everyone is, including children and young people. And some of the most vulnerable groups in this respect, which have also been highlighted by research, include people with learning disabilities, people with physical disabilities, people with mental health problems, people with dementia, people with terminal illnesses and people from minority ethnic cultures – all of whom can be of any age.

This publication is about services relating to adults and does not cover issues of dignity and rights specific to children and young people because there are different administrative systems, legislation and national policy (under the overall heading of *Every Child Matters*) for this group, which would require a lengthy separate discussion to do them justice. However, one group it is particularly important to highlight when thinking about adults is young people leaving local authority care and those "in transition" from children's services to adults' services. The personal transition from childhood to adulthood can be a time when young people particularly need to "stand on their dignity" as we say; and the quality of care services for young people receiving them can make a big difference to this.

Loss of dignity and lack of respect for individuals can lead to downright abuse. This guide does not attempt to cover issues of abuse, although the section on further information points to useful sources on this topic.

The need for greater dignity and respect is consistently highlighted by people using health and social care services; and lack of dignity and respect is one of the most cited reasons for complaints made about these services (Woolhead, 2004). So it clearly matters a lot to people who use services. And since people's sense of self worth is so closely related to their wellbeing and resilience, dignity is closely related to quality of care. Promoting dignity and respect for individuals must be at the very heart of good quality care and service delivery – it is not an optional extra.

What can scrutiny add?

Since dignity is consistently cited as a high priority for service users, OSCs who investigate the issue will undoubtedly be responding to an issue of importance to their residents. Dignity is not a highly technical issue – although it may be difficult to define precisely, we all know when we or someone we care about has not been treated with dignity or respect. At the same time, it requires considerable sensitivity and an exploration in some detail to establish whether an organisation or service is one which embodies dignity and respect for individuals. Listening to the experience of health and social care service users and their relatives and

carers is a hugely important source of evidence on such a personal issue. All of this makes it a central and appropriate topic for OSCs – and there are notable examples where OSCs have been proven to be effective in this area. Some of these are briefly described in the 'scrutiny review' boxes throughout this guide.

Almost all the scrutiny work so far relating explicitly to dignity has been about services for older people. OSCs are now beginning to think about dignity and respect in relation to other groups. The examples in the 'dignity in care' boxes throughout the text show the huge range of activity across the country – we hope that these examples will spark some ideas among OSCs about how they might investigate and promote good practice in their own areas.

Experience to date shows that where OSCs have already looked at dignity issues they can contribute to ensuring that dignity in care is embedded in service planning and delivery. One example is that of the London Borough of Hackney whose Health Scrutiny Committee recommended the widespread adoption and use of a Dignity Code. It is clear that this recommendation has been highly influential and the Code now informs both commissioning and providing of health and social care in the Borough.

Overview and Scrutiny Committees already have a track record in raising sometimes overlooked issues on behalf of those whose voices are seldom heard. Sometimes also, their members can bring a perspective to an issue that may go straight to the heart of what matters to ordinary people. A simple example is that of mixed-sex wards in hospitals. Research has shown that, whereas NHS managers count wards as "single-sex" where there are bays with members of only one sex, the general public perceives them as mixed-sex if there are people of the two sexes in different bays in the same ward. This is seen by many people as an issue of dignity and is just the sort of issue which Overview and Scrutiny Committees can raise and bring a commonsense view.

Similarly, commissioners and providers of health and social care have tended to think of specific services or institutions when considering the quality of services. But, as councillors know, most people who are finding their way through the health and social care system don't distinguish carefully between its different components – what matters to them to them is the quality of service *as a whole*. Unfortunately, it is precisely at the interface between different sectors or services that quality of care and the factors that impact positively on dignity can break down. This is just the sort of area to which the scrutiny function can bring added value by looking across the whole "care pathway" from the perspective of an individual who is traversing it.

The care pathway can even extend beyond traditional health and social care services. For example, the suitability of people's housing and their access to their neighbourhood – public transport, shops, meeting places, green spaces, leisure facilities - can make a big difference to their quality of life and to their dignity. The local authority wellbeing power provides a remit for OSCs to look holistically at all of these issues through the "dignity lens".

OSCs are also in a good position to raise the profile of the issue locally, as, for example, North East Lincolnshire Dignity in Care Select Committee did, with an article in the Grimsby Telegraph. As an authoritative voice on the quality of care in their area and as a channel for people who use services and people who care for them to make their own voices heard, OSCs are ideally placed to present evidence to the Care Quality Commission and to inform the Comprehensive Area Assessment. In sum, they have an opportunity to influence the agenda locally and drive forward better quality services.

2. The national context

The Dignity in Care Campaign

Dignity in Care is far higher up the policy agenda for care services than ever before. Services are now operating against a policy backdrop that places quality, patient experience, dignity and respect at the heart of care. Dignity features in key performance frameworks including the NHS Operating Framework and the *National Indicator Set* and is a consistent theme in the key strategies including: *Living Well with Dementia – a National Dementia Strategy* (February 2009), *High quality care for all adults at end of life* (July 2008) and *Carers Strategy – Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own* (June 2008).

The direction of travel of the *NHS Next Stage Review "High quality care for all"* places a strong emphasis on dignity and respect and the new *NHS Constitution* includes the right for patients to be treated with dignity and respect. Key organisations representing service users and care providers are taking action to promote dignity in care. For instance, the *Care Quality Commission* has included dignity and respect as one of its six key area of inspection.

Launched by the Department of Health (DH) in November 2006, the 'Dignity in Care Campaign' (www.dignityincare.org.uk) aims to end tolerance of care services that do not respect people's dignity by:

- Raising awareness and stimulating a national debate around Dignity in Care
- Inspiring and equipping local people to take action
- Rewarding and recognising those who make a difference

The Campaign was originally launched specifically to promote dignity for older people but its focus is gradually being extended to all those receiving health and social care services. As part of the Dignity in Care Campaign, the Dignity Challenge was issued. Based on consultations with service users, carers and professionals, it lays out the national expectations of what constitutes a service that respects dignity. It focuses on ten different aspects of dignity – the things that matter most to people. As such, it will be an important starting point for any scrutiny relating to dignity issues.

The Dignity Challenge

High quality care services that respect people's dignity should:

1. have a zero tolerance of all forms of abuse.
2. support people with the same respect you would want for yourself or a member of your family.
3. treat each person as an individual by offering a personalised service.
4. enable people to maintain the maximum possible level of independence, choice and control.
5. listen and support people to express their needs and wants.
6. respect people's right to privacy.
7. ensure people feel able to complain without fear of retribution.
8. engage with family members and carers as care partners.
9. assist people to maintain confidence and a positive self-esteem.
10. act to alleviate people's loneliness and isolation.

Dignity Champions

The Department of Health has set up a network of well over 10,000 Dignity Champions, people who are "committed to taking action, however small, to create a care system that has compassion and respect for those using its services". The role of Dignity Champions varies depending on their knowledge and influence and the type of work they do. Members of OSCs may already be Dignity Champions or may consider becoming Dignity Champions in the course of their scrutiny work.

Dignity Champions can be a very useful source of advice and evidence for local authority OSCs. The Department of Health has set up a database of several thousand Dignity Champions (see section on further information below). You can search this database for Champions in your area with different roles and particular interests.

Local Involvement Networks

All local authority scrutiny committees concerned with health and social care issues will have made links with the Local Involvement Network (LINk) for their area. LINks will almost certainly have some members who have signed up as Dignity Champions, but even where LINks do not include Dignity Champions, LINks members will be important sources of experience and evidence in any scrutiny relating to dignity in care. LINks members, as users of services, as carers and as members of different communities of interest and identity will be able to bring an invaluable range and a richness of experience to scrutiny work. Additionally, with their "enter and view" power to visit providers of both health and social care, LINks can make an important contribution to the information on dignity available to OSCs.

Some health OSCs have co-opted LINks members onto their committees, others use LINks members as expert advisers for particular scrutiny reviews and others have begun to take evidence from LINks in the course of carrying out reviews. The host organisations supporting LINks have a particular remit to assist their LINks to reach out to minority communities and those whose voices are seldom heard. This is important in relation to dignity, as these groups can sometimes suffer the greatest indignities, due to lack of access to appropriate services and lack of understanding of their needs and the sources of their self respect.

Issues that should be covered in any scrutiny review of dignity

Corporate issues

What sort of leadership is given on dignity?

How is dignity embedded in governance? (Eg how are dignity issues reported to the Board/Executive, how often, in what form?)

How are people who use the service(s) involved in developing strategies on dignity and in the training and development of leaders and staff?

What do external assessments (eg those of the Care Quality Commission) say?

Procedural issues

What policies are in place to ensure that dignity and respect are central to care?

What systems are in place to support these policies? What training is made available to staff on the policies and how to manage their implementation?

Collecting evidence

How does the organisation or service monitor the implementation of its dignity policies?

How are people who use the service(s) and their relatives and carers involved in monitoring aspects of dignity?

Can the Local Involvement Network provide any evidence of the experience of people using services?

Learning from experience

Is systematic incident reporting used to inform reviews of service(s) and improve them?

What is the “whistleblowing” policy, how is it promoted and used, are there any examples of its use?

What use is made of complaints reporting and feedback from people using services and their carers to learn and improve?

Who is responsible at different levels of the organisation to learn from mistakes?

Can the organisation/service provide examples of learning from mistakes, showing that it is a “learning organisation”?

As the discussion in the previous sections suggests, and as readers’ own experiences will tell them, there are many components to dignity and respect and the focus will shift depending on what aspects of health and social care services are being scrutinised. As with any scrutiny review, it will be important for OSCs considering dignity issues to be clear from the outset what questions they are seeking to answer in the course of a review. For example, it will be important to be clear about the following when thinking about the kinds of outcomes you are seeking from a review.

Is your review about the commissioning or about the delivery of services?

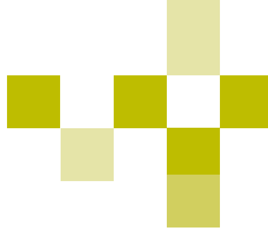
If you are looking at commissioning issues, your main concern will be to understand how and to what extent dignity is reflected in overarching commissioning strategy and how this translates into individual contracts for commissioned services. Whereas if you are

looking at how services are delivered, you will want to look more closely at operational issues, specific dignity policies of the organisation or service, how these are implemented, what people who use services have said about dignity issues in surveys, how complaints are dealt with, how the organisation or service learns from its mistakes, how it is rated in relation to dignity by regulators and inspectors and so on.

Commissioning for Dignity

The Department of Health places considerable emphasis on the commissioning role as a shaper of services. Commissioning is central to providing effective health and social care for both children and adults. It is the process by which PCTs and local authorities decide how to spend their money to get the best possible services for local people. If commissioning strategies and the contracts that are made with providers do not capture the priority issues, the services are unlikely to do so either. This means that, to be influential in relation to dignity issues, OSCs will need to get to grips with how local commissioning strategies are developed and how they are reflected in contracts.

- How have people who use services been involved in developing commissioning policies to include dignity issues?
- Is there an outcomes-based approach to commissioning that emphasises outcomes relating to dignity and respect?
- What general evidence is there that commissioners have thought about dignity in commissioning strategies, frameworks, service specifications, individual contracts and in their approach to personalisation of services?
- How have dignity issues been built into health commissioners' Commissioning for Quality and Innovation (CQUIN) schemes?
- How are dignity issues built into contracts for individual commissioned services (for example is dignity built into the accreditation process for home care providers)?
- How are the dignity aspects of contracts monitored in relation to outcomes achieved?
- What action is taken to feed positive and negative experiences into future commissioning strategies?
- How is compliance with dignity policy reported to the Board/Executive/Governing Body and how often?
- Does any member of the commissioning Board/Executive/Governing Body have responsibility for leadership on dignity issues?
- What other dignity champions are there among commissioners?
- What training is provided for commissioners on how to commission for dignity?
- Are PCT and Council policies on commissioning for dignity aligned with each other?
- Is there a "whistle-blowing" policy and evidence that those who raise issues of concern are encouraged and not victimised?



Dignity in care – commissioning

NHS Western Cheshire has embedded the dignity agenda in the Quality Section of the standard NHS contracts with its main providers for acute, community services and mental health services. Providers will be performance managed against these Quality Schedules through annual work plans at formal contract and quality meetings.

These documents encompass a number of components including:

- patient/service user experience – how will the journey feel for patients/service users and families/carers?
- personalised care – will the service meet an individual's need?

Specific mention is made of providers ensuring services are delivered in line with the Dignity in Care Campaign, and ensuring all best practice guidance is used eg Age Concern's *Hungry to be Heard*. However these documents go further, for example: there are sections on Personalised Care and Equality and Diversity. To highlight the importance given to the dignity agenda NHS Western Cheshire has stipulated compliance (demonstrated through audit) against providers' Privacy and Dignity Policy.
NHS Western Cheshire has used the new national Commissioning for Quality and Innovation (CQUIN) scheme, which links payments to providing high quality care, to select areas which contribute to the dignity agenda, such as focusing on improved care at the end of life by all providers.

Is your review about an organisation or institution or a particular service?

In any of these cases, you will want to be aware in what **settings** care is provided, as these may determine which aspects of dignity are paramount in your review.

- For example, if you are looking at a hospital setting, you may want to prioritise issues such as modesty and privacy
- whereas if you are looking at care provided in people's homes, your focus may be on issues such as communication and autonomy (for example, do care providers respect the service user's wishes about how things are done in their own home or do they insist on doing it "their way"?).

Dignity in care – recently bereaved people

Winner of the South West Peoples Award for Dignity 2009, the Viewing Rooms Project at North Bristol NHS Trust aims to improve the experience of the hospital's recently bereaved service users, increasing their privacy, dignity and access by creating a warm, welcoming environment where the grieving process is less distressing.
Twenty recently bereaved families were given disposable cameras and asked to capture their experience at the hospital. The resulting images showed that more thought needed to be given to the perspective of bereaved people.
A Viewing Room Steering Group was established which included patient panel members, carers, local funeral directors and next of kin who had used the viewing rooms. Over 200 people gave their ideas on redevelopment of the rooms. SANDS, a support group for parents, was also involved to ensure that the new design met the needs of parents and siblings. Both mortuary viewing rooms were refurbished in 2009, following the new designs and were due to open at the end of October 2009.

What type of care are you investigating, who is providing it and for whom?

Being clear about this from the beginning will help you decide on which aspects of dignity you want to focus. For example:

- you would want to ask different questions about an incontinence service largely used by older people from the questions you would ask about a mental health service for people of all ages
- if you are looking at a service provided to a very multi-ethnic community, you will want to ensure that you understand the different concepts of dignity that may prevail in different groups and that cultural and religious differences are respected
- similarly, if you are looking at dignity issues for young adults you will need to understand what matters to the young people themselves – eg, being with other young people may be more important to them than being with people of the same sex
- if the organisation you are looking at provides meals and helps people to eat, you will have a whole set of questions around dignity and food which would probably not be relevant to, say, a sexual health service for younger people, where you would want to focus on issues such as confidentiality.
- if you are looking at nursing care which involves helping people with normally private bodily functions, you may want to focus on different aspects of dignity than if you are looking at the role of medical consultants, where communication may be the most important aspect of dignity.

All of the above examples indicate that scrutineers should be clear from the beginning which aspects of dignity they want to look at. A number of different policy documents and "dignity audit tools" may be helpful to you in thinking through the issues at the scoping stage of your review. Many of these relate to care of older people, but there is an increasing awareness of dignity issues for other groups, such as those with learning disabilities. Many of these are listed in the further information section at the end of this guide. Being clear about the aspects of dignity that you want to investigate will help you put the **right questions** to the **right people** and make the **right recommendations**.

Service areas in which respect for dignity may be particularly important and challenging

As this guide makes clear, dignity is important in all aspects of health and social care. However, there are some areas, groups and stages in people's lives or their "care pathway" where respect for people's dignity may be more at risk, or where it has proved precarious in the past. By paying particular attention to these areas and stages, OSCs may be able to add extra value to their scrutiny work.

- Transitions **within** services (eg the number of ward moves an individual experiences within an acute hospital; consistency in assistance for people receiving supported living; the overuse of transitory agency staff)
- Transition **between** different NHS services or between different social care services, eg when people are coming out of hospital and moving from acute to intermediate care, have any aids or equipment they may need been arranged, has their medication and any information and help they may need to take it been sorted out? Or when young people, such as young people with learning disabilities, are moving from children's services to adult services, how much have they been involved in decisions about their care?

- Transition **between health and social care**, eg when people are discharged to home from hospital and needing social care services
- Transition **between statutory and voluntary services**, eg transition from hospital to the Red Cross Home from Hospital service
- Services for people with dementia and their carers
- Services for people with learning disabilities
- Services for people who are receiving both health and social care
- Care at the end of people's lives and bereavement services.

Dignity in care – people at the end of life

Winner of the National 2009 Peoples Award for Dignity in Care, chef Chris Took has transformed meal times for terminally-ill patients at the Hospice of St Francis in Berkhamsted.

Chris tailors his menus for each individual patient, taking note of dietary requirements and people's preferences. When he joined the hospice eight years ago, he made the unconventional move of leaving the kitchen to chat to patients and families about their meals. Since then Chris has trained teams of volunteers who serve the meals. They have learned the importance of good presentation, knowing each patient's preferences and double-checking each tray before it goes out. They know, for example, that metal spoons should not be given to cancer patients as chemotherapy gives them an unpleasant taste.

Chris also prepares meals for family celebrations - a home-cooked meal for family members and a fruit smoothie for the patient if they can no longer manage solid food.

Clinical staff recognise the important role he plays in improving the quality of patients' lives and marvel at how he can get a reluctant patient to eat again. For the patients, knowing that food has been prepared with such care and close attention to detail brings peace of mind.

Dignity in care – people with learning disabilities

1. Adults with learning disabilities across Derbyshire are being provided with 'Health Files'. These are personal records that they have about their own health. They are to help with communication, appointments and information. They give the person more control of their own health information and help health professionals to give information to the patient, rather than to the carer.

2. Northamptonshire County Council won the 2008 East Midlands Health and Social Care dignity award for its work with a number of people with a learning disability who wanted to have an ordinary life, using the *In Control* approach to enable them to self-direct their support. The Council's approach is to move away from thinking of people as clients, service users or as having 'special needs'. Instead it is endeavouring to work with them as citizens who have the right to many of the things that most citizens take for granted, such as: making decisions, deciding the 'direction' of their life, a home, money, what kind of support they have, and involvement in their neighbourhood / community.

During 2006/07 an 'ordinary living project' had enabled 22 people with a learning disability to move into their own homes with support and made a 19% reduction in the number of admissions to residential care. Self-directed support - bringing together a person's own plan with a personal budget to fund it - is the tool that has been used to make this happen.

Measuring dignity – sources of local information

The Care Quality Commission (CQC) uses the following core standard (number 13 of 24) against which it assesses both commissioners and providers of **healthcare:**

Core standard 13: *Healthcare organisations have systems in place to ensure that staff treat patients their relatives and carers with dignity and respect.*

Service inspections of **adult social care** use the CQC Adult Social Care Outcomes Framework. Within this Framework, seven "outcome areas" are defined:

Outcome area 7: *Maintaining Personal Dignity and Respect.*

In grading the seven outcomes for adult social care 2008-09,an authority cannot obtain a higher overall judgement on how well it is delivering outcomes than the classification *"performing adequately"* if services are graded as performing poorly at outcome 7. Nor can it obtain the classification *"performing excellently"* unless the grading for outcome 7 is at least *"performing well"*. In short there is a key threshold applied to the outcome on dignity and respect.

CQC assessments for your local institutions commissioning and providing health and social care are available on the CQC website for comparison (your own social services department and PCT should also be able to provide you with copies of these).

NHS Choices (www.nhs.uk) in the section "Find and choose services" can also be a useful source of anecdotal evidence on individual NHS trusts. People who have used services can make their own comments on this website and they are listed by Hospitals, GPs, Dentists and Other services.
The website Patient Opinion (www.patientopinion.org.uk) also contains individuals' views in their own words about treatment they have received. It is searchable by postcode and NHS institution.

Measuring dignity – using indicators

Measuring dignity is ultimately about assessing people's experience and can involve some very personal feelings – this is notoriously difficult to capture in the form of objective evidence and statistical reporting. However, there has been considerable recent work to develop ways of assessing the factors that will lead to the desired outcome of an experience of being treated with dignity and respect. This has led to a number of "dignity indicators" being developed for different settings, different kinds of care and different groups of people, many of which have been gathered together in the "dignity audit tools" referred to above. (Details of all of these are given in the section on further information, see page 26.)

For example, on behalf of Help the Aged, the Picker Institute produced a report on measuring dignity in care for older people. This develops dignity indicators under four main themes: **choice, control, staff attitudes** and **facilities**. These are used to assess services against Help the Aged's "dignity domains", developed through consultation with older people:

autonomy – eg involvement in decision-making about care

communication – eg forms of address, access to translation, telling people in advance when changes are being made to their domiciliary care

end-of-life care – eg choice of where to die and who to be with

eating and nutrition – eg appropriate and sensitive assistance to eat when required

pain – eg staff ask about/acknowledge pain

personal hygiene – eg sufficient, clean and suitable washing/toilet facilities

practical assistance/personal care – eg respect for personal possessions, ensuring consistency in the staff providing personal care – it is not appropriate for a different person to arrive every day to give someone a shower

privacy – eg permission sought before students are present during examination or when a carer enters someone's home, bedroom or bathroom (including residential care homes, which are also people's homes)

social inclusion – eg contact maintained with friends and family

The Royal College of Nursing (RCN) has concluded that providing dignity in care centres on three integral aspects: **respect, compassion** and **sensitivity**. Translating these hard-to-measure characteristics into practical action, the RCN believes that this results in indicators such as the following.

- Facilities such as toilets should be well maintained and cleaned regularly
- Curtains between beds should close properly to offer some measure of privacy
- Toilet doors should be closed when in use
- Bays in wards should be single-sex (this is controversial as patient surveys indicate that patients don't always see single-sex bays amounting to single sex accommodation)
- Gowns should be designed and made in a way that allows them to be fastened properly to avoid accidental exposure
- Privacy should be provided for private conversations, intimate care and personal activities, such as going to the toilet.

Different indicators will of course apply for people living in their own homes, including care homes. Many people whose dignity has not been respected say that it's "the little things" that make a difference. Of course, the issues above aren't really "little things" if they take away people's dignity. The fact that they may not always be considered important by those in charge, doesn't mean that this is right.

Dignity in care – hospital in-patients

The Dignity and Respect Action Group at Southend University Hospital brings together staff, patients and volunteers to share stories and take forward plans to improve the experience of patients. The group was set up by tutors from the Hospital and Anglia Ruskin University along with staff who received specially designed dignity and respect training. They decided to set aside time, away from their day-to-day clinical duties, to explore and develop their ideas further.

Since forming in 2004, the group's approach has led to a pioneering range of innovations in the hospital. These include: a complete overhaul of the nightwear and gowns used in the hospital, introducing more dignified designs; rain-proof covers for wheelchair users when travelling between hospital buildings; the provision of quiet-closing bins in patient areas to cut down noise levels; and the introduction of 'Privacy Pegs' for securing bed curtains together to make staff more aware that they are entering a patient's personal space.

A website is now being developed to help spread the word and promote the group's ethos of respect and dignity for all.

The NHS Institute for Innovation and Improvement (www.institute.nhs.uk) has produced a number of training and development modules under the general heading of "The Productive X". (eg The Productive Ward, The Productive Community Hospital, The Productive Mental Health Ward, Productive Community Services). These are all designed to improve practice with a strong emphasis on the experience of people using health services, and include many issues relating to dignity. They may be helpful for OSCs in developing a set of measures against which they can make assessments of dignity and respect as part of a scrutiny review.

Listening to personal stories

We all know that the things on the above lists could all be in place and could certainly afford a measure of dignity but without the right personal qualities, such as compassion, that are needed to complete the picture. This is why OSCs need to use a range of styles and settings to obtain a rounded picture. Many OSCs are becoming more adventurous in using a mixture of formal and informal methods, such as focus groups, visits and workshops. Capturing people's direct experiences in their own words and hearing their "stories" is vital in assessing dignity. It is something that OSCs are uniquely suited to – many OSCs have found that the scrutiny process, in giving people an opportunity to tell their own stories, has itself contributed to validating and making them feel better about their experiences, even negative ones. And listening to stories eg by talking to Dignity Champions and LINks members is a way for OSCs both to engage with people's experiences, to get a sense of how the system is working, and to "triangulate" the evidence they receive – that is, to test out evidence from different sources.

Dignity in care - dignity in a word

Warrington Borough Council is the only council to have achieved Beacon Status for Dignity in Care in 2008/09. The Council recognises that, alongside other authorities, it is on a journey to improve service user experience of care, addressing all aspects of dignity and respect. The Council's initiative, "Dignity makes sense" asks people simply to use their five senses to identify and respond to problems.

It has created a DIGNITY acronym to sum up the approach it believes will capture the most important factors:

D eveloping capacity – maximising the contribution of partners across all sectors

I nvolving – supporting people who use services and their carers to be involved in service development

G iving a lead – setting high standards for all health and social care services

N oting detail – attention to detail makes a real difference

I ndividualisation – recognising and treating each person as an individual with real choices about services

T raining – dignity is an ongoing journey and we must continue to learn more

Y our story… – always being alert to people's real experiences of health and social care services

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Listening to people's personal stories is actually also a way of helping them retain dignity, as it shows respect for them as a whole person with a lifetime of experience, reminding both the carer and the person cared for that there is much more to the individual than is visible at the moment of care. Some organisations have developed programmes of work based on the idea of Life Stories, as part of their approach to dignity.

Dignity in care – life story work with older people

The Oldham Life Story Steering Group (including Age Concern, Oldham Council Social Services, Pennine Care, Oldham PCT and the Carers Forum) have developed a joint approach to Life Story work becoming integral to the care planning process for older people and their carers. The award-winning work was developed by a former carer who started by preparing an account of his wife's life for the staff in the residential home she was moving to. Life Story work is used in different settings in Oldham, including in Urdu with older Pakistani women.

Dignity in care – an active role for care home residents

Kim Hirst, Care Manager for Highroyd Residential Home in Huddersfield decided to invite a resident for two years, Alison M, to help interview prospective new staff. With Kim's help, Alison put together questions from the residents' point of view for interviewing new staff members. Alison recently played an active part in interviewing candidates for night care.

Alison commented, "I was very nervous at first but soon got used to it, I read my questions out and listened to the answers. [The successful candidate] stood out and is very nice."

Manager Kim Hirst said, "This home is for our residents and at the end of the day carers are very important and the residents should have a say in who is going to look after them".

Leeds City Council has recently adopted an initiative pioneered by Warrington, focusing on dignity in the commissioning of external services. Leeds developed new performance indicators for external contracts using the ten dignity standards of the Dignity Challenge, including intolerance of abuse, maintaining independence, listening to people's wants and needs, maintaining privacy and alleviating loneliness.

It can be seen from the above examples that different indicators will be more relevant to some settings, services, groups of people and care givers than to others. Most of the well-developed indicators to date relate to the care of older people, but many of these apply more generally. OSCs may either wish to use or adapt a tried and tested set of indicators for a particular review on which to base their questions, or may wish to develop their own indicators, based on their discussions at the scoping stage. What is important is that Members should reach their own understanding in relation to any group whose care they are reviewing of what it means to treat this group of people with dignity and respect, bearing in mind that the answers may be different for different groups of people.

Dignity in care – older people

Leeds won the National Dignity in Care Award 2008 for its work on the Dignity in Care campaign. Its work was started when the Leeds Older People's Forum prioritised "being treated with respect and dignity" as one of their most important issues. A Scrutiny Board inquiry into dignity in care has helped make it a key organisational priority across the system. For example, older people were involved in setting criteria for the allocation of capital grants to care homes and in the selection process. Other changes that have taken place include:

- more small lounges in care homes so that people can talk to visitors in private
- improving garden areas or creating better ones
- small kitchens where residents can prepare their own meals when they want to
- better training for staff
- a range of posters and postcards to raise awareness, including quotations from older people about their expectations of being treated with dignity and respect
- a number of dignity audit tools, including a tool for evaluating dignity and respect in care homes, and another for mental health settings (see section on further information below).

Who should you talk to and what should you ask them?

Members of OSCs and officers supporting them are well aware that the people who provide evidence and information for a particular review can make a big difference to its success. The following is a list of people who might assist OSCs in a review involving dignity issues and the sort of information they could help to provide.

Decision makers/policy makers (including members of governing bodies, non-executive directors and councillors)

Do they understand issues of dignity and respect and what they mean to the people who use their services? How do they keep informed of service users' views? Can they show that they take account of dignity issues in developing policies and making decisions? How do they show leadership and act as dignity champions?

Commissioners

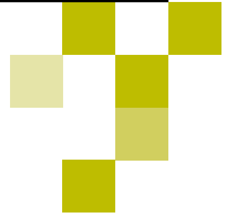
What is their own understanding of dignity and respect? How do they systematically build dignity issues into contracts? What measures of dignity do they use and how do they assess compliance? How do they collect evidence of service users' experiences? How do they ensure that those experiences influence future commissioning?

Service providers (managers)

How do they show leadership on dignity issues? What policies do they have? What measures of dignity do they use? How do they monitor them? How do they collect evidence of service users' experience? What induction and training of staff do they provide? How do they learn from mistakes and complaints?

Service providers (frontline staff)

How do frontline staff themselves understand dignity and respect? Do they know about, understand and systematically implement relevant policies? How do they translate these into their own professional practice and relationships with the people they care for?
Do contact centre or reception staff reflect the culture of the organisation and its approach to dignity?



Service users
What is their understanding of what it means to be treated with dignity and respect? Do they have personal experiences that reflect how care is commissioned in the area, or on organisations and services as a whole? Have they been included in developing policies on dignity and respect? In talking to individual service users and hearing their stories, as with other scrutiny reviews, it will be important to have a strategy for testing out whether one individual's experience reflects the experience of others, or is unique in terms of the quality of care they have received.

Carers (for example, carers of people with dementia who may not be able to speak for themselves, young carers of parents with disabilities)
Carers, both young and old will have their own perspective on the kind of care the person they care for has been receiving. What can they tell you about how the people they care for are treated? Are they themselves treated respectfully by health and social care professionals? Have they felt able and been encouraged to raise issues and/or complaints without fear of retribution for themselves or the person they care for?
It will be important to keep a clear distinction between service users and carers. For example, it hardly needs saying that hearing the views of a service user's parent, child or spouse is not the same thing as hearing the views of the service user herself/himself.

Local Dignity Champions
Can they help you gain an overview of what is happening generally in relation to dignity in an area and how the issue is being promoted and received?

Patients', service users' and carers' organisations (such as LINks and organisations for particular groups, eg older people, black and minority ethnic people, young people)
Do they monitor issues of dignity and respect? What evidence do they have of service users' and carers' experiences? If they have raised dignity issues with commissioners and providers, what response have they had?

Professional organisations, national voluntary sector organisations and researchers
How have they developed their measures and indicators? What advice can they give to the OSC on how it should be testing organisations/services in relation to dignity? Consulting such organisations may be particularly important for reviews not restricted to dignity for older people, as there is much less literature available in relation to other age groups. OSCs may also be able to enlist the help of third sector organisations and/or universities in gathering the views of people using services, eg through focus groups or surveys.

Representatives of partnerships (such as the Health and Well-being Partnership Boards that are part of Local Strategic Partnerships)
The Dignity in Care campaign has shown that strong local leadership and effective partnership working is essential to raising the profile of the issue and ensuring that all local commissioners and providers of health and social care are consistently promoting dignity. Have issues of dignity and respect been discussed by the Health and Well-being Partnership Board or other partnership forums? Are any members of these forums Dignity Champions? Is there a common understanding of dignity (possibly embodied in a code of practice)? Are any performance indicators relating to dignity regularly monitored by partnerships, for example in the Local Area Agreement?

Dignity in care – people with dementia

1. Working in partnership, Cambridgeshire Libraries and "Dementia Positive" have developed a project, Countering Stigma in Dementia Through Creativity. The project employs a poet with extensive experience of working with people with dementia, enabling them to express themselves about their condition and life generally, and to shape their insights in poetic form. Their work will be disseminated through readings, posters and a book. Training will be offered to librarians, care staff and medical practitioners to help them to encourage and value creativity beyond the end of the project. Carers will be involved and encouraged to use library facilities. The results of the project will be shared across the region, with media involvement, to promote the Dignity in Care campaign.

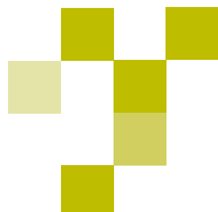
2. Meri Yaadain (meaning My Memories) is a nationally recognised award winning initiative to break down misconceptions about dementia and provide information and support to individuals and carers in the South Asian communities. Its success has led to a long-term initiative to raise awareness of dementia amongst the older South Asian communities in Bradford. See a short video and more information at:
http://www.meriyaadain.co.uk/about_meri_yaadain_project.html

Dignity in care – people with learning disabilities

The Warrington Checking Out Project supports tenants with learning disabilities to check out, comment on and influence the quality of supported living provision. Using the experiences, views and ideas of people receiving support the project promotes their rights as tenants to receive a quality service that recognises individuality and choice, enabling individuals to live the life they want in the way they want.

The project is a joint venture between Warrington Borough Council and Changingtogether, an independent consultancy.

The project has developed an information and resource pack which will be published nationally as a legacy of the Dignity in Care beacon award 2008-09.



5 Scrutiny - making a difference

After carrying out scrutiny work for a number of years now, OSCs are familiar with the importance of laying out **evidence, findings** and clear, focused **recommendations**, making clear to which organisation individual recommendations are addressed. With a concept as complex, shifting and individual as dignity, it is particularly important to be clear about what definitions you have been using, what aspects of dignity you were focusing on, what questions you were seeking to answer, what you found out, from whom, what you are recommending, to whom and why.

OSCs will want to make recommendations on dignity issues to a number of bodies, depending on the aspects they have been considering in a scrutiny review. This could include the Council's Executive, the PCT and/or NHS Trusts, providers of social care, voluntary organisations etc. It is worth remembering also, that OSCs may make recommendations to their fellow councillors. This was done at Lincolnshire County Council when a scrutiny task group looked at the Member role in Adult Social Services. The task group identified dignity as an important issue where Members themselves could add value, for example in their regular visits to care homes. As a result of this, a series of workshops was organised for Members to discuss the issues and the actions they themselves could take in relation to dignity and respect for their residents.

In addition to formal reports and recommendations, OSCs might consider other kinds of outputs to support their findings. Given the importance of personal experience in relation to dignity, a review might produce case studies and "stories" that reflect on individual experiences discovered by the OSC. Of course, if general conclusions are drawn from an individual experience, they will need to be supported by other evidence. Nonetheless, reflecting on one person's experience can lead to discoveries about a whole system or organisation and such reflections can bring a human touch to what might otherwise be a rather dry report. They can also be used to illustrate conclusions about an issue as the culture of an organisation which can be difficult to pin down without examples.

Other potential outputs could include examples of good practice and improvement tools such as the Leeds dignity audit tool which was developed as the result of a scrutiny review.

Because dignity is such a personal issue, and because OSCs are likely to have heard some very personal experiences in the course of a review involving dignity issues, it will be particularly important to give **feedback** to people who have given their time to provide evidence and to plan **follow-up** to assess the impact of the review and its recommendations. As OSC Members will be aware, the knowledge that you will be returning to your recommendations and asking questions about their implementation can be a very effective driver of concerted action.

Scrutiny Reviews Prioritising Dignity Issues

LONDON BOROUGH OF HACKNEY: DIGNITY IN CARE (OLDER PEOPLE SERVICES) (2008)

Outcomes: Dignity Code included in Floating Support service contract for older people; plans to vary existing contract to include Dignity Code,;Code included in all training for staff who provide services; PCT has attached Code as an appendix to its contracts; monthly report to PCT Board of Directors; Code adopted by all NHS trusts.

Download report

HALTON BOROUGH COUNCIL: SAFEGUARDING VULNERABLE ADULTS (2008)

Outcomes: development of a protocol on safeguarding vulnerable adults between Halton Borough Council and local NHS trusts; training for elected Members on safeguarding issues; setting up of a Dignity in Care Board to monitor dignity issues.

Download report

LEEDS CITY COUNCIL: DIGNITY IN CARE FOR OLDER PEOPLE (2007)

Outcomes: a joint action plan between the Council and the PCT to meet the OSC's recommendations – included publicity materials; improved food and help with eating in hospitals; dignity performance measures in contracts; new safeguarding procedures and dignity workstreams in NHS trusts; a dignity audit tool developed.

Copy of responses to recommendations

LINCOLNSHIRE COUNTY COUNCIL: MEMBER ROLE IN ADULT SOCIAL CARE (2009)

Outcomes: dignity identified as important area for Members to add value, series of workshops arranged for Members on Dignity and Choice, Council signed up to Dignity in Care Campaign, monthly newsletter for Members on social care.

Download report

MIDDLESBROUGH COUNCIL: DIGNITY IN CARE FOR OLDER PEOPLE (2008)

Outcomes: Inclusion of questions on dignity and respect in annual surveys of people receiving home care and residential care.

Copy of the report

NORTH EAST LINCOLNSHIRE DIGNITY IN CARE SELECT COMMITTEE (2008)

Outcomes: meetings between OSC Chair and Chair of NE Lincs Care Trust Plus; OSC recommendations incorporated into wider action plan by care trust.

Copy of the report

6 Further information

General publications referenced in this guide

Audit Commission (2004), ***Older people - independence and well-being: the challenge for public services***. London, Audit Commission.

CSIP, Care Services Improvement Partnership (2005), ***Everybody's Business: integrated mental health services for older adults - a service development guide.*** Department of Health.

DH (2004a), ***Seeking consent: working with older people.*** London, Department of Health.

DH (2005a). ***Independence, well-being and choice: Our vision for the future of social care for adults in England.*** London, Department of Health.

DH (2006f). ***Our health, our care, our say: a new direction for community services.*** London, The Stationery Office, HM Government.

DH (2003c). ***Essence of Care: patient-focused benchmarks for clinical governance.*** NHS Modernisation Agency.

Help the Aged & Royal College Of Nursing (2000). ***Dignity on the ward: improving the experience of acute hospital care for older people with dementia or confusion - a pocket guide for hospital staff.*** London, Help the Aged

Horton, R. (2004) ***'Rediscovering human dignity'***. The Lancet, 364, 1081-1085.

Housing Learning & Improvement Network, Care Services Improvement Partnership (2006) ***Dignity in housing.***

SEU/ODPM (2006). ***A sure start to later life: ending inequalities for older people: final report***, London, Social Exclusion Unit/Office of the Deputy Prime Minister.

Wanless, D. (2006). ***Securing good care for older people. Taking a long-term view.*** London, King's Fund.

Useful websites

Dignity indicators

Dignity Indicator – NHS Inpatient Survey results for 2007/8 and 2008/9 by Trust – contains data on the percent of patients in each NHS Trust who felt they were treated with dignity and respect while in hospital.

Dignity Map for Older People – Department of Health document and web resource which looks at indicators for different aspects of dignity. Designed to relate to older people, but also useful more generally.

Magee, H., Parsons, S., and Askham, J., *Measuring Dignity in Care for Older People*, Picker Institute for Help the Aged, 2008.

Leeds Dignity Challenge Audit Tool - Mental Health Settings.

Leeds Older People's Strategic Partnership and Age Concern Leeds, **Privacy and Dignity Care Home Evaluation Tool**

Central and Eastern Cheshire PCT and Age Concern Cheshire, **Dignity Assessment Tool**

Healthcare Commission report, **Caring for Dignity: a national report on dignity in care for older people while in hospital**, contains a number of recommendations which could be used as benchmarks against which to evaluate NHS Trusts.

Woolhead G, Calnan M, Dieppe P, Tadd W (2004), *Dignity in older age: what do older people in the United Kingdom think? Age and Ageing. 2004 Mar;* 33(2): p165-70

Further reading

Much more information about the Dignity in Care Campaign, the Dignity Challenge and Dignity Champions can be found on the Department of Health Website at:
www.dignityincare.org.uk
The Dignity Champions database can be found from the Dignity in Care websites or by going to: http://www.dhcarenetworks.org.uk/dignityincare/BecomingADignityChampion

The Royal College of Nursing dignity campaign is described on the RCN's website which has a number of downloadable documents on dignity issues, examples of good practice, practical toolkits etc: http://www.rcn.org.uk/newsevents/campaigns/dignity

A Dignified Revolution is a group of individuals, the majority of whom are nurses, who want to improve the care of older people in hospital. They have their own website with guides, case studies and other useful information: http://dignifiedrevolution.org.uk

The Social Care Institute for Excellence has an extensive web-based resource on dignity in care at: http://www.scie.org.uk/publications/guides/guide15/index.asp

Warrington Borough Council, as Beacon Council for Dignity in Care 2008-09, has set up a website to act as a portal of good practice documents, links to useful articles, events and websites: http://www.warrington.gov.uk/beacon/

Bradford Dementia Group have produced a powerful and thought provoking DVD about caring respectfully for people with dementia. More information at:
http://www.exmemoriafilm.co.uk/

Barnsley Primary Care Trust and Barnsley Metropolitan Borough Council have produced *Focus on Dignity in Health and Social Care*, a self-directed learning tool for those working with people with learning disabilities. This was written by Joanne Brown and Katrina Latham and is obtainable from Barnsley Integrated Learning Disability Service (BILDS).

There are many sources of information on how "life story" work is used with a number of groups of people using health and social care services , such as children people with learning disabilities, older people on medical wards and with older people who have dementia. It can help challenge ageist attitudes and assumptions, provide an approach to people as individuals, assist in transitions between different care environments, and help to develop improved relationships between care staff and family carers.The website of the Social Care Institute for Excellence has a description of life story work with older people at: http://www.scie.org.uk/publications/elearning/mentalhealth/mh10/resource/html/object10/object10_4.htm
The Life Story Network is a community of interest developed to create further discussion and sharing of positive practice in the use of life stories:
http://www.lifestorynetwork.org.uk/

The Equality and Human Rights Commission has produced a report, *From safety net to springboard*, on a new approach to care and support based on equality and human rights: http://www.equalityhumanrights.com/uploaded_files/safetynet_springboard.pdf

The Institute of Public Care has developed a "roadmap" on good practice in outcomes-based commissioning for ADASS North West, NHS North West, North West Joint Improvement Partnership and the North West Regional Director of Public Health: http://www.northwestroadmap.org.uk

The NHS Institute for Innovation and Improvement has produced a number of modules in the Productive Series which supports NHS teams to redesign and streamline the way they manage and work – intended to release more staff time for patients: http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_series.html

High quality services for carers rely on high quality commissioning. With this in mind, the Department of Health has funded a consortium to produce a guide for commissioners that is available on the IDEA website:
www.idea.gov.uk/idk/core/page.do?pageId=13255730

The Centre for Public Scrutiny has an extensive, searchable on-line library of scrutiny reviews: http://www.cfps.org.uk/scrutiny-exchange/library/

Abuse

"No secrets" is the Department of Health guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse: http://www.elderabuse.org.uk/Useful%20downloads/No%20Secrets%20etc/No%20Secrets.pdf

The Social Care Institute for Excellence practice guidance on making referrals to the Protection of Vulnerable Adults (POVA) gives information on the "warning signs" of abuse: http://www.scie.org.uk/publications/guides/guide12/deciding/deciding4.asp

Action on Elder Abuse provides guidance on how to report suspected abuse and runs a confidential helpline: www.elderabuse.org.uk (0808 808 8141).

Appendix 1
Legislation and policy background

Legislation

The **Human Rights Act** came into force on 2 October 2000. It gives individuals a number of rights, including rights which impact directly on health and social care, such as the right to life, the right not to be subjected to inhuman or degrading treatment, and the right to family life. The Human Rights Act means all public authorities must ensure that everything they do is compatible with the European Convention on Human Rights (based on the Universal Declaration).

From 1st December 2008, the protection of the Human Rights Act was extended to people living in publicly funded accommodation with nursing or personal care. Under section 145 of the Health and Social Care Act 2008 providers of accommodation with care will be treated as exercising a function of a public nature. This means that people using these publicly funded care services will now be protected by the Human Rights Act.

Anti-discrimination legislation (sometimes known as equalities legislation) is designed to eliminate unjustifiable discrimination on legally specific grounds, including disability, race, religion, sexuality and gender legislation. The Department of Health is currently conducting a consultation on eliminating unjustifiable age discrimination. The equalities legislation is constantly evolving, as society recognises new areas of inequality, and over the last 30 years a number of laws have been passed in response to changing public perceptions and the development of human rights law.

Anti-discriminatory practice is fundamental to the ethical basis of care provision, and equalities legislation is critical to the protection of service users' dignity. It imposes particular responsibilities on public bodies and service providers to avoid stereotyping and to respect service users' diverse needs and cultural diversity. Providers of health and social care also have equivalent responsibilities to their employees.

The legislation is designed to promote the dignity of citizens by ensuring that they are treated with respect.

The **Mental Capacity Act 2005** (MCA) which came into force on 1 October 2007, provides a statutory framework to protect and empower adults who may lack capacity (ability) to make all or some decisions about their lives. The principles set out in the Act promote the human rights and dignity of people who may lack capacity, because they enshrine respect for individual autonomy and make it clear that we should always presume that a person has the capacity to make decisions unless it is established otherwise.

The **Mental Health Act 2007** which amends the 1983 Mental Health Act introduced the 'Deprivation of Liberty' or 'Bournewood' safeguards. These protect against illegitimate deprivation of liberty for people who do not have the capacity to consent to arrangements made for their care that would deprive them of liberty. The Mental Health Act also enhances the human rights and dignity of people who have a mental disorder, including requirements to respect patients' past and present wishes and feelings.

The **Safeguarding Vulnerable Groups Act 2006** sets out a new scheme which aims to help avoid harm, or risk of harm, to children and vulnerable adults by preventing people who are deemed unsuitable to work with children and vulnerable adults from gaining access to them through their work. The potential for enhancing the dignity of people using services is that the Act allows for more effective checking of staff, including workers in healthcare settings who are not covered under the Protection of Vulnerable Adults (POVA) List. People receiving direct payments or individual budgets are also able to access the scheme to make checks.

Information held by public bodies is governed by the requirements of the **Data Protection Act 1998** (DPA) which requires data controllers who process personal information to comply with a range of data protection principles. In essence, this Act supports the importance of sharing information with people using services. There are very few exceptions to this. Enhancing the dignity of people using services demands that practitioners pay attention to confidentiality. There are some limits on confidentiality and these apply where there is a risk of harm to other people.

The **Freedom of Information Act 2000** (FoIA) provides statutory rights for members of the public requesting information. The FoIA imposes a duty on public bodies to adopt schemes for the publication of information which must be approved by the Information Commissioner.

In general, information legislation protects the human rights, privacy and dignity of service users by protecting confidentiality and enabling service users in certain circumstances to have access to the information that is held about them.

National and international policy

The Department of Health's Green Paper, 'Independence, well-being and choice' (2005a) and subsequent White Paper, 'Our health, our care, our say' (2006f), are set around seven key outcomes identified by people who use services, one of which is personal dignity and respect. The Commission for Social Care Inspection (CSCI) incorporated these into its assessment framework, 'A new outcomes framework for performance assessment of adult social care' (2006) and the issue of dignity is now being taken up by the CSCI's successor body, the Care Quality Commission in relation to both health and social care. The Department of Health's National Service Framework for Older People (2001) also supports a 'culture change so that all older people and their carers are always treated with respect, dignity and fairness', and its 'Essence of Care: Patient-focused benchmarking for health care practitioners' (2003c) offers a series of benchmarks for practice on privacy and dignity. Lord Darzi's review of the NHS, **'High Quality Care for All'** puts quality at the heart of all that the NHS does; and the new **NHS Constitution** gives people the right to be treated with dignity and respect. Improving the experience of individuals is a key aspect of quality. And whether people are treated with dignity and respect has a huge impact on their experience of using services and is therefore an important contributor to quality.

Putting People First, sets out a vision for transforming social care, enabling a social care system that 'provides care equally for all, whilst enabling people to retain their independence, control and dignity'.

Similar themes appear in documents by a range of agencies. They deal with all services for older people (Audit Commission, 2004) housing and housing-related support (the Housing Learning and Improvement Network, 2006) mental health services (CSIP, 2005), consent to treatment: standards in care homes (DH, 2004a), social exclusion (Social Exclusion Unit / ODPM, 2006) and so on. Voluntary organisations have based campaigns around the idea of dignity in care (Help The Aged and Royal College of Nursing, 2000), and the Wanless Social Care Review (Wanless, 2006) uses the idea of dignity as one factor explaining the relative fairness of different funding systems. Codes of conduct for health and social care practitioners aim to preserve dignity.

In the international field, the **World Health Organisation** has called for healthcare systems which promote dignity: "The standard equation of ideas used by international agencies is well known: Respect for Persons = Autonomy + Confidentiality + Dignity" (Horton, 2004).

The Centre for Public Scrutiny

The Centre for Public Scrutiny promotes the value of scrutiny in modern and effective government, not only to hold executives to account but also to create a constructive dialogue between the public and its elected representatives to improve the quality of public services. The Centre received funding from the Department of Health to run a three-year support programme for health, care and wellbeing overview and scrutiny committees of social services authorities as they develop their power to promote the well-being of local communities through effective scrutiny of health and care planning and delivery and wider public health issues.

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AGENDA ITEM NO. 6

Health Scrutiny Committee – 1 June 2010

RESUME OF THE HEALTH AND WELLBEING PARTNERSHIP 22 MARCH 2010

Report of the Assistant Chief Executive (Strategy & Democracy)

1. MATTER FOR CONSIDERATION

To consider the proceedings of the last meeting of the Health and Wellbeing Partnership Board on 22 March 2010.

2. INFORMATION

2.1 The Partnership considered the following items:-

Healthy Weight Strategy
Sarah Newsam (Head of Health Improvement), Stockport Council - 07891 949204

The Partnership received a presentation on the implementation of the Healthy Weight Strategy, highlighting key facts and drivers for change.

The presentation focussed on:-

The Context

- Broadly 2/3 adults and 1/3 children overweight or obese
- Pattern increases with deprivation
- In Stockport childhood obesity highest in 2nd most deprived quintile
- Modern-day problem linked to modern-day lives, but not all due to over-eating
- Major public health challenge - obesity reduces life-expectancy by about 9 years

The vision of the Strategy
- to understand healthy weight including the risk factors and motivations
- have evidence of what works to reduce the number of people with unhealthy weight
- see a reducing trend in childhood obesity.

The immediate priorities
- Deliver the action plan in the next 3 years
- Focus on the early years – primary prevention
- Sustainable funding and commissioning
- Scaling-up services that work
- Focus on equalities – especially vulnerable groups
- Promote overweight as a social / lifestyle issue and invest in social marketing

Challenges

- Working in a 'whole system' way
- Lining up local structures & groups to deliver the strategy
- Develop local knowledge about what works
- Health Trainers, PARiS, Keep it Off for Good, A2A, MEND, risk-factor screening etc
- Need to be able to demonstrate interim progress

Members made a number of comments, including:-

- The implementation of this Strategy demonstrated the need for greater integration of activity across partners, particularly in respect of lifestyles, as there was clearly significant interventions taking place which may benefit from greater co-ordination.
- It was important not to neglect other 'fronts' to tackle this problem and not focus exclusively on children.
- There was a need for greater use of social marketing to assist with this agenda.
- Children and young people were a 'captive audience' while at school and were generally very receptive to messages about healthy weight which can translate into improvements in the habits of the wider family.
- While Stockport was performing comparatively well with obesity rates there was a marked increase in rates between Reception and Year 6.
- There were often competing demands at schools which meant less priority for physical activities. A greater emphasis was needed on simple activities, such as walking.
- It was vital to ensure that all the projects in the Strategy were being evaluated to ensure they were effective.
- It was important to recognise and support the role for the Foundation Trust in signposting patients to services to assist with healthy weight and other lifestyle issues.
- As employers partners can contribute to healthy lifestyles, and the hospital has been a pioneer in this respect.

The Partnership agreed that:-

- a summary of the evaluations from the activities within the Healthy Weight Strategy be submitted to a future meeting once the evaluations have taken place.
- a further report be submitted to a future Partnership meeting on proposed interventions for children between Reception and Year 6 age to address the increased rate of obesity during this phase of education.
- a further report be submitted to a future Partnership meeting on support to enable people receiving either primary or secondary care to make healthy lifestyle choices.
- clarification be provided on provision for public health/ lifestyle issues within the new contract between NHS Stockport and the Stepping Hill Foundation Trust.

Health and Wellbeing Partnership Quarterly Performance Management Report

Susie Wright, (Policy Manager - Health & Well Being), Stockport Council - 07527 387251

The Partnership considered the Health and Wellbeing Partnership Framework third quarter performance monitoring report for 2009/10.

The Partnership discussed the issues surrounding early diagnosis and the impact on mortality rates for cancer/ heart disease. It was stressed that the recent figures were likely to have been a temporary anomaly in the long–term downward trend with reducing mortality rates. Concern was expressed about performance in relation to alcohol–related admissions to hospital, and alcohol services.

The Partnership agreed that 'alcohol' be considered at a future meeting.

Smoking In Pregnancy
Debbie Garrod, (Consultant Midwife), Stockport Foundation Trust – 0161 419 5531

The Partnership received a presentation on the work of Midwifery Service, with particular focus on the work of the service to address smoking in pregnancy.

The presentation focussed on the following issues:-

- The national and local context was one of decreasing prevalence of smoking both in the general population and during pregnancy.
- There was evidence that there was a lack of understanding about the impact of smoking on pregnancy, particularly in those groups where prevalence is highest.
- There was a decline in the number of parents wanting to stop smoking, particularly amongst women.
- In Stockport 27% of pregnant women were smokers before booking to see a midwife, which reduced to 17% at delivery, although this was above the target.
- The prevalence of smoking was higher amongst disadvantaged groups, with women from most deprived areas being five times more likely to smoke during pregnancy and less likely to quit (19% against 50% in most affluent). There was evidence that these women often had other more pressing concerns in their lives than quitting smoking.
- Younger mothers were also more likely to smoke, and those who smoked were less likely to breast feed.
- The Stop Smoking in Pregnancy Service had recently been reconfigured. The service provided training to practitioners on smoking cessation to standardise the provision available; provided links with other public health midwives; provided direct support to mothers with direct referrals to the clinic which has improved response times.
- Other help was available through Smoke free Northwest Incentive Scheme which would encourage long term cessation by incentivising non-smoking, through use of carbon monoxide monitoring.
- Recent NICE Guidelines encouraged carbon monoxide monitoring to ensure continued cessation.
- Recommendations for future activity for the service were:
    - Target communities/ social marketing
    - Information campaign
    - Continue joint working
    - Service for in-patients

- o Targeted support for pregnancy loss - need to be clearer to mothers who suffer loss about the impact of smoking.

Members made a number of comments, including:-

- Although NICE Guidelines suggested referrals for every smoker in pregnancy they was likely to be more success in achieving long term success by working through the midwife/ patient relationship.
- It was important to target first time mothers to prevent smoking in subsequent pregnancies and to make clear the long term health implications on the child's health.
- There was significant progress being made in this area, but persistent problems in priority areas. There was a cultural change that needed to be addressed, through social marketing, including making clearer the benefits for mothers in stopping smoking. This was a responsibility that extended beyond the midwife service.

The Partnership noted the presentation.

LINk Welcome And Progress Report
Marie Kildunne, PEEBLE Enterprises, 0161 480 1211

The Board considered the third quarter performance report for the Stockport LINk.

The Partnership welcomed the increasing engagement between LINk and other partners.

JSNA
Emma Dowsing, Policy and Intelligence Manager), Stockport Council - 07800 618822

The Partnership was updated on the JSNA Refresh project. It was reported that work had now started on the project to ensure data was available for commissioning going forward. The Health and Wellbeing Integrated Commissioning Board would have an executive role in the project, with this Partnership taking the lead on the policy implications of the findings.

The update would focus on detailed and 'richer' analysis of the priority outcomes, as opposed to the focus on prevalence in the last assessment. There would be a series of workshops over the next months to help refine these priorities, which were likely to include alcohol, weight management and smoking.

Performance Reward Grant
Vince Fraga, (Head of Modernisation), Stockport Council - 07800 618822

The Partnership considered reports on two projects that had received support through the Stockport Partnership's Performance Reward Grant (PRG):-

(i) Lifestyle Service

A project to pilot personalised, face-to-face support with health and/or healthier lifestyles in Brinnington. The project had received a grant of £110k from the PRG. The report also provided an update on the integration of lifestyle services.

Members welcomed the proposals to integrated further lifestyle services to provide a more holistic service, and stressed the need for evaluation of the effectiveness of activity.

A further report was requested on the reconfiguration of Lifestyle, including a timetable for this work.

(ii) Micro Social Care Enterprises

A project to develop a support service to encourage the development of micro social care enterprises that would provide services as par of the Personalisation agenda through users micro-commissioning services to meet their needs. The project had received a grant of £139k over three years from the PRG.

It was commented that this project complemented the business start-up projects of other partnerships within the Stockport Partnership family and would be a driver for innovation in service provision.

A further report on progress with developing Micro Social Care enterprises was requested.

Marmott Review
Sarah Newsam (Head of Health Improvement), Stockport Council - 07891 949204

The Partnership received a presentation on the recent 'Fair Society; Healthy Lives' report, referred to as the Marmott Review, and the likely impact its findings would have on the activity of the Stockport Partnership.

The Marmott Review challenged the current thinking on improving health inequalities by placing the emphasis on improving 'wellbeing' in a broader sense.

Marmott stressed the following messages:
- Health inequalities were not inevitable
- Local partnership & co-ordination was essential to reducing them
- Action needs to be taken across the life course
- The need for active involvement and engagement of local people
- *'Proportionate universalism'*
- Prioritise wellbeing

The challenge for Stockport was to:
- Recognise that Marmot reflects a strategic shift towards wellbeing
- Tackle multiple 'risks' simultaneously
- Focus on population-level changes – long term, sustained programmes not small scale initiatives
- Stockport Partnership family should consider reviewing / rebalancing strategic objectives and outcomes in light of the report.

Cllr Pantall in the chair

Members commented on the impetus the Marmott Review may have on furthering the integration agenda with respect to health services.

The Partnership supported the proposal that the implications of the Marmott Review be considered by the Stockport Partnership and appropriate thematic partnerships.

Engaging Communities Strategy and HWBP Response
Vince Fraga, (Head of Modernisation), Stockport Council - 07800 618822

The Partnership considered a report setting out a preliminary response from the Health and Wellbeing Partnership to the challenge set down by the Engaging Communities Strategy that had recently been adopted by the Stockport Partnership.

The Partnership endorsed the proposal within the report to establish a group to further the aims of the Engaging Communities Strategy for in respect, to include representatives from children's services, with that a further report be submitted to the next meeting on the priorities for this Partnership.

RECOMMENDATION

That the Scrutiny Committee note the report.

BACKGROUND PAPERS

Reports and Minutes of the Health and Wellbeing Partnership – 22 March 2010

Copies of past minutes and reports are available on the Partnership's website at:-
http://s1.stockport.gov.uk/hwbp/meetings.html

Anyone wishing to inspect the above background papers or requiring further information should contact Jonathan Vali on telephone number 0161 474 3201 or alternatively e-mail jonathan.vali@stockport.gov.uk

AGENDA ITEM NO 7.

COMMITTEE: HEALTH SCRUTINY COMMITTEE

DATE: 1st June 2010

REPORT OF: ASSISTANT CHIEF EXECUTIVE (STRATEGY AND DEMOCRACY)

REPORT TITLE: AGENDA PLANNING

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1) PLANNED AGENDA ITEMS FOR THE NEXT 2 MEETINGS
(Committee Members are asked to note that agenda items are indicative at this stage and may be subject to change)

13th July 2010

Item	Type/Purpose
Health and Wellbeing Partnership Board performance update	Performance monitoring
Take up rates for breast screening services	Monitoring / questions / comments
Joint Scrutiny	Update report
Agenda Planning	Update report

21st September 2010

Item	Type/Purpose
Healthy Weight Strategy update report	Update report / monitoring / comments
Teenage pregnancy follow-up report	Update report / monitoring / comments
Joint Scrutiny	Update report
Agenda Planning	Update report

2) RELEVANT ENTRIES IN JUNE 2010 FORWARD PLAN

There are no relevant entries to report for the Health Scrutiny Committee in the June 2010 Forward Plan.

Management & Leadership by Care Commissioners and Providers

We will:

- Be open and transparent about all aspects of service delivery
- Take account of service quality and reward excellence
- Be clear about expectations, timescales and outcomes
- Be responsible for ensuring services are properly staffed and funded and staff are properly trained, supervised and supported
- Have procedures and policies in place to support dignity in care, respect individual needs, and challenge discrimination and inequality
- Regularly ask for feedback to enable us to continue to improve services
- Continue to work in partnership with all relevant organisations and be supportive towards each other.

A free interpreting service is available if you need help with this information.

Stockport Interpreting Unit

0161 477 9000

Email: eds.admin@stockport.gov.uk

Fax: 0161 480 1848

如果你需要他人爲你解釋這小冊子/單張的內容，我們可以提供免費的傳譯服務，請致電 0161 477 9000 史托波特傳譯部。

W przypadku gdybyś potrzebował pomocy odnośnie tej broszurki/ulotki, dostępne są usługi tłumaczeniowe. Prosimy dzwonić do Interpreting Unit pod numer 0161 477 9000.

যদি এই পুস্তিকা/ প্রচার পত্রটি সম্পর্কে আপনার কোন সাহায্য দরকার হয় তবে বিনা খরচে আপনার জন্য দোভাষীর ব্যবস্থা করা হতে পারে। মেহেরবানী করে স্টকপোর্ট ইন্টারপ্রিটিং ইউনিটে ফোন করুন টেলিফোন নম্বর, 0161 477 9000.

اگر آپ کو اِس کتابچے/لیفلٹ کے بارے میں مدد کی ضرورت ہے تو مفت ترجمانی کی سروس دستیاب ہے۔ براہِ مہربانی انٹرپریٹنگ یونٹ کو 0161 477 9000 پر فون کریں۔

شما میتوانید از خدمات ترجمه رایگان استفاده کنید و در صورت احتیاج به ترجمه ی این نشریه به طور حظوری با شماره تلفن 0161 4779000 اداره ترجه تماس بگیرید

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ADULT SOCIAL CARE

Dignity in Care

Draft agreement for discussion & consultation

Dignity in Care Event Thursday 28 January 2010

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

Stockport Council, NHS Stockport, voluntary organisations and the independent care sector have been working in partnership over a number of years to deliver high quality care services for the people of Stockport.

Together we want to provide the best quality services.

This agreement sets out the minimum levels of service that people in need of care can expect to receive in the care setting and those providing care should be supported to deliver.

Dignity, Respect, Privacy & Rights

We will:

- Treat each individual involved receiving or providing care with the same respect and dignity we would want for ourselves or a member of our family
- Be ethical, honest, courteous and professional and we will respect confidentiality
- Not tolerate any forms of abuse
- Treat everyone fairly
- Ensure that processes are in place so that people can tell us what they think about the quality of services without fear of repercussions.

Health & Wellbeing

We will:

- Encourage everyone to have information and support to access services that promote healthy living and general wellbeing to achieve their personal aims
- Aim to support, maintain and where possible, improve good mental health and wellbeing
- Help people to identify and understand their personal healthy lifestyle options and opportunities
- Support people's rights to access a full range of health and personal care services to maintain and improve good health and wellbeing
- Assist people to maintain confidence.
- Help people to feel good about themselves
- Promote a positive environment
- Enable people to engage in activities which give them enjoyment and fun
- Support, encourage and stimulate a culture of care for each other.

Personalised Care

We will:

- Enable people to maintain their independence, choice and control as far as possible
- Recognise people as individuals with different needs and provide personalised care
- Respect people's wishes including taking into account and supporting active involvement of people who are important to them.
- Ensure that services meet the needs of individuals
- Respect people's choices in end of life care including helping people to understand what options are available to them.

Monitoring and celebrating good practice

We will:

- Regularly ask people through the established Local Involvement Network and customer surveys how we are performing
- Use a variety of media and events to share and celebrate best practice
- Ensure that people have access to good quality information which enables them to make choices.

AGENDA ITEM 4(ii)

AGENDA ITEM 4 – SUPPLEMENTARY REPORT

COMMITTEE: **HEALTH SCRUTINY COMMITTEE**

DATE: **1 JUNE 2010**

REPORT OF: **SERVICE DIRECTOR, ADULT SOCIAL CARE**

REPORT TITLE: **DIGNITY IN CARE**

1. Introduction

1.1 One of the times at which people are most in danger of losing their dignity and their self-respect is when they need help with health and social care. By their nature, health and social care services are provided when people are most vulnerable – when they are feeling at their weakest, when they are afraid and when they have to expose the most intimate and personal parts of themselves (their bodies and their minds) to inspection and handling by others.

1.2 Dignity in Care is far higher up the policy agenda for care services than ever before. Services are now operating against a policy backdrop that places quality, patient experience, dignity and respect at the heart of care. Dignity features in key performance frameworks including the NHS Operating Framework and is a consistent theme in key strategies such as: Living Well with Dementia – a National Dementia Strategy (February 2009), and Carers Strategy – Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own (June 2008). Key organisations representing service users and care providers are taking action to promote dignity in care. For instance, the Care Quality Commission has included dignity and respect as one of its six key area of inspection.

1.3 Launched by the Department of Health (DH) in November 2006, the 'Dignity in Care Campaign' (www.dignityincare.org.uk) aims to end tolerance of care services that do not respect people's dignity by:

- Raising awareness and stimulating a national debate around Dignity in Care;
- Inspiring and equipping local people to take action;
- Rewarding and recognising those who make a difference

1.4 The Campaign was originally launched specifically to promote dignity for older people but its focus is gradually being extended to all those receiving health and social care services. As part of the Dignity in Care Campaign, the Dignity Challenge was issued. Based on consultations with service users, carers and professionals, it lays out the national expectations of what constitutes a service that respects dignity. It focuses on ten different aspects of dignity – the things that matter most to people. (See Below)

The Dignity Challenge

***High quality care services that respect people's dignity should*:**

1. **Have a zero tolerance of all forms of abuse.**
2. **Support people with the same respect you would want for yourself or a member of your family.**
3. **Treat each person as an individual by offering a personalised service.**
4. **Enable people to maintain the maximum possible level of independence, choice and control.**
5. **Listen and support people to express their needs and wants.**
6. **Respect people's right to privacy.**
7. **Ensure people feel able to complain without fear of retribution.**
8. **Engage with family members and carers as care partners.**
9. **Assist people to maintain confidence and a positive self-esteem.**
10. **Act to alleviate people's loneliness and isolation.**

1.5 In response to the DOH campaign on implementing Dignity in Care Champions Stockport Adult Social Care services took the initiative to develop an approach that would bring the principles of this work to life in the borough.

1.6 A group was constituted comprised of representatives of statutory, voluntary and private sectors that are part of the wider care economy across the borough. The group has been working over the last year to drive this work forward and to ensure that within the borough we are able to promote the campaign for 'Dignity in Care' and to develop a partnership approach that promotes and embraces good quality care services.

2. Approach

2.1 Following the development of a quality steering group and agreement for terms of reference, work was undertaken to do an audit to develop a common understanding of potential information sources about

- Good practice
- Concerns about poor practice
- Skills and knowledge gaps in the market

This exercise was seen as a way to develop a baseline picture of potential information sources and has lead to the development of a draft quality assurance framework and an extension to the information on provider quality already collated by the Council' Contract and Market management service..

2.2 Subsequently the group worked to draft an agreement of principles and conditions to provide dignity and quality services to people in receiving services from independent and statutory providers in Stockport. This has come to be known as our Dignity in Care Partnership Agreement.

2.3 The group has been investigating development of an accreditation process based on a voluntary code of practice for all providers to sign up to. The Council already has an accreditation process for home care and care home providers within Stockport who accept the Council's framework agreement contracts. Further development of this may take the shape of a 'Kite Mark' that will be applied to provider organisations following the principles of the partnership agreement. There is the potential to have link to "Kite Marked" providers on the Council's "My Care, My Choice" web site

2.4 The group has been clear that this work needs to be based on collaboration and sharing good practice across the sector. In particular serious discussion has taken place on providing capacity to ensure that there is access to good training and leadership development for care providers. There is very much a feeling that the work needs to build on existing incentives and market levers aimed at securing the best quality services for the people of Stockport

5. Stockport Dignity in Care Event

5.1 To support this work, Stockport Council in partnership with other locally based health, voluntary and independent sectors organised an event to celebrate what is already being done across the borough and share best practice on how to further improve quality for all. Furthermore, we used this as an opportunity to consult on a draft of our Dignity Partnership Agreement. This agreement articulates the principles and conditions to provide dignity and quality services to people in receiving services from independent and statutory providers in Stockport. See Appendix 1.

5.2 The event took place on 28 January 2010and was opened by Gordon Burns from BBC Northwest Tonight, with speakers Cllr John Pantall; Executive Member Adults & Health and Maggie Kufeldt; Older People's Joint Commissioning Manager from NHS Stockport.

The purpose of the event was:

- To encourage local people to take part in discussions and consultation on how best to deliver health and social care in Stockport;

- To give local organisations the opportunity to network and share ideas to promote and embed dignity and respect for all.

5.3 Over 300 people came along to the Dignity in Care event and many took part in the public consultation. We asked people to comment about their concerns, issues and personal experiences of dignity in care in Stockport. We received over 125

www.stockport.gov.uk/dignityincare):

- Good care can only happen alongside friendship/companionship
- I want to go to bed when I want to – not when someone can fit it in
- Personalised care is improving
- The point about it being down to leadership and training was well made
- Failed operation – dented confidence
- Current systems still very much one size fits all
- In principal it looks good
- Want people to talk to me, not at me
- Carers/patients are still afraid to complain.

6. Match funding

6.1 At the aforementioned event Councillor Pantall announced that Stockport Council Adult Social Care has set aside £50,000 to help make a real difference to the way in which social care services deliver support to people in Stockport. Applications were welcomed from independent, voluntary and private but not from statutory organisations, delivering social care services in Stockport.

6.2 Any successful bid to the Dignity in Care fund will need to have matched funding from the successful organisations. So for example if the bid is for £5,000 of funding the Council will contribute £2,500. It is expected that successful projects will start within 2 months of the funding being agreed

6.3 All successful bids will need to evidence the cost of the bid with appropriate quotations and, on completion, receipts. Appropriate documentation will be kept for audit purposes and future evaluation. In addition the successful organisations will need to provide evidence of the outcomes achieved and be willing to share their experience with others.

6.4 The deadline for submission of application has now passed with over 15 received. A panel is being constituted that will include representation from the Local Involvement Network, Adults & Health portfolio holder as well as individuals from both the Council and PCT who will approve the successful bids.

7. The Walk a Mile in My Shoes Guide

7.1 The Centre for Public Scrutiny has published ‘Walk a mile in my shoes: Scrutiny of dignity and respect for individuals in health and social care services’. (Appendix 2) The guide (funded by the Department of Health and the Improvement and Development Agency) is intended to help local authority overview and scrutiny committees understand what dignity is, why it matters and review whether dignity and respect are embedded in local services.

7.2 The guide is aimed primarily at chairs and members of overview and scrutiny committees and those supporting overview and scrutiny. It will also be of interest to council cabinet members and Directors of Adult and Children’s Services, NHS Trusts and care home providers, Local Involvement Networks and dignity

champions.

7.3 The key points covered in the guidance include:

- Why dignity and respect are priorities for patients and service users and why lack of dignity and respect can lead to complaints about services.
- Citizens have a right to high quality services and to be treated as individuals. This being a key outcome of CAA.
- Dignity and respect need to be embedded in the planning and delivery of health and social care services.
- How overview and scrutiny committees can assure themselves that people's experiences of health and care services reflect published policies about dignity and respect.
- Support for health and social care practitioners who champion dignity in care

8. Conclusion

8.1 There is a general positive feeling around this work and the commitment from all partners involved has been consistent and useful. The group is conscious that much work is needed to turn rhetoric into action and provide evidence of demonstrable outcomes of improved practice, but is confident that the current direction of the work will lead to better quality services for people.

8.2 It is clear that the responsibilities of promoting dignity and ensuring that those receiving care are afforded the highest quality services irrespective of their individual circumstances goes beyond one organisation or body. It can also, be argues that the responsibility for ensuring services maintain one's dignity can go beyond the traditional health and social care economies and include such as areas as transport services. To this end working in partnership in particular with Service Users, Carers and Members is crucial to embed dignity in the planning of services.

9. Recommendations

9.1 Members are asked to consider the following recommendations:

- The report is noted with consideration of the content presented herewith.
- Consider the 'Walk a Mile in My Shoes' guide for potential activities in relation to dignity in care for the relevant Scrutiny Committees.
- Receive an update on local activities in relation to dignity in care at future Scrutiny Committees meeting.

Health Scrutiny Committee

Annual Public Health Report 19: Draft summary of the evidence base for preventive initiatives

1. There is good evidence that effective investment in **tobacco control** produces early benefits from reduced health care expenditure and that the most successful programmes (those in California) build up to a return of 50 times the investment with less effective programmes developing returns in the region of 20 to 30 times. The Californian programme is effective in inner city areas as well as in other parts of the state. A large part of the savings accrue after about three years.

The British programme, with its emphasis on smoking cessation support rather than on measures to tackle tobacco control, is unbalanced and therefore likely to be less effective. The most effective programmes include community programmes to change normative behaviour and also include robust and controversial challenges to the way that tobacco companies attract people to addiction for commercial benefit.

2. There is good evidence of the effectiveness of programmes which allow **young people** to understand the way that they are enticed into becoming addicted to **tobacco**. However that there is also evidence that programmes aimed at young people are less cost-effective than programmes aimed at adults but visible to young people, the reason for this being that young people take up smoking to demonstrate their adulthood so they are more likely to be influenced by addressing them as adults rather than as children.

American evidence suggests that the proportion of young people's uptake of smoking attributable to the presentation of smoking as normal in **films** is 50%. It is plausible that the British proportion will be higher as America does not have our stringent advertising bans. However the British Board of Film Censors refuses to accept that this means that smoking in films is "harmful to young people" even though it is hard to see what could be more harmful than taking up the use of a product which will kill one in four of those who use it in the way the manufacturer intends (the only lawful product of which any remotely similar statement could be made).

3. **Alcohol-related diseases** are a major contributor to inequalities in health and the main reason for the deteriorating health of young middle aged women which explains why inequalities in life expectancy are not improving as fast or as consistently as inequalities in age-standardised mortality rate. Potentially this is a very serious problem for the future – if the deteriorating health of young middle aged women continues as the cohort ages it will not be long before it starts to impact on age-standardised mortality and on life expectancy overall (rather than, as at present, only on inequalities in life expectancy).

There is good evidence of the effectiveness of brief interventions by health professionals and of arrest referral schemes. On a population level there is good evidence of the harm caused by the availability of very cheap alcohol and of the development of harmful drinking patterns in response to this.

Salford has saved admissions worth £1.5 million at tariff by investing £660,000 in a hospital alcohol nurse and assertive outreach services. Benefits accrued within 12 months.

However unless the capacity saved can be decommissioned rather than re-used the saving to the health economy as a whole is only about £200,000.

4. **Risky behaviours**. There are common psychosocial issues underlying many unhealthy behaviours. This is particularly true in relation to 'recreational' drug and alcohol misuse and sexual health issues, where the risky behaviours are often engaged in simultaneously, and the underlying issues around wellbeing, such as self esteem and locus of control, are largely the same. Interventions to improve wellbeing, promote empowerment, and provide structured activity have been shown to be protective against a range of risky behaviours and should be provided alongside traditional approaches aimed at providing information and advice and treating dependency.

5. **Physical activity** is a major contributor to good health. There is evidence for the effectiveness of measures to promote physical activity. Brief interventions for physical activity in primary care cost between £20 and £440 per QALY. This contrasts with the £30,000 per QALY which is NICE's current cost-effectiveness cut off for health care spending and the £10,000 to £17,000 per QALY of statins. NICE has issued guidance recommending that all agencies take simple measures in relation to their staff, buildings, grounds, organisation etc to promote physical activity with particular roles for schools, for parks and for active travel. The DfT has accepted American evidence that pedestrian permeability of street networks can cause a 6lb difference in mean population weight, equivalent to a difference in death rate of 1 per 1,000 per year. There is evidence of successful promotion of walking and cycling, for example a canal tow path scheme in London had a benefit to cost ratio of 22:1.

6. **Early years / Parenting**. Early engagement pays a very high rate of return. Early years investment promotes economic growth by creating a more able workforce and, ultimately, reducing the costs borne by criminal justice, health and welfare systems. There is good evidence that early years investment is effective in tackling social exclusion and teenage pregnancy. US modelling studies have estimated a payback of between 3 and 7 times the original investment in high risk families by the time the young person reaches the age of 21.

There is increasingly strong evidence that parent training produces positive results in addressing child conduct disorder, including both children who already have behaviour problems and those at high risk of developing difficulties in the future (London Economics, 2006). Efficacy can be increased by involving both the mother and the father, and working directly with the child. Positive effects also extend to parental wellbeing. However, it seems the most disadvantaged families benefit less from parenting programmes than do more stable and affluent families (Hallam, A. 2008). There is a lack of cost-effectiveness analysis in this field; however, the long-term benefits of any parenting programme would only have to be small to make the very small investments in parenting programmes efficient.

7. Agencies providing services for **vulnerable young people** work better together providing multi-component interventions than they do alone, and this can increase efficiency and cost-effectiveness (DfES 2007: 4). Interventions targeting young people at risk of future poor health outcomes seem rarely to address the range of risk factors associated with these poor outcomes (such as drug and alcohol misuse, NEET, and low

attainment) (Thomas et el. 2008). Complex, holistic interventions addressing the wider socioeconomic context to teenage pregnancy have historically lacked evidence of effectiveness; however a body of good evidence for the effectiveness of youth development programmes in preventing teenage pregnancy is now developing (Harden et al. 2009). The scope to reduce health inequalities and social exclusion is considerable. There have, however, been some notable examples of interventions in this field yielding the opposite of their intended outcomes (e.g. increases in crime, or rates of teenage pregnancy) so it is important that interventions are well evaluated.

8. **Mental Health and Wellbeing**. We are increasingly understanding the importance of mental wellbeing to health, and the Marmot report has reviewed the issues and identified healthy places and communities, fair employment and good quality work, empowerment and self development, reducing inequalities in early years and a healthy standard of living for all as the key objectives. The Alameda County Study suggests that the impact of the strength of social support networks could be as great an impact on mortality as poverty. The Department of Health advocates Five Ways to wellbeing – Connect, Be Active, Take Notice, Keep Learning, Give.

One of the problems of this area is that knowledge is emerging so rapidly and the impacts so far exceed what we have previously thought that there have been no evaluated programmes addressing this problem as fundamentally as it seems to require. Marmot calls for innovation and experiment. Nonetheless, ten best buys recommended by UCLan 2009 are:

1. Universal routine enquiry and targeted treatment for *women at risk of depression* with home visiting therapist for post natal depression, as part of a package of measures to improve perinatal mental health.
2. Universal assessment of potential parenting problems and targeted *early intervention programmes for common parenting problems*, including school-based learning.
3. Early intervention programmes with individual home-based programmes for *conduct disorders*
4. Build social and emotional resilience of children and young people through whole *school* approaches
5. Interventions to increase opportunities for *participation, personal development and problem-solving*- specifically volunteering, including timebanks, exercise arts and creativity, learning and educational opportunities, green activity, bibliotherapy, employment and debt advice.
6. Integrate physical and mental well-being through *universal access to lifestyle programmes* to reduce smoking alcohol use, substance use, and obesity. This means that key groups may need to be specifically targeted, for example people with a mental illness or learning disability, older people and pregnant women.
7. Improve *working lives* by:
    a. Early intervention to reduce risks of unemployment through primary care and Job centres.

   b. Support organisations offering locally based interventions to improve healthy working lives and support occupational health schemes.

8. Implement initiatives to prevent, identify and respond to emotional, physical and/or sexual *abuse*.
9. Ensure access to *psychological therapies*, including CBT, for people with long term conditions, disabilities and carers
10. Early intervention and targeted approaches for high risk groups, including suicide reduction programmes (e.g. facilitate *registration with GPs for homeless people*; Education programme for GPs to detect depression)

In connection with item 5 from the above list it should be noted that we have local evidence suggestive of a strong positive impact from community development (the use of community organisers to strengthen and improve a community) but one district is too small a base for proper evidence.

9. Prevention and **healthy ageing** carry considerable scope for reductions in health service demand. An analysis of the theoretical impact of healthy ageing was presented as part of last year's Annual Public Health Report and we are now doing analyses to see if the theoretical predictions are borne out – so far it has seemed that they have been. A stitch in time saves nine and it is important to consider how far earlier interventions in pathways can save money further down the line. Screening programmes and secondary prevention play a part here.

There is evidence, from South Yorkshire and locally, of a strong positive impact of properly organised risk factor screening in primary care.

Marmot has recommended attention to whether general practices are achieving their expected uptake of secondary prevention and whether their chronic disease registers are missing cases that would be expected from normal prevalences.

10. There is **macroeconomic evidence** supporting the importance of public services to health. There is clear need for investment in programmes to address deprivation. There are undoubtedly unmet needs and requirements for quality improvement in existing public services. Public expenditure is likely to be cut by some 10% in the next few years. Although the NHS will enjoy a degree of relative protection the challenge will still be substantial and our protection will place greater burdens on other health-relevant services such as our local authority partners. It seems likely therefore that in order to address all of these issues the public services in Stockport may need to achieve efficiency improvements of as much as 30% (10% reduced funding, 10% improvement and growth without new resources, and 10% resources released for new programmes). There is no evidence that such an efficiency improvement has ever been genuinely achieved by conventional budgeting. There is however some evidence from Australia and Japan that changes of this order might be feasible by participative methods which involve service users and staff in radical redesign. It is impossible to ignore the public sector pay bill when making changes of this kind. At the same time it is impossible to get the necessary degree of staff involvement if pay and conditions are under threat and redundancies are planned. There is strong evidence that for most workers (all but the very lowest-paid) job security, more

autonomy and involvement in the planning of their work and a better work/life balance would make a greater contribution to their health and well being than more pay.