Commission on Improving Dignity in Care
Consultation on Draft Report and Recommendations

Response from the Association of Directors of Adult Social Services

Background

The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in Local Authorities in England. As well as having statutory responsibilities for the commissioning and provision of social care, ADASS members often also share a number of responsibilities for the commissioning and provision of housing, leisure, library, culture, arts and community services within their Councils.

ADASS welcomes the opportunity to comment on the key recommendations set out by the Commission on Improving Dignity in Care.

Name: Dwayne Johnson and Dawn Warwick
Job title: Joint Chairs, Older People Network
Organisation: Association of Directors for Adult Social Services
Email: Dwayne.johnson@halton.gov.uk dwarwick@wandsworth.gov.uk

Please return the completed consultation form to dignity@nhsconfed.org

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INTRODUCTION

The Commission on dignity in care published its draft report and recommendations for public consultation on Wednesday 29 February.

The draft report sets out ten key recommendations for hospitals and ten key recommendations for care homes to help them tackle the underlying causes of undignified care, as well detailed recommendations on the changes the Commission believes need to take place across the wider health and social care system.

Individuals and organisations are invited to comment on as many or as few of the recommendations as they wish.

ABOUT THIS FORM

SECTION 1

Section 1 outlines the questions that the Commission would like individuals and organisations to consider when providing feedback as part of the consultation.

SECTION 2

Section 2 sets out how the Commission would like to use the feedback that it receives, including publishing a list of all individuals and organisations that have responded to the consultation. Where appropriate, the Commission may also chose to publish a summary of the feedback submitted alongside publication of its final report.

Please indicate in this section how you would be happy for your evidence to be used.

SECTION 3

Section 3 sets out the ten key recommendations for hospitals. Individuals and organisations are invited to provide feedback on as many or as few of the recommendations as they wish.

SECTION 4

Section 4 sets out the key recommendations for care homes. Individuals and organisations are invited to provide feedback on as many or as few of the recommendations as they wish.

SECTION 5

The report makes further detailed recommendations in a number of specific areas. Individuals and organisations are invited to provide feedback on as many or as few of these recommendations as they wish.

SECTION 6

The report includes an action plan setting out the steps that the three organisations that established the Commission – the NHS Confederation, Age UK and the Local Government Association – will take to support all those involved in the provision, commissioning and monitoring of care, to take up the Commission's final proposals.

Individuals and organisations are invited to provide feedback on the action plan.

SECTION 7

The Commission is keen to hear about any tools, guidance or good practice examples that the Commission should highlight to help spread existing best practice.

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SECTION 8

Individuals and organisations are invited to make any further comments on the content of the report.

SECTON 1: HOW TO FEED IN YOUR VIEWS

The *Delivering Dignity* report sets out ten key recommendations for hospitals and ten key recommendations for care homes to help them tackle the underlying causes of undignified care.

The Commission would like to gain feedback on its recommendations based on the following questions:

a) Is the Commission making the right recommendations? If not, how should the recommendations change?
b) What would you like to see included in the action plan?
c) Are you aware of a particular tool, set of guidance or good practice example that the Commission should highlight to help spread existing best practice across the health and social care system?

Individuals are invited to provide feedback on as many or as few of the recommendations as they wish.

SECTION 2: USING YOUR FEEDBACK

The Commission will use the feedback that it receives to help inform the final report due for publication in summer 2012.

The Commission would like to publish a list of all individuals and organisations that have responded to this consultation. Where appropriate, the Commission may also chose to publish a summary of the feedback submitted alongside publication of its final report.

X	Please put a cross in this box if you are happy to be included in the published list of individuals and organisations that have contributed to the consultation.

X	Please put a cross in this box if you are happy for your feedback to be summarised and published alongside the final report.

Please note that if you do not indicate in this section that you are happy for us to use your evidence as outlined above, we will not include your name in the published list nor include a summary of your evidence to sit alongside the final report.

SECTION 3: TEN KEY RECOMMENDATIONS FOR HOSPITALS

Is the Commission making the right recommendations? If not, how should the recommendations change?

Individuals and organisations are invited to comment on as many or as few of these recommendations as they wish.

	RECOMMENDATION	**FEEDBACK (please type your feedback in this column)**
1	All hospital staff must take personal responsibility for putting the person receiving care first. Staff should be required to challenge practices they believe are not in the best interests of the people in their care.	▪ ADASS believes that dignity needs to be embedded within organisational cultures, with good leadership top-down and through leading by example. ▪ Ward Matrons and Senior Nurses could support staff to feel empowered to challenge poor practice or neglectful behaviour. ▪ Staff supervision and appraisal could assist with time for reflective practice. ▪ There needs to be an increase in staff awareness of their responsibility to take ownership and proactively respond perhaps with consideration of prosecutions in relation to 'wilful neglect'. Patient stories and experiences could highlight the impact of poor practice. ▪ Dignity Champions' Expectations of Role and Characteristics could help staff feel more empowered.
2	Hospitals should recruit staff to work with older people who have the compassionate values needed to provide dignified care as well as the clinical and technical skills. Hospitals should evaluate compassion as well as technical skills in their appraisals of staff performance.	▪ Dignity and Safeguarding must be intrinsic in organisational ethos and clinical activities ▪ There needs to be a focus on person-centred care to highlight the importance of dignity and compassion to improve 'bedside manner'. ▪ Ward and peer observations could be used to support evidence-based practice highlighting good and poor practice. ▪ Recruitment panels could include patients to assess compassionate values, Halton Dignity Champions' Expectations of Role and Characteristics might be helpfully adapted to assess candidates. ▪ Staff should be subject to "probationary periods" regardless of prior experience whilst evaluation of compassionate behaviour should include observed behaviour and feedback from patients and their families.

3	Hospital boards need to embrace a devolved style of leadership that values and encourages staff and respects their judgment when they are the people working closest with older people and their families. Hospitals must enable staff to 'do the right thing' for patients.	
4	The leadership role of the ward sister or charge nurse is crucial. They should know they have authority over care standards, dignity and wellbeing on their ward, expect to be held accountable for it, and take the action they deem necessary in the interests of patients. They should play a leading role in coordinating services to provide the most dignified and seamless care for each person.	▪ The "leadership" role and acceptance of responsibility is crucial. ▪ The co-ordinating role regarding discharge and the bridge between hospital and community services needs to be strengthened by affording the ward leader the opportunity to directly commission community services in partnership with the patient and their family. ▪ There are good examples of alternatives to hospital care being provided with dignity, for example the Wandsworth Community Wards.
5	Hospitals need to provide older people with a comprehensive geriatric assessment when they are admitted, so that a coordinated care plan can be developed. They need to be reassessed regularly throughout their stay in hospital and before they are discharged, and action taken as a result. When undertaking assessments staff must take time to understand and record the needs and preferences of older people and their relationships with family, friends and carers, in addition to recording physical and mental health.	▪ Patient status should be regularly monitored and assessed with better communication and co-ordination of information between staff and the patient, family and carers. This would improve standards of care and transitions in care environments.
6	Hospitals should see older people's families, friends and carers as partners in care rather	▪ Families, friends and carers alongside volunteer schemes could provide additional support on wards, particularly at mealtimes which can promote

	than as a nuisance or interference. Hospitals should encourage family, friends and carers to come in and augment care if the older person wishes it, while retaining responsibility for ensuring care is delivered.	social interaction and reduce loneliness.
7	Boards should regard maintaining each patients' independence as a key measure of their hospital's performance in delivering care for older people. They need to work with patients, relatives and carers to compare a patient's level of independence when they are discharged from hospital with how independent they were before they were admitted.	▪ Measures of independence also need to include risk assessments and actions to reduce risk but ADASS is deeply mindful that any measures do not add unnecessary burden upon councils. ▪ Measures need to be personal and outcomes focussed for individuals.
8	Hospital boards must understand how people experience care in their hospital, and view dignity as a key measure of performance. All boards and management teams must have robust processes in place to collate feedback and complaints from older people, their families and staff so they can identify emerging trends and respond to them. This should include effective whistle-blowing procedures for staff who are concerned about care standards. Hospital boards must respond quickly to any suggestion of deterioration in dignity performance.	• ADASS welcomes the recently revised NHS Constitution which places strong emphasis upon supporting staff to raise concerns around poor practice
9	Feedback from patients and their families	

	should be discussed and responded to on the ward every day. Hospitals should give staff the time to reflect on the care they provide and how they could improve; this is an essential part of giving good care.	
10	Hospitals should introduce facilitated, practice-based development programmes – 'learning through doing' – to ensure staff caring for older people are given the confidence, support and skills to do the right thing for their patients.	▪ Ward and peer observations could be used to support evidence-based practice highlighting good and poor practice. This may also assist staff confidence in challenging poor practice and the use of 'whistle-blowing' or confidential reporting systems. ▪ Carer input to these programmes may offer useful insights of experiences.

SECTION 4: TEN KEY RECOMMENDATIONS FOR CARE HOMES

Is the Commission making the right recommendations? If not, how should the recommendations change?

Individuals and organisations are invited to comment on many or as few of these recommendations as they wish.

	RECOMMENDATION	**FEEDBACK (please type your feedback in this column)**
1	The Government should establish a Care Quality Forum (in parallel with the Nursing Quality Forum) to look at all aspects of care home staffing, including issues of status and pay, qualifications, recruitment, retention, development, monitoring and regulation. In the longer term the profession should consider working towards establishing a College of Care to lead on these issues.	▪ ADASS would welcome a Care Quality Forum as it would raise the profile of the care sector workforce to improve pay, status and qualifications which in turn would support staff retention, training, knowledge and skills.

2	The care sector should work with professionals, residents, relatives' organisations, local authorities and government to develop a clear rating scheme for care homes based on nationally agreed standards and benchmarks.	▪ Nationally agreed standards and indicators would be welcomed as they could be utilised by local authorities and HealthWatch as part of their ongoing monitoring of services. ▪ Any rating of a care home should include observed behaviour and feedback from patients and their families.
3	Care homes need to work with residents to create an environment that make their lives happy, varied, stimulating, fulfilling and dignified. This means involving older people as full and active participants in shaping their daily lives, rather than seeing them as passive recipients of care.	▪ The recommendation could improve and maintain people's identity, promote their independence and increase the level of information through feedback systems about service operation, dignity and care quality. ▪ Individual action plans arrived at collaboratively with the person and their family should, however, be the norm e.g. WRAP (Wellness recovery action plans) as used in mental health.
4	Building links with the wider community is an important part of creating a caring environment and developing a culture of openness. Volunteers can greatly enhance the quality of life in care homes.	▪ This could promote closer community links and involvement which would prevent 'closed' institutional care environments.
5	Care homes should invest in greater use of technology to improve the quality of care and support residents in enjoying active and independent lives.	▪ ADASS is working closely with the providers regarding the application on new technologies such as telehealth
6	All care home staff must take personal responsibility for putting the person receiving care first, and staff should be urged to challenge practices they believe are not in the best interests of residents.	▪ Dignity needs to be embedded within organisational cultures, with good leadership top-down and leading by example. ▪ Senior Managers, Ward Matrons and Senior Nurses could support staff to feel empowered to challenge poor practice or neglectful behaviour. ▪ Staff supervision and appraisal could assist with time for reflective practice. ▪ There needs to be an increase in staff awareness of their responsibility to

		take ownership and proactively respond perhaps with consideration of prosecutions in relation to 'wilful neglect'. Patient stories and experiences could highlight the impact of poor practice. ▪ E.g. Dignity Champions' Expectations of Role and Characteristics could help staff feel more empowered. ▪ E.g. Wandsworth's accredited training scheme for care home staff working with people with dementia
7	Care home providers should invest in support and regular training for their managers. Local authorities have an important role to play in facilitating this as commissioners of care.	▪ Local authorities provide training programmes which are available to staff and volunteers working within health and social care services and includes a wide range of E-Learning programmes. ▪ Programmes should be evaluated.
8	Boards and managers have a duty to ensure buildings are fit for use for older people, particularly those with dementia.	▪ This recommendation should also include council owned and managed buildings
9	Ensuring access to medical care is an important responsibility of care homes. Residents in a private care home have just the same rights to NHS care as everyone else.	▪ The availability of services and ways to access information should be promoted to private care home recipients to ensure equality.
10	Providing end-of-life care tailored to the wishes and needs of each individual is central to dignified care in all care homes. Residents should be allowed to die in their own care home if that is their wish.	▪ End of Life Care Pathways and programmes must support this to ensure people's wishes are adhered to and respected.

SECTION 5: DETAILED RECOMMENDATIONS

The report makes detailed recommendations on a number of specific areas. Individuals and organisations are invited to comment on as many or as few of these recommendations as they wish.

Is the Commission making the right recommendations? If not, how should the recommendations change?

	RECOMMENDATION	**FEEDBACK (please type your feedback in this column)**
	Report section: Who we care for	
1	Securing major reductions in hospital admissions by delivering care at home or in the community when it is appropriate should be a major priority for the health service; it is both cost efficient and care effective and places the patient and their needs at the centre of what we do.	▪ ADASS fully supports this policy direction.
	Report section: What standards of care do older people have a right to expect?	
2	<u>Caring for each individual</u> Boards should regard maintaining each patient's independence as a key measure of their hospital's performance in delivering care for older people. They need to work with patients, relatives and carers to compare a patient's level of independence when they are discharged from hospital with how independent they were before they were admitted.	▪ Hospital passports have been trialled and are regarded as good practice.
3	<u>Talking with and about older people</u>	

	Language that denigrates older people has no place in a caring society – particularly in caring organisations – and should be as unacceptable as racist or sexist terms. Hospitals and care homes should recognise that age is a 'protected characteristic' under the Equality Act 2010, and it should form part of their policies and practice around equality	▪ Older people have the same Human Rights (HR) as everyone else therefore an increase in HR profile with user-friendly guidance which staff can understand in context of health and social care environments should be commonplace. This may ensure people's HR's are not breached. ▪ For example, Halton's Dignity E-learning programme delivers dignity training whole-system in the context of Human Rights legislation covering: Dignity Basic Awareness; Dignity Human Rights and Legislation and Dignity Advanced.
	Report section: Providers of NHS hospital care	
4	<u>Patients and their families</u> Hospitals need to provide older people with a comprehensive geriatric assessment when they are admitted, so a coordinated care plan can be developed. They need to be reassessed regularly throughout their stay in hospital and before they are discharged, and action taken as a result. When undertaking assessments staff must take time to understand and record the needs and preferences of older people and their relationships with family, friends and carers, in addition to recording physical and mental health.	▪ Patient status should be regularly monitored and assessed with better communication and co-ordination of information between staff and the patient, family and carers. This would improve standards of care and transitions in care environments.
5	Nutritional needs must be identified on admission, food intake must be constantly monitored and action taken to ensure each person has enough to eat and drink.	▪ In addition to the completion of food/fluid charts and monitoring staff must be trained to recognise the signs of malnutrition and dehydration to enable them to act on observations made or alerted to them by others including concerns raised by family, carers and friends.
6	Families, friends and carers should be seen as partners in care,	▪ Family, carers and friends can provide expert knowledge of

	where the older person wishes it, not as a nuisance or interference. They are the people who were there before and will be there after formal care services have gone, and are a vital emotional link.	people e.g. what is the 'norm' in terms of health and behaviour. Involving them and maintaining regular communication can assist seamless transitions for people between care environments.
7	The Government should consider the best way of providing a "This is Me" record for older people as part of its forthcoming information strategy for health and social care.	▪ Health Passports, the 'Butterfly' and 'Forget-me-Not' schemes are similar information records for people with dementia and learning disabilities. ADASS would welcome the introduction of one information record which could be utilised across all services.
8	Older people and their families should be urged to give feedback to help hospitals continually learn and improve. Hospitals must put in place simple mechanisms to ensure direct feedback and any complaints are gathered from older people and their support network, alongside confidential feedback, for example through anonymous surveys.	▪ Informal mechanisms for feedback, concerns and complaints have been introduced and have proved successful e.g. Listening Clinic at Whiston Hospital and Afternoon Tea with Matron at Warrington Hospital. Similar systems have been introduced by some care providers. ▪ Wider promotion of 'Patient Opinion' should be introduced to support hospital patient experience surveys. ▪ For example, Halton's Help Us, Help You service provides an informal approach to support people receiving social care to raise concerns about services provided or arranged by the Council. It supports issues being resolved as informally or formally as the person wants e.g. a "quiet word" or a formal complaint.
9	<u>Ensuring every member of staff is responsible for dignity</u> All hospital staff must take personal responsibility for putting the person receiving care first. Professionally registered staff are required to challenge poor care, and they should be urged to do so as soon as they see any shortcomings. This helps colleagues understand how their interaction with a patient can be improved.	▪ Dignity needs to be embedded within organisational cultures, with good leadership top-down and leading by example. ▪ Ward Matrons and Senior Nurses could support staff to feel empowered to challenge poor practice or neglectful behaviour. ▪ Staff supervision and appraisal could assist with time for reflective practice. ▪ There needs to be an increase in staff awareness of their

	Other staff, such as healthcare assistants, should be encouraged to take the same approach.	responsibility to take ownership and proactively respond perhaps with consideration of prosecutions in relation to 'wilful neglect'. Patient stories and experiences could highlight the impact of poor practice. ▪ Dignity Champions' Expectations of Role and Characteristics could help staff feel more empowered.

10	Hospitals should introduce facilitated, practice-based development programmes to ensure staff caring for older people are given the confidence, support and skills to do the right thing for patients.	▪ Ward and peer observations could be used to support evidence-based practice highlighting good and poor practice. This may also assist staff confidence in challenging poor practice and the use of 'whistle-blowing' or confidential reporting systems. ▪ Carer input to these programmes may offer useful insights of experiences.
11	Hospitals should recruit staff to work with older people who have the compassionate values needed to provide dignified care as well as the clinical and technical skill.	▪ Dignity and Safeguarding must be intrinsic in organisational ethos and clinical activities, raise the profile of person-centred care to highlight the importance of dignity and compassion to improve 'bedside manner'. Ward and peer observations could be used to support evidence-based practice highlighting good and poor practice. Recruitment panels could include patients to assess compassionate values, Halton Dignity Champions' Expectations of Role and Characteristics might be helpfully adapted to assess candidates.
12	With around a quarter of people in hospital having dementia, national clinical director for Dementia Professor Alistair Burns has argued that 10 per cent of staff should be dementia experts, 50 per cent dementia trained and 100 per cent dementia aware. We recommend all hospitals use this benchmark.	
13	<u>Effective and supportive leadership</u> Hospitals need to embrace a devolved style of leadership that values and encourages staff and respects their judgment. This type of leadership is the foundation on which excellent care is built.	
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	Leadership on the board Boards must understand how people experience care throughout their organisation, and see it as a key measure of performance. All boards and management teams must have robust processes in place to collate feedback and complaints from older people, their families and staff so they can identify emerging risks and respond to them. This should include effective whistle-blowing procedures for staff who are concerned about care standards. Boards must respond quickly to any evidence of deterioration in the delivery of dignified care.	
15	Leadership on the ward The leadership role of the ward sister or charge nurse is crucial. They should know they have authority over care standards, dignity and wellbeing on their ward, expect to be held accountable for it, and take the action they deem necessary in the interests of patients.	
16	Feedback from patients and their families should be discussed and responded to on the ward every day. Immediate feedback to staff is important – discussion on the ward on the day about how care can be improved is far more powerful than discussion in a training room or appraisal weeks later, and can be acted on straight away. Just as individuals' stories offer powerful insights for boards, they are vital for learning on the ward.	
17	Hospitals should give staff the time and space to reflect on the care they provide and how they could improve; this is an essential part of giving good care.	▪ Dignity needs to be embedded within organisational cultures, with good leadership top-down and leading by example. ▪ Ward Matrons and Senior Nurses could support staff to feel empowered to challenge poor practice or neglectful behaviour.
18	All clinical staff must understand they have a professional duty to	▪ There needs to be an increase in staff awareness of their

	challenge and correct poor care no matter who is technically in charge.	responsibility to take ownership and proactively respond perhaps with consideration of prosecutions in relation to 'wilful neglect'. Patient stories and experiences could highlight the impact of poor practice. ▪ A clarification of 'grey' areas involving the difference between abuse/neglect and poor care-dignity issues could assist.
19	It should be mandatory for hospitals to ensure staff are appropriately trained in the Protection of Vulnerable Adults process.	▪ Safeguarding Adults Boards work in partnership across the multi-agencies including hospitals to provide a range of safeguarding training which is widely publicised and available to all staff, the uptake of these are monitored through the Board.
20	<u>Mind the gap: moving between home, hospital and care home</u> Hospitals should carry out a comprehensive assessment of an older person's health and care needs before they are discharged. The outcome of the assessment needs to be discussed with the person themselves, family, carers and others such as the GP, care home manager and social workers, to ensure the right support is in place when they leave hospital. A named staff member should be responsible for each patient's discharge and the patient and family given their contact details.	▪ Patient status should be regularly monitored and assessed with better communication and co-ordination of information between staff and the patient, family and carers. This would improve standards of care and transitions in care environments.

	Providers of residential and nursing home care	
21	Care homes should apply the same values and respect for human rights irrespective of narrow legal differences around the rights of residents depending on who is funding their care.	▪ People in private care homes have the same Human Rights as everyone else therefore providing the same opportunity to services and access to information should be promoted to all residents to ensure equality.
22	The Commission recommends that the status and role of those working in the care sector needs to be elevated to assist the better integration of health and social care. The Government should establish a Care Quality Forum (in parallel with the Nursing Quality Forum) to look at all aspects of care home staffing, including issues of status and pay, qualifications, recruitment, retention, development, monitoring and regulation. In the longer term the profession should consider working towards establishing a College of Care to lead on these issues.	▪ ADASS would welcome a Care Quality Forum as it would raise the profile of the care sector workforce to improve pay, status and qualifications which in turn would support staff retention, training, knowledge and skills
23	The care sector should work with professionals, residents, relatives' organisations, local authorities and government to develop a clear rating scheme for care homes based on nationally agreed standards and benchmarks.	▪ Nationally agreed standards and indicators would be welcomed as they could be utilised by local authorities and HealthWatch as part of their ongoing monitoring of services. ▪ Any rating of a care home should include observed behaviour and feedback from patients and their families.
24	<u>Building a caring community</u> Care homes need to work with residents to create an environment that make their lives happy, varied, stimulating, fulfilling and dignified. Being a caring community must be the overarching principle that guides home life. The My Home Life movement (see case study) aims to support care home managers in achieving	▪ All opportunities to promote and increase people's independence, engagement and sense of self-worth is advocated by ADASS.

	this.	
25	It is important that care recognises what the person would like to do for themselves. Homes should ensure that every resident has a care plan that refers to residents' personal wishes, preferences and priorities and to the support they need in order to retain and develop their sense of dignity and personal identity.	▪ This could improve and maintain people's identity, promote their independence and improve their dignity and care quality.
26	Boards and managers have a duty to ensure buildings are fit for use for older people, particularly those with dementia.	
27	Families, friends and carers should be seen as partners in care, where the older person wishes it, not as a nuisance or interference. They should be encouraged to be an active part of the care home's community.	▪ Family, carers and friends can provide expert knowledge of people e.g. what is the 'norm' in terms of health and behaviour. Involving them and maintaining regular communication can assist seamless transitions for people between care environments.
28	Building links with the wider community is an important part of creating a caring environment and developing a culture of openness. Volunteers can greatly enhance the quality of life in care homes.	▪ This could promote closer community links and involvement which could prevent 'closed' institutional care environments.
29	Care homes should invest in greater use of technology to improve the quality of care and support residents in enjoying active and independent lives.	
30	<u>Ensuring every member of staff is responsible for dignity</u> Regular appraisal is an essential part of staff development and quality improvement. Care homes should include 360 degree reviews of staff that incorporate feedback from residents, relatives, carers and independent advocates as well as peers and managers.	
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	All care home staff must take personal responsibility for putting the person receiving care first, and staff should be urged to challenge practices they believe are not in the best interests of residents.	▪ Dignity needs to be embedded within organisational cultures, with good leadership top-down and leading by example. ▪ Ward Matrons and Senior Nurses could support staff to feel empowered to challenge poor practice or neglectful behaviour. ▪ Staff supervision and appraisal could assist with time for reflective practice. ▪ There needs to be an increase in staff awareness of their responsibility to take ownership and proactively respond perhaps with consideration of prosecutions in relation to 'wilful neglect'. Patient stories and experiences could highlight the impact of poor practice. ▪ Dignity Champions' Expectations of Role and Characteristics could help staff feel more empowered.
32	Ensuring access to medical care is an important responsibility of care homes. Residents in a private care home have just the same rights to NHS care as everyone else. Managers need to ensure there is effective cooperation with NHS community services, and all care home staff, including assistants, should be given basic training such as first aid and identifying the warning signs for pressure sores.	▪ ADASS believes the availability of services and ways to access information should be promoted to private care home recipients to ensure equality.
33	Providing end-of-life care tailored to the wishes and needs of each individual is central to dignified care in all care homes, whether they are residential or nursing facilities. Residents should be allowed to die in their own care home if that is their wish; hospital admissions should be avoided where possible if that is not the wish of the individual, and should not be made simply because it is easier for the home. NHS services should give the support to enable people to die in their care home, an important example of integrating health and social care.	▪ End of Life Care Pathways and programmes must support this to ensure people's wishes are adhered to and respected.
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	Effective and supportive leadership Leadership at the top The boards of large care home organisations must understand how residents experience care and see it as a key measure of performance. All boards and management teams must have robust processes in place to monitor key quality indicators and collate feedback from older people, their families and staff so they can identify emerging issues and respond to them. This should include effective whistle blowing procedures for staff who are concerned about care standards.	▪ Informal mechanisms for feedback, concerns and complaints have been introduced and have proved successful e.g. Halton's Dignity Issues Log and Listening Clinics/Sessions introduced by some care providers. ▪ Wider promotion of the 'Good Care Guide' rate and review website should be introduced to support feedback mechanisms. ▪ Halton's Help Us, Help You service provides an informal approach to support people receiving social care to raise concerns about services provided or arranged by the Council. It supports issues being resolved as informally or formally as the person wants e.g. a "quiet word" or a formal complaint. ▪ Floor and peer observations could be used to support evidence-based practice highlighting good and poor practice. This may also assist staff confidence in challenging poor practice and the use of 'whistle-blowing' or confidential reporting systems.
35	Non-executive directors and senior managers need to invest sufficient time in seeing what is happening in individual care homes to get a personal impression of how care is being delivered. This should include talking with residents, their families, independent advocates, visitors and staff.	▪ Completion of dignity audits may assist, for example Halton have developed a suite of audit frameworks and guidance covering hospitals, residential care, domiciliary and generic services. These enable services to benchmark their practice, provide a baseline to measure progress and highlight best practice or gaps in services. To provide a balanced audit of services a dignity questionnaire is completed by people accessing the service to learn about their care experiences.
36	Leadership in the care home	

	Care home providers should invest in support and regular training for their managers. Local authorities have an important role to play in facilitating this as commissioners of care.	▪ Adult Social Services work in partnership across the multi-agencies including care homes to provide a range of social care and safeguarding training which is widely publicised and available to all staff.
37	<u>Making care homes more accountable to residents</u> All care homes should provide a residents' charter laying out their care standards and residents' rights.	▪ This would be welcome as an example Halton Dignity Charter and the Champions' Expectations of Role and Characteristics might be helpfully adapted to support this type of charter.
38	Older people and their families should be urged to give feedback to help homes continually learn and improve. Care homes must put in place simple mechanisms to ensure direct feedback and complaints are gathered from older people and their support network, alongside confidential feedback gathered by independent advocates and via anonymous surveys. Care homes must then be able to demonstrate how they have acted on that feedback.	▪ Informal mechanisms for feedback, concerns and complaints have been introduced and have proved successful e.g. Halton's Dignity Issues Log and Listening Clinics/Sessions introduced by some care providers. ▪ Wider promotion of the 'Good Care Guide' rate and review website should be introduced to support feedback mechanisms. ▪ Halton's Help Us, Help You service provides an informal approach to support people receiving social care to raise concerns about services provided or arranged by the Council. It supports issues being resolved as informally or formally as the person wants e.g. a "quiet word" or a formal complaint. ▪ Floor and peer observations could be used to support evidence-based practice highlighting good and poor practice. This may also assist staff confidence in challenging poor practice and the use of 'whistle-blowing' or confidential reporting systems.

	Report section: Commissioning dignified care	
39	<u>Commissioners of NHS care</u> When the NHS Commissioning Board is deciding whether to authorise a local clinical commissioning group, it needs to judge the effectiveness of the group's plans to secure dignified care for older people through its contracts with providers of NHS funded services.	
40	The NHS Commissioning Board must satisfy itself that commissioning organisations properly specify the dignity standards they expect to be delivered. The NHS Commissioning Board should review and comment on the extent to which commissioning organisations performance-manage providers to deliver required dignity standards.	
41	The National Institute for Health and Clinical Excellence (NICE) new quality standard for patient experience in adult services, which includes dignity, should be used by providers, commissioners and regulators across health and social care to provide a consistent standard by which to define and measure performance.	▪ Currently the 10 Dignity Challenge Standards have been used and promoted widely across the multi-agencies and the new NICE quality standard for patient experience could supplement these in gathering information about patient experiences.
42	<u>Commissioners of care home placements</u> Organisations commissioning care home services should incorporate dignity into all their standards and requirements. Standards must reflect the need for care homes to involve residents in decision-making so relationships between residents and staff are based on interdependence rather than dependence.	▪ Commissioners should ensure dignity and Human Rights elements are incorporated within service specifications, tenders and contracts.

	Report section: Patient, resident and public representation	
43	<u>The role of patient and resident advocates</u> Hospitals and care homes should work with local advocacy groups to provide access to independent advocates for older people and their families. Commissioners should consider requiring independent advocates in service specifications, who would then give feedback to both the commissioners and the providers.	▪ Advocacy Works Halton support the local community and have also piloted a scheme within several care homes to provide independent services for residents, family, carers.
44	<u>The role of HealthWatch</u> HealthWatch England and local HealthWatch organisations should put dignity in care at the centre of their work. In particular, HealthWatch should give a voice to people with dementia.	
	Report section: Universities, professional bodies and staff development	
45	Universities and professional bodies responsible for preparing the health and care workforce of tomorrow must satisfy themselves that applicants have both the academic qualifications and the compassionate values needed to provide dignified care.	

	Report section: Regulation	
46	The regulatory system must place as much emphasis on securing dignity in care as it does on financial and clinical outcomes when regulating health and social care providers.	
47	Healthcare assistants are an integral part of the health and social care team caring for older people. As the NHS strives to improve care standards for older people, employing healthcare assistants who are appropriately trained and qualified will be essential. The Department of Health should consider setting minimum training and qualification standards for healthcare assistants in the NHS. If this recommendation is accepted, the Department of Health will need to resolve how healthcare assistants are registered and regulated.	
48	When regulating care homes, the Care Quality Commission should assess the extent to which residents are given a say in the day-to-day running. The Care Quality Commission also needs to ensure that meeting standards on dignity and nutrition are core components of the compliance regime for care homes.	▪ ADASS supports this policy direction.

SECTION 6

The report includes an action plan setting out the steps that the three organisations that established the Commission - the NHS Confederation, Age UK and the Local Government Association - will take to support all those involved in the provision, commissioning and monitoring of care, to take up the Commission's final proposals.

Action plan:

A ‘hearts and minds’ campaign to seek support from leaders across health and social care to prioritise improving dignity in care for older people

Helping hospitals and care homes to learn from good practice

Helping staff across hospitals and care homes recognise good dignity in care and take individual responsibility for it

Working with key national bodies to ensure they prioritise dignity

Helping older people and their families understand the dignity they have a right to expect.

What would you like to see included in the action plan?

FEEDBACK (please type your feedback here)

Action Plan needs to be robust in terms of who will lead. Detailed objectives, timescales and outcomes.

SECTION 7

The Commission is keen to hear about any existing tools, guidance or good practice examples that it should highlight to help spread existing best practice.

FEEDBACK: Please let us know here if there are any existing tools, guidance or good practice examples that you would like to share with the Commission. Please attach any additional documentation with the completed consultation form to dignity@nhsconfed.org

Halton's Dignity Charter
Halton Dignity Champions' expectations of Role and Characteristics
Halton's suite of Audit Frameworks, Guidance and People's Questionnaires
Halton Dignity Champions' Network Action Plan 2012-13
Halton Dignity Champions' Network Dignity Best Practice Pack
Quality Pledges within hospitals
Dignity matrons appointed
Dignity being embedded within training

SECTION 8

Individuals and organisations are invited to provide any further comments on the content of the report.

FEEDBACK: Please let us know here if there are any other comments that you would like to make about the report

The focus of both sets of recommendations does seem to be predominantly on physical health, leadership and environment and would benefit from also considering how mental health needs are responded to with dignity, the use of advocates, staff communication skills to enable full patient participation in decision making and equality and diversity training.

March 2012