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# Health and Well Being Overview and Scrutiny Committee

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| **Date:** | **Monday, 12 March 2012** |
| **Time:** | **6.15 pm** |
| **Venue:** | Committee Room 1 - Wallasey Town Hall |


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# AGENDA

**1. MEMBERS' CODE OF CONDUCT - DECLARATIONS OF INTEREST / PARTY WHIP**

Members are asked to consider whether they have personal or prejudicial interests in connection with any item(s) on this agenda and, if so, to declare them and state what they are.

Members are reminded that they should also declare, pursuant to paragraph 18 of the Overview and Scrutiny Procedure Rules, whether they are subject to a party whip in connection with any item(s) to be considered and, if so, to declare it and state the nature of the whipping arrangement.

**2. MINUTES (Pages 1 - 14)**

To receive the minutes of the Health and Well Being Overview and Scrutiny Committee meetings held on 19 January and 6 February, 2012.

**3. SOCIAL CARE SERVICES FOR PEOPLE WITH DEMENTIA (Pages 15 - 56)**

**4. PROGRESS REPORT FOR DEMENTIA SCRUTINY REVIEW - THE CARE OF PEOPLE WITH DEMENTIA IN AN ACUTE HOSPITAL SETTING (Pages 57 - 64)**

**5. PRESENTATION ON KENT HOUSE CQC REPORT**

Sheena Cumiskey, Chief Executive, and Andy Styring, Director of Operations at the Cheshire and Wirral Partnership NHS Foundation Trust, will give an update on the outcome of the CQC inspection at

Kent House, Oxton.

**6. LINKS TRANSITION TO A LOCAL HEALTH WATCH ORGANISATION (Pages 65 - 70)**

**7. BRIEFING UPDATE FROM CLINICAL COMMISSIONING GROUPS**

Verbal update from CCGs on commissioning of services.

**8. 2011/12 THIRD QUARTER PERFORMANCE AND FINANCIAL REVIEW (Pages 71 - 82)**

**9. KINGSLEY HOUSE, WALLASEY - BRIEFING NOTE**

A briefing note will be provided for the Committee.

**10. TRANSFORMATION OF DAY SERVICES - BRIEFING NOTE**

A briefing note will be provided for the Committee.

**11. NEW LEGISLATIVE FRAMEWORK SUMMARY REPORT (Pages 83 - 116)**

The report considered by the Scrutiny Programme Board at its meeting on 28 February, 2012, and the paper, 'New Legislative Framework' from the Centre for Public Scrutiny, are attached for the committee's information particularly in relation to the implications arising from the Health and Social Care Bill.

**12. WORK PROGRAMME**

Report to follow.

**13. FORWARD PLAN**

The Forward Plan for the period March to June, 2012 has now been published on the Council's intranet/website and Members are invited to review the Plan prior to the meeting in order for the Committee to consider, having regard to the Committee's work programme, whether scrutiny should take place of any items contained within the Plan and, if so, how it could be done within relevant timescales and resources.

**14. MINUTES OF THE CHESHIRE AND WIRRAL COUNCILS JOINT SCRUTINY COMMITTEE (Pages 117 - 122)**

The minutes of the meeting of the Cheshire and Wirral Councils Joint Scrutiny Committee held on 23 January, 2012 are submitted for the Committee's information.

**15. ANY OTHER URGENT BUSINESS APPROVED BY THE CHAIR**

# HEALTH AND WELL BEING OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 19 January 2012

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|---|---|---|---|
| Present: | Councillor | P Glasman (Chair) | |
| | Councillors | S Clarke<br>P Doughty<br>M Hornby<br>C Povall<br>D Roberts | D Roberts<br>J Walsh G Watt P Williams Lowe M Johnston (In place of A Bridson) |
| Deputy: | Councillor | M Johnston (in place of A Bridson) | |
| Co-opted: | | S Lowe (Service users under OPP age group)<br>L Reecejones (Carers – deputy for S Wagener)<br>A Sullivan (OPP – deputy for S Wall) | |
| Apologies | | D Hill (LINks) | S Saagar (BME) |

## 40 MEMBERS' CODE OF CONDUCT - DECLARATIONS OF INTEREST / PARTY WHIP

Members were asked to consider whether they had a personal or prejudicial interest in any matters to be considered at the meeting and, if so, to declare them and state what they were.

Members were reminded that they should also declare, pursuant to paragraph 18 of the Overview and Scrutiny Procedure Rules, whether they were subject to a party whip in connection with any matter to be considered and, if so, to declare it and state the nature of the whipping arrangement.

No such declarations were made.

## 41 MINUTES

Members were requested to receive the minutes of the meeting of the Health and Well Being Overview and Scrutiny Committee held on 8 November, 2011.

Councillor Mrs P M Williams referred to minute 27 (Providing Excellence in Healthcare into the Future) and expressed her concern regarding dehydration of patients in hospitals. Gary Doherty, Acting Chief Executive, Wirral University Teaching Hospital NHS Foundation Trust, commented that the Trust was doing quite a lot of work in addressing this issue and he would be happy to speak to Councillor Mrs P M Williams and pick up any specific concerns.

**Resolved – That the minutes be approved as a correct record.**

## 42 VASCULAR SURGERY - UPDATE REPORT ON CONSULTATION PROCESS

Further to minute 29 (8/11/11) Kathy Doran, Chief Executive, NHS Cheshire, Warrington and Wirral (Primary Care Trust Cluster) submitted a report which updated the Committee on the consultation plan on changes to vascular services across Cheshire and Merseyside and built upon already extensive engagement with patients, the public and stakeholders on the principles involved in the Vascular Services review. Martin McEwan, Director of Communications and Engagement, NHS Cheshire, Warrington and Wirral, presented the report and outlined the three consultation phases envisaged as part of the engagement plan:

- Pre-consultation as part of the development of recommendations.
- Active consultation on the actual recommendations.
- Post-consultation on how the decision is being implemented.

A formal consultation would begin on 23 January 2012 for a period of 12 weeks. The consultation would ask for views on two arterial centres as the preferred option, agreed by the Project Board and the Commissioning Groups. These would be the Countess of Chester for the south of the Mersey and the Royal Liverpool Hospital for the north and operate as centres of arterial networks for the area.

A comprehensive consultation plan had been drawn up, including the latest draft of the formal consultation document. Comments on earlier drafts had already been received by LINks and patient representatives, and amendments incorporated. A planning meeting with the local LINks had taken place and a series of public meetings to specifically include LINk members would be taking place during the formal consultation process. Four main events would take place at a range of locations in Liverpool, Warrington, Wirral and Western Cheshire in January /February 2012, the first of these being in Wirral at Hulme Hall, 3pm-8pm on Tuesday 24 January.

Further engagement opportunities would take place at the main hospital trusts involved, as well as other public places such as other health sites and shopping centres, with exhibition materials being produced for this purpose.

Martin McEwan responded to comments from the Committee, and stated that although the consultation period was a minimum of 12 weeks, he would be happy for it to be extended beyond the May local elections. He referred to the National Clinical Advisory Team (NCAT) review which took place in December, 2011, when an independent clinician from London had interviewed all those involved in the review; the formal report was expected this month. He outlined a whole range of methods which would be used to capture people’s views during the consultation. This would include a combination of closed questions along with the opportunity for more descriptive responses. Stakeholder groups and representatives of patient groups would also be involved in the consultation.

Mr McEwan stated that an advertisement had appeared in the Wirral Globe on 18 January regarding the consultation event at Hulme Hall on Tuesday 24 January, as it was felt that a week in advance was the best time to publicise an event such as this. He would be happy to arrange another consultation event in Wirral later on during the consultation period and would consult with the Chair over this.

The Chair referred to a petition of some 583 signatures opposing changes to vascular services and this would be forwarded onto NHS Cheshire, Warrington and Wirral.

The Chair invited Mr R Chandrasekar, Consultant at Arrowe Park Hospital, to address the Committee on his concerns regarding the consultation. He commented upon the need for the correct information to be given in the consultation document and referred to the map of the areas involved. Mr McEwan, in response stated that he would be happy to double check the accuracy of the mapping information.

**Resolved – That the consultation plans be noted with the addition of an extra public meeting to be held in Wirral.**

## 43 AKA REPORT - ANY OTHER URGENT BUSINESS APPROVED BY THE CHAIR

The Chair agreed to consideration of an item of urgent business in view of the seriousness of the issues which needed to be considered.

It was moved by Councillor C Povall and seconded by Councillor S Clarke –

"In view of the report produced by AKA into the appalling culture and practices of the Adult Social Services Department of this Council for over a decade, we request that a special meeting of this Committee be convened. The Health and Well Being O&S Committee is the one responsible for the scrutiny of this department and until this Committee has got to the bottom of the problems identified we cannot possibly demand the fundamental changes that need to be made.

Despite the Peer Review and the CQC Improvement Plan members of this Committee need to be assured that these practices are no longer in operation.

This meeting shall be to discuss this report exclusively."

Councillor Hornby suggested that each member of the Committee be provided with an un-redacted copy of the AKA report, as it would be impossible to scrutinise the department not knowing which employees were still in Council employment and their former and current responsibilities. In addition the Committee needed to know the identity of the external service providers and their former and current contractual arrangements.

The Director assured the Committee that there would be a detailed investigation of those instances of abuse and a report on actions taken and plans in place.

The Director of Law, HR and Asset Management's representative informed the Committee that AKA had taken independent legal advice in respect of the redactions. The Director's representative commented that she would pursue this with the Director and the Committee would be provided with as much information as could legally be provided.

The Committee, having also discussed a possible date for the proposed special meeting, then -

**Resolved (unanimously) –**

**(1) That in view of the report produced by AKA into the appalling culture and practices of the Adult Social Services Department of this Council for over a decade, we request that a special meeting of this Committee be convened. The Health and Well Being O&S Committee is the one responsible for the scrutiny of this department and until this Committee has got to the bottom of the problems identified we cannot possibly demand the fundamental changes that need to be made.**

**(2) That despite the Peer Review and the CQC Improvement Plan members of this Committee need to be assured that these practices are no longer in operation.**

**(3) That this meeting shall be to discuss this report exclusively.**

**(4) That the special meeting be held at 5.00pm on Monday 6 February, 2012.**

44 **CORPORATE PLAN 2012/13**

In accordance with Council minutes 77 and 78 (12 December, 2011), the Committee considered those parts of the Corporate Plan within its remit. The Committee had also had sight of a motion which had been referred to all Overview and Scrutiny Committees by the Council at its meeting on 12 December, 2011 (minute 76 refers) and which was considered in connection with the Corporate Plan.

The Draft Corporate Plan and report of the Chief Executive which had been considered by Cabinet at its meeting on 8 December were considered by the Committee and the Chair invited comments from the Committee.

Responding to comments from Members the Director of Adult Social Services stated that more detail would be provided in a Departmental Plan which would include targets and indicators. The Corporate Plan's aim was to provide a holistic picture of how the Council would meet the needs of its residents in a strategic manner. With regard to criticism of poor quality reports, the Director assured the Committee that this would be addressed and there would be adequate opportunity for the Committee to drill down into issues at whatever level of detail was required.

A Member suggested that if the Plan provided too much detail it would become unwieldy and would be less likely to engage the public.

Members made the following suggestions for inclusion in the Corporate Plan:

- In the goal, 'Enhance the quality of life of the people of Wirral who have care and support needs', the sentence, 'Providing integrated, high quality services…..' should state how this would be measured and therefore how it could be scrutinised.
- Need to mention work carried out with Carers' Associations.
- In the goal on 'safeguarding' there was no mention of the AKA Report, this could be incorporated as an addendum with the actions arising from it.
- There was a need to see where the Department was currently and how it was going to move on.

- There was a need to refer to the Alcohol Scrutiny Review as a reduction in alcohol harm needed to be a target.
- There was a need to refer to the duties that the Council would have under Public Health.
- There was no mention of:
    - Affordability of social care
    - An increasing elderly population
    - Personal Budgets
    - Empowerment
    - Continuing public consultation
- One reference to regaining independence but no reference to retaining independence.

**Resolved – That the comments of the Committee be referred to the Cabinet.**

45 **HEALTH AND SOCIAL CARE SERVICES FOR PEOPLE WITH AUTISM**

The Director of Adult Social Services submitted a report which provided an update on the progress in Wirral against the expectations of the Statutory Guidance on the Autism Act 2009 as at December 2011. The Statutory Guidance (which also applied to NHS bodies as if they were Local Authorities) was published in December 2010 and set out the responsibilities for Local Authorities and NHS Bodies.

Rick O'Brien, Head of Access and Assessment, introduced the report and together with Russell Grant, Integrated Commissioning Manager, NHS Wirral gave details of the work being done, areas for development and the implications for social care and health provision. The cost and resource implications to the Council of funding autism services would be significant. There were currently two specialist providers of services for people with autism in Wirral, Autism Initiatives and Wirral Autistic Society. The combined revenue cost within the DASS budget of this provision covering supported living, day care, domiciliary care and day care was £3,060m. This figure precluded the wider expenditure on services for adults with autism in other areas such as local day services and supported living.

Linda Jones, a carer of an adult son with autism, addressed the Committee and spoke of her family's experience.

Both Rick O'Brien and Russell Grant responded to comments from Members and expanded on the numbers of people with autism being supported through both specialist services and day services. The Wirral Autistic Society did provide some free training and a Member referred to the excellent level of training undertaken at Foxfield School. There was a need for more work to be done on the prevalence of older people with autism (who may previously have had an incorrect diagnosis of a learning disability) and also those adults not in education, employment or training.

A Member suggested that it would be useful to see the progress report and action plan on autism in Wirral which had been received by Wirral's Learning Disability Partnership Board in October 2011.

**Resolved –**

**(1) That the progress on the development of services in response to the Statutory Guidance arising from the Autism Act 2009 be noted.**

**(2) That the potential resource implications on public sector agencies and the challenge of commissioning services in this area be noted.**

**(3) That this Committee receives a further report on progress in a year.**

## 46 LINK TRANSITION TO A LOCAL HEALTHWATCH ORGANISATION

The Director of Adult Social Services submitted a report on the progress towards establishing a local HealthWatch organisation as directed by the Health and Social Care Bill which was currently progressing towards Royal Assent.

It was agreed that as Diane Hill, LINks representative on the Committee had sent her apologies, this item be deferred to the next meeting on Monday 12 March, 2012.

## 47 SELF EVALUATION / PEER CHALLENGE

The Director of Adult Social Services submitted a report on the outcome of the Peer Challenge carried out in late November/early December 2011. The Peer Challenger considered a "Self Evaluation" prepared by the Department which was informed by a report considered by Committee in November 2011 (minute 36 refers).

These documents had been used to produce the Department of Adult Social Services Draft "Local Account" which was a way of demonstrating and describing performance in adult social care to local people. Committee's views on the Local Account were sought as part of the consultation process.

Responding to comments from Members the Director outlined how the process would be kept fresh whilst being subject to external challenge. In respect of the Local Account he acknowledged that some of the targets needed to be more challenging and the language more ambitious. He suggested that all the targets would be reviewed so that they were robust and more stretching. The Director would also ensure that respect and dignity were more explicitly referred to and that any duplication of targets would be addressed.

With the permission of the Chair, Councillor A McArdle, Cabinet portfolio holder for Social Care and Inclusion, addressed the Committee and commented that having listened to the discussion she would be happy to discuss the issues raised with the Director and also how the Local Account could relate to the Corporate Plan.

**Resolved –**

**(1) That the outcome of the Peer Challenge process be noted.**

**(2) That the Committee's comments on the content of the Local Account be noted.**

## 48 ANNUAL PUBLIC HEALTH REPORT

Fiona Johnstone, Director of Public Health, gave a presentation on the Annual Public Health Report for Wirral 2011. The report took a life-cycle approach to reviewing the health of people on Wirral. It looked at the different stages in people's lives, beginning before birth right through to older age, considered the challenges and opportunities to improve health and wellbeing and made a number of recommendations.

Having already achieved a great deal for the people of Wirral; the health of the population in general was improving, premature deaths from conditions such as heart disease were reducing and life expectancy was increasing. However, there were still considerable challenges ahead. 'Fair Society, Healthy Lives' showed that men living in Wirral's richest areas could expect to live nearly 15 years longer than those from the poorest parts of the borough and that in parts of Birkenhead deaths from heart disease were 15% higher than the national average.

There was no doubt that vast improvements in public health had led to people living longer, whereby more than four in five deaths now occurred after the age of 65. The nature of health threats had also changed dramatically, with most people now dying in old age and of noncommunicable diseases. The biggest threats to life today were diseases that usually occurred later in life or those brought on earlier by poor lifestyle choices.

Responding to comments from Members, the Director, with reference to 'the unsustainable nature of the long-term costs of ill-health' stated that in continuing to provide good treatment for all and supporting those in need, the key essence of the direction of travel needed to be to try and stop a health issue escalating into a crisis. A radical approach was needed to develop wellness services through the NHS and Social Care.

She outlined her current position as a joint appointment between the NHS and the Council and that she would be happy to bring her Departmental Plan to the Committee. Explaining the role and membership of the Health and Well Being Board, the Director informed the meeting that the Board, which was in shadow form at the moment, had met formally for the first time in December. The Board would become statutory in April 2013. She would be happy to make the minutes of the Board available to the Committee and there was a need to consider the Committee's relationship with the Board to ensure the Committee were aware of what the Board was doing.

With regard to the disappointing figures for breastfeeding within deprived areas, the Director outlined a number of reasons why this was so and stated that a comprehensive programme was in place to try and increase the numbers.

**Resolved – That the Annual Public Health Report and presentation be noted and this Committee endorses the recommendations contained within it.**

## 49 WORK PROGRAMME

The Committee received an update on its work programme and Members were invited to consider whether any issues should be added to the schedule for the current municipal year.

The Chair suggested that changes to maternity services within the Hospital Trust be added to the work programme. In respect of the working group on the transformation of day services, which had been established at the November meeting (minute 32 refers) the Chair informed the Committee that a scoping meeting had now been held and it was felt that the working group would work more efficiently if it was slightly smaller so those co-opted members on the group be asked to give evidence, rather than be members of the group.

**Resolved – That the work programme be noted with the above addition.**

## 50 FORWARD PLAN

The Committee had been invited to review the Forward Plan prior to the meeting in order for it to consider, having regard to the Committee's work programme, whether scrutiny should take place of any items contained within the Plan and, if so, how it could be done within relevant timescales and resources.

**Resolved – That the Forward Plan be noted.**

## 51 MINUTES OF THE CHESHIRE AND WIRRAL COUNCILS JOINT SCRUTINY COMMITTEE

**Resolved – That the minutes of the meeting of the Cheshire and Wirral Council's Joint Scrutiny Committee held on 10 October 2011 be noted.**

# HEALTH AND WELL BEING OVERVIEW AND SCRUTINY COMMITTEE

Monday, 6 February 2012

| | | | |
|---|---|---|---|
| Present: | Councillor | P Glasman (Chair) | |
| | Councillors | A Bridson<br>S Clarke<br>P Doughty<br>M Hornby<br>C Povall<br>D Roberts | J Walsh<br>S Mountney<br>A Brighouse |
| Deputies: | Councillors | A Brighouse<br>S Mountney | |
| Co-optees: | | S Wagener (Carers)<br>S Wall (OPP) | |
| Apologies: | Councillors | G Watts<br>P Williams | |
| | Co-optees | S Lowe (Service users under OPP age group)<br>S Saagar (BME) | |

52 **MEMBERS' CODE OF CONDUCT - DECLARATIONS OF INTEREST (INCLUDING PARTY WHIP DECLARATIONS)**

No declarations of interest were received.

53 **ANNA KLONOWSKI ASSOCIATES LTD (AKA) REPORT - INDEPENDENT REVIEW OF THE COUNCIL'S RESPONSE TO CLAIMS MADE BY MARTIN MORTON (AND OTHERS)**

Each Member of the Committee received a copy of the Recommendations Action List following Anna Klonowski's (AKA Ltd) Final Report. A written resolution provided by the Chair was also circulated.

A short adjournment was requested so that Members could read the documentation supplied and discuss it in their Political Groups.

54 **ADJOURNMENT**

The Chair adjourned the meeting at 5.15pm to give Members the opportunity to consider the documentation they had just received.

The meeting resumed at 5.30pm.

## 55 FURTHER CONSIDERATION OF ANNA KLONOWSKI ASSOCIATES LTD (AKA) REPORT - INDEPENDENT REVIEW OF THE COUNCIL'S RESPONSE TO CLAIMS MADE BY MARTIN MORTON (AND OTHERS)

Councillor P Glasman, in her capacity as Chair, and with the agreement of the Committee, read out the following resolution:

> 'This Committee recognises the seriousness of the issues raised within the Anna Klonowski report.
>
> Committee welcomes the Action Plan put forward by the Cabinet to tackle these issues, which incorporates the recommendations made by the author of the report.
>
> It further welcomes the fact that the Council has formally apologised to Mr Martin Morton, and that there is an ongoing review into the Council's whistle blowing and bullying and harassment policies.
>
> Committee recognises that the Chief Executive has already asked the Director of Adult Social Services, supported by the Head of Safeguarding, to urgently review the Final report for any further safeguarding issues that need to be addressed, and that Cabinet has already asked them to consider whether any historic safeguarding failures should be referred to the police or any other regulatory body..
>
> Committee therefore asks the Director of Adult Social Services to provide a verbal report to the committee on these issues at this point, followed by a written report to a subsequent committee.
>
> Committee notes that a series of measures have already been taken to strengthen safeguarding, and seeks assurance from the Director that these measures will be sufficient to ensure that the serious failures detailed in the AKA report cannot be repeated in the future.
>
> Committee welcomes the setting up of Improvement Board, with an independent chair, three party membership and members from the LGA, an external Chief Executive, Ms Klonowski and the District Auditor to oversee improvements and the implementation of best practice in the Council, and to monitor the implementation of the Action Plan on the AKA report.
>
> Committee further notes the work that has been done with the Care Quality Commission on improvements within Adult Social Services, and the Peer Evaluation which demonstrated that good progress was being made in Adult Social Services.
>
> Committee believes that vital lessons have to be learnt from mistakes that have been made in the past, but believes that it is important to move forward at this point, with a new Director, and for members of all parties to work together with officers and other agencies on Wirral to create the best possible Adult Social Services in Wirral.'

Some Members raised concerns about not receiving a copy of the Action Plan in advance of the meeting and therefore, not having enough time to look at it in detail before being expected to discuss it. They considered that, although it appeared grand and laudable, it was designed to bypass the scrutiny process and, they were unhappy about that.

The Chair informed that the Action List had, in fact, been published on the Council's website with the Cabinet agenda well over a week ago.

Some Members made the point that as it had taken four years to get to this stage of the enquiry. They reported that members of the public were asking for those who had behaved inappropriately to be named and shamed. The AKA report had been redacted, and without names, it was impossible for the Committee to hold the wrong doers to account. They considered that a very serious matter was being "swept under the carpet" and that the Council was unable to move on until Members knew exactly who was responsible. It was also considered that the alleged serious incidents detailed in the report could result in prosecutions in the future.

Attention was drawn to references that had been made in the AKA report to alleged abuse, rape and people turning up on a door step with a baseball bat. Some Members where of the opinion that these alleged incidents should to be investigated publicly and those identified as being responsible should be held to account. They considered that this was something that should not be ignored. They informed that, by putting this resolution forward, it appeared that other Members of the Committee were ready to move on. Some Members indicated that they wanted answers and to know who was responsible for one of the most serious issues to happen in the Council for many years.

The Chair was asked who had drawn up the resolution, whether it was her or someone else.

Some Members informed that they were keen to see the scrutiny process follow its proper course. It was noted that the people on the Cheshire and Wirral Partnership had not known of the serious safeguarding issues set out in the AKA report.

The Director of Adult Social Services informed that all officers had a clear responsibility to the people they served and that they all had a legal and professional duty in that regard.

The Director of Law, HR and Asset Management advised that following a previous meeting of the Committee, he had been informed that there had been requests made by a number of Members to receive an non-anonymised copy of the Anna Klonowski's Final Report. The Director had relayed these requests to Anna Klonowski's lawyers and had subsequently received a response from them making the point that people had voluntarily participated in the investigation on the understanding that they would remain anonymous. He also told the meeting that senior Council officers, who had taken part in the investigation, in his view, should be named.

The Director of Law, HR and Asset Management confirmed that the Council did not have a non-anonymised copy of the report in its possession. However, there had

been a list of names supplied with the draft report which had been made available to a small number of Members and officers.

Some Members expressed surprise that other Members did not want to comply with the way forward suggested by the person (Anna Klonowski) who had put the report together. However, in response, other Members considered that the principle was that people of Wirral and those who had suffered great injustice should now have all of the detail out in the open. They considered not to do so would make the situation deplorable.

Some Members made the point that the Council had been criticised over its corporate governance and that a copy of the Action Plan should have been sent to every Member of the Council and, that it was not enough to say, it was available on the internet if Members wanted to read it.

Reference was made to the fact that the report had been commissioned by the Council and paid for by Wirral tax payers. The Director of Law, HR and Asset Management agreed that the report had been financed by tax payers but informed that assurances had been made by AKA that people's names would not appear in the report. The people concerned had taken part in a voluntarily process and assurances had been given to them that they would remain anonymous. Therefore, there was a legal and moral obligation to respect this. The Director was seeking clarification, through lawyers, and he informed that he was working towards this goal but that there might well be resulting legal consequences.

Councillor C Povall moved the following Motion which was seconded by Councillor S Clarke:

> Committee resolves that due consideration and proper scrutiny of the AKA Ltd Final Report is vitally important, but that this cannot take place without all the facts.
>
> Committee believes that, in the interests of transparency and in order to give the issues set out in the report the detailed scrutiny they require, elected Members must have access to a non-anonymised version of the AKA Ltd report.
>
> Therefore, Committee agrees that this special meeting be deferred to a future date, to be agreed by the Chair, in consultation with Group Spokespersons.

Some Members, again, reiterated that it was in the best interests of residents and, particularly, the most vulnerable residents, for the Committee to look at the AKA report in detail and to be given the names and, particularly, officers' names. They were of the view that people of Wirral wanted to know that improvements were being made.

Councillor J Green, who was in attendance at the meeting, referred to a letter he had received from AKA Ltd which stated that it was outside its scope to respond to requests from third parties but that if the Council wanted to put information into the public domain that was for it to decide.

The Director of Law, HR and Asset Management informed that it was important to understand the consequences that would flow from unanonymising the report and that he was trying to obtain a full response from Anna Klonowski's lawyers on the assurances that had been given.

The Chair asked the Director of Adult Social Services to provide an oral update on safeguarding and the historic safeguarding failures. He proceeded to do so reporting on safeguarding concerns around individuals identified in the AKA report and improvements that had been made in the last year or so. He then asked the Head of Safeguarding to address the Committee.

Councillor S Mountney rose on a point of order. He asked if the Motion that had been moved and seconded could be voted on at this point. The Director of Law, HR and Asset Management informed that it was a matter for the Chair how she managed the meeting and who was invited to speak but it was possible to move a procedural Motion (without debate) that the vote be now put.

Councillor S Mountney moved the following procedural Motion which was seconded by Councillor C Povall:

That the vote be now put.

**RESOLVED: (6:4)**

**That the vote be now put.**

The substantive Motion was moved.

**RESOLVED: (6:4)**

Committee resolves that due consideration and proper scrutiny of the AKA Ltd Final Report is vitally important, but that this cannot take place without all the facts.

Committee believes that, in the interests of transparency and in order to give the issues set out in the report the detailed scrutiny they require, elected Members must have access to a non-anonymised version of the AKA Ltd report.

Therefore, Committee agrees that this special meeting be deferred to a future date, to be agreed by the Chair, in consultation with Group Spokespersons.

## 56 POLICE INVESTIGATIONS

The Head of Safeguarding provided the Committee with a brief oral report on interviews being held with those who had raised concerns (referred to on Page 94 of the AKA report) and on the Police's involvement. The Committee was informed that the names had been obtained from Anna Klonowski via the Director of Law, HR and Asset Management. A further report would be presented to the Committee when more details became available.

The Committee was aware that the redacted report had been provided for officers in September 2012. Members asked when it had been decided to involve the Police.

The Director of Law, HR and Asset Management confirmed that the Police had been contacted after the final AKA report was received.

The Director of Adult Social Services reported that there was no service provider named in the report who currently had a contract with the Council.

# WIRRAL COUNCIL

## HEALTH AND WELL BEING OVERVIEW AND SCRUTINY COMMITTEE

**12 MARCH 2012**

| | |
|---|---|
| **SUBJECT:** | ***SOCIAL CARE SERVICES FOR PEOPLE WITH DEMENTIA*** |
| **WARD/S AFFECTED:** | ***ALL*** |
| **REPORT OF:** | ***GRAHAM HODKINSON*** |
| **RESPONSIBLE PORTFOLIO HOLDER:** | ***COUNCILLOR JEFF GREEN*** |
| **KEY DECISION?** | **NO** |

### 1.0 EXECUTIVE SUMMARY

1.1 This report sets the challenges faced by the Council and its partners in supporting people with dementia in Wirral. Set against a backdrop of significant demographic growth in the Wirral older population where the prevalence of dementia is higher, members may wish to consider their further scrutiny role in this area.

### 2.0 BACKGROUND AND KEY ISSUES

National Position

2.1 The term ‘dementia‘ is used to describe the symptoms that occur when the brain is affected by specific diseases and conditions. Dementia presents as one of the great welfare challenges of the modern age, caused by one of the great successes in developed societies: increased health and longevity. There are over 100 types of dementia, the most common being referred to as ‘Alzheimers’. All types of dementia are progressive. This means that the structure and chemistry of the brain becomes increasingly damaged over time. Dementia is primarily a condition related to older age and the prevalence rates increase significantly as people grow older. For those over the age of 85 years, 2 in 5 will experience dementia. The impact on service users and families who experience dementia can be distressing. The loss of a loved one, sometimes through a prolonged period of decline where an individual’s personality and memory may fragment and their presenting behaviour may significantly deteriorate further compounds the experience of loss and grief.

2.2 The facts about the growing number of people with dementia in the UK are firmly established. As a response, in February 2009 the Department of Health launched the first ever National Dementia Strategy in England in recognition of the pressures and challenges faced by public sector agencies, individuals affected by the condition and their family carers. It was published following a series of reports from the National Audit Office, Alzheimers Society and the Kings Fund that highlighted growing evidence that dementia care services were not sufficiently supporting people with dementia to live well, or making the best use of available resources. Recommendations made in the national strategy focussed on three key themes:

- Raising awareness and understanding about the condition
- Providing early diagnosis and support services
- Living well with dementia

2.3 As the numbers of people who need support have grown in this area so have the associated planning and resource implications for Councils and their partners. In July 2011 the 'All Party Parliamentary Group on Dementia' produced a report that highlighted the growing pressure on health and social care budgets and the urgent need to improve the cost effectiveness of services, whilst at the same time using resources effectively to improve outcomes for people with dementia. The cost of dementia in the UK in 2010 was estimated to be £20 billion and this is expected to grow to over £27 billion by 2018.

Supporting people with dementia has implications for the wider health and social care system. Three main areas to consider are as follows:

2.3.1 Community Services

Ensuring the right support is in place is essential to maintaining good quality of life and allowing people to remain in their own homes. Ensuring there are good diagnosis services, skilled general practitioners, access to pharmacological and non pharmacological interventions at the early stages of illness can avoid a decline that could precipitate the need for hospital or residential care. Access to good quality community nursing services, social work support services, domiciliary care, respite care services, day care and access to personal budgets are all critical in promoting positive outcomes for people with dementia and their families. The role of the voluntary community and faith sector also has significant expertise in this area and they are critical to providing good quality advice information support for carers and a range of support services, often targeted at early intervention.

2.3.2 Care Homes

It is vital that care homes are able to provide a good quality of life for people with dementia, given that most care home residents will have some form of dementia. Well trained support staff are essential to the provision of good quality care. Care homes need to access the support and advice from specialist mental health teams and have access to anti psychotic drugs to avoid unnecessary hospital admissions.

2.3.3 Hospital Care

Providing high standards of care in hospitals for people with dementia is essential. Changes to the environment can help improve the experiences of hospital stays and focussing on well being and specific aspects of care, including nutritional care and management of delirium are critical. Psychiatric liaison is also critical to ensure that people on hospital wards have access to specialist psychiatric support when receiving treatment for physical conditions. Pathways for discharge need to include models of reablement and intermediate care to establish most effective ways of supporting people.

2.4 Local Developments in Wirral

In 2009 NHS Wirral and the Council's Adult Social Care Department produced a local strategy setting out the strategic direction and investment priorities of mental health services for older people in Wirral covering primary care, secondary care, adult services care and the voluntary community and faith sector (Appendix 1). The strategy recognised the need to increase funding for services in this area.

2.5 Local partners had also taken the initiative the previous year, 2008, by progressing a project with the Care Services Efficiency Delivery national team to model and evidence the positive impact of investing in early diagnosis and support services which could prevent admissions to care homes and allow for improved management, planning and support for carers.

2.6 The strategy reported prevalence rates of dementia with Wirral listed in the top 11% of local authorities. The current number reported of people with dementia in Wirral is 4.442 as provided by the Wirral Joint Strategic Needs Assessment. This figure is projected to rise to 5,282 in 2020.

2.7 Since the 2009 strategy the drive to improve dementia services has focussed on addressing the overdependence of the local care economy on care home admissions, raising awareness, diagnosis, support, care management, mental capacity and end of life care services.

2.8 A summary of local developments and improvements in the last three years includes the following:

- Local public awareness of prevention services through the 'Memory Matters' campaign
- The use of assistive technology to assist with dementia support
- The recommisioned memory and assessment services alongside the 'Carers Support Services' from the Alzheimers Wirral, which have been externally evaluated by the Nuffield Trust with positive results
- Training, support, medication advice and reviews for care home staff provided by Alzheimers Wirral
- Training for Acute Sector staff and improved psychiatric services
- Specialist support being made available on discharge to address 'winter pressures'
- An improved organic inpatient unit (Springview) commissioned in 2008
- A specialist long term extra care unit for 14 people opened in 2008

- Updated domiciliary/personal support and care home contracts and increased access to personal budgets

2.9 Whilst recognising the progress there has been these services, there remain significant challenges for the Council and its partners in addressing the increase in demand for dementia related services which is placing pressures on resources across the health and social care economy.

2.10 Current development priorities include:

- Managing the increase in demand for memory assessment and support services
- Developing new models of community support
- Quality assessing standard of care and support provided by contracted social care agencies
- Skills development in the wider social care workforce
- Developing more bespoke dementia services in intermediate care, home treatment and crisis response services
- Improving discharge planning, and joint working between specialist mental health services and general acute services
- Developing advanced care planning support to allow services users and family carers to plan for their longer term support needs such as end of life care

**3.0 RELEVANT RISKS**

3.1 Dementia presents a shared challenge and risk to the local health and social care community. Local services need to be of the right standard and availability to ensure that people with dementia and their families get the right support and positive outcomes.

**4.0 OTHER OPTIONS CONSIDERED**

4.1 None. However, Members may wish to consider a number of options in relation to their future scrutiny role:

- Contributing to a current programme of engagement events which are setting priorities for development in this area
- Nominating lead officers from the Overview and Scrutiny Committee to develop a scrutiny work programme for dementia services
- Identifying specific areas of interest within the field of dementia. Examples could include the experience of carers in accessing support services for family members with dementia, standards of quality in care homes. safeguarding adults with dementia
- Receiving additional reports from officers as advised on key issues:
  - Finance
  - Workforce
  - Performance
  - Developments
  - Systems modelling and evidenced based improvements

- Site/observational visits to dementia services by members in areas of interest

## 5.0 CONSULTATION

5.1 To be confirmed on agreement of the focus of the future scrutiny role.

## 6.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

6.1 None listed in this report.

## 7.0 RESOURCE IMPLICATIONS: FINANCIAL; IT; STAFFING; AND ASSETS

7.1 None listed for this report.

## 8.0 LEGAL IMPLICATIONS

8.1 None listed in this report.

## 9.0 EQUALITIES IMPLICATIONS

9.1 Has the potential impact of your proposal(s) been reviewed with regard to equality?

No because of another reason which is: -

Not for the purpose of this overview report which is intended to scope the future role of the Overview and Scrutiny Committee in this area. Where recommendations are specifically made for service changes or developments Quality Impact assessments would be considered.

## 10.0 CARBON REDUCTION IMPLICATIONS

10.1 None.

## 11.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

11.1 None.

## 12.0 RECOMMENDATION/S

12.1 Members of the Overview and Scrutiny Committee are requested to consider options for further scrutiny by the Overview and Scrutiny Committee for Health and Wellbeing on Dementia Services.

## 13.0 REASON/S FOR RECOMMENDATION/S

13.1 To allow Members to advise on future scrutiny arrangements in this area.

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## APPENDICES

Appendix 1 : NHS Wirral and Wirral Department of Adult Social Services - Strategy for Services for Older People with Mental Health needs (2009 and beyond).

**REFERENCE MATERIAL**

All Party Parliamentary Group on Dementia. The £20 billion question. An inquiry into improving lives through cost effective dementia services July 2011.

The National Dementia Strategy for England (NDSE) – Department of Health February 2009.

Kings Fund, paying the price 2008.

**SUBJECT HISTORY (last 3 years)**

| Council Meeting | Date |
|---|---|
| **Social Care, Health and Inclusion Overview and Scrutiny Committee** | **24 November 2008** |

# NHS Wirral and Wirral Department of Adult Social Services

## A Strategy for Services for Older People with Mental Health Needs 2009 and Beyond

**APRIL 2009**

**Final Version (1)**

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## INTRODUCTION

1.0 This document sets out the strategic direction and investment priorities for mental health services for older people in Wirral from 2009 and beyond. It has been developed as a consequence of and is linked with:

- The NHS Wirral Strategic Plan 2008
- The Mental Health and Wellbeing Commissioning Strategy 2008-2013.
- The National Dementia Strategy
- Local initiatives arising from the Care Services Efficiency Delivery project (CSED).
- The recommendations of the Older Persons Review (Gott Review)

1.1 The strategy covers services for older people aged 65 and over and includes primary and secondary care mental health services. It is a joint strategy between NHS Wirral and the Wirral Department of Adult Social Services (DASS) and recognises the important role of the Third Sector.

1.2 The strategy is based on the underlying philosophy of the prevention of mental ill health and the promotion of positive mental health.

1.3 In Wirral people with mental health problems will be able to expect services that will:

- Involve service users and carers
- Deliver high quality treatment and care
- Be person centred and based on need not age and be accessible
- Promote safety for carers, staff and the wider public
- Have a philosophy and focus of rehabilitation and recovery
- Be well co-ordinated and deliver continuity of care
- Empower and support service providers
- Be accountable to the public, service users and carers
- Be informed by public health assessments of need
- Be provided in the community and as close to people's homes as possible when possible.

1.4 Commissioning is a real opportunity to involve service users and carers. We recognise the need to respect, acknowledge and address the views of different people involved in the care of a person with mental health problems, including the person themselves. We believe that the involvement of service users and carers in all aspects of the development, commissioning and management (as appropriate) of mental health services is essential.

1.5 A fundamental approach will be to continue to support services that seek to empower service users or carers. This will include supporting the development of user-run services and user-led service monitoring. Supporting organisations that promote the service user voice; and supporting the employment of people with mental health difficulties within mental health services. Support will include access to training and development opportunities and to at least some dedicated financial resources, as well as access to staff time.

1.6 This strategy has been developed in anticipation of the National Dementia Strategy over a period of 2-3 years of active engagement with carers, patient representative groups and patients where possible. It reflects the National Dementia Strategy recommendations.

1.7 The intention is to actively engage with patient representatives and carers in an active way in implementing the recommendations of the strategy.

## VISION AND AIMS FOR THE FUTURE

**Our vision and aim is to improve the mental health of Wirral residents and for the services available to be effective and of the highest quality[1].**

2.0 If you live in the Wirral as an older person we believe you should have:

- A positive image of ageing
- Live as independently as possible in a safe environment of your choice
- Access to mental health services, if you need them, based on need not age
- High quality general health care according to your needs

2.1 To achieve this vision we recognise that there is a need to:

- Focus on promotion, prevention and early intervention
- Deliver high quality care and support on a locality basis
- Improve awareness of mental health issues in older people
- Offer personalised self-determined support

2.2 This will require people and facilities to provide high quality care through:

- A skilled workforce at locality level
- Integrated commissioning and
- Leadership to deliver comprehensive services and continuous service improvement.

2.3 Statutory services will need to be complemented by:

- Service users, carers and professionals who are fully informed about the mental health issues faced by older people.
- Staff, carers and service users who have a heightened awareness of early signs and symptoms of mental health problems.
- Clear public health messages which inform public views and address stigma and fear.

2.4 Partnership working to develop a range of services which support older people with mental health needs to remain at home for as long as possible will be implicit in all aspects of service provision.

2.5 Our intention is to continue to engage with patient representatives and carers to continuously review our vision and aims, to develop investment proposals and to evaluate service provision.

## OLDER PEOPLE'S MENTAL HEALTH NEEDS

The details below provide a synopsis of the more detailed work undertaken as part of the Joint Strategic Needs Assessment for Older People (JSNA). This is available at:

http://www.wirral.nhs.uk/Wirrals_Joint_Strategic_Needs_Assessment/Wirrals_Joint_Strategic_Needs_Assessment.html

3.0 Wirral NHS and the Department of Adult Social services (DASS) are responsible for commissioning services for a GP registered population of circa 334,000 residents (164,000 males and 170,000 females). This is the current population number and follows a period of steady decline in total population numbers. However, compared to England and Wales, Wirral has a relatively high ageing population and a low proportion of people in their twenties and thirties. These demographics become increasingly important when looking at issues such as caring for Wirral's older people in the future[2].

3.1 The term older people applies to people who are 65+ years of age. There were 58,300 people over 65 as at December 2008 in Wirral. These people make up 17.5% of the total population (according to the GP registered population). This is higher than the national average. Population projections produced by the Office of National Statistics (ONS) estimate that this population group will increase to make up 26% of the Wirral population by 2031. DH statistics indicate that that there will be 76,000 people over 65 in Wirral by 2025. **The statistics, from whatever source, demonstrate that there is currently significant pressure on services and that there will be an increasing demand on services. Additional investment and re-profiling of existing investments will be required as a minimum to maintain current service levels**.

3.2 Healthy life expectancy is the number of years a person can expect to live in good health. It is apparent from Table 1 that both men and women in Wirral are significantly more likely to have a poorer healthy life expectancy than the national average.

Table 1

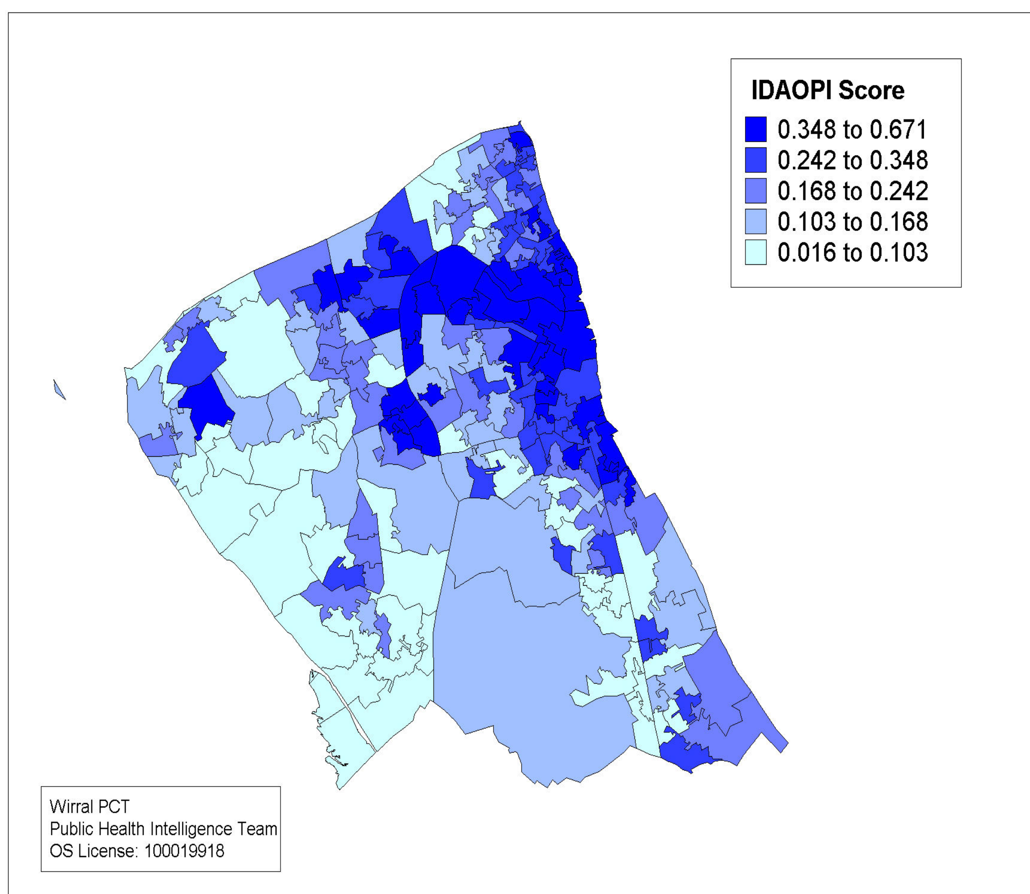
| Healthy life expectancy at age 65 years | Males | Females |
|---|---|---|
| Wirral | 11.9* | 14.1* |
| North West | 11.4 | 13.3 |
| England | 12.5 | 14.5 |

Source: ONS, 2008
* Significantly below the national average

3.3 Health inequalities in Wirral exist between and within geographical communities. There are many specific population groups that have needs requiring a targeted approach for an intervention or service development[3]. The ageing population will need particular attention, as a higher number of people living longer will mean an increase in the number of people with long term conditions, higher risk of falls leading to injury, depression and dementia, cancer and cardio vascular disease, amongst others. This is likely to present significant challenges in relation to an increased demand for care.

3.4 To highlight this position further, in 2007/08, a total of 451 hip replacement procedures were carried out on Wirral residents aged 65 years and above. This was significantly higher than comparable data for England. Similarly, in 2007/08 a total of 449 knee replacement procedures were carried out on Wirral residents aged 65 years and above, again giving a higher than expected rate compared to national figures. As there is evidence that mental health problems such as anxiety and depression can be linked to physical health we can predict that as the population ages, and their physical health demands increase, so mental health problems will be linked to this increase.

3.5 The Index of Multiple Deprivation 2007 includes a measure of Income Deprivation Affecting Older People (IDAOP). It measures the number of adults aged 60 years and over living in pension credit households, as a proportion of all those in this population group. Pension credit is a benefit for people aged 60 or over that guarantees a minimum income; entitlement is, therefore, a good indicator of income deprivation.




Source IDSOPI, 2007

3.6 In total 17,970 older people in Wirral are in receipt of pension credit (Department for Work and Pensions 2007). There are a greater proportion of older people on pension credit in areas in the East of Wirral, particularly areas of Birkenhead and Tranmere, Bidston and St James and Seacombe and Rock Ferry. It is, however, important to note the pockets of deprivation in other areas of the borough[4].

3.7 The ageing population means that the number of people with dementia and other mental health conditions will rise considerably over the next few years. Whilst dementia is the predominant problem account must be taken of other conditions and co-morbidity factors (e.g. depression associated with acute conditions (diabetes, COPD)). It will be important that these conditions are not ignored in planning future service provision.

3.8 The projections for the number of people in Wirral over 65 years that will have dementia, between 2008 and 2025, are outlined in table 2

Table 2:

| | 2008 | 2010 | 2015 | 2020 | 2025 |
|---|---|---|---|---|---|
| Total males | 1,398 | 1,483 | 1,717 | 1,942 | 2,217 |
| Total females | 3,118 | 3,132 | 3,298 | 3,537 | 3,930 |
| Total population aged 65 and over | 4,516 | 4,615 | 5,016 | 5,479 | 6,147 |

*Source: CSIP, 2006 (Projecting Older People Population Information System*)

These estimates suggest that rates of dementia in older people will increase by 11% between 2008 and 2015, and 36% by 2025.
A report by Dementia Care UK (published February 2007) reported the number of people with dementia in Wirral as 4,294. They estimated a rise of 28% in numbers of people with dementia by the year 2020.

3.9 Research published by the Alzheimer's Society suggests that Wirral is in the top 11% of local authorities with the highest whole population prevalence of dementia (16th of 150) with a prevalence rate of 1.37%. Local authorities with larger populations of older people, and with more institutional places, will tend to have a higher whole population prevalence of dementia.
The definition of dementia adopted is that it is "a progressive global loss of mental function (concentration, memory and orientation) occurring in clear consciousness. Most cases are due to the degenerative process of Alzheimer's disease (loss of brain cells generally, especially those containing acetylcholine) or to cerebro-vascular disease (multi infarct dementia)" (Bandolier).

3.10 As part of the Quality Outcomes Framework (QoF) GP Practices are expected to produce a register of patients with dementia. In Wirral, a total of 1,696 people were recorded on the registers between April 2006 and March 2007, which gives an unadjusted prevalence rate of 0.5%. This is slightly higher than the North West and England GP practice prevalence rates which are both recorded as 0.4%. This information has been derived from the Joint Strategic Needs Assessment. However nationally and locally there is some concern about the accuracy of this data. This is due to a number of factors including:

- the late presentation and/or diagnosis of the condition within primary care
- the differential application of the definition of dementia within primary care
- the robustness of data collection
- the none application of a clinical diagnosis at first contact with statutory organisations

3.11 The gap between current and future demand is demonstrated. Anecdotal evidence also suggests that there is a current level of unmet need supported by "hidden carers" where services have not yet been accessed.

**Taking these issues into account it is highly likely that the extent of the current problem is significantly understated.**

3.12 Admissions to acute hospital care (Wirral University Hospital Trust only) for dementia with associated conditions in Wirral are considerable. The admission rate in 2005/6 for Wirral was 3.2 per 1,000, which is above the national average of 2.1 per 1,000 and dementia contributed to 5,443 emergency bed days, with the average length of stay being 46 days.

3.13 People with dementia are more likely to be admitted to care homes than older people in general. In Wirral in 2007, approximately 1,166 people with dementia were in care. This suggests, based on incidence projections (see Para 3.8) that in excess of 3,000 people with dementia are living in their own homes in the community. This calls into question the robustness of the GP registered figures (see 3.11).

3.14 In January, 2007, Wirral launched a consultation on the future of older people's mental health services. In terms of early intervention, prevention and awareness 70% of carers experience major barriers to initial diagnosis. This tends to support the need for enhanced awareness and training within the general community and in primary care services. Issues relating to patient confidentiality may also exacerbate early identification of this problem. Service users and their carers were left to find information and support for themselves. It was found 50% of people waited until a crisis point before seeking help or support.

3.15 The consultation found that people thought an increased awareness by staff is required in relation to the care of people with dementia. In addition there is a need for a smoother transition from general to specialist consultant support. There were also concerns about access to information and choices for accessing community services as opposed to institutional options.

3.16 People consulted also thought the local picture reflects a lack of access to crisis home support where more choice and flexibility is needed. There needs to be more information about services available at home, and more understanding of the impact the environment has on a person's care. Carers and staff need to be more aware of specific conditions when working with people who have dementia. Families need support with younger people who have dementia and there is a need to review End of Life Support.

## CURRENT INVESTMENT

4.0 In terms of an overall picture for NHS Wirral, the number and types of provider who provide specific services to people with a mental health problem are listed below.

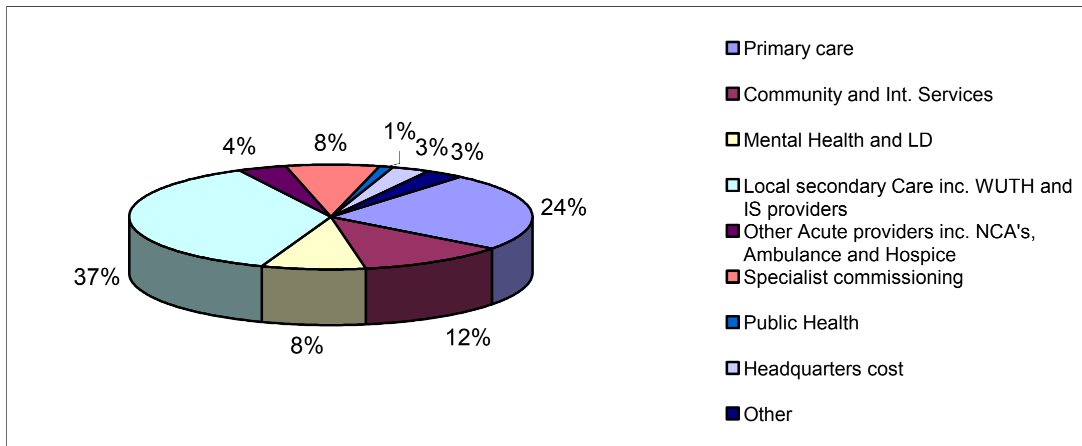



**Table 2: Key Providers**

4.1 In Autumn 2008 a financial mapping exercise for the Wirral based on information from the Local Implementation Team (LIT)[24] was produced. The financial mapping covers all reported investment by the PCTs and Local Authority in adult and older adult mental health services, including delivery of services from all providers to, and all commissioners for the Local Implementation Team, not just NHS organisations.

This report is an analysis of the financial mapping for the Local Implementation Team as at November 2008. The overall picture of investment in adult and older people's mental health is outlined including the delivery of all services from all providers to the Local Implementation Team and all commissioners for the Local Implementation Team - not just the NHS. The data has been validated at local level and has been submitted to the Department of Health for review.

4.2 It must be noted that this is only the third year for the Local Authority to collect Older People Mental Health (OPMH) financial mapping information and data quality will improve with future years.

4.3 The population data has been weighted for both mental health need and financial factors and therefore also takes into account the varying staff costs around the country. Therefore, the data can be seen as a good picture of the present comparable financial picture of Wirral's mental health investment compared to the rest of the Strategic Health Authority, other organisations that are comparable as a cluster, using Office of National Statistics (ONS) data, and LITs in England as a whole. An ONS cluster is the latest classification by the ONS which allocates all HAs and LAs on one of 12 "family groups" or areas with broadly similar characteristics – Wirral is within the industrial hinterlands group.

4.4 In terms of older people with a mental health problem the total annual investment for older people in Wirral LIT is £19,846,000. Comparative figures across the SHA and related clusters are not yet available.

4.5 Using 2007 figures, when weighted per head of population comparative expenditures were:

- £290 per head for Wirral Local Implementation Team
- £267 per head for Strategic Health Authority
- £283 per head for Office of National Statistics
- £273 per head for England Local Implementation Teams

However, when you compare this in terms of the investment directly on services rather than overheads or other indirect costs the picture is Wirral LIT spends 84%, SHA 83%, ONS 83% and England LITs 81%. NHS Wirral has invested an additional 8.2% on all mental health services over the last 12 months and therefore the comparative analysis in paragraph 6.5 should be treated with caution.

4.6 In addition NHS Trusts are required to make cash releasing efficiency savings which will be reinvested in services. This will not necessarily be with the organisation generating the savings. Out of the total £19.8m spend approximately £7.5m is spent with secondary care providers for older people's mental health services. This means that an additional annual investment of £75k over and above inflation will be immediately available. This is clearly insufficient to develop services at the required pace. **The PCT will therefore finalise a strategic investment plan for older people's mental health services. This will:**

- **Be based on additional recurrent investment of £500k in 2009-10 and a further recurrent investment of £250k from 2010-11.**

- **Require a significant reengineering of current investment with a major shift from residential care (DASS funded) to primary and community care (DASS and PCT funded).**

## CURRENT SERVICES

5.0 For older people with mental health problems in Wirral there are a range of services provided across health, social care and the independent and voluntary sector. The intention is to continue to develop, redesign and improve these services and where needed increase provision. Some of the services that are delivered within general health services have an immense effect on people with mental health problems, as there is evidence that physical and mental health are intertwined. This section gives a picture of the services and areas of care currently provided. Whilst this concentrates on mental health, the impact of associated initiatives which relate to general health are recognised.

5.1 Older people in the Wirral, who have long term conditions, use secondary care services. There is an ongoing process to develop alternatives in primary care and utilise the experience and knowledge of primary care staff. Older people with mental health problems also have a range of chronic conditions, so it is vital that general health and social care services ensure access to these services is as effective as possible. Staff in these general services must have the appropriate training in order to care for people who have mental health problems with chronic conditions.

5.2 There are a number of **general services** provided to which older people with mental health problems require equal access and which need to be capable of responding to their specific needs. These include:

- Wirral Case Management Project Team (Community Matrons). We will need to ensure that older people with mental health problems are able to access such schemes and benefit from the valuable services they offer [12].
- Wirral Falls Prevention Service. Older people with a mental health problem are encouraged to make full use of this service and access will be improved as needs are further identified.
- Wirral Homecare Assessment and Rehabilitation Team (HART) which provides rehabilitation and reablement services within the community.
- Primary Care and Community services including dietetics, community nursing and community equipment services etc.

- Older People Independence Network (popin). This provides a low level preventative service working with older people within the local community (including a dementia café for older people and their carers to access advice and support in coping with dementia).
- Assistive Technology Team. Assistive Technology has the potential to support many more older people with mental health needs in relation to providing memory prompts, maintaining safety inside and outside of the home and enabling independence and positive risk taking. It could support the transformation of the quality of dementia care. It has potential within residential/nursing home, day care and community settings to promote choice, dignity and well being.
- A range of Local Authority services which aim to help older people remain active and independent. These services focus on promoting independence, ensuring safety and protecting vulnerable adults.

### 5.3 Specialist Community and Primary Mental Health Services Older People

These services include:

- Psychological therapies for older people. Talking Changes (New PCMHS) will incorporate psychological therapists for older people and access is expected to improve in 2009.
- Integrated Community Mental Health Teams
- Crisis Resolution Home Treatment Team for people with a functional mental illness
- Early Onset Dementia Team
- Extra Care Housing

All these services need to be reviewed in association with other planned service developments and redesign projects.

## 5.4 Secondary Care

As part of the improvements to Older People's Mental Health Service the current number of older people's beds will be reconfigured by October 2009 to reflect the level of need for inpatient services. There will be 33 beds (20 functional and 13 organic). Mental illness such as dementia is a result of brain impairment and is usually described as 'organic'; whereas non-organic mental illness such as schizophrenia is usually described as 'functional'.

The bed reconfiguration will require a reduction of 18 functional beds and the closure of Balmoral ward; this will be supported by expansion of the Older People's Crisis Resolution and Home Treatment team. The reduction in organic inpatient beds will require the loss of 2 beds from Church ward. This will take place once the functional beds have been reorganised. The reduction in beds will be achieved in a safe and clinically appropriate manner and any risks identified will be managed.

**From October 2009 all the in patient beds will be in the Springview Unit on the Clatterbridge Hospital site. The beds currently at St Catherine's Hospital will be relocated to Clatterbridge.**

Current investments in secondary care services will be reviewed in the context of national recommendations and the National Dementia Strategy.

## 5.5 Service Redesign

Wirral has a specific Local Area Agreement (LAA) Local Improvement Target relating to dementia. The target relates to a planned reduction in the numbers of people with dementia admitted to residential and nursing home care.

Wirral DASS and NHS Wirral are participating with key partners in a national pilot project on dementia with Care Services Efficiency Delivery team, DH. This project was completed in September 08 and involved care pathway development and the use of Systems Dynamic Modelling to analyze and test out the use of resources, related to activity, capacity and demand. The work is further described in section 7.

## 5.6 **Service Gaps**.

It is recognised that **intermediate care** for older people with mental health problems is a gap within services in Wirral. This strategy highlights this area. The commissioning intentions indicate how this will be addressed. In developing intermediate care services for the future we will ensure that we develop services that are locality based and demonstrate cost effectiveness. The services will be flexible and provide person centred services responding to need.

Initially we will need to provide a range of community bed and home based services to provide "bridging" support in the community. The implementation of robust community services will impact on the number of intermediate care beds needed in the future and therefore must be recognised as part of an integrated health and social care approach to provision.

## STRATEGIC DIRECTION

6.0 The need to address the requirements of an increasingly ageing population by working across agencies (including health, social care, housing, the Third Sector, service users and carers) is acknowledged. Following the completion of the Older Peoples Services Review (Gott), participation in the National Care Services Efficiency Delivery Pilot Project on Dementia (CSED) and the launch of the National Dementia Strategy, it is evident there is a real need for direction built upon integrated commissioning and a joint approach for older people's mental health services.

6.1 The aims of the Wirral integrated older people's mental health strategy will be to commission services based on:

- Increased public and professional awareness of mental health needs of older people
- Good quality early diagnosis, prevention and intervention for all within a clear pathway
- Good quality timely information for older people and their carers
- The 'Wellbeing approach' to service development and provision
- Improved quality of care in institutional settings and community settings

6.2 **Significant additional investment and service redesign** will be planned to sustain existing service levels and to develop new services.

6.3 The intention will be to commission innovative joint schemes that address the issues of employment, environment, housing, education and other factors that influence wellbeing.

6.4 The intention is that health, social care and independent sector and voluntary sector services develop an approach where the person directs, as far as possible, the services they receive.

6.5 We will develop services which help people to stay healthy and independent, focusing on prevention, improving health as well as treating sickness. The local health and social services economy will commission, in partnership, comprehensive well being and prevention services which are personalised and meet the specific needs of the local population.

6.6 For people with long term mental health conditions personalised care plans will be the focus. Plans will be agreed by the patient and a named professional and provide a basis, for the NHS and its partners, to organise services around the needs of the individual.

## DEMENTIA SERVICES

7.0 Dementia is one of the biggest health and social challenges facing the country: in less than 20 years time, there will be over one million people living with a form of dementia.

7.1 The term ‘dementia’ describes a collection of symptoms, including a decline in memory, reasoning and communication skills, and a gradual loss of skills needed to carry out daily activities. These symptoms are caused by structural and chemical changes in the brain as the result of physical diseases such as Alzheimer’s disease

7.2 Dementia can affect people of any age, but is most common in older people. One in six people over 80 have a form of dementia and one in 14 people over 65 have a form of dementia. Dementia is a progressive condition, with the symptoms becoming more severe over time. Understanding how this progression happens can be useful in helping someone with dementia anticipate and plan for change.

7.3 As well as the person with dementia, there is a need to consider the invisible burden of their carers. Of older people who have dementia, it is estimated that 63.5% live at home and are cared for by their families, friends and close relatives.

7.4 The Government has made a commitment to making dementia a national health and social care priority, through the development of a National Strategy for England. The strategy focuses on three key areas:

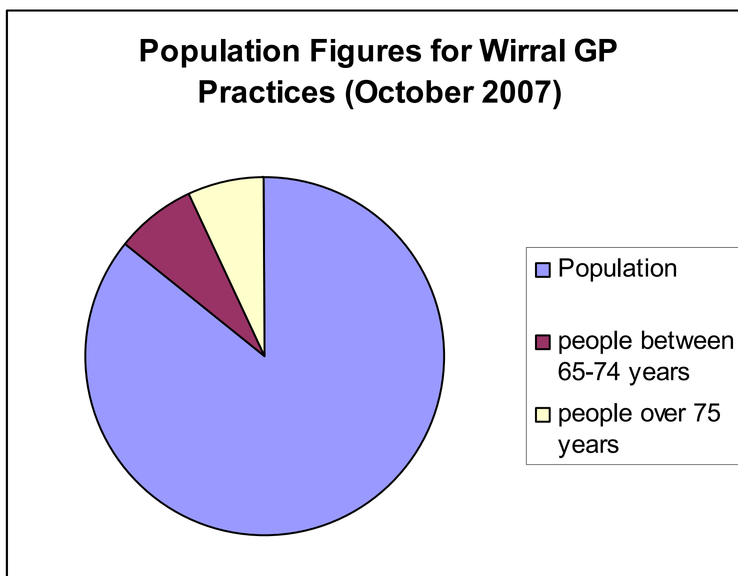
- Improving awareness of dementia
- Early diagnosis and intervention
- Improving quality of care

7.5 Locally NHS Wirral and DASS have accessed a national systems modelling programme (CSED) to support a review of current service delivery and to inform future service provision.

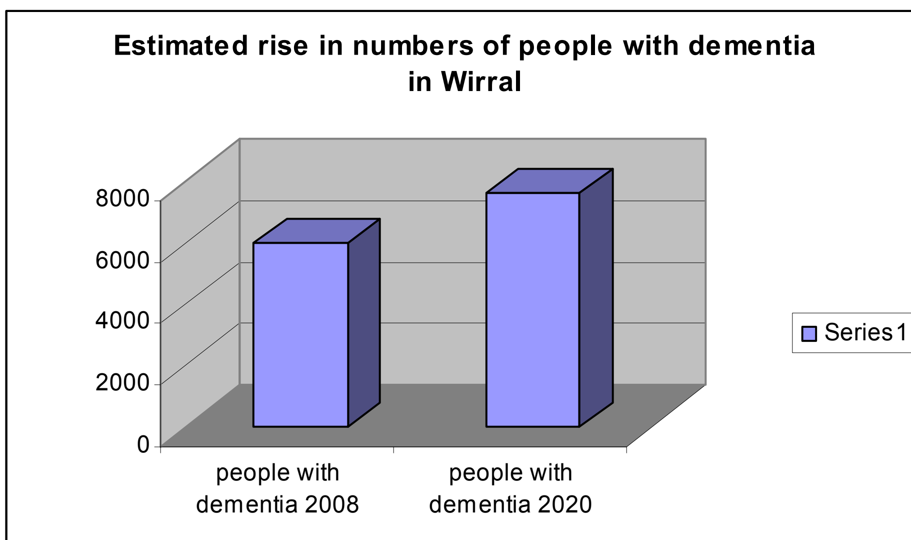
7.6 The Dementia UK report of February 2007 reports numbers of people over 65 years with dementia in Wirral as 4,294. Current alternative data suggest this has risen to 4,516. This figure is estimated to increase by 28% by 2020.

NHS Wirral figures for Wirral GP practices in October 2007 show an approximate patient population figure of 359,209 in total. 60 practices report 30,015 people between 65-74 years and 29,064 over 75 years (five practices gave overall figures only).

Wirral Older Peoples Community Mental Health Teams showed a caseload figure of 1,217 patients for the four teams, for the month of May 2008. This figure is a snapshot figure, including dementia and functional mental health, as an indication of the level of activity. This is significantly less than the GP dementia register figure. This is explained by the fact that the Cheshire and Wirral Partnership Trust Community teams provide care to the most severely ill people with mental health issues (dementia, psychosis, depression). A significant number of patients are "managed" at primary care level.




**The Dementia UK report shows figures in Wirral rising by 28% by the year 2020.**



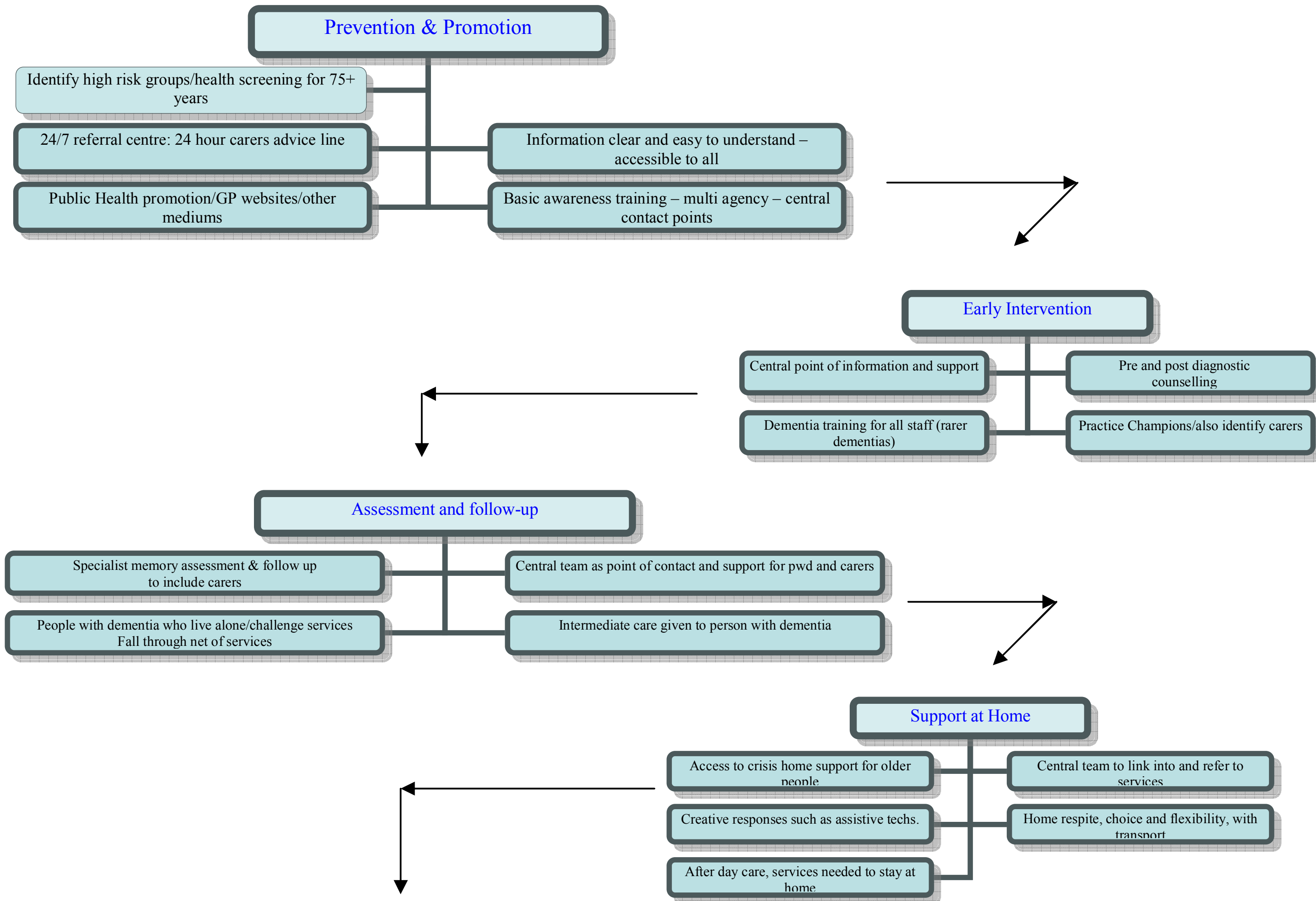
**Care Services Efficiency Delivery (CSED)**

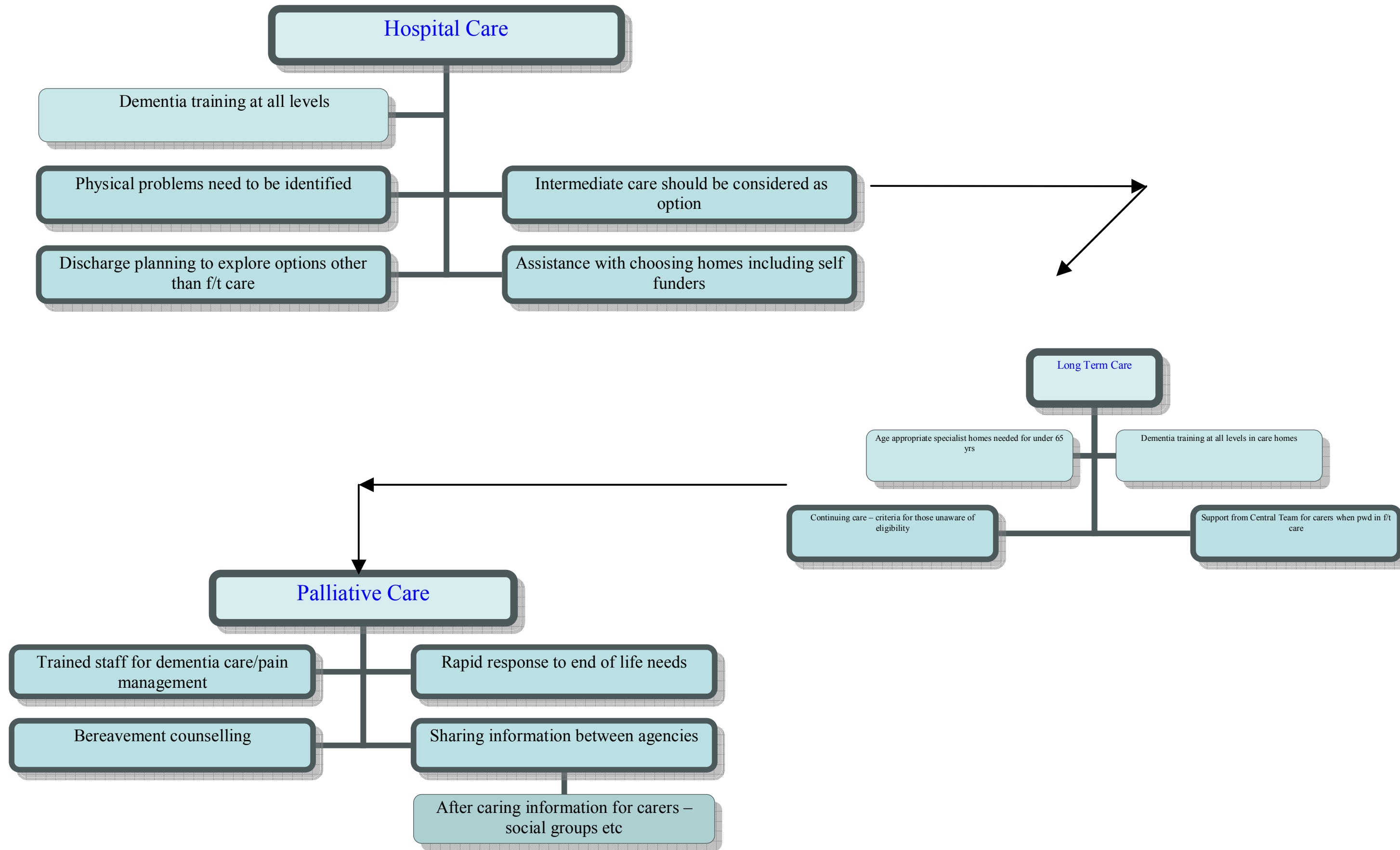
Wirral DASS and NHS Wirral have participated in a national Pilot Project on dementia, in partnership with the care Services Efficiency Delivery Unit (DH). The project supported pathway development building on work already undertaken within the local health and social care economy and gave access to Systems Dynamic Modelling. Specific commissioning intentions have emerged from this project which have been included in this strategy. CSED has enabled the testing out of a range of hypotheses, based on inputted local data, relating to current investment, resources and activity.

**Development of a Dementia Care Pathway**

The table below provides detail about the proposed local dementia care pathway which has been developed as a consequence of detailed consultaion with all appropriate parties.

# DEMENTIA PATHWAY MAPPING EXERCISE





Hospital Care
Dementia training at all levels
Physical problems need to be identified
Intermediate care should be considered as option
Discharge planning to explore options other than f/t care
Assistance with choosing homes including self funders
Long Term Care
Age appropriate specialist homes needed for under 65 yrs
Dementia training at all levels in care homes
Continuing care – criteria for those unaware of eligibility
Support from Central Team for carers when pwd in f/t care
Palliative Care
Trained staff for dementia care/pain management
Rapid response to end of life needs
Bereavement counselling
Sharing information between agencies
After caring information for carers – social groups etc

As indicated Pathway development has involved all key stakeholders and within the separate report key findings and recommendations are set out. The details below provide a synopsis of that more detailed work.

7.7 The need to develop a 'gold' standard dementia care pathway from pre-diagnosis for preventative measures, support at point of diagnosis and at all points along the dementia journey to include end of life care, is vitally important.

7.8 The process for developing a pathway began with a series of small workshops and interviews with stakeholders from primary/secondary health, DASS, the Third Sector and various other agencies. Carers and people with dementia were also involved and the events reviewed current services, identified gaps and mapped emerging issues.

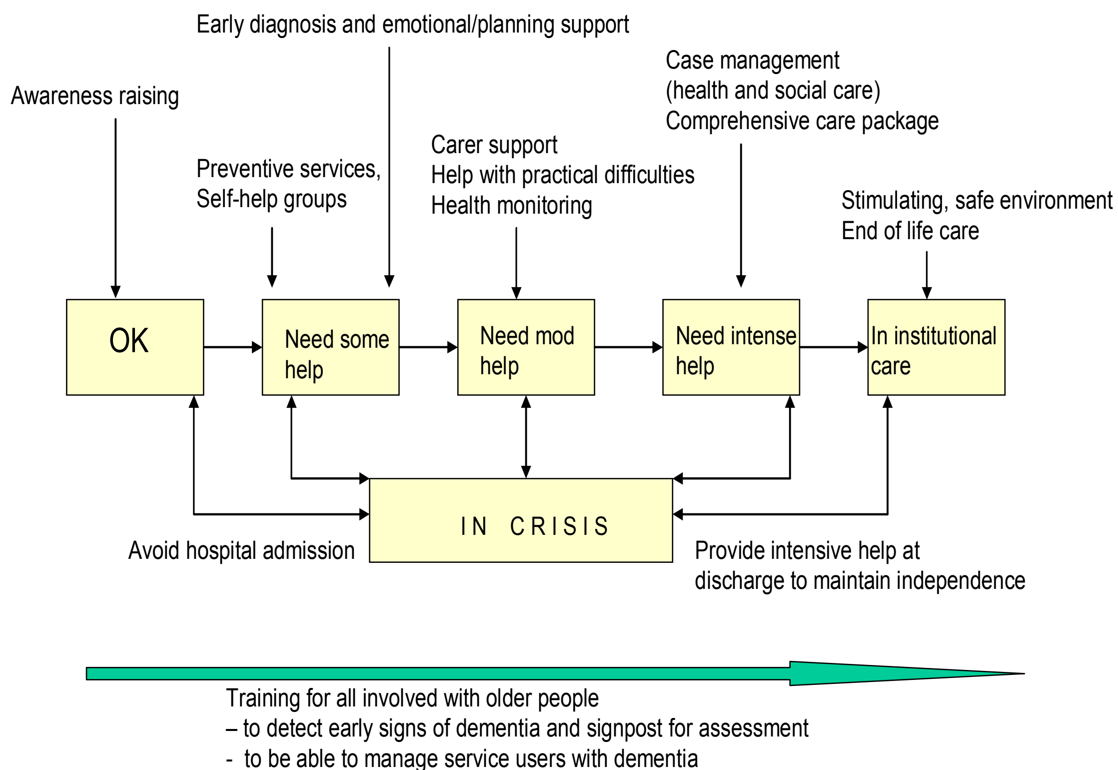
7.9 To ensure that NHS Wirral is able to manage the future demand of people with dementia a dementia service review project was commissioned in November 2007. The project involved a detailed analysis of current services and understanding of some of the bottlenecks within the system. A multi agency team was involved in this process and has developed an 'ideal' pathway for dementia care in Wirral.

7.10 The carer and service user perspective was crucial to the review process. The carers took part, initially in focus groups, considering the present services from their experiences, from diagnosis throughout the course of the illness. A small group also considered end of life issues.

7.11 The Vision and objectives for the dementia work were established at the beginning of the process and they were to:

- Enable people with dementia to remain in their environment of choice
- Reduce use of residential and nursing care homes
- Reduce admissions to the local acute hospital
- Earlier intervention and detection to reduce the "unknown" cohort (people who turn up in an advanced stage of dementia, where a care home may be the only option)

7.12 As a consequence a high level pathway has now been defined. Once finalised and in the light of the National Dementia Strategy, this will be commissioned for the future. It is described in the diagram below. It takes a patient through a four level process from needing a small amount of care, to a moderate level of care to intense care and than to care within an institutional environment.



Recommendations

7.13 The key to the whole pathway will be the establishment of a central multi disciplinary older person's resource/team to act as the focal point for dementia information and support. This resource/team will complement the three community mental health teams for the elderly which will be established in each locality. There are currently four teams and these will be reorganised on a locality basis. The central resource will co ordinate an operating model that:

- Focuses on preventative services
- Increases public and professional awareness of dementia to enable their earlier identification of people who need support
- Ensures that once identified people are pro actively monitored and helped to obtain an integrated support package
- Is geared towards minimising admissions to hospital time in hospital and discharges from hospital straight into a residential setting and is flexible in how it supports people to stay at home where this is their choice
- Helps carers to be confident for longer to delay consideration of residential options
- Ensures dignity and choice and control to the end of their life
- Allows development of Intermediate Care Services for this client group.

7.14 In order to improve the pathway there needs to be a healthy active population with a lower probability of memory loss/dementia. To do this we will make services equally accessible to people with dementia and train the workforce.

7.15 The need to raise public and staff awareness of memory loss and dementia, how to spot early signs and common causes of symptoms and have a willingness to talk about it is recognised. This will need public education and awareness campaigns and staff training for the workforce in Wirral likely to encounter people with memory loss or dementia.

7.16 The need to have easy access to information, advice and support 24/7 when aware that self or loved ones may have memory issues or dementia is evident. This will enable early intervention to have the maximum impact. A single access and information service which would maintain a register accessible to appropriate professionals and offer advice arranging crisis response and interventions will be considered.

7.17 Access to support services early in the disease will improve the individuals and carers quality of life and prolong time in the mild stages of the disease. This would be done by

incorporating access to medical advice (GPs, improved memory clinic) support to carers and suitable housing and transport.

7.18 We need to help to arrange person specific care (where possible) so that choice and control is retained over time. We will do this by new brokerage and advocacy services that the information service would direct people to.

7.19 We need to enable a wide range of flexible respite care and support services that are integrated where appropriate and a real alternative to residential or hospital care. We will also develop an integrated therapy service and prompt the market to offer flexible support services

7.20 We need to retain dignity and choice and control at the end if life as well as throughout the disease. We would do this by initiating the planning process early in the disease via the access and information service, facilitating choice at the end of life (e.g. to die at home with dignity) and develop end of life services for this client group. We will ensure that the needs of older people with mental health problems will be addressed in the End of Life Care Strategy.

7.21 Wirral's ageing population and the increasing likelihood of age related mental health issues, like dementia also has implications for the local housing, care and support agendas and highlights the need for a more joined up approach to the planning and delivery of services. In the Mental Health and Wellbeing Commissioning Strategy we have outlined the housing situation in the current services section and our recommendations in the commissioning intentions section. This will include the development of tailored housing for clients with dementia.

7.22 The recovery model as outlined in the Mental Health and Well Being Integrated Commissioning Strategy is a positive approach which has been generated expressly from service users themselves. In summary, the emphasis of the recovery approach is on using what works for each individual in a planned and structured way, by promoting a self-help approach to maintaining wellness, identifying and monitoring illness triggers and the development of a personal crisis plan. The recovery approach utilises key individuals whether they are family members, friends or professionals to support the person with mental health problems. It enables people to take back control over their 'treatment' and encourages people to develop their own 'wellness' tools to compliment mainstream health care approaches.

7.23 This approach could be used to explore models with older people who are in the early onset of dementia, to build up the recovery principles and a picture of what is key to the patient. As a progressive illness takes hold carers are still able to communicate with the patient about their likes and wants. They would have a wellness recovery plan which is an individual and personalised approach – this could not only make a difference to the service user but to carers as well.

7.24 Specifically Memory Services will be expanded and developed.

7.25 Crisis support services will be provided.

7.26 This overall direction will need to be supported by the identification and increase of senior medical support with special responsibility for dementia. Additional investment will address the issue of Wirral's comparative position in relation to other PCTs. The recommendations of Royal Colleges, the need to improve care for older people with mental health problems in acute hospital settings, the need to support patients, carers and staff in education and awareness programs will all need to be considered.

## INTEGRATED COMMISSIONING

8.0 The local health and social services economy has identified mental health as one of its key priorities in the development of its Strategic Plan, in line with the World Class Commissioning Framework.

8.1 For these services the aim will be to undertake the process of commissioning jointly between the NHS and the Local Authority where appropriate.

8.2 Joint commissioning may mean we will have to change the way in which we deliver services. Some services may no longer meet our priorities or deliver the outcomes that we wish to achieve. Some services may not offer value for money or not deliver to contract specifications. In such circumstances services will need to be de-commissioned and monies disinvested.

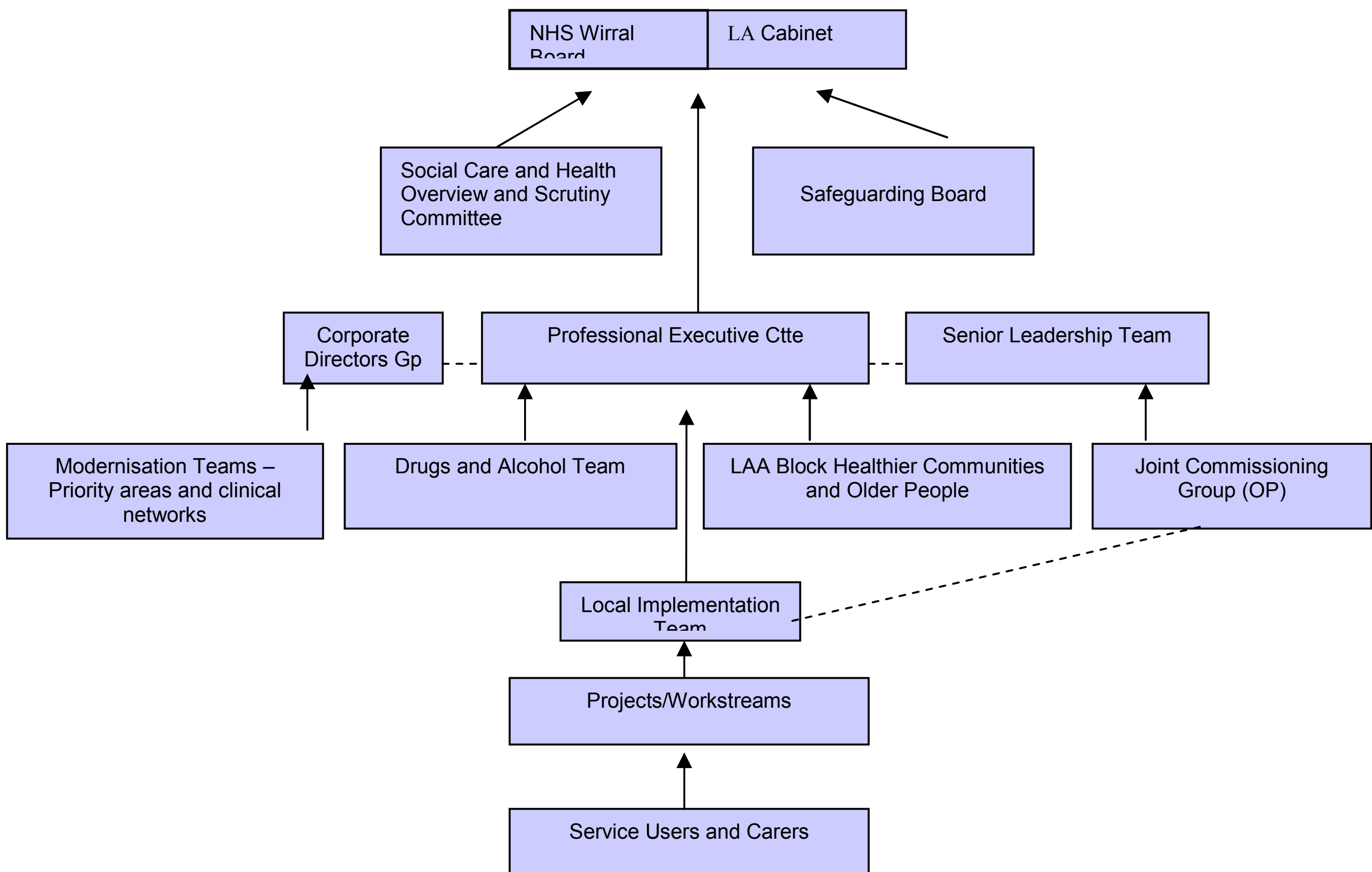
8.3 Secure mental health services for Wirral residents are commissioned on behalf of NHS Wirral by the North West Specialised Services Commissioning Team. The establishment of Specialised Commissioning Groups (SCGs), coterminous with the SHA footprints, and supported by dedicated teams of specialised service commissioners, will facilitate a more integrated and cohesive approach to the commissioning of these specialist services.

8.4 The Local Implementation Team (LIT) for Wirral currently acts as the key commissioning forum to bring together stakeholders involved in the planning and development of mental health services in Wirral[7]. Its place in the joint planning process is illustrated below. Stakeholders include representatives from NHS Wirral, Wirral DASS, Cheshire and Wirral Partnership NHS Foundation Trust, service user and carer representatives, and representation from the Third Sector.

8.5 Wirral LIT has commissioned a service user led organisation, Disability Consultancy Service (DCS), to undertake a rolling programme of reviews of mental health services, the outcomes of which are reported back to the LIT on a regular basis. All of the recently undertaken reviews of service have involved key stakeholders in a number of process mapping workshops, and DCS have been commissioned to involve service users and carers in these processes. The advice and recommendations of DCS have and will directly influence the design of services.

8.6 Service users and carers will be invited to attend and actively take part in all relevant meetings concerning the development and commissioning of mental health services. Adequate training and support will be provided for service users and carers to enable them to take a full and equal part in the meetings they attend[8].

**GOVERNANCE STRUCTURE**
**PARTNERSHIP ARRANGEMENTS**




8.7 The governance arrangements will be the subject of early and urgent review to ensure that appropriate arrangements are in place to develop services in a timely way.

8.8 The Joint Commissioning Group (Older People) includes representatives from The Cheshire and Wirral Partnership Trust, the Alzheimer's Disease Society and carers.

8.9 The governance arrangements are subject to current review to ensure that they are responsive to current priorities and timetables and that they are based on an inclusive approach.

## SERVICE USERS AND CARERS

9.0 As already stated the engagement of service users and carers in the planning, development, commissioning and provision of services is recognised as crucial.

9.1 A Commissioning Strategy for Carers has been drawn up to refresh the last Carers Strategy that was approved in 2006 and to take account of changes in legislation and guidance. It is intended as a statement of how services will be developed and delivered for carers in Wirral over the next three years.

9.2 There are many reasons why carers should be supported: In summary:

- The number of people needing carer support is increasing.
- Carers are a valuable resource and make a vital and meaningful contribution to care.
- If appropriate support is not provided, the result is that the caring role becomes unsustainable, or carers themselves become ill

In recognition of this it will be more important than ever to make sure that available resources are targeted appropriately and used to support carers in the way that they themselves perceive to be the most beneficial.

9.3 The vision for carers in Wirral is one of a consistent and accessible programme of support. The pathway into the system should be straightforward: anybody who becomes a carer should be able to find accurate and up-to-date information quickly and easily and they should have access to the level of support they want from the outset.

9.4 Each carer should be able to talk to a specialised worker if they want to, who can point them in the direction of support agencies specific to their individual circumstances. All of the agencies in Wirral should work in harmony, and the crossover between DASS, NHS Wirral and the Third Sector should be as seamless as possible. Agencies should have enough information to feel comfortable in cross-referring carers to other agencies where this is appropriate.

9.5 The vision for carers in Wirral is also one in which carers are actively encouraged to participate at all levels in the decision making processes, in respect of issues that affect them or the person they care for.

9.6 Locally information from the last census (2001) shows that in Wirral there are 22.52% of the population who have a limiting long term illness, compared to 17.93% nationally. As a result, there are also proportionately more carers in Wirral than there are nationally, with 23.75% of carers in Wirral providing care for 50 hours or more per week, compared to 20.48% of carers nationally, who are providing care at that level.

9.7 During Carers Week in June 2007, partners from the Carers Development Committee hosted advice and information stands throughout Wirral. These events provided an opportunity to gather anecdotal evidence from carers about the services that they felt would be most helpful. Comments received related to, lack of information, the feeling of isolation as a carer, confusion and poor communication about carers assessments, the need for a counselling service, information about holidays, support groups, financial advice, advice about employment issues and information about specific illnesses.

9.8 A survey was undertaken in September 2007 of 670 carers in Wirral aimed to establish basic information and to identify their priorities for the provision of support services. In the main, the results of the local survey confirmed findings from national surveys. For example, accessible information was needed, practical help around the home, training in connection with their caring role, recreation and relaxation classes, employment and breaks in order to sustain the caring role. In summary the findings were; make the system accessible, give carers peace of mind, co ordinate the current services, improve facilities and value carers contribution.

9.9 Within Wirral a Carers for Dementia project was launched in September 07. The objectives of the project were to:

- Identify and seek out carers of older people with dementia who are not currently receiving services and may not be aware of the support available
- Help prevent later carer breakdown that would otherwise be likely to result in an emergency admission to hospital or institutional care
- Work to have this service established within the care pathway for first diagnosis of dementia, whether in primary care or elsewhere
- Demonstrate that project objectives have been achieved through formal evaluation that is robust and valid

9.10 All carers contacting the project are offered timely information. Carers accessing the project, after the initial visit are put in touch with appropriate services and follow up visits arranged as required. Carers also feel able to contact the worker for ongoing support as and when issues arise[11].

9.11 Carers are one of the key resources in service provision and we see them as part of the service that needs support, training and above all to be valued.

**Annex 1**

**DH National Dementia Strategy (Objectives and Outcomes).**
**(See ww.dh.gov.uk/dementia)**

| **Objectives**<br><br>What we want the Strategy to achieve | **Outcomes**<br><br>What the Strategy will mean for people with dementia and their carers |
|---|---|
| 1. Raise awareness of dementia and encourage people to seek help | The public and professionals will be more aware of dementia and will understand dementia better. This will:<br>• help remove the stigma of dementia<br>• help people understand the benefits of early diagnosis and care<br>• encourage the prevention of dementia<br>• reduce other people's fear and misunderstanding of people with dementia. |
| 2. Good-quality, early diagnosis, support and treatment for people with dementia and their carers, explained in a sensitive way | All people with dementia will have access to care that gives them:<br>• an early, high-quality specialist assessment<br>• an accurate diagnosis which is explained in a sensitive way to the person with dementia and their carers<br>• treatment, care and support as needed after the diagnosis.<br>Local services must be able to see all new cases of people who may have dementia in their area promptly. |
| 3. Good-quality information for people with dementia and their carers | People with dementia and their carers will be given good-quality information about dementia and services:<br>• at diagnosis<br>• during their care. |
| 4. Easy access to care, support and advice after diagnosis | People with dementia and their carers will be able to see a dementia adviser who will help them throughout their care to find the right:<br>• information<br>• care<br>• support<br>• advice |

| | |
|---|---|
| 5. Develop structured peer support and learning networks | People with dementia and their carers will be able to:<br>• get support from local people with experience of dementia<br>• take an active role in developing local services. |
| 6. Improve community personal support services for people living at home | There will be a range of flexible services to support people with dementia living at home and their carers.<br>Services will consider the needs and wishes of people with dementia and their carers. |
| 7. Implement the New Deal for Carers | Carers will:<br>• have an assessment of their needs<br>• get better support<br>• be able to have good-quality short breaks from caring. |
| 8. Improve the quality of care for people with dementia in general hospitals | This way people with dementia will get better care in hospital:<br>• it will be clear who is responsible for dementia in general hospitals and what their responsibilities are<br>• they will work closely with specialist older people's mental health teams. |
| 9. Improve intermediate care for people with dementia | There will be more care for people with dementia who need help to stay at home |
| 10. Consider how housing support, housing-related services, technology and telecare can help support people with dementia and their carers | Services will:<br>• consider the needs of people with dementia and their carers when planning housing and housing services<br>• try to help people to live in their own homes for longer. |
| 11. Improve the quality of care for people with dementia in care homes | Services will work to ensure:<br>• better care for people with dementia in care homes<br>• clear responsibility for dementia in care homes<br>• a clear description of how people will be cared for<br>• visits from specialist mental health teams<br>• better checking of care homes |

| | |
|---|---|
| 12. Improve end of life care for people with dementia | People with dementia and their carers will be involved in planning end of life care.<br><br>Services will consider people with dementia when planning local end of life services. |
| 13. An informed and effective workforce for people with dementia | All health and social care staff who work with people with dementia will:<br>• have the right skills to give the best care<br>• get the right training<br>• get support to keep learning more about dementia. |
| 14. A joint commissioning strategy for dementia | Health and social care services will work together to develop systems to:<br>• identify the needs of people with dementia and their carers<br>• best meet these needs.<br><br>There is guidance in the Strategy to help services to do this. |
| 15. Improve assessment and regulation of health and care services and of how systems are working | There will be better checks on care homes and other services to make sure people with dementia get the best possible care. |
| 16. Provide a clear picture of research about the causes and possible future treatments of dementia | People will be able to get information from research about dementia.<br>We will do lots of things to identify gaps in the research information and do more research to fill the gaps. |
| 17. Effective national and regional support for local services to help them develop and carry out the Strategy | The Government will give advice and support to local services to help them carry out the Strategy.<br><br>There will be more good-quality information to help develop better services for people with dementia. |

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| 7 | Strategic Plan 2008 -2013, Working Together for a Healthier Future, NHS Wirral |
| 8 | A Strategic Joint Commissioning Framework for Children and Young People in Wirral 2007 |
| 9 | A Strategic Joint Commissioning Framework for Children and Young People in Wirral 2007 |
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| 11 | Update - Carers for Dementia Project DASS 2008 |
| 12 | Health Impact – DASS - 2008 |
| 13 | Joint Commissioning Strategy for Carers DASS 2008 (draft) |
| 14 | Strategic Plan 2008 -2013, Working Together for a Healthier Future, NHS Wirral |
| 15 | SHA Utilisation Management Review - 2007 |

# WIRRAL COUNCIL

## THE HEALTH & WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

## 12 MARCH 2012

| | |
|---|---|
| **SUBJECT:** | Report for Dementia Scrutiny Review:' The care of people with dementia in an acute hospital setting'<br>Final report February 2011 |
| **WARD/S AFFECTED:** | All |
| **REPORT OF:** | Gary Doherty<br>Acting Chief Executive - WUTH |
| **RESPONSIBLE PORTFOLIO HOLDER:** | Councillor Jeff Green |
| **KEY DECISION** | NO |

### 1.0 EXECUTIVE SUMMARY

1.1 This report provides the Overview and Scrutiny Committee with the progress made against the recommendations in "The care of people with dementia in an acute hospital setting" Final Report February 2011.

### 2.0 BACKGROUND AND KEY ISSUES

2.1 The National Dementia Strategy for England, launched in February 2009, stated that up to 70% of acute hospital beds were occupied by older people and up to half of those may be people with cognitive impairment, including those with dementia and delirium.

2.2 The Alzheimer's Society report, 'Counting the Cost' produced in 2009, estimated that people with dementia over 65 years of age are occupying one quarter of hospital beds at any one time. The same report found that people with dementia stay far longer in hospital than other people without dementia who are treated for the same procedure.

2.3 The 'Joint Strategic Needs Assessment ', for Wirral, produced by NHS Wirral in 2009/10, estimated that there were 4,266 older people with dementia in Wirral.

2.4 Data from Dr Foster (2009) identified that Wirral has a higher number of hospital admissions for dementia when compared to the North West and the national average. Emergency admissions for dementia in Wirral were 53.8% higher than expected against the national average.

2.5 In 2010 the Trust participated in the first National Audit of Dementia (Care in General Hospitals) and the interim report was published in December 2010, which provided a base line for action to be taken by the Organisation. This included the establishment of a Dementia Care Steering group with key stakeholders and the development of an action plan to improve dementia care at the Trust.

2.6 This report details the progress made at Wirral University Teaching Hospital with the recommendations set out in the Wirral Overview and Scrutiny Committee *"Dementia*

*Scrutiny Review: 'The care of people with dementia in an acute hospital setting' Final report February 2011".*

**PROGRESS WITH RECOMMENDATIONS**

**Register of patients with dementia / dementia passport**

2.7 A register of patients who have dementia will be developed as the implementation of the new patient administration system Cerner Millennium is introduced. As part of the admission process a flag will be applied to the electronic patient record to identify patients with dementia.

2.8 The use of the health passport which is already in place for patients with complex needs is encouraged with the addition of the **This is me** document.

2.9 The **This is me** document has been distributed to urgent care admission areas and relevant wards. The Nursing documentation has been updated to include a prompt for nursing staff to implement the **This is me** document or to ask the patient, relative or carer if they have one in place. The use of **This is me** documentation is being monitored by the Deputy Director of Nursing.

2.10 The Dementia Care pathway has also been developed by the Dementia Care Steering group, led by Dr Mike Rimmer (CWP Trust), and is now available on the intranet for staff to follow.

**Receipt of information regarding the patient with dementia**

2.11 The use of the **This is me** documentation is being promoted by the urgent care admission and ward areas. The Trust is in discussion with the Ambulance service about the use of this document.

2.12 If the diagnosis of dementia is known on admission the use of the 'forget me not' symbol is used at ward level.

2.13 Community Trust and Social Care colleagues are based at the Arrowe Park hospital site and are aware of the use of the health passport and **This is me** documentation for patients with complex needs and dementia.

**Minimise the number of moves within hospital**

2.14 The Trust has a policy and procedure for the Transfer of Patients within the organisation. The policy has key performance indicators which are monitored through audit and weekly incident report data. The implementation of delivering same sex accommodation has removed a transfer for patients who are now admitted to the female or male medical assessment units.

**Assistance at mealtimes / personal care**

2.15 A separate Nutrition action plan for the Trust was developed in April 2011 by the Deputy Director of Nursing and included improving assistance at mealtimes. During the past year to raise awareness of the importance of the nutritional needs of patients

the Executive Directors participated in a monthly programme of assisting at mealtimes. Spot checks are undertaken by the senior Nurses. Compliance with the MUST nutrition assessment is monitored through the monthly ward performance audits, wards identified as deficient present an action plan to the Care Standards Executive which is chaired by the Director of Nursing & Midwifery.

2.16 The use of the 'forget me not ' symbol and laminated card, details information for healthcare professionals and support staff including Housekeepers and Porters about what name the patient with dementia likes to be referred to and their eating and drinking preferences such as " I like sugar in my tea".

2.17 Patient experience data gained through the learning with patient's questionnaire returns and kiosk deployment provide valuable intelligence into the provision of assistance at mealtimes and attention to personal needs.

**Information flow with carers**

2.18 On admission to hospital the nursing undertake a patient's needs assessment which is recorded in the nursing documentation. This includes a prompt for the nursing staff to check if the patient has a health passport and or **This is me** document in place. The 'forget me not' card is also completed with the patient, relative or carer.

2.19 If the patient has a health passport and or **This is me** document, there is a prompt on the discharge action plan to ensure that the documentation is returned to the patient on discharge.

**Environmental issues on the ward**

2.20 The Matron for the Directorate of Medicine for the Elderly (DME) has undertaken a pilot project to evaluate the use of movement sensor assistive technology. Product selection has been made and a business case is in development to purchase the equipment.

2.21 Signage on the wards has been improved as part of the model ward programme and delivering same sex accommodation requirements.

2.22 The use of a 'Reminiscence Pod' was launched at an open day event on 9 January 2012. This is a 1950s style pop up living room, complete with authentic furniture and fully working 1950s television and radio (see appendix for photograph).

**The role of specialist dementia nurses**

2.23 Matron M Davies (DME) has taken the lead from a nursing perspective, who acts as a source of advice for nursing staff to access for help relating to care of patients with dementia. Three nurses from DME are undertaking the University post qualification module in Dementia care.

**Safeguarding**

2.24 The Trust's safeguarding team works very closely with ward staff to develop a care plan for the management of patients admitted with dementia. Extra staff are requested

from the flexibank to cover the duties that should be undertaken by the ward nurse who is providing one to one care for the patient with dementia. The use of the **This is me** document provides valuable information to support the management of a patient with dementia.

**Discharge planning**

2.25 Discharge planning begins on admission to hospital and the nursing documentation used for all patients contains a discharge action plan to ensure that the specific needs of patients are met. The Trust has a Discharge policy and procedure which is monitored through audit and incident reporting data.

**Staff training**

2.26 A Dementia update was held in October 2011 for medical staff and another event is planned for the spring term 2012. In association with the Alzheimer's Society two successful dementia care awareness one day programmes have been held for priority staff who include DME Nursing and Care Support workers, Medical staff and Security staff. These sessions will be repeated throughout 2012.

2.27 To comply with NHS LA risk management standards other safeguarding training which includes dementia awareness is well attended and monitored.

2.28 There is also access for nursing staff to the University post qualification modules for dementia care and care of the Older person.

2.29 A dementia care awareness event has taken place on 9 January 2012 to promote the work being done at the Trust to improve care for patients with dementia.

2.30 A training DVD on the management of patients with dementia has also been produced in collaboration with Cheshire & Wirral Partnership Trust , and with advice and input from the relatives and carers of people affected with dementia and was launched on 9 January 2012.

## 3.0 RELEVANT RISKS

3.1 The care of people with dementia is a priority for WUTH.

## 4.0 OTHER OPTIONS CONSIDERED

4.1 Not applicable.

## 5.0 CONSULTATION

5.1 Not applicable.

## 6.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

6.1 The Trust has worked in partnership with the voluntary sector and community groups.

## 7.0 RESOURCE IMPLICATIONS: FINANCIAL; IT; STAFFING; AND ASSETS

7.1 Not applicable.

## 8.0 LEGAL IMPLICATIONS

8.1 Not applicable.

## 9.0 EQUALITIES IMPLICATIONS

9.1 Has the potential impact of your proposal(s) been reviewed with regard to equality?

## 10.0 CARBON REDUCTION IMPLICATIONS

10.1 Not applicable.

## 11.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

11.1 Not applicable.

## 12.0 RECOMMENDATION/S

12.1 Progress is being made with the dementia care action plan as described and the Dementia Care Steering group remains active in the pursuit of improvement. A Dementia awareness day has taken on 9 January 2012, to celebrate and promote the work that has been done during 2011 and advertise initiatives for 2012. Collaboration with partners such as the Older People's Parliament, Age Concern, Alzheimer's Society and volunteers will continue to support the delivery of action required to improve the care for patients and their relatives and carers at the Trust.

12.2 Publication in December 2011 of the final Report of the National Audit of Dementia Care in General Hospitals 201, contains recommendations for action which will further populate the existing dementia care action plan for the Trust throughout 2012.

## 13.0 REASON/S FOR RECOMMENDATION/S

**REPORT AUTHOR:** Lesley Metcalfe
Deputy Director of Nursing on behalf of Tina Long, Director of Nursing and Midwifery/DIPC – January 2012
Telephone: (0151) 604 7240
email: Lesley.metcalfe@nhs.net

## APPENDICES

Dementia Awareness Event flyer (attached).

## REFERENCE MATERIAL

## SUBJECT HISTORY (last 3 years)

| Council Meeting | Date |
|---|---|
| | |

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**APPENDIX 1**

# Dementia Awareness Event

**Learn:** About the work being done in our hospitals to improve care for patients with dementia.

**Hear:** About the 'This Is Me' and 'Forget Me Not'

**View:** The 'Reminiscence Pod' – a1950s pop-up living room, complete with authentic furniture and a fully working 1950s television and radio.

**Who:** Hospital staff, relatives, carers and anyone who wants to learn more about Dementia Awareness.

**When:** Monday 9th January, 1pm to 5pm

**Where:** Main Foyer, Arrowe Park Hospital

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# WIRRAL COUNCIL

## HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE

## 12 MARCH 2012

| | |
|---|---|
| SUBJECT: | LINKS TRANSITION TO A LOCAL HEALTHWATCH ORGANISATION |
| WARD/S AFFECTED: | ALL |
| REPORT OF: | GRAHAM HODKINSON<br>DIRECTOR OF ADULT SOCIAL SERVICES |
| RESPONSIBLE PORTFOLIO HOLDER: | COUNCILLOR JEFF GREEN |
| KEY DECISION: | NO |

### 1.0 EXECUTIVE SUMMARY

1.1 This report updates the Overview and Scrutiny Committee on the progress towards establishing a local HealthWatch organisation as directed by the Health and Social Care Bill currently progressing towards Royal Assent.

### 2.0 BACKGROUND AND KEY ISSUES

2.1 A requirement of the Local Government and Public Involvement in Health Act (2007) was that Local Involvement Networks (LINks) should be established to supercede existing Patient Forums. Each Local Authority was obliged to contract an organisation (known as a host) to establish and then support a LINk. Each Local Authority area had autonomy to decide how they wanted their LINks to be run and the issues on which it was to focus.

In Wirral, Voluntary Community Action Wirral (VCAW) won the contract to host the Wirral LINks and has successfully provided support and guidance for the activities of the Wirral LINks to date. The Health and Social Care Bill (2011) makes provisions for the establishment of HealthWatch England and the transition of existing LINKs into local HealthWatch organisations. This was to have taken effect from 1 October 2012. However, a new start date of April 2013 was announced on 3 January 2012. The Act will charge Local Authorities with the duty to ensure that there is an effective and efficient local HealthWatch in their area, with functions, roles and responsibilities not currently available to LINks.

2.2 The relationship between the host organisation, VCAW, and the Wirral LINks has been very productive; all LINk members are volunteers and have been able to concentrate on the areas of interest whilst the infrastructure has been overseen by VCAW. The relationship with the Department has also functioned well, whilst not compromising the ability of LINks to operate as an independent champion for continually improving the quality and standards of health and social care provision for the people of Wirral.

2.3 A criticism of the LINks mechanisms has been that there is no national voice for all of the local networks, and this is to be addressed by the creation of a national body, HealthWatch England, which will have three core responsibilities: leadership, advice, and escalating concerns nationally. The announcement of 3 January also included £3.2m to be made available nationally for start up costs in setting up local Healthwatch. Notification of the allocation for Wirral has not been received.

2.4 Local HealthWatch organisations will maintain all existing LINk functions, such as their powers of 'Enter and View', and will continue to have a role in influencing the provision of local services and monitoring any concerns about services but in addition will have a seat at the Health and Wellbeing Board and take on responsibility for advocating for individuals who wish to make a complaint about healthcare.

2.5 The key issue for Wirral HealthWatch is the form of the organisation that will enable these functions. Although the Government's 'HealthWatch Transition Plan' states clearly that there should be an evolution from the current LINks organisations to the new HealthWatch organisations, there is contradictory advice and guidance about how this should happen.

**2.6 The organisational model of Wirral HealthWatch**

2.6.1 Although the Government advises an evolution from the current system, under which a host supports volunteers to carry out the LINks functions, there is a stipulation that the local HealthWatch organisation must be a 'body corporate', or legal entity, in its own right, so the host relationship must end. The Government has not provided any clear advice or guidance on what is to replace this arrangement.

2.6.2 A local HealthWatch Transition Group has been established, comprising members from DASS, NHS Wirral, VCAW, Wirral LINks, Wirral University Teaching Hospital, Clatterbridge Centre for Oncology, the Community Trust and the Ambulance Trust. This group has deliberated on the best model for the delivery of the required HealthWatch outcomes and is being advised by the Borough Solicitor and guided by the work of the various Pathfinder sites. In the absence of clear Government guidance on the form of a local HealthWatch organisation, Wirral's position reflects that other Local Authorities around the region.

2.6.3 The Transition Group considers the following model (see attached) developed in association with Transition Alliance NorthWest (a grouping of stakeholders from Local Authorities, NHS and Public Health) as the most appropriate. In this model:

- The Transition Group (after wide consultation with stakeholders about the form and representation) co-ordinates the establishment of a Wirral HealthWatch Board, which would take the necessary steps to become the 'body corporate'.
- This Board would appoint a Project Manager/ Chief Officer to co-ordinate the work of the volunteers who would carry out the required HealthWatch functions of signposting, influencing and complaints advocacy, as well as the necessary business support functions.

- At least two HealthWatch volunteers will be invited to sit on the Board as non-executive Directors.
- Wirral HealthWatch would be commissioned and regulated by DASS, with regular monitoring meetings in place.
- A member of the HealthWatch volunteers will have a place on the Health and Wellbeing Board.

2.6.4 Advice is being sought from the Borough Solicitor's office and Transition Alliance NW about how this model could be funded, as by definition it could not be tendered out (there can only be one body corporate known as 'Wirral HealthWatch', for example). Given that 150 Councils are likely to be in a similar position, it may be that an enabling clause will have to be introduced into the Bill.

## 3.0 RELEVANT RISKS

3.1 There is a risk that the new model may not function as well as the current arrangement, either because volunteers can not be identified of sufficient calibre to run the body corporate, or because of some other, unforeseen factor.

## 4.0 OTHER OPTIONS CONSIDERED

<u>Mitigation of Risk</u>

4.1 The HealthWatch Transition Plan provides a contingency measure for the Local Authority to put in place 'different arrangements if a local HealthWatch organisation is not operating effectively'. This exact nature of these 'different arrangements' would have to be discussed, but the wording does provide the opportunity for the Local Authority to intervene.

4.2 In the event of difficulties with the model, the Local Authority could discuss the issues with HealthWatch England, an option that is not currently available (nor has been needed) with Wirral LINk.

## 5.0 CONSULTATION

5.1 A full programme of consultation with the public and the Voluntary, Community and Faith sector about the shape and what they would expect from a Wirral HealthWatch organisation will take place in early 2012.

## 6.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

6.1 See 5.1 above. The transition to HealthWatch is designed to maximise the involvement and voice of people either as individuals or via the groups to which they belong.

## 7.0 RESOURCE IMPLICATIONS: FINANCIAL; IT; STAFFING; AND ASSETS

7.1 **FINANCIAL** – there is no envisaged change to the current funding arrangements at present but see 2.4 above about how the body corporate could be funded within current procurement arrangements.

7.2 **IT** – there are no IT implications

7.3 **STAFFING** – depending on the job description for the Project Manager, there may need to be a TUPE arrangement with the current host.

7.4 **ASSETS** – there are no asset implications arising from this report.

## 8.0 LEGAL IMPLICATIONS

8.1 There is a legal requirement to establish a Wirral HealthWatch as a body corporate and the Borough Solicitor's office is providing advice.

## 9.0 EQUALITIES IMPLICATIONS

9.1 An Equality Impact Assessment will be carried out when the shape of the HealthWatch model is clarified.

## 10.0 CARBON REDUCTION IMPLICATIONS

10.1 There are no implications arising directly from this report.

## 11.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

11.1 There are no implications arising directly from this report.

## 12.0 RECOMMENDATION/S

12.1 That Committee support the Transition Group in seeking to develop the most appropriate model for a successful Wirral HealthWatch organisation.

## 13.0 REASON/S FOR RECOMMENDATIONS

13.1 The development of HealthWatch is a statutory requirement – therefore the support to develop a successful model is vital.

**REPORT AUTHOR:** ***Nick Broadhead***
*Principal Manager - Community Services*
Telephone: 0151 666 3632
email: nickbroadhead@wirral.gov.uk

## APPENDICES

Appendix 1 - HealthWatch model flowchart

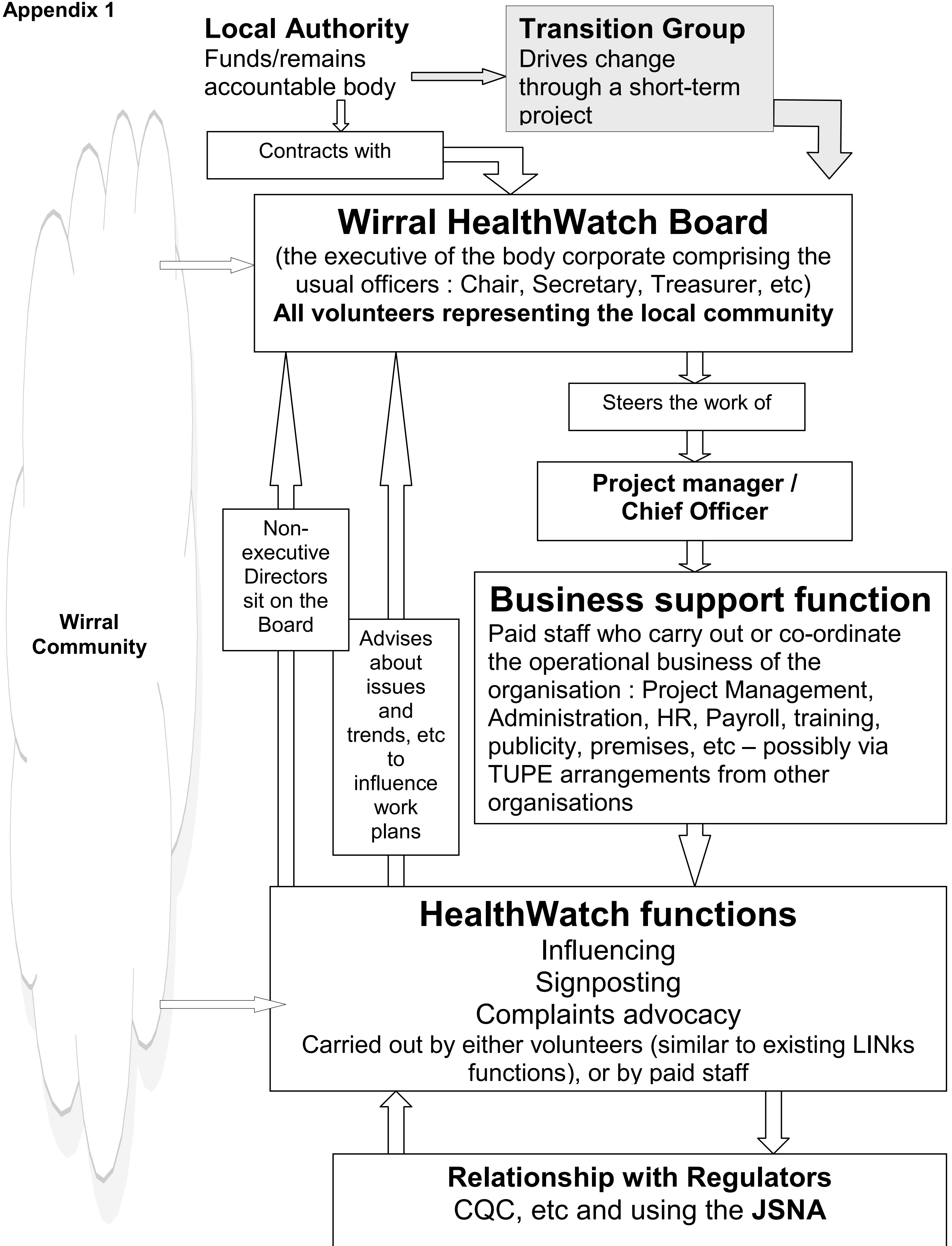
## REFERENCE MATERIAL

- Health and Social Care Bill: - http://www.publications.parliament.uk/pa/cm201011/cmbills/177/11177.156-162.html#j555
- HealthWatch Transition Plan, DoH March 2011: - http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126325.pdf
- DoH Gateway Reference 17068, 3 January 2012

## SUBJECT HISTORY (last 3 years)

| Council Meeting | Date |
|---|---|
| N/A | N/A |

**Appendix 1**



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# WIRRAL COUNCIL

## HEALTH & WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

**12 MARCH 2012**

| **SUBJECT:** | 2011/12 Third Quarter Performance and Financial Review |
|---|---|
| **WARD/S AFFECTED:** | All |
| **REPORT OF:** | Graham Hodkinson, Director of Adult Social Services |
| **KEY DECISION:** | No |

**1.0 EXECUTIVE SUMMARY**

1.1 This report sets out performance of the Council's Corporate Plan 2011-14 for the period October to December 2011 in relation to health and wellbeing and provides members with an overview of performance, resource and risk monitoring.

**2.0 BACKGROUND AND KEY ISSUES**

2.1 The presentation accompanying this report provides an overview of quarter three performance with more detail outlined in this report including corrective action where there are performance issues.

2.2 **PERFORMANCE HEADLINES - YOUR FAMILY: ADULTS**

**Corporate Goal (1): Ensure vulnerable people in Wirral are safe and protected**

**What's working well**

- Wirral's Family Safety Unit has been awarded the prestigious Leading Lights status, one of only two authorities to receive the award. Leading Lights status is awarded by the charity Co-ordinated Action Against Domestic Abuse (CAADA). The organisation supports Independent Domestic Violence Advisors (IDVA) in their work with current and potential victims of domestic violence and their families.

- The enhanced 'front-end' management of safeguarding alerts in the Central Advice and Duty team is impacting positively upon on the numbers of cases being referred to the Department for consideration.

**Corporate Goal (2): Ensure that the widest possible options for care and support are made available close to where people live**

**What's working well**

- Pioneering work on an innovative local scheme 'The Wirral Rapid Access Service' by the Council and NHS Wirral reached the finals of the national Health and Social Care Journal awards. The Wirral Rapid Access Service was commissioned by NHS Wirral and local GPs in partnership with the Department of Adult Social Services, Wirral Hospital Trust and Wirral Community Trust and started in December 2010.

- Work undertaken by the Department in partnership with NHS Wirral has led to the Council becoming the best performing Authority in the region for ensuring that people are appropriately discharged from hospital.

**Corporate Goal (3): Ensure that people can choose the care they need from a range of high-quality support services and options for care**

**What's working well**

- A new online 'one stop shop' for wellbeing, health and social care services in Wirral www.wirralwell.org has been developed by Voluntary and Community Action Wirral (VCAW). The site brings together information and advice on health, social care and wellbeing, and will be an invaluable resource for all residents, particularly those who need signposting to health and social care services, and services for families and carers.

- As part of Wirral's 'Personalisation' agenda a proposal has been set out to pilot a new business centre that will offer training, education and work opportunities to vulnerable adults, as part of day service transformation.

- The Department is also engaged in consultations with people with learning disabilities, their families and carers about the wider future of day services in Wirral.

**Corporate Goal (4): Ensure that vulnerable people and those in later life can get the care and support they need at an early stage to prevent problems getting worse**

**What's working well**

- There has been a significant expansion of long term care and support options for older people through the commissioning of two extra care schemes.

- The investments made through targeted funding of health and social care schemes have led to improvements in facilitating hospital discharges, supporting reablement and rehabilitation.

## 2.3 PERFORMANCE AGAINST CORPORATE PLAN PROJECTS

All of the Corporate Plan projects are on target.

## 2.4 PERFORMANCE AGAINST CORPORATE PLAN INDICATORS

The following indicator has missed its quarter three target and is therefore assessed as **amber:**

<table>
<tr><th rowspan="2">Portfolio</th><th rowspan="2">PI no</th><th rowspan="2">Title</th><th colspan="2">2011/2012</th><th rowspan="2">On target</th><th rowspan="2">Direction of travel</th></tr>
<tr><th>Q3 Target</th><th>Q3 Actual</th></tr>
<tr><td>Social Care & Inclusion</td><td>NI 130</td><td>Percentage of Social care clients receiving Self Directed Support</td><td>68.94%</td><td>63.33%</td><td>Amber</td><td></td></tr>
<tr><td>Corrective Action:</td><td colspan="6">It has become clear that it is not possible to reach the 100% target for NI 130 (set for April 2013) because the original National indicator guidance requires that cases that cannot be considered to receive a personal budget must be included. It is proposed to review this position for 2012/13.<br><br>Close monitoring of referral activity in operational teams is being undertaken to determine if referral rates are impacting on this indicator.<br><br>Performance in service areas and localities is also being evaluated to determine if there are any related issues, such as delays in inputting assessments, which may have impacted on the Qtr 3 Performance. Measures can then be put in place to address this.</td></tr>
<tr><td>Performance Analysis:</td><td colspan="6">Performance for the first half of 2011/12 was on target, but the Q3 target has been missed by 5.61%.<br><br>Although currently forecast to miss the 2011/12 year end target by 5% corrective action should ensure that the year end target of 80% is achieved.</td></tr>
</table>

## 2.5 PERFORMANCE AGAINST STRATEGIC CHANGE PROJECTS

The following strategic change projects have been assessed as **red:**

<table>
<tr><th colspan="3">Status</th><th rowspan="2">Project</th><th rowspan="2">Corrective Action</th></tr>
<tr><th>Q1</th><th>Q2</th><th>Q3</th></tr>
<tr><td colspan="3">Red</td><td>Learning Disabilities</td><td>This project was initiated some time ago to stabilise the £2m overspend in this service area and to contain costs from increasing demand (estimated at £800,000 a year). Although progress has been made in delivering efficiencies in this area it has been difficult to separate the project from the Department's core business. In addition, new projects such as the Market Management project and the Re-provision of in-house care services have impacted on this service area and have contributed to reducing costs. The project is currently under review and the Department is to request closure of this project.</td></tr>
</table>

| Status | | | Project | Corrective Action |
|---|---|---|---|---|
| Q1 | Q2 | Q3 | | |
| Red | | | Market Management | The project was set to deliver £5.37m savings during 2011/12. Current projections indicate a shortfall of £1.167m against the target for this quarter. The current "Red" status reflects the end of year forecast which is projecting a shortfall of £1.55m. |

The shortfall of £1.167m against the target for this quarter is due to the following:

- **Providers not accepting new rates**
  90 out of 113 residential and nursing care providers (80%) are being paid at the reduced fee levels. Those providers who have not accepted the new rates are still being paid at the 2010/11 fee levels and this has contributed to the projected shortfall. Providers will continue to be paid at the higher rate until the placements end or they accept the new rates. No new placements are being made in homes that have not accepted the new rate.

- **Out of Area Placements**
  It was anticipated that the fee rates paid to providers for placements outside of Wirral would also be reduced. However, this has proved difficult to achieve as in many cases the fee levels are determined by the Local Authority where the individuals are placed or represent bespoke packages for people with complex needs.

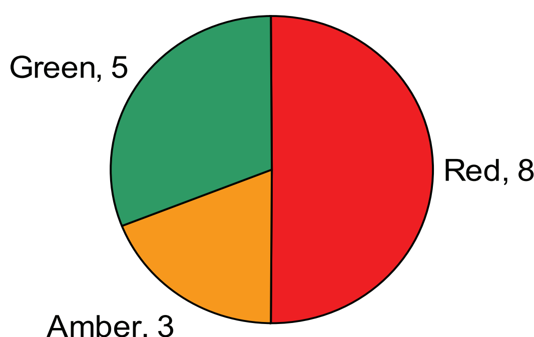
- **Specialist Rates paid to providers in Wirral**
  It was anticipated that the fee rates paid to providers in Wirral for people with more complex support needs would also be reduced. Again many of the care packages are bespoke and in order to establish if savings can be achieved each package must be reviewed. This work is underway but it is estimated that there will be a shortfall against the target for 2011/12.

- The project was ambitious in anticipating a reduction in all fees but it is still forecasting the highest level of savings in the Strategic Change programme.

## 2.6 PERFORMANCE AGAINST DEPARTMENTAL INDICATORS

- The quarter 3 performance against the Department's core and critical indicators is shown below. Further detail is provided in Appendix 1.

**Qtr 3 Performance Summary**




| | |
|---|---|
| Performing well | 5 of the 16 Performance Indicators (31%) achieved their quarter 3 target (green). |
| Performing adequately | 3 (19%) performed adequately within 5% of the target (amber). |
| Performing Poorly | 8 (50%) performed below the target (red). |

## 2.7 RESOURCE IMPLICATIONS

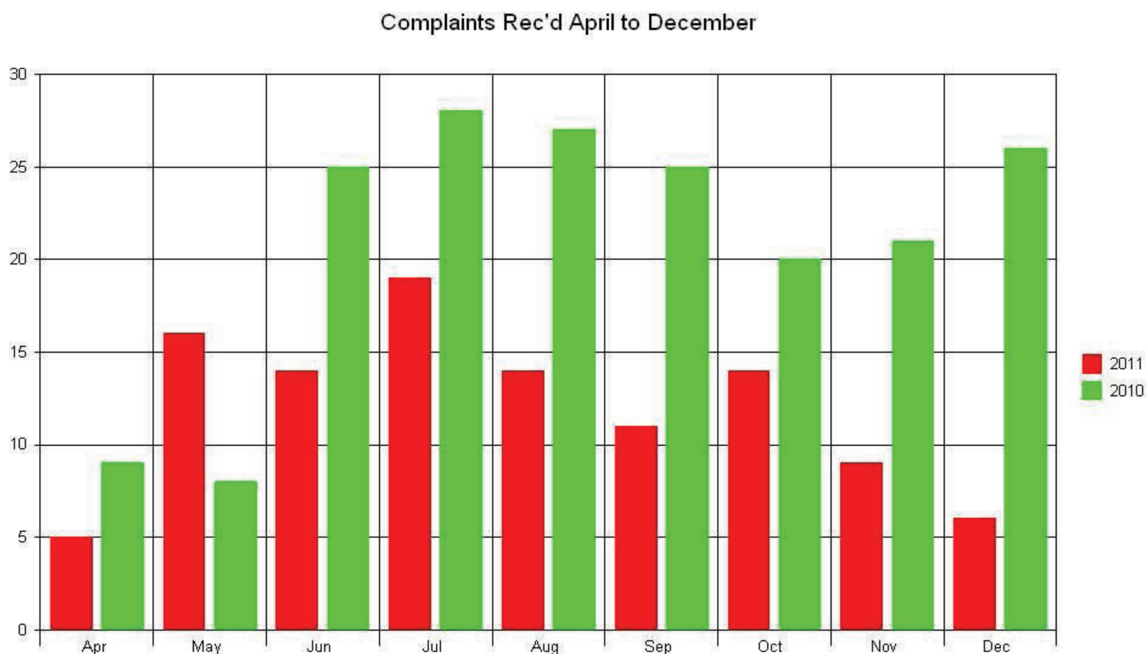
- Significant financial pressures of £6.8 million are being experienced upon the Adult Social Services revenue budget. Underlying pressures include increased demand on older peoples and learning disability budgets, potential slippage on savings relating to the implementation of the market review contract negotiations. Other pressures include Early Voluntary Retirement / Voluntary Severance savings and Community Care re-provision. The financial monitoring statement as at December 2011 is shown in Appendix 2.
- The £3 million Adult capital programme for 2011/12 includes a new grant allocation of £941,000 to support developments relating to personalisation, reform and efficiency and £732,000 relating to the final payments for the Mendell Lodge extra care housing scheme. The capital monitoring statement as at December 2011 is shown in Appendix 3.

## 2.8 FUTURE CHALLENGES AND RISKS

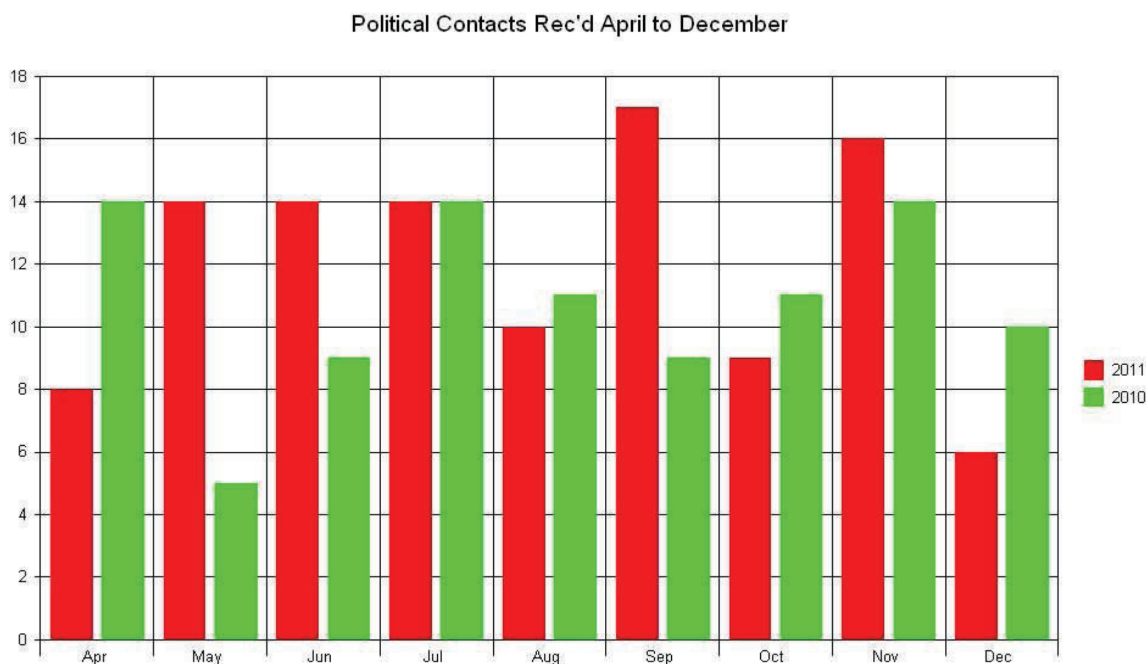
- Safeguarding arrangements for adults are under constant review by the Department of Adult Social Services and its partners on the Safeguarding Adult Partnership Board.
- The Department continues to respond to the outcomes of the Corporate governance report.
- On going challenges remain linked to the increased demand for services for older people and adults with learning disabilities and the need to reconfigure services to deliver greater levels of personalisation and choice to individuals requiring support.

## 2.9 CUSTOMER FEEDBACK

- The graph below shows the number of registered complaints received by the Department of Adult Social Services in the first 3 quarters of this year. Figures remain low compared to previous years, partly due to more informal action being taken at the initial point of contact, and some complaints being made via politicians.




- There has been a slight overall increase in the number of political enquiries received by the Department of Adult Social Services in the year to date. The average timescale for response to political contacts for quarter 1-3 has improved from 25 days to 20 days.




## 3.0 RELEVANT RISKS

3.1 The successful implementation of actions to deal with issues arising from the report into Corporate Governance issues remains a key priority. There remains a key risk in ensuring issues arising are dealt with in a timely and appropriate manner.

3.2 Enhancements to corporate risk management arrangements and procedures continue to be examined. The Risk Management strategy over the medium term will provide a framework and processes which are in accordance with the latest British Standard for Risk Management. To achieve this, 'a gap analysis' has been undertaken to identify actions required for improvement.

3.3 The Corporate Risk Register has been evaluated and added to by the Executive Team during the quarter. Progress in mitigating actions has been included within the relevant sections above.

## 4.0 OTHER OPTIONS CONSIDERED

4.1 Not applicable to this report.

## 5.0 CONSULTATION

5.1 Consultation in relation to the draft Corporate Plan engaged individuals and organisations from across Wirral's diverse communities and this is reflected in the Corporate Plan.

## 6.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

6.1 The Corporate Plan sets out commitments and clear actions in relation to working with voluntary, community and faith sector organisations to improve outcomes for local people.

## 7.0 RESOURCE IMPLICATIONS: FINANCIAL; IT; STAFFING; AND ASSETS

7.1 The financial implications are set out in the report. There are no other specific resource implications arising from this report.

## 8.0 LEGAL IMPLICATIONS

8.1 Legal implications relating to the actions set out in the Corporate Plan will be addressed by Departments as appropriate.

## 9.0 EQUALITIES IMPLICATIONS

9.1 Has the potential impact of your proposal(s) been reviewed with regard to equality? No because of another reason which is:

- Equalities implications relating to the actions set out in the Corporate Plan will be addressed by departments as appropriate, and details set out in individual departmental plans. This work is also monitored by the Council Excellence Overview and Scrutiny Committee, the Corporate Equalities and Cohesion Group and the Departmental Equality Group.

## 10.0 CARBON REDUCTION IMPLICATIONS

10.1 Carbon reduction is a specific goal in the Corporate Plan, with associated actions and measures as set out in the agreed Interim Carbon Budget 2011-12.

## 11.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

11.1 Planning and Community Safety is a specific goal in the Corporate Plan, with associated actions and measures.

## 12.0 RECOMMENDATION/S

12.1 That the contents of this report be noted.

## 13.0 REASON FOR RECOMMENDATION/S

13.1 Council approved the Corporate Plan on 18 April 2011. This report provides an update on progress in delivering the health and wellbeing section of the Council's Corporate Plan, including performance of relevant projects and indicators and associated financial and risk monitoring information.

**REPORT AUTHOR:** Steve Rowley
Head of Finance and Performance Branch
Telephone: (0151 666 3662)
Email: stephenrowley@wirral.gov.uk

## APPENDICES

**Appendix 1** – Core and Critical Performance Indicators
**Appendix 2** – Financial Monitoring Summary
**Appendix 3** – Capital Monitoring Summary

## SUBJECT HISTORY (last 3 years)

| Council Meeting | Date |
|---|---|
| Health and Wellbeing Overview and Scrutiny Committee | 13/09/11<br>20/06/11<br>22/03/11<br>18/01/11<br>01/11/10<br>09/09/10<br>21/06/10<br>25/03/10<br>19/01/10<br>10/11/09 |
| Social Care, Health and Inclusion Overview and Scrutiny Committee | 08/09/09<br>22/06/09<br>25/03/09<br>20/01/09<br>24/11/08 |

APPENDIX 1

## DEPARTMENTAL PERFORMANCE INDICATORS

| PI No. | Title | Qtr 3 Target | Qtr 3 Actual | Qtr 4 Target | Likelihood of meeting target |
|---|---|---|---|---|---|
| NI 130 | Self Directed Support | 68.94% | 63.33% | 80% | Diminishing |
| LI 8858 | Self Directed Assessments | 87.06% | 93.39% | 100% | Diminishing |
| NI 131 | Delayed Transfers of Care | 2.22 | 1.74 | 2.00 | Good |
| NI 132 | Assessments undertaken within 28 days | 79.50% | 82.36% | 80% | Good |
| NI 133 | Support Packages in place within 28 days | 91.20% | 93.20% | 92% | Good |
| NI 135 | Carers Assessments | 33.80% | 18.75% | 36% | Poor |
| NI 136 | People with Learning Disabilities supported to live independently | 2,798.80 | 2,882.63 | 2,900.00 | Good |
| NI 145 | People with Learning Disabilities in settled accommodation | 70.93% | 13.82% | 75% | Poor |
| NI 146 | People with Learning Disabilities in employment | 8.68% | 1.43% | 10% | Poor |
| NI 149 | People with Mental Health issues in settled accommodation | 74.67% | 72.64% | 77% | Diminishing |
| NI 150 | People with Mental Health issues in employment | 9.78% | 3.94% | 12.3% | Poor |
| D40 | Reviews | 75.13% | 51.81% | 75% | Poor |
| QOM | Admissions to Residential Care (per 1,000 population) | 1.64 | 2.05 | 1.5 | Poor |
| LI 8856 | Timeliness of equipment delivery and adaptations | 99% | 96.76% | 99% | Good |
| LI 8866 | Safeguarding alerts dealt with in 24 hours | 97.8% | 93.37% | 100% | Good |
| LI 8867 | Safeguarding referrals dealt with in 28 days | 92.85% | 74.83% | 100% | Poor |

**APPENDIX 2**

**ADULT SOCIAL SERVICES DEPARTMENT**
**FINANCIAL MONITORING 2011/12** **POSITION AS AT 31 DECEMBER 2011**

**SUMMARY**

| Policy Options | Savings Target | Agreed Budget | Changes Agreed | Changes Not Agreed |
|---|---|---|---|---|
| £000 | £000 | £000 | £000 | £000 |
| - | 16,907 | 63,411 | +4,280 | Pressure of £6.8m |

Financial pressures remain from an underlying overspend in 2010/11, potential 'one-off' slippage of approximately £3.0 million against some savings targets as identified below and £1.2m shortfall in funding for the re-provision of services following the release of staff under the EVR/VS scheme. Whilst additional resources were allocated towards adults and learning disabilities the pressures remain from increasing demand in these areas.

**POLICY OPTIONS FOR 2011/12 ONLY**

| Details | £000 | Comments / progress on implementation |
|---|---|---|
| Armed Forces Veterans | | Transferred to Technical Services |

**SAVINGS TARGETS**

| Details | £000 | Comments / progress on implementation |
|---|---|---|
| Employees under EVR/VS | 10,550 | At risk of slippage :<br>Savings from the re-provision of Supported Living started to accrue from 1 July when the service transfers to the Independent sector (£765k).<br>People withdrawing request for EVR/VS or date of leaving delayed beyond 31 March 2011 (£585k) |
| Market Management Review | 5,368 | At risk of slippage due primarily to homes that have not accepted new rates. (£1.6m) |
| Respite & Interim Care | 488 | Respite and intermediate care re-commissioned from Independent sector. Savings achieved. |
| Area Based Grant | 50 | Saving achieved through vacant post |
| Transport | 130 | Relates to year 2 Strategic Change Programme (SCP) savings in respect of the Integrated Transport Unit. Responsibility for the Unit has now transferred to CYPD. |
| Car allowances, supplies, etc | 321 | Some slippage against car allowance saving but anticipated that other savings will be achieved (£50k) |

**CABINET – CHANGES AGREED**

| Date | Details | £ |
|---|---|---|
| 17.03.2011 | Retention of Fernleigh during 2011/12 | +480 |
| 21.07.2011 | Re-provision costs identified as part of budget preparation | +3,500 |
| 13.10.2011 | Departmental Staffing Restructure | +300 |

**VOLATILE AREAS/POTENTIAL VARIATIONS - CHANGES NOT AGREED**

| Details | £000 | Comments / actions to address any issues |
|---|---|---|
| Community Care | 2,600 | Underlying pressure from increased demand particularly older peoples services / learning disabilities. Includes £700k funding for GP Social Care Fund |
| EVR / VS savings | 1,350 | Potential slippage as identified above |
| Market Review savings | 1,600 | Potential slippage as identified above |
| Car Allowances | 50 | Potential slippage as identified above |
| Community Care | 1,200 | Re-provision shortfall following EVR/VS scheme |

**APPENDIX 3**

**ADULT SOCIAL SERVICES DEPARTMENT**
**CAPITAL MONITORING 2011/12** **POSITION AS AT 31 DECEMBER 2011**

**SUMMARY**
The most significant scheme has been the Extra Care Housing facility at the former Mendell Lodge site which was completed March 2011. The final instalment was paid in 2011/12.

There is new overall capital grant allocation in 2011/12 of £941,000 replacing the Information Management, Mental Health Single Capital and Social Care Single Capital allocations. The grant is designed to support three key areas Personalisation, Reform and Efficiency with priorities including innovative alternatives to residential care and service re-design to the care infrastructure – supporting the community based approach.

The Consultation exercise of 2010/11 led to an assessment of Day Care Services and it is anticipated that there will be requirements to develop the centres during the next year which were detailed in the Business Case submitted in October 2011.

Further Business Cases were submitted in October outlining proposals for schemes linked to the PSS allocation.

**APPROVED PROGRAMME**

| PROGRAMME | Original Approved Programme 2011/12 £000 | Approved Adjustments 2011/12 £000 | Total Approved Programme 2011/12 £000 | Actual to Date £000 | Projected Outturn 2011/12 £000 | Approved 2012/13 £000 | Approved 2013/14 £000 |
|---|---|---|---|---|---|---|---|
| Information Management | 141 | -141 | 0 | | 0 | 0 | 0 |
| Mental Health Single Capital Pot | 521 | | 521 | | 521 | 0 | 0 |
| Social Care Single Capital Pot | 492 | -133 | 359 | | 359 | 0 | 0 |
| Development of Ward 41 Star Team | 0 | 80 | 80 | | 80 | 0 | 0 |
| Information Management | 0 | 53 | 53 | 53 | 53 | 0 | 0 |
| Extra Care Housing | 0 | 732 | 732 | 732 | 732 | 0 | 0 |
| Social Care Capital Reform | 0 | 257 | 257 | | 257 | 0 | 0 |
| PSS Capital | 0 | 941 | 941 | | 941 | 0 | 0 |
| **TOTAL PROGRAMME** | **1,154** | **1,789** | **2,943** | **785** | **2,943** | **0** | **0** |
| **FUNDING** | | | | | | | |
| General Capital Resources | 141 | -141 | 0 | | 0 | 0 | 0 |
| Grants - Other | 1,013 | 1,930 | 2,943 | | 2,943 | 0 | 0 |
| Revenue/ Reserve contributions | 0 | 0 | 0 | | 0 | 0 | 0 |
| **TOTAL FUNDING** | **1,154** | **1,789** | **2,943** | | **2,943** | **0** | **0** |

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# WIRRAL COUNCIL

## SCRUTINY PROGRAMME BOARD

**28 FEBRUARY 2012**

| SUBJECT: | *NEW LEGISLATIVE FRAMEWORK – SUMMARY* |
|---|---|
| WARD/S AFFECTED: | *ALL* |
| REPORT OF: | DIRECTOR OF LAW, HR AND ASSET MANAGEMENT |
| KEY DECISION? | NO |

## 1.0 EXECUTIVE SUMMARY

1.1 At the previous meeting of the Scrutiny Programme Board, held on 4th January 2012, a briefing paper regarding new legislation was provided to members. The paper, titled 'New Legislative Framework – Update', had been issued by the Centre for Public Scrutiny. During the meeting, members resolved "that a summary report from officers on the content of the Policy Briefing, and its implications for Wirral, be presented to the next meeting of the Board" (Minute 23).

## 2.0 RECOMMENDATION/S

2.1 Members are requested to note the report and refer it to the other five Overview and Scrutiny Committees.

2.2 The Committee is also requested to distribute the report to all members of the Council in order to raise awareness of the forthcoming legislative changes.

## 3.0 REASON/S FOR RECOMMENDATION/S

3.1 The new legislation will impact directly on the Council's scrutiny arrangements. It is important that members are aware of the implications of the legislation.

## 4.0 BACKGROUND AND KEY ISSUES

Appendix 1 to this report provides a summary of the document produced by the Centre for Public Scrutiny, putting the proposed legislative changes into a Wirral context. The report examines the provisions of the Localism Act, the Police Reform and Social Responsibility Act and the Health and Social Care Bill (expected to receive Royal Assent in Spring 2012) and draws conclusions from the new legislation about the future of scrutiny. It is important to note that this report discusses only the implications of the new legislation on scrutiny; it does not cover some of the wider implications of the legislation.

The full briefing paper produced by the Centre for Public Scrutiny, 'New Legislative Framework – Update' can be found on the Scrutiny Programme Board meeting agenda of 4th January 2012.

In addition, further information regarding the provisions of the Police Reform and Social Responsibility Act are available in another report on this agenda, titled 'Police and Crime Panels and Commissioner Elections'.

## 5.0 RELEVANT RISKS

5.1 There are none arising directly from this report.

## 6.0 OTHER OPTIONS CONSIDERED

6.1 This report describes the impact of Government legislation on scrutiny.

## 7.0 CONSULTATION

7.1 There has been no specific consultation in relation to this report.

## 8.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

8.1 There are no implications arising directly from this report.

## 9.0 RESOURCE IMPLICATIONS: FINANCIAL; IT; STAFFING; AND ASSETS

9.1 There are no resource implications arising directly from this report.

## 10.0 LEGAL IMPLICATIONS

10.1 The Council's Constitution will need reviewing to take account of the new legislation.

## 11.0 EQUALITIES IMPLICATIONS

11.1 There are no implications arising directly from this report

11.2 Equality Impact Assessment (EIA)
(a) Is an EIA required? No

## 12.0 CARBON REDUCTION IMPLICATIONS

12.1 There are no implications arising directly from this report.

## 13.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

13.1 There are no implications arising directly from this report.

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## APPENDICES

**Appendix 1** - Summary of 'New Legislative Framework – Update'

**REFERENCE MATERIAL**

*Centre for Public Scrutiny (CfPS)* 'New Legislative Framework – Update' – December 2011

**SUBJECT HISTORY (last 3 years)**

| Council Meeting | Date |
|---|---|
| **Scrutiny Programme Board** | **4 January 2012** |

**APPENDIX 1**

## SUMMARY OF 'NEW LEGISLATIVE FRAMEWORK – UPDATE'

### 1. INTRODUCTION AND BACKGROUND

The Government argues that the new legislation has community power as its core theme. This will have an impact on existing accountability mechanisms and particularly on overview and scrutiny. This briefing paper provides information on the implications for scrutiny of:

- The Localism Act 2011
- The Police Reform and Social Responsibility Act 2011
- The Health and Social Care Bill

In addition, a commentary is provided regarding the major impacts on Wirral Council. It should be noted that, in general, the Council's Constitution will require amendment to cover a number of the issues outlined below.

### 2. LOCALISM ACT

The Localism Act received Royal Assent on 15th November 2011 and the scrutiny elements are expected to formally commence by April 2012. The Act contains provisions on a wide range of services delivered by local authorities, or in which councils might have an interest. Licensing, planning, housing and governance are all covered. The broad policy intention behind the Act is to devolve power over a range of services to local people and local communities.

#### 2.1 Governance changes

Councils will have the option to change governance arrangements from a strong leader model (with Cabinet); moving to either a committee-based model of governance or to a directly-elected executive mayoral model. The 12 "core cities" in England are due to hold referendums on the establishment of a directly elected Mayor. In the case of Liverpool, the Council has decided to opt for an elected mayor, removing the requirement to hold a referendum. The elected mayor option also remains open to other Councils.

Authorities choosing to adopt a committee system must first agree a resolution to this effect at Full Council, with the change itself happening following the subsequent Full Council AGM. With the Committee system, local authorities will have flexibility as to how this will operate, though the Secretary of State is given power to specify by regulation any functions which must be exercised by Full Council. It should also be noted that once Council decides on an alternative form of governance, it will not be possible to change back until five years have elapsed, without a referendum being held on the issue.

Councils can operate overview and scrutiny under a committee system. The Centre for Public Scrutiny believes that, for most authorities who choose to change their arrangements, a "streamlined" or "hybrid" committee system,

incorporating both subject committees and O&S, is the most likely outcome (on the basis of anecdotal information which is being collected to support further research on this issue, to be published in February 2012). This will allow committee system councils to exercise the scrutiny powers around healthcare, flood risk management, crime and disorder and external partners, as well as providing some independent challenge to decisions made by these committees. The Government plans to announce regulations defining the operation of overview and scrutiny in committee system authorities shortly.

**Implications for Wirral -** On 17th October 2011, Council agreed "that an all party working party comprising two members of each party be set up to seek to achieve consensus on the most appropriate form of democracy within the Council, taking into account the strengths and weaknesses both of the old Committee system and the current Cabinet system, and of any legislation and subsequent regulations as these become known. Council asks that any new system meeting all party approval be prepared ready for adoption at the Council's AGM, in May 2012 or as soon thereafter that the enactment of the Localism Bill and any subsequent regulations allow". The Democracy Working Party has now met on several occasions as it carries out this remit. The views and opinions of members are currently being gathered and analysed to assist the Working Group in completing its work.

2.2 Powers for scrutiny

The Act will increase the powers for local government scrutiny functions in key areas, including:

2.2.1 Powers over partners – Prior to the Localism Act, Overview & Scrutiny committees could scrutinise the work of partners, as long as that work related to a local improvement target under the Local Area Agreement. Under the Localism Act, committees will be able to scrutinise the activities carried out by a Government-prescribed list of named partners. This could (and will) include services funded not by the local council, but from other funds. This important change makes it clearer than ever that scrutiny's future lies in a view of public services as they are delivered across a given locality; not just those for which the council has a direct responsibility. The Department for Communities and Local Government (DCLG) has advised that they may consider an extension to the list of named partners in the future.

**Implications for Wirral –** Once the work of the Democracy Working Party is completed, the requirements for partner scrutiny in Wirral will become clearer. As a minimum, scrutiny of the Community Safety Partnership and of Council's health partners, under the umbrella of health scrutiny, will continue.

2.2.2 Changes to the Councillor Call for Action – The Localism Act has widened the provisions of the Councillor Call for Action to enable councillors to bring Councillor Calls for Action on issues that relate to partners, not just Local Authority issues.

**Implications for Wirral -** Wirral Council approved procedures for the operation of the Councillor Call for Action scheme on 15th February 2010. To date, there

have been no Councillor Calls for Action introduced by members in Wirral. The current procedures will need to be updated to take the provisions of the Localism Act into account.

2.3 Tenant Scrutiny

The Government is bringing in, through the Act, a more central role for the existing tenant scrutiny arrangements in social housing. The previous model of "co-regulation" is being extended as central government regulation is scaled back and more challenge to landlords at local level by tenants replaces it. The Act will move two principal consumer protection responsibilities from regulators to tenant scrutiny, namely:

- Proactively monitoring landlords' compliance with service standards;
- Scrutinising landlord performance and driving service improvement generally.

There is a clear steer from the Department of Communities and Local Government and other national bodies that landlords will be expected to support tenant scrutiny panels or other arrangements, as a part of the co-regulatory environment. Earlier research on tenant scrutiny does provide numerous examples of good working relationships having been built up, but Overview and Scrutiny Committees may wish to explore how well arrangements are developing in their local area, both in relation to the council's own housing stock (either directly managed or by an Arms Length Management Organisation) and in relation to any social housing landlords with housing locally.

**Implications for Wirral –** Housing currently falls within the remit of the Economy and Regeneration Overview and Scrutiny Committee. Therefore, that Committee could take up the suggestion from the Centre for Public Scrutiny and investigate the progress of tenant scrutiny as part of the Committee's work programme.

2.4 Neighbourhood planning and "community right to challenge"

The Act will allow local people to directly influence policy, and the delivery of services, in neighbourhoods in two principal ways – through neighbourhood planning (the production by local people of planning documents which, as long as they complement the Core Strategy of the Local Development Framework, will be adopted by the Council as a Development Plan Document) and the "community right to challenge", the system by which local people can challenge the delivery of a service by a certain provider, with a view to a procurement exercise for the delivery of that service being opened up.

**Implications for Wirral –** The Council will need to ensure that appropriate processes are in place.

2.5 Referendums

The expansive referendum provisions in the Bill, as originally introduced, have been removed following lobbying by the Local Government Association. Referendums will still need to be held on certain council tax increases.

**Implications for Wirral -** The Council will need to ensure that appropriate processes are in place.

## 3. POLICE REFORM AND SOCIAL RESPONSIBILITY ACT

The Police Reform and Social Responsibility Act received Royal Assent in October 2011. A central part of the Act is the introduction of directly-elected Police and Crime Commissioners. However, the plans for Police and Crime Commissioner elections, previously scheduled for May 2012, have been delayed by six months.

3.1 Police Commissioner

The Act abolishes police authorities and replaces them with an elected Police and Crime Commissioner (PCC). The Commissioner will be responsible for holding the Chief Constable in the Force area to account. The Police and Crime Commissioner is perceived as having a more high profile and responsive role in relation to the public. Innovations such as crime mapping, and mandated neighbourhood meetings, along with direct elections, are designed to make the Commissioner more accountable. The Commissioner will have wide-ranging powers and responsibilities. On consultation and engagement, he or she will have a duty to consult local people, including victims of crime.

**Implications for Wirral -** Merseyside Police Authority have set up a Transition Committee to make sure the necessary communications, negotiations and agreements take place to allow the change to happen as smoothly as possible. The Wirral members sitting on the Transition Committee are Councillors Kate Wood and Tony Smith. A small number of meetings have already been held.

The election of the Police and Crime Commissioner for Merseyside, as is the case nationwide, is due to take place on 15th November 2012. Once elected, the Commissioner will take office on 22nd November 2012. The elections will use the Supplementary Vote electoral system. Under the supplementary vote system, a voter is asked to indicate first and second preferences. If no candidate has 50 per cent of the first preference votes, the two candidates with the highest number of first preference votes go forward to a second round. In the second round of counting, ballots indicating a first preference for a candidate that lost in the first round are reallocated according to the second preference indicated in the ballot paper.

3.2 Community Safety Partnership (CSP)

The Police and Crime Commissioner will have sole responsibility for disbursing community safety funding from the Home Office (currently provided through a range of funding streams to local authorities, police and community safety partnerships), and will also have responsibility for a range of other budgets. The Commissioner will be able to direct this funding where he or she wishes, in the form of grants, either to Community Safety Partnerships or other bodies.

**Implications for Wirral -** The funding relationship for Wirral's Community Safety Partnership will change. Further work will be required by the Partnership to determine the implications of the changes. The implications for the scrutiny of the Community Safety Partnership will also require clarification.

3.3 Police and Crime Panel

The Commissioner will him/herself be held to account by a Police and Crime Panel, a body made up of local councillors from all authorities in the Force area. The Panel will be a joint committee of all the authorities in the Force area and must be politically and geographically balanced, as far as possible. The Centre for Public Scrutiny strongly recommends that the Panel should be made up of non-executive (that is non-Cabinet) members.

A lead authority will need to be assigned to co-ordinate arrangements between the authorities involved. Guidance produced jointly by the Centre for Public Scrutiny and the Local Government Association suggests the establishment of a "shadow PCP" to consider the role, responsibilities and composition of the final Panel.

The Police and Crime Panel will be a scrutiny body. Under the Act, the Panel has certain "special functions", including considering the Commissioner's Police and Crime Plan, reviewing the planned police precept and reviewing certain senior appointments. The Police and Crime Panel will also have formal duties around dealing with certain complaints against the Commissioner (to be exercised as a last resort). Beyond these statutory powers there is other work in which the Panel could engage. The view of the Centre for Public Scrutiny is that the Police and Crime Panel will find it difficult to transact its statutory functions, particularly scrutiny of the Police and Crime Plan, without carrying out scrutiny-style investigations into issues of local concern. The "set piece" scrutiny outlined in the "special functions" will, for its success, need to rely on a wider body of evidence from more detailed scrutiny investigations, in order to be meaningful.

Further Guidance will contain more detail on the expected timescale of the lead up to the new structural arrangements coming into force later in the year. At the moment it seems most likely that the Home Office will require councils to agree on "who leads" on PCP arrangements by April 2012, with arrangements having been established in shadow form by July 2012 at least. This timescale is of course subject to change and has not been confirmed by the Home Office.

**Implications for Wirral -** The Merseyside Police and Crime Panel must have a minimum of ten members, made up of members from the composite Local Authorities, that is, Liverpool, Knowsley, Sefton, St Helens and Wirral plus some Independent persons. Official Home Office guidance on setting up the panels is still awaited. However, it is clear that the Merseyside Local Authorities will need to agree on which authority will lead the process and commence arrangements for the implementation of the Panel.

## 4. HEALTH AND SOCIAL CARE BILL

The Health and Social Care Bill is still undergoing parliamentary scrutiny and has not yet received Royal Assent. It is expected that the Bill will receive Royal Assent during Spring 2012. It is, therefore, possible that the contents of the Bill will change before the new legislation is implemented. Among the proposed reforms are:

- Replacement of Strategic Health Authorities and Primary Care Trusts
- Introduction of GP Commissioning Consortia and an NHS Commissioning Board
- Provision of economic regulation of the Health Service by the regulatory body, 'Monitor'
- Transfer of responsibilities for Public Health to Local Authorities
- Development of Health & Wellbeing Boards
- Replacement of LINkS (Local Involvement Networks) by Local HealthWatch

The three Clinical Commissioning Groups being established as Pathfinders in Wirral are:

- Wirral Health Commissioning Consortium
- Wirral GP Commissioning Consortium
- Wirral NHS Alliance

Their work in 2011/12 will provide the foundations for when consortia are established in 2012/13 and will take on the leading responsibility for commissioning healthcare services, ahead of them becoming fully statutorily accountable from April 2013 onwards. This report does not attempt to describe the wider health reforms but instead concentrates on those issues closer to scrutiny.

**Implications for Wirral -** For scrutineers, the element of most initial interest will be "proper constitutional and governance arrangements". The new arrangements will naturally need to include overview and scrutiny and collaboration between scrutiny, local HealthWatch and lay people involved in Clinical Commissioning Group governance.

The Council's health scrutiny will need to adapt to the new relationships in order to best influence developments such as the preparation of the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS). The Centre for Public Scrutiny has recently produced a report

‘Health Overview and Scrutiny: Exploiting opportunities at a time of change’. The report draws on the experiences of pilot projects that have been running in seven different Local Authorities. Perhaps Wirral could learn from some of the experiences highlighted in the report.

4.1 The Health and Wellbeing Board

The Health and Wellbeing Board will be a committee of the local authority, buts its membership will be broad. The Board will include a number of local partners, including the local authority, local HealthWatch, Clinical Commissioning Group representatives and other professionals. Under the provisions of the Bill, the Board must encourage integrated working. This duty will be especially relevant in the development of the Joint Strategic Needs Assessment (JSNA) and the joint health and wellbeing strategy (JHWS), for which the local authority and the clinical consortia will be jointly responsible. The Health & Wellbeing Board cannot compel Clinical Commissioning Groups in its areas to do, or not do, something. However, the Board will be able to challenge the Clinical Commissioning Groups (through reference to the Secretary of State) if it feels that the Clinical Commissioning Group’s commissioning plans do not conform to the JSNA or the JHWS.

**Implications for Wirral -** A report, titled ‘Proposal for the Establishment of a Shadow Health & Wellbeing Board for Wirral’ was presented to Cabinet on 23rd June 2011. The Shadow Health and Wellbeing Board has subsequently been established in Wirral, with terms of reference having been agreed. The lead officer is the Director of Public Health and the Shadow Board is chaired by the Leader of the Council. It will be part of the role of health scrutiny in the future to scrutinise the work of the Health and Wellbeing Board.

4.2 The Role of HealthWatch

At the moment it is still too early to make detailed predictions for how Local HealthWatch will work with overview and scrutiny, although it will certainly need to do so. The Centre for Public Scrutiny has carried out detailed studies of the development of LINkS (Local Involvement Networks), since their establishment, which may provide some further guidance on this subject, and recently published a major evaluation of the lessons that Local HealthWatch can learn from the experience of LINkS.

**Implications for Wirral -** Plans for the transition of LINk into HealthWatch are progressing in Wirral. A report, titled ‘LINk Transition to a Local HealthWatch Organisation’, was presented by the Director of Adult Social Services to the recent meeting of the Health and Wellbeing Overview and Scrutiny Committee, held on 19th January 2012.

4.3 Health scrutiny’s position and powers

The Bill amends the scrutiny provisions in the National Health Service Act 2006. Powers are now to be exercised by the authority, rather than by a health overview and scrutiny committee. This provides more flexibility to local

authorities in how they manage the delivery of their scrutiny responsibilities. This could enable creativity but risks dilution of independent scrutiny.

**Implications for Wirral -** Once the work of the Democracy Working Party is completed, the options for the most appropriate arrangements for health scrutiny will become clearer.

## 5. BROAD IMPLICATIONS FOR SCRUTINY

The Centre for Public Scrutiny draws several conclusions arising from the new legislative framework. Powers in all three pieces of legislation emphasise the importance of partnership working in the delivery of public services. It is likely that it will become more difficult to distinguish between "internal" council-only services and "external" ones delivered by partners. The merging of the two will mean that the way in which scrutiny deals with all issues across a local area will need to be harmonised.

This may involve a number of changes:

- More proactive consultation and discussion with partners about the scrutiny work programme
- A better understanding of scrutiny by partners
- More scrutiny on specific issues, that may involve partners, rather than "scrutiny of partners"
- More joint scrutiny across local authorities

In practice, this may mean that overview and scrutiny will be carrying out more joint work with other bodies and agencies to pursue areas of mutual interest. For example, local authority scrutiny functions might collaborate with tenant scrutiny panels to jointly challenge housing providers in the local area, draw evidence from Local HealthWatch to challenge health and social care providers and share information with Police and Crime Panels, amongst other opportunities.

Scrutiny will also need to sit alongside emerging approaches for "sector self-regulation". The "Taking The Lead" document, produced by the Local Government Association, sees a key role for scrutiny in allowing councillors to drive the local improvement process, to maintain momentum and to provide constructive scrutiny based on challenging traditional approaches to service delivery.

The Centre for Public Scrutiny's briefing paper concludes by highlighting two possible barriers to progress, namely:

- potential partner and executive resistance to scrutiny
- new scrutiny powers being in existence at a time when no new resources are available.

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# New legislative framework - update

Policy Briefing 14 December 2011

Report author: Ed Hammond, (020) 7187 7369, ed.hammond@cfps.org.uk

Additional research Alison Yates

This briefing, the fourteenth in the Policy Briefing series, examines the provisions of the Police Reform and Social Responsibility Act, the Localism Act and the Health and Social Care Bill (expected to receive Royal Assent in Spring 2012), and draws conclusions from the new legislation about the future of scrutiny.

This briefing is complemented by the forthcoming revision to our comprehensive guide to scrutiny legislation, "Pulling it together", which will be published in the early spring (to coincide with the commencement date for much of the content of this briefing, in early April), and by other briefings that explore the implications of legislation in more detail and which are referenced throughout this document.

**Contents**

1. Introduction and background
2. Localism Act
3. Police Reform and Social Responsibility Act
4. Health and Social Care Act / Bill
5. Broad implications for scrutiny

## 1. Introduction and background

1.1 The Localism Act[1], Police Reform and Social Responsibility Act[2] and Health and Social Care Bill[3] arguably form the bedrock of the Government's legislative programme for the first half of the 2010-14 parliamentary term. Significant structural reform in the NHS, in policing and in the powers and responsibilities of local government will mean big changes to formal accountability, and to the way that ordinary citizens interact with the state.

[1] 2011 ch 20: http://www.legislation.gov.uk/ukpga/2011/20/contents/enacted
[2] 2011 ch 13: http://www.legislation.gov.uk/ukpga/2011/13/contents/enacted
[3] At the time of writing (late November 2011), at committee stage in the House of Lords: http://services.parliament.uk/bills/2010-11/healthandsocialcare.html

1.2 The new legislation has community power at its heart[4] – exerted either at neighbourhood level (for example, the planning powers in the Localism Act) or by individual citizens, now empowered as "consumers" able to exercise control through choice[5], made possible through increased transparency (as posited by all three reform packages[6], and the education reforms covered separately in Policy Briefing 13[7]).

1.3 This will have an impact on existing accountability mechanisms, and particularly on overview and scrutiny. It is a truism to say that with change of this nature comes both opportunities and challenges, but those opportunities are there for the taking by effective, focused scrutiny functions. This will be possible in authority areas where scrutiny is able to find, and capitalise upon, a new and perhaps expanded niche in these new structural arrangements, that increases its profile by linking more directly to local people's concerns.

Background to the legislation

1.4 Localism Act – the Localism Act was introduced as a Bill in December 2010, after a relatively long gestation. Many of the ideas in the Bill were long-standing Conservative party policy, brought together and fleshed out by the pre-election Green Paper, "Control Shift", published by the Conservatives in early 2009[8].

1.5 The Bill made slow progress through the Commons. Much was made of its length and of the large number of powers reserved for use by the Secretary of State[9]. A number of amendments were made before the Bill received Royal Assent in November 2011 – many of them relating to local democracy, but some pertaining to planning and housing. Most changes were introduced following report stage in the Lords, reflecting the subject of significant disagreement between the parties at committee stage in the Commons – issues about local referendums in

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[4] See "The Coalition: our programme for government" (2010), foreword, p7: "In short, it is our ambition to distribute power and opportunity to people rather than hoarding authority within government. That way, we can build the free, fair and responsible society we want to see." (http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/documents/digitalasset/dg_187876.pdf)
[5] For example, through personalisation in the provision of health and social care services, through the provision of "free schools" and additional marketisation of the further and higher education sectors (see Policy Briefing 13), and so on.
[6] Both Acts, and the Bill, conflate accountability and transparency.
[7] http://www.cfps.org.uk/publications?item=7009
[8] Conservative Party Policy Green Paper No. 9: http://www.conservatives.com/News/News_stories/2009/02/Its_time_to_transfer_power_from_the_central_state_to_local_people.aspx
[9] "Essential guide to decentralisation and the Localism Bill" (LGA, 2010), mentions that at the time of introduction 142 powers to make regulations had been reserved - http://www.lga.gov.uk/lga/aio/16742200

particular[10]. The Bill received Royal Assent in mid-November 2011 and the scrutiny elements are expected to formally commence in April 2012.

1.6 Police Reform and Social Responsibility Act – it had been Conservative and Liberal Democrat policy before the General Election to introduce a directly elected element to policing governance[11]. The view was the police authorities were ineffective and had too low a profile[12], meaning that police forces were essentially seen as unaccountable. The introduction of directly-elected police commissioners became a prominent part of the coalition agreement and the subsequent plan for government[13].

1.7 Notwithstanding this apparent agreement early on in the process, the Bill was beset by problems as it progressed through Parliament. Notably, Lib Dem peers in the Lords managed to amend the Bill to remove a single directly elected police commissioner, replacing them with a directly-elected body made up of a number of people (essentially a directly-elected, decision-making police and crime panel, which bore more than some similarities to police authorities)[14]. In order to overturn this amendment the Government had to make a number of concessions – notably, over the powers of the police and crime panel, whose role in holding the police and crime commissioner to account had previously been seen by some commentators as too weak[15].

1.8 The Bill received Royal Assent in October 2011, earlier than expected[16]. However, the plans for commissioner elections, previously scheduled for May 2012, have been delayed by six months. Even with this delay, a number of those in the sector have raised concerns over the length of time, and resourcing, necessary to make the transition to the new arrangements[17]. It should be noted in this context that the Home Office are planning the introduction of secondary legislation to

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[10] These were challenged (with the relevant sections being removed from the Bill) on the fact that they would involve significant cost to local authorities, and that in any case the results would be non-binding.
[11] Conservative and Liberal Democrat Manifestos, 2010
[12] A view expressed in particular in the aftermath of the summer riots on 2010. The APA response to the Home Secretary's criticisms can be found at http://www.norfolk-pa.gov.uk/user_files/article/APA%20to%20Rt%20Hon%20Theresa%20May%20MP%20170811.pdf
[13] "The Coalition: our programme for government", p13
[14] Full details at http://www.parliament.uk/business/news/2011/september/police-reform-and-social-responsibility-bill-lords-amendments/
[15] Principal among the amendments was the reduction in the threshold for the operation of the "veto" from three-quarters to two-thirds of the PCP's membership.
[16] Home Office Structural Reform Plan (July 2010), http://www.homeoffice.gov.uk/publications/about-us/corporate-publications/structural-reform-plan/pdf-version?view=Binary
[17] The Electoral Commission have expressed concerns about low turnout and high cost if elections are run in November 2012 – the APA have suggested a further delay, to May 2013 or beyond, to enable the transition process to work more smoothly.

deal with a number of ancillary issues, which will have an effect on the commissioner and his/her relationship with the panel[18].

1.9 Health and Social Care Bill – the health reforms are the ones that, while they had the shortest gestation in policy terms post the formation of the Coalition Government, are taking longest to progress through Parliament.

1.10 Introduced shortly following the General Election, following the initial publication of a White Paper[19], the Bill quickly became in the focus for arguments about the realities of GP commissioning (through which control of NHS spending would be vested almost entirely in the hands of GPs). Concern was expressed that the proposals to relocate public health in local government, replace Strategic Health Authorities and Primary Care Trusts with GP commissioning and an NHS Commissioning Board were too radical, and had not been subject to adequate research and consideration beforehand. Added to this was opposition based on the fact that this kind of structural reform in the health service had not been mentioned in the manifesto of either coalition party, nor was it present in the coalition agreement. There were also concerns expressed about the lack of obvious checks and balances in the new architecture.

1.11 For scrutineers, the most concerning element was the proposal in the Health Reform White Paper to transfer of the statutory health scrutiny powers to new Health and Wellbeing Boards, which would be executive bodies with decision-making responsibilities around joint needs assessments and joint health and wellbeing strategies. It was felt that these proposals represented a clear conflict of interest between decision-making and scrutiny responsibilities on "substantial variations" to health services[20]. After listening to the views of a range of stakeholders, the Government decided to retain a separate health scrutiny function.

1.12 The Government temporarily withdrew the legislation, tasking the NHS Future Forum to carry out a review into the plans and make suggestions for changes. This not only significantly delayed the legislation, and the proposed introduction of the changes[21], but also resulted in some substantive alterations. .

[18] Home Office Plan of Secondary Legislation (October 2011), http://www.homeoffice.gov.uk/publications/about-us/legislation/secondary-legislation?view=Binary

[19] "Equity and excellence: liberating the NHS" (DH, July 2010), http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

[20] Powers originally given by sections 7 and 11 of the Health and Social Care Act 2001.

[21] It had initially been planned that new commissioning arrangements would be introduced from 2013, across the country – now, the plan is to introduce them during 2013/14, at a speed to be defined more by local circumstances.

1.13 Now, new clinical commissioning groups (bodies involving GPs, together with other health professionals and lay people) will be introduced, with the bulk of the changes happening in 2013/14. Local accountability arrangements will also be strengthened, with scrutiny retaining its powers and Local HealthWatch, the successor body to LINks, having a more clearly defined role.

## 2. Localism Act

2.1 We discussed the main provisions of the Localism Act, when it was introduced into Parliament, in Policy Briefing 7, published in December 2010[22]. Since then, a number of amendments have been made. This briefing focuses on scrutiny and governance issues rather than the community rights to challenge and to "buy", and associated changes to planning, which are covered in the previous Policy Briefing. .

2.2 The Act contains provisions on a wide range of services delivered by local authorities, or in which councils might have an interest. Licensing, planning, housing and governance are all covered. The broad policy intention behind the Act is to devolve power over a range of services to local people and local communities (although some dispute that there is any clear vision behind the legislation at all)[23].

Powers for scrutiny

2.1 The Act will see increased powers for local government scrutiny functions in a number of key areas.

2.2 Powers over partners – as it stands, the Local Government and Public Involvement in Health Act 2007, and the Local Democracy, Economic Development and Construction Act 2009, between them give general powers to O&S to look at the work of partners – so long as that work relates to a local improvement target under the Local Area Agreement.

2.3 The Localism Bill retained the link to Local Area Agreements and local improvement targets. It was known that these were being abolished and consequently it was planned that, at some point in the Bill's progress, a new form of words would be substituted. It was, however, not known how expansive this form of words would be.

2.4 In the Act, the relevant section has been changed to encompass any activities carried out by a named partner (the list is at s104 of the 2007 Act). This could (and will) include services funded not by the local council, but from other funds. This important change makes it clearer that ever that scrutiny's future lies in a view of public services as they are delivered across a given locality – not just those for which the council has a direct responsibility. CfPS's recent work on health

[22] http://www.cfps.org.uk/publications?item=104&offset=0
[23] "Plain English guide to the Localism Act" (DCLG, November 2011), http://www.communities.gov.uk/documents/localgovernment/pdf/1896534.pdf

inequalities, summarised in “Peeling the Onion”, explores this potential in more detail[24].

2.5 The Government plans[25] to lay in Parliament regulations that will replace the regulations issued pursuant to the Local Democracy, Economic Development and Construction Act 2009, relating to information requirements[26]. Those regulations referred extensively to LAAs and local improvement targets and will need to be altered to reflect the position described above.

2.6 These powers should also be seen in the context of the “general power of competence”. Local authorities generally will have far wider powers to influence policy and public service delivery in their area[27]. As a function of the council, scrutiny can use these powers to investigate issues beyond its traditional remit, but which nonetheless affect local people. The lack of formal powers for scrutiny to explicitly carry out a particular review, or to work in a certain way, cannot be used by a recalcitrant executive who would prefer that scrutiny stays within a limited and unchallenging “box”[28].

2.7 Increased powers for districts – under existing legislation, the scrutiny functions of district councils have been circumscribed in the way that they can engage with local partners. The Localism Act will expand the existing partnership powers (explained above) to districts in two tier areas. Districts will also be able (but not required) to designate a “statutory scrutiny officer”.

2.8 Changes to the Councillor Call for Action – the Act also amends the provisions relating to the Councillor Call for Action[29]. The reference to “local government matters” has been removed, providing the opportunity for councillors to bring CCfAs on issues that relate to partnership business (so long as that business is within the scope of a committee’s terms of reference). The existing statutory guidance relating to CCfA remains in force.

2.9 Putative future changes – DCLG have advised[30] that they may consider, in the near future, a change to the “list of partners” under section 104 of the Local Government and Public Involvement in Health Act 2007. In CfPS’s view, this would involve either an expansion in the current list of partners to bring in more organisations over which

[24] http://www.cfps.org.uk/tackling-health-inequalities
[25] Information given to the National Overview and Scrutiny Forum, 2 November 2011
[26] Local Authorities (Overview and Scrutiny Committees) (England) Regulations 2009 (SI 2009/1919)
[27] “Localism Bill: General power of competence – impact assessment” (DCLG, 2011), http://www.communities.gov.uk/publications/localgovernment/localismcompetence
[28] See section 5 below on “resistance from partners/executive”
[29] Originally brought in via s119 of the Local Government and Public Involvement in Health Act 2007, and subject to statutory guidance produced on behalf of DCLG by CfPS in March 2009.
[30] Minutes of the National Overview and Scrutiny Forum, 2 November 2011

scrutiny currently has no formal powers – for example, the Highways Agency – or the replacement of the list with a "class" of organisation over which scrutiny would have some powers. CfPS has previously suggested a description such as, "any organisation in receipt of public funds delivering services to the local community".

Governance changes

2.10 Councils will have the option to change governance arrangements, moving to a committee-based model of governance, or to a directly-elected executive mayoral model.

2.11 Elected mayors - The 12 "core cities" in England are holding confirmatory referendums on the establishment of a directly elected Mayor. The Government is currently (December 2011) consulting on the powers for directly elected mayors, through the document, "What can a mayor do for your city?"[31]. The consultation makes clear that the Government wishes the core cities to approach the Government with their own ideas of what powers will be given to Mayors. However, given amendments made to the Localism Bill/Act in September 2011, which make Mayoral powers available to other authorities, it seems difficult to consider that a decision to adopt this form of governance will be taken because different powers will be provided[32]. It seems more likely that – as has been suggested by a number of commentators[33] - the Mayor's role will be a "strategic" one (reflected in the offer made in December 2011 to city regions on these wider strategic issues[34]). This mirrors, in many ways, the strategic, partnership-building role of the Police and Crime Commissioner (see below) – both will have a responsibility to go out and forge positive relationships outside the authority, with the leaders of other councils and partners across the conurbation. The CfPS response to the mayoral powers consultation[35] makes clear that stronger partnership powers for O&S should go alongside a partnership-focused Mayor – equally, we and others have noted the particular importance, in Mayoral authorities of dedicated officer support for scrutiny[36].

2.12 It has been confirmed[37] that elected Mayors will be able concurrently to hold the post of Police and Crime Commissioner, although this appears

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[31] http://www.communities.gov.uk/publications/localgovernment/mayorsconsultation
[32] See comment on this issue at http://www.birmingham.ac.uk/schools/government-society/departments/local-government-studies/news/2011/11/elected-mayors.aspx
[33] See publications by the Institute for Government, NLGN and the Core Cities Group. In particular, see Sims, "Making the Most of Mayors" (Institute for Government, 2011), http://www.instituteforgovernment.org.uk/publications/40/making-the-most-of-mayors
[34] LGC, 7 December 2011 (£) - http://www.lgcplus.com/topics/economic-development/exclusive-ministers-set-out-new-offer-to-cities/5038931.article
[35] INSERT REF
[36] As noted by Andrew Adonis, Director of the Institute for Government, in a letter to Eric Pickles, http://www.instituteforgovernment.org.uk/publications/39/mayors-and-the-localism-bill
[37] LGC, 22 November 2011 (£) - http://www.lgcplus.com/policy-and-politics/official-mayors-can-stand-as-police-commissioners/5038233.article

to be at odds with the guaranteed place on the PCP available for Mayors, and would create a conflict of interest between authority-specific, and Force-wide, priorities.

2.13 Committee system – CfPS's Policy Briefing 4 goes into more detail on the committee system; a forthcoming publication will examine the practical issues in more detail.

2.14 The Act makes provision for authorities to either adopt a committee system of governance, or any other form of governance prescribed by the Secretary of State. Authorities choosing to adopt a committee system must first agree a resolution to his effect at Full Council, with the change itself happening following the subsequent Full Council AGM.

2.15 This is a change from earlier iterations of the Bill, which required the date of transition to different governance arrangements to be pegged to the date of ordinary elections. This would have meant that only 109 councils would have been able to change their arrangements in 2012[38] – others would have had to wait until 2013, 14 or 15. As it stands now, all English councils can opt to change in May 2012.

2.16 Councils can operate overview and scrutiny under a committee system. CfPS believes that, for most authorities who choose to change their arrangements, a "streamlined" or "hybrid" committee system, incorporating both subject committees and O&S, is the most likely outcome (on the basis of anecdotal information which we are collecting to support further research on this issue, to be published in February 2012)[39]. This will allow committee system councils to exercise the scrutiny powers around healthcare, social care and health improvement, crime and disorder and external partners, as well as providing some independent challenge to decisions made by these committees.

2.17 DCLG plans to lay in Parliament regulations defining the operation of O&S in committee system authorities shortly. CfPS expects that these will be, for all intents and purposes, identical to the provisions on O&S for "leader and cabinet" authorities.

Tenant scrutiny

2.18 The Government is bringing in, through the Act, a more central role for the existing tenant scrutiny arrangements in social housing. The previous model of "co-regulation" is being extended as central government regulation is scaled back and more challenge to landlords at local level by tenants themselves replaces it[40]. The Act will move

[38] "Impact assessment: governance arrangements" (DCLG, December 2010)
[39] As posited in Policy Briefing 4 (see above).
[40] http://www.tenantservicesauthority.org/server/show/nav.14727

two principal consumer protection responsibilities from regulators to tenant scrutiny, namely:

- Proactively monitoring landlords' compliance with service standards;
- Scrutinising landlord performance and driving service improvement generally.

2.19 A role around complaints is also envisaged for tenant panels, but they may choose not to exercise it.

2.20 Systems and arrangements will be built on existing practice – namely, the existing "Involvement and Empowerment Standard" [41] developed and promoted by the TSA, which is currently consulting on a new Standard[42]. There is a clear steer from DCLG[43] and other national bodies that landlords will be expected to support tenant scrutiny panels or other arrangements, as a part of the co-regulatory environment. Earlier research on tenant scrutiny does provide numerous examples of good working relationships having been built up[44], but O&S may wish to explore how well arrangements are developing in their local area, both in relation to the council's own housing stock (either directly managed or by an Arms Length Management Organisation) and in relation to any social housing landlords with housing locally. Some areas, for example, are developing cross-landlord scrutiny arrangements across the area, and local authorities, with their continuing strategic housing responsibilities, may wish to take an interest in how effective local tenant scrutiny arrangements are.

2.21 Increasing powers and a stronger regulatory role for tenant scrutiny also suggests that local government O&S should seek to integrate its work more with these panels (or other local tenant scrutiny arrangements) – particularly given the importance of housing policy to a range of issues which will be of interest to local councillors. CfPS is carrying out research on this area, with a view to publishing a report and practical guide for tenants in early 2012. We believe that tenant scrutiny will play a valuable and complementary role alongside any scrutiny of housing carried out by council overview and scrutiny committees – tenants have day-to-day experience of living in their homes and bring a unique perspective. The National Tenant Organisations are also expected to produce a report on tenant panels in early 2012 which will provide further guidance and examples of current practice.

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[41] http://www.tenantservicesauthority.org/server/show/ConWebDoc.19976
[42] http://www.tenantservicesauthority.org/server/show/nav.15065
[43] "Review of social housing regulation" (DCLG, 2010), http://www.communities.gov.uk/documents/housing/pdf/1742903.pdf
[44] "Local offer trailblazers – from planning to practice" (TSA, 2011), http://www.tenantservicesauthority.org/upload/pdf/Local_Offer_Trailblazer_Report_July_2011.pdf

Neighbourhood planning and "community right to challenge"

2.22 The Act will allow local people to directly influence policy, and the delivery of services, in neighbourhoods in two principal ways – through neighbourhood planning (the production by local people of planning documents which, as long as they complement the Core Strategy of the LDF, will be adopted by the Council as a Development Plan Document) and the "community right to challenge", the system by which local people can challenge the delivery of a service by a certain provider, with a view to a procurement exercise for the delivery of that service being opened up. There have not been any substantive amendments or clarifications on these powers since the introduction of the Bill, and they are covered in more detail in Policy Briefing 7.

Referendums

2.23 The expansive referendum provisions in the Bill, as introduced, have been removed following lobbying by the LGA. Referendums will still need to be held on certain council tax increases.

## 3. Police Reform and Social Responsibility Act

3.1 We discussed the proposals in this Act, as they were introduced, in Police Briefing 8, published earlier in 2011[45]. Unofficial guidance, drafted by CfPS and published in partnership with the Local Government Association, goes into more detail on the operation of police and crime panels[46].

3.2 The Act abolishes police authorities and replaces them with an elected Police and Crime Commissioner (PCC). The Commissioner will be responsible for holding the Chief Constable in the Force area to account. The PCC is perceived as having a more high profile and responsive role in relation to the public. Innovations such as crime mapping, and mandated neighbourhood meetings, along with direct elections, are designed to make the PCC more accountable.

Powers and responsibilities of the PCC

3.3 The PCC will have wide-ranging powers and responsibilities. On consultation and engagement, he or she will have a duty to consult local people – including victims of crime[47]. There is a statutory requirement for the PCC to work in partnership with a range of other local agencies[48].

[45] http://www.cfps.org.uk/publications?item=104&offset=0
[46] http://www.cfps.org.uk/publications?item=7002&offset=175
[47] Section 14 (arrangements for obtaining the views of the community on policing)
[48] Section 10 (co-operative working)

3.4 The PCC will have sole responsibility for disbursing community safety funding from the Home Office[49] (currently provided through a range of funding streams to local authorities, police and community safety partnerships), and will also have responsibility for a range of other budgets. The PCC will be able to direct this funding where he or she wishes, in the form of grants, either to Community Safety Partnerships or other bodies.

3.5 The PCC will also have wider powers over criminal justice, in partnership with criminal justice bodies, under section 10(3). The precise scope of this work is as yet unclear and may be subject to more detailed discussions at local level.

The relationship with CSPs

3.6 The relationship between the PCC and Community Safety Partnerships (CSPs) – and, consequently, with CSP O&S – is potentially complicated.

3.7 As noted above, the PCC will have sole responsibilities for making grants of cash on community safety issues. There is consequently a funding accountability relationship between the PCC and those CSPs in receipt of this money. This is backed up by a formal power for the PCC to call CSP chairs to meetings to discuss Force-wide issues[50]. This could be seen as a way for the PCC to enforce control over chairs for the spending of money.

3.8 This will see community safety moving to a more commissioning-led approach, depending on the ambition of the individual PCC. Ringfencing seems likely to be removed[51]. With this widespread power, the PCC may choose innovative business models for the delivery of certain services – involving the third or private sector in certain areas. Whatever happens, it seems likely that contract management will take a more central role in the delivery of community safety priorities. It may result in mergers of some CSPs[52], the adoption of shared services between some partners, potential TUPE issues for community safety staff, and a renewed focus on "value for money" – as well as more data transparency.

3.9 These powers should be seen in the context of the remaining CSP scrutiny powers for local government, as well as the likely role of the PCP in scrutinising the PCC's commissioning activities. The CSP scrutiny powers will not be amended but it is clear to see that the wider

[49] Sections 21 – 27 (financial matters)
[50] Schedule 11
[51] "Police and crime commissioners: a guide for councillors" (LGA, 2011), http://www.local.gov.uk/c/document_library/get_file?uuid=30614eb6-7cad-4d50-af52-33b7158b0c73&groupId=10161
[52] While the PCC will not be in a position to "force" CSP mergers, he or she will be able to approve such mergers.

accountability arrangements in play will have a profound impact on the way that CSPs operate. We will explore this tension in more detail in section 5.

The Police and Crime Panel[53]

3.10 The Commissioner will him/herself be held to account by a Police and Crime Panel, a body made up of local councillors from all authorities in the Force area[54].

3.11 The Police and Crime Panel will be a joint committee[55] of all the authorities in the Force area and must be politically and geographically balanced[56], as far as possible – as well as incorporating in its members the key skills necessary to deliver the PCP's functions.

3.12 A lead authority will need to be assigned to co-ordinate arrangements between the authorities involved. The CfPS/LGA guidance suggests the establishment of a "shadow PCP" to consider the role, responsibilities and composition of the final Panel[57].

3.13 The role of the Panel will need to be considered first. The Panel is a scrutiny body. Under the Act the PCP has certain "special functions"[58] – including considering the PCC's Police and Crime Plan, reviewing the planned police precept and reviewing certain senior appointments. The PCP will also have formal duties around dealing with certain complaints against the PCC (to be exercised as a last resort[59]).

3.14 Beyond these statutory powers there is a hinterland of other work in which the PCP could engage. From anecdotal evidence, CfPS understands that many areas are planning a "compliance" approach – mainly for resource reasons. CfPS's view is that the PCP will find it difficult to transact its statutory functions – particularly scrutiny of the Police and Crime Plan – without carrying out scrutiny-style investigations into issues of local concern. The "set piece" scrutiny outlined in the "special functions" will, for its success, need to rely on a wider – but not overwhelmingly detailed – body of evidence from more detailed scrutiny investigations, in order to be meaningful[60].

3.15 This could well involve the PCP drawing evidence from community safety O&S functions in the Force area, and drawing on feedback from neighbourhood beat meetings, to inform its scrutiny work.

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[53] Detailed technical information on the PCP can be found in the joint CfPS/LGA guidance on the subject.
[54] Ibid, 6.1
[55] Ibid, 5.2
[56] Ibid, 7.3 onwards
[57] Ibid, section 8
[58] Ibid, 5.21
[59] Ibid, 3.16 – 3.18
[60] Ibid, 5.14 – 5.19

3.16 The composition of the Panel will need to be considered after the role. It is for authorities in the area to decide how the Panel should be composed, subject to the principles mentioned above on "balanced representation". CfPS has strongly recommended, for reasons set out in detail in the CfPS/LGA guidance, that the Panel should be made up of non-executive members[61].

3.17 Although there is a guaranteed place for an executive mayor on the Panel, the mayor has the power to delegate this if he or she wishes. The prospect of this occurring, and a non-executive member from the relevant authority attending in the mayor's place, should not be discounted as unrealistic. Indeed, in the only example of a directly elected mayor being given the express statutory power to direct policing policy (the powers given to the Mayor of London in 2008 to chair the Metropolitan Police Authority), those powers were delegated by Boris Johnson to Kit Malthouse as a Mayoral appointee.

Subsequent regulations and guidance, and "transition"

3.18 The Home Office is planning the publication of regulations relating to Police and Crime Panels and is likely to produce its own guidance in the New Year[62]. Regulations are definitely expected on complaints (a draft set have already been published[63]) and on the operation of confirmation hearings.

3.19 Guidance will contain more detail on the expected timescale of the lead up to the new structural arrangements coming into force later in the year. At the moment it seems most likely that the Home Office will require councils to agree on "who leads" on PCP arrangements by April 2012, with arrangements having been established in shadow form by July 2012 at least. This timescale is of course subject to change and has not been confirmed by the Home Office.

3.20 On police reform more generally, Leaders and Chief Executives of local authorities, and senior officers in police authorities, expect a range of guidance on wider issues over the coming months[64]. The chief uncertainty in preparation lies in who the PCC will be. It will be reasonably easy to establish new structural and support arrangements in individual Force areas, but ultimately the PCC may decide that he or she wishes to change these. As such, flexibility and responsiveness will be key to any plans being considered between now and November 2012.

3.21 To better assist the PCC in understanding their role, the context of policing and crime policy and in developing their budgets, some Force

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[61] Ibid, 7.8 – 7.10

[62] Home Office Plan for Secondary Legislation (October 2011)

[63] http://www.homeoffice.gov.uk/publications/about-us/consultations/policing-complaints-regulation/

[64] Based on conversations with local authority and police authority employees

areas are considering the drafting of a “strategic assessment” of priorities and activities, to contribute towards a risk-based approach to planning.

## 4. Health and Social Care Bill / Act

4.1 The content of the Health and Social Care Bill as introduced into the House of Lords is substantially different from the Bill as originally introduced in the Commons. In response to concerns expressed inside and outside Parliament, the Government committed to a “pause” in the legislation in 2011, while the NHS Future Forum considered the changes in more detail[65]. Subsequently, a revised Bill was introduced that gave other clinical professionals in local area (not just GPs) responsibility for commissioning decisions a role in clinical commissioning groups.

4.2 CfPS has produced detailed briefings on the way that accountability will operate under the new arrangements – in particular, “Accountability and the New Structures”, published jointly with the BMA (November 2011)[66].

4.2 CCGs and the NHS Commissioning Board - Commissioning remains at the centre of the Bill, with clinical commissioning groups (incorporating GPs, and other professionals, to be introduced by April 2013) taking responsibility for the commissioning of most healthcare services for local people. Local authorities will hold wide powers to steeer healthcare, social care and public health policy, through health and well-being boards – in practice this will mean:

- The assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities;
- The formulation of public policies designed to solve identified local and national health problems and priorities;
- Ensuring that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services, and evaluation of the effectiveness of that care[67].

4.3 CCGs will be authorised by the NHS Commissioning Board. Prospective CCGs will pass through three phases – an **initial development phase** (taking place from now up to and beyond April 2013)**, the application and authorisation process** (from April 2012 to

[65] The Future Forum’s report, and the Government response, can be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443
[66] http://www.cfps.org.uk/publications?item=7007&offset=0
[67] Based on the Government’s long term plans for public health in England, in “Healthy lives, healthy people” (DH, November 2010), http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

April 2013) and finally (to assure quality and continuous improvement), **annual assessment** (from April 2014 onwards).

4.4 The process will begin with a risk assessment of the configuration of the CCG, followed by a "development period" in which the CCG builds up experience, expertise and capacity. This culminates in the formal authorisation process.

4.5 To be authorised, prospective CCGs will need to demonstrate their capability across six specific areas[68]:

- A strong clinical and multi-professional focus which brings real added value;
- Meaningful engagement with patients, carers and their communities;
- Clear and credible plans which continue to deliver the QIPP (quality, innovation, productivity and prevention) challenge within financial resources, in line with national requirements (including excellent outcomes) and local joint health and wellbeing strategies;
- Proper constitutional and governance arrangements, with the capacity and capability to deliver all their duties and responsibilities including financial control, as well as effectively commission all the services for which they are responsible;
- Collaborative arrangements for commissioning with other CCGs, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support; and
- Great leaders who individually and collectively can make a real difference.[69]

4.6 For scrutineers, the element of most initial interest will be "proper constitutional and governance arrangements", arrangements that will naturally need to include overview and scrutiny and collaboration between scrutiny, local Healthwatch and lay people involved in CCG governance..

4.7 Preparation of joint strategies – in additional to the joint strategic needs assessment[70] (JSNA), a joint health and wellbeing strategy (JHWS) will need to be signed off by clinical commissioning groups, working with other partners, Local HealthWatch, councils and other professionals through health and wellbeing boards. Local people must be central to the preparation of the Needs Assessment and the Strategy. Practically

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[68] See for more detail, "Developing Clinical Commissioning Groups: Towards Authorisation" (DH, 2011), at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130293
[69] Ibid, p5
[70] DH Guidance on JSNAs from 2007 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097

speaking scrutiny will want, and need, to be involved in developing these as well.

4.8 The Health and Wellbeing Board for the area – a board comprising a number of local partners, including the local authority, local HealthWatch, CCG representatives and other professionals – must, under the Bill, encourage integrated working. This duty will be especially relevant in the development of the JSNA and the joint health and wellbeing strategy. The HWB cannot compel CCGs in its areas to do, or not do, something, but it will be able to challenge the CCG (through reference to the Secretary of State) if it feels that the CCG's commissioning plans do not conform to the JSNA or the JHWS.

4.9 The HWB can also take on other responsibilities, beyond those set out in statute[71]. In this context, HWBs will have a stake in a range of decisions that affect health and health priorities in the area, but which might not be considered to be "traditional" areas for healthcare professionals – particular in respect of prevention and early intervention. For example, a significant focus of the Government's current community budgeting agenda is on children's services, which is seeing public health playing a leading policy role in other services that affect young people.

4.10 National structures – the existence of national structures will exert a significant effect on local policies. The NHS Commissioning Board, for example, has broad, continuing powers in the Bill over CCGs[72], to ensure that they are properly commissioning services. Information will also be collected by DH to support national resource allocation – a process that has already begun in shadow form[73].

4.11 Economic regulation is to be provided by Monitor, the former Foundation Trust regulator. Monitor has a duty to consider VfM (the principles of economy, efficiency and effectiveness) as part of its regulatory role. It has a particular role in encouraging choice and personalisation. Monitor must ensure that services are provided in an "integrated" way, but also has a duty to stop "anti-competitive" practice. The two principles, for practical purposes, could be seen as coming into conflict[74].

4.12 The role of HealthWatch – at the moment it is still too early to make detailed predictions for how Local HealthWatch will work with overview and scrutiny – although it will certainly need to do so. CfPS has carried

[71] "Great expectations: public health is coming home" (LGA, 2011), http://www.idea.gov.uk/idk/core/page.do?pageId=30085271
[72] "Developing Clinical Commissioning Groups: Towards Authorisation" (DH, 2011)
[73] See letter from Sir David Nicholson at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129401.pdf
[74] That is to say, that agreement between providers to provide services in a particular way could be regarded as being inherently anti-competitive.

out detailed studies of the development of LINks (Local Involvement Networks), since their establishment, which may provide some further guidance on this subject[75], and recently published a major evaluation of the lessons that Local HealthWatch can learn from the experience of LINks[76].

4.13 Health scrutiny's position and powers – the Bill amends the scrutiny provisions in the National Health Service Act 2006. Powers are now to be exercised by the authority, rather than by a health overview and scrutiny committee. This provides more flexibility to local authorities in how they manage the delivery of their scrutiny responsibilities – this could enable creativity but risks dilution of independent scrutiny. .

4.14 The Bill is expected to receive Royal Assent in the spring. At that point, it will be easier to draw out some of the practical implications, and it will become clearer in which areas Government plans to lay in Parliament subsequent regulations, or introduce guidance.

## 5. Broad implications for scrutiny

5.1 In this section we will look at the general implications for scrutiny arising from the new legislative framework. At the end, we will look briefly at the issue of effective resourcing and partner/executive resistance – two of the principal barriers in the way of scrutiny being able to capitalise on the opportunities we have set out in the sections above.

Thinking "external"?

5.2 Powers in all three pieces of legislation – and in other legislation enacted by the current Government – emphasise the importance of partnership working in the delivery of public services. Large-scale commissioning, more joint working (as evidenced by the tri-borough arrangements in London and the Combined Authority in Greater Manchester[77]) and different attitudes to procurement will mean that the way that services are delivered will be subject to profound change in the coming months and years.

5.3 While this may initially suggest that scrutiny will need to look at more "external services", the challenge is in fact more fundamental than this.

[75] For example, research carried out with the NHS Centre for Involvement in 2009.
[76] http://www.cfps.org.uk/publications?item=6999
[77] The tri-borough proposals can be found at http://www.westminster.gov.uk/workspace/assets/publications/tri-borough-proposals-report_aw3-1297241297.pdf - information on the Manchester combined authority is at http://www.agma.gov.uk/gmca/index.html

5.4 Increasingly, council business is delivered in partnership with others[78], and the contents of the Acts will only serve to accelerate this trend. It will become more difficult to distinguish between "internal" council-only services and "external" ones delivered by partners. The merging of the two will mean that the way in which scrutiny deals with all issues across a local area will need to be harmonised.

5.5 This may involve a number of changes:

- More proactive consultation and discussion with partners about the scrutiny work programme (most councils consult officers within the council but it is less usual to speak to partners more widely);
- A better understanding of scrutiny by partners more generally. Even "listed" partners under s104 may be unwilling to participate in scrutiny work at the moment, sometimes because they feel that scrutiny is a confrontational process. Future expansion of partnership powers may provoke scrutiny functions to engage with partners to discuss mutual expectations from the process, and if necessary (as we have suggested before[79]) develop a protocol to define relationships in the future, focusing on improvement and the avoidance of duplication;
- More scrutiny on specific issues, that may involve partners, rather than "scrutiny of partners". Traditionally, partners may have been invited to give evidence to scrutiny committees to give an account of their general work. It may make more sense to integrate evidence from partners into scrutiny reviews of "issues" affecting local people;
- More joint scrutiny[80]. The administrative boundaries of some partners or partnerships may not be coterminous with those of the local authority. More informal or formal joint working may be necessary – particularly in two tier areas.

5.6 We have explored the detail of these opportunities in more detail in Policy Briefing 11 (commissioning and shared services) and Policy Briefing 12 (equality impact assessments). We will be covering joint scrutiny in a forthcoming Policy Briefing.

Returning to the "web of accountability"

5.7 Our "Accountability Works" research proposed the existence of a "web of accountability", encompassing a range of different actors at local and national level. This incorporates accountability through regulation and inspection, direct election, scrutiny by non-executives, the media, redress and complaints systems, and management systems. The different institutions – new and old – which will either be affected, or

[78] As we have previously explored in Policy Briefing 11 (shared services and commissioning) and in "Between a rock and a hard place" (2010).
[79] In relation to policing, in the joint CfPS/LGA unofficial guidance on PCPs (referenced above) and in various publications with reference to partnership working more generally.
[80] These issues will be explored in more depth in a subsequent Policy Briefing.

established, by the legislation we have discussed, will all have their own individual accountability arrangements.

5.8 Into this complex landscape, scrutiny, with its broader powers over partners, will have to find a niche. We discussed in "Accountability Works" (2010) how accountability by non-executives, while not having primacy over other forms of accountability, alone has the legitimacy, credibility and utility in local areas to demonstrate that it can and should be involved[81]. While this is subject to the usual caveats about avoiding duplication, and focusing on those areas where value can be added, a strong argument can be made that scrutiny's unique role and composition should be recognised as new accountability arrangements are created and developed over the next few months and years.

5.9 In practice, this may mean that overview and scrutiny will be carrying out more joint work with other bodies and agencies to pursue areas of mutual interest. For example, local authority scrutiny functions might collaborate with tenant scrutiny panels to jointly challenge housing providers in the local area, draw evidence from Local HealthWatch to challenge health and social care providers, share information with Police and Crime Panels, amongst other opportunities. Apart from enhancing the scope and profile of scrutiny work, this could provide a technique to target resources more effectively.

Fitting in with other developments (sector self-regulation)

5.10 Central inspection is largely being withdrawn in the new structural landscape, replaced by the use of marketisation, direct elections and transparency as means to ensure local accountability. Local people, and their representatives, are being expected to take a stronger role in securing accountable and effective services. For local government, this will be most evident through "sector self-regulation", the approach outlined in the LGA's "Taking the Lead" offer to local government[82]. A combination of sector peer challenge, and the sharing of best practice through the Knowledge Hub and LG Inform[83], this will see local authorities taking responsibility for improvement individually and collectively. "Taking the Lead" sees a key role for scrutiny in allowing councillors to drive the local improvement process, to maintain momentum and to provide constructive scrutiny based on challenging traditional approaches to service delivery.

Barriers

5.11 Partner/executive resistance - In many authorities, scrutiny has moved beyond the formal powers set out in this briefing. Positive working

[81] "Accountability Works" (CfPS, 2010), p14, http://www.cfps.org.uk/publications?item=91&offset=0
[82] http://www.lga.gov.uk/lga/core/page.do?pageId=12858175
[83] Both collaborative tools for discussing issues and sharing data.

relationships have built up with partners and the council executive, with the result that the impact of scrutiny work has increased.

5.12 However, in some areas, there is resistance to scrutiny becoming involved with "external" bodies, or becoming involved in the way that the council's executive negotiates, liaises or contracts with those partners. A number of justifications could be given for this. Ultimately, however, this tends to come down to a view – which, as we have seen, is not backed up by the Government, by the sector at large or by the available evidence – that scrutiny is ineffective or would "get in the way". For partners, the perception may be that scrutiny is an antagonistic and confrontational process.

5.13 Ingrained attitudes such as these can be difficult to shift. However, as scrutiny finds itself working in new areas, and looking at existing issues in new ways, some resistance is inevitable. These will need to be addressed through negotiation and dialogue, and through proving scrutiny's worth by producing high quality work. Having the formal legal powers highlighted in this briefing will help in shifting opinion – greater powers would not have been given to a function that is not seen as broadly effective. However, engagement with scrutiny because of legal compliance is not a good basis for an ongoing relationship. The focus should lie in positively changing minds by carrying out high quality work (whether based on robust, focused challenge, or in-depth policy review and development) that is seen as useful by those being scrutinised.

5.14 New powers, no new resources - Police and Crime Panels, new scrutiny powers over partners, the structural reforms in the health services and the wider issues mentioned in this section, all provide new powers and opportunities for scrutiny. However, resources are not expected to increase – in fact, a decrease in scrutiny resources seems more likely in the short term[84]. It is all very well to talk positively about the possibilities and opportunities arising out of the new legislation, but in this financial landscape it is easy to be fatalistic about the capacity of scrutiny in many authorities to capitalise on these.

5.15 We cover resourcing in more detail in Policy Briefing 5, and touch on the issue in a number of other recent publications[85]. It would be trite to assert that scrutiny should do "more with less", but there are lessons from recent experience that suggest that scrutiny resources should be expended only on those areas where scrutiny can add the maximum value[86].

[84] The CfPS Annual Surveys show a mixed picture – a fairly static maintenance of the number of dedicated scrutiny officers per authority, but a consistent downward trend in the amount of discretionary funding available to the function. Anecdotally, we expect this trend to continue, and it seems likely that the number of officers dedicated to scrutiny will suffer a fall in 2011/12.

[85] "Global challenge, local solutions" (2009); "The lion that roared" (2011), "A cunning plan?" (2011)

[86] "A cunning plan?" (CfPS, 2011)

5.16 This may involve the recasting of the role to focus more on services delivered in partnership (helping the council to build and maintain partnership working in difficult financial circumstances), contract management (providing a different, and more public, approach to what is often considered to be a technocratic exercise[87]) or using performance, finance and risk information to drive the scrutiny work programme[88]. In all cases, it will involve more robust prioritisation of scrutiny work – an issue which we explore in more detail in our recent publication on developing an annual scrutiny work programme, "A cunning plan?" (2011).

5.17 Discussing these issues goes beyond the remit of this paper, and they are discussed in more detail elsewhere. The important point to note is that the structural and legislative changes laid out in this briefing should not be regarded as presenting opportunities for scrutiny that lie just out of reach for want of an additional resource. Instead, they might be considered as providing an opportunity to recast the way that overview and scrutiny works to fit within a public service landscape that, in a couple of years time, will be transformed from that in existence in 2000.

Centre for Public Scrutiny
December 2011

[87] Explored further in Policy Briefing 11.
[88] "A cunning plan?" (CfPS, 2011)

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**CHESHIRE AND WIRRAL COUNCILS' JOINT SCRUTINY COMMITTEE**

**23 JANUARY 2012**

**(2.00 pm - 3.50 pm)**

**PRESENT:** Councillor Andrew Dawson (Chairman)

Councillors Keith Butcher, Paul Dolan, Louise Gittins, Eveleigh Moore Dutton, Charles Fifield, Gordon Baxendale, Paul Edwards, Brian Silvester, Mo Grant, Wendy Clements, Patricia Glasman and Cherry Povall

Apologies for absence were received from Councillors Gill Boston, Carolyn Andrew and Ann Bridson

Reserve Member: Councillor Mo Grant

Visiting Member: Councillor Dorothy Flude

| Officers in attendance: | Sheena Cumiskey | – Chief Executive |
|---|---|---|
| | Avril Devaney | – Director Of Nursing, Therapies and Patient Partnership |
| | Penny Housley | – Senior Manager-Overview and Scrutiny |
| | Deborah Ridgeley | – Democratic Services Officer |

## 22 DECLARATIONS OF INTEREST

Members did not declare any personal or prejudicial interests.

## 23 MINUTES

**DECIDED: That**

the minutes of the meeting held on 10 October 2011 be confirmed as a correct record.

## 24 CHIEF EXECUTIVE OFFICER'S REPORT

The Committee considered the report of the Cheshire and Wirral Partnership's Chief Executive, which provided an overview of activity since the last meeting.

Members were informed that following the unannounced visits by the Care Quality Commission (CQC), moderate concerns had been raised at Kent House and Greenways. It was stressed that there was no evidence of any patient being harmed, and the safeguarding concerns raised related to an individual who had made unsubstantiated allegations and there had been a delay in the reporting of this. Members enquired into how the results differed from Greenways achieving an "excellent" accreditation by the Royal College of Psychiatrists (RCP) Adult Inpatient Mental Health Service Accreditation Process AIMS. It was explained that the one service had been reviewed in two different ways. The CQC inspection took a "snapshot" of the Centre at the time of the visit, whilst the RCP took a more systematic approach to examine the way the Centre was being run.

Reference was also given to The Operating Framework for the NHS for 2012/2013 and the Quality Innovation Productivity and Prevention (QIPP) Level 2 Health Economy Savings.

Sheena Cumiskey then referred to the Member Engagement Events, which consisted of 3 half day events entitled “No Decision about me without me”, and of the disappointing turnout at the one event held on 18 January 2012. Councillors were invited to suggest ways of improving attendance at events, and the following were suggested:-

- Hold the event in a more public area, such as a market or shopping centre
- Hold the events at different times, they were often held during the day when people could be working; and
- Hold the event in a more central location within the Boroughs, the locations chosen were at the “extremity” of the local authority areas.

Members were reminded that the events were targeted at Board Members and interest groups. The CWP also attended other meetings to raise awareness, such as the Youth Parliament.

The recently launched television campaign regarding mental health at work was highlighted, and it was described as a national campaign to try and reduce discrimination at work, which did have an impact on services by raising awareness. Historical evidence had shown that during a recession, people did suffer from depression and anxiety and that had to be considered as part of the planning for service demand.

**DECIDED: That**

the report be noted.

## 25 FUTURE INPATIENT SERVICE CONFIGURATION

The Committee considered a report updating Members on the future inpatient service configurations, which had been requested at the last meeting. It was anticipated that the Estates Strategy would be revised over the next 3 months and a further report to outline the development proposals and challenges in service configuration to the Joint Scrutiny Committee’s next meeting in April.

Members were informed that a Strategic Estates Partner had been appointed and a Joint Venture had been established. It was through the Joint Venture that it was hoped the Trust would be able to access funding sources unavailable via traditional routes. A tendering process would have to be followed in compliance with the Official Journal of the European Union, which would be completed by the end of 2012. Alternative venues for providing services were always explored, and where possible, sharing accommodation with other health providers was encouraged as it promoted joint working and was considered to be a better use of space.

Members welcomed the update.

**DECIDED: That**

the update be noted.

## 26 QUALITY ACCOUNTS: PATIENT SAFETY PRIORITY FOR 2011/12 - PROGRESS

Avril Devaney, Head of Nursing, referred Members to the progress report which set out the Quality Account assurance process. Members were reminded of the aim of the inpatient safety metrics programme, which was to undertake an ongoing check of patient safety issues common to all 22 inpatient wards in order to regularly monitor performance in these areas. It was reported that there were no nationally set metrics for mental health, so the tables enclosed in the report were established locally.

Members expressed concern at the improvement percentages provided in the report, and requested more detail with regard to the starting point, as it appeared some services had seen am improvement of 600%, which alarmed Members as to the size of the improvement. Members queried the presentation of the information and suggested that it could have been presented as a Red Amber Green (RAG) system, which would alert Members to the main area of concern.

The Committee were informed that the CWP Board received this information as a RAG rated document, and this too had caused concern. Members were reminded that there was no established standard tool for recording this, and the production of this information would then become the benchmark for future comparisons. The Chairman requested that the detail behind the improvements be emailed to Members to aid their understanding of the results presented in the report.

**DECIDED: That**

the report be noted.

## 27 7 DAY FOLLOW UP PROGRESS

Members considered the report of the Head of Performance and Information which provided an explanation as to the drop in performance in relation to the 7 day follow-up, highlighted at the last meeting.

It was reported that due to an issue with manually recorded data, this information in the July 2011 report was incorrect. An internal task and finish group had been established to oversee a move away from a manual process of collecting this information which is now fully automated.

**DECIDED: That**

the update and explanation provided be noted.

## 28 CWP NHS TRUST SUICIDE PREVENTION STRATEGY

The Committee considered recently developed CWP NHS Trust Suicide Prevention Strategy, and were referred to the 6 objectives set out in the report, which were outlined:-

Objective 1 – to work in partnership with public and private agencies and organisations to prevent and reduce suicide rates in our population
Objective 2 – to target high risk groups to prior reduction in harm and effective recovery strategies

Objective 3 – to promote and endeavour to provide a safe environment for our patients
Objective 4 – to have high quality risk assessment and management as part of the effective care planning for all our patients
Objective 5 – to have appropriately trained and competent staff to ensure effective suicide awareness and prevention; and
Objective 6 – to ensure that there are robust processes in place within the trust to learn lessons identified nationally, regionally and locally from confidential enquiries, national patient safety alerts, serious untoward incidents etc.

Members discussed the Strategy and were informed that reviews would be required due to the production of a new national strategy and the formation of the Health and Wellbeing Board, which would become a local authority responsibility from 2013. The CWP would be targeting their resources towards the individuals currently receiving their services, but were aware that not everyone who commits suicide has mental health issues.

Members enquired if anyone had committed suicide and had mental health issues but were not known to CWP would there be any way of finding this out. It was reported that when the Coroner recorded a death by suicide, or an open verdict, the CWP were not always requested to provide information so were not automatically aware of an individual's circumstances. When the CWP was asked to provide a report, this information guided the budget for support for the following financial year.

Members enquired if consideration had been given to the bereaved family members or friends, and if any support mechanisms were available. It was confirmed that this was contained in the Strategy, and took either an informal or formal approach, depending on the preferences of the individuals concerned. The work carried out by other agencies and connections with partner organisations was outlined in the Implementation Plan, appended to the report, and this recognised that the issue was not just a CWP issue, and that the wider community played an important role.

Objective 3 of the Strategy was referred to, and Members were informed that discharge from inpatient care did present issues for patients going from a hospital environment to home. Families were involved in care planning, where this was permitted by the patient. The subject of discharge was mentioned early in the care if a patient. CWP was involved in a national piece of work entitled "The Triangle of Care", which emphasised the importance of family involvement.

The Chairman suggested that a regular report be submitted to the Joint Committee and it was debated whether this should be quarterly, or based on which information as the reports from the National Confidential Enquirer were usually 12 – 18 months out of date. This would be debated further at the next meeting of the Joint Committee.

Members thanked the officers for their report and full debate.

**DECIDED: That**

(i) the report be noted;

(ii) the most appropriate reporting mechanism be discussed at the next meeting of the Joint Committee.

**29 TASK GROUPS - PROGRESS**

Members were reminded of the three Task Groups established at an earlier meeting of the Committee, and that two had met since the last meeting. The topics covered were Community Treatment Orders and Alcohol Acquired Brain Injury, which were filmed and copies of the DVD and sound file were available, along with the Powerpoint presentations used at the groups.

Members welcomed the first meetings of the Task Groups and it was suggested that due to problems with availability, a date be arranged for the outstanding Group and make it available for anyone who is able to attend. This would also be filmed, and the DVD would be available after the Group.

**DECIDED: That**

The update be noted and the remaining Task Group be arranged for mid-February 2012.

**30 FUTURE OF THE CHESHIRE AND WIRRAL JOINT SCRUTINY COMMITTEE**

Members considered a tabled document concerning suggestions for the future of the Cheshire and Wirral Joint Scrutiny Committee. The document set out the issues that arose from the telephone conference held between the Chairman and the spokesperson.

Members held a detailed discussion about the Joint Scrutiny Committee and the value placed on the Committee by the CWP. Sheena Cumiskey confirmed that she found the Joint Committee to be valuable as it raised the profile of their work and enabled them, through discussion, to improve services and maintain close working with the local authorities of their footprint. The Joint Committee were reminded that the CWP was not alone in being a service provider for mental health, and that the other service providers would be welcome to also attend meetings to discuss service provision.

It was reported that any changed suggested to the remit of the Joint Committee would need to be considered by the three local authorities. A variation in numbers was also discussed, and any changes to this would also require agreement by the three authorities, and the corresponding impact on proportionality. The impact of the changes within the NHS would also have to be considered, with the transfer of the Health and Wellbeing function to local authorities from 2013 and the role of the Joint Committee and the Joint Commissioning Committee.

**DECIDED: That**

the update be noted.

**31 PROVISIONAL DATES FOR FUTURE MEETINGS**

**DECIDED: That**

the dates for future meetings be noted as 16 April 2012, 9 July 2012, 21 January 2013 and 15 April 2013.

Chairman ........................................................................

Date ........................................................................