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WIRRAL

Health and Well Being Overview and Scrutiny Committee

Date:	**Monday, 10 September 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 of the Committee are asked to declare any disclosable pecuniary and non pecuniary interests, in connection with any item(s) on the agenda and state the nature of the interest.

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 - 10)

To receive the minutes of the Health and Well Being Overview and Scrutiny Committee held on 18 June 2012

3. WHITE PAPER - BRIEFING NOTE

A briefing note will be provided for the Committee.

4. DELIVERING THE CORPORATE PLAN: 2012/13 FIRST QUARTER PERFORMANCE AND FINANCIAL REVIEW (Pages 11 - 36)

5. UPDATE - AKA - IMPLEMENTATION OF RECOMMENDATIONS (Pages 37 - 44)

6. ADULT SOCIAL SERVICES - SAFEGUARDING PEER CHALLENGE AND ADULT SOCIAL CARE PEER REVIEW (Pages 45 - 66)

7. BRIEFING UPDATE FROM CLINICAL COMMISSIONING GROUPS

To receive an update report from Dr Phil Jennings, Clinical Commissioning Groups

(TO FOLLOW)

8. CANCER SERVICES IN CHESHIRE AND MERSEYSIDE (Pages 67 - 98)

9. VASCULAR SERVICES IN CHESHIRE AND MERSEYSIDE (Pages 99 - 146)

10. WIRRAL UNIVERSITY TEACHING HOSPITAL UPDATE (Pages 147 - 148)

Report of the David Allison, Chief Executive, Wirral University Teaching Hospital in response to Members requests for information regarding loading and waiting times of ambulant patients and disabled toilet facilities

11. CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST - COMMUNITY MENTAL HEALTH SERVICE REDESIGNATION (Pages 149 - 152)

12. WORK PROGRAMME (Pages 153 - 156)

Along with the attached Work Programme the Committee's attention is also drawn to minute 7 of the Scrutiny Programme Board -18 July, 2012 (attached), in particular part (1) 1 of the resolution.

13. BUDGET CONSULTATION - SCRUTINY WORKSHOPS

The Chair and / or Director will speak to this item.

14. FORWARD PLAN

The Forward Plan for the period September to December 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.

15. ANY OTHER URGENT BUSINESS APPROVED BY THE CHAIR

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HEALTH AND WELL BEING OVERVIEW AND SCRUTINY COMMITTEE

Monday, 18 June 2012

Present:	Councillor	S Mountney (Chair)	
	Councillors	C Povall	G Watt
		P Glasman	R Abbey
		C Jones	
		M McLaughlin	
		T Norbury	
Deputies:	Councillors	R Abbey	
		G Watt	
Co-optees		D Hill (LINks)	
		S Lowe (Services users under OPP age group)	
		A Brighouse	
		Sandra Wall	
		D Hill	
		Lowe	
		Wagener (Carers)	
		Dr Phil Jennings Chairman (Designate) NHS Wirral CCG	
		Dr Abhi Mantgani Accountable Officer (Designate) NHS Wirral CCG	
Apologies	Councillors	M Hornby	
		A Leech	
	Co-optees	S Sagar (BME)	

1 **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.

Councillor Mr T Norbury declared a personal interest in the item, 'Equality and Impact Assessments' by virtue of being an employee of Merseytravel
Councillor Mr R Abbey declared a personal interest in the item, 'Equality and Impact Assessments' by virtue of being the Councils representative on Merseyside Integrated Transport Authority

2 **MINUTES**

Members were requested to receive the minutes of the meeting of the Health and Well Being Overview and Scrutiny Committee held on 12 March, 2012.

Resolved – That the minutes of the meeting of 12 March, 2012 be approved as a correct record.

3 **APPOINTMENT OF VICE-CHAIR**

The Committee was asked to consider if it wanted to appoint a Vice-Chair.

On a motion by Councillor Mountney, duly seconded, it was –

Resolved - That Councillor C. Povall be appointed Vice-Chair of this Committee.

4 **PUBLIC HEALTH UPDATE**

The Chair indicated that unfortunately Fiona Johnstone was unable to attend the meeting; therefore the Public Health Update would be given at the next meeting.

Members raised concern regarding the lack of written reports and asked that in future all report submitted to the Committee be in a written format to enable the Committee to have more time to read information given.

Resolved – That it is the request of the Committee that all reports to be considered at future meetings be submitted in a written format.

5 **THE CLATTERBRIDGE CANCER CENTRE UPDATE**

Helen Porter, Director of Nursing & Quality, The Clatterbridge Cancer Centre, gave a verbal update report on the Clatterbridge Cancer Centre proposals regarding the retention of cancer services at the Clatterbridge site in Wirral and establishing a new comprehensive Clatterbridge Cancer Centre in conjunction with the new Royal Liverpool and Broadgreen University Hospital Trust.

Miss Porter reported that clinical experts recognised and supported the case for re-designing non-surgical cancer services in Merseyside and Cheshire as it presented the opportunity to provide truly integrated cancer care; locating a comprehensive cancer centre on an acute hospital site would improve care for all cancer patients.

Miss Porter indicated that Clatterbridge was the cancer centre to provide chemotherapy to general hospitals and was currently running a pilot scheme offering chemotherapy services at GP surgeries and patient homes; along with the introduction of mobile clinics which would reduce patient travelling times and offer improved access to services.

Miss Porter further highlighted the key principles behind the proposals; which was to ensure that access to care was as close to patients homes as possible; chemotherapy and radiology treatments which no longer needed in-patient care could be dealt with locally and only those with complex needs be treated at hospital. At present those patients requiring additional acute treatment had to access it via other hospitals, making the transfer of patients and doctors difficult. It was hoped that this would be alleviated due the range services that could be offered on the shared site. Research facilities would also be improved; this agenda was at present very strong but restricted to clinical trials as there were no facilities to support patients if they had developed complications.

Miss Porter concluded that the proposals would improve the Cancer Centre in general, specifically the travelling times, improve service provision and research facilities. A series of public engagement events and road shows were to take place during 2012/2013 across the Cheshire and Merseyside region, and to launch the engagement activity programme each respective Hospital Trust would host a launch event:

The Clatterbridge Cancer Centre event would be held at The Clatterbridge Cancer Centre on 9th July 3.30 until 5.00pm at the Post Graduate Centre, Clatterbridge Centre Site

The Royal Liverpool and Broadgreen University Hospital trust would be held at the Liverpool Medical Institute, 114h Mount Pleasant, Liverpool L3 5SR on 12th July 2012, at 2pm until 4pm.

An invitation to Members was extended and plans to engage patients; public and wider stakeholders would take place over the next 6-12 months prior to any formal consultation.

During the course of discussion on this item, Councillor McLaughlin declared a personal interest by virtue of her being a former employee of Clatterbridge Hospital.

It was reported that six options were looked at as part of the business planning process and each option individually evaluated; further evaluation of the options would be undertaken during the consultation process and the strategic planning process would be dealt with further down the line. Acute Oncology services were provided The Clatterbridge Cancer Centre in every Trust with an A & E Department but the changing needs of oncology patients meant that there was a need for an improvement of outpatient services to patients. The proposed Royal Liverpool Hospital site was located close to the university; therefore it was the clinical consensus that the site would be the most suitable.

In relation to alleged leaking of the proposals to the press Ms Porter explained that the proposals in relation to the Cancer Centre had been in the pipeline for some time and that discussions had taken place with the Royal Liverpool Hospital at their Board

meeting, minutes of which were published on their web site which was subsequently picked up and reported on by members of the press.

Members raised concern that public perception may be that Clatterbridge would be surplus to requirements if services such as chemotherapy would be offered to patients at GP surgeries and in their own homes. In response, Miss Porter explained that Clatterbridge would still remain a fully functioning cancer centre offering a range of services to patients, and a wider range of services to those with complex needs.

Chemotherapy services were currently provided by private companies employed by cancer centres as they are able to bypass the VAT loop hole to enable them to provide patients with more expensive treatments, The Cancer Centre were looking into to do doing this, meaning that there would be no change in costs making it a saveable model. The number of in-patients would reduce over time which is what the centres aimed to achieve. Changes in chemotherapy and palliative care and targeted personalised chemotherapy were changing due to the advances in research and radiotherapy had much less side effects.

In relation to the funding, it was reported that this was to be provided from the commissioners and NHS, with a fifth of the funding to come from fundraising. Members asked that a more detailed report be submitted to a future meeting with full details of the proposals to include consultation, financial information and details of the options considered. Dr Phil Jennings, Designate Chair, NHS Wirral CCG agreed to liaise with the appropriate officers to submit a report to a future meeting.

RESOLVED: That

(1) Miss Helen Porter be thanked for her verbal report; and

(2) Dr Phil Jennings, Designate Chair, NHS Wirral CCG be requested to liaise with the appropriate officers to submit a report to a future meeting regarding the full details of the proposals, to include consultation, financial information and details of the options considered.

6 MATERNITY SERVICES - UPDATE

Rosemary Curtis, Commissioning Lead for Children, CAMHS and Maternity Services for NHS Wirral Clinical Commissioning Group provided a written report, on the One to One Maternity Services provision: the written report is detailed below. Mrs Curtis elaborated on the written report and responded to members questions.

One to One Maternity Services Provision

Background

'Maternity Matters – choice access and continuity of care in a safe service' (DH 2007) and Standard 11 of the National Service Framework for Children Young People and Maternity Services (DH 2004) set the standards required for the local development of high quality, safe and accessible maternity services with a 'choice guarantee' to ensure all women had a choice around the type of care that they received, together with improved access to services and continuity of midwifery care and support.

To meet these standards, NHS Wirral commissioned a comprehensive range of services to meet the needs of women and their babies during pregnancy, childbirth and postnatally. Several providers of midwifery care were commissioned which enabled women to choose the venue and style of the maternity service that best met their needs and preferences. Current commissioned providers of maternity care included:

Liverpool Women's Hospital;
Countess of Chester NHS Trust;
Wirral University Hospitals NHS Trust;
One to One Midwives (Northwest) Ltd

The report indicated that women were able to 'book' directly with a midwife for their maternity care, and could receive all their maternity care from a midwife (including a home delivery) in community based settings if they had no 'medical' needs; in practice most women initially contacted their GP who wouldl then refer on to the provider of the woman's choice. Women with identified 'medical' needs could be referred by their midwife or GP to the obstetrician of their choice. Women with uncomplicated pregnancies could choose a home birth with any of the providers of midwifery care. In the event of complications developing during labour at home, women were transferred to the nearest hospital setting for their delivery.

One to One Midwifery Service

The report indicated that in order to provide choice in the type of care available to women, particularly those from areas with high levels of deprivation who did not always access hospital based services, NHS Wirral commissioned a pilot service from an independent midwifery provider, One to One (NW) Ltd, in 2010; the pilot proved to be very popular with women, and was extended until October 2011 when a standard NHS contract for the provision of (Wirral wide) maternity services was put in place.

The overall aim of the service was to provide a community based, person centred model of care for which improved short and long term health outcomes for women and their infants. Pregnancy and birth were seen as a normal part of a woman's life, with the care providing a trusting, mutually respectful partnership between the woman and her midwife. A named midwife was allocated to each woman as early in pregnancy as possible, with women having continued access to advice, support and face to face contact with the named midwife, maximising continuity for the whole period of care.

The service offered access to screening and associated scanning services in community venues at accessible times and .continued access to telephone advice and support, and face to face contact as often as required to provide high quality care, meeting the identified needs and wishes of women.

The service shared care with other appropriate professionals, including obstetric care where it was required, i.e. there was no need for a woman who needed the care of an obstetrician to transfer to the care of a hospital based midwifery service.

All services commissioned by the NHS which provided 'regulated' activities must be registered, met the standards and were inspected by the Care Quality Commission;

midwifery standards of care and practice were regulated by the Nursing and Midwifery Council and the Local Supervising Authority (Supervisors of Midwives). From an LSA perspective at the current time the commissioner had been assured that One to One upheld safe practice in the interests of women and babies and had given no concern to the LSA to date. One to One was registered with the CQC, and all One to One midwives are registered with the NMC.

Service and performance data

Since the start of the full contract in October 2011, One to One had:

Received 420 referrals, more than half of which had come directly from women; 100% of women who contacted the service before 12 weeks were 'booked' by 12 completed weeks of pregnancy (target is 90%);Delivered 72 babies at home; 7.9% required transfer to hospital either pre or post birth; this rate of transfer compared favourably with the findings of the Birthplace Cohort Study (NPEU 2012) of a 12% transfer rate.

Comparative Data	One to One	National
Home birth rate	37.9%	2.4%
Caesarean section rate	15.4%	24.8%
Overall normal vaginal delivery rate	76.2%	62.8%
Breastfeeding initiation rate	72%	55% (Wirral) 66% (NW) 74% (England)
Women intending to breastfeed who initiated breastfeeding	97%	
Named Midwife attendance for routine care	97%	
Average number of antenatal visits	12	8-10
Average number of postnatal visits	12	3
% Babies admitted to Neonatal Unit	3%	10% (Liverpool Women's Hospital)

Evaluation and Future Commissioning Intentions

An evaluation of the 2010/11 pilot informed the commissioning of the currently contracted service; this was now being followed up by an independent evaluation of the maternity services currently available to women in Wirral, carried out by Mott Macdonald on behalf of NHS Wirral. The results and recommendations of the evaluation would inform the future commissioning intentions of the Wirral Clinical Commissioning Group. The final report of the evaluation was expected by September 2012.

Dr Abhi Mangani, (Clinical Commissioning Group) indicated that the One to One pilot was undertaken as a result of the findings of a review of maternity services in 2007 held, when women had indicated that although it was felt that the services provided by the hospital were good, they wanted more, and as a result women now have a choice.

Mr David Allison, Chief Executive Wirral University Teaching Hospital indicated that the hospital would still be dealing with the more complex cases and working closely with One to One Maternity Services and Commissioners to provide the best services for women..

In response to members questions Mrs Curtis indicated that the Wirral Health Visiting service had been redesigned and was now providing a high quality service delivering the 'Healthy Child Programme' for under 5s which was integrated with both maternity providers and Children's Centre services.

In relation to access to the One to One service, information regarding the service was made available at GP Surgeries, the One to One website and via a Facebook page.

Mrs Curtis concluded that the protocol followed by the One to One Midwives allowed the midwife to accompany, stay and support the woman at the hospital, where possible, but the birth would be managed by the hospital midwifery staff.

RESOLVED: That

(1) Ms Curtis be thanked for her written report and supporting verbal information; and

(2) An update report detailing the outcome of the evaluation of Wirrals maternity services be submitted to a future meeting.

7 CLINICAL COMMISSIONING GROUPS UPDATE

Dr Phil Jennings Chairman of NHS Wirral Clinical Commissioning Group gave an update on the latest situation with regard to the commissioning of services.

Dr Jennings indicated that nationally the authorising bodies had now been established and Members appointed, and the constitution had been received. The Authorisation process for the single Wirral CCG should begin in October and be completed by January. The result of this process if that the CCG may be fully authorised or authorised with conditions. A stakeholder survey had been commissioned in by the Department of Health to allow stakeholders to comment on how Wirral as a CCG had been performing. A submission of evidence had been submitted and visits to Wirral to conduct interviews would be scheduled; in relation to the membership the accountable officer, chief finance officer, lay representatives and Chief Officer posts were to be interviewed next week.

Dr Mantgani then informed the committee on areas of planned investment that the CCG would be undertaking in the coming year:-

Primary Care Premises Improvements to help practices obtain CQC compliance
Improvements in the delivery of urgent care working in conjunction with Wirral Hospitals and Wirral Community Trusts
Investments in Urology services offered by Wirral Hospitals Trust

Second centre for breast screening
Alcohol dependency services
Osteoporosis screening

It was indicated that there was a lot of work to be and the hospital would be working alongside the group to ensure areas are prioritised and efficient systems are put in place. Discussions would be taking place with all interested parties to decide how best to spend the investment.

RESOLVED:

That Dr Jennings be thanked for his verbal report.

8 **EQUALITY IMPACT ASSESSMENTS - REFERRAL FROM SCRUTINY PROGRAMME BOARD**

The Committee considered the report of the Director of Law, HR and Asset Management on Equality and Impact Assessments, which had been referred by the Scrutiny Programme Board at its meeting on 28 February, 2012 (minute 33 refers) to all five themed Overview and Scrutiny Committees.

Resolved – That the report be noted.

9 **WORK PROGRAMME**

The Committee was requested to consider what issues should form the basis of its work programme for the ensuing municipal year.

Members raised concern that there was no current work programme and indicated that the previous work programme still had outstanding items on it to include:-

Transformation of Day Services
Domestic Violence
Medicine Management in Hospital Trusts
AKA Report
Domestic Violence
Vascular Services Update
Quarterly Performance Report
Ambulance Service Report – re: loading/waiting times
Disabled toilet facilities at hospitals

In relation to vascular services, the Director of Adult Social Services indicated that he had received a response from Kathy Doyle regarding the Committees comments to be fed into the consultation process. It was agreed that a copy of the letter be sent to the Chair and spokespersons.

In response to Members, David Allison, Chief Executive Wirral Hospital Trust indicated that in relation to the requests for reports regarding the loading and waiting

times at hospitals for ambulances and medicine management he would report back to Members on these issues.

Ms. S.Wall, Older People's Parliament indicated that an issue had been raised at a recent Older People's Parliament meeting regarding the toilet/bathroom facilities at the hospital, especially on certain wards, the foyer and education suites which were deemed inadequate for disabled users. Mr David Allison, Chief Executive agreed to look into the concerns raised and report back to the meeting.

In relation to the work programme, the Chair suggested that a meeting be held to discuss the work programme and outstanding items.

RESOLVED:

That the Director of Adult Social Services be requested to circulate dates to the Chair and Spokespersons to discuss the Work Programme.

10 **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.

A Member suggested that reports be brought to a future meeting on the items, 'Update on Safeguarding' and 'AKA Action Plan'.

Resolved – That the forward plan and suggestions be noted.

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WIRRAL COUNCIL

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE

10 SEPTEMBER 2012

SUBJECT:	Delivering the Corporate Plan: 2012/13 First Quarter Performance and Financial Review
WARD/S AFFECTED:	All
REPORT OF:	Graham Hodkinson, Director of Adult Social Services
RESPONSIBLE PORTFOLIO HOLDER:	Councillor Anne McArdle
KEY DECISION:	No

1.0 EXECUTIVE SUMMARY

1.1 This report sets out performance of the Adult Social Services 2012/13 Departmental Plan for the period April to June 2012 and provides an overview of performance, resource and risk monitoring.

1.2 The report seeks members' views on a proposal to establish a "Task and Finish" group to consider a broader range of indicators that would inform committee about the activity within the overall health and wellbeing system beyond those detailed in this report.

2.0 BACKGROUND AND KEY ISSUES

2.1 The Adult Social Services 2012/13 Departmental Plan was developed from local priorities identified in the Corporate Plan, the Department's improvement programme and the Department of Health's 2012/13 Adult Social Care Outcomes Framework (ASCOF).

2.2 The ASCOF is a set of outcome measures which have been agreed to be of value both nationally and locally for demonstrating the achievements of adult social care.

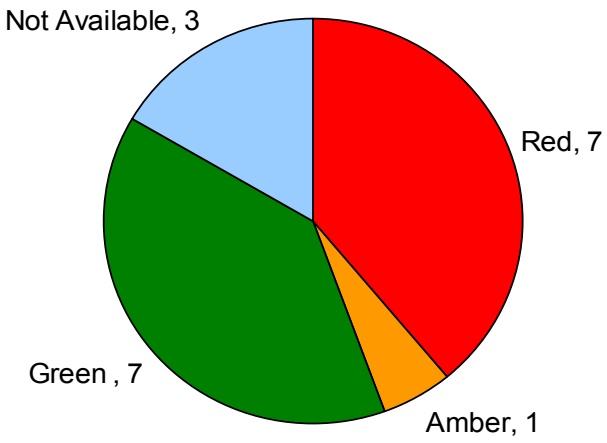
- Nationally, the ASCOF will give an indication of the strengths of social care and success in delivering better outcomes for people who use services.
- Locally, one of the key uses is for benchmarking and comparison between areas.

2.3 **PERFORMANCE INDICATOR ASSESSMENT**

There are 27 performance indicators in the Adult Social Services Departmental Plan. Of these, 17 are specifically identified in the ASCOF and the Department has added a further 10 indicators. Nine of the 27 indicators are calculated annually from information obtained through the Adult Social Care Survey and Carers survey (eight of the 9 are specified in the ASCOF). It is anticipated that the year end targets for these 9 indicators will be achieved. The quarter 1 performance for the remaining 18 indictors is shown below and further detail is provided in Appendix 1.

2.4 It should be noted that at an operational and branch level significant work is undertaken to make best use of this management information through "Performance Surgeries". These meetings consider in detail the underlying issues that have affected performance and put in place action to rectify indicators that are not on target.

Quarter 1 Performance Indicator Summary



Performing well	7 of the 18 Performance Indicators (39%) are currently performing well (green), and 10 (56%) are forecast to achieve their targets by year end.
Performing adequately	1 (5%) is performing adequately within 5% of the target (amber), and 8 (44%) are currently projected to narrowly miss their targets by year end.
Performing Poorly	7 (39%) are currently performing below the target (red). and all are expected to improve by the year end.
Not Available	Performance information for 3 indicators (17%) was not available at quarter 1 but will be available for reporting at quarter 2. Further details are provided in the table below.

Information not available at quarter 1 for the following Indicators:

Title	Reason information not available	2012/13 Year End Target
Percentage of scheduled reviews for residential homes completed	The method of calculation of this indicator has now been completed and a trial run has been held. Full performance information will be reported on at Quarter 2	75%
Percentage of young adults transition plans are put in place	Discussions are being held on this new indicator, and full performance information will be reported on at Quarter 2.	100%
Percentage of Personal Budgets that are Direct Payments	Discussions are being held on this new indicator, and full performance information will be reported on at Quarter 2.	40%

2.5 PERFORMANCE HEADLINES

2.5.1 What's working well

- **Wirral's Outstanding Adult Learners Celebrated -** The achievements of adult learners have been recognised during a celebration event at Williamson Art Gallery. Over 100 people received certificates of outstanding achievement after being nominated by tutors, friends or family for either taking up new learning for the first time in many years, overcoming challenges, working with others and volunteering in their community. The event showed how that a whole range of adult learners in Wirral have worked hard, enjoyed learning and gone on to other things as a result.

- **'Stay nifty after fifty!' -** Dozens of local organisations came together for a special event aimed at the over 50s. 'Stay nifty after fifty' was organised by Wirral's Older People's Parliament in partnership with Age UK Wirral, the NHS and Wirral Council to showcase the opportunities available in the borough.

- **'Best Bites' get their teeth into festival catering for Youthfest -** Best Bites, a local café and catering project which provides work based opportunities for adults with disabilities was the main catering company appointed to feed hungry teenagers at Wirral's recent 'teenagers only' Youthfest. 'Best Bites' operates from Gorsey Lane, Wallasey, giving people with disabilities valuable work experience, paid employment, and qualifications – leading to permanent jobs.

2.5.2 **Performance Issues – Indicators**

The following targets have been assessed as **red** (missed the quarter one target by more than 10%).

Title	2012/13 Quarter 1		2012/13 Year End	
	Target	Actual	Target	Likelihood of meeting target
Percentage of carers receiving a needs assessment or review	47%	12.8%	47%	Fair
Performance Analysis - The targeted improvement of performance in this indicator has not materialised and this may be attributed to the way in which the recording of carers' reviews has not captured ongoing services to the carer, leading to performance that has not been in line with expectations.				
Corrective Action - Improvement in the recording of reviews of carers to ensure that existing, as well as newly established services are re-stated in reviews will count towards the achievement of this target. Guidance is being developed in order to achieve this improvement.				

Title	2012/13 Quarter 1		2012/13 Year End	
	Target	Actual	Target	Likelihood of meeting target
Percentage of people with a learning disability known to the department in paid employment	5%	4%	5%	Fair
Performance Analysis -The percentage of people with a learning disability known to the department in paid employment has missed the quarter one 2012/13 target by 1%. Performance cannot be compared with quarter one 2011/12 as the calculation methodology was adjusted to latest definition in December 2011.				
Corrective Action - Improvement through on-going work to capture data in specific annual reviews aligned with the development of a range of future opportunities to be co-ordinated through the Learning Disabilities Employment Action Plan as part of the on-going work within the Learning Disabilities Partnership Board.				

Title	2012/13 Quarter 1		2012/13 Year End	
	Target	Actual	Target	Likelihood of meeting target
Percentage of people with mental health issues known to the department in paid employment	5%	4.01%	5%	Good
Performance Analysis -The percentage of people with mental health issues known to the department in paid employment has missed the quarter one 2012/13 target by 0.99%. This NHS-derived figure only counts those people who have mental health issues who are subject to a Care Programme Approach (complex needs) and does not include those people known to the 'Working Life' service to be in paid employment. The low figure also in part reflects the national employment situation.				
Corrective Action - Discussions with NHS Wirral, Cheshire and Wirral Partnership Trust and Economic Regeneration are underway to address a number of issues associated with supporting people with mental health issues obtain employment. A second element of the discussions will determine a more accurate method of recording and measuring this target to capture the employment status of adults in contact with secondary mental health services, irrespective of whether they are on the Care Programme Approach.				

Title	2012/13 Quarter 1		2012/13 Year End	
	Target	Actual	Target	Likelihood of meeting target
Percentage of people with a learning disability known to the department in settled accommodation	88%	79%	88%	Good
Performance Analysis - Reported performance is very close to that targeted and achieved in the previous year. Through the ongoing focus on reviews in this sector it is expected that the new target will be met.				
Corrective Action - Improvement is targeted through on going work to capture accommodation data consistently in annual reviews, as part of a wider push on the completion of reviews.				

Title	2012/13 Quarter 1		2012/13 Year End	
	Target	Actual	Target	Likelihood of meeting target
Delayed transfers of care	1.5	1.8	1.5	Fair
	Lower is Better			
Performance Analysis - The rate of delayed transfers of care per 100,000 population has fallen by 1 when compared with quarter one and by 0.4 when compared to year end 2011/12. It has missed the quarter one 2012/13 target by 0.3. Delayed Discharges attributable to social care or jointly to social care and the NHS: 1.5 (rate per 100,000) equates to nearly 4 delays per month on average.				
Corrective Action - The national method of calculation of this indicator has changed to produce the outcome for a rolling year. Under the new calculation performance is in line with Q1 for the previous year. However, there will be a continued focus on the progress of this indicator.				

Title	2012/13 Quarter 1		2012/13 Year End	
	Target	Actual	Target	Likelihood of meeting target
Percentage of Social care clients who are Self Directing their own support	90%	71.1%	90%	Fair
Performance Analysis - The percentage of Social care clients receiving Self Directed Support has improved by 22.14% (Q1) and 4.4% (year end) when compared with 2011/12, but has missed the quarter one 2012/13 target by 18.9%.				
Corrective Action - It is intended to audit each service area in order to identify any areas in which further action may be taken to increase the percentage of people receiving self-directed support				

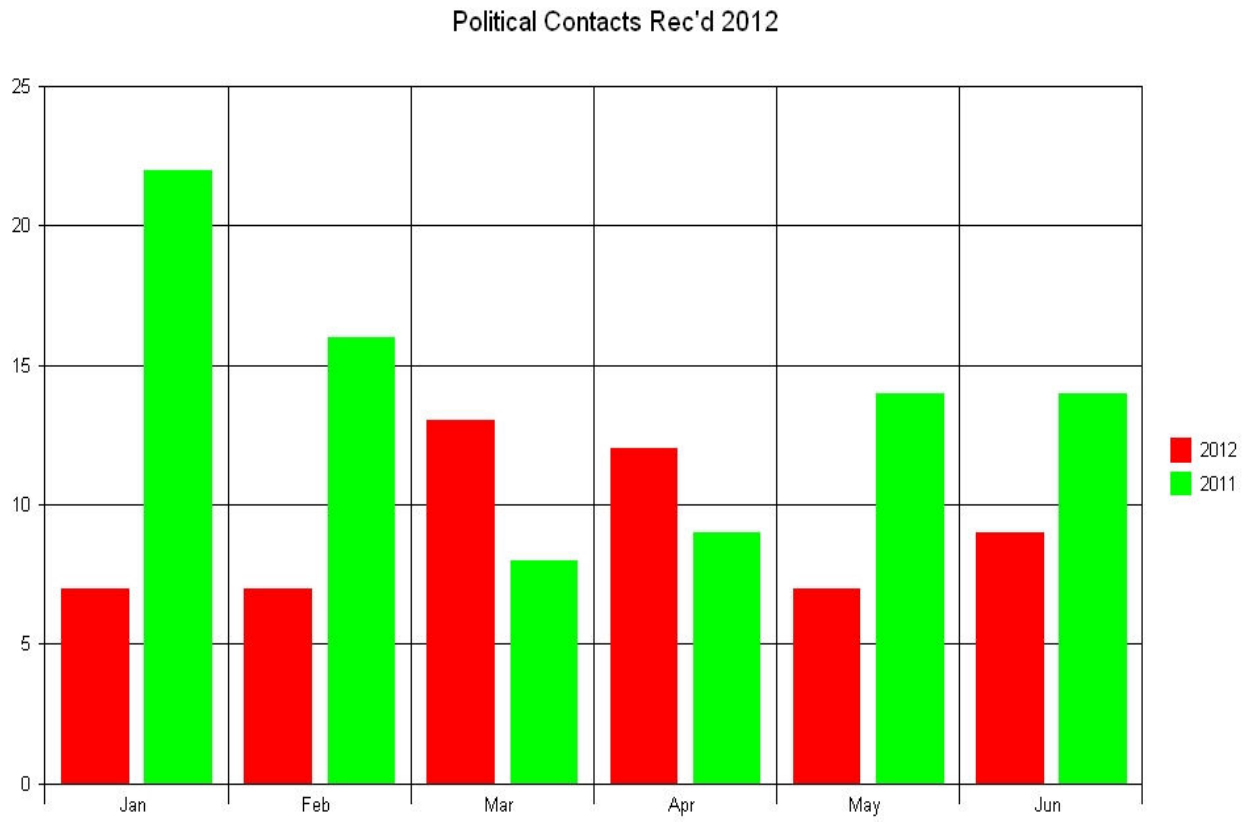
Title	2012/13 Quarter 1		2012/13 Year End	
	Target	Actual	Target	Likelihood of meeting target
Percentage of Assessments undertaken within 28 days	100%	84.3%	100%	Poor

Performance Analysis - The percentage of social care clients receiving an assessment within 28 days has improved from 83.55% at the end of the previous year, and from 81.18% in the corresponding quarter in that year. The Q1 target was missed by 83 assessments.
Corrective Action - It is intended to provide Locality managers with weekly reports detailing the timescale of assessments undertaken by their Locality, enabling a greater focus on improving performance against this target, which will be monitored through Performance Surgeries.

2.6 CUSTOMER FEEDBACK

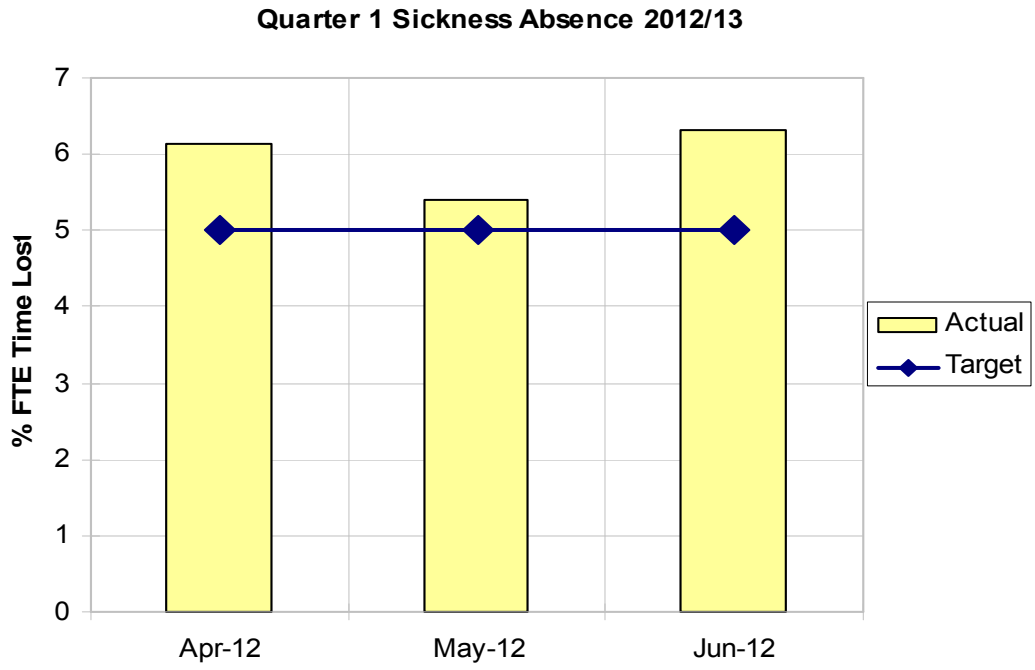
The graph below shows the number of registered complaints received by the Department of Adult Social Services in the last quarter of 2011/12 and the first quarter of this year. The number of registered complaints in the year to date has remained stable at an average of 18 per month. The average response time remains a cause for concern although 73% of complaints responded to in June were closed within 20 days.

The number of political enquiries has remained relatively stable with a slight increase in the months prior to the election period. The performance in responding to political contacts has improved compared to the equivalent period last year.



2.7 SICKNESS ABSENCE

The chart below shows the percentage of time lost through sickness absence from April to June 2012. The rate for June is 6.33% which equates to 15.24 days sickness per employee. This is almost 1% higher than May when time lost was 5.39%. The Department has set a target of 5%.



2.8 RESOURCE IMPLICATIONS

2.8.1 **Revenue Budget -** Significant pressures of £10.2 million have been identified by the Adult Social Services Department. This includes

- underlying care and demand pressures totalling £8.8 million,
- a further £1 million of pressures relating to the loss of health income and
- £0.4 million vacancy control pressures.

The outcome of consultation with care home providers in respect of fee rates for 2012/13 is ongoing and will be reported to Cabinet once completed. This could add further to existing pressures. The financial monitoring statement as at June 2012 is shown in Appendix 2.

2.8.2 **Capital Budget -** The Capital Programme includes funding for the reform of Day Services. The analysis of the Day Services Consultation exercise is complete and the outcome and further options will be reported shortly. A further capital scheme relates to development of an Integrated IT system (£1.5m). This project will be delivered as part of the Efficiency and Improvement review of the Department. The capital monitoring statement as at June 2012 is shown in Appendix 3.

3. NEXT STEPS

3.1 The vast majority of information contained within this report deals with the performance of the Department of Adult Social Services within Wirral Council; clearly the health and wellbeing of the population concerns much more than social care activity.

3.2 Attached as an example of available data at Appendix 4 is a paper produced by the Transition Alliance, which focuses on a number of key indicators across the health and wellbeing spectrum. This example covers Wirral but data is available which brings together the comparative information of the 24 North West council areas that are part of the Alliance.

3.3 In assessing the usefulness of the type of information at Appendix 4, members views are sought on the proposal to establish a "Task and Finish" group consisting of members and officers to agree the most appropriate form and content of performance reports that should be considered by the Health and Wellbeing Overview and Scrutiny Committee.

4.0 RELEVANT RISKS

4.1 Safeguarding adults remains a key focus for the Department and is a clear priority within the Council's Improvement Plan. The Adult Safeguarding Peer Challenge has highlighted a number of areas for development, which are currently being considered by the Department and will be addressed with appropriate actions overseen by the Safeguarding Adults Partnership Board.

4.2 The demand pressures from an ageing population requiring greater levels of support and more complex needs having to be managed continues to present one of the Council's greatest challenges. Added to this is the need to deliver greater levels of personalisation and choice to individuals requiring support.

5.0 OTHER OPTIONS CONSIDERED

5.1 Not applicable to this report.

6.0 CONSULTATION

6.1 There are no specific legal implications arising from this report.

7.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

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

8.0 RESOURCE IMPLICATIONS: FINANCIAL; IT; STAFFING; AND ASSETS

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

9.0 LEGAL IMPLICATIONS

9.1 There are no specific legal implications arising from this report.

10.0 EQUALITIES IMPLICATIONS

10.1 A number of the activities and projects set out in the Adult Social Services Departmental Plan impact on health inequalities with a clear focus on ensuring that all of Wirral's diverse communities are equally able to access services.

11.0 CARBON REDUCTION IMPLICATIONS

11.1 There are no specific carbon reduction implications arising from this report.

12.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

12.1 There are no specific planning and community safety implications arising from this report.

13.0 RECOMMENDATION/S

13.1 The Committee is requested to note the contents of this report.

13.2 Members views are sought on the proposal to establish a "Task and Finish" group consisting of members and officers to agree the most appropriate form and content of performance reports that should be considered by the Health and Wellbeing Overview and Scrutiny Committee.

14.0 REASON/S FOR RECOMMENDATION/S

14.1 This report provides an update on progress in delivering the Adult Social Services Departmental Plan including performance of relevant indicators and associated financial and risk monitoring information.

14.2 The data and information within this report is mainly derived from the department of adult social care, this does not cover the full range of health and wellbeing issues. It is proposed to establish a Task and Finish group to review this and consider the most appropriate information for the Committee.

REPORT AUTHOR: Stephen Rowley
Head of Branch – Finance & Performance
Telephone: (0151 666 3662)
Email: stephenrowley@wirral.gov.uk

REFERENCE MATERIAL

Previous Council and Cabinet reports as detailed in the subject history below

APPENDICES

1 : PERFORMANCE INDICATORS AS AT 30 JUNE 2012
2 : FINANCIAL MONITORING 2012/13 AS AT 30 JUNE 2012
3 : CAPITAL MONITORING 2012/13 AS AT 30 JUNE 2012
4 : ADASS AQuA WIRRAL LOCALITY SCORECARD - DECEMBER 2011

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Health and Wellbeing Overview and Scrutiny Committee	12/03/12 08/11/11 13/09/11 20/06/11 22/03/11 18/01/11 01/11/10 09/09/10 21/06/10
Social Care, Health and Inclusion Overview and Scrutiny Committee	25/03/10 19/01/10 10/11/09 08/09/09 22/06/09 25/03/09

APPENDIX 1

DEPARTMENTAL PERFORMANCE INDICATORS AS AT 30 JUNE 2012

Title	Qtr 1 Target	Qtr 1 Actual	Qtr 4 Target	Likelihood of meeting target
1. Percentage of people who report their services make them feel safe and secure	Annual Indicator	Annual Indicator	93%	Good
2. Percentage of Safeguarding Alerts completed within 24 hours	100%	95.5%	100%	Good
3. Percentage of Safeguarding Referrals completed within 28 days	80%	85.0%	80%	Good
4. Percentage of scheduled reviews for residential homes completed	Not available	Not available	75%	Fair
5. Percentage of young adult transition plans that are put in place 3 months before moving to Adult Social Care Services during 2012/13	Not available	Not available	100%	Fair
6. Percentage of people finding it 'fairly' or 'very' easy to find information about services	Annual Indicator	Annual Indicator	55%	Good
7. Percentage of carers finding it 'fairly' or 'very' easy to find information about services	Annual Indicator	Annual Indicator	40%	Good
8. Percentage of people who report being included in arranging their care	Annual Indicator	Annual Indicator	55%	Good
9. Percentage of carers who report being included in arranging care	Annual Indicator	Annual Indicator	55%	Good
10. Percentage of people who report being 'quite', 'extremely' or 'very' satisfied with their services	Annual Indicator	Annual Indicator	93%	Good
11. Percentage of carers who report being 'quite', 'extremely' or 'very' satisfied with their services	Annual Indicator	Annual Indicator	58%	Good
12. Percentage of people feeling in control of their care services	Annual Indicator	Annual Indicator	77%	Good
13. Percentage of Carers reporting 'alright' or 'better' quality of life as a result of services	Annual Indicator	Annual Indicator	90%	Good
14. Percentage of carers receiving a service	60%	56.6%	60%	Good
15. Percentage of carers receiving a needs assessment or review	47%	12.8%	47%	Fair
16. Percentage of people with a learning disability known to the Department in 2012/13 in paid employment	5%	4%	5%	Fair
17. Percentage of people with mental health issues known to the Department in 2012/13 in paid employment	5%	4.01%	5%	Good

Title	Qtr 1 Target	Qtr 1 Actual	Qtr 4 Target	Likelihood of meeting target
18. Percentage of people with a learning disability known to the Department in 2012/13 in settled accommodation	88%	79%	88%	Good
19. Percentage of people with mental health issues known to the Department in 2012/13 in settled accommodation	80%	81.24%	80%	Good
20. Proportion of people admitted into residential and nursing homes in 2012/13 (per 1,000 population)	1.5	1.53	1.5	Good
21. Percentage of people discharged from hospital into reablement/rehabilitation in 2012/13 are still at home after 91 days	96%	95.92%	96%	Good
22. Proportion of people who are recorded as 'delayed transfers of care' from hospital per 100,000 people	1.5	1.8	1.5	Fair
23. Percentage of all those who approach the Department for support in 2012/13 are self directing their support	90%	71.1%	90%	Fair
24. Proportion of people per 100,000 of the population that are supported to live at home	3,200	3,048	3,200	Good
25. Percentage of assessments undertaken within 28 days	100%	84.3%	100%	Fair
26. Percentage of support packages commenced within 28 days	93%	93.8%	93%	Good
27. Percentage of Personal Budgets that are Direct Payments	Not available	Not available	40%	Fair

APPENDIX 2

ADULT SOCIAL SERVICES DEPARTMENT
FINANCIAL MONITORING 2012/13 **POSITION AS AT 30 JUNE 2012**

SUMMARY

Policy Options	Savings Target	Agreed Budget	Changes Agreed	Changes Not Agreed
£000	£000	£000	£000	£000
500	2,567	66,660	0	10,200

Estimated financial pressures of £8.8 million have been identified from an underlying overspend in 2011/12, and further demand pressures on older people and learning disability budgets for 2012/13. There is additional pressure from an increase to the turnover target of £0.4m and reduced Health income (£1m), agreement with Health colleagues is being sought to confirm 2012/13 funding levels.
Consultation with care home providers in respect of fee rates for 2012/13 is ongoing and the outcome will be reported to Cabinet once completed. This is likely to result in additional costs, which will add to the pressures already identified.

POLICY OPTIONS FOR 2012/13 ONLY – DELIVERY OF THE INVESTMENT

Details	£000	Comments / progress on implementation
Fernleigh	500	The investment allows for the continuation of mental health services at Fernleigh

SAVINGS TARGETS – ACHIEVEMENT OF THE SAVINGS

Details	£000	Comments / progress on implementation
Commissioning Of Services	1,600	The Department is currently reviewing how services are commissioned to deliver savings of £1.6m. An overarching commissioning strategy has been developed and was presented to 21 June Cabinet
Prevention Services	500	The Department is currently undertaking a review of all voluntary sector contracts and is seeking to re-commission this activity at a more efficient cost.
Employee Budgets 2%	400	This saving is in addition to the Department's existing staff turnover target of £496,100. The shortfall against the total target of £896,100 is estimated at £700,000.
Procurement	26	It is anticipated that this saving will be achieved
Austerity – Supplies	24	It is anticipated that this saving will be achieved
EVR Scheme	17	Saving have been achieved in full

CHANGES NOT AGREED – VOLATILE AREAS, PRESSURES AND MITIGATING ACTIONS

Details	£000	Comments / actions to address any issues
Community Care	6,550	Pressure from an underlying overspend, shortfall in re-provision budget allocation in 2011/12, anticipated increase in demand for services in 2012/13 and reduced income.
EVR / VS savings	1,350	Slippage against Corporate savings target due to retention of essential posts following 2011/12 EVR/VS .
Market Review Savings	1,600	Slippage against 2011/12 savings target due primarily to homes that have not accepted new rates.
Employee Budgets	700	Slippage against 2012/13 savings target (£0.4m) and shortfall against existing staff turnover target (£0.3m)

APPENDIX 3

ADULT SOCIAL SERVICES DEPARTMENT
CAPITAL MONITORING 2012/13 **POSITION AS AT 30 JUNE 2012**

SUMMARY

Following approval in the Capital Programme of the business case in respect of the reform of Day Services, the analysis of the Day Services Consultation exercise is now complete. The outcome and further options will be reported to the Leader of the Council in July 2012. It is anticipated that this programme will begin in October 2012.

A Further Business Case also approved in December 2011 outlined the proposals for an Integrated IT system (£1.5m). This project will be delivered as part of the Efficiency and Improvement review of DASS 2012 and implementation is anticipated during 2012/13.

APPROVED PROGRAMME

PROGRAMME	Original Approved Programme 2012/13 £000	Approved Adjustments 2012/13 £000	Total Approved Programme 2012/13 £000	Actual to Date £000	Projected Outturn 2012/13 £000	Approved 2013/14 £000	Approved 2014/15 £000
Transformation of Day Service	1250	0	1250		625	625	0
Integrated IT	1500	0	1500		1500	0	0
TOTAL PROGRAMME	**2,750**	**0**	**1,250**	**0**	**2,125**	**625**	**0**
FUNDING							
General Capital Resources	0	0	0			0	0
Grants - Other	2,750	0	2,750		2,125	625	0
Revenue/ Reserve contributions	0	0	0			0	0
TOTAL FUNDING	**2,750**	**0**	**2,750**	**0**	**2,125**	**625**	**0**

APPROVED BY COUNCIL / CABINET - DECISIONS TO VARY THE PROGRAMME

Date	Details	£000
21 June 2012	Agreed the slippage from 2011/12 capital programme	2,015
	Total	**2,015**

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NHS & Local Government

Quality and Efficiency Scorecard for Frail Elderly

Wirral Locality Scorecard

December 2011

AQuA Advancing Quality Alliance

directors of adass adult social services

Contents

PLEASE SEE DATA CAVEATS ON PG 7

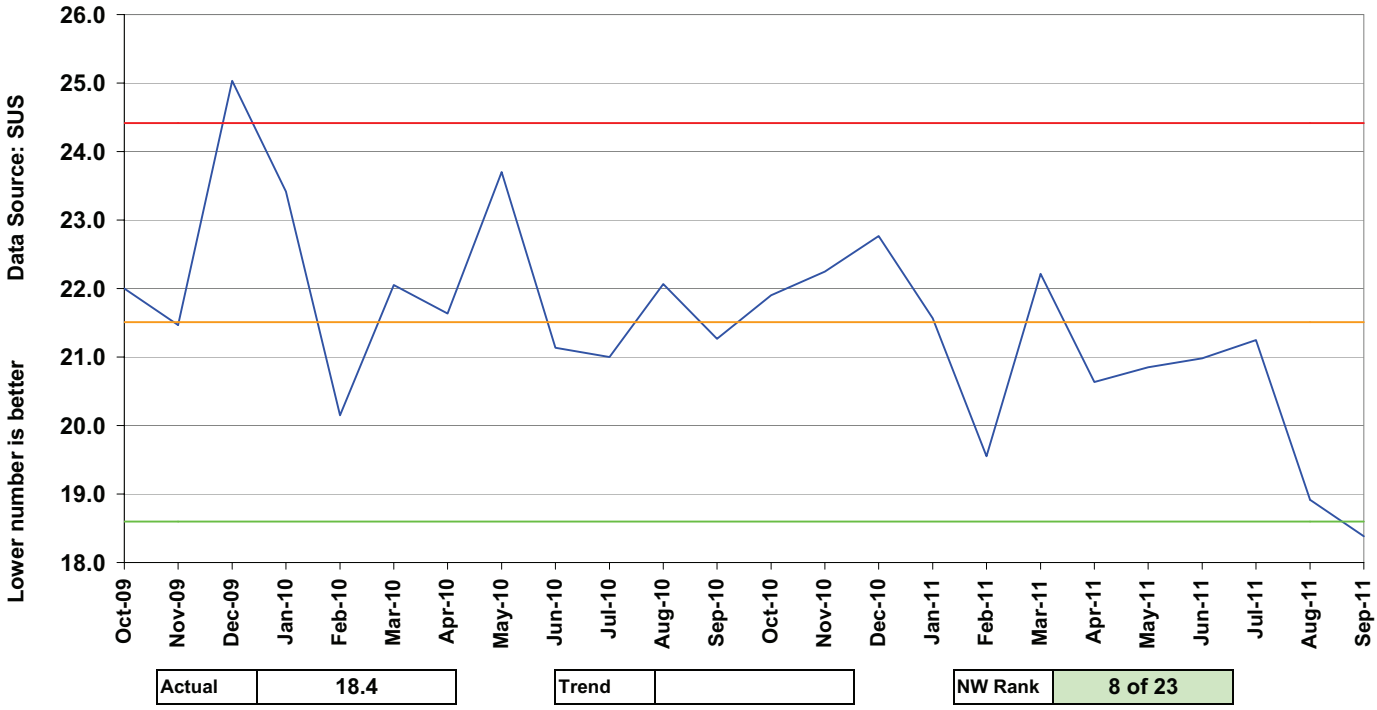
AQuA
Advancing Quality Alliance

directors of adass
adult social services

ADASS / AQuA Whole system quality and efficiency Locality Scorecard Trend Analysis graphs for Wirral

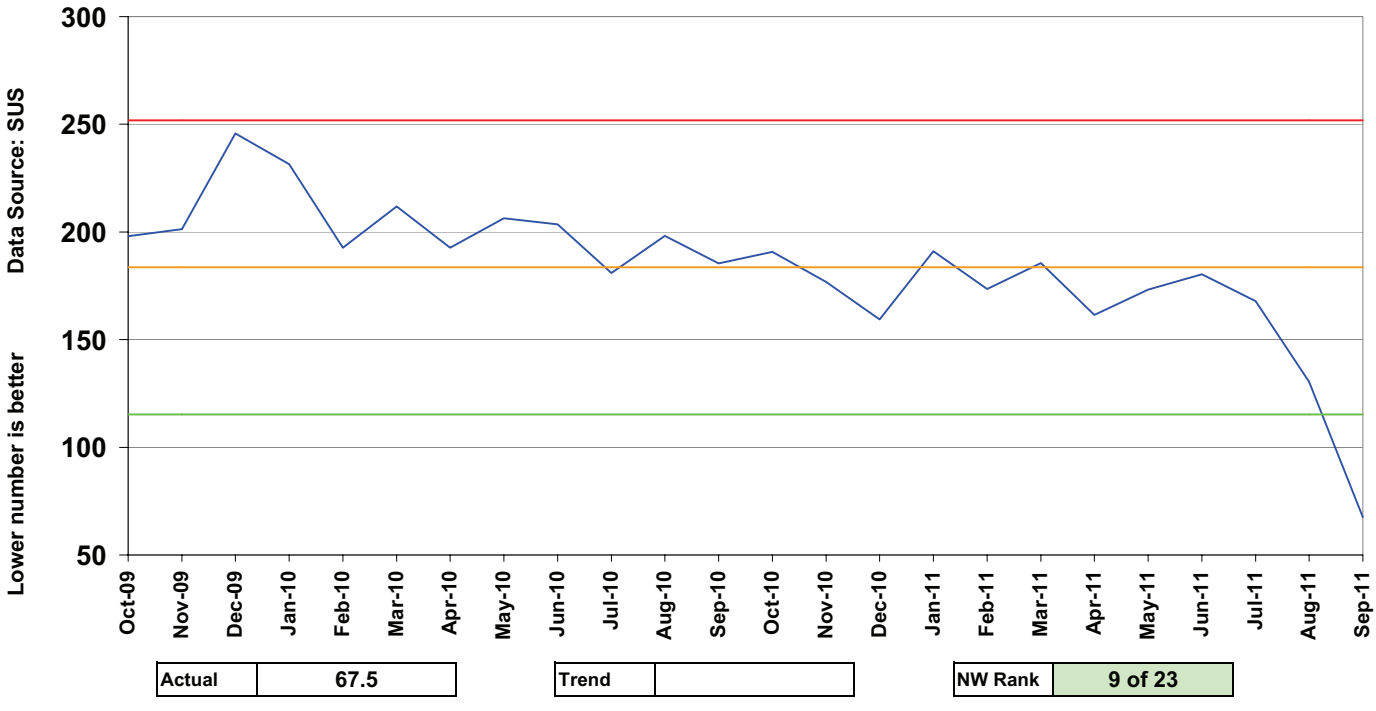
Graphs (a) and (b)

(a) Non-elective admissions aged 65+ per 1000 pop 65+



Actual	18.4	Trend		NW Rank	8 of 23

(b) Non-elective bed days aged 65+ per head of 1000 pop 65+



Actual	67.5	Trend		NW Rank	9 of 23

Key

- Upper Control (2 st dev above average)
- Average
- Lower Control (2 st dev below average)

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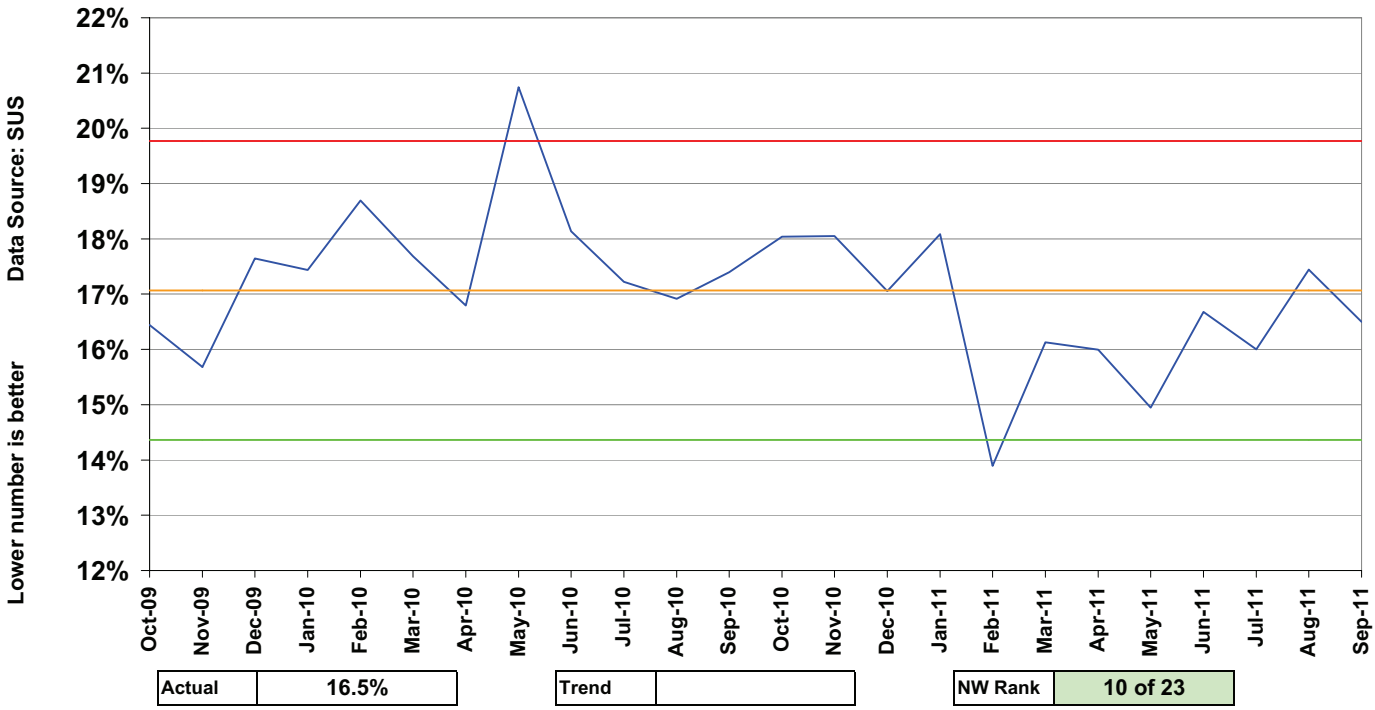
ADASS / AQuA Whole system quality and efficiency Locality Scorecard Trend Analysis graphs for Wirral

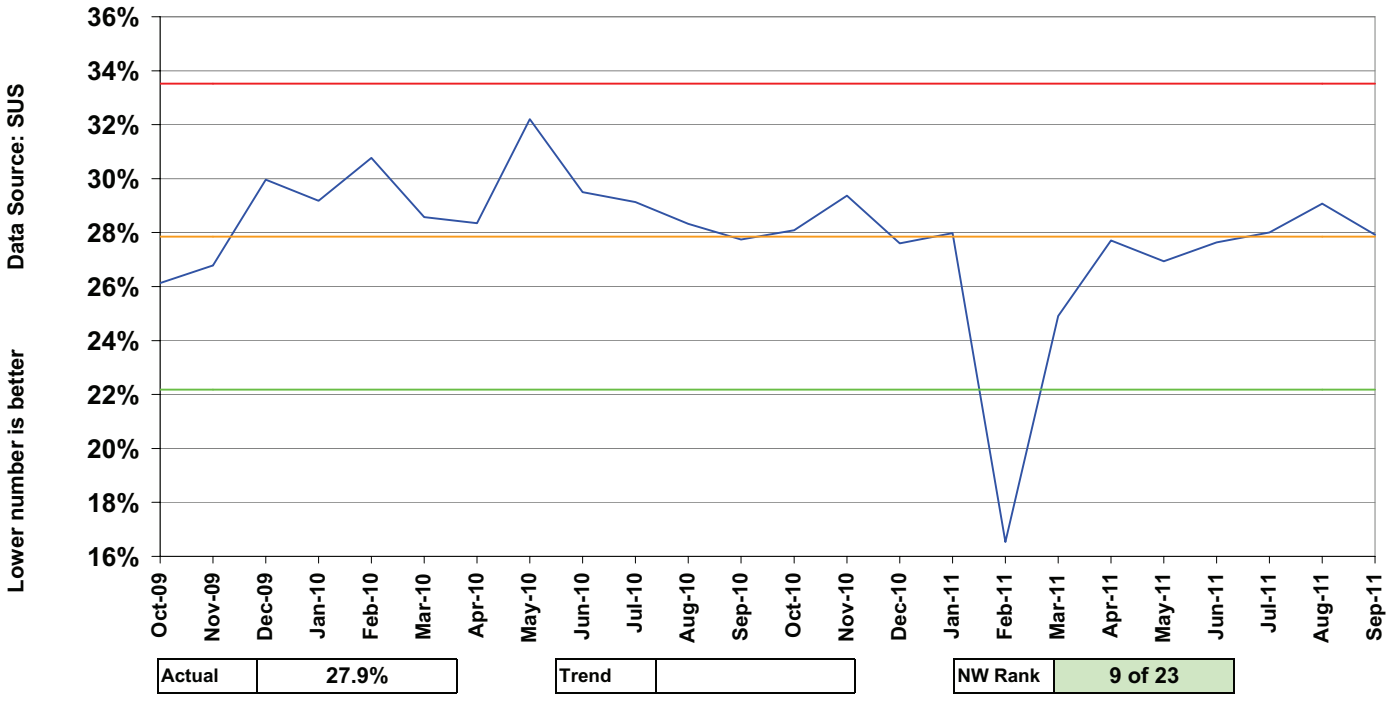
Graphs (c) and (d)

(c) Non-elective re-admission rate within 28 days aged 65 and over



Actual	16.5%	Trend		NW Rank	10 of 23

(d) Non-elective re-admission rate within 90 days aged 65 and over



Actual	27.9%	Trend		NW Rank	9 of 23

Key

Upper Control (2 st dev above average)

Average

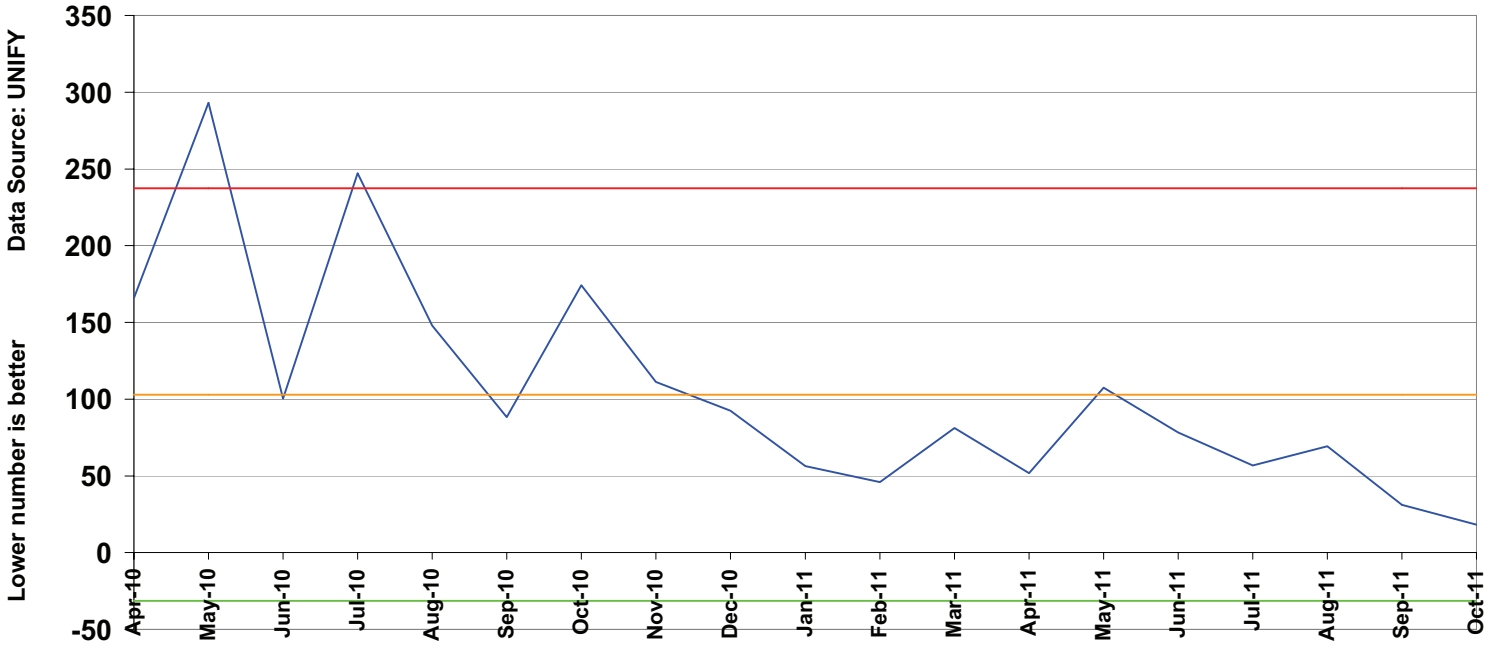
Lower Control (2 st dev below average)

PLEASE SEE DATA CAVEATS ON PG 7

ADASS / AQuA Whole system quality and efficiency Locality Scorecard Trend Analysis graphs for Wirral

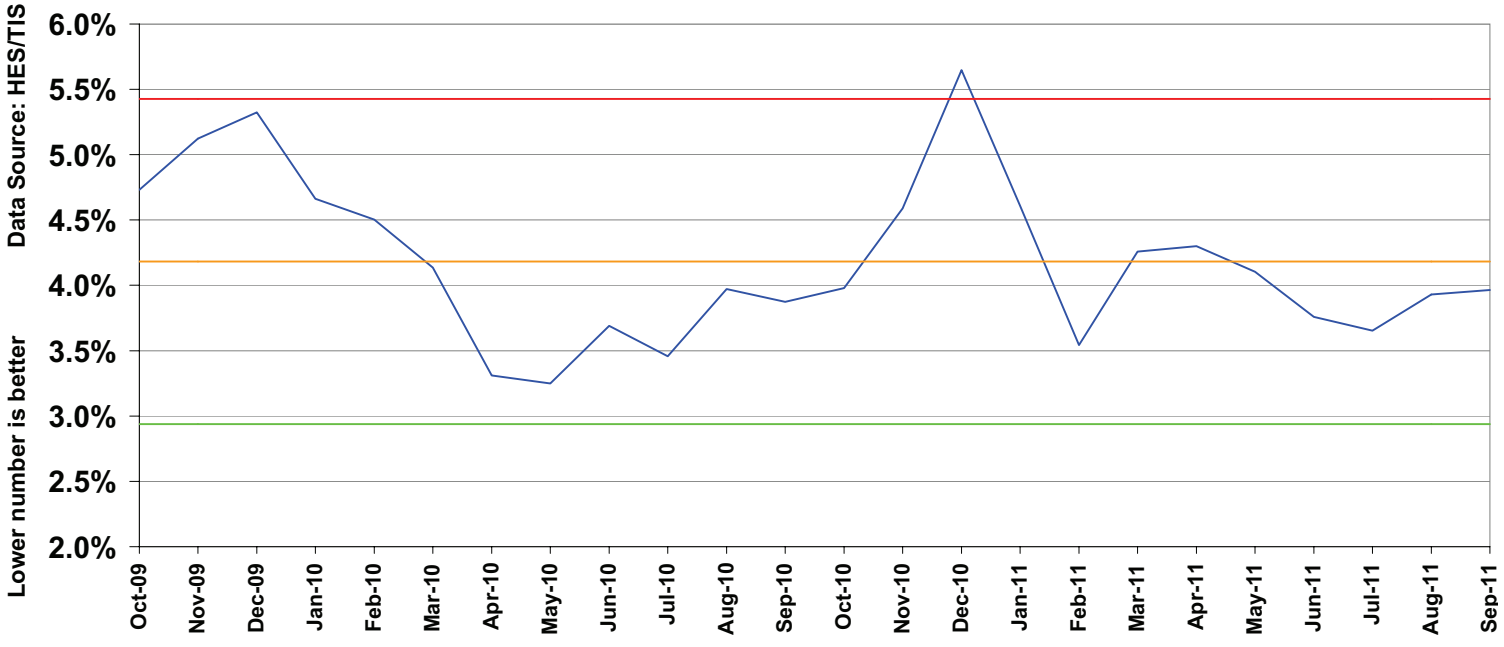
Graphs (e) and (f)

(e) No of delayed transfers of care aged 18+ per 100,000 pop



Actual	18	Trend		NW Rank	1 of 23

(f) Proportion of people aged 65+ discharge direct to residential care



Actual	4.0%	Trend		NW Rank	20 of 23

Key

Upper Control (2 st dev above average)	
Average	
Lower Control (2 st dev below average)	

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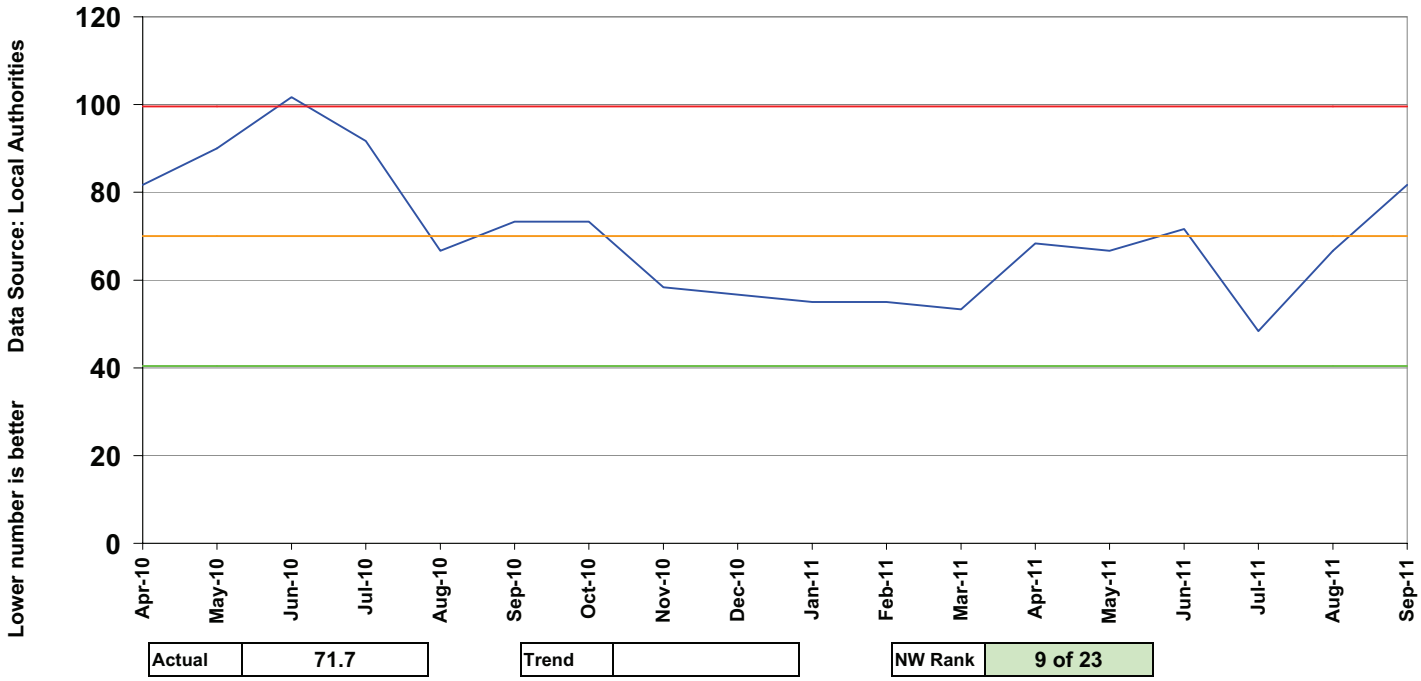
ADASS / AQuA Whole system quality and efficiency Locality Scorecard Trend Analysis graphs for Wirral

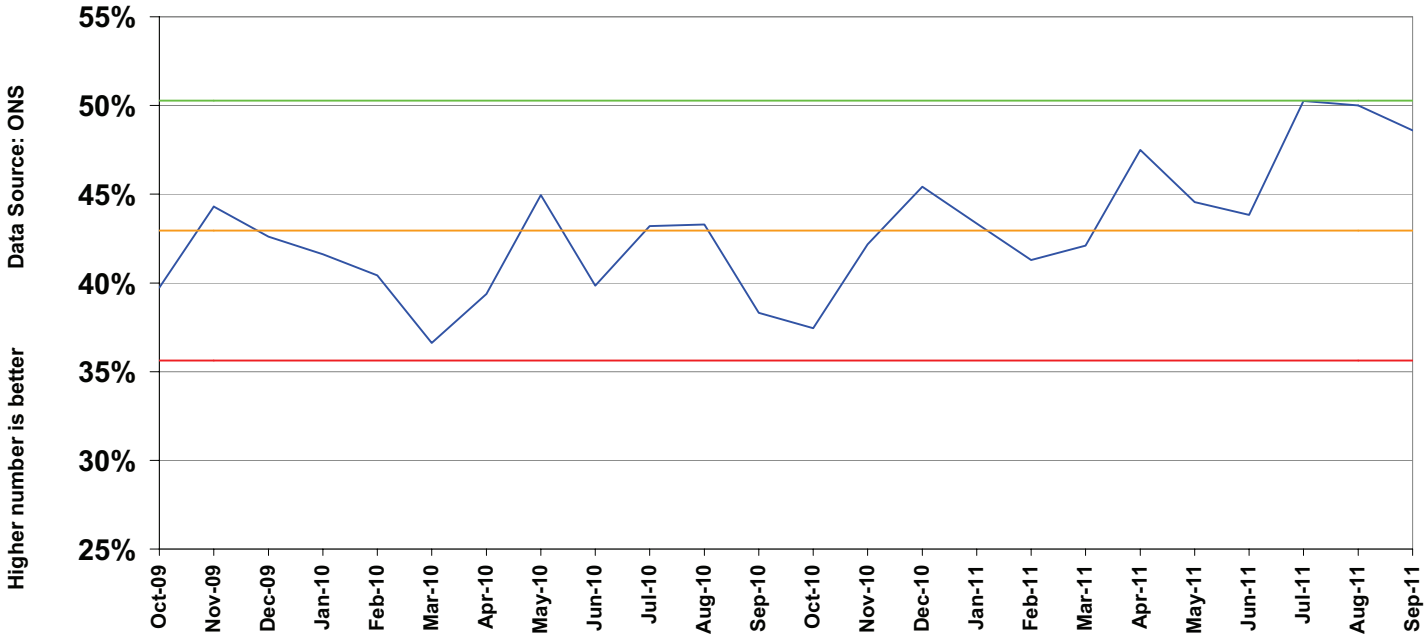
Graphs (g) and (i)

(g) Permanent admissions to residential / nursing care aged 65+ per 100,000 pop 65+



Actual	71.7	Trend		NW Rank	9 of 23

(i) Proportion of all deaths which occur at home - aged 65 and over



Actual	48.6%	Trend		NW Rank	3 of 23

Key

Upper Control (2 st dev above average)

Average

Lower Control (2 st dev below average)

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This comments box will give the story behind the data, the intelligence.

ADASS / AQuA Whole system quality and efficiency - Top 3 partnership interventions for Wirral

Intervention 1
Integrated discharge team
Intervention 2
Development of reablement service
Intervention 3
Integrated Health & Social care working in the community including the rapid access service

METADATA for the measures in the ADASS / AQuA whole system quality and efficiency locality scorecard

Measure name	Data Source	Geography/Location	Data parameters/specification for source data	Data equation/calculation	Date range	Data Caveats
(a) Non-elective admissions aged 65+ per 1000 pop 65+	From CBS via AQUA*. The data is extracted from the SUS Health system	By local authority boundary based on the address of the patient	1. Number of non-elective admissions to any hospital of patients aged 65 and over living within the local authority area.	(1. non-elective admissions aged 65 and over / population 65 and over) *1000	Oct 10 - Sep 11	All of the data for measures (a)-(d) is extracted from the SUS data system and so the last two months data are potentially subject to significant change. The last month of this data will have two more refreshes from local systems onto SUS and the data from the second to last month will have a final refresh. This will effect the data in this scorecard for these measures meaning admissions, bed days and repeats may appear lower or higher than they will actually be. THE DATA IN THIS SCORECARD FOR MEASURES (c) AND (d) WILL BE DIFFERENT TO THE APRIL-11 DRAFT VERSION DUE TO A CHANGE OF METHODOLOGY FOR CALCULATING REPEATS
(b) Non-elective bed days aged 65+ per head of 1000 pop 65+	From CBS via AQUA*. The data is extracted from the SUS Health system	By local authority boundary based on the address of the patient	2. Number of non-elective bed days in any hospital of patients aged 65 and over living within the local authority area.	(2. emergency bed days aged 65 and over / population 65 and over) *1000	Oct 10 - Sep 11	
(c) Non-elective re-admission rate within 28 days aged 65 and over	From CBS via AQUA*. The data is extracted from the SUS Health system	By local authority boundary based on the address of the patient	3. Number of non-elective readmission episodes within 28 days in any hospital of patients aged 65 and over living within the local authority area.	3. non-elective admissions in 28 days aged 65 and over / 1. non-elective readmissions	Oct 10 - Sep 11	
(d) Non-elective Re-admission rate within 90 days aged 65 and over	From CBS via AQUA*. The data is extracted from the SUS Health system	By local authority boundary based on the address of the patient	4. Number of non-elective readmission episodes within 90 days in any hospital of patients aged 65 and over living within the local authority area.	4. non-elective admissions in 90 days aged 65 and over / 1. non-elective readmissions	Oct 10 - Sep 11	
(e) No of delayed transfers of care aged 18+ per 100,000 pop	Monthly DTOC collections from provider trusts from the Unify System	By local authority boundary based on the address of the patient	5. DTOC bed days for month including acute and non acute, and DTOC for any reason and any organisation being responsible. This data is for people aged 18 and over only.	5. all delayed transfer of care bed days for February 2011 aged 18 and over / 18 and over / population 18] and over) *100,000	Oct -11 bed days	This data can be accessed at the DH at the following website: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AcuteandNon-AcuteDelayedTransfersofCare/index.htm
(f) Proportion of people aged 65+ discharge direct to residential care	HES (Hospital Episode Statistics) and/or SUS data from the TIS (Tactical Information Service) via NHS North West	By local authority boundary based on the address of the patient	6. Number of people with aged 65 and over with a discharge code of 54. NHS run care home, 65. Local Authority residential accommodation i.e. where care is provided, 85. Non-NHS (other than Local Authority) run care home	6. total for codes 54, 65 and 85 / total of all discharges	Oct 10 - Sep 11	The data for the last twelve months can be subject to change throughout the year so it may appear differently to previous refreshes of the scorecard. This data could include self funders of residential care. Some patients/service users may have lived in a different authority to the one in which they enter residential care.
(g) Permanent admissions to residential/ nursing care aged 65+ per 100,000 pop 65+	Collected from indivudal local authorities	By local authority boundary based on the address of the patient	7. Number of LA supported PERMANENT admissions aged 65 and over to residential care, nursing care and adult placements during 1 April to 31 March (excluding admissions to group homes),	7. (Admissions to res care aged 65 and over / population 65 and over) *100,000	Oct 10 - Sep 11	This data is collected directly from local authorities and has not all been verified by the Information Centre NHS so is subject to change
(i) Proportion of all deaths which occur at home / in care homes - aged 65 and over	Office of National Statistics (ONS) via NHS North West	By local authority boundary based on the address of the patient	10. Proportion of deaths occuring at home aged 65 and over. 11 all deaths aged 65 and over	10. Proportion of deaths occuring at home or in care homes aged 65 and over / 11. all deaths aged 65 and over	Sep 10 - Aug 11	

* CBS = Commissioning Business Service

AQuA Advancing Quality Alliance

directors of adass adult social services

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WIRRAL COUNCIL

HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

10 SEPTEMBER 2012

SUBJECT:	**UPDATE - AKA - IMPLEMENTATION OF RECOMMENDATIONS**
REPORT OF:	***GRAHAM HODKINSON - DIRECTOR OF ADULT SOCIAL SERVICES***
RESPONSIBLE PORTFOLIO HOLDER	**COUNCILLOR ANNE MCARDLE**

1. PURPOSE OF REPORT

1.1 To inform committee of the completion by the Department of Adult Social Services of various recommendations made by Anna Klonowski Associates (AKA).

2. BACKGROUND

2.1 The attached report was approved, under delegated authority, by the leader of the Council on 16 July 2012. This has been subject to the relevant call in period and is now presented to Committee for information.

2.2 This report considers only those issues identified by AKA as the responsibility of the Department of Adult Social Services; other recommendations will form part of the overall corporate involvement planning process.

3. RELEVANT RISKS

3.1 The AKA Report describes in detail a number of serious and long running failures on the part of the Council that resulted in detriment to vulnerable service users. The department, as part of its improvement planning, is working to ensure the underlying causes and culture that led to those failures occurring are being addressed.

4. OTHER OPTIONS CONSIDERED

4.1 The Council agreed to implement in full the recommendations of the AKA report; no other options are proposed.

5. CONSULTATION

5.1 The implementation of a number of the recommendations will require consultation with service users, families, carers and advocates.

6. IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

6.1 No identifiable implications.

7. RESOURCE IMPLICATIONS: FINANCIAL; IT; STAFFING; AND ASSETS

7.1 There are significant revenue resource implications that arise as a result of implementing these recommendations. Discussions are continuing regarding the funding arrangements.

8. LEGAL IMPLICATIONS

8.1 No specific implications are identified in this report.

9. EQUALITIES IMPLICATIONS

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

No because this report is based on a response to the work carried out by an external organisation. The equality impact of the implementation of the recommendations from this work have been considered.

10. CARBON REDUCTION IMPLICATIONS

10.1 None identified.

11. PLANNING AND COMMUNITY SAFETY IMPLICATIONS

11.1 None identified.

12. RECOMMENDATIONS

12.1 Members note the recommendations agreed by the leader of the Council regarding the AKA report.

13. REASONS FOR RECOMMENDATIONS

13.1 This issue was identified in a previous work programme.

REPORT AUTHOR: **Steve Rowley - Head of Finance and Performance**
telephone: (0151) 666 3662
email: Stephenrowley@wirral.gov.uk

APPENDICES

1. Delegated Decision by Leader/Cabinet Portfolio holder – AKA – Implementation of Recommendations

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Cabinet – Independent Review of Claims Made by Mr Martin Morton (and Others)	12 January 2012

APPENDIX 1

WIRRAL COUNCIL

DELEGATED DECISION BY LEADER/CABINET PORTFOLIO

16 JULY 2012

SUBJECT:	**AKA – IMPLEMENTATION OF RECOMMENDATIONS**
REPORT OF:	***GRAHAM HODKINSON - DIRECTOR OF ADULT SOCIAL SERVICES***
RESPONSIBLE PORTFOLIO HOLDER	**COUNCILLOR ANNE MCARDLE**

1. PURPOSE OF REPORT

1.1 To inform the Leadership of the completion by the Department of Adult Social Services of various recommendations made by Anna Klonowski Associates (AKA).

1.2 To seek endorsement of the actions taken by the Department.

1.3 To request the Leadership's agreement to 'sign off' those elements of the action plan, that were the responsibility of the Department

2. BACKGROUND

2.1 On 12 January 2102 cabinet received a report Independent Review of Claims made by Mr Martin Morton (and others) which made a number of recommendations following a review by AKA. The recommendations were accepted in full and the Chief Executive was asked to prepare an action plan.

2.2 At its meeting on 2 February 2012 Cabinet approved the Action Plan submitted by the Chief Executive. A number of the actions were assigned to the Director of Adult Social Services (or his Senior Leadership staff).

2.3 Since this time work has been undertaken within DASS to address the issues identified in the Action Plan and its work has now been completed.

3. SUMMARY OF ACTIONS TAKEN

3.1 It should be noted that the numbers within the action plan and subsequently referred to are, for consistency, the original numbers from the Action Plan approved by Cabinet in February 2012.

3.2 The following table outlines the additional actions that have been taken since the Action Plan was reported to Cabinet in February 2012.

AKA Report - Recommendations Action Plan

Recommendation	Action Taken
9. The Officers consider and report to a future Cabinet meeting, during Spring 2012, the proposed way forward relating to other charging issues outlined in paragraph 6.2.14 and Appendix 4 to Annex A.	Annex A, Appendix 4 of the AKA report sets out details of the Internal Audit reviews undertaken across the following DASS establishments over the period 1994 to 2006. A detailed investigation into the charging regimes at these properties was carried out. Whilst there were missing records, due to, for example disposal under the Records Retention policy, and certain assumptions have had to be made. The analysis revealed: • *Curlew Way • *Edgehill Road • *Bermuda Road These were dealt with as part of the PIDA report in 2008 follow up • **Manor Road • **27 Shrewsbury Road • **5-7 St Andrews Road/80 Shrewsbury Road No charging regime was in place • ***Fellowship House • ***Balls Road • ***North Road Different charging regimes were in place at each establishment. As a consequence of incomplete information the following calculations are based on the assumption that each service user paid the full charge for the full period in question: • Fellowship House No “overcharging” occurred • Balls Road Of 22 tenants 9 would be classed as “undercharged”; the remaining 13 as “overchanged”. The total reimbursement amounts to **£30,000** • North Road All 9 tenants are classed as “overcharged” to a total reimbursement amounting to **£90,000** **It is recommended that:** **i) All service users classed as “overcharged” are reimbursed, at a cost of £120,000** **ii) An allocation from corporate balances is made to fund the cost of the reimbursements** **iii) no further action is taken where service users have been identified as being undercharged**

10. The Council favourably reconsiders the effective date for the calculation of the reimbursements for those service users who had lived in the 3 West Wirral properties and their surviving relatives. The context of the "benefits trap" also needs to be considered as part of this process.	If the reimbursement of the residents at the 3 West Wirral properties is to be back dated to 1997 a total amount, including interest, of **£320,889.68** will be due to the 17 individuals concerned. Previously reimbursement has been made from December 2000 to March 2003 and a total of £243,460.07 was paid to the individuals concerned. This was a process that took over 12 months to complete due to the need to ensure that each of the individuals received appropriate advocacy and support, enabling them to understand the implications, in particular on benefits entitlements, of receiving the reimbursements. **It is recommended that:** **i) That the reimbursements are made, at a cost of £320,889** **ii) An allocation from corporate balances is made to fund the cost of the reimbursements** **iii) The process previously applied is followed once again, which should be expedited as the service users and advocated will be familiar with the procedures**
11. The Council favourably reconsiders the calculation of the reimbursement for the lack of interest. Again this must be considered in the context of the benefits trap.	
12. The outcome of complaint 3's stage 3 complaint should be reviewed in the light of the context of the events precipitating Service User 2's need to relocate and in the consultant's view this should lead to DASS honouring the commitment to pay the top-up payment	The recommendation will be honoured i.e. at any stage when there is a deficit between the amount of Discretionary Housing benefit and the rent payable by Service User 2, the deficit will be funded by the department. **It is recommended that:** **i) The Head of Locality Personalised Support writes to Complaint 3 to explain the outcome of the review** **ii) The Head of Locality Personalised Support writes to the Housing Benefits section to ensure that any future deficits are charged to the Department**
15. The quality of inputs to and outcomes from Adult Protection strategy meeting should be kept under close review, with a particular emphasis on at least the following questions at each meeting: A. What has changed for the better for the vulnerable adult? B. Why did the change not occur sooner? C. What is the pathway (or project plan) for resolving this referral? D. Who is responsible for each action? E. Who is taking overall responsibility for the case and will be held accountable for the quality and timeliness of both the review and its resolution?	New arrangements for Safeguarding Strategy meetings have been put in place which meets the requirements of the recommendation.

16. Details of Adult Protection concerns raised must be logged centrally with a close monitoring of the inputs, outputs and outcomes recorded in detail such that the Director can report in an open and transparent way Leading Members monthly and the Health and Social Care Select Committee on a quarterly basis.	A four level performance management framework has been put in place for Adult Safeguarding which meets the requirements of the recommendation. In addition the full time post of Head of care Governance has been established which will manage not only safeguarding but also contracts, complaints and knowledge management. An additional £500,000 has been allocated to safeguarding in the 2012/13 revenue budget
17. Opportunities for the improvements in the CCA and review process should be considered and proposals for improvement reported via the Cabinet Portfolio holder during the Spring of 2012.	The Self Directed Assessment process is currently being reviewed and the outcome will be reported to the Leadership as well as the Portfolio holder. **It is recommended that:** **i) A report is produced for the Leadership in July 2012**
18. The effectiveness of the actions put in place since the CQC report in relation to Adult Protection (now Safeguarding) should inform the above, but must be based upon quantitative and qualitative analysis contained within a formal report to Members before the peer review in the Autumn.	The CQC Action was "signed off" by Cabinet at its meeting on 24 November 2011 Adult Safeguarding services have subsequently been Peer Challenged, as part of the overall "Challenge Process" in December 2011 and specifically in May 2012. A further improvement plan will be presented to the Health and Wellbeing Overview and Scrutiny Committee in September 2012
19. The Director of Adult Social Care should continue to ensure that there is a shared understanding of the risks and issues facing DASS, at Member and Corporate Management team levels, together with the proposed mitigating action(s). This should be undertaken both formally and informally.	The Director has weekly meetings with the leader (if required). In addition he meets on a monthly basis with the leader and lead member to discuss risks and issues. On a formal basis Risks and Issues are considered monthly by a Strategic Leadership Team meeting which focuses solely on the performance of the department. In addition departmental performance is reported to the Health and Wellbeing overview and scrutiny committee at each of its regular meetings. The Director is also a member of the Council's Improvement Board
20. DASS needs to improve its early engagement activities with the HB Team to ensure future Supported Living proposals and the providing agencies are clear as to the likely benefits payable.	• DASS has put in place regular mechanisms for communication, problem solving and discussion with the Department of Finance housing benefits section where making applications for housing benefit in supported living. • These arrangements will be further underpinned by a joint protocol of good practice to ensure that there is timely notification about housing benefit applications. • A more strategic approach has been developed to ensure that early identification of housing requirements are shared and key officers are part of the decision making process • Project Group established to agree cohesive pathways on an operational basis which includes a streamlined joint approach to assessment. • Pathway clarified. • Considerable work has been undertaken to develop and ensure sustainability of working relationships

22. DASS should ensure that the planned use of a "peer review" to check, challenge/verify the improvements and achievements of the department is seen as a means by which regular external progress assessments can be undertaken and that the Cabinet portfolio holder is engaged in the discussions with those undertaking the review(s).	As part of this process the Department has undergone two Peer Challenges: in December 2011 a departmental wide examination and in May 2012 a specific focus on safeguarding. A further in depth Peer Review of the department as a whole has been undertaken in June 2012.
24. The Director of Adult Social Services to review the resources allocated to safeguarding and contract monitoring, reporting back to Members at Cabinet or the Cabinet Subcommittee within 6 weeks of the publication of this report.	A structural review was undertaken in September 2011 which resulted in resources allocated to establish;- 5 Quality Assurance Officers 3 Safeguarding Officers 4.5 Social Workers 3 Advanced practitioners All now in post
28. The Cabinet ensures that the outstanding allegation from the Service Provider 3 in relation to the level of DASS funding is thoroughly and robustly investigated with a view to early resolution. This will require the development of an action plan which is approved by the Director and Cabinet Portfolio holder that includes the delivery of written updates to the Cabinet Portfolio holder approximately in a 2 weekly cycle.	This is an area of great complexity and hinges around a significant amount of correspondence between the Council, its legal representatives and Service Provider 3. In order to properly progress this area a meeting was held with the Director of Adult Social Services, key Social Work Staff and a member of the Legal team to ascertain the work involved. This meeting concluded that it will be necessary to forensically consider each of the individual cases (up 24 service users) to assess the extent that the assessments had disfavoured the service users between 2005 and 2009 (when the process was rectified. **It is recommended** **i) An investigation is carried out by an independent officer and that a report is produced for the Leadership in August 2012 setting out the potential financial implications**
31. Pick out all service user related risk and ensure that people are safe	No further action considered necessary following approach agreed with police and interviews of relevant witnesses.
32. Ensure that learning from the investigation is incorporated into both actions and leadership styles in the Directorate	A full review of the report has been undertaken to consider its impact on Policies and Procedures; Processes; Practices and Culture. Feedback from the Safeguarding Peer Challenge indicates approval of the leadership style in the directorate

4. SUMMARY OF RECOMMENDATIONS

4.1 Referring to the Table in Section 3 above the following specific recommendations are made

Item No 9

It is recommended that:
i) All service users classed as "overcharged" are reimbursed, at a cost of £120,000
ii) An allocation from corporate balances is made to fund the cost of the reimbursements
iii) no further action is taken where service users have been identified as being undercharged

Items No 10 and No 11

It is recommended that:
i) That the reimbursements are made, at a cost of £320,889
ii) An allocation from corporate balances is made to fund the cost of the reimbursements
iii) The process previously applied is followed once again, which should be expedited as the service users and advocated will be familiar with the procedures

Item No 12

It is recommended that:
i) The Head of Locality Personalised Support writes to Complaint 3 to explain the outcome of the review
ii) The Head of Locality Personalised Support writes to the Housing Benefits section to ensure that any future deficits are charged to the Department

Item No 17

It is recommended that:
i) A report is produced for the Leadership in July 2012

Item No 28

It is recommended
i) An investigation is carried out by an independent officer and that a report is produced for the Leadership in August 2012 setting out the financial implications

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WIRRAL COUNCIL

HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

10 SEPTEMBER 2012

SUBJECT:	***ADULT SOCIAL SERVICES – SAFEGUARDING PEER CHALLENGE AND ADULT SOCIAL CARE PEER REVIEW***
WARD/S AFFECTED:	***ALL***
REPORT OF:	***GRAHAM HODKINSON, DIRECTOR OF ADULT SOCIAL SERVICES***
RESPONSIBLE PORTFOLIO HOLDER:	***COUNCILLOR ANNE MCARDLE***
KEY DECISION?	NO

1.0 EXECUTIVE SUMMARY

1.1 This report informs members of the Safeguarding Peer Challenge that was undertaken in May 2012 and the Peer Review conducted in June 2012 on wider aspects of Adult Social Care.

1.2 Wirral's Department of Adult Social Services (DASS) requested a Peer Challenge to ascertain progress in safeguarding adults since the Care Quality Commission (CQC) inspection in May 2010 found its performance in relation to safeguarding to be poor with uncertain capacity for improvement. A further Peer Review of adult social care took place in June 2012 which considered the wider work of DASS and its partners.

1.3 The Safeguarding Peer Challenge and wider Peer Review were conducted by the Local Government Association (LGA) with support and involvement from Association of Directors of Adults Social Services (ADASS). This report seeks to inform on key areas highlighted within each of the reports. Both reports will be available on the Council's internet site.

2.0 BACKGROUND AND KEY ISSUES

2.1 The Care Quality Commission announced in 2010 that it would cease the quality ratings system and inspections that it had previously undertaken. As a result of this DASS were left in a position of being classed as "adequate" without a process to move forward. This "limbo" has been addressed by the Local Government Association overseeing a process of Peer Reviews, which, if sufficient evidence is produced, can result in "adequate councils" moving out of that position.

2.2 DASS, therefore, began work on key improvements by seconding a number of senior managers into the leadership team to make the required changes. In November 2011 the Director requested the LGA to conduct an evaluation of progress against safeguarding, choice (personalisation) and quality. This was evaluated in December 2011 by a Peer Challenger who recommended that a separate Safeguarding Peer Review should be conducted to form the basis of a wider Peer Review to be conducted on other aspects of adult social care early in 2012.

2.3 In summary the Peer Challenger stated

'the Council has focused considerable resources into safeguarding since the CQC inspection …..This had led to the improvements as summarised in the Local Account, with which I concur. The department recognises that there are still issues to be addressed in the Account in respect of data quality and analysis'.

3.0 MATTERS ARISING FROM THE SAFEGUARDING PEER CHALLENGE

3.1 The Safeguarding Peer Challenge was carried out from 14 May 2012 to 17 May 2012. Terms of reference were agreed and services were measured against Safeguarding Standards developed by LGA and endorsed by ADASS. The themes of these standards are:

- Outcomes for and experiences of people who use services
- Leadership, strategy and commissioning
- Service delivery/effective practice/performance and resource management
- Working together – the Safeguarding Adults Board

3.2 The methodology used for the Safeguarding Peer Challenge involved:

- Reading documents and files and a self assessment
- Three days on site, discussions with 50 people
- Reviewed 10 files
- Observed a social work practice meeting
- Held follow up discussion with a family
- Held a workshop for 20 staff across the Department

3.3 The Findings and Recommendations (appendix 1)

The Executive Summary of the report states:

' it is evident that a lot of work has gone on in the department to improve the situation since the Care Quality Commission's report of 2010 judged services to be poor and with uncertain capacity to improve'.

This included a view that the Safeguarding Adults Board had a good annual report/business plan and had put in place policies and procedures, structure and clear accountabilities. This was used as an example of good practice and has been placed on the IDEA website (Local Government Improvement and Development). It was however, at an early stage of development and recognised what needs to be done in adult safeguarding work and putting plans in place. An Action Plan will be presented to the Safeguarding Adult Partnership Board on 26 September 2010 to consider how the partnership will respond specifically to the issues of action and development. This draft Action Plan is attached in appendix 2; any significant feedback will be verbally report to committee

3.4 In terms of Council wider issues the Peer Challenge considered that the appointment of the new permanent Director and changes in the senior management team have had a positive impact in terms of the ability of the DASS leadership to set a clear agenda for safeguarding adults. Broadening the approach that 'safeguarding is everybody's business', in terms of a more corporate approach, requires attention through more cross-departmental work on areas such as workforce strategy, corporate management competencies and development programme in safeguarding. There was self-awareness, and openness to external challenges. The front door services at Central Advice and Duty Team was brining consistency but there needs to be less hand-offs later in the system when the cases transfer.

3.5 In addition the report considered that a programme was required for Members which sets out the training and development work plan in adult safeguarding work as well as developing the interface between the Health and Wellbeing Board and Community Safety Partnership. The Head of Safeguarding is working with Members services training group to develop the programme for the next 12 months.

4.0 MATTERS ARISING FROM ADULT SOCIAL CARE PEER REVIEW

4.1 The basis for this review was the "Adult Social Care Key Questions" which are designed to reflect a range of guidance, tools and other materials produced by national and local government, the NHS, police and justice system in the last two years. The headline themes being:

1. Vision, Strategy and Leadership
2. Commissioning
3. How well are outcomes for people who use services being achieved?
4. Participation
5. Working Together
6. Resource and Workforce Management
7. Service Delivery and Effective Practice
8. Productivity and Innovation

4.2 In addition the peer review team was asked to consider the degree to which the department has an "Outward Focus" in particular around its use of the Adult Social Care Outcomes Framework (ASCOF), influence of Think Local, Act Personal (TLAP) and the use of the Safeguarding Adults Framework on policy, practice and performance management culture. However, as a comprehensive Adult Safeguarding peer challenge was carried out during May 2012, the peer review team's consideration of adult safeguarding was not extensive but took into consideration the findings and progress of that challenge.

4.3 In addition to the desktop exercise of reviewing evidence submitted by the department, the programme for the on-site phase included activities designed to enable members of the team to meet and talk to a range of internal and external stakeholders. These activities included:

- interviews and discussions with councillors, officers and partners
- focus groups with managers, practitioners, frontline staff and people using services / carers
- reading documents provided by the council, including a self-assessment of progress, strengths and areas for improvement against the Adult Social Care Key Questions
- An audit of a small number of client records selected by the DASS

4.4 The Executive Summary of the report states

'The peer review team found clear evidence of improvement and a change of culture within the department to one which is more open and transparent. Challenges remain but on evidence throughout the week the peer team are confident that the DASS has demonstrated significant improvement.

4.5 The Recommendations of the Review are at Appendix 3; it is proposed to address these as part of the overall business and improvement planning processes within the department. These will be monitored regularly through the "Programme Management" approach that is being implemented within the Department and where appropriate further reports will be brought forward.

5. NEXT STEPS

5.1 The key objectives of engaging with the robust process of peer challenge and peer review was twofold:

i) To have the work of the department externally validated

ii) To be able to present this external assessment to the Towards Excellence in Adults Social Care Board to show evidence that the Department should no longer be classed as "adequate".

5.2 Throughout the process the Department has been supported by a Peer Challenger nominated by the Local Government Association for the role: was Veronica Jackson, the former Director of Adult Social Services in Oldham. It is proposed that a joint report will be produced by the Director of Adult Social Services and Ms Jackson, to be presented to the Towards Excellence in Adult Social Care Board in the Autumn 2012. It is anticipated that at the stage the Board will agree that the Department should no longer be classed as adequate.

6.0 RELEVANT RISKS

6.1 This report details the findings of a number of external reviews of social care in Wirral. Those reviews have identified a number of recommendations which will, in turn, be reflected in the improvement plans of the department. As these recommendations are developed it will be appropriate to consider, in detail, the potential risks of implementing the actions.

7.0 OTHER OPTIONS CONSIDERED

7.1 The process of peer challenge and peer review are nationally recognised and agreed processes for validating the work of an organisation. The Council has embraced this process and this was the only option considered

8.0 CONSULTATION

8.1 The SAPB considered the Safeguarding Peer Challenge Action Plan on 3 September 2012; any relevant comments will be reported verbally to committee.

8.2 As part of the business and improvement planning process, any actions that stem from the recommendations of the peer challenge and review process will be subject to relevant consultation where appropriate.

9.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

9.1 The Voluntary, Community and Faith sector are represented on the SAPB and will contribute to the development of the attached Action Plan.

10.0 RESOURCE IMPLICATIONS: FINANCIAL; IT; STAFFING; AND ASSETS

10.1 Resources had been made available through DASS and SAPB budgets.

11.0 LEGAL IMPLICATIONS

11.1 None arise as a result of this report.

12.0 EQUALITIES IMPLICATIONS

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

No because this report is based on work carried out by an external organisation; the implementation of the recommendations from this work will be subject to equality impact assessments.

13.0 CARBON REDUCTION IMPLICATIONS

13.1 None identified.

14.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

14.1 None identified.

15.0 RECOMMENDATION/S

15.1 That Members;

i) note the progress made in safeguarding and the outcome of the peer review of adult social care

ii) agree the actions proposed for Member service training programme

iii) agree to receive a further report regarding the outcome of the presentation to the Towards Excellence in Adult Social Care Board

16.0 REASON/S FOR RECOMMENDATION/S

16.1 Significant work has been undertaken within the Council with regards improvements in Adult Social Care services following the report of the CQC in May 2010 when the Council was judged Adequate. In seeking to demonstrate that improvements have been made the peer challenge and review process of external validation have been extensively applied. It is appropriate to keep members informed of this process, the resulting actions and next steps

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APPENDICES

1. Recommendations of the Adults Safeguarding Peer Challenge - Wirral Borough Council. May 2012.
2. Action Plan for Safeguarding Peer Challenge – September 2012
3. Recommendations of the Adult Social Care Peer Review - Wirral Metropolitan Borough Council June 2012

REFERENCE MATERIAL

N/A

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Cabinet – Adult Social Services – Peer Challenge Process	19 July 2012
Cabinet - Department of Adult Social Services Self Evaluation Document	24 November 2011
Health and Wellbeing Overview and Scrutiny Committee - Self Evaluation / Peer Challenge	19 January 2012

Appendix 1

Recommendations of the Safeguarding Peer Challenge, May 2012

1. Outcomes and People's experience of safeguarding
1.1 Develop the mechanisms to build in an outcomes focus and to measure the outcomes that are achieved through safeguarding.
1.2 Build in the mechanisms to ensure that people who are being safeguarded (or their advocates, representatives or best interest assessors if they lack capacity) are involved at every stage of and can influence the process.
1.3 Develop a range of person centred responses and plans to help people towards justice, resolution, restitution or protection.
1.4 Develop more sophisticated models of working that have middle ground and flexibility between "professionals making people safe" or assessments that "there's nothing we can do because someone has capacity to make unwise decisions".

2. Leadership, Strategy and Commissioning
2.1 Take a corporate approach to safeguarding adults as a council, including cross departmental work and community capacity building to safeguard citizens.
2.2 Develop further the interfaces between Boards and Partnerships (the Safeguarding Adults Partnership Board, Health and Wellbeing Board, Community Safety Partnership Board and the Safeguarding Children Board).
2.3 Develop a distinct adult's focus to safeguarding, building on the 'discipline' that has been introduced through the interfaces with children's safeguarding.
2.4 Align safeguarding and personalisation at all levels.
2.5 Challenge each other more to improve: analyse the data you have to understand what is going on and how to improve.
2.6 Improve commissioning for quality and safety at the right price.
2.7 Apply a wider range of preventative practices and approaches to safeguarding to effect a move away from reactive safeguarding.
2.8 Develop a corporate communication strategy to manage press interest and a better message to residents.

3. Service Delivery and effective practice
3.1 Refine the CADT (Assessment and Duty Team) front-end process in a number of areas including clearer processes to weigh up the risks and benefits of different options with people who are in contact with the council
3.2 Consider future models of social care pathways to ensure you make the best use of professional skills and reduce handovers for people. CADT is bringing consistency at the front end, but the cost of this is handoffs between teams, which are not personal and have their own risks.
3.3 Ensure consistent feedback to referrers.
3.4 Ensure that any movement of people to a place of safety is based on consent or relevant legal process.

3.5 Improve clarity on safeguarding roles and responsibilities and how they interface with DASS for key health partners such as the hospital and mental health trust.
3.6 Utilise better the resources and approaches within community safety, particularly for domestic abuse, to support social workers when dealing with complex safeguarding cases.
3.7 Develop the wider care management process to support the prevention of safeguarding concerns, in particular the reviewing system.
3.8 Consider how the recording framework for safeguarding can be revised to allow social workers to analyse and record assessment of risk and decision making with people.
3.9 Develop the social work role in safeguarding beyond responding to immediate safety concerns, including in the following areas: • Use person centred protection planning to define the support available from the beginning of an intervention, and regularly review and update it over the longer term. • Develop practice so that social workers feel confident in considering and using a range of social work responses to deal with safeguarding concerns. • Develop the understanding and use of legal options so that social workers can use a range of appropriate and proportionate responses. • Continue the work on implementing the Mental Capacity Act, and develop practice that includes understanding of the impact of coercion and undue influence for people with capacity. • Develop the understanding of risk management and risk enablement to support decision making.

4. Performance and resource management
4.1 Put in place an outcomes framework to evaluate effectiveness
4.2 Develop a comprehensive workforce development strategy to plan for the future.
4.3 Improve the timeliness of HR responses.
4.4 Improve the analysis and use of management information, including feedback from people using services and carers, to inform improvements in care pathways and the safeguarding process.

5. Working together – Safeguarding Adults Board
5.1 Support the independent chair to lead the Board to become more challenging with more discussion and conclusions.
5.2 Support the Board to develop so that it knows what difference it is making on aggregated outcomes and how it is working pro-actively and reactively in safeguarding.
5.3 Review the engagement of the police and criminal justice system in the board, and the outcomes for people in terms of access to justice.
5.4 Continue to seek multi-agency funding commitment to the work of the Board.
5.5 The Board should find a means of regularly sharing learning from here and elsewhere – serious case reviews, legal judgements and so on.

5.6 Some partners need support and to be held accountable for their contribution.
5.7 Some plans appear to have been rushed and need more ownership
5.8 Take the opportunity for some critical bi or tri lateral developments (e.g. joint processes between DASS and domestic violence, between DASS, Community Safety and the Housing Partnership)
5.9 Develop mechanisms to bring together data and intelligence on quality from safeguarding, contracts management, care management reviews, LINks, (and Health Watch in the future) the regulator, whistleblowing, complaints, feedback from people using services and others to as far as possible ensure that services have basic standards in place that safeguard people's rights and dignity. The Board should consider also doing this for NHS services and police responses, and perhaps at a later date in relation to police custody and prisons.

Appendix 2

Safeguarding Adults Partnership Board - Draft Improvement Plan

Area 1	What was found		Recommendations	Action	Lead
1) Outcomes for and people's experiences of safeguarding	**STRENGTHS:** • There is some sense that a more personalised approach is starting • There were a couple of examples of good outcomes in individual cases • There are some general forums for engagement with citizens that have been used to highlight safeguarding (such as the Older People's Parliament, carers etc)	**AREAS FOR CONSIDERATION:** • Need to ensure outcomes for people are improved • people's experiences of safeguarding it's not built in to process and systems. • CADT is bringing consistency at the front end but the cost of this is handoffs which are not personal and have their own risks • develop a range of person centred responses and plans to help people towards justice, resolution, restitution or protection	Develop mechanisms and ways of measuring outcomes at all levels of safeguarding Ensure that the mechanisms include the views and wishes of service users that demonstrate their involvement and influence. Develop a range of person centred responses to help people towards justice, resolution, restitution and protection	SAPB sub-committee reviewing models for development As above Advanced Practitioner and Team Manager Group (DASS)	

		• opportunity to develop more sophisticated models of working	Develop the social work practice beyond immediate protection	Review practice training for social workers and include diverse models of practice in safeguarding	

Area 2	What was found		Recommendations	Action	Lead
2) Leadership, strategy and commissioning	**STRENGTHS – leading to better outcomes and services:** • setting clear agenda by Management Team • Links with most health partners strong • Self awareness and self assessment • More robust role taken by Local Authority • Developing a robust approach to monitoring of services and contracts • Monitoring and quality assurance becoming preventative and proactive	**AREAS FOR CONSIDERATION:** • Council needs to take a corporate approach to safeguarding adults including cross departmental work and community capacity building to safeguard citizens • The interfaces between Boards and Partnerships SAPB, HWB, CSPB, LSCB etc need to be developed further • The children's 'discipline' has been helpful but now can develop a unique adults' focus • Need to align safeguarding and personalisation at all levels	Develop a corporate strategy for safeguarding and have in place a written policy across CSP, LA , SAPB/LSCB and Health and Well-Being Board DCS/DASS and Heads of Safeguarding with respective chairs of partnerships to develop a communication strategy for connecting the work of safeguarding across the authority Review current Personalisation processes with safeguarding which includes a review of practice and procedure.	Chief Officers and ensure that there is a written strategy in place with robust Governance arrangements through to the Health and Well-Being Board DASS/DCS to set up meeting with relevant senior officers to develop a work-plan. Head of Service in DASS for Personalisation to lead a review of service provision	

		• Challenge each other more to improve, analyse to understand what you have and how to improve • Improve commissioning for quality and safety at the right price • Communication strategy to manage hostile press and manage a better message to residents – corporate role in this	Ensure that Chairs of Partnerships can demonstrate challenge across and the effect on outcomes Head of Care Governance-DASS to review the current commissioning and contracts Develop a corporate communication strategy for safeguarding adults at risk	Each Partnership and Board to review method of challenge and whether it is sufficient SAPB to complete a media management protocol with Press and Public Relations	

Area 3	What was found		Recommendation	Action	Lead
3) Service Delivery effective practice	**STRENGTHS:** • The CADT front end process has produced clarity and understanding on thresholds • There is good legal advice and support available, and understanding of the Mental Capacity Act • The multi agency response to safeguarding concerns has improved. • There is increased confidence among the social work teams how to respond to a presenting safeguarding concern	**AREAS FOR CONSIDERATION 1:** • The CADT front end process could be refined • Improved clarity on safeguarding roles and responsibilities and how they interface with DASS for key health partners such as the hospital and mental health trust • The resources within community safety, particularly for domestic abuse, could be better utilised to support social workers	Refine the CADT process to ensure options on outcomes are developed for service users. Feedback to referrers needs to be systematic Review of CPA process with regard to safeguarding framework Current review of Adults MARAC	Principal Manager for CADT to ensure good effective processes apply Review of CPA and safeguarding framework DASS has begun a review of MARAC/Hate Crime with FSU and agreed work-plan	

	• There is a police family crime investigation unit and services available to people experiencing domestic abuse and hate crime through the MARACs, IDVA service and BME support	• The wider care management process should be developed to support the prevention of safeguarding concerns, in particular the reviewing system	Ensure the Reviewing systems is developed and effective	A review of the current systems for Reviewing protection planning has already begun which includes dedicated training for chairs.	
		• Consideration could be given to the recording framework for safeguarding **AREAS FOR CONSIDERATION 2:** There is scope to develop the social work role in safeguarding beyond responding to immediate safety concerns. These include:	Consider recording framework for safeguarding and necessary revisions	DASS has begun a review of SWIFT and ESCR which has included market testing with practitioners –finance made available for further enhancement of current system.	
		• Person centred protection planning Practice should be developed so that social workers feel confident in considering a range of social work responses to deal with safeguarding concerns	Use person centred planning to define intervention and review plans Develop social work practice	Continue to develop the training on risk enablement and further develop this across the SAPB agencies and agree practice guidance on this through the SAPB	

		• Understanding and use of legal options should be developed • Understanding of risk management and risk enablement should be developed to support decision making	Continue to develop the legal options available Continue to work on implementing the Mental Capacity Act Develop understanding of risk enablement and support decision making		

Area 4	What was found		Recommendations	Action	Lead
4) Performance and resource management	**STRENGTHS:** • Significant investment already made in safeguarding/Contracts • Promising foundations in place to drive improvements in practice and quality assurance • Shift in management and organisational culture has delivered an improved focus on performance management • Developing a learning culture and good recognition and desire to develop skills and competencies	**AREAS FOR CONSIDERATION:** • Put in place an outcomes framework to evaluate effectiveness • Develop a comprehensive workforce development strategy to plan for the future • Some HR responses (getting people into post, workforce development plans etc) have been slow • Develop mechanisms to bring together data and intelligence on quality from safeguarding, contracts management, care management reviews, LINks, the regulator and others • Consider future models of social care pathways	Put in place an outcomes framework to evaluate effectiveness Develop a comprehensive workforce strategy plan Improve the timeliness of HR responses Improve use of management information within Safeguarding Adults/Contracts including service user views	AVA national consultation is being considered locally and agreement being reached with SAPB on key requirements Organisation Development Team in DASS to develop plan Corporate improvement plan includes detail of this work Supervision and appraisal audit to take place Contracts/Safeguarding Principal and Service Managers to develop a database for service improvement	

Area 5	What was found		Recommendations	Action	Lead
5) Working together:	**STRENGTHS:** • The Board is established and has put in place policies and procedures, structure and clear accountabilities. The annual report and business plan are good and have clear priorities • Imposing the discipline of the children's framework and experience was wise. You can now develop more sophistication in safeguarding adults • There are some positive partnerships including carers and providers on the Board, and co-terminosity helps • You have done a case review using the SCIE methodology	**AREAS FOR CONSIDERATION:** • The Board is at a stage of development and has a new chair. Needs to demonstrate challenge. It needs to know what difference it is making on aggregated outcomes. • Some partners need support and to be held accountable for their contribution • Some plans appear to have been rushed and need more ownership	Support independent chair to lead the Board in becoming more challenging. Support the Board to develop outcomes Review engagement of police re: criminal justice options Continue to seek multi-agency funding for the SAPB The Board to find ways to share learning. Partners to become more challenging and held to account. Plans need more ownership	Development day to agreed to further continued development for Board members in terms of challenge, duties to safeguard through self-assessment. Board to develop a Memorandum of understanding Develop links and dialogue between SAPB and LSCB and Health and Wellbeing Board Serious Case Reviews/ Critical Incident Reviews to be published through SAPB	

	• Safeguarding is on the CCG agenda, key posts have been agreed, there is an opportunity for named and designated roles and bringing together safeguarding teams virtually across organisations	• Opportunity for some critical bi or tri lateral developments between DASS/DV, CS and Housing Partnership • developments (e.g. joint processes between DASS and DV, between DASS, Community Safety and the Housing Partnership) • Develop mechanisms to bring together data intelligence on quality of safeguarding, contracts, care management, LINK, CQC etc	Develop joint processes between DASS/FSU/Community Safety and Housing Partnership Data and intelligence on quality from safeguarding, contracts, care management reviews, CQC, complaints and Healthwatch and the Board should consider doing this for NHS and Police responses at a later date.	Additional Safeguarding Posts give SAPB capacity to undertake more Board functions Housing rep. appointed to SAPB and monthly meetings with FSU following review of Hate Crime and MARAC adult process. Joint chairing for Hate crime agreed and additional capacity from DASS Safeguarding team agreed for MARAC attendance. New protocol agreed July 2012. Contracts Principal Managers to lead and develop database to bring together all intelligence on providers.	

Appendix 3

Recommendations of the Adult Social Care Peer Review June 2012

1.	**Vision, Strategy and Leadership**
a)	Ensure key stakeholders and partners understand the priorities of the department of adult social care and the context in which it is operating including budgetary constraints
b)	Develop a departmental media relations strategy within the wider council communications strategy
c)	Develop a co-ordinated programme for personalisation that speeds up the pace of personalisation and embraces the wider health and well being agenda
d)	Distinguish between short, medium and long term priorities and actions in the Departmental Plan
e)	Increase the visibility of senior managers and members on adult social care issues.
f)	Improve the rigour and breadth of Scrutiny on adult social care.
2.	**Commissioning**
g)	Ensure earlier and wider consultation with service users, carers, partners and staff on the commissioning strategy and plans
h)	Ensure that the commissioning plan's priorities are service user outcome focussed
i)	Develop the provider market in a way that focuses on services that will promote independence and preventative approaches for service users.
3.	**Outcomes**
j)	Provide more support for service users and carers to use personal budgets and provide a wider range of community based services
k)	Create opportunities for personal budgets to be used more creatively
l)	Provide resources to ensure reviews are carried out in a more timely fashion
m)	Ensure that risk is routinely considered and is consistently identified.

4.	**Service Delivery and Effective Practice**
n)	Identify and reflect outcomes at the start of the care planning stage
o)	Develop a single risk assessment that covers all assessments.
5.	**Participation**
p)	Involve service users, carers, communities and partners in the design, delivery, and review of services at an earlier stage and in a more systematic way
q)	Strengthen and co-ordinate links and relationships with the voluntary sector
r)	Improve the monitoring and review of all contracts with a focus on user outcomes. Contracts need to be more transparent about the performance measures that will be used to assess a provider's performance
6.	**Working Together**
s)	Develop a strategic forum outside of the Health and Wellbeing Board (H&WBB) that can agree and promote the priorities of DASS such as personalisation
t)	Ensure that adult social care services are maintained during periods of substantial organisational change for the Council and its key partners
u)	Develop joint systems, protocols and policies to improve information sharing with partners safely and appropriately.
7.	**Resource and Workforce Management**
v)	Ensure that the right people are in the right places doing the right things. This is particularly important in the area of adult safeguarding and the mental capacity or where there is limited capacity or specialist isolated services.
w)	Address the Council's recruitment processes to reduce delays in getting staff into post. This will also reduce the need to rely on agency staff.

8.	**Outward Focus**
x)	Create opportunities to further develop an outward focus by working with high performing authorities, participating more in regional and national forums and by organising events in the Wirral to showcase good practices in adult social care.
8.	**Improvement and Innovation**
y)	Use opportunities to test or pilot new ways of working in different localities which can then be rolled out to all localities
z)	Set joint priorities with key partners to achieve shared outcomes. Establish some joint performance measures with Health Service partners so that partners can jointly learn from the information
aa)	Simplify care pathways with less bureaucracy and leaner systems.

WIRRAL COUNCIL

WIRRAL HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

10TH SEPTEMBER 2012

SUBJECT:	Cancer Services in Cheshire and Merseyside
WARD/S AFFECTED:	All
REPORT OF:	Jon Hayes Deputy Director of Clinical Networks Cheshire and Merseyside Networks
KEY DECISION? *(Defined in paragraph 13.3 of Article 13 'Decision Making' in the Council's Constitution.)*	YES/NO *(delete as applicable)*

1.0 EXECUTIVE SUMMARY

1.1 This paper has been prepared to:

- Provide information on the work that has been taking place in Cheshire and Merseyside to consider and bring forward proposals for the development of world class cancer services in Cheshire and Merseyside through the establishment of a new Cancer Centre in Liverpool in conjunction with The Clatterbridge Cancer Centre NHS Foundation Trust, while retaining many services at Clatterbridge to ensure local access, and the further development of services across the area;

- Support the wide-ranging communication and involvement exercise designed to share the proposals with a wide range of stakeholders across Cheshire and Merseyside and further afield where appropriate**.**

1.2 The Clatterbridge Cancer Centre NHS Foundation Trust is the provider of radiotherapy and chemotherapy for the network's population. The Royal Liverpool University Hospital provides the majority of other tertiary cancer services, including specialist surgery, radiology and pathology. The Clatterbridge Cancer Centre NHS Foundation Trust's base in Bebington, Wirral, is not centrally located for the population it serves, with 67% of the population living north of the River Mersey. The uneven distribution of cancer incidence means that approximately 73% of all cancer patients live north of the river.

1.3 The Clatterbridge Cancer Centre's main base at Bebington is isolated from other specialist cancer services and cannot provide acute services such as intensive care for the sickest of patients. Opportunities to pursue ground-breaking innovations such as intra-operative radiotherapy are currently hampered by the physical separation of The Clatterbridge Cancer Centre's main base from other acute hospital facilities and specialist cancer services.

1.4 The key elements of the vision are:

- Development of a specialist Clatterbridge Cancer Centre on the new Royal Liverpool University Hospital site in addition to the provision of outpatient radiotherapy, proton therapy, chemotherapy services on the Wirral;
- Enhanced research capacity (symbolised by more research beds);
- Retention of the outpatient radiotherapy service adjacent to The Walton Centre NHS Foundation Trust on the Aintree Hospital site;
- Maintenance of The Clatterbridge Cancer Centre NHS Foundation Trust's current range of existing network clinic arrangements across Merseyside and Cheshire for chemotherapy. The trust provides chemotherapy treatments at clinics on nine hospital sites in the region.

1.5 The Royal Liverpool University Hospital site is shared with the University of Liverpool School of Cancer Studies, Cancer Research UK and the Clatterbridge Cancer Research laboratories, forming a 'bio-campus' of innovation and collaboration. Only The Clatterbridge Cancer Centre NHS Foundation Trust remains physically isolated from this important and growing research community. By expanding The Clatterbridge Cancer Centre NHS Foundation Trust's franchise to create a comprehensive cancer centre in partnership with other research teams, all patients, including those from Wirral and West Cheshire, will benefit from greater participation in international-standard research and clinical trials.

1.6 In brief these proposals are designed to ensure that the cancer services delivered for the people of Cheshire, Merseyside and beyond are of the highest possible quality and will:

- Ensure better co-ordination of pathways of care for cancer patients by bringing together key specialist services on a single campus, which currently hosts the majority of Specialist Cancer Multi-Disciplinary Teams (SMDTs);
- Ensure that patients benefit from closer integration between the NHS and research teams within the University of Liverpool and other key research partners e.g. Cancer Research UK;
- Enable more clinical trials to be undertaken leading to new medical innovations and treatments for cancer;
- Ensure that specialist services are located in a place most easily accessible to the majority of patients so that more patients could benefit from improved access, particularly those who need repeated and regular radiotherapy for certain types of cancer and for palliation;
- Make best use of NHS resources by enabling clinical teams to work more effectively and efficiently together;
- Be a focus for innovation and knowledge in all aspects of cancer care including medicine, nursing and supportive therapies;
- Maintain those NHS Services which are best delivered in more local settings including local district general hospitals and the community;
- Ensure that the majority of patients will continue to be treated nearer to home where safe to do so.

1.7 In making the above proposals it is recognised that certain patients will have to travel further for certain elements of their care. However, it is important to emphasise that

radiotherapy and chemotherapy services would continue to be provided on the original The Clatterbridge Cancer Centre NHS Foundation Trust site. Outpatient radiotherapy services for patients with more common cancers such as breast, prostate and lung would continue to be provided by Clatterbridge on Wirral, and the trust will continue to provide outpatient chemotherapy for the majority of cancer types locally across the region in district general hospitals, including at Clatterbridge. Only those patients who require more complex treatment, or require inpatient facilities – the minority - would be required to travel to the new Clatterbridge centre in Liverpool.

1.8 Fuller details of these proposals along with a range of statistics in relation to cancer incidence in Merseyside and Cheshire can be found in NHS Cheshire, Warrington & Wirral Board papers at http://www.wirral.nhs.uk/document_uploads/Boardcluster-Nov/Cluster-BoardPack-02-11-2011.pdf

2.0 RECOMMENDATION/S

2.1 The committee is invited to support proposals to develop a comprehensive cancer centre for Merseyside and Cheshire. This would be achieved by the expansion of The Clatterbridge Cancer Centre NHS Foundation Trust from its current location on the Wirral into a new site adjacent to the Royal Liverpool University Hospital NHS Trust. The Clatterbridge Cancer Centre NHS Foundation Trust would maintain a base on the Clatterbridge site providing many outpatient chemotherapy and radiotherapy services for Wirral and West Cheshire patients

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APPENDICES

A New Cancer Centre: Investing in the Future of Merseyside and Cheshire Report
B Equality Analysis for Cancer Centre (in place of Equality Impact Toolkit)

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Health and Well Being Overview and Scrutiny Committee	18th June, 2012

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A New Cancer Centre

Investing in the Future of Merseyside and Cheshire

Section One

- *A summary of the proposal to develop a comprehensive cancer centre for the population of Merseyside and Cheshire through an investment in The Clatterbridge Cancer Centre NHS Foundation Trust, in partnership with the Royal Liverpool and Broadgreen University Hospitals NHS Trust and the University of Liverpool.*

Section Two

- *A summary of the stakeholder communications and engagement pre-consultation plan relating to the above proposal.*

NHS Cheshire, Warrington and Wirral
NHS Merseyside

August 2012

Contents

Section One: A summary of the proposal to develop a comprehensive cancer centre for the population of Merseyside and Cheshire

1.1 Introduction

This paper has been prepared to:

- Provide information on the work that has been taking place in Cheshire and Merseyside to consider and bring forward proposals for the development of world class cancer services in Cheshire and Merseyside through the establishment of a new Cancer Centre in Liverpool in conjunction with The Clatterbridge Cancer Centre NHS Foundation Trust, while retaining many services at Clatterbridge to ensure local access, and the further development of services across the area;
- Support the wide-ranging communication and involvement exercise designed to share the proposals with a wide range of stakeholders across Cheshire and Merseyside and further afield where appropriate**.**

Key stakeholders are invited to support proposals to develop a comprehensive cancer centre for Merseyside and Cheshire. This would be achieved by the expansion of The Clatterbridge Cancer Centre NHS Foundation Trust from its current location on the Wirral into a new site adjacent to the Royal Liverpool University Hospital NHS Trust. The Clatterbridge Cancer Centre NHS Foundation Trust would maintain a base on the Clatterbridge site providing many outpatient chemotherapy and radiotherapy services for Wirral and West Cheshire patients.[1]

The Clatterbridge Cancer Centre NHS Foundation Trust is the provider of radiotherapy and chemotherapy for the network's population. The Royal Liverpool University Hospital provides the majority of other tertiary cancer services, including specialist surgery, radiology and pathology. The Clatterbridge Cancer Centre NHS Foundation Trust's base in Bebington, Wirral, is not centrally located for the population it serves, with 67% of the

[1] The main provider of radiotherapy and chemotherapy for the population of Central and Eastern Cheshire PCT (and Eastern Cheshire CCG, South Cheshire CCG and Vale Royal CCG) is The Christie in Manchester rather than Clatterbridge. The residents of North Wales access services at Betsi Cadwaladr University Health Board with its cancer centre based at Glan Clwyd Hopital.

population living north of the River Mersey. The uneven distribution of cancer incidence means that approximately 73% of all cancer patients live north of the river.

The Clatterbridge Cancer Centre's main base at Bebington is isolated from other specialist cancer services and cannot provide acute services such as intensive care for the sickest of patients. Opportunities to pursue ground-breaking innovations such as intra-operative radiotherapy are currently hampered by the physical separation of The Clatterbridge Cancer Centre's main base from other acute hospital facilities and specialist cancer services.

The key elements of the vision are:

- Development of a specialist Clatterbridge Cancer Centre on the new Royal Liverpool University Hospital site in addition to the provision of outpatient radiotherapy, proton therapy, chemotherapy services on the Wirral;
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- Maintenance of The Clatterbridge Cancer Centre NHS Foundation Trust's current range of existing network clinic arrangements across Merseyside and Cheshire for chemotherapy. The trust provides chemotherapy treatments at clinics on nine hospital sites in the region.

The Royal Liverpool University Hospital site is shared with the University of Liverpool School of Cancer Studies, Cancer Research UK and the Clatterbridge Cancer Research laboratories, forming a 'bio-campus' of innovation and collaboration. Only The Clatterbridge Cancer Centre NHS Foundation Trust remains physically isolated from this important and growing research community. By expanding The Clatterbridge Cancer Centre NHS Foundation Trust's franchise to create a comprehensive cancer centre in partnership with other research teams, all patients, including those from Wirral and West Cheshire, will benefit from greater participation in international-standard research and clinical trials.

In brief these proposals are designed to ensure that the cancer services delivered for the people of Cheshire, Merseyside and beyond are of the highest possible quality and will:

- Ensure better co-ordination of pathways of care for cancer patients by bringing together key specialist services on a single campus, which currently hosts the majority of Specialist Cancer Multi-Disciplinary Teams (SMDTs);
- Ensure that patients benefit from closer integration between the NHS and research teams within the University of Liverpool and other key research partners e.g. Cancer Research UK;
- Enable more clinical trials to be undertaken leading to new medical innovations and treatments for cancer;
- Ensure that specialist services are located in a place most easily accessible to the majority of patients so that more patients could benefit from improved access, particularly those who need repeated and regular radiotherapy for certain types of cancer and for palliation;
- Make best use of NHS resources by enabling clinical teams to work more effectively and efficiently together;
- Be a focus for innovation and knowledge in all aspects of cancer care including medicine, nursing and supportive therapies;
- Maintain those NHS Services which are best delivered in more local settings including local district general hospitals and the community;
- Ensure that the majority of patients will continue to be treated nearer to home where safe to do so.

Fuller details of these proposals along with a range of statistics in relation to cancer incidence in Merseyside and Cheshire can be found in NHS Cheshire, Warrington & Wirral Board papers at http://www.wirral.nhs.uk/document_uploads/Boardcluster-Nov/Cluster-BoardPack-02-11-2011.pdf

1.2 Cancer Incidence and Mortality in Cheshire and Merseyside

Incidence (new cases) of and mortality (death rates) from cancer represent a major challenge within Merseyside and Cheshire.

Mortality rates vary across the network. By comparing the mortality rate for each Primary Care Trust with the average for England, the number of excess deaths can be determined. This is the number of lives that could be saved each year if each Primary Care Trust's mortality rate was the same as England.

The excess deaths by Primary Care Trust against the English average are presented below.

Excess Deaths due to Cancer

Annual number of cancer deaths over the England average mortality rate (annual average 2006-8)

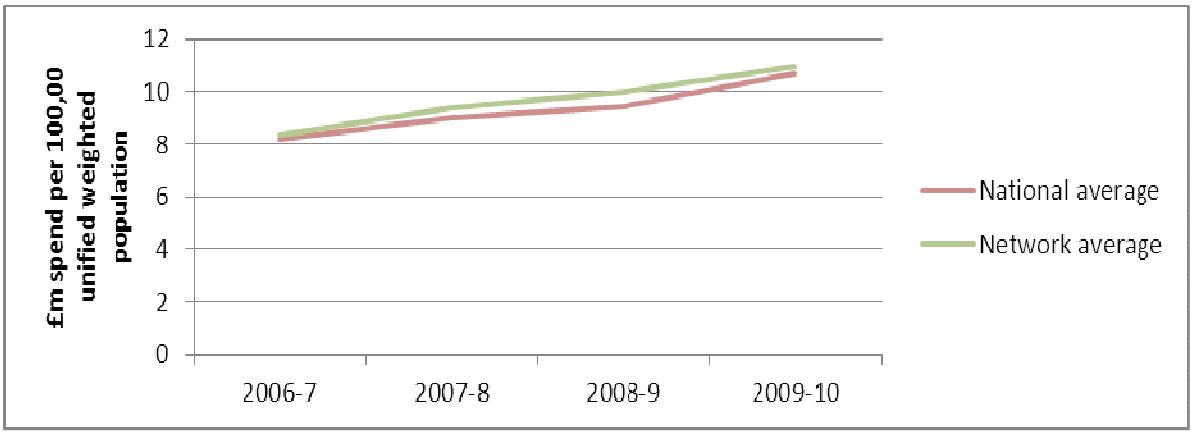
Primary Care Trust	Excess deaths per year
Liverpool	343
Wirral	147
Halton & St Helens	106
Knowsley	86
Sefton	50
Warrington	30
Western Cheshire	15
Central and Eastern Cheshire	-76

For all cancers combined, the incidence of new cancers and cancer mortality rates across the network are higher than the national average.

It is important to note that cancer is now the biggest single cause of death in Cheshire and Merseyside, overtaking cardio-vascular disease.

Given the size of the challenge that cancer presents to the population of Merseyside and Cheshire – the population with the highest death rate from cancer in England – investing in improved access, improved specialist services, improved opportunities for research and innovation are considered to be key priorities.

Fig 3. Spend on all cancers 2006 to 2010



1.3 Benefits for patients living in Wirral and Cheshire

In making the above recommendations it is recognised that certain patients will have to travel further for certain elements of their care. However, it is important to emphasise that radiotherapy and chemotherapy services would continue to be provided on the original The Clatterbridge Cancer Centre NHS Foundation Trust site. Outpatient radiotherapy services for patients with more common cancers such as breast, prostate and lung would continue to be provided by Clatterbridge on Wirral, and the trust will continue to provide outpatient chemotherapy for the majority of cancer types locally across the region in district general hospitals, including at Clatterbridge. Only those patients who require more complex treatment, or require inpatient facilities – the minority - would be required to travel to the new Clatterbridge centre in Liverpool.

1.4 Overall Affordability of the New Centre and Funding Implications

The total cost of the proposals including VAT, has been estimated at £94.5m. There are two elements to funding this proposal:

- The capital cost to fund the proposals;
- The additional revenue funding to service the capital.

The following sources of capital have been proposed:

- The Clatterbridge Cancer Centre NHS Foundation Trust capital and prudential borrowing
- A Charitable Appeal
- Liverpool Primary Care Trust contribution, with Liverpool Primary Care Trust Board approval already given.

The above sources of capital would total £51m, with a further £43.5m to be identified. Additional revenue costs would also be incurred on current estimates. The Board at the Merseyside Cluster has recognised that these proposals should be considered as a 'once in a generation opportunity' to enhance, radically, cancer care for the people of Cheshire and Merseyside.

At their September 2011 meeting the Merseyside Board approved funding to meet the project costs to develop an Outline Business Case and one-off investment of up to £20m for the new centre.

With regard to investment from NHS Cheshire, Warrington and Wirral, the Primary Care Trusts are continuing investment in The Clatterbridge Cancer Centre NHS Foundation Trust, are allowing for anticipated increased demand for services in the future and will pay tariff costs when they are introduced. Any additional investment in local cancer services overall will need to be approved by the Clinical Commissioning Groups.

1.5 Timescales

It is estimated that the Cancer Centre scheme could open with, or shortly after, the new Royal Liverpool University Hospital in 2017. This would involve the completion and approval of outline and full business cases by the Board of The Clatterbridge Cancer Centre NHS Foundation Trust - and Monitor assessment of each - and the completion of formal public consultation. It is considered that the clinical and service case for change has been made effectively.

1.6 Stakeholder Involvement

It is vital to involve a wider range of stakeholders in the debate. It is proposed that the plans identified in this paper are shared with a wider range of stakeholders. This will ensure that people are informed about the reasons for the proposed changes and that they have an opportunity to comment on and influence these plans.

Staff in the Cheshire, Warrington & Wirral and Merseyside Clusters, supported by the Merseyside and Cheshire Cancer Network, are delivering a stakeholder involvement plan It is envisaged that this process will continue over the next 12 months. This will be followed by formal consultation when the Outline Business case is completed. More details are provided in Section Two of this document.

1.7 Recommendation

Taking account of the progress and intentions outlined above the recommendations are as follows:

a Note the background to and the progress achieved with regard to the plans for cancer services in Merseyside and Cheshire since 2008:

b Support the delivery of inclusive stakeholder involvement and engagement plans, led by NHS Merseyside and NHS Cheshire, Warrington and Wirral and in due course by the NHS Commissioning Board post April 2013.

c Note that, at the point at which a formal consultation takes place, it is expected that a Joint Overview and Scrutiny Committee for Cheshire & Merseyside will be appointed, in accordance with the 2003 Directions to Local Authorities relating to the Health and Social Care Act 2001 (appended).

Section Two: *A summary of the stakeholder communications and engagement pre-consultation plan*

2.1 Aims and Purpose of the Stakeholder Communications and Engagement Pre-consultation Plan

The purpose of this plan is to inform and engage with key stakeholders about the proposals to develop a Comprehensive Cancer Centre for Cheshire and Merseyside. The pre-consultation will be undertaken within the spirit and guiding principle that in everything we do we should be cognisant of the Government's commitment in the 2012 Health and Social Care Act, of "***no decision about me without me"*** which puts patients, service users and their carers at the centre of the decision making process.

The aims of this plan are to ensure that decisions/recommendations are informed and guided by the views of our stakeholders and patients, carers, and the public, which should in turn lead to more responsive decision-making and to services that are more appropriate.

This plan also seeks to

- Outline the objectives for communications and engagement within the project;
- Define the communications and stakeholder engagement strategic approach;
- Define the development of communications and key messages;
- Identify the stakeholder groups (key target audiences);
- Identify the channels of communications for these stakeholders;
- Plan communications and engagement activities;
- Systematically record all engagement aligned to the requirements set out in 2012 Health and Social Care Act, encompass Real Accountability standards in regard to "duty to consult"; and also the Cabinet Office Code of Conduct for public consultations;

- To ensure that all phases of the consultation will be composite, and will be compliant with the requirements set out in the Service Reconfiguration Assurance Framework 2011;
- Define the means of monitoring feedback and evaluating the success of communications and engagement.

This plan has adopted a management approach that identifies stakeholder communications and engagement as a key support function. As with any programme of work, clear, effective communications should be a fundamental consideration from the outset to ensure all key stakeholders are informed and engaged. This plan will underpin and contribute to the achievement of the above aims by using the following two key principles:

Communications as a core competency: Regarding engagement we must meet the formal expectations for full, ongoing and meaningful engagement with all stakeholders. We will wish to go further than simply what is required of us to ensure that this engagement is genuinely comprehensive and adds value to the proposals to be detailed in the Outline Business Care, and thereby contributing to the best possible outcomes.

Excellence in planning, managing and evaluating communication: We will ensure we provide feedback to those we engage regarding the outcome of what has been said, where the feedback has made an influence, and if it has not been possible to respond to it, why not.

2.2 Context for Communications and Engagement Activity

This plan supports the Strategic Overview Goup in delivering its communications and engagement responsibilities. The Strategic Overview Group is an executive group that brings together The Clatterbridge Cancer Centre NHS Foundation Trust, The Royal Liverpool and Broadgreen University Hospitals NHS Trust, Commissioners, the Cancer Network and the University of Liverpool to provide leadership for the development of proposals for the new cancer centre. There are a number of key specific documents that have informed and shaped the engagement plan:

- **Service Reconfiguration Assurance Framework, April 2011**

- **Framework for Collaborative Agreement in Managing Service Change at Regional Level**, NHS North of England

- **Major Service Change Briefing Checklist**, NHS North of England

- **Operating Framework for the NHS in England 2012/13**, Department of Health; with specific relevance to Improve Services for Patients, in one of the four key themes for all NHS organisations during 2012/13: *"putting patients at the centre of decision making in preparing for an outcomes approach to service delivery, whilst improving dignity and service to patients and meeting essential standards of care;*

- **New rules on service reconfiguration Indicative evidence requirements against the *"Four Tests"***

  Test 1 – support from GP commissioners
  Test 2 – strengthened public and patient engagement
  Test 3 – clarity on the clinical evidence base
  Test 4 – consistency with current and prospective patient choice

- **2012 Health and Social Care Act** – with specific relevance to The Case for Change in regard to ***Need for improvement.*** *"At its best, the NHS is world□leading, but there are important areas where the NHS falls behind those of other major European countries. If we had cancer survival rates at the average in Europe, we would save 5,000 lives a year".*

There is an absolute commitment to carry out the work with full engagement from all stakeholders, particularly local patients, carers, providers and staff and we plan to take an integrated approach to this.

2.3 Stakeholder Engagement

It is now vital to involve a wider range of stakeholders in the debate for change. It is proposed that the plans identified in the background section of this paper, and the real and continuing benefits for patients that these plans are designed to bring, are shared with a wider range of stakeholders immediately. This will ensure that people are informed about the reasons for the proposed changes and that they have an opportunity to comment on and influence these plans.

NHS Merseyside staff (led by Merseyside Commissioning Support Services) will work closely with colleagues in NHS Cheshire, Warrington, Wirral in having one consistent plan which is inclusive of key stakeholders throughout Cheshire and Merseyside.

The feedback from this activity will be used to inform the Outline Business Case.

Assuming a positive response to the Outline Business Case, the plan will then be built upon what will become an extensive formal consultation programme to run for a minimum of 12 weeks during 2013.

The 3 phases envisaged as engagement are:

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

As an early involvement strategy, Cheshire and Merseyside LINks were brought together in October 2011 to be informed about the proposals and to seek their support and collaboration in ensuring local people are involved in the pre-consultation activity. Representatives have acknowledged and valued this early

indicative plan and have responded positively to our request for a collaboration of approach.

Target Audiences

The approach to communication and engagement aims to be comprehensive and robust. Our aim is to work closely with key organisations that can easily communicate with a range of audiences in the area, as follows:

- Local residents;
- Patients and Carers;
- Third sector providers;
- Voluntary Patient Groups;
- Hospital Trust Members
- Hospital Trust Volunteers
- Local Involvement Networks (LINks);
- Local Council for Volunteer Service networks
- Cheshire and Merseyside NHS Cluster Boards
- Chairs and Chief Officers of Clinical Commissioning Governing Bodies
- GPs members across Cheshire and Merseyside
- Chairs of Local Medical Committees (LMCs);
- Cluster Medical Directors;
- Primary and Secondary Care Trust Communication and Engagement Leads;
- Hospital Trust Chief Executive Officers;
- Hospital Senior Operational Managers;
- Senior Consultant Cancer Clinicians
- Associated Operational Clinicians and staff
- Merseyside and Cheshire Cancer Network
- The University of Liverpool
- Local Authority Health Overview and Scrutiny Committees
- Members of Parliament for constituent localities
- NHS North of England
- Year of Action on Cancer leadership and operational group
- Local media

Engagement Channels

Stakeholder engagement will be carried out through a range of channels to promote and explain the purpose and progress of the review, including:

- Meetings
- Events/Roadshows/Local Activity Programme for 3rd sector
- Targeted letters and emails
- Newsletters/Hospital Trust publications
- Web based consultation information
- Web-based questionnaire

A matrix demonstrating reach to respective groups is detailed in Appendix 1

2.4 Key Messages

A consistent set of key messages will run through all communications. These messages are segmented into the following themes:

- Continue to focus on making sure **patients and service users** receive **high quality** care that treats illness and supports people to stay healthy;

- Support **staff** to have the **skills and knowledge** needed to provide modern, responsive and consistently high quality care;

- Make sure **organisations**, and contractual arrangements between commissioner and providers, are focused on supporting this.

It is vital that we are absolutely clear why these changes are important, what they are about, what was the outcome and that we are consistent in communicating this in all programme activities as well as any formal communications outputs and consultation activities.

The following key messages will be covered in all communications to all key stakeholders:

- The need for change
- Why is this a local priority
- Who will it affect
- What are the benefits
- What are the risks
- What does this means to local people and services
- How it will be implemented
- What are the timescales
- What can you influence
- What are your views on this proposal

2.5 Milestones

This plan is delivered in the context of a changing NHS. In order to be effective in our communications and engagement we may need to adapt this plan over time to reach our target audiences in the most effective way. Progress against the key milestones will be monitored.

- Pre-Consultation
- Consultation
- Post-Consultation

APPENDIX 1 Stakeholder Engagement Matrix Model

Stakeholder Group	Level of Interest (1-5)	Level of Influence (1-5)	Communications / Engagement Channels	Methods of Communication/Engagement				
				Meetings	Events Roadshow Targeted Activity	Briefings Email Letter	Newsletter	Local Media
Patient and Public Groups	4	4	• Cheshire and Merseyside LINks * • Members of the public • Patients / Carers • Trust volunteers • Trust Members • Trust Fundraisers • User and patient groups: o Outreach provision provided by CCC at Hospital Trusts	**X**	**X** **X** **X** **X** **X** **X** **X**	**X** **X** **X** **X** **X** **X** **X**	**X** **X** **X** **X** **X** **X** **X**	**X** **X** **X** **XX** **X** **X** **X**
Community & Third Sector	4	3	• Providers • Council for Voluntary Service Networks • Community Volunteer Groups •	**X**	**X** **X** **X**	**X** **X** **X**	**X** **X** **X**	**X** **X** **X**
Commissioners	5	5	**NHS Cluster Boards** o Cheshire, Warrington & Wirral o Merseyside o Medical Directors **Clinical Commissioning Boards** o Chairs o Chief Officers o GP Members	**X** **X** **X** **X** **X**	 **X** **X** 	**X** **X** **X** **X** **X**	**X** **X** **X** **X** **X**	

Stakeholder Group	Level of Interest (1-5)	Level of Influence (1-5)	Communications / Engagement Channels	Methods of Communication/Engagement				
				Meetings	**Events Roadshow Targeted Activity**	**Briefings Email Letter**	**Newsletter**	**Local Media**
			○ Chairs of LMCs **Communication and Engagement Leads** ○ Clusters/MCSS ○ Hospital Trusts (RLBUH/CCC)	**X** **X** **X** **X**		**X** **X**	**X** **X**	
Hospital Trusts	5	4	• Strategic Operational Group • Chief Executive Officers • Cancer Clinicians • Non-medical professionals • Senior Operational Managers	**X** **X** **X** **X** **X**	**X**	**X** **X** **X** **X** **X**	 **X** **X**	
Merseyside & Cheshire Cancer Network	5	4	• Leadership and Network representatives	**X**	**X**	**X**	**X**	
The University of Liverpool	4	4	• Leadership & Research Associates	**X**		**X**	**X**	
Health Overview and Scrutiny Committees (HOSCs) /	3	3	• HOSCs Chairs / Local Councillors for Cheshire and Merseyside	**X**	**X**	**X**	**X**	

Stakeholder Group	Level of Interest (1-5)	Level of Influence (1-5)	Communications / Engagement Channels	Methods of Communication/Engagement				
				Meetings	Events Roadshow Targeted Activity	Briefings Email Letter	Newsletter	Local Media
Elected Members								
MPs	3	3	• Cheshire and Merseyside	**X**	**X**	**X**	**X**	
NHS North of England	3	3	• NHS North of England – Service Reconfiguration & System Management	**X**		**X**	**X**	
Other	4	4	• NHS Gateway • National Clinical Advisory Team (NCAT) • Year of Action on Cancer Group	**X** **X** **X**		**X** **X** **X**	**X** **X** **X**	
Media	5	3	• Communications leads Hospital Trusts • Local press targeted advertisement via press release			**X** **X**	**X**	**X** **X**

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Equality Analysis

Once completed please return to Tony Wheeler, Equality Analysis Advisor, Email: tony.wheeler@cecpct.nhs.uk to help you to complete this sheet study the EQIA toolkit developed for use by staff in the Cheshire, Warrington & Wirral cluster. If you are from these areas you will need to use information from the following Websites:-
Western Cheshire WWW.wcheshirepct.nhs.uk/ Wirral: WWW.Wirral.nhs.uk/ Warrington: www.warrington-pct.nhs.uk/ Central & Eastern Cheshire: WWW.cecpct.nhs/uk/

Stage 1 – Scope of Work

Piece of work being assessed:	**Cancer Services**	
Directorate:	Corporate	
Service area:		
Other partners or stakeholder:	*MCCN, NHS Merseyside, CCC, RLBUHT*	
Name of lead or person:	*Martin McEwan*	
Date of assessment:	August 2012	
Aims of the piece of work (policy / project / framework etc)	*Reconfiguration of cancer services*	
Expected outcomes as a result of the piece of work, and how they will be measured:	*Improvement in cancer outcomes, measured using morbidity and mortality data*	

Stage 1 – Initial EQA Screening					
Protected characteristic	**Baseline Data and research** What national data is available? What local data is available? What information is available relating to this specific area. Number of young people using a service etc. What does it show? Numbers involved (quantitative data), comments from people (qualitative data) Are there any gaps? Include consultation with users if available, comments, feedback from patients, users etc.	**Likely differential** (from the analysis of data and research?) Is the service being used by all groups the same or one group more than others?	Is the piece of work **direct** or **indirect** discrimination (or not applicable?)	**If indirect discrimination:** and is this justifiable? Indirect discrimination is when a service effect one group more than others but accidentally	**If direct discrimination:** People are openly discriminated i.e. no blacks No gypsies, No disabled people.
SEX	Population of Cheshire is 446,600. On average 49% are male. 51% are female. How many males/females are involved in your service area? How many males/females use the service? Is this figure comparable to Cheshire figures? http://www.homeoffice.gov.uk/equalities/equality-government http://www.equalityhumanrights.com/	A full EA has been commissioned by NHS Merseyside to consider any likely differential effect of this development on this group			
Race	2005 mid year estimate majority of population 94.6% are white British (Cohesia report 2008 Report) and 5.42% of population are non white. The highest number of Non White residents is within the Macclesfield (Dean Row, 11.59%, Hough (9.1%, Morley and Styal (7.1%) and Crewe/Nantwich (St Johns (8.48%, Minshul 6.74%) Boroughs. Gypsy and Travellers- At the last count (July 2006) the boroughs of	As above			

	Congleton (125**), Information came from Cheshire Partnership Area Gypsy Number and location of Gypsies and Travellers** http://www.homeoffice.gov.uk/equalities/equality-government				
Disability	2001 Census data informed Cheshire county Councils DES, Disability and LTI 10 million people in the UK with a disability. Disability includes people with physical sensory or learning disability. UK: 18.2%, NW: 20% , Cheshire: 17.4% Vale Royal: 17.3% Crewe/Nantwich: 17.1% Macc: 15% Congleton: http://www.direct.gov.uk/en/index.htm	As above			
Sexual Orientation	Lesbians, gay men and bi sexual people (LGB) make up to 5-7% of the UK population (Dept of Trade and Industry, 2003). It is estimated that 1 in 5 people living in Great Britain is homosexual or bisexual (National Audit Office, Delivering Public Services to a Diverse Society, 2004). This equates to approximately 40,000 people in Cheshire. Are services accessible to LGB people http://www.stonewall.org.uk/	As above			

AGE	THE POSITION IN CHESHIRE AGE For the Cheshire area the 2001 Census data showed; 0-4 5.63% 5-7 3.68% 8-9 2.63% 10-14 6.5% 15 1.26% 16-17 2.4% 18-19 2.07% 20-24 4.77% 30-44 22.4% 45-59 20.7% 60-64 5.4% 65-74 8.97% 75-84 5.75% 85-89 1.29% 90+ 0.6% Cheshire East has an older population of around 360,800 residents.breakdown of ages:- Male 70 –79 =13,000 Women 70 -79 = 15,500 Men 80 – 84 = 3,700 Women 80 – 84 = 5,800 Men 85+ = 2,600 Women 85+ = 5,800. The mid years estimates of 2007 show more people are living longer in Cheshire. • Although only a small group within Cheshire, over half of mixed ethnic groups were aged between 0-15 = (51.1%). In the mid year estimates of 2007 the proportion for all ethnic groups in Cheshire were = 19.7%. • Black or black British ethnic groups had the highest proportion of people aged 16-64 = (77.0%). • White ethnic groups had the highest proportion of people aged 65+ = (16.9%). Info From Cheshire East Census 2001 Age Groups http://www.homeoffice.gov.uk/equalities/equality-government http://www.ageuk.org.uk/publications/	As Above			

Religion/ Belief	Cheshire area the 2001 census showed; Christian - 80% Buddhists - 0.16% Hindu - 0.15% Jewish - 0.12% Muslim - 0.36% Sikh - 0.05% Other religion - 0.15% No religion - 11.84% Not stated - 6.67% How many people from the different religions are involved in your service area? How many people from the different religions are involved with or use the service? Is this figure comparable to Cheshire figures? http://www.homeoffice.gov.uk/equalities/equality-government	As Above			
Marriage & Civil partnership	**Has been found in response to other questions,** 25 civil partnerships were formed during 2011 in Cheshire East, and over 1,400 couples were married. This information was gathered from Superintendent Registrar Crewe Register Office. tel 01625 374049 www.yourceremony.org.uk	As Above			

Gender Re-assignment	It is estimated that in Cheshire 30 people per year go through gender re-assignment on average 1/12,000, males–transgender from male-to-female. 1/33,000, females–transgender female to male GIRES (Gender Identity Research & Education Society) We are aware of High suicide rates amongst transgender people & mental health problems http://www.gires.org.uk/sprevalence.php	As Above			
Pregnancy & Maternity	723,165 Live births (numbers and rates): quarter of occurrence, 1992-2010 England & North Wales 706,248 Live Births 2009 3,688 Still Births 2009 2009 All 3,081 Asian 418 Black 288 White 1,981 Mixed, Chinese & any other ethnic group 220 Numbers Not stated 174 It is also identified that Gypsy/ Traveller have the Highest mortality rate. Gypsies and travellers face the most serious disadvantages of all ethnic minority groups. Children have high mortality rates and the lowest educational attainment http://www.ons.gov.uk/ons/index.html http://www.homeoffice.gov.uk/equalities/equality-government	As Above			

Stage 1 – Initial EQA Action Plan

Having undertaking the equality analysis, please complete the following action plan detailing how you will tackle and mitigate issues resulting from the findings of the Initial Screening:

Equality Strand	Issue – Initially identified	What information do I need and how will I get it? Consultation, Focus group, Survey, Research etc	Timescale	Lead
Sex	The full EA commissioned by NHS Merside will include recommendations of actions to mitigate any issues resulting from the screening.			
Race				
Disability				
Sexual Orientation				
Age				
Religion/Belief				
Marriage & Partnership				
Gender Reassignment				
Pregnancy & maternity				

After the completing the Action Plan please send the form to Tony Wheeler, Equality Impact Advisor, Email: tony.wheeler@cecpct.nhs.uk

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WIRRAL COUNCIL

WIRRAL HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

10TH SEPTEMBER 2012

SUBJECT:	Vascular Services in Cheshire and Merseyside
WARD/S AFFECTED:	All
REPORT OF:	Martin McEwan Director of Communications & Engagement NHS Cheshire, Warrington & Wirral
KEY DECISION? *(Defined in paragraph 13.3 of Article 13 'Decision Making' in the Council's Constitution.)*	NO

1.0 EXECUTIVE SUMMARY/UPDATE

1.1 The Boards of both NHS Merseyside and NHS Cheshire Warrington and Wirral have approved the final decisions on the Vascular Services Review.

1.2 The Boards each agreed the following decisions:

- that there should be 2 Arterial Centres for Cheshire and Merseyside
- that the North Merseyside centre should be based at the Royal Liverpool Hospital
- that the South Merseyside centre should be based at the Countess of Chester Hospital
- that for those patients in mid-Mersey who would previously have been referred initially into Whiston Hospital, there will be options to be referred to either centre.

1.3 The North Mersey network will be implemented from 3 September at the Royal Liverpool University Hospital NHS Foundation Trust. The South Mersey network is preparing for implementation on 1 April 2013, with the arterial centre based at the Countess of Chester Hospital NHS Foundation Trust. In this context a copy of a recent letter from the Chief Executive of Wirral Hospital Trust detailing progress on local discussions is attached for information at Appendix A.

1.4 At the time of writing, it is understood that the Joint Overview and Scrutiny Committee of Warrington, Halton & St Helens, and also Wirral Council intend to refer the decision relating to the location of the South Mersey network to the Secretary of State for Health.

1.5 Should a referral take place, the Secretary of State has the power to decide whether to accept the decision or require it to be reconsidered. It is possible that the Secretary of State may refer such a decision to an Independent Reconfiguration Panel for review, and for their advice on his decision.

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Director of Communications & Engagement
NHS Cheshire, Warrington & Wirral
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APPENDICES

APPENDIX A - Letter from the Chief Executive of Wirral Hospital Trust

APPENDIX B - Equality and the burden of vascular disease across the Cheshire Clinical Network (in place of Equality Impact Toolkit)

APPENDIX C – Addendum Equality and the burden of vascular disease across the Cheshire Clinical Network.

REFERENCE MATERIAL

NHS Cheshire, Warrington and Wirral Board Paper (CWW12-13/064)
http://www.wcheshirepct.nhs.uk/viewer.asp?docname=../data/Board_Meetings/Cluster_04072012/07042012-4July2012Board.pdf

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Health and Well Being Overview and Scrutiny Committee	8TH November 2012
Health and Well Being Overview and Scrutiny Committee	20th June 2011

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Chief Executives Office
Arrowe Park Hospital
Arrowe Park Road
Upton
CH49 5PE

Tel 0151 678 5111
Website:
http://www.whnt.nhs.uk

David Allison
Chief Executive

Direct Tel. 0151 604 7002
Fax. 0151 604 7148
PA Ext. 2630

Kathy Doran
Chief Executive
NHS Cheshire, Warrington & Wirral PCT Cluster
Quayside
Greenalls Avenue
Stockton Heath
Warrington
WA4 6HL

20 August 2012

Dear Kathy

Re: Vascular Decision

As you know we have been seeking to navigate a pathway with regard to vascular services which on the one hand delivers the benefits of critical mass sought by the vascular society and specialist commissioners and on the other hand recognises that we must ensure the sustainability of our broader portfolio and maximise the provision of services to local people. Having established the South Mersey Arterial Vascular network we have made excellent progress in the last few weeks in shaping an appropriate solution.

I am pleased to report that at the meeting of the South Mersey Arterial Network Board on 16 August 2012 Wirral, Warrington and Chester NHS Foundation Trusts were able to fully endorse the so-called 'Option 3' model which I believe best protects the interests of the spoke hospitals whilst recognising the benefits of a vascular centre (hub) based at Chester. In essence 'Option 3' describes a model where all aortic and carotic surgery goes to the centre at Chester but with amputations, upper and lower limbs surgery, diabetic feet and others (eg: ulcers) remaining at the Spoke Units. Day case and all outpatients will stay at the local sites. Complex lower limb bypass surgery and all emergency or urgent admissions with an acute problem will transfer to Chester for treatment.

Clearly there is still considerable work to be done on practical implementation. One of the key points will be that of Interventional Radiology support across the network, but with the decision today we have a real opportunity to ensure a network approach on all of Interventional Radiology across the 3 hospitals of Wirral, Chester and Warrington. To assist in the implementation we have established two sub-groups of SMART, one leading on IR and the other on Finance so that issues of income, cost and risk sharing can be fully addressed.

With regard to communication we are in the process of pulling together a common SMART script which each of the three constituent Foundation Trusts can use and tailor for their specific communication needs but ensures a consistent message. Mrs Sue Green is leading this exercise on our behalf.

This is an extremely good outcome. I can confirm that from a Wirral University Teaching Hospital perspective that this has the support of the Trust Board, Executive Team, Hospital Management Board and the majority of our Vascular surgeons. On this basis the South Mersey Arterial Network has an agreed way forward with a target implementation date of April 2013.

I believe that this is a pragmatic, positive outcome for all concerned and on this basis am happy, along with the Wirral University Teaching Hospital Vascular Surgeon representation, to fully participate in whatever stakeholder engagement you feel may be appropriate.

With best regards

David Allison
Chief Executive

cc: P Herring – Chief Executive – Countess of Chester Hospital NHS Foundation Trust
M Pickup – Chief Executive – Warrington and Halton Hospitals NHS Foundation Trust
M Carr – Chairman – Wirral University Teaching Hospital NHS Foundation Trust
S Green – Director of HR / OD – Wirral University Teaching Hospital NHS Foundation Trust
G Doherty – Chief Operating Officer – Wirral University Teaching Hospital NHS Foundation Trust
E Moore – Acting Medical Director – Wirral University Teaching Hospital NHS Foundation Trust

NorthWest Public Health Observatory

liverpool JMU Centre for Public Health

Equality and the burden of vascular disease across the Cheshire Clinical Network.

Contents

Executive Summary

This report, commissioned by the Cheshire Clinical Network, provides information regarding the burden of vascular disease across the network in order to inform an Equality Impact Assessment. An Equality Impact Assessment is a necessary step for all public bodies considering a redesign, reconfiguration or development of services, to demonstrate that they have met the equality duty placed upon them by the Equality Act 2010.

A review of vascular services across Cheshire and Merseyside Vascular networks has recommended the reconfiguration of vascular services around a designated specialist centre. This report analyses hospital, mortality and primary care data across three Primary Care Trust footprints (Wirral, Western Cheshire and Warrington), to establish where the burden of disease lies in the context of identifying a suitable location for the specialist centre.

The report identifies that Wirral experiences the highest volume of disease across most measures, and that it also has the largest population. Warrington has the smallest population but for some conditions such as Coronary Heart Disease, the proportion of deaths and age standardised rate of hospital episodes is higher for Warrington than for Wirral, suggesting that Warrington may experience a relative disadvantage in health status and outcomes[a]. Western Cheshire generally lies between the two other areas across most measures. The report also identifies that a geospatial analysis could assist the determination of the specialist centre but argues that this component is less significant than in cases where travel time or distance has a greater influence of service take-up or health outcomes (such as emergency medicine or General Practice).

The report concludes that overall, most protected characteristics under equality legislation will not be specifically disadvantaged by the determination of the specialist centre location. However, the potential disadvantage Warrington currently experiences in health-related outcomes may have particular relevance to the protected characteristic of age. The report recommends that commissioners should decide whether this apparent inequality in health status and outcomes is sufficiently serious to justify locating the centre away from the area with the highest volume of disease and service use. Whatever, the decision commissioners are advised to introduce measures that will mitigate any accruing disadvantage.

[a] Geospatial analysis combines statistical methods with geographic datasets

Introduction

The Equality Act 2010 was introduced to bring together the many different pieces of legislation concerning the elimination of discrimination, promoting fairness and the advancement of opportunity for all. The Act identifies the following nine protected characteristics:

- age
- disability
- gender
- gender reassignment
- pregnancy and maternity
- race
- religion or belief
- marriage and civil partnership
- sexual orientation

The Equality Duty

The equality duty, under the Act, came into force in April 2011. It states that for age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief and sexual orientation characteristics, those subject to the *general* equality duty must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relations between different groups

These are sometimes referred to as the three arms or aims of the *general* equality duty. The duty to have due regard to the need to eliminate discrimination also covers marriage and civil partnership. The Equality Act additionally provides powers for the imposition of *specific* duties through regulations. The *specific* equality duties are legal requirements designed to help those public bodies covered by the specific duties meet the general duty.

Following a government consultation, the Equality Act 2010 (Specific Duties) Regulations 2011 came into force in September 2011. These regulations promote the better performance of the equality duty by requiring the publication of:

- equality objectives, at least every four years
- information to demonstrate their compliance with the equality duty, at least annually

Cheshire and Merseyside Vascular Services Review

A review of vascular services in Cheshire and Merseyside, presented in October 2011, recommended that to provide cost effective and quality services across the area, two networks should be commissioned with one arterial centre in each network. Contingent with this recommendation, a Centre (Royal Liverpool and Broadgreen University Hospitals NHS Trust) has been designated to serve a network North of the River Mersey (the North Network). Both this and the location of a South Network Centre is subject to consultation.

Equality Impact Assessment

The Cheshire Clinical Network has commissioned this report to provide information which can form the basis of a formal Equality Impact Assessment (EqIA). EqIAs provide a framework by which public sector bodies can meet their legal obligations to show due consideration and, where necessary, elimination or mitigation of potential inequality in the provision of services to the public and their staff.

This report considers the general burden of vascular disease across Cheshire and Merseyside, any empirical evidence of the extent to which vascular disease may disproportionately affect people or communities with protected characteristics, and considers these data in the context of the legal requirements to comply with the three aims of the equality duty (i.e. eliminate discrimination, advance equality of opportunity and foster good relations).

Vascular Services and the Burden of Disease

Vascular services are provided for the planned treatment of conditions relating to the circulatory system, or affecting veins and arteries. These conditions are commonly caused by a partial or total blockage of the blood vessel or else by aneurysms[b]. Vascular services also treat blood vessel abnormalities. Health professionals who specialise in vascular disease are required in the support of other medical interventions such as dialysis, chemotherapy and trauma cases involving blood supply within the body.

It is important to acknowledge a distinction between vascular disease and vascular services. Vascular services may not have primacy over the treatment of vascular disease in all cases

[b] Aneurysms are balloon-like bulges in weakened parts of the wall of a blood vessel which can rupture, causing internal bleeding. Hereditary, disease and lifestyle factors can cause the walls of blood vessels to weaken.

and other medical services often provide the treatment of conditions involving blood vessels. These may include cardiac services, emergency medicine and neurology but the exact determination of services and their responsibilities can vary between areas. In other words vascular disease can be defined by a number of conditions but it may be that treatment for those conditions is not delivered through vascular services. For example, Coronary Heart Disease (CHD) which is a narrowing or blockage of the coronary arteries is clearly a type of vascular disease but treatment and interventions are often conducted through cardiac services. However, it is important to consider conditions like CHD in an assessment of the burden of vascular disease because a patient who is at high risk of a condition related to the blood vessels may be just as likely to present with CHD as a stroke or aneurysm. Although it is believed there is a genetic component to how conditions actually manifest[1], this area is not fully understood and therefore it is appropriate to consider all vascular diseases in relation to provision of vascular services.

The Department of Health launched a vascular programme briefing pack in 2009[2] which described that vascular disease includes CHD, Stroke, Diabetes and Kidney Disease. This programme also draws on the evidence of identified risk factors for these conditions. These risk factors include:

- age - risk increases with age
- gender – men are more likely to develop cardiovascular disease (CVD) at an earlier age than women
- smoking - smokers have a higher risk than non-smokers
- obesity – being overweight or physically inactive increases risk
- high blood pressure (hypertension) – high blood pressure increase the risk
- diabetes – those with diabetes (type 2) are at greater risk
- ethnicity – people from certain ethnic backgrounds are more likely to experience higher risks for certain conditions[3] (Figure 1)

Figure 1: British Heart Foundation Ethnicity Statistics [3, 4]

- **coronary heart disease** rates are the highest in **South Asian** communities
- **stroke** rates are the highest in people with an **African Caribbean** background
- you have a higher risk of developing **high blood pressure** if you are from an **African Caribbean** background than all the ethnic groups in the UK
- the prevalence of **type-2 diabetes** for people of **African Caribbean** and **South Asian** ethnicity is **much higher** than in the rest of the population

In the context of the Vascular Services review, it is important to understand the burden of disease as it relates to particular groups or communities and as it relates to potential ill-health. In other words, it is important to consider not just those who already have a diagnosed condition but also those who are likely to have, or may develop, a condition which is predicted by their community characteristics, lifestyle or behaviour. An analysis of the burden of disease should therefore identify both the prevalence of specified conditions and also the prevalence of risk factors associated with these conditions.

Burden of Disease Analysis

In order to understand the burden of disease, a suite of indicators is required which can provide a picture of disease across a given geography. The indicators used in this report are drawn from mortality, Hospital Episode Statistics and primary care or Quality and Outcomes Framework (QOF) data. These data can be used as a proxy for both disease prevalence and also inform understanding about service usage. Figures for the region, which are based on the North West Strategic Health Authority (NW SHA) footprint, are included where it is helpful to provide some context.

Data considerations

Epidemiological data analysis is used to understand disease and population health patterns and this makes use of rates or percentages thus allowing a comparison to be made between different areas that may have different population sizes and characteristics. However, analysis of patient numbers is also important, particularly when considering how to provide clinical services and care.

The example below (Example 1) shows how two different arguments can be made in respect of the problems faced by two fictional areas (areas A and B) by using either rates or numbers, with both options being equally valid. In considering equality it is important that both these analyses are made available so that where there is a dilemma (such as presented in the example), the right level and amount of mitigation can be applied to the decision where one or other of the populations might be disadvantaged. For this reason and where possible, analysis figures in this report include the number of incidents (e.g. deaths, hospital episodes), a Crude Rate (CR)[c] and a Directly Standardised Rate (DSR)[d]

[c] This is the number of people in an area with a characteristic as a proportion of the total number of people in that area.

Example 1: Rate versus Numbers Debate

> Population of Area A is 1000 people and 90% of that population (or 900 people) have a particular health condition. In Area B with a population of 100,000 people, 20% (or 20,000 people) have the same condition.
>
> In equality terms, commissioners have to balance the likelihood that someone will require treatment (*people are 4.5 times more likely to require treatment in Area A than Area B*) with the number of people they have to provide treatment for *(Area B has 22 times more people requiring treatment than Area A)*.

This report also includes QOF data to help understand local prevalence, however, the data should be viewed with caution as QOF is a voluntary annual award and incentive programme which relies on General Practice compliance[5].

Not all data is available on the same geography. For ease of data collection and interpretation, this report presents data based on Primary Care Trust (PCT) and Local Authority geography. Results at this geography may need to be viewed with caution since these boundaries may not be conterminous with those that define a particular local community or group with shared characteristics.

Sociodemographic Characteristics

Local population figures show that the Wirral Primary Care Trust (PCT) area has the highest population (n=308,495; Table 1), followed by Western Cheshire PCT (n= 233,324) and Warrington PCT (n=197,763). Just over 40% of the population in the South Network are served by Wirral PCT. Other demographics, such as gender and the number of people who describe themselves as Black or other Minority Ethnic group, broadly follow this trend (Table 2) with Wirral having the largest number. Population figures for the North Network area are included here to provide a reference point.

[d] A DSR is a way of comparing two or more areas by showing what the rate would be if they all had the same population structure and is expressed as *n* per 100,000 of the population

Table 1: Cheshire and Merseyside Vascular Network Demography– Total Population

Cluster	PCT	Total Population	Male	Female	All Ethnic Groups[e]	White	BME	IMD 2010 Rank
North	Halton and St Helens PCT	295,830	143,925	151,905	295,800	287,900	7,900	34
North	Knowsley PCT	149,361	71,059	78,302	149,400	144,200	5,200	6
North	Liverpool PCT	442,295	217,351	224,944	442,300	402,600	39,700	2
North	Sefton PCT	273,303	130,265	143,038	273,300	263,700	9,700	73
North	**Total**	**1,160,789**	**562,600**	**598,189**	**1,160,800**	**1,098,400**	**62,500**	
South	Warrington PCT	197,763	97,913	99,850	197,800	189,700	8,100	100
South	Western Cheshire PCT	233,324	113,849	119,475	233,300	224,700	8,800	115
South	Wirral PCT	308,495	147,154	161,341	308,500	298,000	10,600	50
South	**Total**	**739,582**	**358,916**	**380,666**	**739,600**	**712,400**	**27,500**	
Total	**Grand Total**	**1,900,371**	**921,516**	**978,855**	**1,900,400**	**1,810,800**	**90,000**	

Source: ONS 2009

Table 2: Cheshire and Merseyside Vascular Network Demography– Population relative to the total population within Northern and Southern Clusters

Cluster	PCT	Total Population	Male	Female	All Ethnic Groups	White	BME	IMD 2010 Quintile
North	Halton and St Helens PCT	25.5	12.4	13.1	25.5	24.8	0.7	4
North	Knowsley PCT	12.9	6.1	6.7	12.9	12.4	0.4	5
North	Liverpool PCT	38.1	18.7	19.4	38.1	34.7	3.4	5
North	Sefton PCT	23.5	11.2	12.3	23.5	22.7	0.8	3
North	Total	100.0	48.5	51.5	100.0	94.6	5.4	4
South	Warrington PCT	26.7	13.2	13.5	26.7	25.6	1.1	2
South	Western Cheshire PCT	31.5	15.4	16.2	31.5	30.4	1.2	2
South	Wirral PCT	41.7	19.9	21.8	41.7	40.3	1.4	4
South	Total	100.0	48.5	51.5	100.0	96.3	3.7	3
Total	Grand Total	100.0	48.5	51.5	100.0	95.3	4.7	

Source: ONS 2009

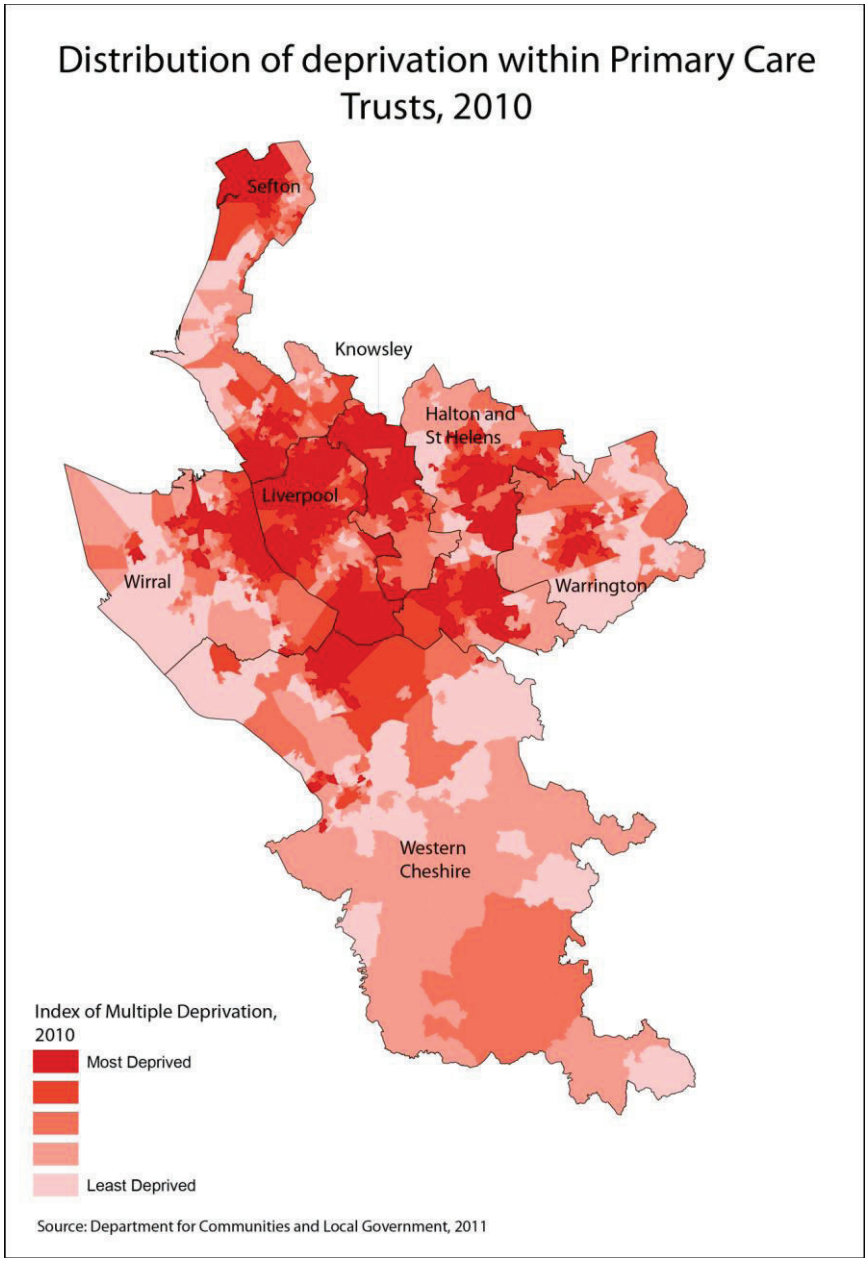
[e] Ethnic groups are based on estimates from ONS and therefore do not match total population exactly.

Deprivation

Deprivation is closely linked to health inequalities with people living in the most deprived areas having a greater risk of a variety of health problems including a higher risk of Cardiovascular Disease [6, 7]. Wirral PCT has the highest level of deprivation in the Network and is in the 4th Quintile of deprivation nationally according to the Index of Multiple Deprivation (IMD) 2010. Western Cheshire and Warrington are both identified to be in the 2nd Quintile[f]. However, analysing IMD ranking at a higher geographic level can be a blunt tool. While Warrington and Western Cheshire share the same IMD quintile rank, more detailed analysis shows that there are communities in both of these areas, who experience very high levels of deprivation but this is masked at a PCT level by a large number of very affluent areas. Similarly, Wirral has some of the most affluent areas in the Network (Figure 2).

[f] IMD Quintiles – 1 is the most affluent through to 5 which is the most deprived.

Figure 2: Map of the Distribution of Deprivation based on IMD (2010)



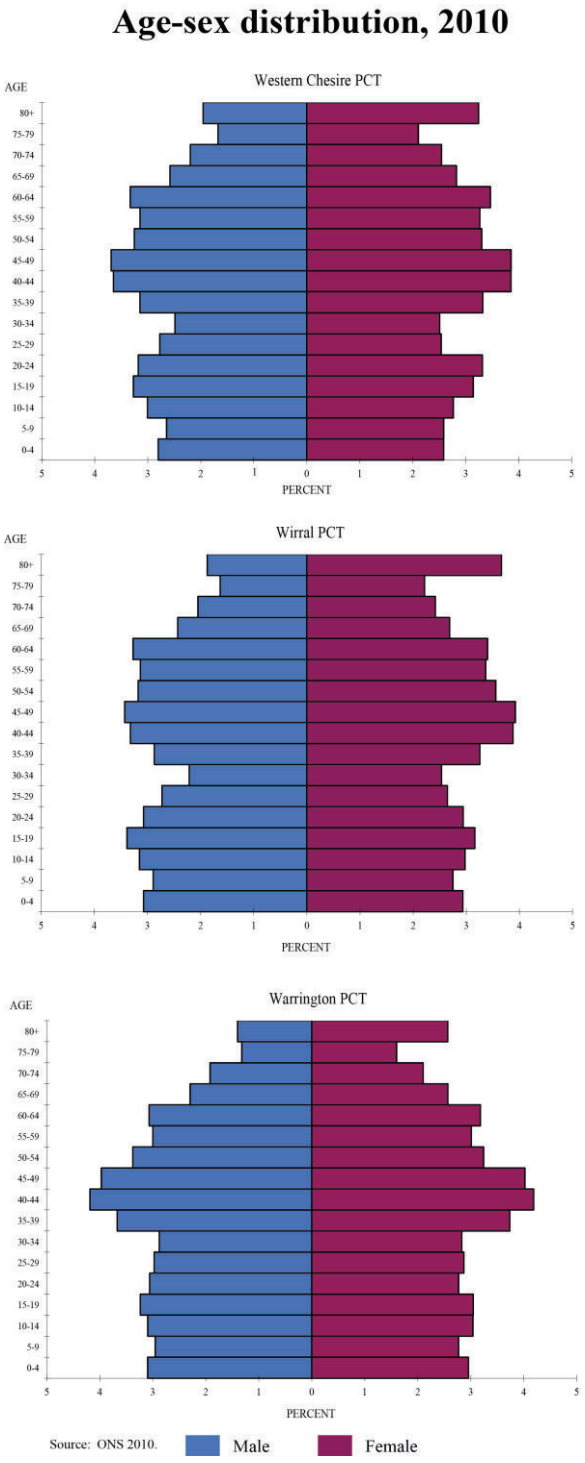
The distribution map (Figure 2) shows that there are communities in each of the PCT areas that are particularly disadvantaged. These tend to be in urban areas and are also located near to the three main hospital sites. Given that the selection of an arterial centre is tied to current hospital locations, it is clear that some mitigation will be needed to ensure that the deprived communities in those areas furthest away from the Centre can still access the service. A geospatial analysis is discussed later in this report.

Risk Factors

Age and Gender Profiles

The age-gender profiles (Figure 3) show that there are broad similarities between the profiles of Western Cheshire PCT and Wirral PCT, whereas Warrington PCT has a considerably larger population of 30-55 year olds and fewer people over 70 years.

Figure 3: Age-Sex distribution for three PCTs (ONS, 2010)



Lifestyle Profiles

Diet, exercise and smoking have all been identified as risk factors for vascular disease. Table 3 uses data from the national Health Profiles[8] to show where the burden of this general ill-health lies. Western Cheshire is identified as being the 'healthiest' area in respect of all these indicators. Wirral performs worst in respect of diet and exercise indicators and Warrington has the highest percentage of adults who smoke.

*Table 3: Selected Health Profile Indicators (Health Profiles, 2011)**

	Adults Smoking[g]	Physically Active[h]	Obese[i]	Healthy eating[j]
Warrington	22.53	11.15	22.90	27.90
Cheshire West and Chester**	20.46	13.27	22.70	28.40
Wirral	21.55	10.21	23.10	26.70
NW Region	23.42	11.25	23.40	26.20

*Each indicator in the 2011 profiles has a defined data period.

**The Health Profiles are produced on a Local Authority geography which it not always fully co-terminous with PCT geography.

[g] This is a measure of the percentage of adults who smoke 2009/10
[h] This is the percentage of adults participating in moderate intensity sport or activities on 20 days in the last 4weeks
[i] Modelled estimates of the percentage of adults who are obese.
[j] Modelled estimates of the percentage of adults who eat healthily.

Vascular Disease

Mortality

Mortality figures show the number of people who die from a given condition. The number of people who die from very specific conditions is usually small and can be unduly influenced by certification and coding practices, so data is presented here which covers only the most common causes of vascular disease-related death. More people die of vascular disease in the Wirral (n=912; Table 4a) than either Western Cheshire (n=550) or Warrington (n=439). However, this pattern is not repeated across all three main conditions. Western Cheshire has the highest number of deaths due to hypertension (n=30; Table 4a).

Table 4a: Mortality – CHD, stroke, hypertension – total deaths

Cluster	Primary Care Trust	All Deaths	CHD	Stroke	Hypertension	Total vascular mortality indicators
South	Warrington	1,792	283	148	8	439
South	Western Cheshire	2,272	306	214	30	550
South	Wirral	3,526	506	389	17	912
South	**Grand Total**	7,590	1,095	751	55	1,901

Source: NHS IC indicator portal 2012

Further analysis (Table 4b) shows that while Wirral has by far the largest number of deaths due to vascular disease it does not necessarily follow that Wirral residents are very much more likely to die of vascular diseases. Indeed, detailed analysis of the conditions shows that CHD is more likely to be the cause of death for residents of Warrington than either Wirral or Western Cheshire residents and Hypertension is more likely to be a cause of death in Western Cheshire than the other two areas.

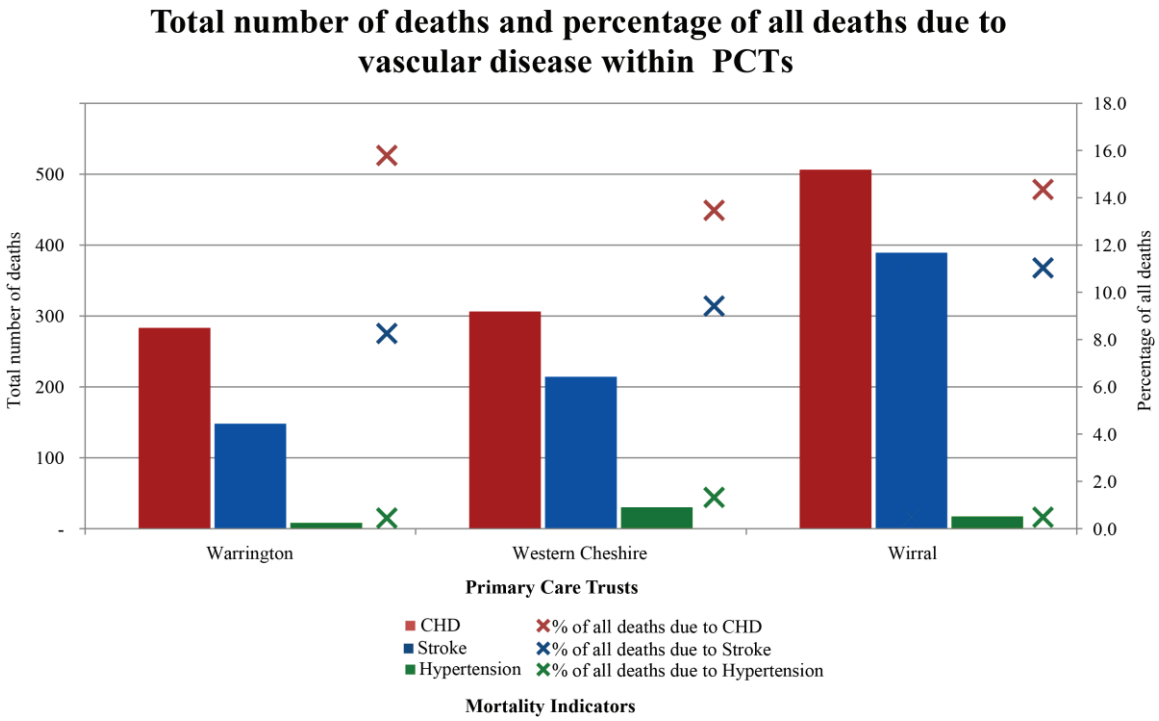
Table 4b: Mortality – CHD, stroke, hypertension – Vascular Mortality indicators as a percentage of all deaths within PCT

Cluster	Primary Care Trust	CHD	Stroke	Hypertension	Total vascular mortality indicators
South	Warrington	15.8	8.3	0.4	24.5
South	Western Cheshire	13.5	9.4	1.3	24.2
South	Wirral	14.4	11.0	0.5	25.9
South	**Grand Total**	14.4	9.9	0.7	25.1

Source: NHS IC indicator portal 2012

Figure 4a below shows how certain conditions make different contributions to the overall number of deaths in each area.

Figure 4a: Number and percentage of vascular disease deaths by PCT 2010



Source: NHS IC 2012

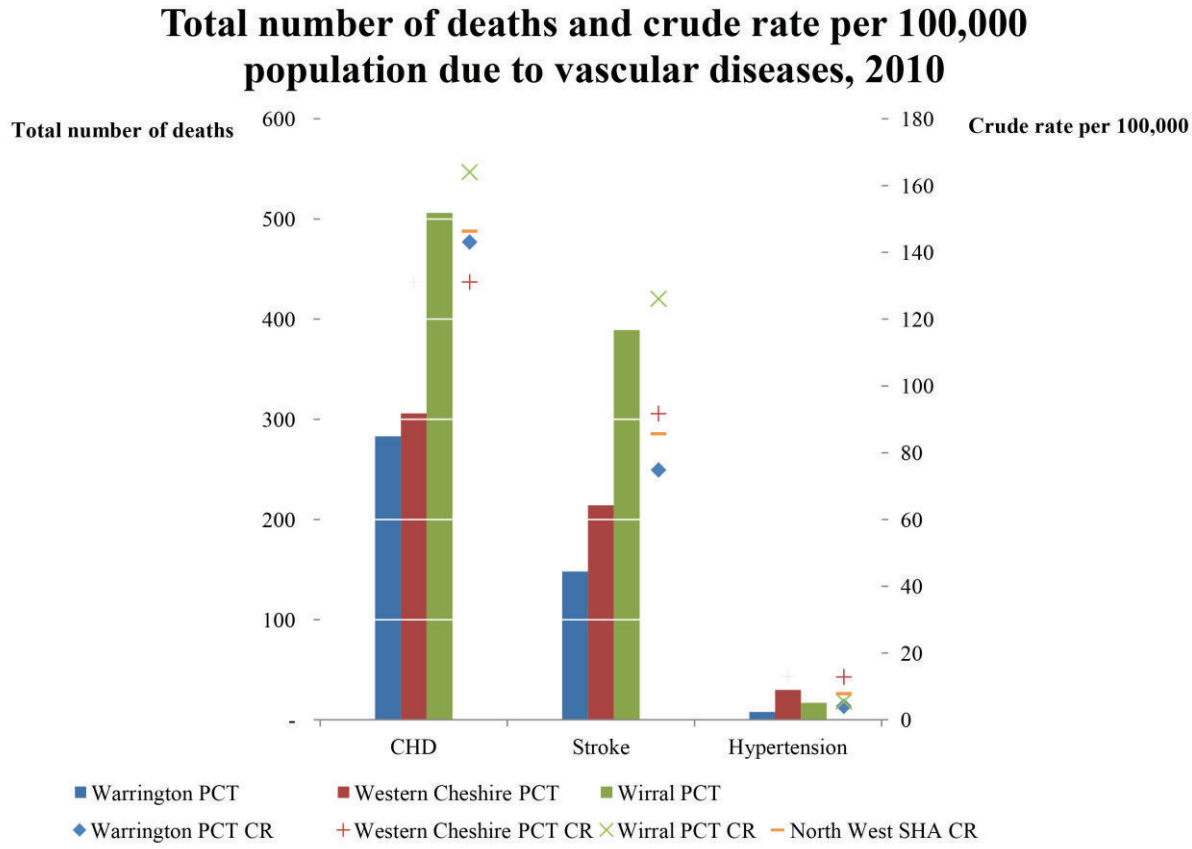
Analysis of the Crude Death Rate in each area allows further comparison as it takes into account the different population sizes (Table 4c; Figure 4b).

Table 4c: Mortality crude rates, per 100,000 population, for selected vascular mortality indicators: CHD, stroke, hypertension

Geographic region	Population	All Deaths	CHD CR	Stroke CR	Hypertension CR	Total vascular mortality indicators
Warrington PCT	197,763	906	143	75	4	222
Western Cheshire PCT	233,324	974	131	92	13	236
Wirral PCT	308,495	1,143	164	126	6	296
North West SHA	6,935,736	971	146	86	8	240

Source: NHS IC indicator portal 2012

Figure 4b: Total number of deaths and crude rate per 100,000 population due to vascular diseases 2010



Source: NHS IC Indicator Portal, 2012

These analyses do not take into account differences in the age profile. As identified earlier, Warrington has a smaller proportion of residents over the age of 60 than either Western Cheshire or Wirral and has a particularly large proportion of 35-55 year olds. It may also be that certain age groups are more likely to die from particular conditions. To assist our understanding of this it is necessary to use DSR in order to control for the fact that these areas do not have the same population age profiles with Warrington having a smaller proportion of older people. It is also important to consider not just mortality data but also morbidity[k] data to see if a similar pattern emerges.

[k] Morbidity is the incidence of a particular disease in a population and not just the number who die from the disease. It can be understood through hospital and GP attendance.

Hospital Episode Statistics[l]

Hospital Episode Statistics (HES) data for the North West were requested and extracted from the North West Public Health Observatory (NWPHO)[m]. Hospital admission data were extracted for the last five available years (2006-2010) and were collected individually for each of the following primary diagnosis codes (Table 5):

Table 5: List of HES codes used in analysis

Condition	ICD 10 Codes
Coronary heart disease (CHD)	I20-I25
Stroke	I61-I64
Hypertension	I10-I15
Abdominal Aortic Aneurysms (AAA)	I71.3 -I71.4
Carotid Stenosis	I65.2
Varicose Veins (Lower extremities)	I83-I86
Diabetes	E10-E14
Renal Failure	N17-N19

These codes were selected based on a similar draft analysis conducted in 2010 by Liverpool PCT[9]. Population data was downloaded from National Statistics online for each PCT for the period 2006-2010. As a general approach, total numbers are presented alongside crude rates and directly age-standardised rates per 100,000 individuals for each PCT. Directly age-standardised rates were calculated for the five year period for each of the condition categories. The data is standardised against the European region population (Table 6)

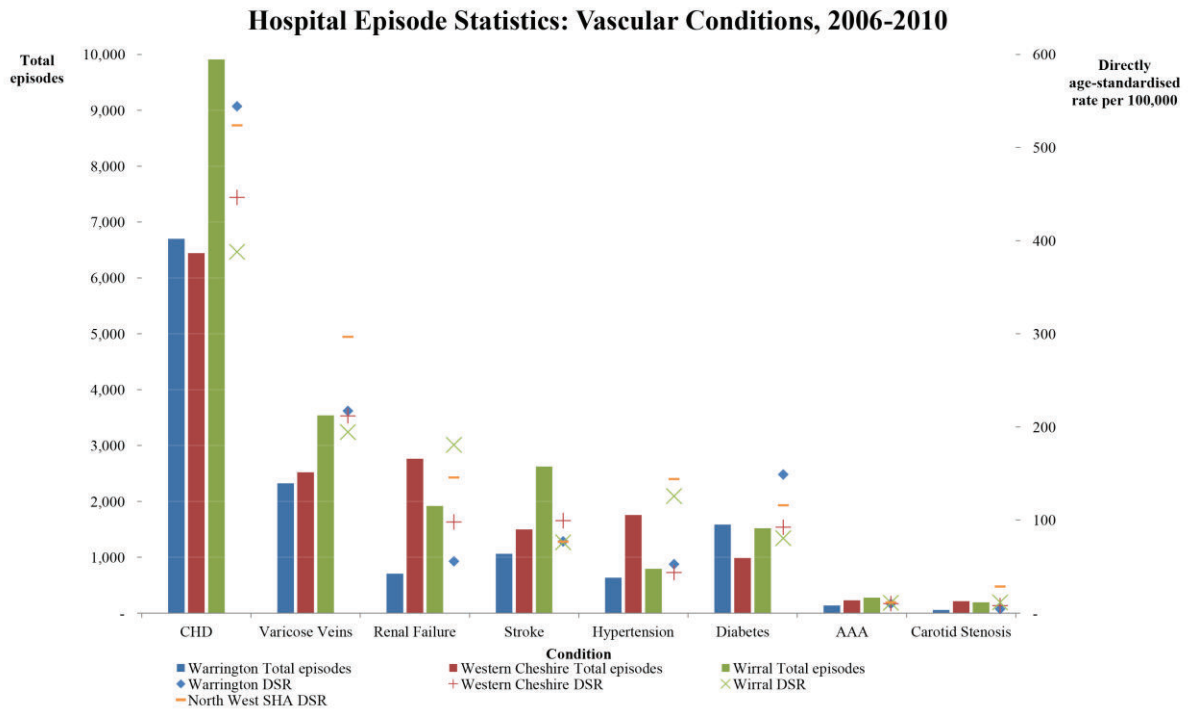
Figure 5 illustrates the total hospital episode statistics for each of the vascular conditions within each PCT. Overall, Coronary Heart Disease (CHD) was the condition that accounted for the largest number of episodes (23,053) followed by varicose veins (8,385), renal failure (5,384), stroke (5,185), hypertension (3,183), diabetes (4,089) abdominal aortic aneurism (AAA) (644) and carotid stenosis (462). Wirral contained the highest total number of episodes (20,773) followed by Western Cheshire (16,407) and Warrington (13,205). Wirral accounts for the largest number of episodes for CHD (9,909), varicose veins (3,541), stroke (2,624), AAA (277) and carotid stenosis (193). Western Cheshire accounts for the largest number of episodes for renal failure (2,761) and hypertension (1,757). Warrington accounts for the largest number of episodes for diabetes (1,586).

However, in contrast to the crude death rates, Warrington has recorded the highest directly age-standardised hospital episode rate (DSR) for CHD (544.2), varicose veins (217.2) and diabetes (148.9). Wirral has the highest DSR for renal failure (180.7), hypertension (125.7), AAA (11.1) and Carotid Stenosis (11.61). Western Cheshire records the highest DSR for

[l] Hospital data used here is the number of first finished consultant episodes (FFCE) which is considered an admission episode

stroke (99.4). In comparison to the North West SHA DSR, Warrington recorded higher rates of CHD and diabetes, Wirral recorded higher rates of renal failure and Western Cheshire recorded higher rates of stroke.

Figure 5: Total Hospital Episodes and DSR for selected conditions by PCT 2006-2010



Source: NWPHO from Hospital Episode Statistics

Table 6: Directly age-standardised rate of Hospital Episodes for vascular conditions by PCT 2006-2010

Geography	CHD	Varicose Veins	Renal Failure	Stroke	Hyper-tension	Diabetes	AAA	Carotid Stenosis
Warrington PCT	544.2	217.2	55.7	77.1	52.6	148.9	10.1	4.4
Western Cheshire PCT	446.5	211.8	97.9	99.4	43.7	92.4	10.2	8.1
Wirral PCT	388.0	194.4	180.7	76.1	125.7	80.4	11.1	11.6
North West SHA	523.9	296.7	145.6	76.8	144.0	115.8	11.6	28.6

Source: NWPHO from Hospital Episode Statistics

Quality and Outcomes Framework (QOF) Data

QOF data records the prevalence of disease as captured through primary care and in particular General Practice. Figures show that Wirral has the highest number of people on the QOF register for all the specified diseases (Table 7; Figure 6). However, as has been observed across the other data, when the analysis takes into account the population size of each area, the areas are more evenly matched.

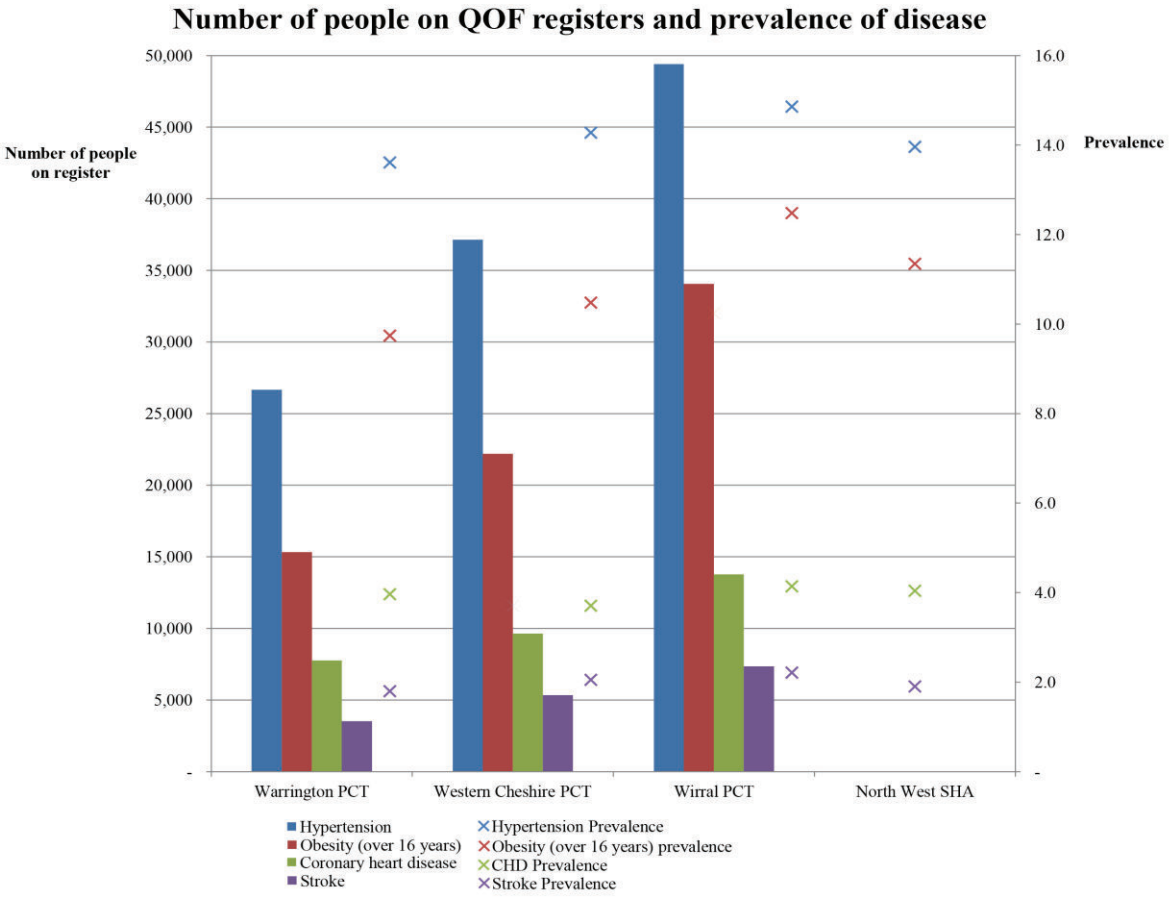
Table 7: Vascular Disease Prevalence: CHD, Stroke, Hypertension, Obesity, Diabetes – Total numbers and Prevalence

Geography		Coronary Heart Disease		Hypertension		Stroke	
	List Size	Register	Prevalence (%)	Register	Prevalence (%)	Register	Prevalence (%)
Warrington	195,885	7,768	4.0	26,663	13.6	3,523	1.8
Western Cheshire	260,193	9,647	3.7	37,149	14.3	5,339	2.1
Wirral	332,529	13,769	4.1	49,411	14.9	7,359	2.2
NW SHA	7,381,814	298,317	4.0	1,030,582	14.0	140,577	1.9

Primary Care Trust		Obesity (over 16 years)	
	List Size	Register	Prevalence (%)
Warrington	159,463	15,338	9.6
Western Cheshire	216,029	22,189	10.3
Wirral	272,867	34,063	12.5
Total	6,022,754	690,599	11.5

Source: QMS database – 2-1-/11 data as at end of July 2011

Figure 6: Number of people on QOF register and prevalence (%) by PCT



Source: QMS database – 2-1-/11 data as at end of July 2011

Vascular Disease and Protected Characteristics

Ethnicity

Table 8 displays the total vascular hospital episodes and the crude rates (CR) for White, and Black and other Minority Ethnic (BME) groups. The crude rates are based upon the 2009 population estimates from the Office of National Statistics (ONS). Due to unavailability of ethnicity population data during the five year period 2006/07 to 2009/10, it is assumed that the total population and ethnic composition has remained constant over time. Therefore, crude rates are based upon a five year total of the 2009 population and ethnic composition. 2,037 records were excluded because ethnicity was either unknown or was not stated. However, these missing values are evenly distributed across all the areas and account for only 2-5% of the total in each area.

In total, Wirral has the highest number of hospital episodes recorded as White ethnicity (19,168) and Western Cheshire contains the largest amount of BME hospital episodes (669). Conversely, Western Cheshire contains the highest crude rate (1,352) for White ethnicity and for BME (1,520). The White ethnicity crude rate (CR) is lower in all three PCTs than the North West average (North West SHA) whereas Western Cheshire records a higher BME CR than the North West average (North West SHA).

Table 8: Hospital episodes and crude rates per 100,000 population, for vascular conditions by ethnicity 2006/07-2009/10 pooled.

Geography	White ethnicity Total Hospital Episodes	BME Total Hospital Episodes	White ethnicity CR	BME CR
Warrington PCT	12,595	289	1,328	714
Western Cheshire PCT	15,189	669	1,352	1,520
Wirral PCT	19,168	441	1,286	832
North West SHA	462,440	33,079	1,463	1,151

Source: HES and ONS 2006-2010

It has already been recorded on Page 6 that there is a recognised body of evidence that ethnicity and cultural factors affect predictive risk of vascular disease, with some BME communities inheriting higher risks. This basic analysis suggests that the number and rate of episodes from BME communities is greatest in Western Cheshire[n]. While the numbers are relatively small, in order that these groups are not discriminated against it is important that

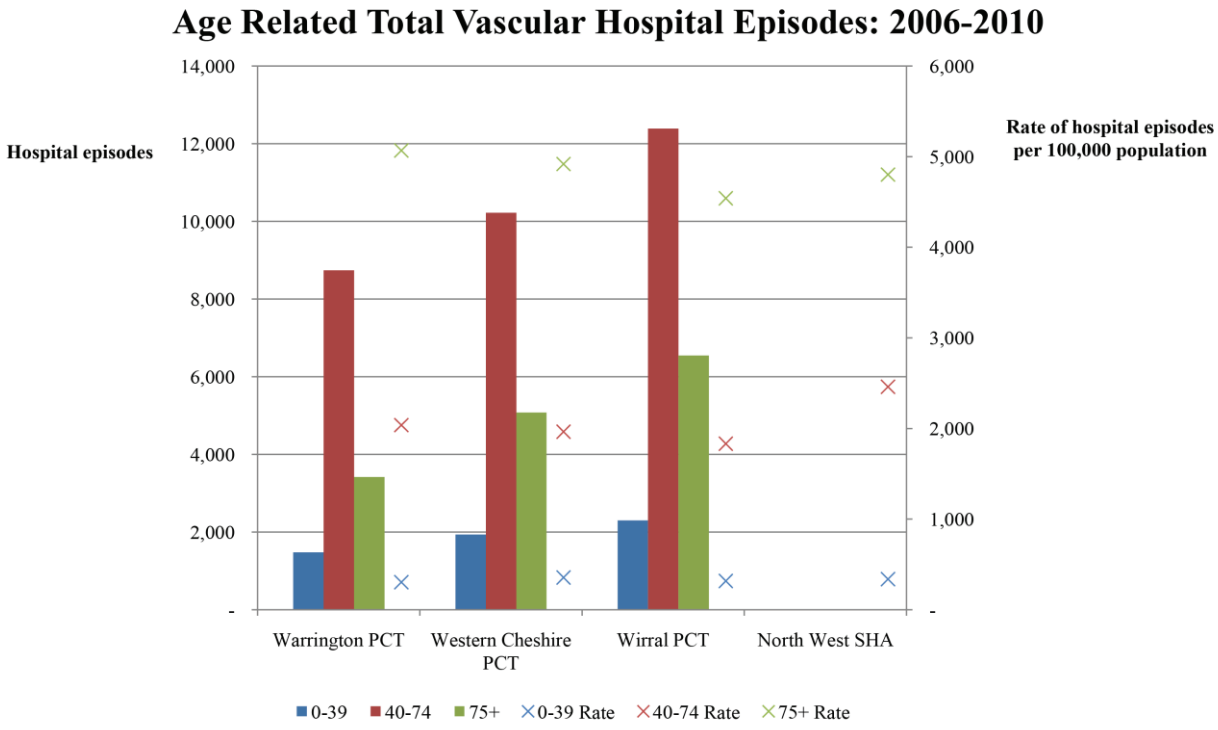
[n] BME as an umbrella classification covers many different ethnicities and therefor it is important to recognise that this is not a homogenous group.

commissioners recognise the difference in the ethnicity profile of each area and where necessary introduce appropriate mitigating steps.

Age

Figure 7 illustrates the total vascular conditions hospital episodes for three different age groups: 0-39 years, 40-74 years and 75+ years. The age group 40-74 years contains the largest number of recorded episodes (30,693), followed by the age group 75+ years (14,271) and then 0-39 years (5,384). Wirral contains the largest number of episodes for all age groups: 40-74 years (12,168), 75+ years (6,412) and 0-39 years (2,186). Warrington has recorded the highest hospital episode rate for the age groups 75+ Years (376) and 40-74 years (92) while Western Cheshire has the highest hospital episode rate for the age group 0-39 years (48). The northwest SHA recorded higher rates than the three PCTs for the age categories 0-39 and 40-74 whereas Warrington and Western Cheshire recorded higher rates than the regional average in the age category 75+.

Figure 7: Total Hospital Episodes and Hospital Episode Rate by PCT for 3 different age groups



Source: NWPHO from Hospital Episode Statistics

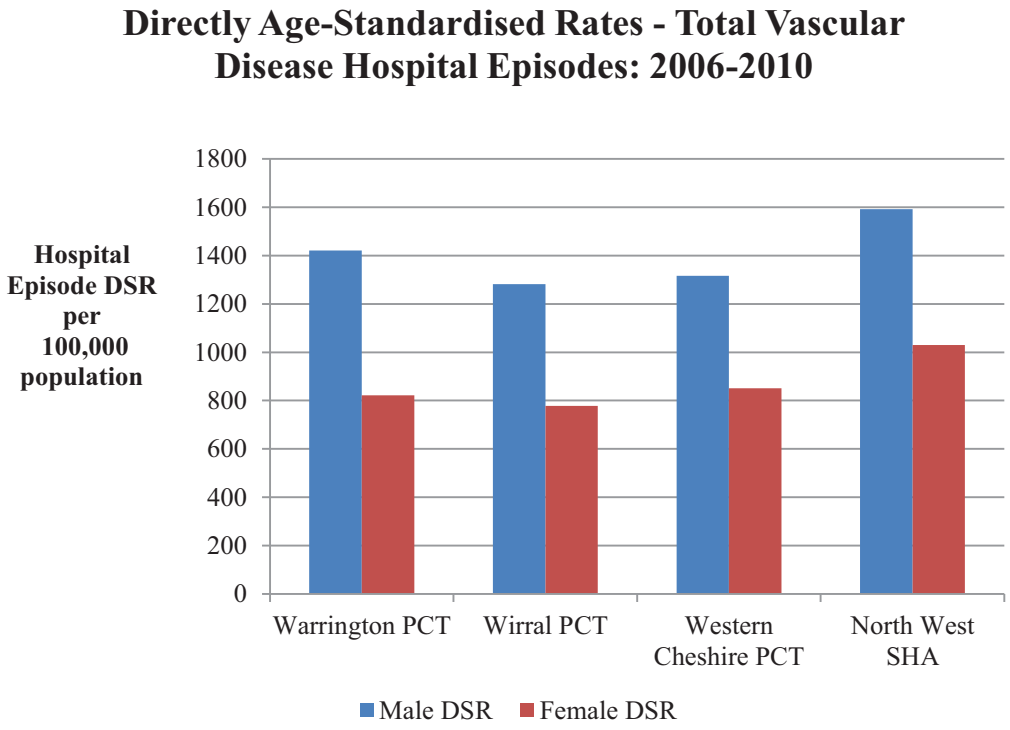
Of particular interest in this analysis is the difference in experience for the 75+ year age group. There were nearly twice as many hospital episodes in the Wirral (n=6,412) as Warrington (n=3,290). However, Warrington residents are 10% more likely to be admitted to hospital. Similarly, in the 40-74 years age group, Wirral has 43% more hospital episodes than Warrington but Warrington residents of this age group are 10% more likely to have a hospital episode than Wirral.

It is not possible to draw any absolute conclusions from this data as many factors could influence a hospital episode including for example, the accessibility of primary care and community services, the severity of the condition and the timeliness of first presentation by patients, general patient perceptions of the health care system[10]. Commissioners will want to give these figures further detailed consideration particularly as transportation and mobility access is a specific challenge for the 75+ years age group.

Gender

Figure 8 illustrates the directly age-standardised rates (DSR), by PCT, for the total number of hospital episodes primarily attributed to a vascular disease from 2006-2010. The vascular diseases included within the total are: diabetes, varicose veins, renal failure, hypertension, chronic heart disease, stroke, abdominal aortic aneurism and carotid stenosis. Across all PCTs, males have higher DSRs than females while Warrington has the highest DSR for males and Western Cheshire, the highest DSR for females. This analysis suggests that while gender is a risk factor for vascular disease and that there are differences between the areas particularly in respect of male hospital episodes it is perhaps not as important in this context as location since all three PCTs recorded, for male and females, lower DSRs than the regional average.

Figure 8: Total Vascular Disease Hospital Episodes, directly age-standardised rates 2006-2010



Source: NWPHO from Hospital Episode Statistics

Disability

There are several ways of quantitatively mapping disability across the network, such as through census data, Disability Adjusted Life Years or a variety of benefit claimant data such as Disability Living Allowance. However, disability data forms a large part of the suite of indicators that make up IMD and therefore this report uses IMD as a proxy for identifying those areas where disability incidence is high. The impact of service reconfiguration relating to IMD is discussed earlier. Mobility and the accessibility of services might be an issue for this group and a geospatial analysis is discussed later in this report. Whilst it is possible that individuals will be disadvantaged by a service reconfiguration, it is unlikely that disabled people as a group will experience any particular discrimination so long as communities in deprived areas are adequately served by any new arrangements. However, commissioners will need to familiarise themselves with the general accessibility of each potential service premises to ensure that relocation from one site to another does not result in reduced access.

Gender Reassignment

Understanding the impact of service provision for this group is difficult due to the scarcity of reliable population data.[11] Although there is some empirical evidence that long term oestrogen therapy may improve vascular function for male to female transsexuals[12], there is little to suggest that this group would be specifically affected by a reconfiguration of services so long as the generic service provision was considered non-discriminatory. Whilst quantitative data is unlikely to provide much to help predict the specific impact of service development on this group and assess potential barriers to access, if efforts are made to ensure that consultation about service development is accessible to those members of this population group and any necessary mitigations are applied based on the consultation results, then this should be sufficient to fulfil the conditions of the equality duty.

Pregnancy and Maternity

Although vascular changes occur during pregnancy and there is an increased risk of hypertension and diabetes (gestational diabetes)[13] and that this predicts an increased risk of CVD in later life[14], data does not suggest that the rate of pregnancy across the Network would impact the burden of disease in the context of equality of access to vascular services. According to the NHS Information Centre, Western Cheshire has the lowest birth rate per 1,000 female population aged 15-44 years (63.0; 95% CI 64.2-69.2)[15]. Warrington has the highest rate (66.7; 95% CI 61.1-65.0) with Wirral in the middle (66.0; 95% CI 63.7-68.3). These figures suggest there is no significant difference between the areas.

More relevant in the consideration of equality in regards to women who are pregnant or under the care of maternity services is the accessibility of vascular services in the context of transport and the quality and availability of local maternity services. This again assumes that women who are pregnant receive non-discriminatory services once they arrive at the designated arterial centre.

Marriage and Civil Partnership

There is no evidence to suggest that this protected characteristic is at risk of discrimination.

Sexual orientation

There is little available research to suggest that sexual orientation has a direct link with vascular disease although research, predominantly from the United States, has indicated that Lesbian, Gay, Bisexual and Transgender (LGBT) groups may be at higher risk of some health conditions such as cancer[16]; and also may be at higher risk of engaging in health harming behaviours such as smoking and excessive alcohol consumption[17]. In this regard, it would be acceptable to assume that as long as service provision is non-discriminatory, LGBT groups would not be significantly disadvantaged by service reconfiguration specifically in relation to their protected characteristic.

Religion or belief

It is difficult to quantitatively assess the impact of service redesign on religion or belief. Commissioners should rely on the strength of their consultation to identify any local groups at risk of unfair treatment. It is likely that any equality issue relating to religion and belief is something that local trusts are already actively engaged upon within the context of wider provision, however, in the context of vascular services, the commissioners' attention are drawn to the service needs of those who, are opposed to certain interventions (such as blood transfusions) on the basis of their religion of belief.

Geospatial Analysis

Geospatial analysis forms a significant part of many EqIAs. The location of services and the availability of public and private transport access clearly has the potential to adversely affect certain populations. For example, a service located where there is infrequent public transport access will adversely affect those most likely to use this form of transport such as people on low incomes and older people. It is possible to develop a quantitative geospatial analysis to investigate how travel might impact those groups with protected characteristics[18, 19] but it is important to consider proportionality. Whilst geospatial analysis is particularly pertinent in the provision of emergency, primary care or other community based services, for tertiary health services there is likely to be a greater tolerance of distance against the impact of non-treatment. In other words, people choosing[o] to access specialist, possibly life-saving, treatment might be less concerned about where they need to go to get this treatment. A recent study by Comber (2011)[10] has shown that distance to

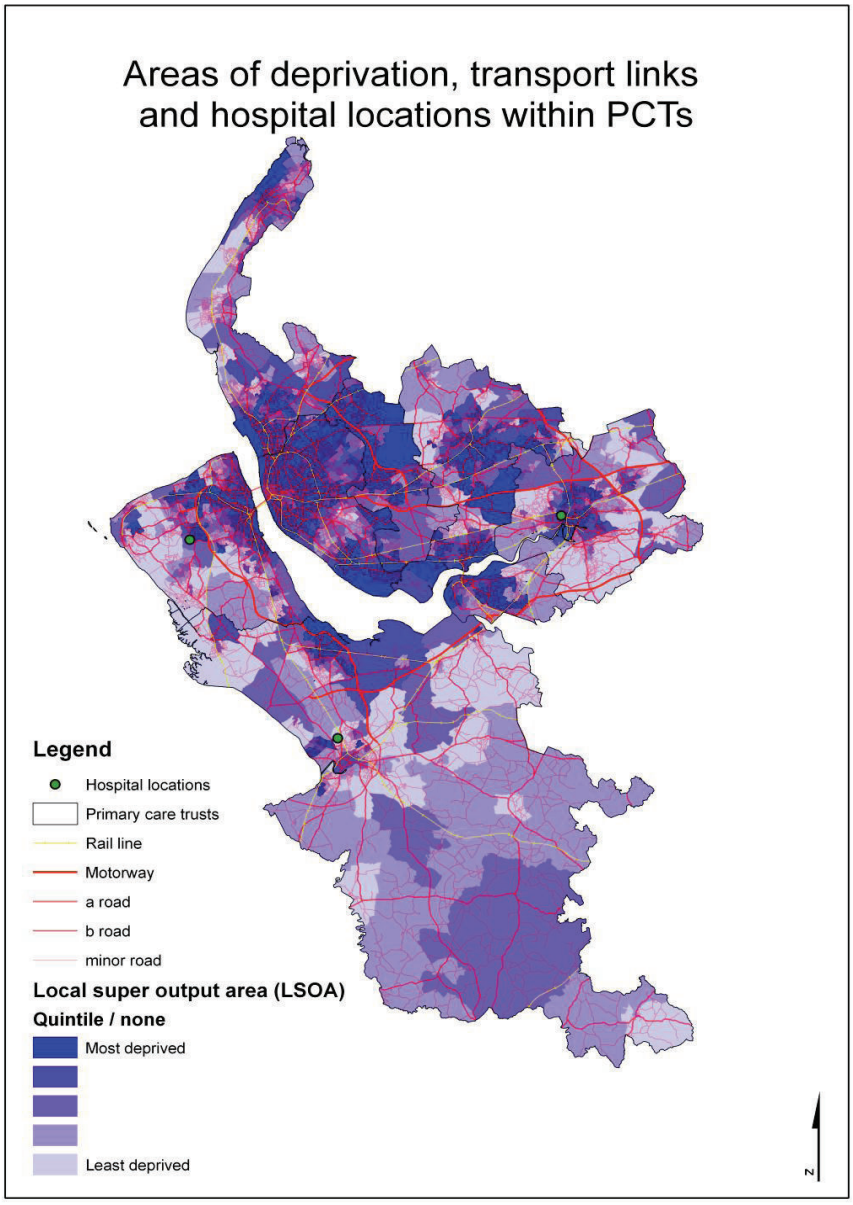
[o] This scenario makes a distinction between planned and unplanned specialist services (i.e Emergency Services)

hospital is not a good predictor of difficulty in accessing services but that car ownership is. Further the research finds that the concept of *choice* is one that underpins assessments of accessibility and that choice is governed by factors such *as "cost, previous experience, reputation (first and second hand), perceived quality of service, convenience etc."* [10] This would suggest that a geospatial analysis should not focus exclusively on distance or travel time but on transportation availability. Therefore key aspects of consideration would need to be car ownership and public transport access.

Additionally, in the context of patient choice it is important to recognise that patients may elect to receive treatment in a specialist centre that is accessible from their residence but not commissioned through the Cheshire Network. For example, it may be easier and/or preferable for residents of the Wirral to access services in Liverpool; residents in Western Cheshire to access services in Eastern Cheshire, Staffordshire and North Wales; or residents in Warrington to access those in Greater Manchester or Lancashire.

In the burden of disease analyses and also those done with specific reference to protected characteristics, it can be argued that IMD at a Lower Super Output Area level is a suitable proxy for identifying areas where potential equality challenges could arise. It has also been discussed that the nature of any potential inequality is likely to be based on transportation access to the service for the patients and their families or carers. In order to help understand the geospatial aspect of this service reconfiguration Figure 9 shows the locations of the Hospital sites in relation to transport links and areas of deprivation.

Figure 9: Map of Hospital Location, transport infrastructure and IMD 2010



Source: Department for Communities and Local Government and ONS, 2012

This geospatial analysis considers that travel distance is not a good proxy for service accessibility and therefore equality of access. However, since transport availability is related to service accessibility, commissioners may wish to consider whether a further, specialist analysis of transport availability is required.

Conclusion

This report has been commissioned to provide evidence upon which to base an Equality Impact Assessment. There are three aspects to this evidence presentation. Firstly, the report presents evidence of the burden of vascular disease across the network; secondly, the report considers research relating to the protected characteristics and vascular disease and prevalence data; and finally, the report considers the geospatial aspects of service provision.

The burden of disease analyses clearly show across several measures that Wirral has the largest number of people accessing treatment for vascular disease. However, the percentage, CR or DSR aspect of these analyses shows that it is the Warrington population, on a person for person basis, who have the greatest need for, or use of, treatment services.

In consideration of the protected characteristics, there is little evidence to suggest that any particular group or community will be specifically disadvantaged by the location of an arterial centre, providing that the centre itself maintains a high level of anti-discriminatory practice. However, the analysis of Hospital Episodes by age does appear to show a pattern of different service usage across the three areas. Whilst it is not possible to draw any definitive conclusions about the nature or reason behind the figures without further qualitative information, it does appear that the older population in Warrington make greater use of hospital services than in the other two areas and because they are also likely to be less mobile than other groups, they are a group that may be at risk of being disproportionately affected by service reconfiguration and appropriate mitigation or further investigation is recommended.

The geospatial appraisal argues that it is possible to develop a quantitative case for the arterial centre based upon figures of car ownership and public transport access. However, such analysis would require specialist input and would need to remain proportionate, given that people are likely to be more tolerate of travel in respect of attending a specialist or tertiary 'centre of excellence'.

Overall the evidence suggests that the location of an arterial centre is unlikely to have a hugely disproportionate effect on groups of individuals that have characteristics which are protected under the Equality Act. However, this is not to say that communities or individual groups will not be affected. Indeed it is very likely that there will be groups who believe that they have been disadvantaged by the agreed location of the arterial centre. Ultimately, it is for commissioners to decide how they will balance and mitigate the competing facets of the number of people requiring treatment and likelihood that someone in a given area will require treatment. This implies that commissioners would either need to identify a location that is equally accessible[p] to all populations or else make a case that either the numbers or

[p] Accessibility in this case refers to mobility and transport and not distance

the prevalence is a more important factor in service provision[q] and introduce measures to mitigate the impact on any communities potentially disadvantaged by the decision.

[q] This could be done by quantifying the economies of scale of locating close to the greater numbers or by quantifying the potential 'prevention' gains from locating near the greatest prevalence.

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NorthWest Public Health Observatory

liverpool JMU Centre for Public Health

Addendum

Equality and the burden of vascular disease across the Cheshire Clinical Network.

This addendum should be read in conjunction with the main report, published June 2012.

Contents

Introduction

Following completion of a report commissioned by the Cheshire Clinical Network to inform an Equality Impact Assessment regarding the reconfiguration of vascular services across the network, the Centre for Public Health has been commissioned to provide a short addendum relating to the inclusion of data relating to Halton residents.

The Addendum provides some basic population and health information in relation to Halton to enable commissioners to scope what impact the inclusion of this new population data might have on their Equality Impact Assessment and whether this will require action, mitigation or further investigation.

Context

The Equality and the Burden of Vascular Disease report analysed data following a review of vascular services. The review recommended the establishment of two specialist centres for the provision of vascular services - one to serve a population North of the River Mersey and one to serve a population to the South. At the time it was commissioned, the report considered a variety of data in respect of the South and the three designated geographic populations: Warrington PCT, Western Cheshire PCT and Wirral PCT. Subsequent consultation has indicated that Halton and St Helens PCT, originally considered part of the North network would see service use split across the two clusters, with Halton residents primarily accessing a service South of the Mersey and St Helens residents continuing to access the services provided in the North. This addendum considers whether the inclusion of the Halton population in the overall burden of disease analysis is likely to materially affect the conclusions of the original report.

Data Considerations

Halton and St Helens PCT formed in 2006, following the merger of two separate PCTs (Halton PCT and St Helens PCT). The Halton PCT footprint no longer exists and therefore health and primary care data is not readily available at this geography. It is possible to extract hospital episode data at a lower geographic output and aggregate this up to a Halton PCT level using the historical footprint. Similarly, it is possible to identify those GP and primary care practices that operate within the former footprint. However, clearly there would need to be caution regarding the assumptions being made by introducing this virtual boundary. Similarly the data produced at this level should not be absolutely compared with the other current PCTs (Warrington, Western Cheshire and Wirral) as population and service arrangements are unlikely to be comparable.

Halton Unitary Authority (UA) data is available and some comparisons can be made with the data that is available at local authority level for Warrington UA, Cheshire West and Chester UA, and Wirral Metropolitan County District.

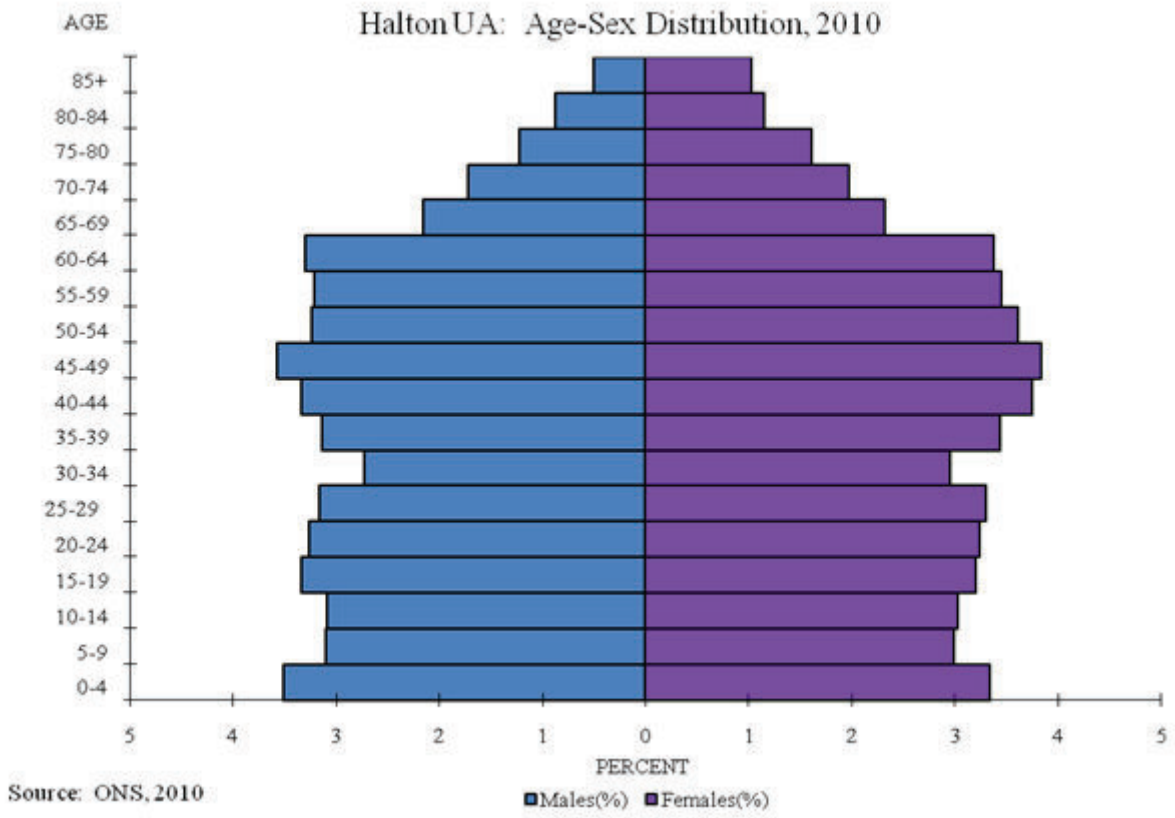
This addendum presents some of the more readily available data for consideration. Caution is advised regarding the limits of conclusions that may be drawn from presented comparisons.

Population profile

According to the Office for National Statistics (2010), Halton UA has a population of 119,263 and is one of the most deprived areas in the country. The Indices of Multiple Deprivation 2010 (IMD) identify that Halton is the 27th most deprived local authority in England.

Figure 1 shows the age-sex distribution profile for the population of Halton UA. This distribution shows that Halton has a relatively young population. Comparing this distribution with those contained within the original report it appears that this profile is considerably different from the other areas although the other area profiles are based on a PCT geography and therefore not directly comparable.

Figure 1: Age-Sex Distribution Profile for Halton UA (ONS 2010)



Deprivation

Table 1 shows that Halton is the most deprived authority in this cluster. Wirral still experiences the highest deprivation at Lower Super Output Area (LSOA) level, however, this appears to be offset at the local authority level by the number of LSOAs within the authority that have high affluence.

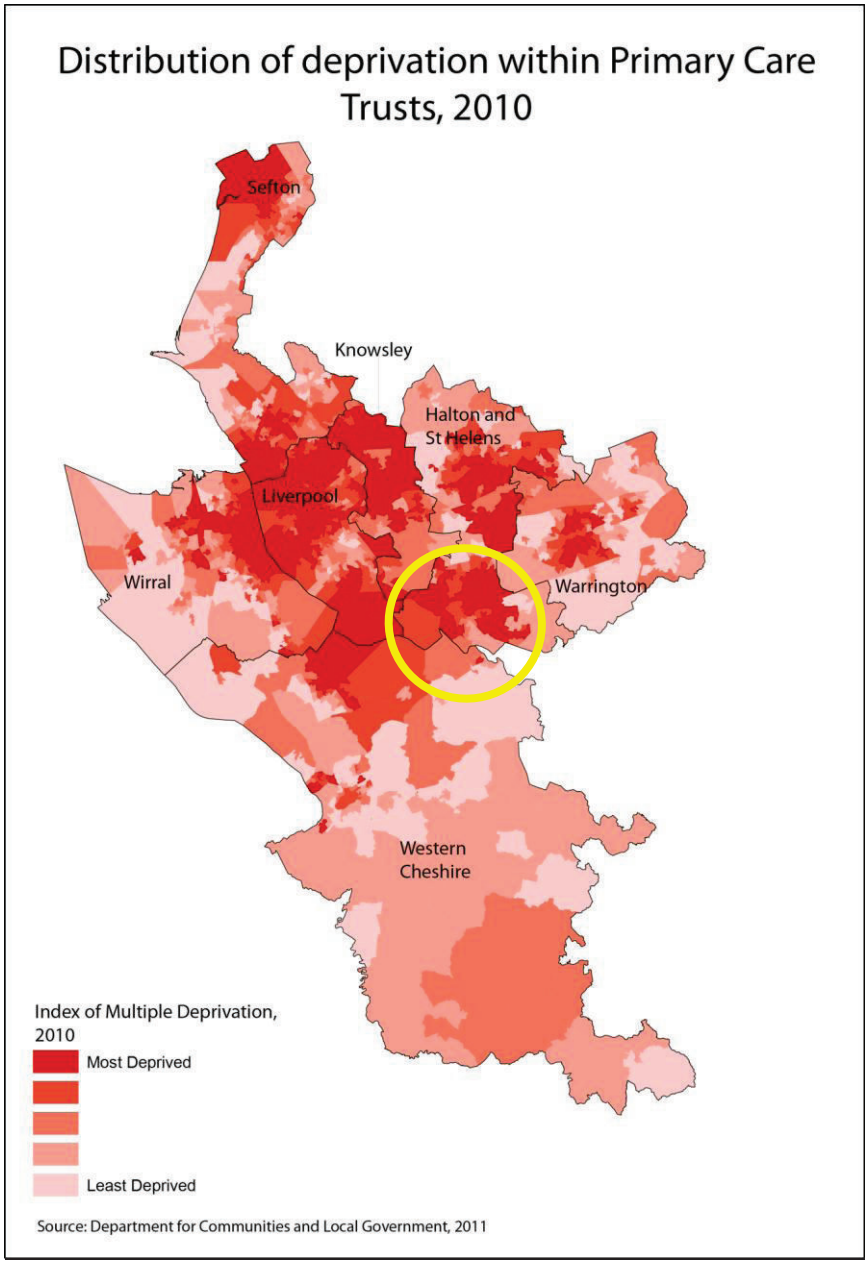
Table 1: Population and IMD scores for Local Authorities, IMD 2010

Geographic region	Population	IMD 2010 Rank of Average Score[1]
Warrington	197,763	153
Cheshire West and Chester	233,324	171
Wirral	308,495	60
Halton UA	119,263	27

Source IMD 2010

[1] IMD Score: 1 is the most deprived and 326 is the least deprived

Figure 2: Distribution of deprivation IMD 2010 highlighting Halton area



Health Profile

Table 2 shows that, consistent with its high level of deprivation, Halton UA experiences relatively poor health in comparison to the other authorities with a greater proportion of smokers; greater levels of obesity and less healthy eating.

*Table 2: Selected Health Profile Indicators (Health Profiles, 2011)**

	Adults Smoking[2]	Physically Active[3]	Obese[4]	Healthy eating[5]
Warrington	22.53	11.15	22.90	27.90
Cheshire West and Chester**	20.46	13.27	22.70	28.40
Wirral	21.55	10.21	23.10	26.70
Halton UA	26.00	12.89	25.90	22.70

*Each indicator in the 2011 profiles has a defined data period.

**The Health Profiles are produced on a Local Authority geography which it not always fully co-terminous with PCT geography

Mortality analysis

Table 3a shows the number of deaths for each area for a range of conditions. These figures are not directly comparable as the Halton figure is based on the local authority population whereas the other figures relate to PCT. Halton, with a relatively small population has much fewer deaths than the other areas.

Table 3a: Mortality – CHD, stroke, hypertension – total deaths

Geographic region	Population	All Deaths	CHD	Stroke	Hypertension	Total vascular mortality indicators
Warrington PCT	197,763	1,792	283	148	8	439
Western Cheshire PCT	233,324	2,272	306	214	30	550
Wirral PCT	308,495	3,526	506	389	17	912
Halton UA	119,263	1,106	187	81	6	274

Source: NHS IC Indicator portal 2012

[2] This is a measure of the percentage of adults who smoke 2009/10
[3] This is the percentage of adults participating in moderate intensity sport or activities on 20 days in the last 4weeks
[4] Modelled estimates of the percentage of adults who are obese.
[5] Modelled estimates of the percentage of adults who eat healthily.

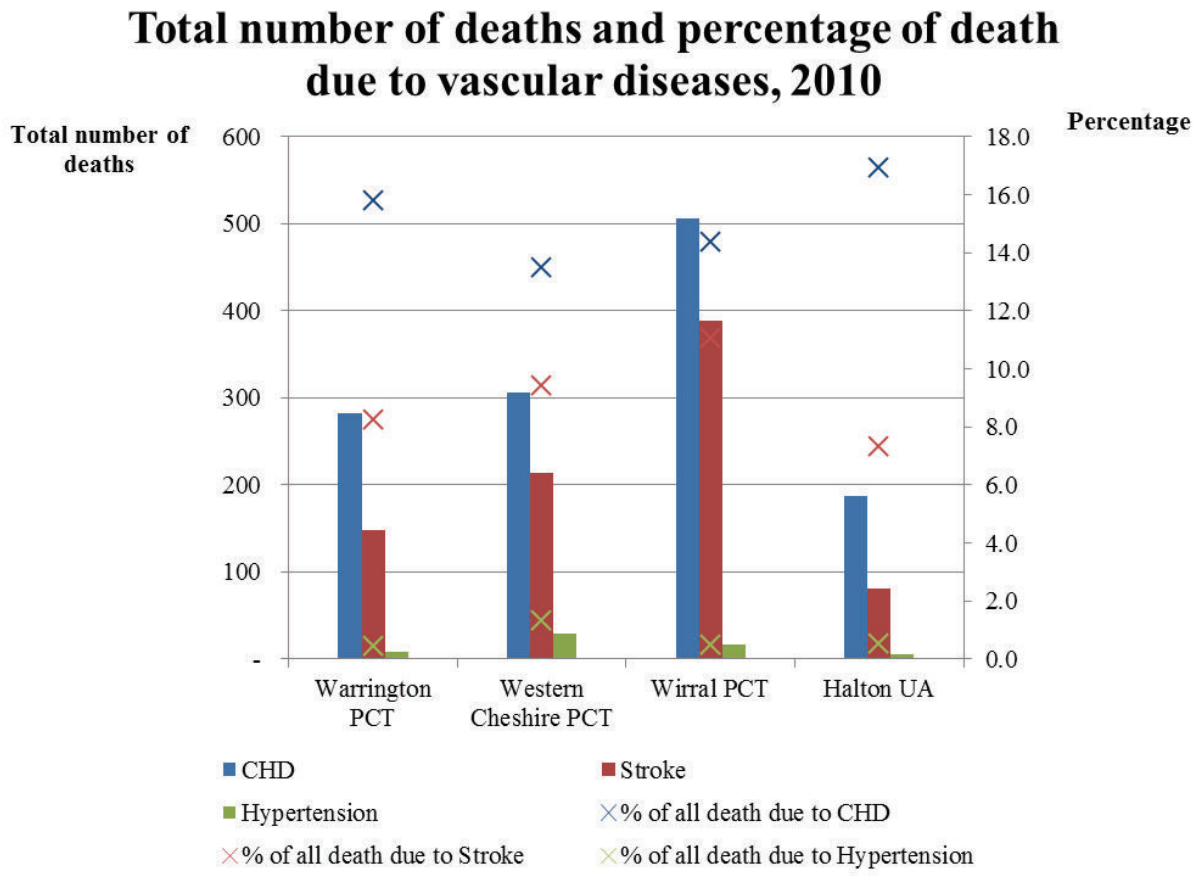
Consistent with the main report, it is important to consider not just numbers but where possible, the rates. Table 3b shows the percentage of all deaths in an area that is due to the selected conditions. While Halton has the fewer number of deaths overall, CHD is a relatively bigger problem in Halton than in any other area with 16.9% of all deaths being attributed to this disease (Figure 2).

Table 3b: Mortality – CHD, stroke, hypertension – Vascular mortality indicators as a percentage of all deaths within Geographic area

			Percentage of deaths due to vascular disease			
Geographic region	Population	All Deaths	% of all death due to CHD	% of all death due to Stroke	% of all death due to Hypertension	Total vascular mortality indicators
Warrington PCT	197,763	100	15.8	8.3	0.4	24.5
Western Cheshire PCT	233,324	100	13.5	9.4	1.3	24.2
Wirral PCT	308,495	100	14.4	11.0	0.5	25.9
Halton UA	119,263	100	16.9	7.3	0.5	24.8

Source: NHS IC Indicator portal 2012

Figure 2: Total number of deaths and percentage of deaths due to vascular diseases, 2010



Source: NHS IC Indicator portal 2012

Conclusion

This brief addendum has been compiled to scope the impact that the inclusion of Halton population data might have on the assessment of the burden of vascular disease across the southern vascular network. Although caution is urged in regards to the comparative mortality data, it is clear that Halton has fewer deaths than the other areas but CHD is a bigger cause of death in Halton than it is in the other areas.

The main report identifies that, in respect of some protected characteristics and risks associated with vascular disease, deprivation is a good proxy. Halton is the most deprived area of the four at upper tier local authority level and the general health profiles (including smoking and obesity rates) show that Halton experiences worse health overall compared to the other local authorities in the southern network. It is not within the scope of this addendum to complete a comprehensive analysis of hospital and primary care data which may describe the health inequality further.

Overall, the inclusion of Halton population data does appear to have pertinence to the general picture of disease in the network. The markedly different age profile combined with the higher deprivation and a summary comparison of mortality numbers suggests there could be considerations to be made in respect of the protected characteristics along the lines of those already made for Warrington and the protected characteristic of age. If a further geospatial analysis is conducted focussing on transport access, the relative deprivation of Halton will also play a key part. The main report concludes that in the interests of promoting equality, commissioners will need to balance the arguments of the greater number of people requiring treatment against the greatest likelihood that people will need treatment. This summary data presentation appears to suggest that the inclusion of Halton population data would make a particular contribution to the likelihood of requiring treatment dimension.

Centre for Public Health

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Wirral University Teaching Hospital NHS Foundation Trust

Health & Wellbeing Overview and Scrutiny Committee
10 September 2012 @6:15pm

Mr David Allison, Chief Executive

- ***Waiting times of ambulant patients***

Clearly it is vital that ambulances are not excessively delayed at hospitals, as the sooner they are able to discharge patients into the hospital's care the better ambulance response times can be.

Put simply, the steps required are:

1. The ambulance arrives at hospital
2. The paramedics take the patient into initial assessment in the A&E department
3. A clinical handover takes place and the patient is transferred to the care of A&E staff
4. The ambulance crew then clean/prepare the ambulance for the next patient, take any breaks/visits to the toilet and when they are ready they radio in for another assignment

Ambulance waiting times are often expressed as the time from 1 to 4 as this is the most straightforward data to measure. On this basis in the first quarter of this year WUTH had an average turnaround of 28.2 minutes – a slight improvement on last year's average. For quarter one, within the North West, 17 hospitals had a better turnaround time than WUTH, while 15 had a worst performance.

However, it is very important to note that hospitals can only influence steps 1 to 3 – the time it takes for ambulances to declare themselves ready within step 4 is outside of our control.

We have met with the North West Ambulance service to discuss turnaround times for July. They have confirmed that our average turnaround time for steps 1 to 3 is 14.7 minutes against a national target of 15 minutes. We have asked for this data to be produced on a monthly basis and will ensure that appropriate steps are taken to ensure that the national target is delivered and ambulances are not delayed by our A&E department.

- ***Disabled toilet facilities***

The Trust takes very seriously its responsibility to provide suitable facilities for staff, patients and visitors who have disabilities.

The Trust has a Disabled Access Champion who has undergone formal training and qualification in assessing and providing accessible environments.

All new capital developments and refurbishments of existing facilities at both hospital sites are reviewed at design stage by the Disabled Access Champion to ensure full compliance with all relevant legislation, NHS guidance and good practice. For the more major capital schemes, such as those being undertaken as part of our Site Strategy, it is the responsibility of the appointed architect to ensure the design is compliant with legislation.

Arrowe Park Hospital – 4 WCs:

- Main Building (Ground Floor - Entrance to Main Outpatient Department near main entrance)

- Main Building (Ground Floor - Emergency Department adjacent to Majors area)

- Main Building (Ground Floor opposite Clinical Skills Centre)

- Womens & Childrens Building (Ground Floor - off Main Entrance waiting area)

Clatterbridge Hospital – 1 WC:

- Main Entrance (waiting area)

In relation to the specific issue of accessible toilet facilities for visitors and the public, following a recent review one additional accessible WC has been provided on the Arrowe Park Hospital site (opened July 2012) which brings the total number of accessible WCs for visitors to five across the two sites as shown.

WIRRAL COUNCIL

HEALTH AND WELL-BEING OVERVIEW AND SCRUTINY COMMITTEE

10TH SEPTEMBER 2012

SUBJECT:	**CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST (CWP) COMMUNITY MENTAL HEALTH SERVICE REDESIGN**
WARD/S AFFECTED:	**ALL**
REPORT OF:	**CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST (CWP)**
KEY DECISION? *(Defined in paragraph 13.3 of Article 13 'Decision Making' in the Council's Constitution.)*	NO

1.0 EXECUTIVE SUMMARY

1.1 This report is to brief committee members on the Cheshire and Wirral Partnership NHS Foundation Trust (CWP) Community Mental Health Service Redesign.

2.0 BACKGROUND AND KEY ISSUES

2.1 This briefing provides an outline of the forthcoming consultation on the proposed changes to trust-wide community mental health services provided by Cheshire and Wirral Partnership NHS Foundation Trust.

2.2 CWP are proposing to introduce the 'Stepped Approach to Recovery' (StAR). This model has emerged as the preferred model of service delivery following an assessment of a number of alternative models in use nationally, and consideration of the outcomes of the various stakeholder engagement and improvement events held earlier in 2012. These assessments and events identified that improvements were required in respect of

- Access to services
- Enhancing the focus on recovery
- Making more effective use of staff resources

The StAR model is firmly based on the concept of recovery, already adopted across CWP focussing on enabling a person's recovery as they progress through the pathway. If approved, the proposed changes will have a significant impact on the way the community mental health service meets the needs of service users in the future. This model focuses on:

- Recovery, health and well-being – including new well-being centres and nurse-led clinics

- Community teams will be structured in line with a stepped approach to recovery care pathway: 'Access', 'Recovery', 'Review'
- Matching the staff skill required with the needs of our service users; and wherever possible by people working in multi-disciplinary teams around individuals and their families
- Local variation to meet local needs (rather than a rigid model, local areas can adapt the model to meet the needs of local people)
- Evidence based interventions – this includes psychosocial interventions, cognitive behavioural therapy, individual counselling and family work aimed to deliver positive outcomes and demonstrate value for money
- Care Programme Approach – this is the framework which supports individual care, promoting social inclusion and recovery

2.3 The proposed changes to trust-wide community mental health services will go through consultation with both the public (running for three months from September 10th to December 3rd 2012) and with affected Trust staff (for three months starting 3rd October 2012). The public consultation will seek feedback from service users, carers, our foundation trust membership and partner organisations. The outcomes of the consultations will inform decisions on the way forward and subsequent changes will be implemented from January 2013.

2.4 The review is happening as part of the NHS efficiency saving requirements, of which the Trust has to achieve over £13m of savings over the next three years. The review of the community mental health service is part of this process. It is in keeping with CWP's earlier consultation where we received support for redesigning care pathways and new ways of working (for example nurse-led clinics) in our public consultation in 2010*: "Developing high quality services through efficient design."*

2.5 The scale of the proposed changes is such that the staff employed within the service will be reduced and new ways of working introduced. Measures will be taken to reduce the need for any compulsory staff redundancies. Discussions with affected staff will continue into December 2012.

2.6 The public consultation on the proposed changes will take several forms. This will include a paper based document and questionnaire, an on-line questionnaire, and a series of public meetings held locally. Invitations to these will be extended to anyone with an interest in the developments. The meetings will be hosted and attended by senior officers from the Trust who will present an overview of the proposed changes, and will answer any arising questions and queries. The local meeting for Wirral will be held on Wednesday 7th November, 10.30am at The Lauries Centre, 142 Claughton Road, Birkenhead, Wirral CH41 6EY

2.7 The full consultation document will be circulated to committee members on Monday 10th September.

3.0 RELEVANT RISKS

3.1 There have been comprehensive impact assessments undertaken including an Equality Impact Assessment. We have used these assessments to inform the evaluation process we plan to put in place to monitor the proposed service change to:

- demonstrate the benefits outlined in the consultation are achieved and
- potential adverse impacts are minimised.

4.0 RECOMMENDATION/S

4.1 That committee members note the report and comment on CWP's approach to the Community Mental Health Service Redesign public consultation commencing in September 2012.

5.0 REASON/S FOR RECOMMENDATION/S

5.1 To progress the proposals and consultation as outlined in the report.

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HEALTH AND WELL BEING OVERVIEW & SCRUTINY COMMITTEE

SUGGESTED ADDITIONS TO WORK PROGRAMME - 2012/2013

Topic Description	"Task & Finish" Review Group	Future Agenda Reports	Other (eg visits etc)	Complete / remove from suggested additions
Medicine Management in Hospital Trusts		X		
AKA Report		X		
Vascular Services update		X		
Ambulance Service Report re loading/waiting times		X		
Disabled toilet facilities at hospitals		X		
Wirral Maternity Services		X		
Public Health update		X		
Impact of welfare reform		X		
Key organisations – Health Trusts /Public Health		X		

HEALTH AND WELL BEING OVERVIEW & SCRUTINY COMMITTEE

REPORT ON "TASK & FINISH" SCRUTINY REVIEWS

Title of Review	Completed	Review of report recommendations	Requested update / review date
Wirral Hospital Discharge Review	2009	10.11.2009 25.03.2010 01.11.2010	
The care of people with Dementia in an acute hospital setting	2011	12.03.2012	
Panel on Domestic Violence		Interim Report – March 2011 NO FINAL REPORT	
Transforming Adult Day Centres/Services		NO FINAL REPORT	

Resolved -

(1) That:

1. **Every Overview and Scrutiny Committee Chairperson shall meet, as soon as possible, with the other two party spokespersons of their Committee and:**

    a. **Review the work programme of their Overview and Scrutiny Committee (whether planned or being undertaken) for this Municipal Year, and prioritise the work (with assistance of relevant Council officers) consistently with the Council's Corporate Plan approved by Council on 16 July 2012;**

    b. **Consider the work programmes of all other Overview and Scrutiny Committees and identify (with assistance from relevant Council officers) areas of work that involve (or may involve) cross-cutting issues and/or clear synergies (whether in law, fact or issue) with areas of work falling within their own Overview and Scrutiny Committee work programme.**

    c. **The Acting Director of Law, HR and Asset Management (or his nominee) shall report the outcome the meeting(s) referred to above to the Scrutiny Programme Board at its next meeting.**

2. **The Improvement Board be reminded and asked to note that:**

    a. **the Scrutiny Programme Board offers its assistance with regards to taking forward any improvement action, initiative or area of work that the Improvement Board considers appropriate; and**

    b. **the Scrutiny Programme Board is, as part of its work programme, reviewing the Council's Forward Plan (which includes its structure and any work undertaken to date) to it to ensure the Plan is effective in delivering its objectives and purpose.**

3. **Relevant Council Officers involved in overview and scrutiny work shall review all the work programmes of Overview and Scrutiny Committees and identify any areas of duplication (or potential duplication) whether in relation to the work that is planned (or already being undertaken) or in relation to the resources being expended (or likely to be expended) in undertaking the work programmes.**

The Acting Director of Law, HR and Asset Management (or his nominee) shall present the findings of the review to the next meeting of the Overview and Scrutiny Committee.

(2) That training be delivered to Members from the Centre of Public Scrutiny.