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Health and Well Being Overview and Scrutiny Committee

Date:	**Tuesday, 22 March 2011**
Time:	**6.15 pm**
Venue:	Committee Room 1 - Wallasey Town Hall

Contact Officer: Andrew Mossop
Tel: 0151 691 8501
e-mail: andrewmossop@wirral.gov.uk
Website: http://www.wirral.gov.uk

AGENDA

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

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

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

2. MINUTES (Pages 1 - 16)

To receive the minutes of the Health and Well Being Overview and Scrutiny Committee meetings held on 22 January and 17 February, 2011.

3. PRESENTATION ON THIRD QUARTER PERFORMANCE

The Quarter 3 Performance (Final) Report on activities relevant to Health and Well Being Overview and Scrutiny Committee is available to view in the web library and a presentation will be made by the Interim Director of Adult Social Services.

4. PROVIDING EXCELLENCE IN HEALTHCARE INTO THE FUTURE (Pages 17 - 24)

5(A). ALCOHOL RELATED HOSPITAL ADMISSIONS (Pages 25 – 32)

Report of the Director of Public Health.

5(B). COMMITTEE REFERRAL - SCRUTINY REVIEW OF ACCESS TO ALCOHOL BY YOUNG PEOPLE IN WIRRAL (Pages 33 – 78)

Scrutiny Programme Board at its meeting on 5 January, 2011 (minute 44 refers) referred this report to this Committee for consideration.

6. HEALTH AND HOMELESSNESS UPDATE (Pages 79 - 84)

7. CHANGES TO INDEPENDENT LIVING FUND - UPDATE REPORT (Pages 85 - 88)

8. DASS COMPLAINTS ANNUAL REPORT (Pages 89 - 122)

9. CHESHIRE AND MERSEYSIDE VASCULAR SURGERY REVIEW CONSULTATION (Pages 123 - 158)

10. HOMEOPATHY COMMISSIONING (Pages 159 - 164)

11. DEMENTIA SCRUTINY REVIEW - FINAL REPORT (Pages 165 - 206)

12. REPORT ON WORK OF DOMESTIC VIOLENCE PANEL (Pages 207 - 230)

13. WORK PROGRAMME

Report to follow.

14. FORWARD PLAN

The Forward Plan for the period March 2011 to June 2011 has now been published on the Council’s intranet/website. 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

HEALTH AND WELL BEING OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 18 January 2011

Present:	Councillor	M McLaughlin (Chair)	
	Councillors	A Bridson	S Mountney
		W Clements	C Povall
		P Glasman	P Reisdorf
		B Kenny	G Watt
Deputy:	Councillor	J Salter (in place of T Smith)	
Co-opted:	S Lowe (Service users under OPP age group) S Wall (OPP) I Bowman (Interim Carer's Representative)		

41 **CHAIR'S ANNOUNCEMENTS**

The Chair welcomed everybody to the meeting and congratulated Howard Cooper on being made a Commander of the British Empire in the New Year's honours.

The Chair informed the Committee that item 9 on the agenda, 'Commissioning and Procurement from the Voluntary Sector' had been withdrawn.

The Chair also referred to the temporary appointment of Ina Bowman as Carer's Representative and welcomed her to the Committee.

42 **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 P Glasman declared a personal interest in minute 49 (Consultation Task Forces and Planned Service Changes between January – March 2011) by virtue of her attendance at a Management Board meeting of the Cambridge Road, Wallasey Day Centre.

43 **MINUTES**

Members were requested to receive the minutes of the meeting of the Health and Well Being Overview and Scrutiny Committee held on 1 November, 2010.

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

44 **PRESENTATION ON THIRD QUARTER PERFORMANCE 2010/11**

Mike Fowler, Head of Service (Finance and Performance) gave a presentation on the progress made against the indicators for 2010/2011 in the third quarter and key projects which were relevant to the Health and Well-Being Overview and Scrutiny Committee.

He referred to those performance indicators which had exceeded or met their target and expanded on those performance issues which weren't achieving on target, and the corrective action being taken to address them, these included:

- Self Directed Support & Personal Budgets
- People supported with Assistive Technology
- Safeguarding alerts dealt with in 24 hours
- Safeguarding incidents closed within 28 days

In respect of the financial position Mike Fowler outlined the key financial pressures and the budget efficiencies and actions in place to reduce the projected overspend which as at December, 2010 was £4.4m.

Responding to Members' comments Mike Fowler informed the Committee that Authorities had been lobbying the Government regarding the share of £1bn grant to be distributed via Personal Social Services element of the Formula Grant, although this grant was not ringfenced and the final settlement was due to be announced in February.

Kathy Doran, Chief Executive of NHS Wirral, informed the Committee that NHS Wirral would receive a ringfenced grant of £4.9m to support integration and the distribution of this would have to be agreed through a number of different agencies, including NHS Wirral, GP Consortia and the Department.

Responding to comments, the Director outlined the need to review the position around appointing staff because of the increased need for assessment and indicated that there would be some flexibility for existing staff to increase their hours.

Resolved – That the presentation be noted.

45 **PROGRESS REPORT ON REIMBURSEMENT IN RELATION TO PUBLIC DISCLOSURE ACT 1998 (PIDA)**

The Interim Director of Adult Social Services submitted a report which updated the Committee on the progress in implementing reimbursement to certain residents and former residents of Bermuda Road, Curlew Way and Edgehill Road following the agreement of Cabinet to the recommendations of this Committee.

Of the 16 individuals, relatives of the 4 deceased people had received reimbursements; one person with capacity had received theirs; the department had been appointed deputy by the Court of Protection for one person without capacity and payment had been made.

Since the report was written, Rick O'Brien, Head of Access and Assessment reported that two further court orders had been received by the Court of Protection so these two would also be paid and he outlined the progress made on the remaining cases.

Sandra Gilbert, Chief Executive of Wirral Mind, which had provided an independent advocacy service for 10 of the individuals concerned, addressed the Committee and explained the work of Mind on this matter.

In connection with the report, Councillor Mountney circulated a letter to the Committee, and the Chair then sought the advice of the Director of Law, HR and Asset Management's representative as to whether or not this should be considered in open committee. Vicki Shaw, Group Solicitor, advised that the matter should not be considered in open committee and that there should be further investigation into the matter before being brought back to a future Committee.

Responding to further comments the Interim Director indicated that he would be happy to report back on matters regarding Balls Road. The situation regarding the appointment of families as deputies, which was the responsibility of the Court of Protection, he would clarify with Members, following consultation with Mind. With regard to any story in the Wirral Globe he was unable to comment, having neither seen it nor received any correspondence about it.

On a motion by the Chair, it was –

Resolved –

(1) That the report be noted.

(2) That Committee be informed as to when final reimbursements have been made.

(3) That the Interim Director report on the matters in connection with Balls Road and the letter circulated by Councillor Mountney to a future meeting of this Committee.

46 **TRANSFORMATION OF ADULT SOCIAL SERVICES - PERSONAL BUDGETS PROJECT PHASE 2 EVALUATION**

The Interim Director of Adult Social Services submitted a report on the progress being made on personal budgets in Wirral. The report provided an evaluation of phase 2 and details of phase 3.

Responding to comments from Members, the Director and Heads of Service made the following points:

- The number of carers receiving an assessment had gone up as had the number of carers receiving support from the Department.
- It was important that all carers understood the impact of personal budgets and the involvement of carers in the Carers' Association and the Carers' Development Committee would help in this regard.
- Transition teams were being set up.

- The wording of future evaluation questionnaires would be looked at to ensure that there was no ambiguity in the questions.

The Director and Mike Fowler, Head of Finance and Performance also responded on the issue of resource allocation and explained the points system. All points (after applying the weightings to the responses to the assessment questions) were given the same monetary value, which was currently £1.62, as agreed by Cabinet on 4 November, 2010 (minute 214 refers). The Council only funded up to 29 points, ie a maximum value of £46.98. Points above this would imply the individual might be entitled to other sources of income, such as Health funding and that this would initiate another assessment process. The maximum value of £46.98 was per day giving a maximum weekly figure of £328.86 per week.

Resolved – That the contents of the report and the current progress of implementing personal budgets in Wirral be noted.

47 **TRANSITION SERVICES - UPDATE REPORT**

The Interim Director of Adult Social Services submitted a report which provided an up-date to the Committee on the development and progress of transition services following the agreed formation in January 2010 of a joint Social Care Team of both Children and Adult Services staff to improve the experience of young people with learning disabilities as they moved from children's into adult services. A previous report was submitted to the Children's Overview and Scrutiny Committee on 2 June 2010 (minute 5 refers) on this topic.

The new team, based within the Department of Adult Social Services at Westminster House, supported joint planning from the age of 14, had taken on the majority of social care casework responsibility from the age of 16, and continued a role until an appropriate point in the young person's life to pass onto a relevant service within the authority. Significant links had been established and developed with key partner agencies across the authority which was seen as further consolidation of a holistic service for young people with learning disabilities living in Wirral.

Resolved – That the content of this report be noted and this Committee continues its support of the Transition Services Team and its future development.

48 **CARE QUALITY COMMISSION - UPDATE PRESENTATION**

The Interim Director of Adult Social Services gave a presentation to the Committee on the progress being made to address the issues raised by the Care Quality Commission inspection of Adult Social Services in May, 2010. He also combined this with a presentation on planned service changes.

In addition to a graphic representation of Wirral's position in comparison with other authorities nationally, he set out the areas in which there was a need for changes to be made. These included:

- Integrated working and localism
- Personalised support and the personalised journey
- Access and personalised assessment

- Early intervention and prevention
- Policies, practices and safeguarding

The Interim Director went on to outline how this could be achieved by commissioning rather than providing. In respect of respite, intermediate care and residential care there were:

- 155 beds of public provision
- 523 independent sector vacancies
- The current fee was 9.5% above average

So, this would mean:

- Remove supply from the Council
- Reduce the fee to the average
- Increase occupancy and reduce unit costs

In respect of personal support and reablement:

- Both public and independent providers were available
- There was a relatively high public cost base
- Other providers were willing and able to diversify

So, this would mean:

- Invite interest from independent providers
- Encourage diversification amongst providers
- Retain assessment and quality assurance in the Council

Responding to comments from Members the Interim Director stated that staff with the department needed systematic development. A workforce strategy was critical to developing the workforce, equipping them with new skills to manage external providers rather than in-house providers. 450 staff would be leaving by the end of March, 2011 and there were areas which would need restructuring. This was an opportunity to build new teams around such areas as day centres. He acknowledged that there were risks in the pace of change but there would also be risks in not doing anything. Risks would be continually monitored and evaluated and he stated that the changes required would be delivered safely and within timescale.

In respect of the co-location of health and social care services, Kathy Doran, Chief Executive, NHS Wirral, informed the Committee that it was the intention of the new GP Consortia to retain these currently co-located services and the Interim Director commented that the department was likely to have a much closer working relationship with GP practices.

With regard to the charging policy review for residential care Cabinet had taken the decision to enter into a period of consultation.

Resolved – That the presentation be noted and a follow up report be brought to the March meeting.

49 **CONSULTATION TASK FORCES AND PLANNED SERVICE CHANGES BETWEEN JANUARY - MARCH 2011 - UPDATE PRESENTATION**

(See minute 48).

50 **COMMISSIONING AND PROCUREMENT FROM THE VOLUNTARY SECTOR**

This item had been withdrawn at the request of the Interim Director.

51 **LOCAL IMPACT OF GOVERNMENT PLANS FOR FUTURE OF NHS - UPDATE PRESENTATION**

Kathy Doran, Chief Executive NHS Wirral, gave a presentation on the Government's proposed health reforms and their impact on Wirral. The key points were:

- Independent NHS Commissioning Board
- GP commissioning consortia
- New Public Health Service – Director of Public Health to be a Local Authority and Public Health England appointment
- Community Services to be separate from PCTs
- All NHS trusts to become or be part of a foundation trust
- Local authorities to promote joining up of local NHS services, social care and health improvement

In the presentation she gave details of the establishment of a Community Trust, with a Shadow Board operating from January 2011. There would be three GP Consortia:

- Wirral GP Commissioning Consortium (27 Practices)
- Wirral Health Commissioning Consortium (23 practices)
- Wirral NHS Alliance (6 practices)

There were also currently 6 practices unaligned.

The PCT (NHS Wirral) would be abolished in 2013. By June 2011 PCTs would be reorganised into "clusters", with Wirral likely to be grouped with Cheshire and Warrington. These clusters would be responsible for managing the transition to 2013.

Fiona Johnstone, Director of Public Health gave a presentation on the strategy for public health as detailed in the White Paper, 'Healthy Lives, Health People' which would see a return of public health leadership to local government. The new public health service would be directly accountable to the Secretary of State for Health with a clear mission to:

- Achieve measurable improvements in public health outcomes; and
- Provide effective protection from public health threats

It would do this by:

- Protecting people from infectious disease and biological, chemical and radiological threats;

- Helping people and families to be able to take care of their own health and wellbeing; and
- Inspiring challenging and commissioning partners from all sectors.

The Director of Public Health would be jointly appointed by the relevant local authority and Public Health England and employed by the local authority with accountability to locally elected members and through them to the public. She also outlined the activities proposed for the local authority commissioning route. There would be some public health commissioning via the NHS Commissioning Board and some through Public Health England (PHE). In her presentation she also outlined the routes of accountability and gave a summary timetable of the implementation of the proposals which would see PHE take on full responsibility in April 2012 and grant ring-fenced allocations being made to local authorities in April 2013.

Responding to comments from Members Kathy Doran informed the Committee that GPs were already the ones committing resources in the NHS and they had to balance what was right for each of their patients with ensuring that they maintained responsibility for all the patients on their list. The scrutiny role of the Committee on health would continue and additionally a Health and Well Being Board would be established which would have on it representatives from GP Consortia, the Department of Adult Social Services and elected Members amongst others. The GP Consortia would not be strictly geographically grouped as there would be a spread across the Wirral and GP practices in one geographical area could belong to different GP Consortia.

Resolved – That the presentations be noted.

52 **COMMITTEE REFERRAL - SCRUTINY PROGRAMME BOARD - 26 OCTOBER, 2010**

The Committee considered minute 32 (Scrutiny Training) which had been referred by the Scrutiny Programme Board on 26 October, 2010. The minute had resolved, amongst other things, that this Committee be requested to invite the Director of Public Health to provide an overview of health scrutiny and to invite all Members of the Council to attend.

Resolved – That the minute be noted and the Director of Public Health be invited to provide an overview of health scrutiny to which all Members of the Council would be invited to attend.

53 **WORK PROGRAMME**

The Committee received an update on its work programme, which included the proposed outline meeting schedule for the current municipal year. The Chair referred to the report on Homelessness and Health which would now be brought to the March meeting.

A Member also suggested that a report be brought to the next meeting of the Committee on winter pressures and their effects on the department and the health service.

Resolved – That the report and addition to the work programme be noted.

54 **MINUTES OF THE CHESHIRE AND WIRRAL COUNCIL'S JOINT SCRUTINY COMMITTEE**

The Committee received the minutes of the meeting of the Cheshire and Wirral Council's Joint Scrutiny Committee held on 11 October, 2010.

Resolved – That the minutes be noted.

55 **FORWARD PLAN**

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

Resolved – That the forward plan be noted.

56 **ANY OTHER URGENT BUSINESS APPROVED BY THE CHAIR**

With the agreement of the Chair, the Committee considered verbal updates on the affect of the winter influenza outbreak.

Fiona Johnstone, Director of Public Health, informed the Committee that surgeries were being kept busy, though demand for the seasonal 'flu' vaccine had been variable. On the Wirral 74% of those 65+ had been vaccinated and 50% of those under 65 in the 'at risk' groups.

Tina Long, Director of Nursing and Midwifery, Wirral University Teaching Hospital, NHS Foundation Trust, informed the Committee that in addition to the normal winter pressures the added issue of influenza had put a lot of pressure on critical care. The 'flu' plan had been activated early on in Wirral though this was likely to be 'stepped down' this week.

Rick O'Brien, Head of Access and Assessment, reported that there had been increased activity for social care over the last few months and the department was working closely throughout the year with the acute trust.

Resolved – That the report be noted.

HEALTH AND WELL BEING OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 17 February 2011

Present:	Councillor	M McLaughlin (Chair)	
	Councillors	A Bridson B Kenny S Mountney	C Povall G Watt
Deputies:	Councillors	T Harney (for P Reisdorf) A Pritchard (for W Clements) D Roberts (for T Smith) J Salter (for P Glasman)	
Co-opted:		S Lowe (Service users under OPP age group) S Wall (OPP) I Bowman (Interim Carer's representative)	

57 **CHAIR'S ANNOUNCEMENTS**

The Chair welcomed everyone to the meeting and asked members of the Committee to introduce themselves.

She gave an explanation as to why the special meeting had been called and that the meeting would examine the plans for the future delivery of social care on the Wirral following the decisions made by Council last December.

The meeting would hear from both the Interim Director and the Cabinet Member for Social Care and Inclusion, Councillor Bob Moon and also representatives of various interested groups. It was intended that the structure of the meeting would be broadly in four parts;

- Consultation
- Finance
- Service implications
- Staffing issues

Councillor Bridson asked for clarification that no budget arrangements would be discussed other than what came out of the December Council meeting and the Chair confirmed that this would be the case.

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

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

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

No such declarations were made.

59 **BUDGET PROPOSALS**

The Special Meeting of the Committee had been called, in accordance with the Overview and Scrutiny Procedure Rules, by Councillors M McLaughlin, B Kenny and P Glasman, in order to give consideration to matters concerned with budget proposals.

A document submitted by the Labour Group Members referred to:

- The failure of this administration to refer any budget savings to the relevant Overview and Scrutiny committees for proper scrutiny.
- The decision taken by Council on December 13th to suspend the relevant part of the Constitution in order to avoid any such scrutiny.
- The lack of any detailed Cabinet reports setting out the details of the budget savings, and their consequences.
- The lack in particular of any explanation of the impact of the loss of over 1300 posts, the restructuring necessary to protect services, and the costs of that restructuring.

Both the Interim Director of Adult Social Services and Councillor Moon, Cabinet Member for Social Care and Inclusion, responded to questions from the Chair and Committee members.

<u>1. Consultation</u>

Councillor Moon commented that consultation had been ongoing for the past three years since a report on the transformation of Adult Social Services to Cabinet on 6 November, 2008, although this Cabinet decision was the subject of a call-in on 4 December, 2008, the decision was endorsed (4:3), but he stated there was little political will to move on at that time. Since then consultation had taken place on Options for Change papers which had been presented to Cabinet and from May 2010 onwards it had been decided to go ahead with the results of consultation.

The Chair then referred to the Task Force consultation process to which 5600 had responded but of these, only half, less than 3000 had filled in the social care part of the questionnaire and of these, the numbers of people with any experience of using services was approximately 300.

Councillor Moon stated that this was not just a random sample, as they had gone to great lengths to consult with carers and people in care homes with staff, in some cases, helping users fill out questionnaires.

The Chair commented that from December 2010 when proposals were agreed for the closures of homes there should then have been a 12 week period of proper and meaningful consultation.

Councillor Moon stated that an initial letter had been sent out on 6 January, 2011 but acknowledged that this was perhaps not the best worded letter. Since then where concerns had been raised, one-to-one conversations had been held with users and carers.

The Interim Director stated that there were seven permanent residents across the five Council run care homes and a number of other users who accessed those services for a number of days per year. Of the seven, alternative arrangements had been agreed for five and discussions were ongoing with the remaining two. A number of discussions had been held with carer groups broadly and by Tuesday 22 February, 2011 all users would have been contacted and dates would be arranged for further consultation.

The Chair then read out some correspondence which she had received from service users and relatives which amongst other things stated, 'don't feel it is meaningful consultation' with relatives of service users and also the 'indecent haste' of the changes taking place.

Councillor Moon commented that the Department was trying its best to contact all those involved and the most important consultations were taking place with social workers, advocates, service users, family members etc.

At 6.45pm the Chair adjourned the meeting for 5 minutes due to a disturbance by a member of the public.

The meeting resumed at 6.50pm

Councillor Moon referred to an apology which had been issued in the press for the way in which the closures of homes was introduced to those affected.

The Interim Director stated that he had apologised to the Carers' Development Group as it was fair to say that following the decision by Council in December and up until 21 January the implications for service users could have been communicated in a better manner.

Rick O'Brien, Head of Access and Assessment, referred to the consultation requirement for permanent residents which was 80 days, although there was no required timescale for consultation with those in temporary care. He also referred to the involvement of a number of different voluntary sector groups, including those in the adult mental health area.

Responding to comments, he stated the clear need for best practice to be applied and for those family members affected to be involved in discussions. There would be different perspectives about pace and speed of change and for some an extended period of change could create a longer timeframe of uncertainty.

2. Finance

The Interim Director gave a breakdown of employees within his department who he had agreed could leave under the EVR / VS offer. By the end of June 2011 this would amount to a total of 502 staff. A large proportion of these would be staff not working directly on front line services, although there would also be staff working in services which the department would no longer be maintaining.

The Chair suggested that it would appear that financial factors were driving this change and not the best interests of the service.

Councillor Moon responded that the local authority had a statutory duty to meet the needs of vulnerable people within the borough and this was of paramount importance. The personalisation agenda started three years ago and although the pace was fast the changes were being managed in a planned and structured way.

The Interim Director referring to the duty to meet the needs of vulnerable people stated that the Council had to ensure that they were met but not that the Council had to directly provide the service. The Council wanted to make sure there was a diversity of provision available for people to choose through personalisation. He also commented upon the assistive technology service for those with substantial or critical need and the possibility of providing this service at a nominal charge for those with moderate needs. There were no current plans to introduce charges for assistive technology for those with substantial or critical needs.

The Interim Director also commented that there were no plans to charge 100% of disposable income for people supported in their own homes, although this was the case in some neighbouring authorities. He also referred to tenders which were due on 21 February for care home fees, negotiations had been held with care home owners as part of the tendering process. Neighbouring authorities were currently paying lower fees than Wirral. A telephone survey to care homes which elicited a 65% response rate last week showed that there were 300+ beds available. Independent sector provision was available in all categories of provision including, learning disability, nursing care and respite care.

At the invitation of the Chair, Gwen Seller, Chair of Wirral Mencap addressed the Committee and spoke of her concerns for carers and service users and the lack of consultation with service users and the pace at which changes were being introduced.

At the invitation of the Chair, David Johnson, son of a resident in Meadowcroft addressed the Committee and spoke of his concerns at the rushed closures of Council run care homes and the lack of communication from the department.

The Interim Director stated that he could not comment on an individual case in open Committee but would be happy to discuss issues raised by Mr Johnson after the meeting. He responded to comments made and assured the Committee that there would be involvement of carers in the tendering scrutiny process and an 'approved list' of providers would be drawn up, all of whom would have to be of a sufficiently high standard. Independent provision was, on average, higher than other neighbouring authorities and also, on average, higher than the quality the Council provided. He also informed the meeting that a transitional support team would be in

place from Monday 21 February. It was planned that Meadowcroft home would close on 31 March, however, there were reserve plans to keep it open until April. There were processes in place for monitoring external providers.

Maura Noone, Head of Integrated Communities and Well Being informed the meeting of the average weekly occupancy of the Council care homes as follows:

- Mapleholme 14 (Capacity 23)
- Meadowcroft 15 (Capacity 23)
- Pensall House 15 (Capacity 25)
- Poulton House 31 (Capacity 38)

3. Service implications

The Head of Access and Assessment responded to comments by the Chair and stated that intermediate care would be provided with dedicated beds within the independent sector with the support of NHS Wirral. There was also provision within the market for specialised mental health services to be re-provided and work was ongoing with NHS Wirral colleagues to deliver this.

At the invitation of the Chair, Susan Walshe, Chair of Family Tree (an organisation supporting carers and families affected by severe mental illness) addressed the Committee and expressed her concerns regarding the speed of the closures, that services were being dismantled before any viable alternative services were in place and that there had been no reasoned and meaningful consultation process.

At the invitation of the Chair Sue Newnes, Support Services Manager for Wirral Alzheimer's Society, addressed the Committee and spoke of her concerns particularly in relation to the high risk from moving people with dementia for whom routine and continuity were vitally important. Unpaid carers had to be supported as carer support could avoid the need for costly residential care. Carers also had great difficulty in accessing respite care.

The Interim Director responded and informed the Committee that the Council had a duty to continue and a commitment to meet assessed needs. Following the tender process a range of quality providers would be registered and approved. This would include accreditation of a range of providers for those with mental health needs and service users and their families from which they would be able to choose. There was currently a mixed economy now between Meadowcroft and the private sector. For those with Alzheimer's or a related illness, there were 300 in residential care and 400 in nursing care.

In respect of the Home Assessment and Reablement Team (HART) the Chair queried whether there was a mature provider in the market for reablement. In response the Head of Access and Assessment informed the Committee that 1800 people had accessed the service in the past 12 months with significant benefits and he was mindful that there should be no deterioration in service following the outsourcing of the reablement side of the service. Over 40 staff would be retained for the assessment side of the service which was remaining in-house.

At the invitation of the Chair Matthew Hawes, independent Occupational Therapist and consultant on re-ablement services speaking on behalf of himself and colleagues, Gill McGlade and Gareth Pennell, addressed the Committee and spoke of his concern at the rushed manner in which the Council was changing its HART service. Enablement and rehabilitation was a skill which couldn't be learnt over night.

The Head of Access and Assessment assured the Committee that the service would be managed on a daily basis and that NHS Wirral was absolutely committed to investment in the service.

4. Staffing issues

The Interim Director stated that there were 73 staff who would remain with the Council following the closure of the 5 care homes and outlined the process for their redeployment which would involve one to one meetings and the completion of a preference exercise.

The Chair then thanked everybody for their attendance including the officers and Councillor Moon who had responded to questions.

It was then moved by the Chair, seconded by Councillor Kenny, that –

"(1) This Committee is concerned at the breakneck speed at which changes are being railroaded through in order to achieve a reduction in the Social Care budget over the next year.

(2) This Committee believes that this money led approach to change can only be detrimental to service users, creating fear and confusion and undermining and de-stabilising the real process of change which until now, has been moving steadily towards the personalisation agenda.

(3) This Committee supports the introduction and extension of the provision of personal budgets to those users of the care service who want to have the opportunity to have greater choice and control over their lives, and accepts that this process is likely to bring about changes to the type of service required over time. Committee also understands the need to make best use of financial resources.

(4) However, we strongly believe that those changes and the pace of those changes should be dictated primarily by the changing demands from service users and that every effort should be made to create a means and pace of change that is manageable and acceptable to those service users.

(5) This Committee believes that the proposals for re-provision passed by Cabinet and Council in December, 2010 and due to be implemented by 31 March, 2011are now being undertaken at such speed, and on a scale so big, that they fail to conform to the principles of personalisation. Committee is concerned that the way in which the December budget decisions have been implemented has failed to allow for proper consultation with, and involvement of, those who use our services and their carers, which in turn has created a climate of fear and confusion and a loss of confidence in the whole exercise. This in turn has created a much higher risk for individuals and increased the risk that the exercise will fail.

(6) Committee further expresses great concern over the viability of the plans to complete by 31 March the redesign of staff teams in Day Centres and residential care homes for the most vulnerable group of people with severe learning and physical disabilities. Committee believes that this leaves insufficient time to re-train redeployed staff to work in a very challenging environment, and to restructure services in a safe and appropriate way.

(7) Committee therefore asks that Cabinet delay any implementation to allow for proper risk assessments and equality impact statements to be produced, and to allow for meaningful consultation, and a phased introduction of changes in line with the decisions originally taken by Cabinet in March 2010."

It was moved as an amendment by Councillor Watt and seconded by Councillor Mountney, that –

Delete all the above motion and substitute the following –

"(1) That this Committee welcomes the opportunity to hear the concerns of service users, carers and the voluntary and charitable organisations who are affected by the current changes in the provision of Adult Social Services.

(2) Committee accepts the explanations and assurances given by the Cabinet Member and the Interim Director in response to the issues raised.

(3) Committee welcomes the apologies previously given and repeated at this meeting for recent shortcomings in communications with service users and their carers and notes the undertaking given that individual contact has, or is now, being made with all concerned.

(4) Committee therefore recommends to Cabinet that the current process of change should continue with all due diligence for the best interests of service users and their carers, ensuring that the quality of service is maintained or improved, and that a progress report be brought to the next scheduled meeting of this Committee."

The amendment was put and carried (6:4)

The amendment, then becoming the substantive motion, was put and it was –

Resolved (6:4) –

(1) That this Committee welcomes the opportunity to hear the concerns of service users, carers and the voluntary and charitable organisations who are affected by the current changes in the provision of Adult Social Services.

(2) Committee accepts the explanations and assurances given by the Cabinet Member and the Interim Director in response to the issues raised.

(3) Committee welcomes the apologies previously given and repeated at this meeting for recent shortcomings in communications with service users and their carers and notes the undertaking given that individual contact has, or is now, being made with all concerned.

(4) Committee therefore recommends to Cabinet that the current process of change should continue with all due diligence for the best interests of service users and their carers, ensuring that the quality of service is maintained or improved, and that a progress report be brought to the next scheduled meeting of this Committee.

WIRRAL COUNCIL

HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

22 MARCH 2011

SUBJECT:	***PROVIDING EXCELLENCE IN HEALTHCARE INTO THE FUTUTRE***
WARD/S AFFECTED:	***ALL***
REPORT OF:	***TINA LONG DIRECTOR OF NURSING AND MIDWIFERY AT WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST***
RESPONSIBLE PORTFOLIO HOLDER:	
KEY DECISION?	NO

1.0 EXECUTIVE SUMMARY

This report provides an outline of the work undertaken to develop a Site Strategy for the Trust and the plans for engagement over the next three to four months. In addition it udates the Committee on progress with Same Sex Accommodation, Hospital Discharge and Ward Closures.

2.0 TREATING YOU WELL INTO THE FUTURE – SITE STRATEGY

Placing patients at the heart of healthcare is at the core of our work at Wirral University Teaching Hospital NHS Foundation Trust. We do this through our vision of Excellence in Healthcare, which has been adopted throughout our Trust not only as our vision but also as the way in which we ensure that we provide our patients with the best possible care, services and hospital experience.

In order for our patients to have a positive experience of our hospitals we need to have the appropriate services in the right place so that high quality treatment can be carried out in the right way and at the right time. We also need to provide services in a safe, comfortable environment that is fit for purpose and enables our patients to maintain their privacy and dignity. All these factors taken together greatly improve what is often referred to as a patient's "journey" and we are committed to doing everything we can to make that journey through our hospitals as smooth and stress free as possible. It is for these reasons, and also to ensure that we are making the

most effective use of our accommodation, that we have been undertaking a comprehensive review of the location of all our services.

In 2009 we began a major review of how and where our services are provided at Clatterbridge and Arrowe Park Hospitals. The review found that we need to make changes to the location of some outpatient services, day case surgery and planned operations. These changes will be designed to ensure that we can continue to provide the highest quality of care in the best place for our patients in the coming years. None of these options are about reducing the range of services we provide, but about where and how they are delivered.

To date our proposals for change have been informed by wide ranging discussions with our doctors, nurses and other clinical staff. Their views have been invaluable in framing the main options under consideration.

A draft outline business case, developed following these discussions has now been produced. This contains three main options for the future location of outpatient services, daycase and planned operations which will allow the Trust to continue to provide the best possible care, services and hospital experience for patients from accommodation at both Arrowe Park and Clatterbridge.

The closure of Clatterbridge Hospital is NOT one of the options.

This draft is now being discussed further with the Board of Directors and Hospital Management Board with a view to an outline business case being approved at the end of March.
As part of a Stakeholder Engagement Plan, a Stakeholder Engagement Board has been established including representation from the Local Authority, GPs, our Assembly of Governors and other key partners and stakeholders. The aim of this board is to involve our key stakeholders in the development and delivery of the engagement plan in April, May and June. We have liaised with the Council's engagement team and has been grateful for the support received to date, particularly in ensuring that our plans incorporate appropriate methods of engaging with all areas of the community.

All options aim to:

- Place the patient at the heart of care
- Provide best possible care, services and hospital experience for patients
- Continue to ensure safe, high quality facilities in modernised accommodation for patients and staff
- Improve efficiency and provide affordable, cost effective clinical facilities
- Offer outpatient services in the best location for patients
- Help the Trust to meet the financial challenges ahead

Early May will see the start of a wide ranging period of engagement during which everyone - patients, carers, staff, the public, Trust partners and other stakeholders - will be able to have their say on the options. This engagement phase will last until mid-June with engagement documents being made available on the Trust's website and in printed form

This will be followed by a two week period of assessment of all the responses received. The Trust's Board of Directors will then meet at the end of June to consider the final business case, having taken all respondents' views and comments fully into account. July will then see a period of communicating the outcome of the engagement period and the final options to staff and the public.

It is essential that the Trust continues to work with key partners such as the Council and as such over the coming months, regular updates will be provided to members of the relevant Committees.

3.0 PROGRESS ON DELIVERING SAME SEX ACCOMMODATION (DSSA)

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Wirral University Teaching Hospital NHS Foundation Trust is committed to providing every patient with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

Mixed sex occurrences should always be considered as exceptions rather than the norm and staff must always be able to provide clinical justification for any mixed sex occurrence.

To meet the requirement to provide for all patients, same sex sleeping and sanitary accommodation, a programme of work has been completed to effect the necessary changes to ward layouts, where it has not been possible to have a single sex ward. This has included the identification of male and female bays separated by doors and the installation of designated sanitary facilities. An action plan has been developed following a Strategic Health Authority Review. The action plan is updated monthly and submitted to NHS Wirral.

The Trust has also implemented a policy on DSSA for staff to follow, an information leaflet for patients, and records breaches in DSSA using the Trust's incident reporting system and bed management process.

Breaches

The Trust is required to report all breaches, whether clinically justified or not, to NHS Wirral and the SHA monthly. NHS Wirral will apply a sanction for non clinically justified breaches. For example if a patient is declared well enough to be transferred out of ITU/HDU/CCU but there is no bed available for more than 24 hours, a penalty will apply.

Recent work to reduce the number of breaches has been undertaken in the following areas:

CDU/MAU

The information gained from incident reports highlighted that the Clinical Decision Unit (CDU) was breaching DSSA frequently, mixing men and women in the same

bays due to capacity and demand. This would be considered a non clinically justified breach and a penalty would be applied.

As a result two single sex units have now been established and opened at the end of January 2011.

Endoscopy

The Endoscopy Unit has now moved to the introduction of same sex lists from the beginning of February 2011. Where a patient requires an urgent Endoscopy they can be added to a list of the opposite sex for clinically justified reasons.

4.0 UPDATE ON HOSPITAL DISCHARGE

Over the last year the hospital has continued to make improvements to the discharge experience of patients.

The following has been achieved:

- Estimated Date of Discharge (EDD) is now in place on Medical and Elderly Care Wards with Daily Board Rounds now having been implemented. These are multi-disciplinary discussions to assess patients' progress towards their Estimated Date of Discharge

- Improving patient flow and discharge planning is a Trust Goal. The Bed Management System in operation is more robust with 3 to 4 bed meetings held per day with key stakeholders present who can influence the resolution of any pressures as they present

- The Complex Discharge Team manages and co-ordinates the discharge arrangements for patients whose needs may have changed as a result of their long term condition, diagnosis or social situation. They work in collaboration with Social Services colleagues based on Ward 42 at Arrowe Park Hospital

- The nursing documentation completed for every patient contains a discharge checklist for the nursing staff, a copy of which is given to the patient on discharge. Completion of this documentation is audited to monitor compliance by the nursing staff

- Criteria Nurse Led Discharge is now in place on a number of Wards which enables nurses to discharge patients rather than having to wait for a member of the Medical Team

A critical aspect of an effective discharge is the patient and carer/family experience. The Trust has a well developed patient experience feedback system in place. Patients are issued with a questionnaire on discharge which measures their experiences across a range of indicators that we know are important to our service users. In addition, the questionnaire also asks specific questions relating to discharge as follows:

Did you receive a copy of the discharge summary?

Did you find the information in the discharge summary useful?

These questions score 89% and 98% respectively as at December 2010

Measuring these questions is a key aspect of discharge as the summary provides a level of confidence to our service users and ensures that they leave with a tangible summary of their inpatient stay.

The Trust has also worked with the Wirral Local Involvement Network (LINk) throughout 2010 to assist them in their research into discharge from hospital. This research involved "enter and view" visits and random sampling of service users in the main public areas of Arrowe Park Hospital. The report resulting from this research has been received by the Trust and a formal response will be provided to Wirral LINk in March 2011.

By ensuring that patients are being discharged in a timely way the Trust has been reducing lengths of stay. More patients are now being discharged on the day of procedure or surgery and initiatives such as the Enhanced Recovery Programme, which is being rolled out across a number of surgical specialties, has reduced the need for patients to stay in hospital for protracted periods of time.

5.0 BED REDUCTION

Since setting out a vision for reducing lengths of stay a number of years ago much has been achieved.

- A greater focus on patient safety has meant that infection rates have significantly reduced for both MRSA and C Difficile leading to fewer patients acquiring hospital acquired infections and as a result, reducing extended lengths of stay due to infection

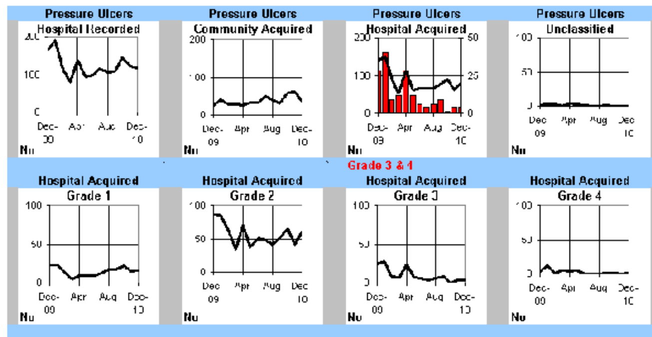
- The Trust is part of a national programme called "Safety Express" which aims to significantly reduce harm caused to patients through:

  Pressure Ulcers
  Falls
  Venous Thrombolysis
  Cather acquire urinary tract infections

  This is a two year programme, but already indications are that fewer patients are developing pressure sores and are having falls resulting in harm.

Executive Team 02 February 2011

Pressure Ulcers



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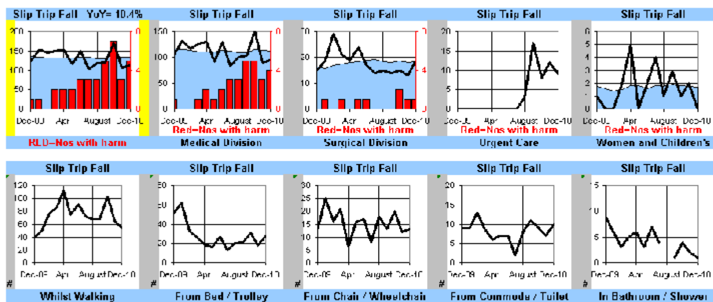
Executive Team 02 February 2011

Clinical Falls

(In Hospital)



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- A whole system approach with close collaborative working with Commissioners and Social Services has resulted in the development of a Rapid Response Discharge Service. This enables early supported discharge of patients back home with support in the Community

The need for continued improvement in the quality of care and safety, increased productivity/efficiency and development of services are complementary rather than mutually exclusive.

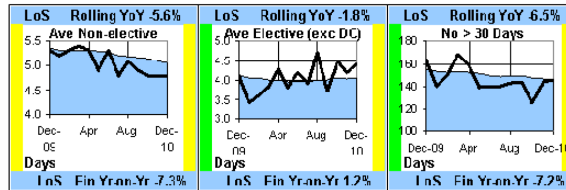
Preventing avoidable harm to patients reduces length of stay which is better for patients and also is more cost effective, i.e. acquiring an infection is unacceptable to patients and costly to the Trust.

Over the last year the Trust has used both quality and performance indicators to undertake more detailed reviews and as a result has identified a number of reductions that have be achieved as a result of improved quality and efficiency.

The Trust has seen the number of patients who are medically fit and who have been in hospital for more than 30 days reduce from more than 100 to between 15 – 20.

Executive Team 02 February 2011

Inpatient Length of Stay



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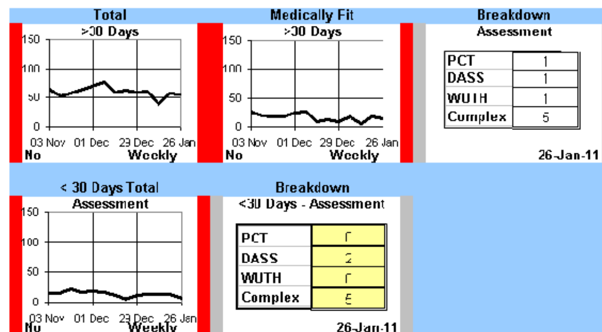
Executive Team 02 February 2011

Delayed Discharges



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6.0 RECOMMENDATION/S

THE COMMITTEE IS ASKED TO NOTE THE DEVELOPMENTS TO DATE.

REPORT AUTHOR: ***Tina Long***
Director of Nursing and Midwifery
telephone: (0151 678 5111)
email: tina.long@nhs.net

APPENDICES

NONE.

REFERENCE MATERIAL

SUBJECT HISTORY (last 3 years)

Council Meeting	Date

WIRRAL COUNCIL

HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

22 MARCH 2011

SUBJECT	**ALCOHOL RELATED HOSPITAL ADMISSIONS - FOLLOW UP REPORT**
WARD/S AFFECTED	**ALL**
REPORT OF:	**FIONA JOHNSTONE, DIRECTOR OF PUBLIC HEALTH (NHS WIRRAL)**
RESPONSIBLE PORTFOLIO HOLDER	**COUNCILLOR BOB MOON**
KEY DECISION?	**NO**

1.0 EXECUTIVE SUMMARY

1.1 Following the submission of the report concerning the performance of National Indicator 39 - alcohol related admissions to Hospital - to the Health and Wellbeing Overview and Scrutiny Committee (OSC) on 1 November 2010 and minutes 33 and 39 of that meeting, members of the Committee requested a follow up report to consider:

- The disease categories which are alcohol related
- The number of people receiving treatment and care for these conditions
- The responses being delivered in Wirral to tackle these conditions

1.2 The NHS Wirral alcohol programme aims to address alcohol related harm, improve access to alcohol treatment services and reduce alcohol related admissions to Hospital. The programme, in broad terms, delivers the following initiatives:

- Delivering developments in primary care screening and brief intervention
- Increasing capacity in specialist treatment programmes
- Increasing the capacity of community based detoxification services
- Improve crisis management responses
- Increase capacity in aftercare services
- Provide interventions in the criminal justice services
- Increase the provision of information and awareness raising
- Delivering a alcohol programme for young people (under 18s)

1.3 The delivery of the alcohol programme is intended to reduce the risk and harm associated with alcohol consumption and, in turn, ease the burden place upon the local criminal justice system and the local health and social care economy.

2.0 RECOMMENDATIONS

2.1 It is recommended that the Health and Wellbeing Overview and Scrutiny Committee note the report for information

3.0 REASON/S FOR RECOMMNEDATIONS

3.1 This report has been requested as a follow-up report and consequently, the recommendation is based upon the status of the report.

4.0 BACKGROUND AND KEY ISSUES

4.1 The burden of disease due to alcohol consumption depends upon at least two factors. Firstly, it depends upon the overall amount of alcohol consumed and secondly it depends upon the way that the amount is consumed, i.e. on a spectrum between regularly in moderate amounts to irregularly in very large amounts (usually referred to as 'binge drinking').

4.2 Chronic alcohol related conditions predominantly depend on the volume of drinking over an extended period of time whilst acute alcohol related conditions depend upon a high volume of alcohol being consumed in a very short period of time. There are, consequently, differences in the manifestation of disease and illness associated with the different levels of consumption (high or low) and the mode of the consumption (regular and moderate or irregular and high).

4.3 In order to enable the conditions caused wholly or in part by alcohol consumption to be analysed, the World Health Organisation have developed a system of 10 condition groups. These groupings are set out in the table below. Alongside the condition groupings is a column that offers a little detail of some of the types of disease and consequences associated with the particular condition. This detail is taken from the International Classification of Diseases, Version 10 (abbreviated in the table as ICD-10)

4.4 When considering the analysis of alcohol related conditions, we need to take regard of what are referred to as 'Alcohol Attributable Fractions (AAFs)'. AAFs are used to express the extent to which alcohol contributes to a health outcome - such as alcohol poisoning or non-alcohol poisoning, road traffic injuries, falls, injuries, etc. Considering the table below, there are 13 conditions which are wholly attributable to alcohol and 32 conditions which are partially attributable to alcohol

Condition groupings	ICD10 category names
Alcohol specific (Chronic)	Degeneration of nervous system due to alcohol
	Alcoholic cardiomyopathy
	Alcoholic gastritis
	Alcoholic liver disease
	Chronic pancreatitis (alcohol induced)
Alcohol specific (Mental/Beh)	Mental and behavioural disorders due to use of alcohol
Alcohol specific (Acute)	Ethanol poisoning
	Methanol poisoning
	Toxic effect of alcohol, unspecified
	Accidental poisoning by and exposure to alcohol
Accidents & Injury (Acute)	Fall injuries
	Work/machine injuries
	Firearm injuries
	Inhalation of gastric contents/Inhalation and ingestion of food causing obstruction of the respiratory tract
	Pedestrian traffic accidents
	Road traffic accidents (driver/rider)
Violence (Acute)	Intentional self-harm/Event of undetermined intent
	Assault
Digestive (Chronic)	Chronic hepatitis, not elsewhere classified and Fibrosis and cirrhosis of liver
	Acute and chronic pancreatitis
Cancer (Chronic)	Malignant neoplasm of lip, oral cavity and pharynx
	Malignant neoplasm of oesophagus
	Malignant neoplasm of larynx
	Malignant neoplasm of colon
	Malignant neoplasm of rectum

	Malignant neoplasm of liver and intrahepatic bile ducts
	Malignant neoplasm of breast
Hypertensive diseases (Chronic)	Hypertensive diseases
Cardiac arrhythmias (Chronic)	Cardiac arrhythmias
Other diseases (Chronic)	Haemorrhagic stroke
	Ischaemic stroke
	Spontaneous abortion

4.5 The table set out below describes the proportion of NI 39 related admissions for alcohol related harm recorded for men and women in Wirral in 2008-09. These data are derived from Hospital Episode Statistics and they are allocated in accordance with the 10 alcohol related conditions described in the previous table and has been collated by the North West Public Health Observatory as part of the Local Alcohol Profile.

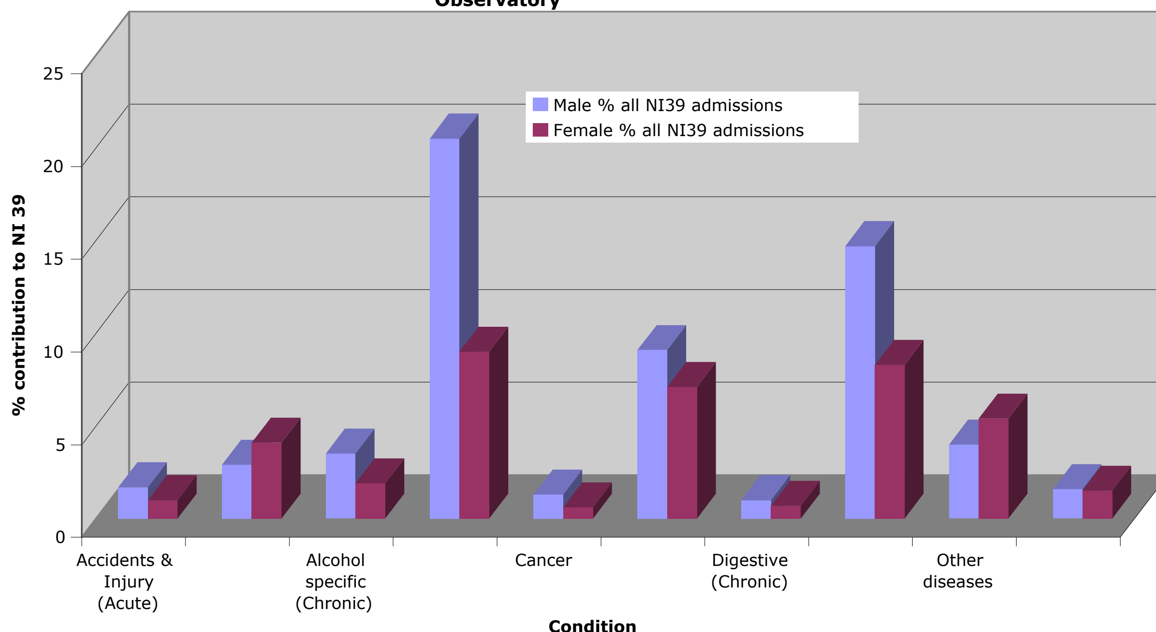
4.6 During 2008-09 (cross referenced with the previous report to the OSC) there were approximately 8,500 admissions made to Hospital which were wholly or partly attributable to alcohol consumption, i.e. they contribute to National Indicator 39.

4.7 Set out below is a table and a chart that describe what proportion (expressed as a percentage) of the 8,500 alcohol related admissions were caused by the ten alcohol related conditions already outlined. It is important to note the following points from this table:

- Male admissions contribute more to the NI 39 indicator (alcohol related admissions) than female admissions
- Hypertension, cardiac arrhythmias and mental and behavioural problems constitute the most common conditions leading to admission

Condition group	**Male % all NI39 admissions**	**Female % all NI39 admissions**
Accidents & Injury (Acute)	1.7	1
Alcohol specific (Acute)	2.9	4.1
Alcohol specific (Chronic)	3.5	1.9
Alcohol specific (Mental)	20.5	9
Cancer	1.3	0.6
Cardiac arrhythmias	9.1	7.1
Digestive (Chronic)	1	0.7
Hypertensive (Chronic)	14.7	8.3
Other diseases	4	5.4
Violence (Acute)	1.6	1.5

* both columns in this table sum to 100%



4.8 In 2007-08 the rate of hospital admissions for alcohol specific conditions for persons aged less than 18 years was the 4th highest in England. However, since that point (assisted by the initiation of the alcohol programme), the rate of admission for this group has reduced by approximately 20%. The data for 2008-09 shows that 373 people under 18 years of age were admitted to Hospital for alcohol related conditions. It is intended that the 'rate of hospital admissions for under 18 year olds' will be adopted as the key performance target for the young peoples alcohol programme.

4.9 Obviously, the most serious consequence of high-risk alcohol consumption is premature mortality. Approximately 4% of deaths within Wirral can be classified as related to alcohol, as described in the table below. It is important to stress that the data for the table refer to the deaths occurring in the period 2001-2008 (this time period increases the statistical validity of the data and may enable us to infer a pattern of mortality between the sexes)

Sex	Age	0-15	16-24	25-34	35-44	45-54	55-64	65-74	75+
Female	Number of deaths from alcohol	0	5	14	45	69	67	54	97
Male	Number of deaths from alcohol	0	21	45	100	137	159	139	111

4.10 There is a strong positive correlation between mortality from alcohol related conditions and deprivation of usual residence. The most recent data analysing this association suggests that the death rate for alcohol related conditions in the most deprived quintile is over three times higher than in the least deprived quintile.

4.11 Members of the Committee will be familiar with the different elements of the Wirral Alcohol Programme and the level of investment made by the Wirral Primary Care Trust, since this has been described in previous Committee Reports.

4.12 The information contained within this report refers to disease categories and conditions that are wholly, or in part, attributable to alcohol consumption. In order to offer assurance to the Committee that the Alcohol Programme remains committed to tackling this issue it may be relevant to illustrate some of the developments that the Wirral Primary Care Trust are intending to pursue in the year 2011-12. These developments to the existing programme are outlined below

- Increase the number of people entering specialist treatment services
- Increase the proportion of people successfully completing their action plan for day care and aftercare
- Broaden the criminal justice element of the programme so that the conditional cautioning indicator incorporates alternative responses to alcohol related crime.
- Deliver a young peoples service based upon the current pilot project which has developed strong links with the local A&E service
- In accordance with the evaluation of the Programme by the R&D Team, introduce a number of Key Performance Indicators that sit beneath the screening and brief intervention target thus:
    - The number of people screened and offered brief intervention from the 20% most deprived areas of Wirral
    - The number of people screened and offered brief intervention by the Health Trainer and Health Advocate service
    - The number of people screened and offered brief intervention by General Practitioners

5.0 RELEVANT RISK

5.1 There are no specific risks arising from this report

6.0 OTHER OPTIONS CONSIDERED

6.1 Report is for information

7.0 CONSULTATION

7.1 There are no local implications regarding public consultation arising from this report

8.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

8.1 There are no implications for voluntary, community or faith groups arising from this report. However, it is germane to point out that the delivery of the Wirral Alcohol Programme is dependent upon the contractual relationship Wirral Primary Care Trust has with a number of Wirral based voluntary, 3rd Sector and independent service providers.

9.0 RESOURCE IMPLICATIONS: FINANCIAL, STAFFING AND ASSETS

9.1 The total budget allocation for the adult and young peoples alcohol programme in 2011-12 is approximately £2.3 million. The investment set aside by the Primary Care Trust to maintain the alcohol programme forms part of the panned expenditure to April 2013.

10.0 LEGAL IMPLICATIONS

10.1 There are no relevant legal implications arising from this report

11.0 EQUALITIES IMPLICATIONS

11.1 The Primary Care Trust complies with all relevant Equality and Diversity legislation.

12.0 CARBON REDUCTION IMPLICATIONS

12.1 There is no carbon usage or relevant environmental implications arising from this report

13.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

13.1 Any reduction in hazardous drinking by residents may be associated with a reduction in alcohol related anti-social behaviour

13.2 There are no implications for planning or approval

REPORT AUTHOR: **John Doyle**
Public Health Strategy Manager (NHS Wirral)
Telephone: 0151 651 0011 Ext 1588
Email: john.doyle@wirral.nhs.uk

APPENDICES

REFERENCE MATERIAL

WIRRAL BOROUGH COUNCIL

SCRUTINY PROGRAMME BOARD – 5th January 2011

REPORT OF THE ALCOHOL SCRUTINY PANEL MEMBERS

ALCOHOL SCRUTINY REVIEW - FINAL REPORT

EXECUTIVE SUMMARY

This report provides background information regarding the Final Report of the Alcohol Scrutiny Review.

1. Background

1.1 At the meeting of the Scrutiny Programme Board, held on 14th September 2009, members agreed to undertake an in-depth scrutiny review regarding progress towards implementation of the Alcohol Strategy in Wirral. The Board members agreed that volunteers should be sought from among scrutiny members to form a Panel. It was agreed that the review should be managed by the Scrutiny Programme Board due to the cross-cutting nature of the topic and the impact on a number of areas such as health, young people, anti-social behaviour / community safety, trading standards and licensing.

1.2 Subsequently, the following members volunteered to be members of the Panel:

- Councillor Dave Mitchell (Chair)
- Councillor Sue Taylor
- Councillor Chris Meaden
- Councillor Ann Bridson

The panel has been supported by a Scrutiny Support Officer, Alan Veitch.

2. Focus for the Review

2.1 The Scrutiny Programme Board agreed the Scope for the review in January 2010. Due to the enormous breadth of the topic, it was agreed to focus on specific areas, concentrating particularly on those issues which are within the direct responsibility of the Council. The panel members proposed that, due to the high profile and significance of excessive drinking among young people, the central focus of the review should be the “access to alcohol by young people in Wirral”.

2.2 The main issues for the review were identified in the Scope document as:

- What is the impact of alcohol on young people in Wirral?
- What is the impact of young people drinking alcohol having on other residents of Wirral?
- What is already being done to enable young people to make good choices regarding alcohol?
- What are the key issues relating to access and availability: Where? Price? Promotions?
- What restrictions of access to alcohol exist at present?
- What additional restrictions of access are available and which have been successfully used elsewhere?
- Can Council policies be sensibly amended relating to the access and availability of alcohol, particularly with respect to young people?

3. Evidence Gathering and the Report

The Panel have used a number of methods to gather evidence for the review:

- Meetings with key officers
- Visits by panel members to local communities accompanied by Youth Outreach workers
- Written evidence

The Panel expresses its thanks to all those who have assisted the review by so readily giving their time, experience and suggestions.

4. The Final Report

The Final Report, 'Access to Alcohol by Young People in Wirral', which includes eleven recommendations, is attached for consideration by the Committee.

RECOMMENDATIONS

(1) That the contents and recommendations of the Alcohol Scrutiny Review be supported;

(2) that the Alcohol Scrutiny Report be forwarded to the Health & Wellbeing, Children & Young People and Sustainable Communities Overview & Scrutiny Committees;

(3) that the Alcohol Scrutiny Report be presented to the next appropriate Cabinet meeting;

(4) and that further reports be presented to the Scrutiny Programme Board to update members regarding the outcomes of the recommendations.

Report of the Alcohol Scrutiny Panel Members:
Cllr Ann Bridson
Cllr Chris Meaden
Cllr Dave Mitchell (Chair)
Cllr Sue Taylor

(13/12/10)

WIRRAL

Wirral

SCRUTINY REVIEW
of
ACCESS TO ALCOHOL BY YOUNG PEOPLE IN WIRRAL

A report produced by
THE SCRUTINY PROGRAMME BOARD

DECEMBER 2010

WIRRAL BOROUGH COUNCIL

'ACCESS TO ALCOHOL BY YOUNG PEOPLE IN WIRRAL' SCRUTINY REVIEW

FINAL REPORT

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1. EXECUTIVE SUMMARY AND RECOMMENDATIONS

Significant evidence of the impact of alcohol on young people in Wirral is available from the Joint Strategic Needs Assessment document, produced by Wirral NHS, which states that in the period between 2001 and 2008, there were 131 deaths of young people in the 16 to 24 age range. Of that total, 26 were specified as alcohol related deaths. "Mortality of cohorts younger than 40 years of age are related to bouts of heavy / binge drinking and end in acute consequences such as accidents rather than chronic conditions".

Furthermore, the Local Alcohol Profiles for England (LAPE), published by the North West Public Health Observatory in September 2010, ranks Wirral as 323 out of 326 local authority areas for alcohol-specific hospital admissions for under-18s (with a rank of '1' being the best performer in the country). However, it is equally significant to note that, since 2006/7, there has been a continual reduction in such hospital admissions for young people. This is to be welcomed and reflects the significant amount of work that has been done through the Wirral Alcohol Harm Reduction Strategy during this period. It was apparent during the review that a huge amount of work is taking place in an effort to both educate and guide young people away from alcohol misuse, as well as to reduce the supply of alcohol to young people wherever possible. Panel Members would like to highlight a letter regarding 'Wirral's Young People Specialist Substance Misuse Treatment Plan Submission', dated 4th January 2010, sent from the National Treatment Agency for Substance Misuse to the Chair of Wirral DAAT (Drug and Alcohol Action Team). The letter is fulsome in praise for the work taking place in Wirral: "The Wirral submission is an excellent example of a fit for purpose and knowledgeable needs assessment and plan. All who have been involved in the process should be proud of their involvement and effort". Nevertheless, although substantial progress has been made, significant challenges clearly remain.

The current Wirral Alcohol Harm Reduction Strategy was launched in 2007 to cover a period up to and including 2010. The three priorities of the existing strategy (2007-10) are:

- Young People's Alcohol Misuse
- Alcohol Related Identification and Treatment
- Alcohol Crime, Disorder and Communities

The implementation of the overall strategy is coordinated by Wirral DAAT (Drug and Alcohol Action Team) in conjunction with a number of key partners in a multi-agency collaboration. However, with specific regard to the delivery of the element relating to young people, the Children and Young People Department of Wirral Borough Council plays a major strategic role. Key to the strategy is a recognition that long-term success is likely to rely on both a reduction in the supply of alcohol to young people as well as a decrease in the demand for alcohol among some young people by changing their behaviour patterns. A third aspect of the Action Plan is an understanding of the need to tackle some of the negative outcomes that arise from alcohol consumption among young people.

Within the context of Wirral, it also important to note that 'Tackle alcohol harm' is a Priority for Improvement in the Council's Corporate Plan for 2010/11. It is hoped that this will result in the subject of alcohol and young people remaining high among the priorities of the Council in the future.

Multi-agency working is a cornerstone on which the delivery of the Wirral Alcohol Harm Reduction Strategy is built. Examples of partners working together constructively have been very impressive throughout this Scrutiny Review process and some of these are highlighted later in the report. Although the NHS proportion of the funding (£194,000) to deliver the alcohol element of the Wirral Prevention Plan is in place until 2013, due to the extensive multi-agency involvement in the alcohol

programme, funding has been provided from a number of different sources, often covering relatively short time periods. Overall, this does not promote long-term stability in service provision. In the future, longer-term budgeting would enable more long-term planning for the delivery of the service.

It is important that there is a process of measurement and performance monitoring in place to evaluate the outcomes of any programme or project. It is recognised that there is a cost associated with the collection of monitoring data and that the measurement of the outcomes of preventative work is not easy. Although some performance indicators are already in place, specific measurements of some further outcomes from the Alcohol Harm Reduction Strategy, and especially with relevance to young people, would enable the decision-makers to make better informed decisions. Further development of suitable data-sharing arrangements among the partners would be beneficial.

It is worth noting that, as with many parts of the public sector, this service area is likely to be subject to change in the coming months. The change is already underway in the form of new Government strategy, the Home Office consultation on licensing policy and subsequent publication of the Police Reform and Social Responsibility Bill, the increasing interest in the proposal for minimum pricing of alcohol as well as the drive to secure more efficient services. Separate management structures and physical locations can very easily create unintentional barriers. It is, therefore, worth noting that the Government's stated intention to transfer public health to Local Authorities may mean that, in the longer-term, opportunities could arise to consolidate some of the reporting structures to provide an even more focused unit.

Licensing for the sale of alcohol is currently governed by the Licensing Act 2003. Since the Coalition Government was formed in May 2010, the Home Office launched a review of the licensing laws pertinent to the sale of alcohol through the consultation document, 'Rebalancing the Licensing Act'. Subsequently, the Police Reform and Social Responsibility Bill has been introduced to the House of Commons on 30 November 2010.

The Scrutiny Review in Wirral revealed clear frustrations with the current legislative framework. The impact of the proposed changes to both legislation and statutory guidance, as detailed later in the report, will influence outcomes for the foreseeable future. The intention is to give local authorities and the Police stronger powers to remove licenses from, or refuse to grant licenses to, any premises that are causing problems. In addition, the proposed reforms include the option of those premises found to be persistently selling alcohol to children being fined a maximum of £20,000. Whether these proposed reforms are found to go far enough remains to be seen. For example, the British Medical Association has called for a ban on all alcohol advertising, including sports and music sponsorship as well as an end to cut-price deals on alcohol. Meanwhile, the debate on the impact of a possible minimum unit price for alcohol continues. In his Annual Report for 2008, the Chief Medical Officer, Sir Liam Donaldson, called for the introduction of minimum pricing, stating: "Cheap alcohol is killing people and it's undermining our way of life. In my report price and access are two crucial factors affecting alcohol consumption. I recommend action taken on both but particularly on price". Subsequently, the Cheshire and Merseyside Public Health Network (CHAMPs) is consulting on the proposal as is the Liverpool City Region Cabinet. The members of the Scrutiny Panel support the principle of a minimum unit price for alcohol.

A key element in the Wirral Alcohol Harm Reduction Strategy is to reduce the supply of alcohol to young people wherever possible. Both the Trading Standards and the Licensing Divisions at Wirral Borough Council play a key role in monitoring the framework within which businesses must operate. The work of Trading Standards, however, is a combination of "carrot and stick". In addition to enforcement action, the team is also involved in educating the owners / managers of off licences.

Although it may be possible to take steps to reduce the supply of alcohol to young people in the relatively short-term, it is considered to be a longer-term objective to reduce their demand for alcohol. Key to the reducing some young people's desire to consume alcohol is the role of education and parental influence and engagement. Although there is confidence that the overall education programme does produce positive outcomes, the extension of the scheme to include more primary school children would be beneficial.

It is recognised that it is very difficult to engage some parents in general, not just on issues regarding alcohol. The involvement of parents is critical as there is a need to educate children about alcohol misuse. It is obvious that parents have a very important role in this education process. However, the influence of parents goes well beyond the education of young people regarding alcohol. One alcohol worker, who works actively with young people commented directly that "many young people think that parents are hypocrites over alcohol". Therefore, it is the role of parents as role models that is just as important.

In considering the evidence found during the review, the Panel Members have formulated the recommendations identified on pages 6 and 7.

RECOMMENDATIONS

A. Wirral Alcohol Harm Reduction Strategy as a Council priority

It is recognised that 'Tackle alcohol harm' is a Priority for Improvement in the Council's Corporate Plan for 2010/11 and an Aim for 2008-2013. Given the statistical evidence of alcohol harm in Wirral, the Cabinet is encouraged to ensure that alcohol misuse remains a priority among the Council's objectives for the foreseeable future. Financial support for the service should follow its recognition as a priority service.
(Reference Section 6.3.1, page 21)

B. Funding

In the past, the alcohol harm reduction services have been provided from a variety of short-term funding streams. This does not promote long-term stability in service provision. In the future, Cabinet is urged to promote long-term planning for the delivery of service by encouraging budgeting for the service over a longer time-frame.
(Reference Section 6.3.3, page 23)

C. Performance Management

Cabinet is urged to support the implementation of a series of performance indicators which will measure the outcomes of the Alcohol Harm Reduction Strategy, including the preventative aspects of the work and the impact on young people. Further development of suitable data-sharing arrangements among the partners, using a single set of data wherever possible, would be beneficial.
(Reference Section 6.3.4, page 25)

D. Education of young people

Council is requested to recognise the importance and continued priority of education for young people regarding the dangers of alcohol misuse. Education is recognised as a cornerstone of the Alcohol Harm Reduction Strategy. The support of all agencies, including schools, health authorities, the Police, Fire & Rescue Service and the voluntary sector, as well as Wirral Council, is fundamental to the delivery of this service. There is concern that appropriate alcohol awareness education should be available to young people in Years 5 and 6 at primary school. Research shows children aged ten and eleven are the most vulnerable age group regarding alcohol.
(Reference Section 6.5.1, page 31)

E. Legislative framework

Wirral Council Cabinet is encouraged to lobby the Home Office for changes in the law aimed at reducing the supply of alcohol to young people by:

- Limiting the promotion of the sale of alcohol, for example, through 'happy hours'
- Restricting the use of alcohol as a 'loss leader' by supermarkets and other retail outlets
- Reducing the promotion of alcohol through advertising
- Reducing the scale of proxy sales by imposing greater fines on those purchasing alcohol on behalf of under-age drinkers

(Reference Section 6.2, page 18)

F. Minimum unit pricing for alcohol

The Review Panel supports the principle of minimum unit pricing for alcohol. Council is requested to engage positively in the process to introduce a regional minimum price for alcohol in the Merseyside region.

(Reference Section 6.4.3, page 30)

G. Cumulative Impact Policy

Council should actively seek to introduce a Cumulative Impact Policy, as has been introduced by Local Authorities such as Liverpool and Brighton, in order to tackle the increase in outlets in specific hotspot areas.

(Reference Section 6.4.2, page 27)

H. Trading Standards

The work of Trading Standards is considered an important element in combating the sale of alcohol to young people. An additional £40,000 was included in the 2010/11 budget of the Council to enable Trading Standards to continue tackling under-age sales of alcohol using a number of methods, including test purchasing, which had led to a reduction in sales to under-age young people. Cabinet is urged to retain that financial support.

(Reference Section 6.4.1, page 26)

I. Alcohol-related hospital admissions

All agencies, including Wirral DAAT, are encouraged to ensure that the excellent advice services currently available to support young people who are subject to alcohol-related hospital admissions are continued and, if necessary, expanded.

(Reference Section 6.1.2, page 15)

J. Relationship with Magistrates

The Council is encouraged to further develop a tripartite relationship with magistrates and the Police in order to cultivate a mutual understanding of issues relating to the application of licensing laws in the courts.

(Reference Section 6.4.2, page 27)

K. Multi-agency working

Wirral Council Cabinet is invited to congratulate all of the agencies and staff involved in the delivery of the Wirral Alcohol Harm Reduction Strategy. Although much progress remains to be made in tackling the problem of alcohol misuse in Wirral, the impressive partnership working already in place provides a firm foundation for future progress. The Outreach Workers are among the key front-line staff who engage directly with young people and are responsible for the delivery of the Alcohol Harm Reduction Strategy. In the current difficult financial circumstances for public services, the protection of the front-line staff should be recognised as a priority in the onward delivery of the strategy. The approach of strong multi-agency working should continue to be supported in the future.

(Reference Section 6.3.2, page 23)

2. ACKNOWLEDGEMENTS

This report presents the findings of a Scrutiny Review into the ‘Access to Alcohol by Young People in Wirral’. The Review was undertaken by a Working Group which was set up by the Scrutiny Programme Board. It is hoped that the recommendations which form part of the report will further develop the good practice that exists within the Council and with our partners. It was apparent during the review that a huge amount of work is happening in both an effort to educate and guide young people away from alcohol misuse as well as to reduce the supply of alcohol to young people wherever possible.

The Panel would like to thank all those people who willingly agreed to contribute and to provide information to this review. In particular, the Panel thanks all of the staff with whom they have met and exchanged ideas. There were many varied contributions to the review process. In addition, all of the Panel Members had the opportunity to take part in visits into our streets, parks and local communities wherever young people congregate. These visits were in the company of the dedicated Outreach Workers of the Response team from the Children and Young People Department. All of the members found these visits enlightening and gave a first hand view of the challenges that alcohol misuse among young people provides for the Council and our local communities in the Borough.

It is worth noting that, as with many parts of the public sector, this service area is likely to be subject to change in the coming months. The change is already underway in the form of new Government strategy, the Home Office consultation on licensing policy and subsequent publication of the Police Reform and Social Responsibility Bill, the increasing interest in the proposal for minimum pricing of alcohol as well as the drive to secure more efficient services. The constantly changing background has, therefore, made the review more difficult.

Thank you to the Panel Members who have all contributed fully to the review, which I hope will contribute to the development of service provision in this area. In the future, it is important that the impact of all of the recommendations is reviewed and that progress is monitored.

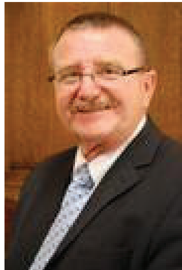
Thank you to all for your participation and contributions to this Review.

Councillor Dave Mitchell (Chair of the Members’ Panel)

3. PANEL MEMBERSHIP

The Alcohol Scrutiny Panel was appointed by the Scrutiny Programme Board on 14th January 2010. The purpose of the Panel is to carry out a Scrutiny Review of the impact that alcohol consumption by young people is having on those young people and the wider community. The Panel will make any relevant recommendations for changes which, in the first instance will be discussed by the Scrutiny Programme Board. The following members volunteered to be members of the Panel:

Councillor Dave Mitchell (Chair)



Councillor Chris Meaden

Councillor Ann Bridson

Councillor Sue Taylor

The Scrutiny Support Officer for this Scrutiny Review was Alan Veitch.

4. BACKGROUND AND ORIGINAL BRIEF

At the meeting of the Scrutiny Programme Board held on 14th September 2009, Members agreed to undertake an in-depth Scrutiny Review regarding progress towards implementation of the Alcohol Strategy in Wirral. The Board Members agreed that volunteers should be sought from among Scrutiny members to form a panel. It was agreed that the review should be managed by the Scrutiny Programme Board due to the cross-cutting nature of the topic and the impact on a number of areas such as health, young people, trading standards, licensing, anti-social behaviour and community safety.

Due to the enormous breadth of the topic, it was agreed to focus on specific areas, concentrating particularly on those issues which are within the direct responsibility of the Council. The Panel Members proposed that, due to the high profile and significance of excessive drinking among young people, the central focus of the review should be the "access to alcohol by young people in Wirral".

The Scope Document for the review, attached as Appendix 1 to this report, was agreed by the Scrutiny Programme Board in January 2010. It was agreed that the review would concentrate on the following issues:

- What is the impact of alcohol on young people in Wirral?
- What is the impact of young people drinking alcohol having on other residents of Wirral?
- What is already being done to enable young people to make good choices regarding alcohol?
- What are the key issues relating to access and availability: Where? Price? Promotions?
- What restrictions of access to alcohol exist at present?
- What additional restrictions of access are available and which have been successfully used elsewhere?
- Can Council policies be sensibly amended relating to the access and availability of alcohol, particularly with respect to young people?

The Panel commenced work in attempting to find answers to these questions.

5. METHODOLOGY FOR THE REVIEW

The Panel has employed a number of methods to gather evidence.

5.1 Meetings / Visits with Officers

A series of individual meetings has taken place at which the Panel Members could discuss relevant issues with key Officers from each of Wirral Borough Council, Wirral NHS (PCT), Wirral Drug and Alcohol Action Team (Wirral DAAT) and Merseyside Police. Those interviewed during the course of the review were:

Wirral Drug and Alcohol Action Team (DAAT)
Terry White (Young Persons Programme Manager)
Gary Rickwood (Manager, Wirral DAAT)
Bev McAteer (Wirral Alcohol Strategy Manager)

Wirral Borough Council
John Malone (Manager, Trading Standards)
Margaret O'Donnell (Manager, Licensing)
Pat Rice (Head of Response, Children & Young Peoples Department)
Donna Callaghan (Young Persons Alcohol Intervention Worker, Response, Children & Young People Department)
Steve McGilvray (Community Safety Team)

Wirral NHS
Sue Drew (Deputy Director of Public Health)
Mindy Rutherford (Alcohol Programme Manager)
Anne Tattersall (Head of Health & Wellbeing, Children and Young People)

Merseyside Police
Sgt Dave Peers (Licensing Sergeant)
Sgt Simon Barrigan (Community Engagement Officer)

Third Sector
Carol Gillam (a worker from the Life Education Wirral Caravan)

5.2 Panel Members' visits with Outreach Workers

During the review, each of the Panel Members undertook visits to street locations, parks and some youth clubs in order to engage directly with young people who were most likely to consume alcohol. Each of the members produced a short report, identifying relevant issues. These reports are attached as Appendix 2 to the main report.

5.3 Written Evidence

Written evidence was received from a variety of sources. Details are shown in Appendix 3 to this report.

6. EVIDENCE AND RECOMMENDATIONS

6.1 Alcohol Consumption in Wirral

6.1.1 The Scale of the Problem in Wirral

The World Health Organisation categorises alcohol use disorders into three categories:

- Hazardous drinking: people drinking above recognised 'sensible' levels (14 units a week for females or more than 21 units a week for males) but not yet experiencing harm
- Harmful drinking: people drinking above 'sensible' levels and experiencing harm
- Alcohol dependence: people drinking above 'sensible' levels and experiencing harm and symptoms of dependence

The 'Joint Strategic Needs Assessment' for Wirral, produced by Wirral NHS for 2009/10, estimates that in the 16+ age range, there are:

- 57,220 drinkers or 22.7% of the 16+ population who are categorised as 'hazardous'
- 16,500 drinkers or 6.6% of the 16+ population who are categorised as 'harmful'
- 11,852 drinkers or 4.6% of the 16+ population who are categorised as 'dependent'

Therefore, the total number of adults (16 years+) estimated to have an alcohol use disorder in Wirral is approximately 74,000. Furthermore, it is estimated that alcohol dependence is higher in younger age groups, with in excess of 2,000 young people in the 16 to 19 age range who are dependent drinkers, with a further 2,400 in the 20 to 24 age range.

Another measure of the impact of alcohol is National Indicator 39 (NI39), which is defined as "The rate of alcohol related hospital admissions per 100,000 of the population over the age of 18". Table 1 displays NI39 statistics for Wirral alongside a number of geographical neighbours. As can be seen, the rate of alcohol-related admissions in Wirral is currently third highest relative to the comparators; Liverpool plus Halton & St Helens being higher.

Table 1: Alcohol related admissions to hospital per 100,000 of the adult population – historical and geographical neighbour comparisons

PCT Name	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Knowsley	1595	1726	1810	1985	2177	2480	2607	2803
Sefton	1215	1299	1413	1671	1771	1939	1999	2338
Wirral	**1261**	**1374**	**1630**	**1856**	**2196**	**2384**	**2427**	**2428**
Liverpool	1699	1833	1992	2330	2642	2613	2853	3125
Halton and St Helens	1667	1833	1804	1842	1963	2144	2399	2528
Western Cheshire	1031	1147	1262	1377	1518	1585	1667	1864
Central and Eastern Cheshire	983	1087	1180	1441	1550	1498	1611	1746

Source: NHS Information Centre data released on 7th October 2010, as presented in the report of the Director of Public Health, 'Alcohol related admissions to hospital', to Wirral Council Health and Wellbeing Overview and Scrutiny Committee, 1st November 2010

The performance of Wirral NHS is measured against a trajectory or target figure, whereby an estimate is calculated for future years. It is noteworthy that, relative to the trajectory figure, Wirral has performed well in 2008/9 and again in 2009/10. In the year 2009/10, the NI39 target rate was 2,762 admissions per 100,000 of the adult population. The actual rate was 2,428. This may well suggest that the work being done through the Wirral Alcohol Harm Reduction Strategy is having a positive impact. The report of the Director of Public Health, 'Alcohol related admissions to hospital', to Wirral Council Health and Wellbeing Overview and Scrutiny Committee, 1st November 2010, states that **"the average cost of an admission to hospital is approximately £1,200". Therefore, based on that figure, an estimated cost of 2,428 admissions per year is approaching £3million to the NHS.**

Although this Scrutiny Review has primarily investigated the implications of alcohol for young people, it is worth noting that The Local Alcohol Profiles for England (LAPE), published by the North West Public Health Observatory in September 2010 ranked Wirral as having the poorest record in England for alcohol-specific hospital admissions among women. Professor Mark Bellis, Director of the Observatory is quoted:

"The price we pay for turning a blind eye to the real extent of alcohol abuse across England is reflected in the new Local Alcohol Profiles for England and it is a price that is paid especially by the poorest communities".

Given the data for the adult population, it is, therefore, perhaps not surprising that Wirral records high level of alcohol misuse among young people too. The Local Alcohol Profiles for England (LAPE), published by the North West Public Health Observatory in September 2010 ranks Wirral as 323 out of 326 local authority areas for alcohol-specific hospital admissions for under-18s (with a rank of '1' being the best performer in the country). Only the Local Authority areas of Copeland, Halton and Liverpool are ranked below Wirral. However, as with the analysis of all-age alcohol-related hospital admissions discussed above, the rate of reductions for young people since 2006/7, reported in Table 4 below, is very welcome.

Table 2: Hospital admissions for alcohol-specific conditions among young people in Wirral, North West and England – 2009/10

Age 0 – 17	Rate per 100,000 population		
	Wirral	North West average	National average
Total	**158***	109	65

*Wirral's national rank = 323 out of 326

Source: North West Public Health Observatory (NWPHO)- Local Alcohol Profiles for England (LAPE)

Table 3: Hospital admissions for alcohol-specific conditions among young people (0 – 17) in Wirral and neighbouring authorities – 2009/2010

Local Authority Area	Rate per 100,000 population (Age 0 – 17)	Local Authority Area	Rate per 100,000 population (Age 0 – 17)
Cheshire East	98.2	Sefton	132.7
Cheshire West	88.9	St Helens	132.4
Halton	165.8	Warrington	111.6
Knowsley	136.1	**Wirral**	**158.4**
Liverpool	168.6		

Source: North West Public Health Observatory (NWPHO)- Local Alcohol Profiles for England (LAPE)

Table 4: Hospital admissions for alcohol-related conditions among young people (0 – 17) in Wirral – Historical trend analysis

Year	**Wirral rate** per 100,000 population
2006/7	181.9
2007/8	161.8
2008/9	144.6
2009/10	128.5

Source: Wirral DAAT – Young People's Specialist Substance Misuse Needs Assessment 2009/2010 and the Hospital Episode Statistics, NHS Wirral

It is worth noting that the data shown in Table 3 (LAPE – North West Public Health Observatory) and in Table 4 (Hospital Episode Statistics, Wirral NHS) are not consistent in terms of the actual figure shown for Wirral. This is due to differing criteria that are used to compile the data. It would clearly be advantageous to have a standard form of data collection, an issue that is now under review by Wirral DAAT.

At a national level, an ICM poll conducted in August 2010 on behalf of the alcohol awareness charity, Drinkaware, found that, of 2,000 young adults aged 18 to 24, 36% of those questioned went out drinking with the specific intention of getting drunk. The survey also found that one in three young adults thought that it was acceptable to wake up without knowing how they got home after a drinking session and one in 25 believed it was acceptable to end up in hospital.

The Wirral Joint Strategic Needs Assessment (JSNA) reports the results of the School Health Education Unit Survey (SHEU), which provides information about alcohol use amongst young people and was gathered during the summer term in 2008. The survey involved 2,054 Year 8 and Year 10 pupils across ten Wirral schools. Key findings include:

- 94% of Year 10 girls have ever drunk alcohol compared to 86% of males; Year 8 boys are least likely to have ever drunk alcohol (76%).
- 16% of the sample report regular drinking (at least once per week). This includes 7% who drink enough to get drunk once a week and 2% who get drunk enough to be sick once a week.
- 33% of the sample had an alcoholic drink in the week preceding completion of the survey. This is in line with the national figure for schools completing the survey in the Spring/Summer terms.
- Of those who had an alcoholic drink in the last seven days, over half (53%) had been drunk on at least one day.
- 23% said they would probably give in and drink alcohol if at a party and encouraged to by friends. This was highest for Year 10 boys (27%).

Tellus4 is a survey of children and young people across England which asks for their views about their local area, and includes questions covering the five 'Every Child Matters' outcomes. The most recent survey for which data is available was undertaken in Wirral in 2009 and assessed the views of a combination of Year 6, 8 and 10 pupils. With regard to views on alcohol, the responses for Wirral, with national and statistical neighbour comparators, were as follows:

Table 5: Results of the Tellus4 survey regarding pupil attitudes to alcohol consumption, 2009

Table 5a

Response	**Wirral (%)**	National (%)	Statistical neighbours (%)
Have you ever had an alcoholic drink – a whole drink not just a sip?			
Yes	**49**	42	47
No	**44**	51	46
I don't want to say	**7**	7	7

Source: Tellus4 survey results for Wirral, 2009

Table 5b

Response	**Wirral (%)**	National (%)	Statistical neighbours (%)
In the last four weeks, how many times have you been drunk?			
None / never had an alcoholic drink	**63**	68	65
Once	**7**	6	7
Twice	**5**	4	5
Three or more times	**7**	5	6
Don't want to say	**9**	8	9
Don't know / can't remember	**3**	2	3
I have never been drunk	**6**	6	6

Source: Tellus4 survey results for Wirral, 2009

Within Wirral, alcohol workers report that the hotspots for young drinkers include Seacombe, Wallasey, Birkenhead and Rock Ferry. However, a senior alcohol worker did comment that, regarding alcohol misuse among young people:
"The problem is everywhere; it is not about social class or geographical area".

6.1.2 The Consequences of Young People Drinking

A publication 'What is the scale of the alcohol problem in Merseyside?', produced in 2009 by the Centre for Public Health at Liverpool John Moores University estimated the following consequences of alcohol consumption for the United Kingdom:

- 530,000 hospital admissions
- 331,248 recorded violent crimes
- 6,514 sexual offences
- 40,940 incapacity benefits claimants
- £20billion cost to the economy in the UK

Stark evidence of the impact of alcohol on young people in Wirral is available from the Joint Strategic Needs Assessment document which states that, in the period between 2001 and 2008, there were 131 deaths of young people in the 16 to 24 age range. Of that total, 26 were specified as alcohol related deaths. "Mortality of cohorts younger than 40 years of age are related to bouts of heavy / binge drinking and end in acute consequences such as accidents rather than chronic conditions".

Data regarding alcohol-related hospital admissions of young people under the age of 18 are detailed earlier in this report (see Section 6.1.1 – 'The Scale of the Problem in Wirral'. As stated, the Local Alcohol Profiles for England (LAPE), published by the North West Public Health Observatory in September 2010 ranks Wirral as 323 out of 326 local authority areas for alcohol-specific hospital admissions for under-18's (with a rank of 1 being the best performer in the country).

A recent study conducted by the charity Alcohol Concern found that, between 2002 and 2007 alcohol-related hospital admissions for under-18s increased by 32%. The report, 'Right time, right place: Alcohol-harm reduction strategies with children and young people', estimates that an average of 36 children a day are admitted to hospital for alcohol related conditions. Among the recommendations of that report are requests for earlier identification of young people engaged in "risky" drinking such as young people attending A&E or getting into trouble with the Police for alcohol, so they can access information, advice and support.

An innovative response to the level of alcohol-related hospital admissions among young people has been the introduction of an Alcohol Worker who delivers targeted interventions to young people who misuse alcohol. This worker takes referrals from across Wirral including the Police, schools and parents, as well as attending A&E at Arrowe Park on a Friday evening to offer advice and support, particularly to the parents / carers of young people who have been drunk. This intervention can result in referrals and home visits. The service is managed by the Youth Service's Response team. There have been 356 alcohol-related hospital admissions of young people to Arrowe Park in 2009/10. The largest group to receive this service is 13 to 16 year-olds in Children's A&E. Those aged 16 and over are admitted to Adult A&E. For those young people who are admitted to Children's A&E, the vast majority of parents / carers are in attendance, which provides the opportunity to engage with them. The Alcohol Worker post has been funded through Wirral Drug and Alcohol Action Team (DAAT), supported by funding from the Area Based Grant and Wirral NHS. It provides an excellent example of the partnership working that has been delivered through the Alcohol Harm Reduction Strategy. It is also an example of the early identification of young people that is recommended in the Alcohol Concern report, Right time, right place'.

In terms of long-term health consequences, a manager of the alcohol programme remarked that:
"The rate of increase for cirrhosis of the liver among young people is going through the roof. Much of the access to alcohol is through adults getting it from shops for the young people. There are no consequences for the adults".

RECOMMENDATION 1 Alcohol-related hospital admissions
All agencies, including Wirral DAAT, are encouraged to ensure that the excellent advice services currently available to support young people who are subject to alcohol-related hospital admissions are continued and, if necessary, expanded.

With regard to the impact of alcohol on the levels of crime and anti-social behaviour, it is generally understood that not all incidents come to the attention of agencies and are, therefore, unrecorded. However, Arresting and Custody Suite officers are able to identify those young people who they believe to be under the influence of alcohol. Therefore, an estimate can be given of the number of young people who have been arrested where alcohol has been a factor in that arrest. Table 6 shows the number of such arrests:

Table 6: Number of arrests of young people (under 18 years of age) in Wirral, who were reported to be under the influence of alcohol 2009/2010

Year	Number of arrests
2006 – 2007	137
2007 – 2008	131
2008 - 2009	257

Source: Report of the Director of Regeneration, 'Young People and Community Safety', to Wirral Council Sustainable Communities Overview and Scrutiny Committee, 18th November 2009

As with the Alcohol Intervention worker who works closely with Arrowe Park hospital, in the case of alcohol-related hospital admissions, a similar approach has been implemented for the arrest of young people. The Young Persons Alcohol Intervention Programme (YAIP) provides a full-time youth worker who operates in partnership with Merseyside Police and the Youth Offending Service (YOS) and the service is managed by the Youth Service's Response team. Funding for the YAIP, provided by Wirral NHS, is available until 2013. The strategy of the YAIP is to provide a graded response relevant to the seriousness of the initial incident.

When young people are picked up, it may result in them being taken to A&E, arrested, given a warning or taken to a place of safety. The worker provides support to those young people who have been arrested by the Police for an alcohol-related offense. Interventions take place with family members and young people in an attempt to prevent repeat arrests and a reduction in alcohol consumption. Initially, the YAIP provided interventions to those young people who were arrested or stopped by the Police for alcohol-related issues or offenses. However, due to the low number of referrals from the Police for 'Stop' incidents, it was decided in June 2010 to continue with referrals only in the case of arrests.

With regard to the YAIP project, a manager of the alcohol programme told the Members' Panel that:
"The YAIP helps to coordinate a programme of work to target young people on the streets and is seen as a model of good practice".

While another commented that:
"The YAIP has been very successful at providing interventions for young people who have been arrested or stopped by the Police for an alcohol-related offence".

The YAIP provides a link between the enforcement action taken by the Police and the support / intervention services which can prevent or reduce the possibility of repetitive behaviour in the future. The apparent success of the project may be due to the double-headed role with the Police providing a fear of arrest running alongside the educational aspects of the programme. The education involves messages regarding the impact of alcohol on health, risky behaviour, the increased risk of violence or sexual behaviour and so on. However, it is essential that, for the YAIP to prosper in the future, information regarding arrests must be passed quickly to Response and, wherever possible, shared data should be used. Under these circumstances, more effective interventions may be expected. Another key issue for the future of the programme is to ensure that there is more effective work and engagement with parents and carers.

A further issue is the anti-social behaviour which excessive drinking generates, much of which goes unreported to the Police. Considerable investment has been made by Wirral Borough Council through the Community Safety Unit and the Anti-Social Behaviour Team in order to combat the impact on communities. Further consequences of young people drinking were seen by Panel Members during their visits with the Outreach Workers. There was evidence of young people aged 12 years old who

were drunk in local parks at 8.30 in the evening. It was noticeable that there were younger girls (who were drunk) in the company of older boys. Indeed, a survey of 13,000 young people aged between 14 and 17, undertaken by Trading Standards North West in 2009 revealed that one in six teenagers regretted having sex after drinking. The impact of risky behaviour can be demonstrated starkly by a case in Wirral where a group of young people were drinking heavily and concluded in a young teenage girl being raped. An officer remarked:
"The consequence is two wrecked families".

6.2 The Legislative Framework

Licensing for the sale of alcohol is currently governed by the Licensing Act 2003, which became law in November 2005. Since the Coalition Government was formed in May 2010, responsibility for licensing law relevant to the sale of alcohol (and the Licensing Act 2003) has moved from the Department of Culture, Media and Sport to the Home Office. Consequently, the Home Office began a review with a formal consultation document, 'Rebalancing the Licensing Act', being formally launched by the Home Office in July 2010, with the intention to review the Licensing Act of 2003. Subsequently, the Police Reform and Social Responsibility Bill has been introduced to the House of Commons on 30 November 2010.

On taking office, the Coalition Government's programme on alcohol, as outlined by the Home Office, included commitments to:

- overhaul the Licensing Act 2003 to give local authorities and the Police much stronger powers to remove licences from, or refuse to grant licences to, any premises that are causing problems
- allow councils and the Police to shut down permanently any shop or bar found persistently selling alcohol to children
- double the maximum fine for underage alcohol sales to £20,000
- permit local councils to charge more for late night licences to pay for additional policing
- ban the sale of alcohol below cost price
- review alcohol taxation and pricing to ensure it tackles binge drinking without unfairly penalising responsible drinkers, pubs and important local industries

Some of these and other proposals form the basis of the Government's Police Reform and Social Responsibility Bill. It is, therefore, reasonable to assume that most or all of these measures will become law at some stage in the future. Under the provisions of the 2003 Licensing Act there is a basic presumption in favour of granting an application for a licence to sell alcohol. In turn, this makes it difficult for Local Authorities to refuse applications. The Government's consultation document and subsequent Bill proposes to alter the emphasis of the law whereby Local Authorities will be given more flexibility to decline or revoke a licence.

Among the provisions of the Police Reform and Social Responsibility Bill, the Government has signalled its intention to make provisions which include the following:

- Overhaul the Licensing Act 2003 to give local authorities and the Police much stronger powers to remove licenses from, or refuse to grant licenses to, any premises that are causing problems by:
  - giving licensing authorities the power to refuse licence applications or apply for a licence review without requiring relevant representations from a responsible authority. This will help licensing authorities to pro-actively target irresponsible businesses.
  - lowering the evidential hurdle for licensing authorities when making licensing decisions by requiring that they make decisions which are 'appropriate' rather than necessary for the

promotion of the licensing objectives. This will help ensure that licensing authorities are able to better reflect the needs of the local area.
    - increasing the opportunities for local residents or their representative groups to be involved in licensing decisions by removing the requirement to show vicinity. This means that any person, body or business will be able to make a relevant representation, regardless of where they live.
- Enable more involvement of local health bodies in licensing decisions by designating Primary Care Trusts (PCTs or their future equivalents) in England as a responsible authority.
- Amend the Statutory Guidance to make it clear to licensing authorities that there should be a presumption that all reasonable recommendations from the Police should be accepted unless there is clear evidence to the contrary.
- Amend the Statutory Guidance to require licence applicants to give further consideration to the interests of the local community when setting out the steps they will take to promote the licensing objectives.
- Local Authorities will be permitted to charge a late-night levy to pay for policing the night-time economy and other services related to the consequences of alcohol on the night-time economy. The levy will be set at a national level and will be an annual charge. However, local authorities will be able to specify the hours (between midnight and 6.00am) during which the levy will apply.

However, on the issue of banning below cost sales, it worth noting that the Government has stated in the document 'Responses to Consultation: Rebalancing the Licensing Act', that "We are committed to taking forward proposals to implement the ban on sales below cost without delay; however they will not form part of the Police Reform and Social Responsibility Bill". It is, therefore, currently unclear how the issue of alcohol pricing will develop in the future. Section 6.4.3, later in this report, investigates the issue of minimum pricing further.

With specific regard to 'Protecting Children from the Harm of Alcohol', the Government's consultation document stated that "Despite the growing problem of children's alcohol misuse and the increasing impact on public services, not enough has been done at the local level to limit the availability of alcohol to children. The current powers do not go far enough to prevent selling alcohol to children. Although pupils' access to alcohol is typically by being given it by friends or parents, about half of pupils who have ever drunk also say that they do buy alcohol, despite being well below the age when they can legally do so". It is the Government's intention to take tougher action to penalise those premises found to be persistently selling alcohol to children. Currently, if a licence holder pleads not guilty to persistent underage selling and is prosecuted, they can face a fine of up to three months suspension of their alcohol licence.

At a national level, in 2008 there were nine prosecutions with four fines issued. The average fine issued was £1,713. However, as an alternative to prosecution, the Police can give the licence holder the option to voluntarily accept a 48 hour closure notice. The 48 hour suspension of alcohol sales was given 54 times in 2008/09. In addition, the Police can ask the licensing authority to review the licence. The Police Reform and Social Responsibility Bill therefore proposes to increase the maximum fine to £20,000 and to provide for a longer period for closure notices, with a minimum of 48 hours and a maximum closure period of two weeks. The Government is also proposing to amend the statutory guidance to encourage licensing authorities to review licenses of all premises found to be persistently selling alcohol to children.

Indeed, during this Scrutiny Review, prior to the launch of the Government's consultation document, the frustration of some of the professionals involved in delivering the Wirral Alcohol Harm Reduction Strategy was summarised by the comment:
"What is needed is for the Government to give Local Authorities the tools to do the job".

In fact, there are organisations who go further than the proposals laid out in the Government's Police Reform and Social Responsibility Bill. As an example, the British Medical Association has called for a ban on all alcohol advertising, including sports and music sponsorship as well as an end to cut-price deals on alcohol. The cost to the NHS for treating injury and illness linked to alcohol has been estimated to be anything up to £3billion a year. It is of interest to note that the Alcohol Bill recently put before the Scottish Parliament includes provisions for a ban on irresponsible drink promotions at off licences, an introduction of a "social responsibility fee" on retailers who sell alcohol while licenced premises will also be required to operate an age verification policy based on the age of 25.

Beyond legislation, there have been government guidelines on alcohol for adults for many years. They say that men should drink no more than three-four units per day and women two-three units. However, it wasn't until December 2009 that the Chief Medical Officer for England and Wales, Sir Liam Donaldson, issued guidelines on alcohol for under-18s and their parents. The 'headlines' of the guidance says:

- Children and their parents and carers are advised that an alcohol-free childhood is the healthiest and best option. However, if children drink alcohol, it should not be until at least the age of 15 years.
- If young people aged 15 to 17 years consume alcohol, it should always be with the guidance of a parent or carer or in a supervised environment.
- Parents and young people should be aware that drinking, even at age 15 or older, can put your health at risk and that not drinking is the healthiest option for young people. If 15 to 17 year olds do consume alcohol, they should do so infrequently and certainly on no more than one day a week. Young people aged 15 to 17 years should never exceed recommended adult daily limits and, on days when they drink, consumption should usually be below such levels.
- The importance of parental influences on children's alcohol use should be communicated to parents, carers and professionals. Parents and carers require advice on how to respond to alcohol use and misuse by children.
- Support services must be available for children and young people who have alcohol-related problems and their parents.

The consequences of the legislative framework can be demonstrated by the comments of a manager:
"There are a number of dimensions resulting in the number of alcohol-related hospital admissions being a significant problem in Wirral. Three key issues are Price, Promotion and Availability".

RECOMMENDATION 2 Legislative framework
Wirral Council Cabinet is encouraged to lobby the Home Office for changes in the law aimed at reducing the supply of alcohol to young people by:

(i) limiting the promotion of the sale of alcohol, for example, through 'happy hours'
(ii) restricting the use of alcohol as a 'loss leader' by supermarkets and other retail outlets
(iii) reducing the promotion of alcohol through advertising
(iv) reducing the scale of proxy sales by imposing greater fines on those purchasing alcohol on behalf of under-age drinkers

6.3 Strategy and Resources

6.3.1 The Wirral Alcohol Harm Reduction Strategy

The current Wirral Alcohol Harm Reduction Strategy was launched in 2007 to cover a period up to and including 2010. The three priorities of the existing strategy (2007-10) are:

- Young People's Alcohol Misuse
- Alcohol Related Identification and Treatment
- Alcohol Crime, Disorder and Communities

The implementation of the overall strategy is coordinated by Wirral DAAT (Drug and Alcohol Action Team) in conjunction with a number of key partners in a multi-agency collaboration. However, with specific regard to the delivery of the element relating to young people, the Children and Young People Department of Wirral Borough Council plays a major strategic role. The Strategy document recommended the delivery of 10 action points regarding young people. The actions, relevant to 'Young People's Alcohol Misuse' were documented in the original strategy document along with those partner organisations responsible for the delivery of that action point in the strategy:

Table 7: Wirral's Alcohol Harm Reduction Strategy 2007-2010: Identified Actions related to 'Young People's Alcohol Misuse'

	ACTION	RESPONSIBLE PARTNER ORGANISATION
1	To ensure that young people, families, carers and professionals are provided with clear accessible information and education, to allow them to make informed choices about alcohol	Children's and Young Peoples Department - Response, Youth Service, Anti Social Behaviour Team Churches Action on Substance Misuse, Connexions, Voluntary and Community Sector
2	To increase the number of professionals trained to address alcohol misuse amongst young people	Children's and Young Peoples Department - Response, Youth Service, Youth Offending Service
3	To tackle, address and reduce alcohol related 'youth' anti-social behaviour	Wirral Joint Community Safety Team, Children's and Young Peoples Department – Response and Wirral Outreach Team, Youth Offending Service
4	To reduce the rate of alcohol related under 18 years teenage conceptions and Sexually Transmitted Infections (STIs)	Wirral Primary Care Trust - Public Health, Children's and Young Peoples Department
5	To reduce admission and re-admission rates amongst young people presenting at Wirral Hospital Trust as a consequence of alcohol misuse	Wirral Hospital Trust, Children's and Young Peoples Department – Response, Child and Adolescent Mental Health Service, Wirral Primary Care Trust – Public Health
6	To improve access into alcohol interventions and specialist alcohol programmes for young people	Children's and Young Peoples Department – Response, Child and Adolescent Mental Health Service, Youth Offending Service Wirral Alcohol Service
7	To secure compliance with relevant legislation within the licenced trade and promote the licensing objectives with a focus on young people and alcohol misuse	Wirral Trading Standards, Wirral Primary Care Trust – Public Health, Connexions *Continued…*

	ACTION	RESPONSIBLE PARTNER ORGANISATION
8	To address alcohol misuse amongst young people within Criminal Justice settings	Youth Offending Service, Merseyside Police, Wirral Joint Community Safety Team
9	To engage more young people in diversionary activities as an alternative to misusing alcohol	Sport and Recreation, Wirral Borough Council, Wirral Primary Care Trust – Public Health, Children's and Young Peoples Department – Youth Service, Connexions
10	Develop and implement a multi partnership performance management framework to measure and monitor alcohol misuse amongst young people	Wirral Drug and Alcohol Action Team, National Treatment Agency, Government Office North West, Wirral Joint Community Safety Team

Source: Wirral's Alcohol Harm Reduction Strategy 2007 – 2010

Key to the Strategy is a recognition that long-term success is likely to rely on both a reduction in the supply of alcohol to young people as well as a decrease in the demand for alcohol among some young people by changing their behaviour patterns. A third aspect of the action plan is an understanding of the need to tackle some of the negative outcomes that arise from alcohol consumption among young people. Indeed, a manager responsible for one of the teams delivering the Action Plan commented that:

"It is important that there are activities aimed at young people but there is also a need to stifle the supply of alcohol too".

Before adding that:

"The issues for Wirral are consistent with other areas. However, without the hard work and effort put into reducing alcohol consumption amongst young people, Wirral could be in a lot worse position".

Within the context of Wirral, it also important to note that 'Tackle alcohol harm' is a Priority for Improvement in the Council's Corporate Plan for 2010/11 and an Aim for 2008 – 2013. It is hoped that this will result in the subject of alcohol and young people remaining high among the priorities of the Council.

It is also worth noting that the current version of Wirral's Alcohol Harm Reduction Strategy ends in 2010. A new strategy is currently in the process of being developed. The original planned launch was due in autumn 2010. However, it has been decided to delay the publication until 2011 due to the amount of change that is underway in the form of new Government strategy, Home Office consultation on licensing policy and the increasing interest in the proposal for minimum pricing of alcohol. It is intended that the same three priorities will be the focus for, and inform the structure of, the new strategy, namely:

- Young People
- Identification and Treatment
- Crime, Disorder and Communities

RECOMMENDATION 3 **Wirral Alcohol Harm Reduction Strategy as a Council priority**
It is recognised that 'Tackle alcohol harm' is a priority for Improvement in the Council's Corporate Plan for 2010/11 and an Aim for 2008 – 2013. Given the statistical evidence of alcohol harm in Wirral, the Cabinet is encouraged to ensure that alcohol misuse remains a priority among the Council's objectives for the foreseeable future. Financial support for the service should follow its recognition as a priority service.

6.3.2 Multi-agency Working

As can be seen from the previous section, multi-agency working is a cornerstone on which the delivery of the Wirral Alcohol Harm Reduction Strategy is built. Examples of partners working together constructively have been very impressive throughout this Scrutiny Review process. Wirral Drug and Alcohol Action Team (DAAT), an organisation that has now existed for twelve years, is integral to the partnership. Partnership working in Wirral is seen to be very successful due to the active input of all of the partners. There has been a consistent high level of co-operation, first on drug use and, more latterly, on alcohol misuse. Historically, the major focus for Wirral DAAT was drug usage. However, during the last five years, the focus for Wirral DAAT has been increasingly on alcohol misuse. It is now estimated that fifty percent of young people who receive support from DAAT is for alcohol-related issues.

Two examples of the partnership working were detailed in Section 6.1.2 of this report in the form of the Response's alcohol worker attending A&E at Arrowe Park on a Friday evening as well as the YAIP project (Young People's Alcohol Intervention Programme), in which Merseyside Police and Response work together closely. Operation Stay Safe, tackling the issues of young people, alcohol and anti-social behaviour provides another example of Merseyside Police working alongside the Council's Community Safety team. Operation Stay Safe has been a multi-agency operation removing young people at risk from the streets to a place of safety and after school Police patrols. A further example is provided by the partnership between Merseyside Police and Wirral Council's Anti-Social Behaviour Team, which sees a dedicated patrol of Police officers specifically focused on removing alcohol from young people, under the title 'Confiscation Cops'. This initiative, which has operated at peak times particularly during the summer months, has targeted hot-spot locations of alcohol fuelled anti-social behaviour, identified by analysis of Police and partner data which includes calls from the public.

The level of positive multi-agency working is impressive. Nevertheless, separate management structures and physical locations can very easily create unintentional barriers. It is, therefore, worth noting that the Coalition Government's stated intention to transfer public health to Local Authorities may mean that, in the longer-term, opportunities could arise to consolidate some of the reporting structures to provide an even more focused unit.

RECOMMENDATION 4 Multi-agency working
Wirral Council Cabinet is invited to congratulate all of the agencies and staff involved in the delivery of the Wirral Alcohol Reduction Strategy. Although much progress remains to be made in tackling the problem of alcohol misuse in Wirral, the impressive partnership working already in place, provides a firm foundation for future progress. The Outreach Workers are among the key front-line staff who engage directly with young people and are responsible for the delivery of the Alcohol Harm Reduction Strategy. In the current difficult financial circumstances for public services, the protection of the front-line staff should be recognised as a priority in the onward delivery of the strategy. The approach of strong multi-agency working should continue to be supported in the future.

6.3.3 Future Funding

As with many areas of the public sector, uncertainty over future funding and organisation is currently a significant issue for those involved in the provision of alcohol services. There is a degree of concern regarding the impact of the likely removal of Wirral NHS (PCT). In the past, a significant amount of

core funding has come via Wirral NHS for both drug and, more latterly, alcohol services. In addition, Wirral has received substantial direct grants, ring-fenced specifically to fund drug treatment services. The level of this funding has grown over the past three years, determined by Wirral's past success at getting high numbers of drug users into treatment.

In recent years, much of this increase in funding has been used to develop services to support people out of treatment and help them avoid relapse. These services have been available to work with those recovering from both drug and alcohol misuse, so the drug funding has indirectly supported the alcohol programme in this vital area.

As the GP Commissioning role is developed, it is not yet clear whether drug and alcohol provision will be commissioned on a central basis and, if so, by whom. The future of the previously ring-fenced drug budgets is also not known and this too has major implications for the alcohol programme.

A manager working within the alcohol programme summarised some of these concerns:
"It is important that alcohol remains a priority in the Young People's Plan. If the Area Based Grant funding is diverted elsewhere (now that it is no longer ring-fenced), there is a danger that alcohol will not be seen as a high priority. In addition, alcohol also impacts on other areas of priority, for example, teenage pregnancy. Currently, both the NHS and the Police regard alcohol as a priority area. There is a risk that, if funding cannot be secured, the services available will be impacted".

Although the NHS proportion of the funding (£194,000) to deliver the alcohol element of the Wirral Prevention Plan is in place until 2013, due to the extensive multi-agency involvement in the alcohol programme, funding has been provided from a number of different sources, often covering relatively short time periods. This does not promote long-term stability in service provision. In the future, budgeting over a more extensive timeframe would enable more long-term planning for the delivery of the service. As can be implied from the previous section, due to the extensive multi-agency involvement in the alcohol programme, funding has been provided from a number of different sources, often covering relatively short time periods. The manager continued:
"We need a sense of being able to plan long-term in order to have the ability for the work to be continued.

It is important to establish the true cost of providing alcohol services. In order to do so, there is need to recognise that the preventative work on alcohol is an investment as savings are made further down the track. In terms of estimating and measuring the savings achieved in the long-term by preventative work, NI39 is the national indicator that measures a reduction in hospital admissions. Although this data is available for Wirral, in addition, research is available at a national level. As an example, based on figures obtained by Alcohol Concern relating only to ambulance call-outs, hospital admissions and visits to emergency departments by young people under the age of 18, the total estimated cost to health services is almost £19million per annum. The Alcohol Concern report, 'Right time, right place' therefore concludes that:
"In order to reduce this financial cost health services need to move collaboratively from simple 'response' towards prevention, working in partnership with local specialist services where possible".

It is this type of partnership working, delivered locally through the Wirral Alcohol Harm Reduction Strategy, that provides the long-term opportunity for these costs to be driven-down locally.

Table 8: Estimated cost of underage drinkers to primary health care services 2007/8

	Annual alcohol-related incidents	Average cost per incident	Total annual costs
Ambulance call-outs	23,254	£198	£4,604,292
Hospital admissions	14,501	£532	£7,714,532
Emergency Department attendances	64,750	£100	£6,475,000
			Estimated Total Cost: £18,793,824

Source: Alcohol Concern Report, 'Right time, right place', October 2010

RECOMMENDATION 5 Funding
In the past, the alcohol harm reduction services have been provided from a variety of short-term funding streams. This does not promote long-term stability in service provision. In the future, Cabinet is urged to promote long-term planning for the delivery of service by encouraging budgeting for the service over a longer time-frame.

6.3.4 Performance Management

Although other Performance Indicators have been used in the past, the only indicators provided by Wirral Borough Council currently in place specifically regarding alcohol are the following:

NI20 Number of "assaults with less serious injury" (including racially and religiously aggravated) offences per 1,000 population as a proxy for alcohol related violent offences
NI39 Alcohol-harm related hospital admission rates
NI115 The percentage of young people reporting either frequent misuse of drugs, volatile substances or alcohol in the Tellus survey
L7031 Percentage of under-age sales of alcohol during test purchase exercises

Indeed, the data collected in support of these indicators has informed some of the analysis in this report. However, of these indictors, only NI115 and L7031 relate specifically to young people. As the "Tell Us" survey process has been withdrawn by the Coalition Government in September 2010, the requirement for Local Authorities to maintain NI115 data has also recently been removed and will not be updated in the future. Nevertheless, Children and Young People Department are currently devising a new method of capturing equivalent information in Wirral.

In addition, Wirral DAAT do report a number of performance indicators regarding specialist substance misuse treatment, although not specifically for alcohol misuse. Therefore, there are currently few performance indicators that appear to adequately measure the work exclusively done regarding young people and alcohol. As an example, one professional in the field commented:

"It is known that young people are committing serious violence offences, often with alcohol as a cause. However, without clear performance measures in place, it is very difficult to measure the success of specific programmes".

The College of Emergency Medicine issued a Position Statement of Alcohol-related Harm in September 2010. While emphasising the harm attributable to alcohol, particularly those relating to short and long-term health, crime and disorder, the College noted that often the brunt fell on the ambulance service and emergency departments. As a result, the College urged policy-makers to take coordinated action to, among other activities, "improve data collection from emergency departments,

and sharing at a local level to inform and drive community action". At a local level, an officer involved in this process commented:

"TIG information (trauma and injury) is recorded and made available to the Police. However, that information is only as good as the hospital staff are told".

It is important that there is a process of measurement and performance monitoring in place to measure the outcomes of any programme or project. It is recognised that there is a cost associated with the collection of monitoring data and that the measurement of the outcomes of preventative work is not easy. However, specific measurements of some outcomes from the Alcohol Harm Reduction Strategy, and especially with relevance to young people, would enable the decision-makers to make better informed decisions. Otherwise, how does the Council (and other partners) know that funding is being spent effectively?

RECOMMENDATION 6 Performance Management
Cabinet is urged to support the implementation of a series of performance indicators which will measure the outcomes of the Alcohol Harm Reduction Strategy, including the preventative aspects of the work and the impact on young people. Further development of suitable data-sharing arrangements among the partners, using a single set of data wherever possible, would be beneficial.

6.4 Stifling the Supply of Alcohol to Young People

A key element in the Alcohol Harm Reduction Strategy is to reduce the supply of alcohol to young people wherever possible. A senior manager in public health remarked that:

"Key issues regarding access to alcohol for young people relate to supermarkets and access to alcohol via adults".

Both the Trading Standards and the Licensing Divisions at Wirral Borough Council play a key role in monitoring the framework within which businesses must operate.

6.4.1 Trading Standards

One recognisable problem is that of proxy sales on behalf of young people, whereby adults are organised as the "middle-man" to buy alcohol for young people. Indeed, a survey carried out in June 2010 on behalf of the charity, Drinkaware, found that nearly 36% of parents would give their 16 and 17-year-olds alcohol rather than them obtain it from an unknown source. A manager involved in the field in Wirral commented:

"Parents supplying young people with booze to get them out of the house is a significant problem".

In general, 'proxy buying' is a serious problem and is often either conducted by:

- adults who are selected to buy for young people, for example, older brothers / sisters or neighbours
- adults who are randomly asked by young people

Work is done, alongside the Police, to identify those people involved in Proxy Sales Operations. However, 'proxy buying' is difficult to deal with as authority is required under the RIPA legislation (Regulation of Investigatory Powers Act) to enable a surveillance operation to be carried out. Local

evidence suggests that it is sometimes very difficult to obtain firm evidence of where the alcohol is from. Some young people will swap the carrier bags to throw the Police off the trail of the true source. Nevertheless, the Local Authority has undertaken a considerable amount of work to combat proxy sales.

One option available to combat the problem of under-age sales is that of 'test purchasing'. Volunteers, aged 15 or 16, can be used to conduct test purchases. However, evidence must be admissible in court. In addition, the volunteer young people must be kept safe. It is considered locally that the 'Test Purchasing' scheme has been a great success. In 2008, there were 184 Test Purchases carried out at off licences, of which 46 (or 25%) were failures. In the 12 months from April 2009 to April 2010, there were 175 Test Purchases carried out at off licences, of which 19 (or less than 10%) were failures. The scheme, therefore, appears to be working as shops are increasingly fearful of failing. The 'test purchasing' scheme relies on a close working relationship between Trading Standards and the Licensing Sergeant of Merseyside Police and is evidently a good example of successful partnership working. However, some obstacles to test purchasing are encountered. For instance, there may be particular off licences who will sell alcohol to young people who they know. Therefore, if young people who are unknown to the shopkeeper try to buy alcohol, the shopkeeper will become suspicious in case they are a test purchaser. In these circumstances, Test Purchasing is not successful. Nevertheless, a senior officer informed the review Panel that:
"In many ways, Wirral is seen as providing best practice, for example, in Test Purchasing".

The work of Trading Standards, however, is a combination of "carrot and stick". In addition to the enforcement action, the team is also involved in educating the owners / managers of off licences. It was reported that the vast majority of off licences are "on board with the process". Indeed, during 2009, over 180 off-licence staff received training and 46 advisory visits were carried out by the Trading Standards team. The education process encourages the off-licence operators to accept both their legal and moral responsibilities. Further activity undertaken by Trading Standards includes promoting the use of the PASS identification card to businesses so that young people can be requested to show their card when buying alcohol.

Additional resources have been provided for Trading Standards, which has enabled greater support / advice to be given to licenced premises. This financial support came initially from Wirral NHS and, more recently, from Wirral Council. This additional funding has been used specifically to enable more under-age sale detections.

RECOMMENDATION 7 Trading Standards
The work of Trading Standards is considered an important element in combating the sale of alcohol to young people. An additional £40,000 was included in the 2010/11 budget of the Council to enable Trading Standards to continue tackling under-age sales of alcohol using a number of methods, including test purchasing, which had led to a reduction in sales to under-age young people. Cabinet is urged to retain that financial support.

6.4.2 Licensing

As a Licensing Authority, Wirral Borough Council is responsible for promoting the Licensing Objectives, which are:

- The prevention of crime and disorder
- Public safety

- The prevention of public nuisance
- The protection of children from harm

In relation to young people and the sale of alcohol, the Licensing team works closely with the Trading Standards team and with the Licensing team at Merseyside Police. In determination of a licence application, the primary principle to be used by the Licensing Authority is to determine each application on its own merits.

With specific regard to the sale of alcohol to young people, as of the first of October 2010, it is a legal requirement that all premises licenced to sell alcohol must have an "age verification" policy Previously, premises, although encouraged to always ask for identification when selling alcohol to anyone who looked under the age of 21, were not legally required to do so. It is interesting to note that some localities, such as Blackpool, have been able to introduce a successful electronic ID scheme with the support of club owners. By contrast, it has not been possible to gain the support of the majority of club owners in Birkenhead and, therefore, a similar scheme has not been possible. In terms of generating a constructive dialogue with bar owners, there are plans to put in place conflict training for bar staff using Birkenhead as a pilot. For example, training will be given in how to avoid conflict when refusing under-age sales and how to stop selling alcohol to customers who are already drunk. It is recognised that there are very few prosecutions for selling to customers who are already drunk. The licensees can obviously side-step the issue by asking "How do I know that they are drunk?"

Under the provision of the Licensing Act 2003, it is possible for a licence to be brought into review if alcohol is sold to under-eighteens. Nine reviews were undertaken in Wirral during 2009 into the sale of alcohol to people aged under-eighteen. However, an added complication relates to young people looking older than their actual age.

In recent times, successful objections have been lodged against a number of new licenses, but it is very difficult. The onus is on the Licensing Committee to grant a licence unless there is evidence to the contrary. Without significant objections from responsible authorities, such as the Police or the Children's Safeguarding Board, it is difficult for members to reject applications. As a senior manager rightly pointed out:
"It is a business and is therefore entitled to trade".

A member of the Licensing Committee told Panel Members:
"If the Local Authority rejects a licence application, the Authority loses out financially on the assumption that the appellant is successful. The appeals are heard by magistrates and it is the case that they often succeed. This is a problem and is very frustrating".

Meanwhile, an officer involved in the licensing process observed that:
"The Licensing Act assumes a clean slate for a new applicant. Therefore, any clever solicitor can ensure that it is very difficult to get conditions appended to the licence".

Cumulative Impact Policies can be introduced as a tool for licensing authorities to limit the growth of licenced premises in a problem area. The effect of adopting a Cumulative Impact Policy is to create a presumption that applications for new licenses will normally be refused (if relevant representations are received to that effect) unless the operator of the premises will not add to the cumulative impact already being experienced. By adopting a Cumulative Impact Policy, it is, therefore, not up to the Responsible Authority to provide evidence that the new or varied licence conflicts with one or more of the four Licensing Objectives as the reasons have already been laid out in the Policy. The burden of proof of

evidence is in effect shifted from the Responsible Authority to the applicant to provide evidence that their premises will not add to the problems generated by the concentration of licenced premises in that area.

In reality, evidence shows that they are often considered to be bureaucratic for licensing authorities as the link to the licensing objectives means that there is a high evidential burden on the authority before one can be introduced. As a result, as of November 2010, the Government estimated that only 134 Cumulative Impact Policies were in place in England and Wales. It is for this reason that, despite requests for the introduction of Cumulative Impact Policies in specific parts of Wirral, for example, Hoylake, sufficient evidence relating alcohol to crime and disorder in the locality was not available. However, an alcohol strategy manager commented to the Panel Members that:

"Our experience from public consultation is that we are frequently asked the question of why a system cannot be introduced whereby a limit on the density of off-sales in a particular area can be imposed. This is a recurring issue".

Meanwhile, a senior alcohol worker remarked:

"The amount of licenses granted should be given consideration which in turn might help reduce availability".

The current situation was summed up by one witness who described the current situation as follows:

"The problem occurs due to possible restriction of trade, for example, where there are two potential off licences next door to each other. If there are no representations from the Police, it is likely that the application will get approved. If the Police have no record of crime, disturbance or law breaking relevant to the application, then they cannot put in a representation".

Indeed, one of the Panel Members drew attention to a particular part of New Chester Road where there are seven outlets in close proximity. In recent months, a Cumulative Impact Policy has been introduced by Liverpool City Council in the Allerton Road area of Liverpool. The success of this and other schemes will be watched with interest.

In the longer term, the Government's consultation document, 'Rebalancing the Licensing Act' proposed to simplify Cumulative Impact Policies and "make them more responsive to local needs". The Government intends to remove the evidential burden on licensing authorities and encourage greater use of them. Therefore, the intention is to give greater weight to the views of local people as the licensing authority will no longer "be constrained by the requirements to provide detailed additional evidence where such evidence is unavailable". On 30th November 2010, the Government announced that statutory guidance will be amended to this effect.

RECOMMENDATION 8 <u>Cumulative Impact Policy</u>
Council should actively seek to introduce a Cumulative Impact Policy, as has been introduced by Local Authorities such as Liverpool and Brighton, in order to tackle the increase in outlets in specific hotspot areas.

With respect to the appeals process, the Panel Members appreciate the distinct yet inter-connected roles of Licensing officers, Merseyside Police and the Magistrates in implementing the provisions of the Licensing Act 2003. It appears to be the case that, since Local Authorities became responsible for licensing, the relationship with the magistrates has altered. It is, therefore, considered appropriate to recommend that tripartite meetings be held, involving officers / members of Wirral Council, Merseyside Police and representatives of the magistrates. The purpose of the meetings would be to consider the most appropriate application of the Licensing legislation on behalf of the residents of

Wirral. It is important that all three parties remain actively involved in licensing matters, despite the magistrate's role having reduced following the implementation of the Licensing Act 2003.

RECOMMENDATION 9 Relationship with Magistrates
The Council is encouraged to further develop a tripartite relationship with magistrates and the Police in order to cultivate a mutual understanding of issues relating to the application of licensing laws in the courts.

6.4.3 Minimum Pricing

In recent years, there has been increasing recognition among health professionals of cheap alcohol as a major concern. As a result, minimum pricing of alcohol has been gaining credibility as a policy option. During this Scrutiny Review, the issue of price became stark when a particular cider product, popular with many young drinkers, was identified to the Panel Members as being sold for less than £3 for a 3 litre bottle. The cider is 7.5% volume and a bottle contains 22 units of alcohol. The price of a unit of such alcohol equates to less than 15 pence per unit. Such a product is high on the list of those readily accessible to young people.

In his Annual Report for 2008, the Chief Medical Officer, Sir Liam Donaldson, called for the introduction of minimum pricing, stating:
"Cheap alcohol is killing people and it's undermining our way of life. In my report price and access are two crucial factors affecting alcohol consumption. I recommend action taken on both but particularly on price".

He continued:
"Introducing a minimum price of 50 pence per unit would mean that a typical bottle of wine could be sold for no less than £4.50 and a typical six-pack of lager for no less than £6. Research has shown that this would hardly impact upon those who drink at low-risk levels. It would significantly affect those who drink at high-risk levels, helping them to reduce their own drinking and reducing the harms of passive drinking. Within 10 years of introducing this 50 pence policy, there would be major benefits. We would expect to see over 3,000 fewer deaths a year, 46,000 fewer crimes, 300,000 fewer sick days and 100,000 fewer hospital admissions. The total benefit could be as high as over £1billion per year".

(Note: The reference to passive drinking in the above statement refers to the impact on behaviour which results in an estimated 39,000 serious sexual assaults every year and one and a quarter million instances of alcohol-related vandalism). Furthermore, it is estimated that making alcohol less affordable will have a greater impact on young people than on the rest of the population. According to Department of Health statistics, one in five young people between 11 and 15 drink more than 600 units a year. A minimum price of 50 pence would significantly affect the price of some of those drinks favoured by young people. In 2009, the University of Sheffield carried out a study, funded by the department of health, with the aim of quantifying the potential impact of policies targeting price and promotion on alcohol related harm in England. One of the many findings of the study was that, among the 11 to 18 year-old cohort, a 40 pence minimum price would be estimated to result in a 4% decrease in consumption, whereas a 50 pence minimum price would lead to a 7.3% reduction.

The issue of minimum pricing has subsequently been endorsed by a number of high profile organisations, which have included NICE (National Institute for Health and Clinical Excellence), the House of Commons Health Select Committee, the British Medical Association and NHS Public Health

Directors. Although the Coalition Government is committed to "review alcohol taxation and pricing", it appears that there is no Government consensus in favour of a national minimum price for alcohol. However, in August 2010, the Prime Minister appeared sympathetic towards the principle of a minimum price being implemented on a regional basis if local authorities chose to do so.

Detailed work towards the implementation of minimum pricing for alcohol has taken place in Scotland, Blackpool and Oldham. In the latter case, Oldham has acted as a pilot case for the ten Greater Manchester local authorities, who acting together as the Association of Greater Manchester Authorities, are considering the introduction of a byelaw which would require pubs, restaurants, supermarkets and off-licenses to price alcoholic drinks based on the number of units they contain.

Subsequently, the Cheshire and Merseyside Public Health Network (CHAMPs) is consulting on the proposal as is the Liverpool City Region Cabinet. At Wirral Council, a report entitled 'Consultation – Minimum Price for Alcohol' was discussed by the Licensing, Health and Safety and General Purposes Committee on 13th September 2010. The committee resolved unanimously:

(1) that the Council seeks views on the introduction of minimum pricing of alcohol from the public, partner agencies, those organisations that support individuals with alcohol addiction and community and voluntary groups and that the results of consultations be brought to the next meeting of the Licensing, Health and Safety and General Purposes Committee.

(2) that Members endorse the usage of Section 235 of the Local Government Act 1972 for the introduction of a local byelaw to deal with this issue if appropriate.

RECOMMENDATION 10 Minimum unit pricing for alcohol
The review Panel supports the principle of minimum unit pricing for alcohol. Council is requested to engage positively in the process to introduce a regional minimum price for alcohol in the Merseyside region.

6.5 Reducing the Demand for Alcohol by Young People

Although it may be possible to take steps to reduce the supply of alcohol to young people in the relatively short-term, it is considered to be a longer-term objective to reduce their demand for alcohol. Key to the reducing some young people's desire to consume alcohol is the role of education and parental influence and engagement.

6.5.1 Education of Young People

An officer working directly with young people commented simply that:
"It is not possible to do too much publicity. It is so important to get the message across about the harm of drinking".

The Local Authority and the partner organisations involved in the delivery of the Alcohol Harm Reduction Strategy in Wirral have made great efforts in terms of publicity aimed at both adults and young people. Much of the work with young people has been delivered through schools. The work will be reinforced shortly by the commissioning by the Children and Young People Department (Wirral Borough Council), with financial support from Wirral NHS, of an Alcohol Guidance document for use by schools. The new guidance for schools has been re-written and is due to be rolled out in December 2010.

With regard to secondary schools, the Response team is central to much of the work that is done. Wirral DAAT work very closely with Response who provide the 'Bite-size' programme or workshops. Issues such as bullying, healthy eating and alcohol are covered. The information is delivered through targeted group sessions aimed at Years 7 to 10. This work is very well received in the schools. A worker from Connexions is also commissioned to support the preventative part of the substance misuse programme. All agencies are working together in a coordinated approach. In addition, the Health Service in Schools initiative delivers services such as the clinic points in schools. These were described by a programme manager as having been "an astounding success". The issues raised are reported to have demonstrated a surprising level of need. At present, CASM (Churches Action on Substance Misuse) also attend a limited number of schools by invitation.

Outside of the schools, the Youth Crime Action Plan ensures outreach work is available on Friday and Saturday nights, supported by targeted funding. In addition, Outreach teams provide the constructive street work, which was witnessed by the Panel Members who undertook individual visits with a variety of Outreach Workers across different locations within the borough. Those visits showed the tremendous value of this work and are further documented in Appendix 2 of this report.

As part of the overall education programme provided within the umbrella of the Alcohol Harm Reduction Strategy, Life Education Wirral has been commissioned to promote healthy choices on a holistic basis to primary school children. The sessions include education on alcohol, smoking and emotional health issues. 55 infant and primary schools have been visited in the last year, aiming at children from nursery age up to Year 6. However, some schools may not participate as they have to pay for the service. An alcohol programme manager informed the Panel Members:
"Research shows that children aged ten and eleven are the most vulnerable age group regarding alcohol".

While an alcohol worker commented:
"The younger age is good as children at that age are more impressionable".

An impression of the overall impact of the alcohol education process in schools can be given by the results of a question in the Tellus4 national survey of Year 6, 8 and 10 pupils.

Table 9: Results of the Tellus4 survey regarding pupil attitudes to alcohol advice, 2009

Response	**Wirral (%)**	National (%)	Statistical neighbours (%)
How helpful is the information and advice you get in school on alcohol?			
Helpful	**64**	58	60
Not helpful	**17**	20	20
Don't know	**10**	11	10
Haven't received any	**8**	11	10

Source: Tellus4 survey results for Wirral, 2009

It is noteworthy that the satisfaction rate for young people in Wirral is higher than both the national average and the rate among statistical neighbours. Therefore, although there is confidence that the

outcomes from the overall education programme are positive, the extension of the scheme to include more primary school children would be beneficial.

RECOMMENDATION 11 Education of young people
Council is requested to recognise the importance and continued priority of education for young people regarding the dangers of alcohol misuse. Education is recognised as a cornerstone of the Alcohol Harm Reduction Strategy. The support of all agencies, including schools, health authorities, the Police, Fire & Rescue Service and the voluntary sector, as well as Wirral Council, is fundamental to the delivery of this service. There is concern that appropriate alcohol awareness education should be available to young people in Years 5 and 6 at primary school. Research shows children aged ten and eleven are the most vulnerable age group regarding alcohol.

6.5.2 Engagement of Parents / Carers

The Children and Young People's Department at Wirral Borough Council have developed a Parenting Strategy. This includes issues regarding parental engagement. However, it is recognised that it is very difficult to engage some parents in general, not only on issues regarding alcohol. The involvement of parents is critical as there is a need to educate children about alcohol misuse. It is obvious that parents have a very important role in the education process. As an example, sessions have been held on parents evenings, specifically with the aim of engaging with parents. However, interest tends to be developed with those parents who are already engaged. The frustration of one professional was apparent in the comment:
"The provision of support to parents is an arm of the strategy. However, there is an element who will refuse to engage"

Therefore, Wirral DAAT commissioned Life Education Wirral to provide workshops at eighteen schools, between October 2009 and April 2010, for parents to cover topics such as bullying, communication with children and the use of role models. The feedback from those sessions showed that it was a useful process for many of the parents who attended. The sessions were split with approximately half of the sessions being held in affluent areas and half in more deprived areas.

Further examples of specific routes for engagement, often with hard-to-reach families, include the Youth Offending Service which has a role in providing support to parents. In addition, the Family Intervention Project in Wirral, which is part of a national scheme, enables intensive work to take place with individual families who have specific issues. Further, in the past two years the DAAT, through the Children and Young People's Department, has commissioned a project that provides a senior social worker to work specifically with specialist drug and alcohol workers where they have cases where there is some degree of concern for the welfare of children due to the drug and alcohol use of their parents. The objective is to minimise the negative impact of the parental behaviour on the children. This project also includes a family support worker who focuses on the individual needs of the children and works to engage them with other projects and organisations that will enable the children to be become involved with and enjoy activities and experiences that their family circumstance may otherwise not offer them. This project is aimed at reducing the incidence of trans-generational drug and alcohol use.

Panel Members were also informed by an alcohol programme manager:
"It is also important to focus on young people and general services such as education, training and employment. These services help to protect young people from alcohol tendencies, for example, a young person who is working is statistically less likely to develop alcohol problems".

However, the influence of parents goes well beyond the education of young people regarding alcohol. One alcohol worker, who works actively with young people commented bluntly:
"Many young people think that parents are hypocrites over alcohol".

Therefore, it is the role of parents as role models that is just as important. Another alcohol worker added:
"Often the parents drink quite heavily too. Therefore, they are more likely to be dismissive of messages given to young people".

While another commented:
"Parents are often not aware of the impact of their own drinking behaviour. A major risk factor is permissive parenting as well as adult drinking behaviour which can transfer to children and families".

At a national level, the impact of parental drinking on young people has given rise to graphic headlines during the last few months. It was reported that ChildLine, the 24-hour helpline, took 5,700 calls between April 2008 and March 2009 from children who were concerned and scared about their parents' alcohol and drug use. The report, published by the National Society for the Prevention of Cruelty to Children (NSPCC) quotes one ten year-old child as telling a counselor:
"My mum drinks all the time. She leaves me alone lots of the time. I feel scared and lonely. I look after mum when she drinks and put her to bed. She shouts and hits me. I don't want to feel pain. I want to die".

Meanwhile, a survey undertaken by Childwise, on behalf of BBC Newsround, during April and May 2010, found that half of the 1,234 10 to 14 year-old participants said they had seen their parents drunk. Nearly a third of those children (30%) felt scared when they see adults drunk or drinking too much; whereas 47% said they were not bothered.

6.5.3 Referral and Treatment

Section 6.1.2 of this report ('The Consequences of Young People Drinking') describes the intervention work of the alcohol worker attending A&E on Friday evenings. It was reported by the alcohol worker that, for those young people who are admitted into Children's A&E there is a considerable acceptance rate of referral to further interventions. However, for those young people admitted to Adult A&E there are many refusals. It is considered that this type of intervention is vital if the number of young people drinking heavily is to be tackled in the long-term. It appears that identification of individuals and then onward referral to the most appropriate service is a key issue. Perhaps one of the strengths of Response is the strong link between their outreach teams and the specialist alcohol workers to whom clients can be readily referred. It was reported that many of the referrals to the specialist side of Response are made via the Outreach team. In the future, it is planned to strengthen the referral processes in the Family Safety Unit to ensure that clients are referred to the correct service.

During the review, Panel Members received anecdotal evidence of the importance of timely and appropriate referral. The impact of referral on a young person can be shown by the recent example of a

thirteen year-old who had been drinking vodka for three months, which resulted in him being picked up by the Police. As a result of the incident and referral he had not drunk since. During a more recent presentation of Bite-size sessions by Response at a local High School, the thirteen year-old was confident and able to peer-educate other young people regarding alcohol-related issues.

The justice system is another source of referrals. In the near future, criminal justice pathways are to be reviewed and updated to improve the identification and treatment of offenders. Within the justice system, conditional cautioning ensures that an offender must take part in a programme. The Panel Members were informed that momentum is moving towards the provision of mandatory or compulsory referrals. Great efforts have already been made to prevent young people from entering the criminal justice system. An officer informed the Panel:
"The prospect of a criminal record is a threat; programmes could be offered as an alternative".

Inevitably, much of the provision of the Alcohol Dependency Service is aimed at the adult population. NHS Wirral are enhancing the Alcohol Dependency service largely through commissioning additional services with Cheshire and Wirral Partnership Trust (CWP) Alcohol Services, but with some other providers too.

This report was produced by the Alcohol Scrutiny Panel.

Appendix 1 : Scope Document for the Alcohol Scrutiny Review

Date: 14th December 2009

Review Title: Access to Alcohol by Young People in Wirral

Scrutiny Panel Chair: Cllr Dave Mitchell	Contact details: 0151 327 2095
Scrutiny Officer: Alan Veitch	Contact details: 0151 691 8564
Departmental Link Officer: Sue Drew	Contact details: 0151 651 3914
Panel members: Cllr Ann Bridson Cllr Chris Meaden Cllr Dave Mitchell Cllr Sue Taylor	Contact details: 0151 201 7310 mobile: 07759 587597 0151 645 1729 0151 327 2095 07736 927201
Other Key Officer contacts:	

1**. Which of our strategic corporate objectives does this topic address?**

1.1 To create a clean, pleasant, safe and sustainable environment, in particular:
- To reduce alcohol related crime
- To reduce levels of anti-social behaviour

1.2 To Improve Health and Well-being for all, ensuring people who require support are full participants in mainstream society, in particular:
- To encourage healthy lifestyles and participation in fulfilling activities
- To narrow the mortality gap on Wirral
- To tackle all forms of alcohol and drug induced harm

2. **What are the main issues?** 2.1 What is the impact of alcohol on young people in Wirral? 2.2 What is the impact of young people drinking alcohol having on other residents of Wirral? 2.2 What is already being done to enable young people to make good choices regarding alcohol? 2.3 What are the key issues relating to access and availability: Where? Price? Promotions? 2.4 What restrictions of access to alcohol exist at present? 2.5 What additional restrictions of access are available and which have been successfully used elsewhere? 2.6 Can Council policies be sensibly amended relating to the access and availability of alcohol, particularly with respect to young people?
3. **The Committee's overall aim/objective in doing this work is:** 3.1 To understand the impact of alcohol on young people and other residents in Wirral. 3.2 To gauge the ease with which young people are able to access alcohol. 3.2 To consider the support available to young people enabling them to make positive decisions regarding alcohol.
4. **The possible outputs/outcomes are:** 4.1 To reduce the ability of young people to access alcohol. 4.2 To further enable young people to make positive choices regarding alcohol.
5. **What specific value can scrutiny add to this topic?** To use new evidence to enable changes which would lead to the outcomes listed in section 4 above.
6. **Who will the Committee be trying to influence as part of its work?** 6.1 Appropriate Cabinet members and Directors, Wirral Borough Council 6.2 Signatories to the Wirral Alcohol Strategy
7. **Duration of enquiry?** Aim to complete by the end of the current municipal year (May 2010)
8. **What category does the review fall into?** Policy Review ☒ Policy Development ☐ External Partnership ☐ Performance Management ☐ Holding Executive to Account ☐
9. **Extra resources needed? Would the investigation benefit from the co-operation of an expert witness?** The review will be conducted by councillors with the support of existing officers. However, the Panel are looking for advice from people with expertise on this topic.

10. **What information do we need?**	
10.1 **Secondary information (background information, existing reports, legislation, central government documents, etc).** Wirral Alcohol Strategy (and the Implementation Action Plan) Recent Committee / Cabinet reports. Statistics regarding the scale of the problem in Wirral, comparative to statistical and geographical neighbours. Relevant Government Departmental documents Relevant national documents Reports from other councils into similar topics. Examples of good practice from other Councils	10.2 **Primary/new evidence/information** Introductory multi-agency presentation to Panel members Interviews with key officers Assessment of the impact on young people Assessment of the impact on Wirral residents
10.3 **Who can provide us with further relevant evidence? (Cabinet portfolio holder, officer, service user, general public, expert witness, etc).** **council officers to include:** Peter Edmondson / Steve Pimblett / Terry White (Children and Young People Department / Youth Outreach) Wirral DAAT Wirral NHS Planning Department Licensing Team (Margaret O'Donnell) Trading Standards (John Malone) School Governors Forum Schools Forum Young People Alcohol Prevention Programme Merseyside Police (Dave Peers) Relevant third sector groups	10.4 **What specific areas do we want them to cover when they give evidence?** How many young people are involved? Where are the hotspots? What activities already take place to encourage young people to make positive choices regarding alcohol? What is the impact on local communities of young people drinking excessive amounts of alcohol? What restrictions to access are currently in place in Wirral? What further restrictions to access are feasible?

11. **What processes can we use to feed into the review? (site visits/observations, face-to-face questioning, telephone survey, written questionnaire, etc).** 11.1 Meetings with officers 11.2 Visits with Outreach Workers / Response / Respect team 11.3 Desk-top analysis
12**. In what ways can we involve the public and at what stages? (consider whole range of consultative mechanisms, local committees and local ward mechanisms).** 12.1 Area Forum meetings / Focus groups 12.2 Youth Parliament

Appendix 2 : Reports from the Visits of Panel Members with the Outreach Workers

REPORT FROM COUNCILLOR CHRIS MEADEN
I had the opportunity to go out with the team from Response on two occasions. We visited Victoria Park on the first visit and I met up with two of our workers and also a member of the Brook who, on this occasion, were talking to the young people in the park about how to keep safe. It seems that a number of young girls and boys actually are unaware of the problems that can arise when drinking at an early age and there are problems with underage sex which can unfortunately result in teenage pregnancy. The Brook are there advising about precautionary measures for them, not just to avoid pregnancy but to avoid STDs.

Our response team are not out to stop any anti-social behaviour although they do get involved if there are reports of this and work really closely with our Respect team against anti-social behaviour but are more there to try and keep our children safe.

It really shocked me that there are some young adult males who are over 20 years who are responsible for supplying drink to mainly young vulnerable girls and then use these young girls for their own gratification. This was when I decided to go out again with the team to learn more about what goes on in our parks and what measures our team goes to to gain the trust of the young people.

My second visit took me first to Birkenhead Park where we engaged with a group of about 20 youngsters aging from 12 to 16. They were just walking in a group and talking when they spotted the four of us walking to wards them and I realised then how close they are to our Outreach Team when they called out their names and just came over. They were interested to know who I was and why I was out with the workers and they proceeded to ask if they could have goal posts in the park to play foot ball and also what we as a Council could do to stop them being bored. I asked why they did not use the Youth Hub and they said that they were territorial and felt threatened when they went there. I also asked if they drink in the park and they do when they have money and when someone will go to the shop for them.

They were all very bright and explained that our workers had told them of the dangers of drinking and drugs and what it can do. A few of them said they do it because of peer pressure; some do it to be part of the group; and some said it was because it made them forget a lot of their problems. This gave me cause for concern and speaking to one of the workers later, he said that he had gained a lot of trust with some of them after working with them for a while and that they had opened up and told them of unhappy home lives, unhappy school lives and basically used our team as a sounding block for them to talk out their worries and their fears.

We then talked about what our team's aim is and they have since explained that, along with the Brook, they now have a young women's group that has been formed within the parks and they discuss the problems facing young girls and the young girls themselves are now talking to other groups about their own experiences and hopefully the message will get across.

We then met a group of young pregnant women who are based at The Beacon project within my own ward. These are young girls who have had problems with drink in the past and through our Response team, who first met them while doing their job, made progress through talking to them and getting them a place to live with the help of Forum Housing. They are now on the road to recovery and are advising other young girls by talking about their experiences.

One of the main things that came to light on these visits was that we do not speak to young people early enough. We need to get into primary schools and start talking to years 5 & 6 before the move up to senior schools so they are aware of what is happening. It is not just about drink. It is about drugs and other risks such as unprotected sex and the fear of catching horrible STDs **.**

As for Wirral Youth Service's Response Team, I have the utmost respect for them. They are doing a fantastic job seven nights a week covering the whole of Wirral talking to and helping our vulnerable young people with limited resources and they are a dedicated, caring set of people who have only one goal and that is to help as many as possible. One of the peer groups I spoke with used to be one of the kids on the streets who was a bully and drank and caused problems who now is married with young children of their own and goes out now and talks to the groups now and explains that there is more to life than drinking and fighting and causing trouble and tells them what he was like at their age and how you can turn your life around.

REPORT FROM COUNCILLOR DAVE MITCHELL
I spent the evening with two Outreach workers. I met them at Eastham Youth Club and we went on a walkabout around the ward. I was very impressed by their ability to approach youths and quickly gain their confidence, through talking with the youths at their level. We met three different groups. The first group was at the local skate park doing BMX bike tricks. As we walked away, from the conversations which had taken place, it was suggested that some of them had been using drugs.

The second group didn't want to know, so both Outreach workers talked to the smaller group, giving advice about condoms; even giving some to one young lady. As they were having a good talk the others joined in, giving both the opportunity to gain information and give advice. This was evident in using the modern language of the youths. I was lost and had to have it explained later. The information gained helped in that they knew what level to pitch the message back, and how to address the local schools when giving talks.

We called into the Youth Club and then went onto Birkenhead Park. They wanted to meet up with a group they had been working with. As we approached them, it was just four young girls; two were totally drunk; two giggly. A group of three walked past two boys and one younger girl keeping their heads down. After a short while, a group of about 8 to 10 boys/youths appeared and started talking to both workers. I just stood back and watched after being introduced to them. I was told later that one boy had agreed to contact the Outreach workers to try to get back into education and they would be having a football match with the rest and another group later in the week. This engages them so as to have one-to-one talks and assist in giving both advice about drugs, drink and sex. I was taken aback when told the very young girls admitted to having sex in the park; this was with older boys as it was a status thing.

I believe this work being done by the team is of the utmost importance, in educating youths about drinking, drugs and sexual habits.

REPORT FROM COUNCILLOR SUE TAYLOR
During the evening, we visited Harrison Park in Wallasey and the Tower Grounds, New Brighton where we found groups of teenagers in possession of cheap lager and cider. It was early, around 2100hrs, and it was fairly obvious that some of the youngsters weren't exactly sober.

Whilst the Police were seizing the alcohol and taking personal details, the Outreach team arrived and immediately became involved and engaged with the teenagers. It was good to see that the young drinkers appeared to be more cooperative with the Outreach workers than the Police. Maybe this was because they didn't appear as authoritative and the kids weren't interested in being so challenging. They seemed to command some respect and began to talk openly about why they drank. Sadly, boredom and 'something to do' seemed to be the reasons. It was all very professionally done in a friendly way but still managing to get the message across about the dangers of alcohol in a non-threatening way and the kids actually seemed to listen, which can only be a good thing…! Quite an eye-opener!

REPORT FROM COUNCILLOR ANN BRIDSON
Ann accompanied Prenton's Outreach Team 6-9pm on a Friday Evening in July; this was an opportunity to observe the work of Alcohol / Street Work members with underage drinkers that takes place in Prenton and the locality.

The Team were acutely aware of the whereabouts of groups of young people/drinkers. On meeting, we discussed the team's previous work done with teenagers in their schools to make them aware of the dangers and also some 'keeping safe' strategies. We went out between 8 and 9.30pm and found groups of drinking teenagers in two local parks beyond the edge of Prenton Ward. The majority of the young drinkers were female, drinking mainly small amounts of cheap vodka and cheap cider. At this time in the evening, they did not appear to be intoxicated. When the workers approached the groups, the young people were friendly and clearly recalled some of the workers from their visits to schools. It was positive that they were happy to take advice from the workers and also they were putting into practice some of the advice previously given (one person not drinking to keep the others safe, going home in groups etc). When I asked the young people what they would prefer to do instead of drinking, they had no response. In Arrowe Park, I noted two groups, one of younger girls and the other boys who looked over 18. I was concerned at leaving these vulnerable young girls open to the approaches of young men. Three previously identified drinking spots within Prenton ward were inspected and found to be empty (on this occasion). Workers had encouraged one group to form a football team, which had successfully diverted them from Friday night drinking. My thanks to Pat Rice and her Team for their efforts.

Appendix 3 References

Letter to Wirral DAAT from The National Treatment Agency for Substance Misuse regarding 'Wirral's Young People Specialist Substance Misuse Treatment Plan Submission' *dated 4th January 2010*

'Right time, right place – Alcohol-harm reduction strategies with children and young people', Report issued by Alcohol Concern, *dated October 2010*

Wirral Joint Strategic Needs Assessment, 2009-10, produced by Wirral NHS. (Use both sections on Alcohol Dependency and on Children & Young People)

'Problem drinking shows up north-south England divisions', BBC website, *dated 1st September 2010*

'Liverpool booze culture highlighted by new report', Daily Post, *dated 1st September 2010*

'Third of under-24's "drink to get drunk", Independent, *dated 7th September 2010*

Report of the Director of Public Health, 'Update on the Performance of National Indicator 39 – Alcohol related admissions to hospital', presented to Wirral Council Health and Wellbeing Overview and Scrutiny Committee, *1st November 2010*

Local Alcohol Profiles for England (LAPE), issued by North West Public Health Observatory (NWPHO) - *September 2010*

Young People's Specialist Substance Misuse Needs Assessment, issued by Wirral DAAT – 2009/2010

'Young People's Specialist Substance Misuse Needs Assessment – 2009/10', Wirral Drug and Alcohol Action Team, *November 2009*

Tellus4 survey results for Wirral *2010*

'Young People and Community Safety', Report to Sustainable Communities Overview & Scrutiny Committee, Wirral Borough Council, *18th November 2009*

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‘Draft Statement of Licensing Policy’, Report to Wirral Council Licensing Act 2003 Committee, *dated 8th November 2010*

‘Lower the evidential hurdle for Cumulative Impact Policies to allow licensing authorities to have more control over outlet density’, Home Office consultation document, *dated December 2010*

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‘Government rejects health watchdog’s alcohol policy by health watchdog’, Independent, *dated 2nd June 2010* – referring to NICE

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‘Consultation – Minimum Price for Alcohol’, Report to Wirral Council Licensing, Health & Safety and General Purposes Committee, *dated 13th September 2010*

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WIRRAL COUNCIL

HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

22 MARCH 2011

SUBJECT:	**HEALTH AND HOMELESSNESS UPDATE**
WARD/S AFFECTED:	**ALL**
REPORT OF:	**FIONA JOHNSTONE, DIRECTOR OF PUBLIC HEALTH (NHS WIRRAL)** **CATHY GRITZNER, DIRECTOR OF HEALTH SYSTEMS MANAGEMENT (NHS WIRRAL)**
RESPONSIBLE PORTFOLIO HOLDER:	**COUNCILLOR BOB MOON**
KEY DECISION?	NO

1.0 EXECUTIVE SUMMARY

1.1 This paper provides an update on service developments reported at the Health and Well Being Overview and Scrutiny Committee (OSC) on 1.11.09. These services support the delivery of medium and longer term homelessness targets in the Wirral Homelessness Strategy and address the health needs of local people who are homeless or at risk of homelessness.

2.0 RECOMMENDATION/S

2.1 Members are asked to note the contents of this report.

3.0 REASON/S FOR RECOMMENDATION/S

3.1 The services outlined are currently being provided and an update report was requested at OSC in November 2009.

4.0 BACKGROUND AND KEY ISSUES

4.1 There is considerable evidence that homeless people; i.e. rough sleepers and those living in temporary accommodation tend to have significantly higher levels of premature mortality and a higher prevalence of poor physical and mental health. There is also strong national evidence to suggest that homeless people do not get the health care they need.

4.2 In 2008 NHS Wirral commissioned a short piece of research into the experience of local homeless people using local health services. The research was conducted by Wirral Council's Supporting People Team and involved interviews with homeless people, hospital staff and other providers working directly with homeless people.

4.3 This research found that:

- More community based, accessible health services were needed to meet the needs of homeless people.
- Homeless patients did not get appropriate support when being discharged from hospital.
- Local quantitative health data on homeless people was inadequate. This limited our ability to plan and target services appropriately.

4.4 In response to these findings a number of Health and Homelessness services were developed. They include;

- A one year pilot project commissioned by NHS Wirral and the Council's Supporting People Team to address the hospital discharge issues faced by homeless people.
- The provision of a two year primary care outreach service for homeless people commissioned by NHS Wirral.
- The provision of a dedicated outreach Mental Health Practitioner for homeless people. This service was commissioned by NHS Wirral and supported by a grant of £17,000 from the Department of Communities and Local Government.

4.5 **Hospital Discharge Project**

4.5.1 In April 2010 a Hospital Link Worker (HLW) was seconded from the Council's Housing Options Team to improve hospital discharge for homeless people and patients reporting other housing issues at Arrowe Park Hospital. The following improvements have been implemented;

- Amended hospital discharge policy and procedure to account for the needs of homeless people.
- A flagging system so that homeless patients or patients who can't return to their accommodation on discharge are identified at admission so any housing issues can be addressed by the HLW at the earliest opportunity.
- Information resources for ward staff and A&E staff
- Support, advice and referral service to 162 patient referrals, ranging from rough sleepers to disabled people who can't return to their own homes because of their health needs.

4.5.2 Some of the outcomes for the patients in question have included;

- Securing temporary accommodation in hostels or in private rented accommodation.
- Securing sheltered or bungalow accommodation for older and/or disabled patients.
- Provision of welfare benefit advice.
- Referral to detoxification and/ or rehabilitation services for patients with alcohol/substance issues

- Arranging aids and adaptations for disabled patients
- Eviction prevention
- Advocacy and support for patients whose needs are not being appropriately addressed; E.g. Young care leaver referred back to and accepted by Bolton Social Services
- Support to secure financial assistance from charities to enable move into new home.

4.5.3 Organisational benefits include;

- Estimated cost savings of £58,500 over a 10 month period due to a reduction in delayed discharges caused by housing issues. These savings relate to 51 patients who would have stayed longer in hospital or who would have been referred to interim care. This equates to an average saving per patient of £1,147.
- Raised awareness of hospital staff of the issues faced by homeless people
- Knowledge of support on offer in the community
- Improved partnership working between APH, the Council and other providers in the community
- Anticipated reductions in repeat admissions caused where inappropriate housing contributes to poor health
- Anticipated reductions in repeat admissions due to referral to appropriate support/treatment services on discharge
- A more holistic service for patients

4.5.4 This project is due to finish at the end of March 2011; however opportunities for its continuation for a further year are being explored.

4.6 **Primary Care for Homeless People**

4.6.1 In July 2010 a dedicated nurse practitioner service for homeless people was commissioned by NHS Wirral for a period of 2 years. The nurse practitioner provides drop-in clinics at the Charles Thomson Mission and at 4 local hostels including the Women's Refuge.

4.6.2 The nurse practitioner also:

- Carries out health assessments (including vascular and respiratory screening)
- Encourages self care
- Provide first line clinical interventions
- Supports patient registration
- Ensures homeless and vulnerable people are supported to attend appointments and complete programmes of treatment.
- Arranges access to health improvement and harm reduction programmes.

4.6.3 Between the beginning of August 2010 and the end of January 2011 the nurse practitioner had 568 patient contacts, an average of 95 contacts per month this involved 354 individual patients. The nurse also carried out 47

health assessments, supported 10 people through alcohol treatment programmes (detoxification) and gave 79 Hepatitis B vaccinations.

4.6.4 This service is proving very popular amongst homeless people as seen in the number of contacts. However further evaluation and analysis is required to assess the full impact of the service on the health and well being of homeless people.

4.7 Mental Health Project

4.7.1 On the basis of local and national evidence a mental health service for homeless people was commissioned by NHS Wirral in October 2010 from Cheshire and Wirral Partnership Trust (CWP) for a 2 year period. The service is linked directly to the 5 local hostels including the Women's Refuge and the local bail hostel Rose Brae. The mental health practitioner carries out the following activities:

- Early assessment for homeless people with mental health problems.
- Support to client and hostel staff whilst awaiting full assessment and treatment for individual clients.
- Design and provision of mental health training for hostel staff.
- Raises awareness of homelessness within mainstream mental health services
- Collection of robust data on the mental health needs of homeless people with mental health problems
- Robust monitoring, review and evaluation of the service and make recommendations for service development if necessary.

4.7.2 The service works closely with local mental health services, the nurse practitioner for the homeless, Wirral Drug Service and Wirral Alcohol Service to ensure that each homeless individual approaching any of these services can easily access the others to ensure a holistic, joined up approach, providing the best opportunity to address the often complex health and social care needs of homeless individuals.

4.7.3 This project is still in its infancy; however qualitative evidence from hostel staff suggests the service is achieving positive outcomes. Further performance management data and service user feedback will be available and reviewed as part of the contract management arrangements with CWP.

4.8 Health and Homelessness Strategy

A Health and Homelessness Strategy is also being developed in support of the Council's Homelessness Strategy which is due to be refreshed. The Health and Homelessness Strategy will review the services currently being provided, assess the information we currently have on the health care needs of local homeless people and make recommendations for future service development.

5.0 RELEVANT RISKS

5.1 All 3 projects are funded on a temporary basis so there is a risk that the services, if withdrawn, will leave a significant gap in service provision.

6.0 OTHER OPTIONS CONSIDERED

6.1 N/A

7.0 CONSULTATION

7.1 The research carried out in 2008 involved consultation with homeless people, hospital staff and providers from the community and voluntary sector working directly with homeless people. The services outlined in this report were developed in response to this research. Further consultation is planned as part of the overall evaluation of the projects.

8.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

8.1 The success of these services depends on a multi-agency approach and providers from the voluntary sector were involved in the original consultation and will be involved in the monitoring and evaluation of the services.

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

9.1 Most of the projects outlined in this report have been funded by NHS Wirral. However the hospital discharge research project and the hospital link worker post are jointly funded by NHS Wirral and the Local Authority (Supporting People). A Rough Sleepers Small Grant of £17,000 has also been awarded by the Department of Communities and Local government (DCLG) as a contribution towards the mental health service outlined above.

9.2 Investment into the 3 health and Homelessness projects amounts to approximately £270,000; this is less than the amount quoted in the earlier report to OSC because the original intention was to commission 2 primary care nurses with a broader remit. It was later agreed that 1 specialist nurse practitioner would achieve the required outcomes.

9.3 51 people have stayed in hospital for a shorter period due to the involvement of the Hospital Link Worker. It is estimated that this achieved cost savings for the health and social care economy of at least £58,500 over a 10 month period.

9.4 Opportunities for the identification of further savings will be monitored in the short and long term by;

- Improving access to low and medium level mental health services for homeless people,
- Preventing the need for more intensive mental health input,
- Reducing the number of hospital admissions and repeat admissions
- Reducing the number of presentations at A & E.

10. LEGAL IMPLICATIONS

10.1 NONE

11. EQUALITIES IMPLICATIONS

11.1 Homeless people are amongst the most socially excluded, experiencing the worst health, social and housing conditions. Their chaotic lifestyles make it difficult for homeless people to access mainstream services and the projects outlined in this report aim to provide the right service in the right place at the right time to ensure the often complex needs of homeless people are addressed.

The services provided form part of an overall strategy to move homeless people through a health and social care pathway out of poverty and into a more stable lifestyle.

11.2 Equality Impact Assessment (EIA)

These services form part of the Council's Homelessness Strategy and an EIA was carried out on the Strategy in March 2007.

12. CARBON REDUCTION IMPLICATIONS

12.1 NO

13. PLANNING AND COMMUNITY SAFETY IMPLICATIONS

13.1 NO

REPORT AUTHOR: **Lesley Hilton**
Health and Housing Programme Manager (NHS Wirral)
telephone: 0151 651 0011 ext 1557
email: lesley.hilton@wirral.nhs.uk

APPENDICES

REFERENCE MATERIAL

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Health and Well Being Overview and Scrutiny Committee	10 November 2009

WIRRAL COUNCIL

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE

22 MARCH 2011

SUBJECT:	***CHANGES TO INDEPENDENT LIVING FUND - UPDATE REPORT***
WARD/S AFFECTED:	***ALL***
REPORT OF:	***HOWARD COOPER***
RESPONSIBLE PORTFOLIO HOLDER:	***COUNCILLOR BOB MOON***
KEY DECISION?	**NO**

1.0 EXECUTIVE SUMMARY

1.1 *Following the report to the Health & Wellbeing Overview & Scrutiny Committee on 9 September 2010, which reported changes to the Independent Living Fund (ILF), this report provides an update of developments in this area and their impact on DASS and the Council since that date.*

This items falls within the Social Care and Inclusion portfolio.

2.0 RECOMMENDATION/S

2.1 That Members of the Health & Wellbeing Overview & Scrutiny Committee note developments linked to ILF changes in the last six months.

3.0 REASON/S FOR RECOMMENDATION/S

3.1 As above.

4.0 BACKGROUND AND KEY ISSUES

4.1 The Independent Living Fund is a source of income administered through a national government charity to enable people to pay for a range of support services that are not statutory. The funds have been predominately used to support people with complex needs alongside other funding streams, including social care, to live independently.

4.2 In March 2010, ILF changed its regulations which significantly reduced access to this funding stream. However, soon after, new applications to the scheme, which were submitted before this date, were suspended without notice due to unprecedented levels of demand.

4.3 ILF subsequently took steps to reassure people who already had funding in place that this funding would continue.

4.4 The impact of this policy decision was felt locally, as there were thirteen people who had outstanding applications for ILF funding which were not processed. These individuals were mainly in the service areas of Learning Disabilities.

4.5 Since that time DASS has worked with these individuals and their families to develop support plans which will meet their Fair Access to Care (FACS) eligible needs and continue to provide opportunities for independence. While DASS has not been in a position to directly replace ILF funding, the introduction of personalisation has meant that the impact of these changes have been reduced.

4.6 There remain currently 118 people supported by DASS who receive ILF funding. This is a static position from the previous report provided.

4.7 In December 2010, a ministerial statement was made through the Department of Work & Pensions. On ILF, the following advice was issued:

- That there should be an emphasis on the critical role that local authorities have under their statutory responsibilities to consider the requirements of clients who would otherwise have received an additional ILF package.
- The need for broader independent living strategies as part of the local authority brief in line with local priorities and accountability.
- A view that, following consultation with disability organisations, local government representatives and other stakeholders, the current model of ILF was not sustainable.
- The ILF should remain permanently closed to all new applications
- That arrangements for the protection of existing recipients of ILF should be put into place.
- That further consultation takes place following the publication of the report by the Commission on the funding of care and support on the theme of how best to support existing service users of ILF into the personalised social care system.

4.8 Further to this, the Joint Committee on Human Rights, which is part of the United Kingdom Parliament, has launched a consultation to find out what disabled people think about the right to independent living. The committee is accepting information from a wide range of stakeholders, disabled people, their families and groups and organisations that support disabled people. The consultation will end on the 29 April 2011. This initiative will further inform the national direction of policy in relation to independent living and providing people with disabilities choice, control and access to the right support.

4.9 As a result of this statement the department will need to respond to the future needs of people with disabilities with the understanding that ILF funding will not be available in the future.

5.0 RELEVANT RISKS

5.1 Longer term evaluation will be required on the impact of the Council of the withdrawal of ILF funding.

6.0 OTHER OPTIONS CONSIDERED

6.1 Not applicable.

7.0 CONSULTATION

7.1 External to the council, undertaken on a national basis. Housing and support for adults with disabilities will be subject to local discussion and consultation through the Learning Disability Partnership Board.

8.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

8.1 A possible increase in demand for non FACS eligible services provided through this sector, although this needs to be substantiated.

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

9.1 None at present.

10.0 LEGAL IMPLICATIONS

10.1 None.

11.0 EQUALITIES IMPLICATIONS

11.1 None to report but potential impact on people with disabilities which restrict opportunities for independent living is still a consideration.

11.2 Equality Impact Assessment (EIA)

(a) No but any local plans to support people with disabilities to live independently would be subject to and Equality Impact Assessment.

12.0 CARBON REDUCTION IMPLICATIONS

12.1 None.

13.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

13.1 None.

REPORT AUTHOR: ***Rick O'Brien***
Head of Branch, Access & Assessment
telephone: (0151) 666 4761
email: richardobrien@wirral.gov.uk

APPENDICES

None

REFERENCE MATERIAL

Joint Committee on Human Rights Consultation on Disabled People and their Right to Independent Living. www.parliament.uk.jchr

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Health & Wellbeing Overview & Scrutiny Committee	9.9.10

WIRRAL COUNCIL

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE

22 MARCH 2011

SUBJECT:	***DASS COMPLAINTS ANNUAL REPORT***
WARD/S AFFECTED:	***NONE***
REPORT OF:	***HOWARD COOPER***
RESPONSIBLE PORTFOLIO HOLDER:	***COUNCILLOR BOB MOON***
KEY DECISION?	**NO**

1.0 EXECUTIVE SUMMARY

1.1 Under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 it is a statutory requirement to produce an annual report which provides information on the quantity of the complaints received and the adequacy of the Complaints Process. The annual report is attached as an appendix.

1.2 On 1 April 2009 new legislation was introduced that substantially revised the previous approach to complaints. The new legislation, *The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009* and accompanying guidance (Listening, Responding, Improving) operates across Health and Adult Social Care and places significant emphasis on a personalised approach to complaints and 'learning from complaints'.

1.3 As a result DASS has made changes to how complaints are managed. A new 'Complaints, Comments and Compliments Procedure' was formally introduced on 1 June 2010; however many of the changes have been in place throughout the year. The Department no longer operates a stage based system; instead complaints are handled in a reasonable and proportionate manner agreed with the complainant and detailed in a personalised Complaints Plan.

1.4 This report details Complaints Management for the period 1 April 2009 to 31 March 2010, and covers all complaints received by the Department and other customer feedback. The report includes four case studies drawn from actual feedback received that have been amended for editorial and confidentiality reasons.

1.5 There has been an increase in average response times due to the switch to the new system of dealing with complaints and the removal of stages. This has been addressed and there is evidence in the early months of 2010-11 that performance is improving and will continue to do so. There is also a commitment to broaden out the area of work beyond complaints and to capture and learn from across the spectrum of customer experience including compliments and suggestions. These ongoing improvements are outlined in section five of the annual report.

1.6 The importance of learning from complaints is recognised by the Department and this is dealt with specifically at section four. four of the annual report. Thirty nine different actions were agreed as a result of complaints to effect improvement in service provision. These are an important development although it is acknowledged that more can be done to achieve a fully learning culture.

1.7 Compliments are dealt with at section six of the annual report. Three hundred and fifty two compliments were received in the year. It is significant that more people took the time to say how good the service was compared those who made a complaint.

1.8 Section seven of the Annual Report details the ongoing improvements to how customer feedback is managed to ensure that maximum advantage is drawn from the customer experience in developing services in the future.

1.9 This report after formal agreement from the Council Overview and Scrutiny Committee, will be made public via the Council website, and shared with relevant partners.

1.10 Also attached is the Quarterly Report on Complaints Performance for Quarters 1-3 in the current year. This report highlights how performance has improved throughout 2010-11, which is reflected in shorter response times to complaints and political contacts.

2.0 RECOMMENDATION/S

2.1 That members note the contents of the report.

3.0 REASON/S FOR RECOMMENDATION/S

3.1 This report is a statutory requirement

4.0 BACKGROUND AND KEY ISSUES

4.1 None

5.0 RELEVANT RISKS

5.1 Complaints about the service need to be addressed, and relevant improvements made in order to reduce risk to the individual and/or carer, and for any organisational or reputational risks which may be raised as a result.

6.0 OTHER OPTIONS CONSIDERED

6.1 None

7.0 CONSULTATION

7.1 None required

8.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

8.1 The department will also address complaints raised about services from this sector which it receives.

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

9.1 Complaints which require commissioned investigations are currently carried out by operational managers from parts of the department which are not covered in the complaint.

10.0 LEGAL IMPLICATIONS

10.1 There are possible legal challenges which may arise as a result of a complaint.

11.0 EQUALITIES IMPLICATIONS

11.1 People who use the services of the department are amongst the most vulnerable in Wirral; in particular older people, disabled people and carers.

11.2 Equality Impact Assessment (EIA)

(a) Is an EIA required? No
(b) If 'yes', has one been completed?

12.0 CARBON REDUCTION IMPLICATIONS

12.1 None

13.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

13.1 People who use services and their carers may be at a higher risk of exploitation by others than the general population.

REPORT AUTHOR: ***David Jones***

Complaints Manager
telephone: (0151) 666 4787
email: davidjones@wirral.gov.uk

APPENDICES

Complaint & Customer Feedback Annual Report 2009-2010
2010-11 Quarterly Complaints and Customer Feedback Report Quarters 1-3

REFERENCE MATERIAL

None

SUBJECT HISTORY (last 3 years)

Council Meeting	Date

Complaint & Customer Feedback Annual Report

1 April 2009 to 31 March 2010

Listening

Responding

Improving

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1. Executive Summary

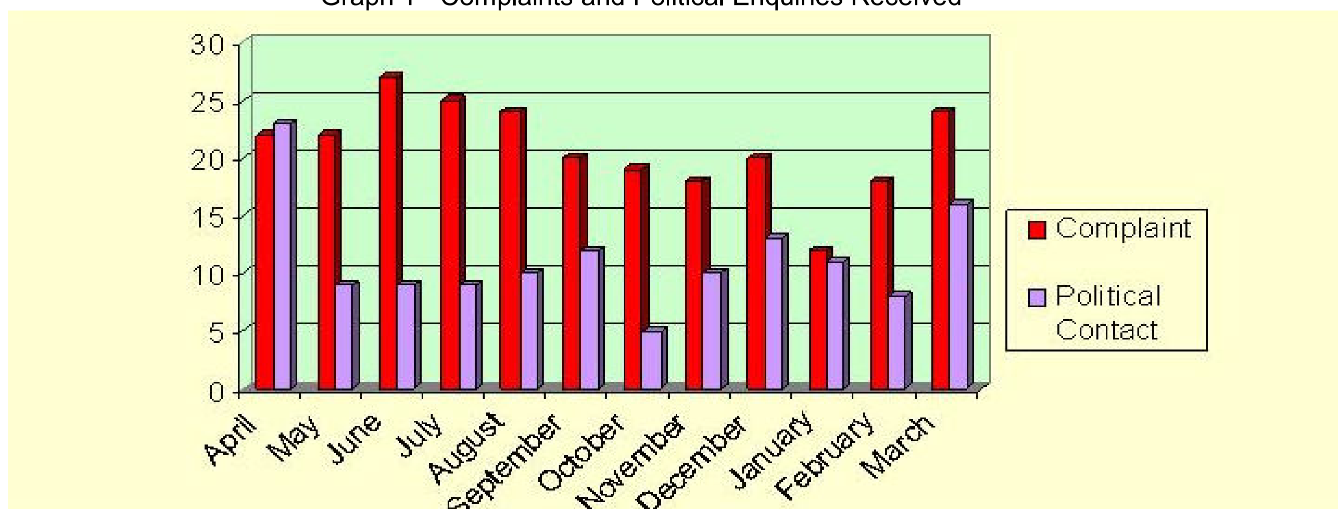
1.1 On 1 April 2009 new complaint legislation was introduced that substantially revised the previous approach to complaints. The new legislation, *The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009* and accompanying guidance (Listening, Responding, Improving) operates across Health and Adult Social Care and places significant emphasis on a personalised approach to complaints and 'learning from complaints'.

1.2 As a result DASS has made significant changes to how we manage complaints; a new 'Complaints, Comments and Compliments Procedure' was formally introduced on 1 June 2010; however many of the changes have been in place throughout the year. The Department no longer operates a stage based system; instead complaints are handled in a reasonable and proportionate manner agreed with the complainant and detailed in a personalised Complaints Plan.

1.3 This Report details Complaints Management for the period 1 April 2009 to 31 March 2010, and covers all complaints received by the Department and other customer feedback. The Report includes four case studies drawn from actual feedback received that have been amended for editorial and confidentiality reasons.

1.4 *Overview of complaints and political contacts received*.
Graph 1 highlights that the number of complaints has remained constant at or around twenty each month. By contrast political contacts whilst averaging about ten a month has fluctuated from month to month between five and twenty three.

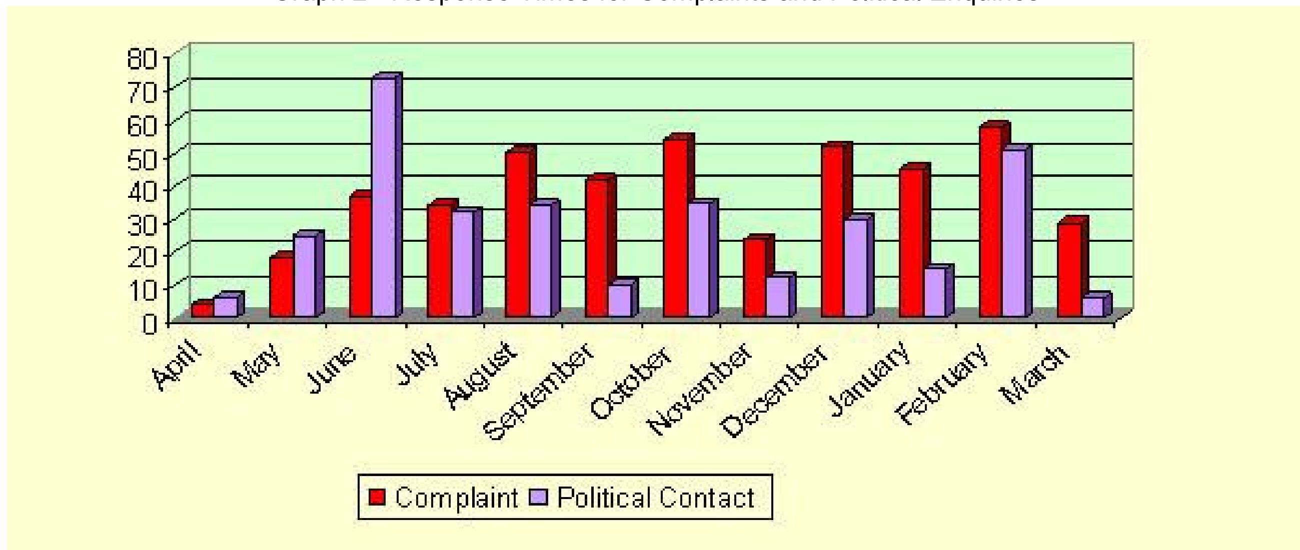
Graph 1 - Complaints and Political Enquiries Received



1.5 *Overview on response timescales.*
Complaint response timescales have an average of forty days (graph 2); most months show an average of between thirty and fifty days; figures for an individual month may need to be treated with caution as one lengthy complaint can distort

the average response time. Response times to politicians have increased and in only three months did the average response time meet the corporate standard. Action has already been implemented to address timescales which is detailed in the body of the report.

Graph 2 - Response Times for Complaints and Political Enquiries



1.6 The average response times highlights that the switch to a new system of dealing with complaints has had an impact upon timescales. This has been addressed and there is evidence in the early months of 2010-11 that performance is improving and will continue to do so. There is also a commitment to broaden out the area of work beyond complaints and to capture and learn from across the spectrum of customer experience including compliments and suggestions. These ongoing improvements are outlined in section 5 of the report.

1.7 The importance of learning from complaints is recognised by the Department and this is dealt with specifically at section 4.4 of the report. Thirty nine different actions were agreed as a result of complaints to effect improvement in service provision. These are an important development although it is acknowledged that more can be done to achieve a fully learning culture.

1.8 Compliments are dealt with at section 6 of the report. Three hundred and fifty two compliments were received in the year. It is significant that more people took the time to say good the service was compared those who made a complaint.

1.9 Section 7 of the report details the ongoing improvements to how customer feedback is managed to ensure that maximum advantage is drawn from the customer experience in developing services in the future.

1.10 This Report after formal agreement from the Council Overview and Scrutiny Committee, will be made public via the Council website, and shared with relevant partners.

2. Purpose

2.1 This report provides information about complaints, compliments and other feedback received by the Department during the twelve months between 1 April 2009 and 31 March 2010.

2.2 Under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 it is a statutory requirement to produce an Annual Report which provides information on the quantity of the complaints received and the adequacy of the Complaints Process.

2.3 This Report, after consideration by the Council Overview and Scrutiny Committee will be published on the Council Website and shared with our partners.

3 Definitions

3.1 Complaints and associated feedback are managed within the Quality Assurance Team, as part of the Quality Assurance and Customer Care Team. The Quality Assurance Team consists of:

- Complaints Manager
- Investigation Officer (currently vacant)
- Team Support Officer (x1.5)

3.2 A complaint is defined as any expression of dissatisfaction about the exercise of social services functions that requires a response. Complaints that are made orally and can be resolved on the same working day may be excluded from the procedures; all other complaints are dealt with through the complaints procedure.

3.3 To be considered, a complaint must be made by an eligible person. An eligible person is either (i) a person who receives services or may be eligible to receive services, (ii) a person who is affected, or likely to be affected by the action, omission or decision of the Department, or (iii) a person with sufficient interest or consent acting on behalf of a person described in (i) & (ii).

3.4 A complaint must be made within twelve months of the event complained about. This may be extended at the discretion of the Complaints Manager.

4. Complaints

4.1 Complaints Activity

4.1.1 Registered Complaints

4.1.2 All complaints meeting the definition at 3.3 are registered on a database system called Respond by the Quality Assurance Team. Each complaint is acknowledged with three days, and a guide to the complaint procedure issued.

4.1.3 The total number of complaints registered in 2009-10 was two hundred and fifty one (table 1). The number of complaints received does not necessarily have a direct correlation to the quality of service. While it may highlight issues relating to the quality of services it can also confirm that the complaint process is well promoted, accessible and that people who use services and their representatives have confidence that making a complaint will not only resolve their concerns but also make a difference.

4.1.4 There has been thirty three per cent reduction in the number of Commissioned Investigations. Previously these formed stage two of the complaint process, and the complainant had the right to an investigation if they were not satisfied with the initial response, or if a response was not sent within twenty days. However an investigation now only takes place if the Complaints Manager, after discussion with the complainant, feels it is reasonable and proportionate to undertake an investigation.

4.1.5 As with Commissioned Investigations, Review Panels (formerly Stage three) will only be convened if the Complaints Manager feels it is reasonable and proportionate in relation to the complaint. Review panels when arranged normally follow the conclusion of a commissioned investigation.

Table 1 – Complaints Received

	2007-08	**2008-09**	**2009-10**
Complaints Received	206	278	251
Commissioned Investigation	26	33	22
Review Panels	14	10	5

4.1.6 *Customer Groups*

4.1.7 The largest proportion of complaints received was from the families of older people, (fifty per cent); this has traditionally been the group which has made most complaints. Only twenty per cent of complaints were received direct from people who use services.

Table 2 – Complaints Received by Customer Group

	2007-08	**2008-09**	**2009-10**
Adult Mental Health	4	4	5
Adult Physical Disability	31	24	27
Adult with Learning Disability	8	38	11
Older Person	29	27	14
Carer	6	6	2
Family of Adult with LD	21	31	32
Family of Adult with MH	4	5	6
Family of Adult with Phys Disability	12	16	12
Family of Older Person	71	116	125
Professional	5	2	10
Other	7	9	7
Total	**198**	**278**	**251**

4.1.8 *Type of complaint*

4.1.9 Complaints are categorised under broad issues, in 2009-10 the most complained about issues were assessment of need, provision of care and financial issues (Table 3). However many complaints were exacerbated by and refer to poor communication and staff attitude. Often it is not the message but how it is communicated that results in it becoming a complaint and it is recognised that this is an area that requires further work in the coming period.

4.1.10 There were twenty seven complaints received last year that related to assessment of need. This covers a variety of concerns, however, concerns that were particularly prevalent include delays within the assessment process and cases where the family / client desired residential care but the assessment did not support this as a need. The Department will support people in their homes whenever this is possible, but the complaints perhaps highlight that more needs to be done to provide re-assurance to people who use services and their families that remaining at home is a safe and viable option.

4.1.11 There were thirty six complaints in 2009-10 that were categorised as relating to the provision of care. This again addresses a variety of issues, but included: delays in arranging/reinstating care packages following discharge from hospital; problems encountered in requesting extra support; and the quality of care provided by commissioned services.

4.1.12 Thirty nine complaints were categorised as ‘financial’ issues. The majority of these focussed on disputed financial assessments, or were about incorrect invoicing, for example continuing to send invoices after being notified of a change in circumstance.

4.1.13 In 2009-10 the Department received no complaints about the processes or the decision in relation to personalised budgets. This is against the background of the Cabinet decision to do the following:

- extend Phase two of the pilot to all adults with a learning disability, all people recovering from stroke across Wirral and all people in Birkenhead locality, approximately potentially three thousand new referrals or reviews
- test the Resource Allocation System (RAS) on a minimum ten per cent of people receiving community based services (approximately 200 people).

Phase two of the pilot runs until the end of August with evaluation in September and report to Cabinet on 23 September. Full roll out of Personal Budgets will begin in November 2010.

Table 3 – Complaints Received by Issue

Main Complaint	2007-08	2008-09	2009-10
Accommodation	7	2	0
Adaptation Issue	7	1	2
Adult Protection	4	5	3
Assessment of Need	27	22	27
Behaviour of Residents	1	2	0
Breach of Confidentiality / Privacy	1	2	2
Care Provision	13	34	36
Carer Issues / Assessment	6	7	7
Change in home care provision	2	6	4
Charging Policy Issue	3	2	2
Day Centre	0	3	4
Delay in Service Delivery	1	6	1
Direct payment	4	10	6
Disputed Assessment	3	0	4
Equipment	1	1	0
Failed / Late Visit	1	1	1
Financial Issues	19	31	39
Funding Assessment Disputed	2	5	2
Health and Safety issue	1	3	1
Home Care Issues	2	2	0
Home Closure	1	1	0
Independent Home Care Issues	15	13	6
Lack of support	3	7	6
Meals on Wheels Tender	4	2	0
Mental Health Assessment	1	0	0
Outcome of Assessment Review	24	16	11
Policy / Resource Issue	5	3	8
Poor Communication	4	9	13
Property Issue	1	0	1
Provision of Service	3	6	10
Quality of Care	2	8	15
Quality of Service	4	6	11
Removal from placement	1	0	0
Residential Assessment	4	4	2
Residential issue	3	0	2
Respite Assessment	5	6	5
Service Implementation	3	0	0
Staff Conduct	9	9	14
Supported Living	0	27	1
Transport Issue	5	7	4
Other	5	2	1
Total	**198**	**278**	**251**

4.1.14 *Complaints by Management Structure*

4.1.15 The majority of the complaints received come from distinct areas of service (table 4) and this is primarily a reflection of the tasks carried out, rather than the

performance of the teams. Access and Assessment receive sixty per cent of complaints and this reflects the work conducted in deciding the size and type of package that someone may receive. Twelve per cent of complaints relate to Learning Disabilities, which may be indicative of the complexities of many cases in this area.

4.1.16 Finance and Performance account for a further twelve per cent of complaints. This primarily relates to financial assessments and involves complaints from families rather than people who use services.

4.1.17 Commissioned services are services provided by an external company or voluntary agency on behalf of the Department. Commissioned Services account for sixteen percent of complaints. These are complaints that are made direct to the Department; it is expected that a number of complaints are also made direct to service providers. The complaints primarily relate to domiciliary care rather than residential services.

4.1.18 Residential services both in house and external traditionally receive only a small number of complaints, which may be due to feelings of apprehension about complaining in a residential setting. This is recognised and has been evidenced by a number of national organisations and customer surveys e.g. *“residents or their representatives may be reluctant to complain because of the resident's position within the home”* (Office of Fair Trading 2004).

4.1.19 A review of complaints management in residential services commenced in 2009-10. This review will be concluded in 2010-11. The outcome of this will identify ways to increase transparency and confidence in the complaints system for residential services.

Table 4 - Complaints Received by Team

	Number of Complaints	**Percentage**
Access and Assessment – Bebington & W Wirral (excl MH)	41	16%
Access and Assessment – Birkenhead (excluding LD)	45	18%
Access and Assessment – Wallasey (excl Integrated Discharge)	21	9%
Access and Assessment – Learning Disabilities	29	12%
Access and Assessment – Mental Health	3	1%
Access and Assessment – Integrated Discharge	6	2%
Direct Support Locality Services - Bebington & W Wirral	9	4%
Direct Support Locality Services - Birkenhead	2	>1%
Direct Support Locality Services - Wallasey	5	2%
Direct Support Locality Services - Transport	4	2%
Integrated Communities and Well Being	1	>1%
Finance and Performance	30	12%
Commissioned Services	39	16%
Other	16	6%
Total	**251**	**100%**

4.1.20 *Complaints by Ward*

4.1.21 There are a number of wards where a high level of complaints is received in comparison to the client base in the areas; these include Bromborough, Hoylake & Meols and Rock Ferry. Conversely there are relatively few complaints from Eastham and Seacombe.

Table 5 – Complaints Received by Ward

Ward	**2007-08**	**2008-09**	**2009-10**	**2009-10 %**	**% Client base**
Bebington	10	17	10	4%	4.78%
Bidston & St James	6	4	5	2%	0.04%
Birkenhead & Tranmere	8	26	18	7%	4.90%
Bromborough	7	11	12	5%	0.07%
Clatterbridge	12	11	7	3%	3.75%
Claughton	7	8	5	2%	4.78%
Eastham	4	5	2	1%	4.15%
Greasby, Frankby & Irby	11	9	11	5%	7.04%
Heswall	11	10	6	2%	3.05%
Hoylake & Meols	14	12	17	7%	0.02%
Leasowe & Moreton East	13	7	10	4%	2.78%
Liscard	8	7	1	>1%	2.72%
Moreton West & Saughall Massie	10	10	11	5%	0.02%
New Brighton	8	7	5	2%	4.43%
Oxton	12	23	12	5%	0.01%
Pensby & Thingwall	8	8	10	4%	4.24%
Prenton	11	21	15	6%	5.40%
Rock Ferry	7	16	18	7%	0.05%
Seacombe	5	2	2	1%	4.36%
Upton	16	18	10	4%	5.90%
Wallasey	7	19	20	8%	4.19%
West Kirby & Thurstaton	2	13	8	3%	3.51%
Total*	**197**	**264**	**215**	100%	100%

** Total excludes complaints from out of borough or the ward is not known*

4.2.22 *Equal Opportunities.*

- Thirty four per cent of complainants indicated that they had a disability
- sixty one per cent of complainants were female
- Details of ethnicity were volunteered in approximately one third of cases. All bar three classed themselves as White (British); one Asian (Chinese), one British, and one White (European).
- No information was supplied for Sexual Orientation.
- Two people volunteered information on Religion – one Roman Catholic and one Church of England.

4.3 Complaints Management

4.3.1 *The complaint system*

4.3.2 All complaints are dealt with in a personalised manner that is reasonable and proportionate. All complaints should be acknowledged with three days; however only fifty per cent were acknowledged within three days during 2009-10, although this did improve through the year, and the figure for the final quarter alone was seventy two per cent.

4.3.3 An individualised complaint plan is now drawn up for the majority of complaints, were possible this will be completed following discussion and agreement between the complainant and the Complaints Manager. The complaint plan will detail how the complaint will be dealt with, the manager with responsibility for responding, and the timescale in which a response is due.

4.3.4 In drawing up the complaint plan the Complaint Manager will discuss and consider the most appropriate method of dealing with the complaint to meet the complainant's desired resolution. If a method does not successfully resolve a complaint, consideration will be given to using a further method; therefore in some cases more than one method of resolution will be attempted.

4.3.5 Once all reasonable methods have been attempted, the complainant will be directed to contact the Local Government Ombudsman if they remain dissatisfied. The complainant has the right to go to the Ombudsman at any point; however the Ombudsman normally expects that the complainant exhausts the Departmental procedures first.

Table 6 - Method of Dealing with Complaint

Method	Number
Case Review	196
Commissioned Investigation	22
Review Panel	5
Information Provision	3
Representation Against Policy	3
Management Review	1
Facilitated Meeting	5

4.3.6 Case Study One - Sharon's story

4.3.7 Sharon is a young woman with a mild learning disability who lives in supported living. Following a review of her care package, Sharon thought that she had been overcharged for some of the services she required. This upset Sharon considerably and she wrote a letter of complaint to the Department.

4.3.7 The Complaints Manager rang Sharon to discuss he complaint, to ensure that he fully understood the issues and to consider how resolution could be agreed.

Sharon was quite emotional during the conversation and it was agreed that she would feel better about a meeting to try and resolve the complaint. The Complaints Manager made arrangements for the meeting and ensured that Sharon would be supported by an advocate at the meeting.

4.3.8 The meeting was arranged at a date and venue suitable for Sharon. Prior to the meeting the Complaints Manager explored the issues and established what had happened. The meeting was very successful with an explanation provided, an apology offered and re-imbursement agreed.

4.3.9 Sharon subsequently wrote into the Quality Assurance Team, expressing her thanks for how her complaint had been handled and for the resolution reached.

4.3.10 *Advocacy*

4.3.11 Advocacy is a key part of a successful complaints system, and helps to empower clients who may be vulnerable or lacking in confidence. All complainants are informed of the availability of advocacy. In 2009-10 a total of thirty three complainants (thirteen per cent) were supported by an advocate, and six (two per cent) were supported by a legal representative.

4.3.12 *Independent Person's*

4.3.13 The Department maintains a pool of Independent Person's to assist in the complaints process. An Independent Person is a volunteer from the community who has no connection with the Council, and provides valuable independent scrutiny of the process and increases complainant confidence in the transparency of the department.

4.3.14 There is currently a pool of twenty one Independent Persons who receive training and support in their role from the Complaints Manager. The Complaints Manager recruits, maintains and manages this pool for Adult Social Services and Children's Social Care.

RESPONDING

4.4 <u>Complaints Performance</u>

4.4.1 *Timescales*

4.4.2 Timescales are not statutorily prescribed, however they must be as short as reasonably possible to allow for effective consideration. Each complaint has a personalised timescale following a discussion with the complainant.

4.4.3 Whilst each complaint has a personalised timescale, taking account of the individual circumstances, Departmental guidelines have been put in place to determine what a reasonable timeframe is for most circumstances (See Table 7) This provides added protection and re-assurance for complaints, in particular the most vulnerable, as it protects against any suggestion that people may be talked into unreasonable timescales.

Table 7 – Complaints Performance

Target against guideline	Performance
100% of complaints acknowledged within 3 days	**50%**
70% percent of complaints to be fully responded to within 20 days	**51%**
70% of complaints involving formal investigation to be fully responded to within 45 days	**20%**
70% of complaints to be fully responded to within initial agreed timescale	**41%**
100% of complaints to be fully responded to within agreed extended timescale.	**44%**
100% of complaints fully responded to within 6 months	**94%**

4.4.4 The number of complaints acknowledged within three days was low due to capacity issues within the Quality Assurance Team in the early part of the year. In the final quarter of the year seventy four per cent of complaints were acknowledged within three days.

4.4.5 The timescales for responding to complaints and the percentage that comply with the initial agreed timescale is an area where performance needs to be improved. Changes to the Complaints Procedure and greater liaison between operational teams and the Quality Assurance Team, have subsequently been implemented, which it is anticipated will lead to an improvement in performance in 2010-11.

4.4.5 Commissioned Investigations are a much more detailed approach than case reviews and by their nature take place over a longer period of time. This can distort the performance figures for a team that has received few complaints; this was the case for Direct Support Locality Services Wallasey this year.

4.4.6 Training on conducting Commissioned Investigations was agreed in 2010-11 and has subsequently been provided to fourteen Officers, which makes the Department more effective in conducting detailed investigations into complex complaints.

Table 8 - Complaint Timescales by Team

	Closed	Completed within initial timescale	Average days to respond	Completed within 6 months
Access and Assessment –Beb'n & W Wirral (excl MH)	38	34%	34	97%
Access and Assessment –Birkenhead (excl LD)	43	35%	30	97%
Access and Assessment –Wallasey (excl Integ'd Disch)	21	43%	15	100%
Access and Assessment - Learning Disabilities	27	37%	35	96%
Access and Assessment –Mental Health	3	0%	21	100%
Access and Assessment – Integrated Discharge	5	20%	46	80%
Direct Support Locality Services – Beb'n & W Wirral	8	50%	11	100%
Direct Support Locality Services - Birkenhead	2	100%	1	100%
Direct Support Locality Services - Wallasey	5	0%	73	100%
Direct Support Locality Services - Transport	3	67%	107	67%
Integrated Communities and Well Being	1	100%	1	100%
Finance and Performance	28	57%	26	96%
Commissioned Services	37	32%	32	97%
Other	17	47%	24	100%
Total	**238**	**39%**	**40**	**97%**

4.4.7 Each method of responding to a complaint has a bench mark timescale for completing the consideration. Whilst this is merely a guideline is does give some indication of the performance expected; performance is detailed at table 9. The following benchmarks apply:

- Case Review (consideration by operational manager) ten days
- Commissioned Investigation (formal off line investigation) forty days
- Review Panel (following commissioned investigation) thirty days
- Representation against Policy (i.e. a decision of the council) five days

Table 9 - Complaint Timescales by Method

	Closed	**Completed within initial timescale**	**Average days to respond**	**Completed within 6 months**
Case Review (only)	225	42%	33	96%
Commissioned Investigation	10	10%	163	58%
Review Panel	3	100%	159	66%
Representation Against Policy	3	33%	32	100%
Facilitated Meeting	5	40%	25	100%
Total	**246**	**41%**	**40 Days**	**94%**

4.4.8 A swift response to a complaint can make resolution easier to achieve, and minimise anxiety to the complainant. It is recognised therefore the importance of not just meeting agreed timescales but improving upon them. The Quality Assurance Team can and does take a more proactive approach at the earlier stages of a complaint to assist in this process.

4.4.9 <u>Case Study Two - Beryl's Story</u>

4.4.10 Beryl is a woman in her late sixties and is the carer for her brother, who is in his seventies. Beryl made her complaint after the riser on her brother's bed broke. An Occupational Therapist had been out and confirmed the device needed to be replaced but said he could not give a timescale for when the new device would be delivered and installed.

4.4.11 Beryl contacted the Quality Assurance Team because she was concerned about how she would be able to provide care for her brother for any length of time without the riser. The uncertainty over the timeframe for replacement was causing a great deal of anxiety, although she worried about causing 'trouble'.

4.4.12 The Quality Assurance Team was able to re-assure her that she was not causing trouble. We also liaised with the operational service, and within two hours we were able to ring Beryl and tell her the riser would be delivered in two days time.

4.4.13 Beryl was re-assured by receiving this timeframe and felt able to care for her brother in the intervening period. Two days later Beryl rang Quality Assurance Team to say the riser had been installed and to thank the team for prompt assistance.

4.5 Learning from Complaints

4.5.1 *The Importance of Learning*

4.5.2 Complaints are valuable. Not only is the public's confidence and trust in our services eroded when they are handled badly but they also provide a vital source of feedback and learning to help drive improvement.

4.5.3 As well as providing an efficient, effective and understanding way for users of public services to get their issues addressed, complaints offer a chance to gain an accurate picture of the level and quality of service offered from the perspective of the user. They provide free feedback on service delivery and provide a means for the user to have an input into the continuous improvement of the Department.

4.5.4 It is recognised that we need to do more to harness the information and experiences of our clients and their families. The Department has traditionally been good at identifying learning following commissioned (or stage two) investigations, but we need to expand upon this. This will require all managers to actively consider organisational learning when dealing with a complaint. The Complaints Manager will also be seeking clear evidence of the implementation of changes, and the effect that they have had upon the service.

4.5.5 *Actions from Complaints*

4.5.6 In the last year, thirty nine actions agreed from complaints were due for implementation. These were based upon recommendations made by the officer investigating the complaint and agreed with the relevant head of service or branch. To date fifty six percent have been implemented. Improvements to procedures were the most common action and improvement identified. The full detail is provided at Table 10.

4.5.7 The actions agreed in the past year are summarised by type in Table 10. These examples demonstrate the increasing focus on organisational learning alongside personal resolution.

Table 10 - Types of Actions

	Number	Closed	Closed in Timescale
Advice / Support	1	0	0
Amendment to Procedure/Protocol	6	3	1
Assessment / Review	2	1	1
Amend / Review Documents	2	0	0
Briefing Note / Memo	2	1	0
Discussion - Supervision	3	2	3
Meeting	1	1	0
New Procedure / Protocol	8	6	0
Review of Practice	4	3	1
Review of Procedure	3	1	1
Training	3	0	0
Written Apology	4	4	4
Total	**39**	**22**	**11**

Table 11 – Examples of Actions

• That decisions by officers, that relate to financial commitment are fully recorded in writing and include rationale and timescales.
• That the Review Procedure is amended to ensure that service users are provided with a rationale behind any decision.
• That when a Carer has caring responsibilities for more than one person, only one Carer's Assessment shall be conducted but a copy held on each appropriate file.
• That the Department conduct a review of complaints management in relation to in house and commissioned residential and nursing homes. Specifically this review should consider the number of complaints currently received from homes and how to promote an open and welcoming approach to complaints within this sector.
• That consideration be given by the Department to a representative from health being included in the contracts monitoring visiting process to enable a professional review of nursing and medical care within the home.
• That a feasibility study is conducted into the use of anti falls technology in Wirral's DASS respite homes.
• Introduction of "summary of pre-existing condition" document to be supplied to health staff when a resident is admitted to hospital from a respite placement.
• A sample file check is undertaken of cases recently placed in residential care, from the community, in order to ensure that commitment of expenditure is based on sound evidence based judgement.
• DASS should develop a Standard where social workers, A.S.O.'s and all fieldwork staff become pro-active in terms of regularly communicating with people who use services and those who may potentially use services. A contact log on each file (electronic or hard copy) must be maintained.

4.5.8 Case Study Three - Andrew's Story

Photo: gr ionut

4.5.9 Andrew is the main carer for his uncle. To enable him to take a break from his caring responsibilities, Andrew agreed for his uncle to go to one of the Department's respite facilities for a fortnight. Unfortunately whilst he was there he suffered a fall and had to be admitted to hospital. Although Andrew acknowledged that the Department was not to blame for his uncle's fall he wished to make a complaint about how the situation had been handled.

4.5.10 The Complaints Manager met with Andrew to discuss his complaint. Andrew explained that he felt a number of mistakes were made during his uncle's stay both before and after the fall. He acknowledged that the clock could not be 'turned back' for his uncle, but he wanted the Department to learn from his experience to improve services for others in the future.

4.5.11 It was agreed that a commissioned investigation would take place and a timescale was agreed; this was subsequently extended with the agreement of the complainant due to staff absence. The investigation identified a number of areas for improvement and made a number of recommendations. Before these were finalised the Investigation Officer and a Senior Manager met with Andrew to discuss the report and recommendations in light of his experience.

4.5.12 Following the discussion a number of changes were made to the recommendations before these were agreed and subsequently implemented. These actions had a direct impact on how the Department provides respite and communicates with families. The process was completed by Andrew being kept informed about the progress made in implementing the actions and service changes.

5. Political Contacts

5.1 Definitions

5.1.1 Political Contacts are any written contact with the Department by an elected Politician (e.g. Councillor, M.P.). Political Contacts will be divided into three types- a referral, a complaint or a request for information. All Political Contacts will be forwarded to the Quality Assurance Team for assessment, recording and tracking.

5.1.2 *Political Enquiry – Referral.* This is a request for services received from an individual via a political representative. This is dealt with as any other request for services, i.e. as a referral. A response is sent to the politician advising them of this process within ten working days.

5.1.3 *Political Enquiry – Complaint.* This is a complaint that is made through the conduit of a political representative. This is dealt with in accordance with the complaints procedure. An acknowledgement is sent to the politician advising them of this process within ten working days. The politician will receive a copy of the complaint response letter when it has been issued.

5.1.4 *Political Enquiry – Request for Information.* This is a general request or enquiry from a politician that may be their own enquiry or made on behalf of a constituent. This will be acknowledged and referred to the relevant Principal Manager to respond formally. This response is sent within ten working days.

5.2 Political Contacts – Performance

5.2.1 The corporate standard is that all political contacts are responded to within ten working days. Previous years saw approximately seventy per cent of responses meeting this standard, with an average response time of ten days. However 2009-10 has seen a decline in performance both in the percentage meeting the timescale and the average response time (Table 12).

5.2.2 Performance has fallen generally across all teams that received more than three political contacts in the year (table 14). This has occurred at a time when the actual number of political contacts has fallen, and although there have been increased demands upon staff generally, it has been recognised that this performance is not acceptable. Changes in procedure have been made so that political contacts are assessed upon receipt to allow for a more efficient response. Political contacts are now classed as enquiries, referrals or complaints, which it is anticipated will lead to an improved performance in 2010-11.

Table 12 – Summary of Political Contacts

Political Contacts	**2007-08**	**2008-09**	**2009-10**
Number of Political Contacts Rec'd	198	196	135
% responded to with 10 days	68%	71%	45%
Average time to respond to political contacts.	10 days	10 days	42 Days

Table 13 – Political Contacts by Team

	Received	**Closed**	**Ave. days to respond**	**% response in 10 days**
Access and Assessment Bebington & W Wirral (excl. MH)	19	19	61	26%
Access and Assessment Birkenhead (excluding LD)	27	25	38	52%
Access and Assessment –Wallasey (excl. Integrated Discharge)	24	26	14	65%
Access and Assessment – Learning Disabilities	13	11	54	27%
Access and Assessment –Mental Health	5	5	11	60%
Access and Assessment – Integrated Discharge	3	3	5	100%
Direct Support Locality Services Bebington & W Wirral	1	2	80	0%
Direct Support Locality Services - Birkenhead	-	-	-	-
Direct Support Locality Services - Wallasey	4	2	19	0%
Direct Support Locality Services - Transport	-	2	147	0%
Integrated Communities & Well Being	4	5	31	60%
Finance and Performance	5	6	36	50%
Commissioned Services	2	1	4	100%
Other	28	39	42	36%
Total	135	146	42	45%

(Of the other political contacts twenty six related to decisions by Senior Management or the Council, including the changes to fees paid to residential and nursing homes (twenty one))

5.2.3 The nature of the issues raised via political contacts (table 15), broadly mirrors the areas of concerns raised by complaints. There is however, a tendency for disagreements about policy decisions made by the Council, (e.g. the level of fees paid to care homes), to be raised via politicians than directly as complaints.

Table 14 – Political Contacts by Issue

Main Complaint	2008-09	2009-10
Accommodation	1	4
Adaptation Issue	17	17
Adult Protection	1	1
Anti-Social Behaviour	2	4
Assessment of Need	28	27
Asylum Issue	-	1
Blue Badge	2	1
Breach of Confidentiality / Privacy	1	-
Care Provision	10	6
Care Fees 09	17	10
Carer Issues / Assessment	-	6
Charging Policy Issue	2	1
Contract Issue	-	1
Day Centre	2	3
Delay in Service Delivery	1	1
Design & Viability 09	-	2
Direct payment	2	1
Financial Issues	21	7
Health and Safety issue	1	-
Independent Home Care Issues	5	2
Lack of support	7	1
Meals on Wheels Tender	4	-
Mental Health Assessment	-	1
Occupational Therapy	10	-
Outcome of Assessment /Review	2	12
Policy / Resource Issue	16	4
Poor Communication	4	2
Quality of Service	9	4
Referral	-	2
Residential Assessment	3	4
Residential issue	2	1
Respite Assessment	3	4
Supported Living	2	1
Transport Issue	6	4
Total	**196**	**135**

6. Compliments

6.1 <u>Compliments Performance</u>

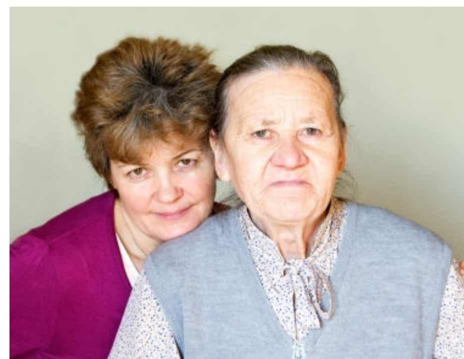
6.1.1 The Department received three hundred and fifty two compliments in 2009-10 (table 16) a significantly higher number than complaints received, which reflects well on the overall performance of the Department. Approximately one-third of compliments related to the Locality teams in the Access and Assessment Branch; given that this area of the work is often about making difficult decisions on the support that can be offered, it again reflects positively on the staff in those teams.

6.1.2 No compliments were made directly to the Department regarding the performance of Commissioned Services; however many compliments are made to the Service Providers.

Table 15 – Compliments by Team

	Number of Compliments
Access and Assessment –Bebington & W Wirral (excluding MH)	38
Access and Assessment –Birkenhead Locality (excluding LD)	21
Access and Assessment –Wallasey Locality (excluding Integrated Discharge)	29
Access and Assessment – Learning Disabilities	2
Access and Assessment –Mental Health	1
Access and Assessment – Integrated Discharge	6
Direct Support Locality Services - Bebington & W Wirral	53
Direct Support Locality Services - Birkenhead	28
Direct Support Locality Services - Wallasey	120
Direct Support Locality Services - Transport	4
Integrated Communities and Well Being	30
Finance and Performance	20
Commissioned Services	0

6.2 <u>Case Study Four - Irene's Story</u>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6.2.1 In December Jane's mother Irene was taken ill and spent two weeks in Arrowe Park Hospital. Irene is eighty four and lives alone, upon discharge and return to her flat, Jane and other family members were concerned about her continuing convalescence while living alone.

6.2.2 Following initial contact and recommendation from the Department Jane contacted the Promoting Older People's Independence Network (POPIN) service who conducted an assessment in a friendly, helpful and professional manner. This resulted in the provision of some devices to assist Irene and advising of the availability of an allowance that both assisted Irene and reassured her family.

6.2.3 Jane subsequently took time to write to congratulate not just on the service provided, but the manner in which it was provided. It made a stressful situation seem more manageable.

6.3 And finally here is a small selection of some of the other comments we have received during the year:

"An assessment carried out in an extremely friendly, helpful and professional …Jack is absolutely delighted."

"I must commend you and your team for making this procedure so effective, speedy and efficient. What an absolute pleasure to deal with in such a stressful situation"

"A very grateful thank you for all your help – I could not have managed without it."

"You have really helped me in mum's having to go into EMI long term care. I was re-assured, details explained and, all-in-all treated with the highest standard of courtesy and care. A truly distressing situation was made so much easier by your caring and professional staff."

7. Objectives for 2010-11

7.1 *Learning from Complaints*. Steps have already been taken to ensure that we adopt a more robust approach to considering organisational learning from all complaints. This includes clear procedures to ensure that learning is implemented and is effective. Organisational learning from complaints will be embedded in all working practices. We will also develop procedures to ensure that complainants are informed of the changes that result from complaints.

7.2 *Development of Complaints Management*. The introduction of new complaints legislation in 2009 marked a cultural shift in how complaints are dealt with, with an emphasis on a personalised approach leading to quick effective resolution feeding into organisational learning. The introduction of Wirral's new complaints procedure on 1 June 2010 laid the framework for adopting this cultural shift; the forthcoming year must see the development in practice of this approach.

7.3 *Improving Complaint Performance***.** There has been an increase in the taken to respond to complaints (and political contacts) over the last two years. This is a trend that will be reversed in the coming year, and changes have already been implemented to ensure this. The Complaints Manager will work more closely with teams to promote improvement and ensure that they receive information from complaints to assist in their performance.

7.4 *Development of Mediation*. Many complaints grow from a breakdown in relationship, often the most appropriate way to resolve these type of complaints will be through mediation. The Department of Health specifically recommend

mediation as a complaint resolution tool. This will be developed in 2010-11 and the Complaints Manager will be trained as an accredited mediator.

7.5 *Publicity.* The Complaints Manager will ensure that the new approach to complaints is publicised in the coming year, to ensure full user awareness. This will involve liaising with forum's user groups etc, a clear emphasis will also be given to the BME community.

7.6 *Training for staff in dealing with complaints.* This training will be reviewed and revised in the coming year to ensure that staff are fully conversant with the new approach to complaints and that they give full consideration to learning from complaints.

7.7 *Capturing the Customer Experience.* The Complaint Manager will liaise with operational managers to ensure that all elements of the customer experience, good, bad or neutral are considered from an organisational learning perspective and fed in to service improvement.

David Jones
Complaints Manager
November 2010

WIRRAL

Department of Adult Social Services

2010-11 Quarterly Complaints and Customer Feedback Report

Quarter 1, 2 & 3 – 1 April 2010 to 31 December 2010

Contents

1. Introduction
2. Complaints
3. Political Contact
4. Other Feedback

1. Introduction

1.1 This report details the volume of complaints and other customer feedback including political contacts and compliments and how they have been managed across the Department during the period April to October 2010.

1.2 A new Complaints, Compliments and Comments procedure was implemented on 1 June 2010. A briefing and a summary of the procedure was distributed to all staff by email. Briefings were offered and delivered to teams on request by the Complaints Manager.

2. Complaints Activity

2.1 Complaints Received

2.1.1 The complaints received in Quarters 1, 2 and 3 are analysed by issue (Table 1) and by Team (Table 2) as follows:

Table 1 - Complaint Issues

Issue	Quarter 3	Quarter 2	Quarter 1
Abuse/Discrimination/Harassment	1	2	
Accommodation Query		2	
Adaptation Issue	2	4	
Carer Issues / Assessment	1	2	n/a
Complaint Process		2	
Delay in Service Delivery	4	1	2
Direct payment		2	1
Disputed Assessment	5	3	7
Failed / Late Visit		2	2
Financial Issues	10	12	7
Home Closure		2	
ILF		1	
Independent Home Care Issues	5	5	
Lack of consultation/ communication			2
Lack of support	6	2	2
Personal Budgets	5	3	
Poor Communication	5	7	
Provision of Service	1		2
Quality of Care	1	5	3
Quality of Service	5	2	4
Residential issue		3	
Respite Assessment		2	
Review of Package of Care			4
Staff Conduct	4	7	
Transport Issue	4	5	1
Other	8	2	4
Total	**67**	**78**	**41**

Table 2 - Complaints by Team

Team	Quarter 3		Quarter 2		Quarter 1	
	No.	%	No.	%	No.	%
Access and Assessment –Bebington & W Wirral (excluding MH)	8	12%	12	15%	8	20%
Access and Assessment –Birkenhead Locality (excluding LD)	12	18%	8	10%	6	15%
Access and Assessment –Wallasey Locality (excluding Integrated Discharge)	6	9%	4	5%	2	5%
Access and Assessment – Learning Disabilities	12	18%	13	17%	4	10%
Access and Assessment –Mental Health	1	1%	1	1%	n/a	n/a
Access and Assessment – Integrated Discharge	n/a	n/a	2	2%	n/a	n/a
Direct Support Locality Services - Bebington & W Wirral	2	3%	4	5%	1	2%
Direct Support Locality Services - Birkenhead	n/a	n/a	1	1%	n/a	n/a
Direct Support Locality Services - Wallasey	n/a	n/a	1	1%	n/a	n/a
Direct Support Locality Services – Transport	4	6%	5	6%	n/a	n/a
Integrated Communities and Well Being	1	1%	3	4%	2	5%
Finance and Performance	5	7%	8	10%	9	22%
Commissioned Services*	11	16%	16	20%	7	17%
Other	5	7%	0	0%	2	5 %
Total	**67**	**100%**	**79**	100%	**41**	100%

* Commissioned services relate to services provided by external agencies under contract to Wirral DASS

2.1.2 There has been a noticeable increase in complaints received in the second and third quarter compared to the first quarter. This is the beginning of a trend and it is forecast that complaints will exceed 300 for the full year.

2.1.3 The main source of complaints continues to relate to the outcome of assessments, reviews and financial assessments. Further analysis of complaints in these areas indicates that where people have not been kept informed and communication has been poor, dissatisfaction with the outcome of the assessment, review or financial assessment is then pursued further as a formal complaint.

2.2 *Complaints Closed*

2.2.1 There is a statutory expectation that complaints are fully responded to within 6 months of receipt. An analysis of the complaints closed in Quarter 1, 2 and 3 is provided in Table 3.

Table 3 - Complaints Closed by Team

Team	Closed in initial timescale			Average days to respond			Closed in 6 months		
	Q3	**Q2**	**Q1**	**Q3**	**Q2**	**Q1**	**Q3**	**Q2**	**Q1**
Access and Assessment –Bebington & W Wirral (excl. MH)	22%	23%	0%	63	48	42	89%	88%	100%
Access and Assessment –Birkenhead Locality (excl. LD)	43%	50%	50%	44	27	27	93%	100%	100%
Access and Assessment –Wallasey Locality (excl. Integ'd Discharge)	60%	50%	40%	13	16	84	100%	100%	80%
Access and Assessment – Learning Disabilities	54%	22%	14%	25	40	50	100%	100%	86%
Access and Assessment –Mental Health	100%	100%	n/a	15	10	n/a	100%	100%	n/a
Access and Assessment – Integrated Discharge	n/a	0%	n/a	n/a	21	n/a	n/a	100%	n/a
Direct Support Locality Services - Bebington & W Wirral	100%	40%	n/a	4	31	n/a	100%	100%	n/a
Direct Support Locality Services - Birkenhead	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Direct Support Locality Services - Wallasey	0%	100%	n/a	25	6	n/a	100%	100%	n/a
Direct Support Locality Services - Transport	n/a	66%	n/a	n/a	42	n/a	n/a	83%	n/a
Integrated Communities & Well Being	100%	100%	n/a	8	11	n/a	100%	100%	n/a
Finance and Performance	100%	42%	75%	5	40	16	100%	92%	100%
Commissioned Services (Dom/Res/Nur/AT)	38%	46%	22%	35	32	48	93%	92%	89%
Other	100%	n/a	50%	7	n/a	23	100%	n/a	100%
Total	**53%**	**40%**	**37%**	**32**	**36**	**39**	**96%**	**91%**	**93%**

2.2.2 Whilst there has been a increase in response times compared with the equivalent period for 2009-10 this has improved noticeably as the year has progressed. Quarter on quarter there has been improvement in response times

2.2.3 Over half of complaints are now responded to within the initial agreed timescale but there is room for further improvement. It remains the case that in the majority of cases where timescales are missed, no reason is offered by the operational manager dealing with the complaint to the Quality Assurance Unit, and by extension the complainant, for delay, and this exacerbates customer dissatisfaction.

2.2.4 Table 4 shows the number of complaints closed in this quarter for each of the methods used to investigate and the average number of days these complaints were open.

Table 4 - Method of dealing with complaints

	Completed within initial timescale			Average days to respond			Completed within 6 months		
	Q3	Q2	Q1	Q3	Q2	Q1	Q3	Q2	Q 1
Case Review (only)	56%	44%	36%	26	27	31	98%	94%	97%
Comm'd Investigation	0%	0%	0%	150	109	89	50%	60%	0%
Review Panel	n/a	n/a	100%	n/a	n/a	348	n/a	n/a	0%
Provision of Information	n/a	n/a	100%	n/a	n/a	18	n/a	n/a	100%
Management Review	n/a	0%	n/a	n/a	223	n/a	n/a	0%	n/a
Meeting	n/a	0%	n/a	n/a	74	n/a	n/a	100%	n/a
Total	**53%**	**40%**	**37%**	**32**	**36**	**39**	**96%**	**91%**	**93%**

2.2.4 Commissioned Investigations (formerly Stage 2) are in-depth investigations that typically require longer to complete. These have not been conducted by a dedicated Investigation Officer during this year, and this has led to a significant increase in the time taken to conclude investigations.

3. Political Contact Activity

3.1 Political Contacts Received

3.1.1 This section of the report highlights the number of political contacts received in quarters 1-3 of the year broken down by issue (Table 5) and locality (Table 6).

Table 5 - Political Contact Issues

Main Complaint	Q3	Q2	Q1
Accommodation		1	1
Adaptation Issue	4	3	2
Adult Protection		1	1
Assessment of Need		4	
Blue Badge	1		1
Carer Issues	2	1	
Change in Home Care Provision		2	
Delay in Assessment	2		
Delay in OT Equipment/Adaptation		4	
Delay in Service Delivery	1		6
Disputed Assessment			5
Financial Issues	4	3	2
Independent Home Care	2		
Independent Living Fund		2	2
Lack of Support	4	3	2
Personal Budgets / SDA	2		
Policy / Resource Issue	3	2	
Political Enquiry - Support/Referral		4	
Provision of Service	2		2
Residential Issue	2	1	
Respite Assessment		1	
Review of Package of Care	1		3
Transport Issue		2	
Other	4		1
Total	**34**	**34**	**28**

3.1.2 Political contact issues in the first two quarters of this year broadly reflect the issues raised as complaints.

3.1.3 Table 6 highlights that the majority of political contacts relate to Access and Assessment Locality Teams - 63% in Quarter 1 and 57% in Quarter 2.

Table 6 - Political contacts by Team

Team	Quarter 3		Quarter 2		Quarter 1	
	No.	%	No.	%	No.	%
Access and Assessment –Bebington & W Wirral (excluding MH)	5	15%	10	29%	6	22%
Access and Assessment –Birkenhead Locality (excluding LD)	6	18%	6	17%	3	11%
Access and Assessment –Wallasey Locality (excl. Integrated Discharge)	3	9%	4	11%	8	30%
Access and Assessment – Learning Disabilities	7	21%	5	14%	3	11%
Access and Assessment –Mental Health	1	3%	1	3%	2	7%
Access and Assessment – Integrated Discharge	n/a	n/a	n/a	n/a	n/a	n/a
Direct Support Locality Services - Bebington & W Wirral	n/a	n/a	n/a	n/a	n/a	n/a
Direct Support Locality Services - Birkenhead	n/a	n/a	n/a	n/a	1	4%
Direct Support Locality Services - Wallasey	n/a	n/a	n/a	n/a	n/a	n/a
Direct Support Locality Services - Transport	n/a	n/a	2	6%	n/a	n/a
Integrated Communities and Well Being	3	9%	4	11%	2	7%
Finance and Performance	n/a	n/a	1	3%	n/a	n/a
Commissioned Services	3	9%	1	3%	2	7%
Other	6	18%	1	3%	n/a	n/a
Total	**34**	**100%**	**35**	**100%**	**27**	**100%**

3.2 Political Contacts Closed

3.2.1 The corporate standard requires all political contacts to be responded to within 10 working days. Where this is not possible the responsible officer must advise the Complaints Manager so that a letter of explanation can be sent. All letters must state the reasons for the delay and provide a deadline by which the final response will be made.

3.2.2 Table 7 and Table 8 details performance against the corporate standard; this is now separated for Councillor and MP contact. Performance in the first quarter was poor with only 46% of Political Contacts from MP's being closed within 10 days and an average response time of 40 days. However, the new procedures have addressed this issue and the third quarter shows 79% responded to within 10 days and an average response time of 22 days.

3.2.3 The average response times have also improved with Councillors now responded to on average within 7 days. For MP's the average in the third

quarter is 27 days, but this was distorted by one response which took 275 days. If that response is excluded the average response is 8 days.

Table 7 – Political Contacts (Councillors) Closed by Team

Team	Average days to respond			% responded to in 10 days		
	Q3	Q2	Q1	Q3	Q2	Q1
Access & Assessment –Beb'n & W Wirral (excl. MH)	1	42	96	100%	75%	66%
Access & Assessment –Birkenhead (excl. LD)	4	39	83	100%	0%	0%
Access & Assessment –Wallasey (excl. Integrated Discharge)	5		13	66%		0%
Access and Assessment – Learning Disabilities	8	79		66%	50%	
Access and Assessment –Mental Health	30		1	0%		100%
Access and Assessment – Integrated Discharge						
Direct Support Locality Services – Beb'n & W Wirral						
Direct Support Locality Services - Birkenhead						
Direct Support Locality Services - Wallasey						
Direct Support Locality Services - Transport		3			100%	
Integrated Communities and Well Being	12	2	1	0%	100%	100%
Finance and Performance		4			100%	
Commissioned Services			2			100%
Other	3	16		100%	0%	
Total	**7**	**33**	**43**	**66%**	**62%**	**66%**

Table 8 – Political Contacts (MP's) Closed by Team

Team	Average days to respond			% responded to in 10 days		
	Q3	Q2	Q1	Q3	Q2	Q1
Access & Assessment –Beb'n & W Wirral (excl. MH)		12	63		71%	33%
Access & Assessment –Birkenhead (excl. LD)	6	28	106	75%	60%	50%
Access & Assessment –Wallasey (excl. Integrated Discharge)		3	11		100%	57%
Access and Assessment – Learning Disabilities	64	15	11	60%	33%	75%
Access and Assessment –Mental Health		3			100%	
Access and Assessment – Integrated Discharge						
Direct Support Locality Services – Beb'n & W Wirral						
Direct Support Locality Services - Birkenhead			2			
Direct Support Locality Services - Wallasey						
Direct Support Locality Services - Transport						
Integrated Communities and Well Being	8	8	22	100%	100%	0%
Finance and Performance						
Commissioned Services	2	19	12	100%	0%	0%
Other	8	4	17	100%	100%	0%
Total	**27**	**13**	**43**	**79%**	**72%**	**46%**

4. Compliments and other Feedback

4.1 *Compliments*

4.1.1 56 compliments were received in the third quarter of which 43% related to the Access and Assessment Branch and reflects well on performance in this area.

Table 8 – Compliments Received

Team	No. of Compliments		
	Q3	**Q2**	**Q1**
Access & Assessment –Bebington & W Wirral (excl. MH)	7	25	15
Access & Assessment –Birkenhead (excl. LD)	9	9	4
Access & Assessment –Wallasey (excl. Integ'd Discharge)	8	8	11
Access and Assessment – Learning Disabilities	2	1	5
Access and Assessment –Mental Health	n/a	0	n/a
Access and Assessment – Integrated Discharge	1	0	1
Direct Support Locality Services - Bebington & W Wirral	2	6	n/a
Direct Support Locality Services - Birkenhead	n/a	1	2
Direct Support Locality Services - Wallasey	21	35	25
Direct Support Locality Services - Transport	n/a	0	n/a
Integrated Communities and Well Being	1	6	7
Finance and Performance	3	4	2
Reform Unit	2	2	
Total	**56**	**97**	**82**

David Jones
Complaints Manager
14 February 2011

Cheshire and Merseyside Vascular Review NHS

CONSULTATION DOCUMENT

Improvements to vascular services in Cheshire and Merseyside

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"The current review of vascular services in Cheshire and Merseyside is a once in a generation opportunity to shape the provision of increasingly specialist vascular and endovascular care to our population. This can only be brought about by concentrating expertise into a small number of centres dealing with an increased volume of patients, which we know results in better outcomes for our patients."

John Brennan
Consultant vascular surgeon
Royal Liverpool Hospital

Introduction

This document describes some improvements that the NHS is planning to make to the way vascular services are provided in Cheshire and Merseyside, and asks you for your views on these changes.

We want to make sure that all of our vascular services give patients care of the highest possible quality. Although current services are good and offer safe treatment, we believe that to sustain high quality services into the future, things will have to change, which may involve the relocation of some services. This document sets out the planned changes, why they are necessary, what benefits they will bring and how they will be delivered.

There is a glossary on page 11.

What are vascular services?

Vascular services are for people with disorders of the arteries and veins. These include narrowing or widening of arteries, blocked vessels and varicose veins, but not diseases of the heart and vessels in the chest.

These disorders can reduce the amount of blood reaching the limbs or brain, or cause sudden blood loss if an over-stretched artery bursts. Vascular specialists also support other medical treatments, such as kidney dialysis and chemotherapy.

All of these diseases used to be treated by surgery only. More recently, specialists have been able to treat many vascular disorders by reaching the site of the problem via the inside of the blood vessels. This is known as interventional radiology, and is a much less invasive approach. Making these advanced techniques readily available to all patients is one of the goals of the review.

"There is good evidence to suggest that complex vascular procedures have better outcomes when performed in major centres with multidisciplinary teams working closely together. Major trauma and endovascular aneurysm repair are good examples of procedures where groups of interventional radiologists and vascular surgeons can obtain better results for patients. When patients realise the benefits of arterial centres, they will be willing to travel for their elective and emergency treatment. The high volume of work will result in more experience in dealing with vascular disease and produce dedicated specialist doctors to provide the service. Fewer, larger, better staffed high quality vascular arterial centres will enable patients to obtain better treatment for vascular disease."

Gian Abbott
Consultant interventional radiologist
Countess of Chester Hospital

At the moment, treatment for vascular conditions takes place at most district hospitals. The district hospitals in Cheshire and Merseyside which currently provide vascular services are Aintree Hospital, Arrowe Park Hospital, Countess of Chester Hospital, Halton Hospital, Leighton Hospital Crewe, Royal Liverpool Hospital, Southport Hospital, Warrington Hospital and Whiston Hospital.

Why are vascular services important?

Vascular services are an important part of the local NHS. People helped by vascular services include:

People with abdominal aortic aneurysms: This is a condition in which the main artery in the abdomen becomes stretched and prone to bursting. Timely detection and treatment of abdominal aortic aneurysms prevents later problems with rupture and bleeding, and can be life-saving. About 350 aortic aneurysm repairs are carried out annually on people from Cheshire and Merseyside.

People with strokes or transient ischaemic attacks (TIAs or mini-strokes): Sometimes, these problems with the blood supply to the brain occur because of a narrowing in a blood vessel in the neck called the carotid artery. This can be treated with an operation to improve the flow of blood and reduce the risk of future strokes. About 300 of these procedures are carried out annually on people from Cheshire and Merseyside.

People with poor blood supply to the feet and legs: Some people, particularly those who smoke or have diabetes, can develop narrowings in the blood supply to the legs and feet. This can cause pain on walking, ulceration and infection. Surgical or interventional radiological treatment can improve the blood supply, make walking easier and prevent the serious complications of inadequate blood supply. About 450 of these procedures are carried out annually on people from Cheshire and Merseyside.

All these operations take place in local hospitals in Cheshire and Merseyside. However, some people live nearer to a hospital in Manchester or Staffordshire and may have their operations there instead.

Why do we need to change how we provide vascular services?

To provide the best possible care for our patients

Treating vascular disease very well is not easy. Research shows that the chances of survival and improved quality of life after treatment of arterial diseases are greatest when patients are treated by a highly trained specialist team working in a large centre to which many patients are referred.

"With the increasing evidence base which links higher volumes to improved clinical outcomes, a reconfiguration of vascular services across the region is timely. We are very happy to be part of a process that will improve patient quality of care in the NHS."

Sameh Dimitri
Consultant vascular surgeon
Countess of Chester Hospital

The more operations carried out at a particular hospital, the more likely it is that treatment will be successful. Seeing more patients allows doctors and other staff to hone their skills and maintain them at the highest level, ensuring that patients get the care they need.

This means that we need to have a small number of hospitals carrying out higher numbers of operations, rather than lots of hospitals carrying out only a few operations each year.

To ensure specialist doctors are available at all times

In some smaller hospitals, there are not enough consultants to provide high quality twenty-four hour care for patients with vascular diseases. By concentrating specialists in fewer

hospitals and ensuring patients are taken to those hospitals promptly, we can ensure everyone gets the treatment they need, when they need it.

One particular issue is the availability of interventional radiology. Skilled consultants can use specialist techniques to save limbs and organs that might otherwise have to be removed. Changing the service so that round-the-clock interventional radiology rotas become possible will ensure that no-one misses out on these benefits because of where and when they become ill. The delay in accessing treatment will be more than outweighed by the better outcomes.

To meet the standards set by our doctors

Vascular specialists in the UK have set out how they think vascular services should be organised so that they can give their patients the best possible results. We have built on that work with specialists from Cheshire and Merseyside, developing our own clinical standards for our future services; these are in Appendix 1. We are determined to improve our local NHS so that these standards are met in full. We can only achieve this by changing where some treatments are provided.

To make sure that everyone has equal access to innovative procedures, such as keyhole techniques

At the moment, patients in the region are not all able to access the latest treatments and techniques. For example, a type of treatment for blood clots which are blocking important arteries is not at present available at all times in every hospital in Cheshire and Merseyside, because of the way in which interventional radiology services are arranged. We do not think that this is fair and want to make sure that all patients can benefit from innovations such as this.

To be ready for a new screening programme

The NHS is starting to screen older men for abdominal aortic aneurysms. Men who are discovered to have the condition need specialist treatment to reduce their risk of dying from their aneurysm. At present, local vascular services are not set up to undertake a screening programme that would meet the standards required by the NHS.

"The best outcomes from modern treatments for patients with vascular disease require the input of a multidisciplinary team working in an environment with high quality imaging equipment and with access to a wide range of expensive medical devices. It makes clinical and economic sense to concentrate the efforts of the health service on fewer centres to guarantee that all the facilities and personnel are available for our patients."

Richard McWilliams
Consultant interventional radiologist
Royal Liverpool Hospital

What changes are planned?

Vascular services are changing in a similar way throughout the country to secure these benefits for patients. In Cheshire and Merseyside, we are proposing that hospitals work in partnership to deliver vascular services, with complex and emergency operations carried out at a small number of specialist vascular centres and the remaining care continuing to be provided locally. The only services which will be relocated are surgery on the arteries and some more complex endovascular procedures. There will be no change in the location of outpatient clinics, initial investigations, surgery for venous disease, amputation, some angioplasties and follow-up, all of which will continue to be available at local hospitals, provided they meet quality standards. Emergency transfers will be completed quickly enough that the improved service outweighs any effect of a delay.

"We vascular surgeons know that hospital services for patients with blood vessel disease can be improved. This review will guarantee that patients with blood vessel disease in Cheshire and Merseyside will receive the best possible standard of hospital care, in a timely fashion."

Francesco Torella
Consultant vascular surgeon
Aintree Hospital

Pathways of elective care for vascular disorders

The flowchart on page 7 shows the pathway of care of patients who consult their GPs with vascular problems. It shows that only one of the six key steps in the pathway of care will change as a result of the proposed improvements to vascular services.

How many patients will be affected?

We cannot yet tell exactly how many patients will receive their specialist arterial treatment at a different hospital as a result of these changes. This is because the number depends on which hospitals become vascular centres. Our estimate is that about 550 patients a year will be affected in this way, having a longer journey time but with better results following treatment.

Present arrangements		Proposed future arrangements	
Step	**Setting**	**Step**	**Setting**
Patient sees GP	Local GP surgery	Patient sees GP	Local GP surgery
↓		↓	
GP refers to vascular specialist	Local GP surgery	GP refers to vascular specialist	Local GP surgery
↓		↓	
Outpatient consultation	Local hospital	Outpatient consultation	Local hospital
↓		↓	
Investigations	Local hospital	Investigations	Local hospital
↓		↓	
Arterial operation	Local hospital	Arterial operation	Vascular centre
↓		↓	
Follow-up	Local hospital	Follow-up	Local hospital

How many vascular centres will there be?

At this stage, we think about two vascular centres would be optimal. This will ensure that

- all patients are treated at hospitals that meet the minimum number of operations per year specified by local clinicians (Appendix 1) and where specialist surgeons and interventional radiologists are available all the time
- care will still continue if one hospital becomes temporarily unavailable, for example because of a fire or an outbreak of infection.

However, the purpose of the consultation is to check that these benefits are worth the change in accessibility, so the final outcome depends on what the consultation shows.

Which hospitals will be vascular centres?

We do not yet have all the information we need to say which hospitals might become vascular centres. We have proposed clinical standards for the vascular centres and other hospitals (Appendix 1), but there are other factors we will need to take into account when we decide upon the most suitable hospitals. These factors are set out on pages 8 and 9. We

want to wait until we have heard your opinions about these aspects of vascular services before we decide on how the vascular centres will be chosen.

What are the benefits of the changes?

The changes will mean that

- Patients have better outcomes from vascular procedures. They will be more likely to survive aortic aneurysm surgery and less likely to have a stroke after treatment of a narrowing in the carotid artery. We estimate that three to five lives a year could be saved if surgery was concentrated in fewer centres. In addition, fewer patients are expected to suffer avoidable complications of surgery, such as renal failure, stroke and damage to the blood supply to the spinal cord and legs.

> "The national strategy to consolidate major vascular surgery into fewer, larger centres is based on evidence that patients get better outcomes at larger centres."
>
> **Stephen Blair**
> **Consultant vascular surgeon**
> **Arrowe Park Hospital**

- The new clinical standards will ensure that designated vascular centres and other hospitals offer prompt access to high quality services, and will be monitored against those standards to make sure they continue to provide a consistently high service.
- Patients can have a wider range of treatments, because of the twenty-four hour availability of consultant interventional radiologists.
- Screening for abdominal aortic aneurysms can be successfully introduced. This will save about 150 lives per year in Cheshire and Merseyside, because people with a problem will be detected early and treated before there is a risk of life-threatening bleeding.

Are there any risks from the change?

The transition period will need careful management to ensure services continue to be delivered successfully, and that relationships are correctly set up between the vascular centres and other parts of the NHS. Non-medical staff, such as nurses and technicians, play a vital role in vascular services. We will need to ensure that they are able, if necessary, to transfer to new hospitals so that their skills are not lost to the local NHS.

How will vascular centres be selected?

We are proposing the following criteria, but would like your comments on whether they are the right ones:

1. *Compliance with clinical standards (Appendix 1)*

   Hospitals that would like to be vascular centres will need to show how they will satisfy the clinical standards.

2. *Maximum degree of co-location with inter-dependent clinical services*

   People who are in hospital because they have just had a stroke, people with kidney disease and people with major injuries benefit from rapid access to vascular services (Appendix 2). This is easiest if all the services such people need are available in one hospital, but we cannot achieve this for all services in every hospital for practical reasons. The clinical standards require a vascular centre to be able to provide a vascular specialist to other hospitals quickly.

3. *Close to where most people live, with good public transport links*

   If patients are to travel further for some parts of their treatment, we need to make the journey as straightforward as possible for them and their visitors.

4. *Lowest investment required to bring about the changes*

   We need to bring about the service reconfiguration at the lowest financial cost to the NHS.

"From a Southport and Ormskirk perspective I feel an important benefit of an arterial centre for our patients would be on-site 24 hour specialist care for our major vascular cases allowing prompt treatment of complications or issues arising from their condition without the need for transfer due to lack of a vascular specialist out of hours."

Frank Mason
Consultant vascular surgeon
Southport Hospital

The consultation process

The necessity for change is evident to all the Primary Care Trusts, hospitals and vascular specialists in Cheshire and Merseyside. They feel a clear responsibility to arrange services in as safe and effective a way as possible, and are therefore keen to carry out the reconfiguration.

Given the strength of scientific evidence and professional consensus, we are not consulting on whether to make the change. However, we need your views on how vascular centres should be chosen, and also on the balance between local access and high-quality specialist care.

The Project Board will review the results of the consultation, and publish a report on what it revealed. Hospitals wishing to be vascular centres will be invited to explain how they will fulfil the criteria and quality standards. The Project Board will then recommend which hospitals should become vascular centres, with local NHS commissioners making the final decisions.

There are a number of ways in which we are trying to make sure that we hear from as many of the people of Cheshire and Merseyside as possible. The details are below. We have organised two key meetings, the first for clinicians and commissioners, and the second for patients, carers, local LINk members and the general public. Health Overview and Scrutiny Committee members are also invited to the second meeting, and we have been invited to present our plans to some Health and Wellbeing Scrutiny Committees. We will invite

Cheshire and Merseyside MPs who are unable to attend these events to a meeting to share their views and hear the feedback from stakeholders.

In addition to events, the consultation is accessible electronically by accessing PCT websites. NHS Stakeholders and the public can view and download this consultation document, and the questions posed at the events will be uploaded on to the internet for all NHS Stakeholders and members of the public to post their feedback. Alternatively, you can request paper copies of the consultation document, and ask questions by post; a prepaid return reply will be provided. For postal requests, please contact Jackie Robinson on 0151 244 3459 or email Jacqueline.robinson@knowsley.nhs.uk

All feedback will be collated and submitted in report format for the Project Board to consider. The Project Board recommendations will be sent to Cheshire and Merseyside PCTs who will take the final decision. The outcome of their decision will be made public, all respondents will be sent this information and it will be publicised on each PCT website.

Key dates

27 January 2011	Consultation opens
27 January 2011	Consultation event for NHS stakeholders
10 February 2011	Consultation event for public and patient stakeholders, members of locality Health Overview and Scrutiny Committee
February 2011	Consultation with Cheshire and Merseyside MPs
March 2011	Consultation closes
May 2011	Recommendation announced
May to October 2011	Preparation for reconfiguration
November 2011	Reconfiguration begins. This will be undertaken in phases.

Tell us what you think

NHS staff can comment by attending a consultation event from 2.00 pm to 4.00 pm on 27 January 2011 at the Halliwell Jones Stadium, Winwick Road, Warrington WA2 7NE. If you would like to come, please register in advance with jacqueline.robinson@knowsley,nhs.uk or telephone (0151) 244 3459.

Alternatively, you can respond to the consultation questions which will be posted onto NHS Knowsley Survey Monkey. Please go to www.surveymonkey.com/s/CMVSR-Staff after 28 January 2011.

Patients and the public can comment on the consultation by attending a consultation event from 12.30 pm to 3.30 pm on 10 February 2011 at the Halliwell Jones Stadium, Winwick Road, Warrington WA2 7NE.

Attendance will need to be registered as above. Transport can be provided to support your attendance.

If you wish to comment on via the internet, please go to www.surveymonkey.com/s/CMVSR-public after 28 January 2011.

Glossary

An **abdominal aortic aneurysm** is a condition in which the main artery in the abdomen becomes stretched and prone to bursting. If it bursts, major bleeding occurs, which may be fatal.

An **angioplasty** is an interventional radiological procedure to widen an artery which is narrowed by disease.

Carotid endarterectomy is an operation to remove a narrowing from the carotid artery, which carries blood to the brain. In correctly selected patients, the operation reduces the risk of a future stroke.

Endovascular procedures are tests and treatments carried out via the inside of blood vessels.

Interventional radiologists are doctors trained to investigate people with vascular disease, to find out what and where the problem is. They can also treat vascular disease by gaining access to the site of the problem via the inside of blood vessels.

A **stroke** is a permanent disruption to the brain's blood supply. Strokes can cause problems with speech or movement, and can be fatal.

Transient ischaemic attacks occur when the blood supply to the brain is temporarily interrupted. Although full recovery occurs, they indicate a higher risk of a future more severe stroke.

Vascular centres are hospitals with enough specialist staff and facilities to ensure the best possible outcomes for all patients who are referred there.

Vascular services are for people with disorders of the arteries and veins. These include narrowing or widening of arteries, blocked vessels and varicose veins, but exclude diseases of the heart and vessels in the chest.

Vascular specialists are doctors who treat vascular disorders. Some are vascular surgeons and others are interventional radiologists.

Vascular surgeons see patients with vascular disease in outpatients, arrange investigations, perform surgical operations and follow their patients up after treatment.

Appendix 1: Quality standards for vascular services

Introduction

In June 2010, the Cheshire and Merseyside vascular review convened a Clinical Advisory Group to develop clinical standards for vascular services. These were to guide the reconfiguration of vascular services in the region, and specifically to ensure that hospitals providing arterial surgery were able to secure excellent outcomes for patients. The standards are partly based on *Quality Standards Services for People with Vascular Disease,* published by the West Midland Quality Review Service.

The standards refer to the vascular service, which is all the hospitals in Cheshire and Merseyside which provide care to patients with vascular disease, and to vascular centres, which are hospitals providing arterial surgery and higher risk interventional radiology as part of the vascular service.

Clinical standards for vascular centres

Number	Standard	Demonstration of compliance
Staffing		
1.	The centre should have a nominated lead consultant vascular specialist (surgeon or radiologist), and nominated lead surgeon, radiologist and nurse with responsibility for ensuring implementation of the quality standards across the centre's catchment area.	Name of lead consultants and lead nurse. *Note: The lead clinicians may be supported by senior clinicians who take a lead role on particular aspects of the service, for example, screening or training.*
2.	A nurse should be available with specialist expertise in each of the following areas: a. Wound, ulcer and diabetic foot management b. Claudication, and lifestyle advice	Staffing details, including cover arrangements. *Notes:* *1. The nurse with specialist expertise in vascular access may*

	c. Amputation and liaison with rehabilitation and limb-fitting services d. Vascular access for patients with renal disease e. Aneurysms. These nurses should have responsibility for leadership and service development for their area of specialist expertise. There should be arrangements for cover during absences.	*be managed by the renal service or by the vascular service.* *2. These specialist roles may be undertaken on a full-time or part-time basis and may include, for example, senior ward nurses with additional responsibilities. Sufficient time should, however, be allocated for the leadership and service development aspects of the roles.* *3. Specialist expertise should be available to all patients from the centre's catchment area. The roles may, however, be undertaken by different people in different localities.*
3.	A consultant vascular surgeon should be available at all times.	Staffing details. *Note: A minimum of a 1:6 on call rota is required to achieve this standard.*
4.	Robust middle-grade cover must be in place.	Staffing details. *Note: As an aspiration, this middle grade cover should be provided by a vascular specialist trainee.*
5.	A consultant anaesthetist with up-to-date skills and competencies in managing vascular emergencies should be available at all times.	Staffing details
6.	A nominated lead consultant anaesthetist should be identified for liaison with the vascular service.	Name of nominated lead
Organisation of care		
7.	All patients should be treated in accordance with normal standards of consent, support and provision of written information.	Written policies

8.	The service should have defined the locations on which in-patient, day case and out-patient vascular services are provided. Each vascular service should have only one in-patient arterial site. Out-patient vascular services should take place on, at least, all hospital sites accepting general medical and surgical emergency admissions.	Locations of services agreed by commissioners. *Notes:* 1. *In hospitals without on-site in-patient vascular services, out-patient and day surgery or interventional procedures may be provided by local vascular specialists or by specialists visiting from another hospital – usually the hospital with in-patient vascular services.* 2. *The best possible local access to vascular services should be achieved by providing out-patient and day case services as close to patients' homes as possible. This may include locations other than those admitting vascular, general medical and general surgical admissions.*
9.	A consultant interventional radiologist should be available at all times.	Staffing details. *Note: A minimum of a 1:6 on call rota is required to achieve this standard.*
10.	Participation in the interventional radiology service should be open to all interventional radiologists from hospitals in the centre's catchment area who wish to participate, subject to their maintaining competence.	Details of service available. *Notes:* 1. *The radiology service should satisfy the requirements in The Royal College of Radiologists' document 'Standards for providing a 24-hour interventional radiology service' (2008), The Royal College of Radiologists/British Society of Interventional Radiology document 'Achieving Standards for Vascular Radiology' (2007) and the RCR/RCN document 'Guidelines for Nursing Care in Interventional Radiology' (2006), or subsequent updates to these*

		documents. 2. *This standard does not require a separate vascular interventional radiology rota.*
11.	For arterial centres which are part of a trauma network, the on-call vascular specialist must be able to reach the trauma unit within thirty minutes.	Records of call-outs
12.	All emergency and elective vascular interventional procedures should be undertaken by consultant vascular specialists or by staff under their supervision. All vascular specialists should undertake sufficient interventional procedures (operations or interventional radiology procedures) per annum to maintain competence.	Details of staffing available. Audit results. *Note:* *For the purpose of considering interventional procedures to maintain competence, activity undertaken in hospitals other than the vascular centre may be included as part of surgeons'and radiologists' activity.* *Recommended staffing levels are one vascular surgeon per 150,000 population or one transplant surgeon with a vascular interest per 100,000 population.*
13.	Endovascular aortic aneurysm repair and carotid stenting should be undertaken only by vascular specialists with competence in these procedures.	Normal clinical governance arrangements in place and implemented. Audit results. *Note: Trust processes for introduction of new procedures should also be applied to the introduction of these procedures.*

14.	A vascular specialist and support staff with competence in interventional radiology should be available for all elective vascular radiology procedures.	Staffing details. *Notes:* 1. *Trust governance procedures must ensure that vascular specialists are competent in the procedures they propose to undertake.* 2. *In hospitals without on-site in-patient vascular services, the vascular specialist and support staff may be based in the local hospital or may travel from another hospital – usually the one where in-patient services are located.* 3. *These services should satisfy the requirements in The Royal College of Radiologists/British Society of Interventional Radiology document 'Achieving Standards for Vascular Radiology' (2007), or subsequent updates of this document.*
15.	An in-patient ward should be available, staffed by nurses and health care assistants with appropriate competence in the care of patients with vascular disease. The competence framework should cover at least: a. Acute Life-threatening Events Recognition and Treatment (ALERT) or similar b. Tissue viability and wound care c. Pain management d. Care of patients with diabetes	Staffing details, competence framework showing expected competences and summary of competence assessments.

	e. High dependency care f. Care of patients with disabilities, including patients with amputations.	
16.	Physiotherapy services should be available daily with time allocated for their work with in-patients with vascular disease.	Details of services available. *Note: These services should be available at weekends as well as Monday to Friday.*
17.	Access to the following services should be available for in-patients with vascular disease: a. Occupational therapy b. Social work. Staff providing these services should have specific time allocated to their work with the vascular service.	Details of services available. *Note: These services may be provided by staff who provide the post-discharge service or by different staff.*
18.	Vascular ultrasound should be available for all vascular out-patient services.	Staffing details. *Note: The service may be available within the out-patient clinic or imaging department. The service may be provided by a vascular technologist, radiographer, nurse or radiologist. More detail on the competences expected for these staff is available from Skills for Health.* *Further advice on competences is expected from the British Medical Ultrasound Society in the near future.* *In hospitals without in-patient vascular services, staff may be based in the local hospital or may travel from another hospital, usually the one where in-patient services are*

		located.
19.	In-patient and community-based rehabilitation services with expertise in the care of patients with vascular disease, including amputees, should be available, including at least: a. Physiotherapy b. Occupational therapy c. Limb fitting and orthoses.	Description of services available. *Note: These services should be available for the whole of the vascular centre's catchment population but may be organised in different ways in different locations.*
20.	Sufficient administrative, clerical and data collection support should be available.	Discussion with staff. *Note: 'Sufficient' is not strictly defined. Clinical staff should not be spending unreasonable amounts of time on administrative duties, including data collection, that detract from their ability to provide patient care.*
Facilities		
21.	The following facilities and services should be available at all times: a. Emergency theatre b. Vascular angiography suite c. Spiral CT d. Critical care (levels 2 and 3)	Details of facilities and staffing available. *Note:* *1. The Medicines and Healthcare Products Regulatory Agency has published guidance on facilities for endovascular aortic aneurysm repair (Joint Working Group to produce guidance on delivering an Endovascular Aneurysm Repair Service). The guidance does not require immediate cessation of endovascular*

	e. Haematology (for urgent cross-match and blood products) f. Blood biochemistry and blood gas analysis g. Facilities for electronic transfer of imaging from, or ability remotely to view imaging at, other acute hospitals within the catchment area of the vascular centre. h. As an aspiration, fixed imaging facilities in a sterile theatre environment for endovascular aneurysm repair. These facilities should have staff with appropriate vascular expertise and sufficient capacity for the expected number of patients with vascular disease, including incoming transfers and unexpected rises in demand.	*aneurysm repair in hospitals without fixed imaging facilities in a sterile theatre environment.* *2. The angiography suite should be staffed as stated in the RCR / RCN guidance.* *3. Images must be available via Dicom links (i.e. on PACS) not via a web based system.*
22.	A vascular laboratory should be available at the vascular centre.	Viewing facilities
23.	Magnetic resonance angiography should be available during normal working hours.	Viewing facilities.
24.	In-patient wards for patients with vascular disease should have: a. Hand-held Doppler ultrasound machine b. Portable duplex device.	Viewing facilities.
25.	All vascular surgery should take place in a theatre with: a. All standards for sterility met b. Theatre staff trained in vascular instruments, prosthetics and techniques and in the use of cell salvage devices for	Viewing facilities.

	blood conservation c. Stocks of grafts, instruments and sutures required for patients with vascular disease d. Radiolucent operating tables and X-ray C-arms. X-ray C-arm should have DSA capability. A back up C-arm of similar specification must be available. e. Hand-held Doppler ultrasound machine and portable duplex devices f. Access to blood and blood products.	
26.	Elective clinic and theatre sessions for patients needing permanent dialysis access should be sufficient to meet the needs of patients from the catchment area with end-stage renal failure.	Details of vascular access services. *Notes:* *National recommendation is one session per week for every 120 adult patients on dialysis.*
27.	All vascular out-patient clinics should have: a. Hand-held Doppler ultrasound machine b. Portable duplex scanner c. Facilities to perform ankle brachial pressure tests.	Observation of facilities and equipment.
Clinical policies		
28.	Clinical guidelines should be agreed with the ambulance service covering the clinical indications for taking emergency patients to the vascular centre and the patients who may be taken to	Written guidelines agreed with the ambulance service.

	Emergency Departments without on-site in-patient vascular services.	
29.	Arterial surgery and higher risk arterial interventional radiological procedures are carried out at the arterial centre. Varicose vein surgery and lower risk arterial interventional radiological procedures are carried out at non-arterial centres. The appropriate site at which to carry out amputation will vary. The multi-disciplinary team will decide whether each patient's procedure is sufficiently low risk that it could be carried out appropriately at non-arterial centres, or higher risk and therefore suitable for the arterial centre.	Notes of meetings held.
30.	Clinical guidelines should be in use covering direct transfer from each of the following services to the vascular centre: a. Burns services b. Stroke services c. Neurosurgery services d. Spinal surgery services e. Cardiac services f. Trauma services	Written guidelines. *Notes:* *1. These guidelines should be based on agreed local clinical networks' or regional guidance and pathway or on the latest evidence-based national guidance, including NICE guidance.* *2. Guidelines must be clear about the arrangements for emergency transfer of patients with head injury, sub-arachnoid haemorrhage, hyper-acute stroke, ST elevation myocardial infarction and abdominal aortic aneurysm.* *3. The guidelines may also cover information required for referral, documentation, treatments to undertake before transfer and escorting staff.*

31.	Clinical guidelines should be in use throughout the vascular service covering assessment and management of: a. Open and endovascular repair of abdominal aortic aneurysm b. Surveillance of abdominal aortic aneurysm c. Carotid artery disease d. Diabetic foot e. Leg ulcers f. Claudication g. Varicose veins h. Limb-threatening ischaemia i. Lymphoedema. The guideline for amputation should comply with the standards published by the Vascular Society of Great Britain and Ireland, including their Quality Improvement Framework. These guidelines should cover: a. Indications for seeking advice b. Lifestyle advice c. Investigations d. Treatment options available, including surgical and	Written guidelines. *Notes:* *1. The guidelines should be explicit about who will undertake interventional imaging (i.e. interventional radiologist or vascular surgeon). Where a vascular service covers more than one hospital, this should be specified for each hospital.* *2. Guidelines on the assessment and management of abdominal aortic aneurysm should comply with the Vascular Society's document 'Framework for improving the results of elective AAA repair' (2009).* *3. Guidelines on carotid artery disease assessment and management should be agreed with local stroke / TIA service(s) and should ensure that, where indicated, carotid intervention takes place within 48 hours of referral.* *4. Guidelines on diabetic foot assessment and management should be agreed with the local diabetes service(s).* *5. The pre-operative assessment aspects of the guidelines should have been agreed with the local cardiology service/s.*

	radiological interventions and conservative options e. Indications for choice of treatment f. Investigation and management of emergency patients g. Management of haemodynamically unstable patients h. Indications and arrangements for emergency transfer i. Indications and arrangements for non-urgent referral j. Arrangements for transfer of cross-matched blood k. Pre-operative assessment l. Post-operative monitoring m. Management of side-effects and complications of treatment n. Follow up arrangements o. Referral for rehabilitation p. Responsibilities for giving information to patients and carers.	
32.	High-risk patients including all patients undergoing aortic surgery should be seen for pre-assessment by an anaesthetist with experience in elective vascular anaesthesia. Medication should be reviewed and optimised for the intervention.	Written guidelines.
33.	Centres treating patients with thoracic or thoracoabdominal aortic	Viewing equipment

	aneurysms need to have a system in place to treat spinal cord ischaemia with lumbar CSF drainage and blood pressure augmentation at all times.	
34.	Guidelines on lifestyle advice for all patients should be in use covering, at least: a. Support for smoking cessation b. Dietary advice c. Programmes of physical activity and weight management.	Written guidelines.
35.	Clinical guidelines on monitoring and management of peripheral arterial disease risk factors should be in use covering, at least: a. Anti-platelet therapy b. Lipid reduction therapy c. Control of hypertension.	Written guidelines.
36.	Clinical guidelines on the management of patients with diabetes should be in use covering, at least: a. Management of ischaemia and sepsis in patients with diabetes b. Peri-operative management of patients with diabetes c. Indications for involvement of the diabetes service in the care of the patient.	Written guidelines agreed with the local diabetes service.

37.	Clinical guidelines on the management of patients with, or at risk of, impaired renal function should be in use, including: a. Indications for involvement of the renal service in the care of the patient b. Prevention and management of complications.	Written guidelines agreed with the local renal service.
38.	A protocol for by-pass graft surveillance should be in place.	Written protocol. *Note: The protocol may be that no surveillance is undertaken unless further evidence of effectiveness becomes available.*
39.	Clinical guidelines should be in use covering indications for involvement of cardiology services in the care of patients with vascular disease.	Written guidelines agreed with cardiology service.
40.	Clinical guidelines should be in use covering indications and arrangements for referral for psychological support.	Written guidelines.
41.	There should be a local policy covering ultrasound screening of relatives of patients with abdominal aortic aneurysm.	Written policy. *Notes:* 1. *The policy should cover relatives of patients identified by both screening and symptomatic pathways.* 2. *The policy should be consistent with the information for patients.*
42.	Discharge planning guidelines should be in use covering, at least: a. Discharge to rehabilitation facilities	Written guidelines.

	b. Discharge home with support from local rehabilitation facilities c. Referral to limb-fitting service d. Communication with the patient's GP.	
43.	Guidelines, agreed with the specialist palliative care services serving the local population, should be in use covering, at least: a. Arrangements for accessing advice and support from the specialist palliative care team. b. Indications for referral of patients to the specialist palliative care team. c. Arrangements for shared care between the vascular service and palliative care services.	Written guidelines, agreed with specialist palliative care service(s) serving the local population.
44.	A protocol on driving advice should be in use, covering establishing the type of licence and giving appropriate advice on DVLA notification.	Written protocol. *Note:* *The protocol should comply with the latest version of 'Guidance to the current Medical Standards of Fitness to Drive' produced by the DVLA and reviewed every six months*.
45.	The vascular centre's staff should be aware of local guidelines for end-of-life care.	Availability of guidelines relating to end-of-life care that are used by specialist palliative care services in the local area.
Multi-disciplinary working		
46.	A multi-disciplinary team meeting to discuss the treatment of patients with abdominal aortic aneurysms and peripheral vascular	Notes of meetings held.

	disease should be held at least weekly. Job plans must include attendance at multi-disciplinary team meetings.	
47.	All images should be discussed at a multi-disciplinary team meeting attended by a consultant radiologist.	Notes of meetings held.
48.	A ward-based multi-disciplinary team meeting to discuss the care of patients with complex rehabilitation and discharge needs should be held at least weekly, involving at least: a. Ward manager b. Nurse with specialist expertise in care of patients with amputations c. Physiotherapy d. Occupational therapy e. Social work.	Notes of meetings held. *Note: Other staff, for example, community matrons, may also attend the multi-disciplinary team meetings.*
49.	Consultant and nurse representatives of the vascular service should participate regularly in multi-disciplinary meetings with services responsible for the care of: a. Patients with renal disease b. Patients with stroke or TIA	Discussion with renal, stroke and cardiothoracic surgery services.

50.	Multi-disciplinary clinics for assessment of patients with diabetes and complex foot problems should be held involving: a. Vascular surgeons b. Diabetes services c. Orthopaedic services d. Orthotic services e. Podiatry services.	Details of services available.
51.	A meeting with local rehabilitation services should be held at least annually to review the links with the vascular service and address any problems identified.	Notes of meetings held.
52.	The vascular centre should offer an educational session on the assessment of vascular emergencies for emergency department staff, general surgeons, GPs and ambulance staff at least annually.	Details of sessions provided. *Note:* *The educational session should be offered to staff from all hospitals within the catchment area of the vascular centre.*
Clinical audit		
53.	The centre should collect and submit data to the National Vascular Database (all index procedures) and British Society of Interventional Radiology Registries. This standard is of the highest importance.	National Vascular Database reports showing risk-adjusted comparative outcomes for the centre. BSIR Registries information. *Note:* *1. Data should cover all parts of the vascular service including activity in hospitals without on-site in-patient services.*

		2. *Appropriate support staff are needed to collect and upload data.*
54.	The centre should comply with national mortality standards.	Annual report
55.	The centre should have an annual programme of audits covering at least: a. Number of interventional procedures (surgical and interventional radiology) undertaken by each vascular specialist in the centre's catchment area b. Medical management of patients with peripheral vascular disease c. Compliance with evidence-based guidelines.	Details of audit programme. *Note: Audits should cover all parts of the vascular service including activity in hospitals without on-site in-patient services and should include comparison of HES data and National Vascular Database / BSIR Registries numbers. Audits of operations by surgeon should include all vascular operations, including any undertaken by general surgeons.*
56.	The centre should produce an annual report summarising activity, compliance with quality standards and clinical outcomes. The report should identify actions required to meet expected quality standards and progress since the previous year's annual report.	Annual report. *Note: The National Vascular Database reports will provide much of the data for the annual report.*
57.	All policies, procedures and guidelines should comply with Trust document control procedures.	Policies, procedures and guidelines meeting reasonable document control quality requirements of monitoring, review and version control.

Clinical standards for non-arterial centres

Number	Standard	Demonstration of compliance
Equipment and facilities		
1.	Vascular out-patient clinics should have: a. Hand-held Doppler ultrasound machine b. Portable duplex scanner Facilities to perform ankle brachial pressure tests.	Observation of facilities and equipment.
2.	The service should have defined the locations on which in-patient, day case and out-patient vascular services are provided. Each vascular service should have only one in-patient arterial site. Out-patient vascular services should take place on, at least, all hospital sites accepting general medical and surgical emergency admissions.	Locations of services agreed by commissioners. *Notes:* 1. *In hospitals without on-site in-patient vascular services, out-patient and day surgery or interventional procedures may be provided by local vascular specialists or by specialists visiting from another hospital – usually the hospital with in-patient vascular services.* 2. *The best possible local access to vascular services should be achieved by providing out-patient and day case services as close to patients' homes as possible. This may include locations other than those admitting vascular, general medical and general surgical admissions.*

3.	Vascular ultrasound should be available for all vascular out-patient services.	Staffing details. *Note: The service may be available within the out-patient clinic or imaging department. The service may be provided by a vascular technologist, radiographer, nurse or radiologist. More detail on the competences expected for these staff is available from Skills for Health.* *Further advice on competences is expected from the British Medical Ultrasound Society in the near future.* *In hospitals without in-patient vascular services, staff may be based in the local hospital or may travel from another hospital, usually the one where in-patient services are located.*
4.	Non-arterial centres should have available sets of instruments for common arterial procedures, in case they are unexpectedly required.	Inspection
Organisation of care		
5.	Arterial surgery and higher risk arterial interventional radiological procedures are carried out at the arterial centre. Varicose vein surgery and lower risk arterial interventional radiological procedures are carried out at non-arterial centres. The appropriate site at which to carry out amputation will vary. The multi-disciplinary team will decide whether each patient's procedure is sufficiently low risk that it could be carried out appropriately at non-arterial centres, or higher risk and therefore suitable for the arterial centre.	Notes of meetings held.

Clinical audit		
6.	All policies, procedures and guidelines should comply with Trust document control procedures.	Policies, procedures and guidelines meeting reasonable document control quality requirements of monitoring, review and version control.
7.	The centre should collect and submit data to the National Vascular Database (all index procedures) and British Society of Interventional Radiology Registries.	National Vascular Database reports showing risk-adjusted comparative outcomes for the centre. BSIR Registries information. *Note:* 1. *Data should cover all parts of the vascular service including activity in hospitals without on-site in-patient services.* 2. *Appropriate support staff are needed to collect and upload data.*
8.	The centre should have an annual programme of audits covering at least: a. Number of interventional procedures (surgical and interventional radiology) undertaken by each vascular specialist across the centre's catchment area. b. Medical management of patients with peripheral vascular disease. c. Compliance with evidence-based guidelines.	Details of audit programme. *Note:* 1. *Audits should cover all parts of the vascular service including activity in hospitals without on-site in-patient services and should include comparison of HES data and National Vascular Database / BSIR Registries numbers. Audits of operations by surgeon should include all vascular operations, including any undertaken by general surgeons.* 2. *Data should cover all parts of the vascular service including activity in hospitals without on-site in-patient*

		services. 3. *Appropriate support staff are needed to collect and upload data.*

Clinical Advisory Group

Mr Andrew Guy, consultant general and vascular surgeon, Mid Cheshire Hospitals (chair)
Dr Gian Abbott, consultant radiologist, Countess of Chester Hospital
Mr Stephen Blair, consultant vascular surgeon, Arrowe Park Hospital
Mr John Brennan, consultant vascular surgeon, Royal Liverpool and Broadgreen Hospitals
Mr Sameh Dimitri, consultant vascular surgeon, Countess of Chester Hospital
Dr Rajesh Gedela, consultant radiologist, Southport and Ormskirk Hospitals
Dr Liz O'Grady, consultant radiologist, Aintree Hospital
Mr Magdi Hanafy, consultant vascular surgeon, Mid Cheshire Hospitals
Dr Simon Lea, consultant radiologist, Arrow Park Hospital
Dr Richard McWilliams, consultant interventional radiologist, Royal Liverpool and Broadgreen Hospitals
Dr Glen Masey, consultant radiologist, Warrington and Halton Hospitals
Mr Frank Mason, consultant vascular surgeon, Southport and Ormskirk Hospitals
Mr Deji Olojugba, consultant vascular surgeon, Warrington and Halton Hospitals
Mr Francesco Torella, consultant vascular surgeon, Aintree Hospital
Dr Salman Zaman, consultant radiologist, Mid Cheshire Hospitals
Dr Oliver Zuzan, consultant anaesthetist, Royal Liverpool Hospital

Appendix 2: Inter-dependent clinical services

Patients often have more complex care needs which overlap several clinical services. We need to make sure that, after the change in vascular services, patients get care that is at least as joined up as at present.

The most important of these linked services are those for people with kidney failure, stroke, diabetes and trauma. Clinicians have recommended arrangements to ensure services work well together:

Stroke

The National Stroke Strategy requires that patients presenting with a high-risk transient ischaemic attack or minor stroke should be assessed for possible carotid endarterectomy within 24 hours, and within seven days in all other cases, with carotid intervention within 48 hours of referral where clinically indicated.

The future model of care in Cheshire and Merseyside is that patients with an obvious stroke will be taken direct to a hyper-acute stroke centre for immediate imaging, thrombolysis and other urgent management. After a few days, they will be transferred to a more local hospital to continue rehabilitation.

- It is highly desirable, but not essential, that arterial centres are co-located with hyper-acute stroke centres. This is because it will expedite carotid endarterectomy for those patients admitted there.
- The arterial centre will need to be able to offer treatment in line with these standards to patients presenting there and at other hospitals.
- The selection of a hospital as a hyper-acute stroke centre will be a factor in its favour when identifying arterial centres.

Diabetes

Most patients with diabetes presenting with vascular disease can be investigated at a non-arterial centre hospital and referred if necessary as an outpatient. Inpatients can be investigated and in most cases treated with angioplasty without recourse to open vascular surgery. The minority of patients presenting with an acutely ischaemic limb or other vascular emergency would need transfer to the arterial centre. Inpatients with diabetes benefit from specialist diabetic input, and there is evidence that this may shorten length of stay.

- The arterial centre will need to be able to offer immediate admission to diabetic patients with vascular emergencies.
- Arterial centres will need to ensure adequate input from the diabetes team.

Critical care and trauma

The reconfiguration of trauma services on Cheshire and Merseyside is likely to culminate in the designation of four or five hospitals as trauma units; no hospital in the North-West has all the clinical components necessary for trauma centre status. Only a small minority of trauma cases involve vascular injury, so it is desirable but by no means essential that these hospitals should be arterial centres – in any case, the likely number of these centres is fewer than the number of trauma units.

When a patient with vascular trauma is admitted to a hospital without arterial surgery on site, a general surgeon can treat the haemorrhage and stabilise the patient, while a vascular surgeon is called from elsewhere. The vascular surgeon's role is to repair and reconstruct the damaged vessels, and s/he would need to be onsite within thirty minutes of being called.

With regard to critical care, all hospitals in Cheshire and Merseyside are expected to have a 24/7 intensivist rota, and nearly all do. Any hospital offering arterial surgery should offer this level of cover.

- The selection of a hospital as a trauma unit, and especially as a trauma unit plus, will be a factor in its favour when identifying arterial centres.
- Critical care capacity should be considered in the configuration of vascular services, with a requirement for 24/7 intensivist cover.

Renal services

Hospitals fall into three categories: those with no haemodialysis facilities, those offering nurse-led haemodialysis to outpatients supported by a visiting nephrologist, and those with a full-scale renal unit. There are three of the latter in Cheshire and Merseyside: the Royal Liverpool, Aintree and Arrowe Park.

There are three areas where renal and vascular services intersect:

Creating and maintaining arterio-venous fistulae for haemodialysis patients
From April 2011, Trusts will face financial penalties if more than 20% of patients on long-term haemodialysis lack permanent vascular access via an arterio-venous fistula. Fistulae need to be created within six weeks of referral to a surgeon. Fistulae sometimes stenose or thrombose, both of which need prompt interventional radiology to maintain or restore patency.

For this reason, onsite vascular services contribute substantially to the success of a haemodialysis centre.

The management of acute renal failure after vascular surgery
Patients with acute renal failure after surgery need expert management, not least to shorten the length of stay in critical care. Nephrologists are helpful in such situations, but an appropriately trained intensivist is also fully satisfactory.

The management of peripheral vascular disease in patients on dialysis
Cardiovascular and peripheral vascular disease is common among patients on dialysis. When they are admitted for any reason, patients on dialysis need particularly expert

treatment because of their renal failure. Therefore, many hospitals without a full renal service have a policy of not admitting patients on dialysis for any indication. So substantial clinical difficulties would arise for a renal centre which was not also an arterial centre, unless existing clinical relationships could mitigate the problem.

- Ideally renal and vascular units should co-exist on the same site. Any other arrangement requires close discussion between hospitals to ensure that these standards are achieved.

A renal unit's key requirements for vascular support are:

1. Access to imaging for work up of a new vascular access (within four weeks).
2. Access to imaging for diagnosis in cases of sub-optimally performing fistulas (within two weeks, degree of urgency will depend of degree of fistula underperformance).
3. Facilities for long-line placement with radiology imaging and interventional radiologist expertise (within 24 hour interval to reduce the number of temporary procedures and duration of in-patient stay)
4. Elective list time for placement of Tenchkoff catheters and peripheral haemodialysis access (enough list space so that 80% of patients known to nephrology for over 90 days and planned for peritoneal dialysis start on that treatment and 80% of patients start haemodialysis with peripheral access).
5. Access to theatres (and surgical staff) for uncontrollable haemorrhage, or graft or peritoneal sepsis (within hours).
6. Access to ultrasound for diagnosis of acutely thrombosed fistulae (09.00 to 17.00 seven days a week)
7. Access to interventional radiology for diagnosis, angioplasty and thrombolysis (09.00 to 17.00 7 days a week).
8. Access to theatres and surgical staff for fistula thrombectomy (09.00 to 17.00 seven days a week).

WIRRAL COUNCIL

HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTTEE

22 MARCH 2011

SUBJECT:	**HOMEOPATHY COMMISSIONING**
WARD/S AFFECTED:	**ALL**
REPORT OF:	**NHS WIRRAL PROFESSIONAL EXECUTIVE COMMITTEE**
RESPONSIBLE PORTFOLIO HOLDER:	
KEY DECISION?	NO

1.0 EXECUTIVE SUMMARY

1.1 The purpose of this report is to provide an update for members on the commissioning plans of NHS Wirral for homeopathy.

2.0 RECOMMENDATION/S

2.1 The Professional Executive Committee approved a recommendation not to commission homeopathic therapies subject to patient & public engagement, and to ensure that all NHS Wirral policies are consistent to this effect.

3.0 REASON/S FOR RECOMMENDATION/S

3.1 The scientific evidence relating to the efficacy of homeopathy treatments was recently reviewed at NHS Wirral's Professional Executive Committee (PEC) to inform consistent commissioning decisions.

4.0 BACKGROUND AND KEY ISSUES

4.1 Homeopathy is a 200-year old system of medicine that seeks to treat patients with highly diluted substances that are administered orally. It is claimed that homeopathy works by stimulating the body's self-healing mechanisms[1]. Homeopathic products should not be confused with herbal remedies. Some homeopathic products are derived from herbal active ingredients, but the important distinction is that homeopathic products are extremely diluted and administered according to specific principles. Homeopathic therapies do not include acupuncture.

4.2 Decisions on the use of homeopathy are left to the National Health Service (NHS) [2]. Primary Care Trusts (PCTs) are responsible for commissioning care services and are thus currently free to fund homeopathy [2].

4.3 Currently, NHS Wirral has a block contract with Liverpool PCT for homeopathy to the value of £35,270 per year. This contract is due to expire on 31 March 2011. Due to the need to ensure a consistent commissioning approach, and at a time of change by the provider, the future of the service required review.

4.4 NHS Wirral has received seven letters (to 23 February 2011) from service users relating to homeopathy treatments. These refer to a range of conditions (skin condition, prostate cancer, asthma and osteoarthritis, a learning difficulty/behaviour condition, several complaints together and also chronic fatigue syndrome and insomnia). All seven letters praise the homeopathy services and treatments received [3].

In addition, the Chairman of the '*North West Friends of Homeopathy'* has written to the PCT in support of homeopathic services on the Wirral, and asking for an overview of the patient consultation plans should the treatments be discontinued [4]. All letters have received a response with details that the PCT recognises that homeopathic care on the Wirral is valued by the patients receiving the care, and that the matter is currently under review due to changes being made by the provider of the homeopathy services.

4.5 The NHS Wirral complex case team have received general queries regarding homeopathy treatments; however the team have not received any formal letters regarding this area. These queries have related to:

- Two patients already in the system and receiving homeopathy treatment and their ongoing management – advice was given in line with the NHS Wirral procedures of low clinical priority (see sections 4.9 and 4.10) and they were informed also of the current review of homeopathy services.
- One new potential referral - advice was given in line with the NHS Wirral procedures of low clinical priority (see sections 4.9 and 4.10).

Scientific Evidence for the Use of Homeopathic Products

4.6 In February 2010, the House of Commons Science and Technology Select Committee reported in detail on the effectiveness of homeopathy and policies relating to homeopathy provision in the National Health Service.

4.7 Based on the current scientific evidence, the Select Committee concluded that:

- There is no evidence that homeopathy works beyond the placebo effect.
- By providing homeopathy on the NHS, the Government runs the risk of appearing to endorse it as a working system of medicine.
- There is also a danger that when doctors prescribe placebos, they risk damaging the trust that exists between them and their patients.

4.8 Other PCTs have also reviewed their commissioning arrangements for homeopathic therapies:

- NHS West Kent undertook a high quality review of their homeopathy commissioning in 2007 and concluded that it did not represent value for money in the light of competing NHS funding prioritises. NHS West Kent now does not fund routine homeopathy treatment
- Oxfordshire PCT Priorities Forum in February 2009 confirmed that because there was no conclusive evidence for the effectiveness of complementary therapies, and that Oxfordshire's health economy had to prioritise mainstream treatments for which there was evidence of effectiveness, the commissioning of alternative and complementary therapies (including homeopathy) was a low priority for Oxfordshire PCT
- Greater Manchester Medicines Management Group decided In July 2010 that the prescribing, referral or recommendation of homeopathy is a low priority for the NHS and cannot be supported.

Local NHS Policies

4.9 The Cheshire and Merseyside Prior Approval Scheme Policy (June 2010) states that for homeopathy/acupuncture:

> *"Based on recent Effective Health Care Reviews (Effective Health Care Vol. 7 York University) there is currently insufficient evidence to recommend homeopathy as a treatment for any specific condition or to warrant significant changes in the provision of homeopathy (in the NHS). The PCT will therefore not provide funding for individuals to receive homeopathic treatment as part of current care pathways or outside usual pathways…The PCT will not commit additional resources to extend the current service provision in primary care nor provide for alternative routes of access to homeopathy."*

4.10 The NHS Wirral Commissioning Policy for Alternative and Complementary Therapies states:

> *"Complementary medicine/alternative therapies are generally not funded by NHS Wirral. They are occasionally used as a treatment as part of a mainstream service care plan (e.g. as part of an integrated multidisciplinary approach to symptom control by a hospital based pain management team) and as such will be funded either as part of the PBR tariff or explicitly agreed in the SLA. On existing available evidence the PCT would not support referral outside the NHS for these services. Prior approval is required on a case by case basis by the PCT Health Treatment Panel for any requests outside the above criteria. The HTP will require proven evidence of effectiveness of the therapy, failure of conventional treatment and assurance concerning the training and qualifications of the proposed provider practitioners."*

NHS Wirral conclusions

4.11 The Professional Executive Committee (PEC) of NHS Wirral:

- Noted the evidence regarding the lack of efficacy and cost-effectiveness of homeopathic therapies
- Approved a recommendation not to commission homeopathic therapies subject to patient & public engagement, and to ensure that all NHS Wirral policies are consistent to this effect
- Agreed the need for GP consortia to engage with patients and patient groups with support from the Director of Communications and Engagement.

5.0 RELEVANT RISKS

5.1 The key risk is that NHS Wirral fails to maintain its reputation as an evidence-based commissioning PCT.

6.0 OTHER OPTIONS CONSIDERED

6.1 None

7.0 CONSULTATION

7.1 The PCT is consulting affected patients and groups as well as wider stakeholders

Audience	**Mechanism**
LINK	To be invited to meeting
Health Overview and Scrutiny Committee	Presentation to 22/3 committee.
North West Friends of Homeopathy	Electronic copy of doc for circulation to members/users on their database. Feedback via NHS Wirral website available Open meeting to provide opportunity for discussion
Patients directly affected	Letter and invitation to open meeting Feedback via NHS Wirral website available
Patient Groups: • Voice of Wallasey • Patient Matters • Birkenhead Patient Council	Letter to chairs Presentation by GPs to patient groups and responses captured.
NHS Wirral membership	Hard copy of consult doc for circulation to database
MPs	Letter to members; topic at MP meetings
Other stakeholders	Electronic copy of consult doc for circulation to database
General Public	Local press coverage Websites posting (NHS Wirral & Wirral Council)

Responses will be considered by the Professional Executive Committee of the PCT.

8.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

8.1 There are no direct implications

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

9.1 There is no impact on the NHS workforce. There is a need to communicate the policy to relevant commissioning and provider staff.

10.0 LEGAL IMPLICATIONS

10.1 The scientific evidence base regarding homeopathy is an evolving field and may change in the future. The evidence base regarding homeopathy will need to be monitored regularly its commissioning policy reviewed accordingly. This is imperative as there may be challenges to the commissioning decision.

11.0 EQUALITIES IMPLICATIONS

11.1 We do not believe there are any discrimination issues, social inclusion or human rights implications.

11.2 Equality Impact Assessment (EIA)

(a) Is an EIA required?
No – NHS Wirral has considered this issue already following an EIA screening process. Given the lack of evidence on the efficacy and cost-effectiveness of homeopathic therapies, measuring the positive or negative impact is inappropriate at this time.

However, NHS Wirral will keep this under review during the consultation process and any issues arising will be considered.

12.0 CARBON REDUCTION IMPLICATIONS

12.1 Not applicable

13.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

13.1 Not applicable

REPORT AUTHOR: **Teresa Owen**
Consultant in Public Health
telephone: 0151 651 0011
email: teresa.owen@wirral.nhs.uk

Martin McEwan
Director of Communications & Engagement
telephone: 0151 651 3929
email: martin.mcewan@wirral.nhs.uk

APPENDICES

None

REFERENCE MATERIAL

1. "What is homeopathy?" The Society of Homeopaths, www.homeopathy-soh.org cited in Reference 2
2. House of Commons Science and Technology Committee (2010) Evidence Check 2: Homeopathy, Fourth Report of Session 2009–10, The Stationery Office, London.
3. Letters from service users (PCT references) – *Names removed for public disclosure.*
    - KD/JPH/2142
    - KD/JPH/2170
    - KD/JPH/2171
    - KD/JPH/2197
    - KD/SR/2291
    - KD/JPH/2302
4. Letter from the North West Friends of Homeopathy: KD/JPH/2189

SUBJECT HISTORY (last 3 years)

Council Meeting	Date

WIRRAL COUNCIL

HEALTH AND WELL BEING OVERVIEW AND SCRUTINY COMMITTEE - 22nd MARCH 2011

REPORT OF THE DEMENTIA SCRUTINY PANEL MEMBERS

DEMENTIA SCRUTINY REVIEW – FINAL REPORT

EXECUTIVE SUMMARY

This report provides background information regarding the Final report of the Dementia Scrutiny Review.

1. Background

1.1 The Hospital Discharge Scrutiny Review was held during 2008/9, with the final report being presented to the Social Care & Health Overview and Scrutiny Committee meeting held on 25th March 2009. During the evidence-gathering stage of that review, issues were raised with the panel members regarding support for people with dementia in hospital and in the community.

1.2 It was therefore agreed by the Health & Wellbeing Overview and Scrutiny Committee that an in-depth review should be held to investigate the care of patients with dementia in general hospitals. A Panel of members was sought to undertake the review.

1.3 Subsequently, the following members volunteered to be members of the Panel:

- Councillor Ann Bridson (Chair)
- Councillor Denise Roberts
- Councillor Sheila Clarke
- Former Councillor Chris Teggin

The panel has been supported by a Scrutiny Support Officer, Alan Veitch.

2. Focus for the Review

2.1 The Health & Wellbeing Overview and Scrutiny Committee agreed the Scope for the review in June 2009.

2.2 The main issues were identified in the Scope document as:

- Management of patients with dementia in an acute hospital setting.
- Impact of patients with dementia on other patients during a stay in hospital.
- Are there alternative approaches which allow more patients with dementia to be cared for outside an acute hospital setting?
- Is it possible to keep more people with dementia in their own home for as long as possible?

3. Evidence Gathering

The Panel has employed a number of methods to gather evidence:

- Meetings / visits with officers
- Meetings with carers of people with dementia
- Written evidence from individuals
- Written documentation / reports, both from a national and local perspective

4. The Final Report

The Final Report, 'The Care of People with Dementia in an Acute Hospital Setting', which includes 14 recommendations, is attached for consideration by the Committee

RECOMMENDATIONS

(1) That the contents and recommendations of the Dementia Scrutiny Review be supported;

(2) that the Dementia Scrutiny Report be presented to the next appropriate cabinet meeting;

(3) and that further reports be presented to the Health & Wellbeing Overview and Scrutiny Committee to update members regarding the outcomes of the recommendations.

Report of the Dementia Scrutiny Panel Members

(07/03/11)

WIRRAL

Wirral

DEMENTIA SCRUTINY REVIEW

‘THE CARE OF PEOPLE WITH DEMENTIA IN AN ACUTE HOSPITAL SETTING’

DEMENTIA

A Report produced by The Health & Wellbeing Overview and Scrutiny Committee

FINAL REPORT
FEBRUARY 2011

WIRRAL BOROUGH COUNCIL

'THE CARE OF PEOPLE WITH DEMENTIA IN AN ACUTE HOSPITAL SETTING' SCRUTINY REVIEW

FINAL REPORT

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1. EXECUTIVE SUMMARY AND RECOMMENDATIONS

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

"The majority of these patients are not known to specialist mental health services and are undiagnosed. General hospitals are particularly challenging environments for people with memory and communication problems, with cluttered ward layouts, poor signage and other hazards. People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation".

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

"The longer people with dementia are in hospital, the worse the effect on the symptoms of dementia and the individual's physical health; discharge to a care home becomes more likely and antipsychotic drugs are more likely to be used. As well as the cost to the person with dementia, increased length of stay is placing financial pressure on the NHS".

Reports such as 'Counting the Cost' (Alzheimer's Society, 2009) and the Interim report of the National Audit of Dementia (The Royal College of Psychiatrists, December 2010) both estimate that 750,000 people in the UK have dementia. The 'Joint Strategic Needs Assessment' for Wirral, produced by Wirral NHS for 2009/10, estimated that there were 4,266 older people with dementia in Wirral. This is significantly higher than the number of people recorded with dementia on GP registers in Wirral.

According to data recorded on Dr Foster (2009)[1], Wirral has a significantly higher number of hospital admissions for senile dementia when compared to the national average and the North West. It was estimated that emergency admissions for senile dementia in Wirral were 53.8% higher than expected against the national average.

The development of the National Dementia Strategy, launched in 2009 and the Local Care Pathway in Wirral have both raised the profile of the care of people with dementia. Both strategies include the provision of care to people with dementia during a stay in an acute hospital. The evidence presented during the course of this Scrutiny Review resulted in the Panel Members identifying a number of principles regarding the care of patients with dementia in an acute hospital setting.

In turn, these principles inform the more detailed recommendations which are included in this Report. Indeed, some of these principles are already highlighted within the National Dementia Strategy and the Local Care Pathway in Wirral. However, it is necessary to recognise the financial climate which the public services, including the NHS, now face. Some of the recommendations may, therefore, be achievable more quickly than others.

[1] Dr Foster Intelligence is a public-private partnership that aims to improve the quality and efficiency of health and social care through better use of information

The following principles underpin the recommendations which are formulated in this Report:

Not to admit patients with dementia to hospital if at all possible.

If a patient with dementia is admitted to hospital, their stay in hospital should be kept to a minimum period and, while in hospital, the patient should be subject to as few moves as possible.

While in hospital, the patient with dementia should be supported to minimise disruption to their normal daily routines, for example, meal times and personal care.

During a stay in hospital for a patient with dementia, both the dignity of the patient and the involvement of the carer(s) should be central to the processes.

Whenever possible, a patient with dementia should be discharged to the residence of origin.

It is widely acknowledged that the impact of a stay in hospital, in some cases, is that the patient with dementia is not able to return home and, as a result, has to go into residential care. The experience of going into hospital can be extremely confusing for a patient with dementia. A combination of the disruption to everyday routine, the chance of infection, a period without stimulation and safeguarding issues mean that hospital can be a risky place for a person with dementia. It is, therefore, considered by many professionals that **hospital admission should be avoided if at all possible** for this group of patients. The Panel Members were informed that the best option is to provide low-level support early in order to prevent periods of crisis. Furthermore, members were told that early intervention is most cost effective. In order for admission rates to be reduced, alternative forms of care will have to be provided in different locations, including in the community. Although progress has been made in Wirral, further changes need to be made to provide greater patient choice. The creation of a Crisis Response Team or a Specialist Home Care Dementia Service, as exists in other areas, such as Liverpool, should help to prevent some hospital admissions.

However, it is inevitable that a significant number of patients with dementia will be admitted to acute hospitals In these circumstances, **the disruption to the patient will be minimised if the length of stay is reduced to a minimum and the number of moves within the hospital are kept to as few as possible.** The early identification that the patient has dementia is instrumental in enabling hospital staff to offer an appropriate care plan. The availability of a register of patients with dementia and / or a dementia passport would assist staff. In addition, processes to ensure that the maximum amount of information is received from the carer or nursing home, at the time of admission, would significantly assist in the care planning. Once admitted, it is not unusual for a patient to be moved up to four times, which may increase the level of confusion for a patient with dementia.

From the point of admission, it is considered that **patients with dementia should be supported to minimise disruption to their normal daily routines, for example, meal times and personal care.** Normalising the hospital setting, by, for example, involving family to help with personal care and feeding would be less disruptive, and may facilitate return to home more promptly. This, in turn, would reduce costs and improve the patients' outcomes. Fundamental to this approach is the direct

involvement of a carer(s) / family member(s) in the planning and, if appropriate, the delivery of some of the care. During this Scrutiny Review, a number of carers insisted that a major concern for them was the nutrition and personal care given to the person for whom they cared. Those concerns can best be allayed through hospital staff developing a closer relationship with the carer(s) and mutual trust being gained. Disruption to the patient may also be minimised by environmental changes on the wards, some of which have already taken place.

During a stay in hospital for a patient with dementia, both the dignity of the patient and the involvement of the carer(s) should be central to the processes. The dignity of the patient can be best preserved through the quality of the care provided by hospital staff. Evidence from carers during this review suggested that some staff appeared to not have sufficient understanding of the requirements to care for patients with dementia. There seems to be a recognition by the majority of witnesses (to this Scrutiny Review) that not all staff understand and are able to respond to the demands of dementia. A common theme, both from national reports and from local evidence, is the need to ensure that hospital staff have received adequate training and feel as comfortable as possible while caring for patients with dementia. Again, significant progress has been made by Wirral University Hospital Trust; an example of which is the Trust having been the first in the country to include input from the Alzheimer's Society in providing relevant training to staff.

It is recognised that significant effort and progress has been made by both Wirral NHS and Wirral University Hospital Trust to provide a more efficient discharge process for all patients. It is particularly important that the period in hospital for a patient with dementia is reduced to a minimum. Clearly, an efficient discharge process, which minimises delays, is, therefore, particularly important for this group of patients. Anecdotal evidence suggests that this is not always the case. In addition, **whenever possible, a patient with dementia should be discharged to the residence of origin.** Many of the professional witnesses interviewed during the review insisted that a hospital bed was not the correct place for long-term care choices to be made. However, evidence from the Alzheimer's Society Report, 'Counting the Cost', produced in 2009, estimated that, nationally, over a third of people with dementia who go into hospital from living in their own homes are discharged to a care home setting.

Overall, the fundamental dilemma is to provide a balance between the short-term gain (of needing physical support) and the long-term deficit (of being away from familiar surroundings for a lengthy period) which may exacerbate dementia.

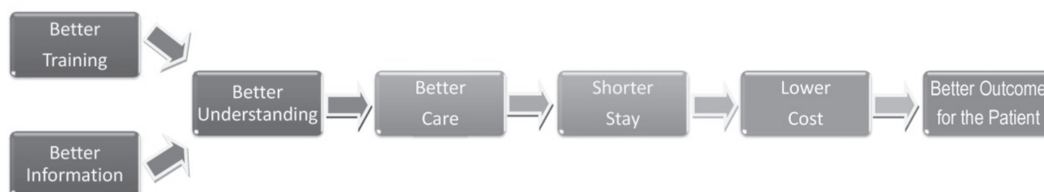


Figure 1: Potential Impact of Improved Staff Training and Information Flow

In considering the evidence found during the review, the Panel Members have formulated the recommendations shown on pages 6 and 7. These recommendations underpin the principles which are described above.

RECOMMENDATIONS

1 **Alternatives to hospital admission** (Para 6.3.1)
Wirral NHS, GPs and Social Services are encouraged to continue to enhance services which reduce the need for people with dementia to be admitted to hospital if at all possible. All staff are encouraged to look positively at alternatives rather than admission to hospital and critically assess whether it is in the best interests of the patient.

2 **Register of patients with dementia / dementia passport** (Para 6.3.2)
The creation of a local register of patients with dementia, accessible to hospital staff, should be investigated as should the development of a dementia passport. These will enable the early identification of patients with dementia on admission to an acute unit.

3 **Receipt of information regarding the patient with dementia** (Para 6.3.2)
Processes should be developed to ensure that, at the time of admission of a patient with dementia, maximum information is received from the carer or nursing home. This could include the development of a simple questionnaire to be used in such circumstances.

4 **Minimise the number of moves within hospital** (Para 6.3.2)
Wirral University Teaching Hospital (WUTH) is requested to develop processes to minimise the number of moves for patients with dementia within the hospital.

5 **Assistance at meal times / personal care** (Para 6.3.3)
Ward staff should welcome offers of help from family / carers to minimise disturbance to the patient with dementia during a stay in hospital. This could include family members being able to support relatives at meal times and aspects of personal care without being pressured to do so.

6 **Information flow with carers** (Para 6.3.3)
The special role of carers of patients with dementia should be recognised by staff. Processes should ensure that greater information exchange with carers is established at the outset. This should include ongoing care and developments towards discharge.

7 **Environmental issues on the ward** (Para 6.3.5)
In order to assist patients with dementia, Wirral University Teaching Hospital is encouraged to investigate further environmental improvements to wards where appropriate. These might include:

- Clear signage to identify bathroom / toilet
- Use of pastel colours
- Positioning of beds in the ward
- Use of side rooms
- Alarm system to prevent patients with dementia from wandering, especially at night when staff numbers are reduced
- Use of Activity Lounge for patients with dementia

8 The role of specialist dementia nurses (Para 6.3.5)
The role of specialist dementia nurses, to be deployed wherever needed in the hospital to support other acute staff, should be considered.

9 Safeguarding (Para 6.3.6)
The deployment of security staff to manage patients with dementia should be avoided if at all possible. (Further recommendations for staff training and availability of experienced staff reflecting the number of patients with dementia on a ward at any one time should assist with the management of disruptive behaviours).

10 Discharge planning (Para 6.3.7)
Support is given to the principle of long-term care needs not being decided from a hospital bed. Planning for discharge from the time of arrival must involve the carer(s) with the prime objective being to discharge the patient to the residence of origin wherever possible.

11 Care requirements following discharge (Para 6.3.7)
Appropriate discharge needs include:

- Reducing the time taken for the care assessment
- Prompt availability of care packages including reablement support

An alternative pathway for patients with dementia may involve the development of a short-term assessment unit and / or an intermediate care service.

12 Staff training (Para 6.4)
Participants in training sessions regarding the care and management of patients with dementia should be expanded to include:

- Doctors
- Ward managers
- Triage nurses
- Paramedics and ambulance staff
- Security staff

More staff from all appropriate wards should be involved in dementia training, which could include on-line modules.

13 Crisis Response Team / Specialist Home Care Dementia Service (Para 6.5.1)
Recognising that any move from familiar surroundings is likely to exacerbate dementia, people with dementia should be cared for in their own home or residential / nursing home if at all possible. Therefore, Wirral NHS is encouraged to investigate the feasibility of developing a Crisis Response Team and / or a Specialist Home Care Dementia Service to keep patients with dementia in a familiar environment.

14 Nursing Homes (Para 6.5.2)
The current work undertaken by Wirral NHS to provide support to nursing homes to enable fewer patients to be admitted to hospital is endorsed. This practice should be extended wherever possible.

2. ACKNOWLEDGEMENTS

This Report presents the findings of a Scrutiny Review into the ‘Care of people with dementia in acute hospital’. The Review was undertaken by a Working Group which was set up by the Health & Wellbeing Overview and Scrutiny Committee. For many people with dementia, a stay in hospital and subsequent recuperation can be a stressful and frightening experience, both for that person and for family members. The Panel hopes that this Scrutiny Review has, in a small way, enabled some of the thoughts of residents to be heard and to be reflected in future decision-making.

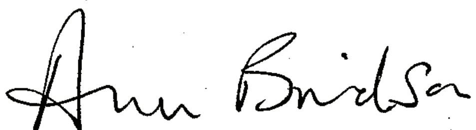
Dementia is increasingly being recognised as providing a major challenge for service providers and communities. Already a substantial issue, the numbers of people living with dementia is expected to rise significantly over the next few years. The challenge is going to become greater. The National Dementia Strategy, first adopted in 2009, laid the foundations for the UK’s response. It is important that local communities now take that work forward. Although this Scrutiny Review focused primarily on the relationship between people with dementia and acute hospitals, this is only one facet of the national strategy. It is hoped that the recommendations which form part of the Report will further develop the good practice that exists within Wirral University Teaching Hospital and other partners.

The Panel would like to thank all those people who willingly agreed to contribute and to provide information to this review. In particular, the Panel thanks the staff at Wirral University Teaching Hospital who have facilitated a number of visits to Arrowe Park Hospital during the course of the review. Thank you also to all of the staff from Wirral University Teaching Hospital, Cheshire and Wirral Partnership Foundation Trust, NHS Wirral, Wirral Borough Council, Age Concern and Alzheimer’s Society with whom they have met and exchanged ideas. There were many varied contributions to the review process.

A significant part of the evidence gathered during the review was generated by discussion and written submissions from carers of people with dementia. The Panel is extremely grateful to all of those contributors. In particular, thank you to the participants in the two focus groups as well as to the staff at Age Concern and Alzheimer’s Society for facilitating those sessions. Thanks are also due to those other interested parties, such as carers’ representatives, who contacted the panel.

Thank you to the Panel Members who have all contributed fully to the review, which I hope will contribute to the development of service provision in this area. In the future, it is important that the impact of all of the recommendations is reviewed and that progress is monitored.

Thank you to all for your participation and contributions to this Review.



Councillor Ann Bridson (Chair of the Members’ Panel)

3. PANEL MEMBERSHIP

The Dementia Scrutiny Panel was appointed by the Health & Wellbeing Overview and Scrutiny Committee on 22nd June 2009. The purpose of the Panel is to carry out a Scrutiny Review of the care of people with dementia in acute hospitals. The panel will make any relevant recommendations for changes, which in the first instance will be discussed by the Health & Wellbeing Overview and Scrutiny Committee. The following members volunteered to be members of the Panel:

Councillor Ann Bridson (Chair)

Councillor Denise Roberts

Two former members of the Panel who were involved in most of the 'Evidence Gathering' stage were:

Former Councillor Chris Teggin

Councillor Sheila Clarke

The Scrutiny Support Officer for this Scrutiny Review was Alan Veitch.

4. BACKGROUND AND ORIGINAL BRIEF

The Hospital Discharge Scrutiny Review was held during 2008/9, with the final report being presented to the Social Care & Health Overview and Scrutiny Committee meeting held on 25th March 2009. During the evidence-gathering stage of the review, issues were raised with the Panel Members regarding support for people with dementia in hospital and in the community. The final report of the Hospital Discharge Scrutiny Review included the following section:

> 6.7 Needs of Specialist Groups - Dementia patients
> Evidence, particularly from the voluntary sector, has raised a number of issues relating to patients with dementia and their treatment in hospital. A representative of a third sector organisation commented that:
> *"As a society, there is a need to look at creative alternatives to keep people at home. At present, people are being admitted into residential care earlier than they really need to".*
>
> The discharge process for dementia patients is often longer than average. To many such patients, the environment is confusing and they do not understand why they are in hospital. However, the point was made to the Panel that the real issue is that there is often no adequate support available to keep the person with dementia in their own environment.
>
> The Panel suggested that further scrutiny should take place into issues for patients with dementia.

The Scope Document for the Dementia Scrutiny Review, attached as Appendix 1 to this Report, was agreed by the Health & Wellbeing Overview and Scrutiny Committee on 22nd June 2009. It was agreed that the review would concentrate on the following issues:

- Management of patients with dementia in an acute hospital setting.
- Impact of patients with dementia on other patients during a stay in hospital.
- Are there alternative approaches which allow more patients with dementia to be cared for outside an acute hospital setting?
- Is it possible to keep more people with dementia in their own home for as long as possible?
- What support is available for carers?
- Is it possible to support more people with dementia in residential or nursing home rather than acute hospitals?

The Panel commenced work in attempting to find answers to these questions.

5. METHODOLOGY FOR THE REVIEW

The Panel has employed a number of methods to gather evidence:

1 Meetings / visits with officers
2 Meetings with carers of people with dementia
3 Written evidence from individuals

Details of these witnesses are available in Appendix 2 to this Report.

In addition, evidence was sought from written documentation / reports, details of which are shown in Appendix 3 to this Report.

6. EVIDENCE AND RECOMMENDATIONS

6.1 Introduction – Dementia in an Acute Care Context in Wirral

6.1.1 The Scale of the Problem in Wirral

Dementia is a syndrome that can be caused by a number of progressive disorders that affect memory, thinking, behaviour and the ability to perform everyday activities. Alzheimer's disease and vascular dementia are two of the most common types. Dementia mainly affects older people, although there is growing evidence of cases that start well before the age of 65. People with dementia are at an increased risk of physical health problems and become increasingly dependent on health and social care services and other people.

Reports, including 'Counting the Cost' (Alzheimer's Society, 2009) and the interim report of the National Audit of Dementia (The Royal College of Psychiatrists, December 2010) both estimate that 750,000 people in the UK have dementia. A further report, 'Dementia 2010: The economic burden of dementia and associated research funding in the United Kingdom', produced by the Alzheimer's Research Trust estimated that over 820,000 people in the UK live with dementia, representing 1.3% of the UK population. The cost to the UK economy is £23 billion per year in terms of health and social care, informal care and productivity losses. This is estimated to be more than the cost to the UK of cancer (£12 billion per year) and heart disease (£8 billion per year) combined. The Alzheimer's Research Trust report estimates that 37% of all dementia patients in the UK are in long-term care institutions costing in excess of £9 billion per year in social care. Health care costs are estimated at about £1.2 billion of which hospital inpatient stays account for 44% of the total.

The 'Joint Strategic Needs Assessment' for Wirral, produced by Wirral NHS for 2009/10, estimated that there were 4,266 older people with dementia in Wirral. This is significantly higher than the number of people recorded with dementia on GP registers.

Table 1: Dementia Prevalence on GP registers (2008/9) in Wirral

Area	*Number of Patients*	*Prevalence (%)*
Bebington & West Wirral	628	0.58
Birkenhead	895	0.59
Wallasey	313	0.43
Wirral (Total)	1836	0.55

Source: Wirral Joint Strategic Needs Assessment, 2009-10 (as supplied by Wirral NHS)

As part of the Quality Outcomes Framework (QOF), GP Practices are expected to produce a register of patients with dementia. In Wirral, a total of 1,836 people were recorded on the registers between April 2008 and March 2009, which gives an unadjusted prevalence rate of 0.6%. This is slightly higher than the North West and England GP practice prevalence rates which for England is 0.4% and the North West is 0.5%.

The ageing population means that the number of people with dementia is expected to rise considerably over the next few years. The projections for the number of people in Wirral aged 65 years and over with dementia, between 2008 and 2025, are shown in Table 2.

Table 2: Projections of Dementia Prevalence in Wirral for over 65s (from a base figure of 2008)

Dementia by Gender	*2008*	*2010*	*2015*	*2020*	*2025*
Males 65+	1374	1455	1686	1977	2282
Females 65+	2892	2953	3133	3366	3771
Total 65+	4266	4408	4819	5343	6053

Source: Wirral Joint Strategic Needs Assessment, 2009-10 (as supplied by Wirral NHS)

These estimates suggest that rates of dementia in older people will increase by 13% between 2008 and 2015. Rates will increase by 42% by 2025.

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

According to data recorded on Dr Foster (2009), Wirral has a significantly higher number of hospital admissions for senile dementia[2] when compared to the National average and the North West. This is a trend that has occurred over the last few years. For Wirral in 2008/09, there were 690 emergency admissions for senile dementia. It is estimated that emergency admissions for senile dementia in Wirral were 53.8% higher than expected against the national average. The average length of stay for all dementia admissions was 21.2 bed days/admission. This is actually lower than the national average length of stay, which is 28.5 days.

However, Dr Foster data only records primary diagnosis. Information recorded through Secondary Uses Service (SUS) (2008), records both primary and secondary diagnosis and has identified that there are more dementia related admissions to hospital when the secondary diagnosis is taken into account. In 2008/09, 1,075 people aged 60 and over, were admitted on a primary or secondary diagnosis of dementia (13.31 per 1,000). The total number of emergency admissions (for people aged 60 and over) was 2,470 (which means that some people were admitted more than once).

The figure of 690 emergency admissions had the primary cause of admission as 'senile dementia'. This raises the question of why so many people with dementia were admitted to an acute hospital rather than receiving another form of care; a question that is discussed later in this Report.

6.2 **Responding to the National Dementia Strategy**

6.2.1 The National Dementia Strategy

The first National Dementia Strategy for England, titled 'Living Well with Dementia' was launched in February 2009. The aim of the strategy is that all people with dementia and their carers should live well with dementia. Three key areas for improvement were identified as:

- Improved awareness
- Earlier diagnosis and intervention
- Higher quality of care

The Joint Leads of the National Dementia Strategy, Sube Banerjee and Jenny Owen, in launching the strategy, wrote:

"This is a comprehensive strategy which requires us to transcend existing boundaries between health and social care and the third sector, between service providers and people with dementia and their carers. Our vision is for a system where all people with dementia have access to care and support that they would benefit from"

Although this Scrutiny Review investigated specifically the care of people with dementia in acute hospitals, the need for joint working of a variety of service providers is a theme that recurs throughout this Report. The National Strategy identified 17 key objectives:

[2] Senile dementia is a clinical term used to categorise a range of dementia related conditions, including Alzheimer's disease

Table 3: Objectives of the National Dementia Strategy

	Objectives
1	Improving public and professional awareness and understanding of dementia
2	Good-quality early diagnosis and intervention for all
3	Good-quality information for those with diagnosed dementia and their carers
4	Enabling easy access to care, support and advice following diagnosis
5	Development of structured peer support and learning networks
6	Improved community personal support services
7	Implementing the Carers' Strategy
8	Improved quality of care for people with dementia in general hospitals
9	Improved intermediate care for people with dementia
10	Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers
11	Living well with dementia in care homes
12	Improved end of life care for people with dementia
13	An informed and effective workforce for people with dementia
14	A joint commissioning strategy for dementia
15	Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers
16	A clear picture of research evidence and needs
17	Effective national and regional support for implementation of the Strategy

Source: National Dementia Strategy: 'Living Well with Dementia, February 2009

Although only Objective 8 refers specifically to the care of people with dementia in general or acute hospitals, many of the other objectives are relevant to this Scrutiny Report as they underpin the services available to people with dementia which may prevent their admission to hospital in the first place or may enable more effective and efficient discharge after a stay in hospital. The Strategy document specifically identifies a series of actions to enable the delivery of Objective 8, 'Improved quality of care for people with dementia in general hospitals'. These are:

- Identification of a senior clinician within the general hospital to take the lead for quality improvement in dementia in the hospital
- Development of an explicit care pathway for the management and care of people with dementia in hospital, led by that senior clinician
- The gathering and synthesis of existing data on the nature and impacts of specialist liaison older people's mental health teams to work in general hospitals
- Thereafter, the commissioning of specialist liaison older people's mental health teams to work in general hospitals

The Strategy document observed that:

"There is a lack of leadership and ownership of dementia in most general hospitals. There are also marked deficits in the knowledge and skills of general hospital staff who care for people with dementia. Often insufficient information is sought from relatives and carers. This means that person-centred care is not delivered and it can lead to under-recognition of delirium and dementia. Currently, families are often excluded from discharge planning, so false assumptions may be made about whether it is possible for people with dementia to be cared for at home".

The National Dementia Strategy document was supported by an Implementation Plan, which set out how the Department of Health intended to support delivery of the strategy through its national and regional structures. However, subsequent to the change of Government following the General Election in May 2010, a further document has been published in September 2010. This document, 'Quality

outcomes for people with dementia: building on the work of the National Dementia Strategy', highlights the priorities of the new Government within the strategy. The priority objectives are now defined as:

- Good-quality early diagnosis and intervention for all
- Improved quality of care in general hospitals
- Living well with dementia in care homes
- Reduced use of antipsychotic medication

With respect to 'Improved quality of care in general hospitals', the document comments that:

- 40% of people in hospital have dementia
- The excess cost is estimated to be £6 million per annum in the average General Hospital
- Co-morbidity with general medical conditions is high
- People with dementia stay longer in hospital

The document puts particular emphasis on implementation plans being developed at a local level and specifically refers to the education and training needs of the workforce working with people with dementia.

The importance of the need to improve the care of patients with dementia in acute hospitals is made in the report, 'Acute Awareness – Improving hospital care for people with dementia' produced by the NHS Confederation in 2010. That report comments that:

"The National Dementia Strategy highlights the need to improve care for people with dementia in hospital. This is, in fact, one of the objectives of the strategy, but hospitals need to act soon if they are to meet the goals of the national strategy and the needs of an increasing number of patients with dementia".

6.2.2 Development of the Dementia Care Pathway in Wirral and Future Priorities

The local response to the National Dementia Strategy has been positive, with one leading professional in the field commenting:

"The National Dementia Strategy was a good starting point. The recommendations and objectives were all sensible. All of the recommendations apply to Wirral".

The Local Care Pathway has now been developed in Wirral and is being used as a guide to commission services by Wirral NHS. The pathway was developed through the involvement of stakeholders from primary and secondary health care, social services, the Third Sector, carers and people with dementia. Subsequently, work was done with CSED (Care Services Efficiency Delivery) from the Department of Health to help develop a Pathway for Care, responding to the 17 objectives highlighted by the National Dementia Strategy. A key aim of the pathway is to enable more resources to be made available earlier in the process following diagnosis. In respect of Objective 8 ('Improved quality of care for people with dementia in general hospitals'), the Wirral Pathway has identified the development of dementia training for staff in the acute hospital as a key priority.

More recently, a Dementia Care Pathway is being developed by Wirral University Teaching Hospital to specifically define the care of patients with dementia during a stay in the acute or general hospitals. The identification of a senior clinician within the hospital to lead on quality improvement in dementia care is encouraged, as outlined in the National Strategy. Within the context of Wirral Borough Council, it is also important to note that 'Improve support for those with mental health problems' is included as an aim in the Council's Corporate Plan for 2008 – 2013. It is hoped that this will result in the issue of dementia remaining high among the priorities of the Council.

The evidence presented to the Panel Members during the course of the Review identified a number of principles by which the care of patients with dementia in acute hospitals should be provided. In turn,

these principles inform the more detailed recommendations which are included in this Report. Indeed, some of these principles are already highlighted within the National Dementia Strategy and the Local Care Pathway in Wirral.

The following principles underpin the recommendations which are formulated in this Report:

Not to admit patients with dementia to hospital if at all possible.

If a patient with dementia is admitted to hospital, their stay in hospital should be kept to a minimum period and, while in hospital, the patient should be subject to as few moves as possible.

While in hospital, the patient with dementia should be supported to minimise disruption to their normal daily routines, for example, meal times and personal care.

During a stay in hospital for a patient with dementia, both the dignity of the patient and the involvement of the carer(s) should be central to the processes.

Whenever possible, a patient with dementia should be discharged to the residence of origin.

Subsequent sections in this Report will investigate key areas of service delivery for people with dementia in Wirral's acute hospitals, ranging from pre-admission, the patient's experience on the ward, the discharge process, and services post-discharge.

6.3 The Stay in Hospital: The Experience for Patients and Carers

6.3.1 Pre-admission

One of the principles to guide the ways of working recommended by the Panel Members is "not to admit patients with dementia to hospital if at all possible". However, if a patient with dementia becomes ill or carers become incapacitated, there is currently little evidence of emergency care being provided specifically for people with dementia in their own home. Although there are some general admission prevention services already available in the community, extension of this type of service and the improvement of support to prevent crises from occurring is seen by the Panel Members as a high priority. An example of this type of service already established is the intravenous therapy in the community.

A health professional commented that:
"The best treatment for a person with dementia is to treat them at home. Hospitals are confusing, noisy, provide the opportunity for little sleep and carry the risk of infections. The thrust of national strategies is to keep people out of hospital, especially, people with dementia".

While another added:
"Once in the hospital system, it is in the nature of the environment that a patient will become more dependent. If a patient is in hospital for two or three weeks their circumstances can become more difficult. Therefore, keeping them out of hospital is imperative".

A consultant informed the panel that:

"The best option is to provide low-level support early on in order to prevent periods of crisis. Early intervention is most cost effective".

Certainly, support to a carer(s) can be instrumental in ensuring that a person with dementia is able to remain in their own home for longer. As an example, information-giving for carers is very important for people with dementia. Providing information such as the available resources, the nature of the illness, what to expect, how to make choices and planning to make those choices are all very important. Information is the key because it enables families to plan.

'Inappropriate' admissions

During this Scrutiny Review, the main reasons for the admission of patients with dementia were described as:

- Carers may no longer be able to cope, which can result in the person with dementia being admitted to hospital. If there is not enough support, then a crisis will develop. The easiest option can then often be to admit the person with dementia to Arrowe Park hospital.
- People with dementia are more likely to get physical problems, for example, they may forget to take medicine. If they have a physical illness this may make the patient more confused. The treatment involves looking for a medical cause of the problem.

Research documented in 'Counting the Cost', the report produced by Alzheimer's Society in 2009, shows that of those admitted with a physical problem, the primary reasons for hospital admission were falls, broken hips or hip replacements, urine infections, chest infections and strokes.

Strong support was given by those interviewed during this Scrutiny Review for the principle of avoiding hospital admission for people with dementia if at all possible. Panel Members have reached the view that staff should be expected to look positively at alternatives rather than admission to hospital and critically assess whether it is in the best interests of the patient. A hospital professional explained:

"When a patient is admitted through A&E, a lot of investigation can be done within four hours. If initial tests can be done and no physical illness is identified, do they need to be admitted? There is a strong case to argue that the patient should either go home or go to another facility. How can this process be better managed?

- Urgent care could be put in place, via Social Services, to keep the patient at home.
- A short-stay assessment unit could be available for patients with dementia while a care package is put in place. A small assessment unit is much better for patients than a busy hospital ward.

If a demented person does not need to be there, being in hospital will create confusion".

Specific actions aimed at reducing admissions in general have a high priority within Wirral NHS. It is expected that these policies will predictably impact on people with dementia. Some of these initiatives will be discussed in more detail later in this Report (see Sections 6.5 'Alternatives to Hospital for Patients with Dementia'). Nevertheless, admissions of people with dementia to acute hospital are inevitable, typically in the case of crisis or end of life care.

The recent Alzheimer's Society Report, 'Support. Stay. Save. – Care and support of people with dementia in their own homes', published in January 2011 argues:

"There are significant perceived negative repercussions when people with dementia and carers do not receive enough support. Insufficient support is thought to lead to an exacerbation of needs and is frequently believed to result in avoidable admission to hospital and early admission to long-term care."

Another report produced by Alzheimer's Society, 'Counting the Cost' found that 47% of carers who were surveyed suggested that being in hospital had a significant negative effect on the general physical health of the person with dementia, which was not a direct result of the medical condition.

RECOMMENDATION 1 Alternatives to hospital admission
Wirral NHS, GPs and Social Services are encouraged to continue to enhance services which reduce the need for people with dementia to be admitted to hospital if at all possible. All staff are encouraged to look positively at alternatives rather than admission to hospital and critically assess whether it is in the best interests of the patient.

6.3.2 The Admission Process

Identification that the patient has dementia - Register of people with dementia
The care provided for a person with dementia in an acute hospital can be directly influenced by the early identification, at the time of admission, that the patient has dementia. The importance of this issue is highlighted in the report, 'Acute Awareness – Improving hospital care for people with dementia' produced by the NHS Confederation in 2010, which comments that:
"Ambulance services and hospitals often come into contact with people with dementia that has not yet been identified and 50 per cent of dementia in a general hospital is unrecognised. Early identification in hospitals is essential to effective care planning and can lead to improved outcomes for the patient, as it reduces the likelihood of that patient's physical and mental health worsening during their stay. The NAO (National Audit Office) argues that effective identification of patients with dementia at admission, together with more proactive, coordinated management of their care and discharge, could produce savings of between £64 million and £102 million a year nationally".

Although GP practices are encouraged to hold a dementia register, action based on the register is not mandatory. The incentive for a GPs' register is provided by the Quality Outcomes Framework (QOF); but not the use of the data. Furthermore, it has already been discussed earlier in this Report (see section 6.1.1) that although GPs are encouraged to hold a register of patients with dementia, analysis shows that there are many cases that remain undiagnosed or, at least, not registered. There is certainly no centralised register available to hospital staff at the time of admission. The development of access to such a register would be beneficial in order to aid care planning.

Identification of patient requirements
The NHS Confederation report, 'Acute Awareness – Improving hospital care for people with dementia' comments that:
"Once patients are identified as having dementia it is very important that their particular needs are recognised and understood. Systems need to be in place to ensure that patients can tell hospital staff how long they have had their condition, what makes the patient feel more comfortable, what needs to be done to ensure that meals are appropriate and other important personal details".

In the past, the Alzheimer's Society has produced a leaflet titled, 'This is Me', which can be used by the person with dementia and / or their carer to fill in when they are admitted to hospital. This captures important data that will assist with care planning. It may be possible to draw on the experiences of Leighton Hospital at Crewe where a proforma was developed called "Information about Me to help You" that patients and carers can complete together with staff. The proforma highlights how it can be discerned that the patient is in pain or is feeling anxious plus personal information such as their previous employment, hobbies and likes and dislikes. The Privacy & Dignity Matron at Leighton Hospital, Phil Pordes, is quoted:
"The key to success we feel is the involvement of patients, carers, families and friends in the care planning process from admission".

In addition, Wirral University Teaching Hospital Trust and Wirral NHS have done some work on developing the concept of a dementia passport, as has been used previously for people with learning difficulties. A health professional commented:

"Patients with Learning Disabilities possess a Health Passport which provides a great deal of information. However, a Health passport is not available for patients with dementia, for example, to describe what a patient likes to eat, medication requirements, and so on".

At the time of admission, there is a need for maximum information to be obtained from the carer or the nursing home. Evidence suggests that this problem is most pronounced for those patients admitted from a residential or nursing home. Discussing the circumstances of her mother's admission to Arrowe Park from a respite care home, one carer informed the panel:

"Information was given to the Respite Home. However, once in hospital, there is a need to identify what the patient likes to eat. That was not done".

It later transpired that no personal information had evidently been transferred to hospital staff.

A hospital professional informed the panel:

"15% of elderly admissions come from care homes. The passing of information from residential care homes to hospital staff is often poor".

Meanwhile another manager commented:

"The patient journey may involve spending several hours in A&E. It is important that in those circumstances someone is available to give information to the hospital staff, for example, last night the wife of a patient was present to give staff a full history of the patient's condition. From a residential home setting, it is important that someone accompanies the person with dementia in to A&E. As an example, it is important that hospital staff need to understand the drugs regime of the patient and what works for them".

RECOMMENDATION 2 Register of patients with dementia / dementia passport
The creation of a local register of patients with dementia, accessible to hospital staff, should be investigated as should the development of a dementia passport. These will enable the early identification of patients with dementia on admission to an acute unit.

RECOMMENDATION 3 Receipt of information regarding the patient with dementia
Processes should be developed to ensure that, at the time of admission of a patient with dementia, maximum information is received from the carer or nursing home. This could include the development of a simple questionnaire to be used in such circumstances.

The admission process

Particular concerns were raised during the review regarding both the length of the admission process and the possible number of moves for the patient within the hospital. Anecdotal evidence suggests that patients who do arrive in A&E can remain there for a considerable period prior to a decision regarding admission. Cases were cited when patients have been in A&E from 9.30am until 6.00pm. It is, therefore, extremely difficult for a person with dementia to cope for that length of time. As a result, a key issue is how the person with dementia is triaged. However, a health professional did advise the Panel Members:

"In the case of a patient with dementia, it is hoped that they will be moved on quite quickly. While on the assessment ward, a full nursing assessment will be carried out with as much information as possible being gathered from the carer or family member".

With respect to the number of moves between wards, the comment was made:
"The admissions process means that patients may move up to four times and then occasionally within a ward. There are not a lot of beds sitting empty on wards. Therefore, there is often little flexibility".

A health professional added:
"As the hospital is so busy, it is inevitable that patients are moved. There is a difficult balancing act that does not go in favour of the patient with dementia".

RECOMMENDATION 4 Minimise the number of moves within hospital
Wirral University Teaching Hospital (WUTH) is requested to develop processes to minimise the number of moves for patients with dementia within the hospital.

6.3.3 Experience on the Ward

Care provided on the ward
Considerable concern was expressed by carers who attended the focus groups regarding the level of care provided on the wards. It is recognised that the presence of patients with dementia on acute wards add to the pressures on staff. However, all patients must receive adequate levels of care and the dignity of the patient should be preserved. The frustration of some carers is reflected by comments to the Panel Members:

"I believe patients with dementia need to be treated with dignity and from many visits to hospital, I have observed this is sometimes not the case because staff don't have time and are not actually in with the patients a lot of the time but have to spend time around the desk. There is often a reason for a dementia patient repeating requests and the temptation may be to ignore rather than spend time getting to the reason. Staff need to have the time to manage the dementia patient for that patient's sake and for the other patients nearby".

"Staff did not seem to realise that it is not like dealing with a normal patient" .

"Families simply do not know what happens outside visiting times".

"There needs to be a lot of trust when caring for a person with dementia".

"Emotionally it is as bad as caring for a child".

A common theme from many of the carers was their belief that a significant number of staff, including nursing staff, appeared to have insufficient understanding of the requirements to care for patients with dementia. In turn, this reflected on their judgement of the level of care provided to the dementia patient. Nevertheless, an experienced health professional reflected that:
"On a busy acute ward, how can you give the extra time that the patient with dementia needs?"

Nutrition / personal care
One specific area of concern for carers is that of the nutrition and personal care of the person with dementia. Circumstantial evidence suggested that support is not available to all patients. For instance, there is anecdotal evidence of patients losing their personal items such as spectacles and dentures. One experienced worker with dementia patients remarked:
"There are cases where meals are left at the end of the bed because no one helps the patient to feed".

Meanwhile, a family member told Panel Members:

"It was not that mum was not eating and drinking; she needed help. The family members sat patiently with mum and slowly but surely she gained weight. People with dementia have to have someone willing to spend time with them. The family did not know what she had been given to eat. If we had gone at meal times we would have helped. However, visiting times were between 3.00pm to 4.00pm and between 7.00pm to 8.00pm. Drinks were always found to be full. However, when helped, mum would usually drink most of it while we were there".

And a carer said:

"No visitors are allowed in the hospital at meal times. It is assumed that staff will do their best given the time constraints. However, often if food is taken in to hospital, the patient will eat it. Some visitors would do anything either in a Care Home or in hospital to help care for their family member. However, the carer is never asked".

Another carer added:

"There were six patients in the same bay; all in a similar condition. All six were not able to take drinks. Nurses don't have the time. We helped others to drink and took in some clothes for another lady. All that is needed is some TLC. What about all those patients who didn't have anyone to care for them"?

However, a health professional commented that:

"Some patients do not want to eat. Staff will also sit and feed patients at meal times if necessary. Family members are encouraged to do that if they want. However, there is a double-edged sword as nurses cannot appear to be pushing families to do it. The role for family members in helping to feed patients is determined by the ward manager".

As a result, it has been suggested that greater involvement of family helpers could be made. It is fully recognised that family members / carers should not feel that they are overly pressured to be involved. However, the point was made that many family members are willing to provide that support. Indeed, one carer informed the panel that she was not encouraged to stay as it would disturb other patients. In the future, it may be possible to offer more flexible visiting times for carers of patients with dementia so that they can help care for the patient who, in turn, would feel more comfortable. The involvement of carers could go beyond meal times and extend into other areas of personal care. Particular concern from carers was raised regarding assistance that is available to assist patients in toileting. Additional support from carers and family members is likely to reduce the disturbance to the routine of the patient with dementia, as it is recognised that the patient can deteriorate quickly if not given support.

However, it is also recognised that, in practice, it is not all relatives who want to actively help. Some may prefer to opt out. In the past, there have been attempts to raise a campaign to get volunteers for assisted feeding on wards. A scheme in Cardiff enabled a named volunteer, who visited twice per day, to be allocated to a patient. Outcomes for the patients were seen to have improved. However, such a scheme will generate issues regarding the training of volunteers and the responsibility of the hospital for the volunteers. Clearly any scheme that invites volunteers or carers into the hospital must take account of safeguarding and infection control.

With regard to further assistance for patients at meal times, suggestions during the review included simply chopping the food into small pieces, alternative menus being written on a board or coloured pictures of the menu being given to patients. There could also be a dignified form of cover to protect the patient's clothes, for example, an attachable napkin rather than a bib.

RECOMMENDATION 5 Assistance at meal times / personal care
Ward staff should welcome offers of help from family / carers to minimise disturbance to the patient with dementia during a stay in hospital. This could include family members being able to support relatives at meal times and aspects of personal care without being pressured to do so.

Contact with carers
A key issue for carers is the relationship which is developed with hospital staff and the subsequent transfer of information. It is important that the information flow is two-way and carers feel involved in the process. The circumstances of patients with dementia were summarised by a representative of the voluntary sector who commented:
"The relationship with staff is different for patients with dementia. There tends to be little day-to-day information. Staff do not share information with family members".

A Carer's representative added:
"I believe carers need to be more closely involved when the patient is on the ward as the carer can give information which will assist in managing the care of the patient".

Meanwhile, a carer commented:
"It was hard to get information from hospital staff"

Although leaflets are available in information racks, it is still difficult to ensure that people collect the right general information. Therefore, improvements could be made in this area, perhaps through the development of a special advice point. Indeed, the panel met one carer who had only recently been put in touch with Alzheimer's Society, six years after his wife had been diagnosed with dementia. This suggests that the need for better signposting spreads well beyond the acute hospital wards. However, it is important that the special role of the carer of a person with dementia is recognised. That can only come through the development of a direct relationship between hospital staff and the carer(s).

RECOMMENDATION 6 Information flow with carers
The special role of carers of patients with dementia should be recognised by staff. Processes should ensure that greater information exchange with carers is established at the outset. This should include ongoing care and developments towards discharge.

6.3.4 Impact of Patients with Dementia on Other Patients During a Stay in Hospital

There are inevitable conflicts that arise both from the viewpoint of staff and of patients resulting from the presence of patients with dementia on acute wards. From the perspective of staff, issues arise regarding ward management as well as behaviour management. The concerns and dilemmas of hospital staff were summarised by a senior health professional:
"As Patients with Dementia are confused, they do impinge on other people in the ward. Sometimes they will wander around the ward or open lockers, and so on. Particularly at night, the disturbance can lead to non-demented patients not being able to settle very well. This can lead to some non-demented patients being rude with comments such as "I don't want to share a ward with mad people". It is not unknown for a patient with dementia to get into someone else's bed or to take their clothes off. The reaction of other patients can sometimes be sympathetic; sometimes offended. Each ward has a mixture of bays and single rooms. The hospital is now in the process of moving towards single sex wards. If a patient with dementia is in a bay, they may disturb other people around them. Alternatively, if the patient with dementia is in a single room, they may wander off as it is more difficult for staff to monitor their movements. Staff on the ward have to deal with an increasing number of situations that they did not anticipate when they did basic training. The care of patients with dementia is going to become an increasing problem".

Another health professional commented:

"It is difficult to manage patients with dementia in a ward. It is very hard, particularly if the patient is mobile. On the late shifts there are only four members of staff on the ward. It is particularly difficult if there are two or three patients with dementia in the ward at the same time".

It is obvious that other patients will expect the staff to be able to do something about the situation. The Panel Members were informed that there are cases when members of staff do get abused. Behaviour can also be worrying for other patients. The positioning of patients on the ward is a judgment for staff as well as depending on the availability of beds. Side rooms are available on the ward, although these are often used for infection control. However, if a patient with dementia is in a side room, it becomes more difficult to observe that patient. The Psychiatric Liaison staff, who are based at Arrowe Park, are available to intervene and help to assess individual needs. It was reported that they are very helpful in suggesting techniques to manage patient behaviour. A professional commented:

"Sometimes it can be our behaviour and our treatment of the individual, not the patient with dementia that sparks the problems".

One health professional did suggest to the Panel Members that if all patients with dementia were nursed on the same ward it would allow the more experienced staff to care for them. It would also be less disruptive for other patients. Meanwhile, it was reported that there are added pressures for staff on late shifts and night shifts. As an example, staff would find it easier if there was an alarm system on the ward. Staff are not allowed to lock the doors on the ward. Therefore, it is not possible to allow patients to wander about as "they could be off to the bus stop". In conclusion, it was noted from interviewees that if there are a number of patients with dementia on the same ward, the nursing care available to other patients is likely to suffer.

Meanwhile from the perspective of other patients and their visitors, other priorities emerge. The differing impacts on other patients can perhaps be summarised by the following two statements, each witnessing very different experiences:

A patient in a medical ward for 48 hours:

"A lady with dementia was in the same bay as myself. Very distressed and demanding. I could not speak more highly of the care and attention she was given almost constantly by the staff. They fell over backwards to reassure and calm her. I did not feel that the needs of other patients were neglected as a result".

Another patient witnessed very different circumstances:

"I experienced a stay in Arrowe Park hospital which included a major operation followed by a period of recovery. I was located in a male-only ward containing six beds. I had no complaints about the staff who carried out their duties, sometimes under difficult conditions. However the behaviour of one patient sometimes during the day but more so during the night was completely unacceptable. At that time he would throw off the bed clothes followed by his pyjamas and lie naked on the floor. Following this, he would crawl from bed to bed in a threatening manner although I am not aware that he actually attacked anybody. The on-duty nurses were summoned and they, with some difficulty, returned him to his bed. This was followed by a short period of normality after which he repeated the same activity. The same routine continued for a few weeks following which a decision was taken at a higher level which resulted in his removal to a more secure ward."

As these examples show, part of going into hospital is the interaction with other patients, some of whom will have some form of dementia. Not all of these contacts are negative. In fact, a professional commented:

"I have witnessed many very positive contacts between patients with and without cognitive impairment".

Evidence shows that the effect of a patient with dementia can be distressing for other patients, especially if the patient is shouting. It can be a frightening experience and patients cannot rest properly. In addition, examples were quoted such as a person dying in one bed adjacent to a patient with dementia, which has led to complaints from relatives. However, a hospital professional reported: "Generally, most patients are incredibly understanding and try to help. They can see that staff are busy. There are complaints from patients because they have had disturbed sleep for days. In some cases, they understand but are not happy because they have had a bad experience".

6.3.5 Ward Environment and Organisation

Environmental issues

The Panel Members were informed that the environment is a key issue for people with dementia. The use of pastel colours and appropriate signage is seen as important. Some wards have made significant effort with signage. There is work taking place to assess, for example, how wards are decorated with colour schemes for particular areas such as a toilet door or the signage.

Progressive work has taken place elsewhere to identify improvements to the hospital environment on behalf of patients with dementia. Such work has taken place at Leighton Hospital in Crewe (Mid Cheshire Hospitals NHS Foundation Trust). Phil Pordes, Privacy & Dignity matron, is quoted: "To help improve the environment there are coloured doors at the entrance to each bay and accessible, clear signage which are helping patients with dementia find their way to and from the bathroom/toilet; promoting both continence and dignity. An Activity Lounge is run twice a week where patients with dementia enjoy games, singing and memory boxes".
The result of the work which has taken place at Leighton hospital has raised considerable interest.

Although there are already some examples of good signage at Arrowe Park, the Panel Members were informed that there is a need to look at possible pilots to improve ward areas, ensuring that best value is obtained from any available resources. Further research is required in this area to identify the effect of these changes. Clearly, if there is a limited pool of money it needs to be focused wherever evidence shows that improvements for patients will be forthcoming. This is one of the areas that the Dementia Strategy Group at Arrowe Park has developed.

Within the ward, positioning of beds is important too. This is a judgment for the staff as well as depending on the availability of beds. Although side rooms are available on wards, they are sometimes used for infection control. However, even when side rooms are available, the professionals were not unanimous regarding the wisdom of placing patients with dementia in side rooms. It was pointed out that, although providing a quieter environment, a patient can also be more isolated in a side room. Furthermore, in the case of a patient with dementia, it becomes more difficult for staff to regularly observe the patient.

RECOMMENDATION 7 Environmental issues on the ward
In order to assist patients with dementia, Wirral University Teaching Hospital is encouraged to investigate further environmental improvements to wards where appropriate. These might include:

- **Clear signage to identify bathroom / toilet**
- **Use of pastel colours**
- **Positioning of beds in the ward**
- **Use of side rooms**
- **Alarm system to prevent patients with dementia from wandering, especially at night when staff numbers are reduced**
- **Use of Activity Lounge for patients with dementia**

Separate dementia ward

There are examples from elsewhere, such as Nottingham University Hospitals and Mid Cheshire Hospitals NHS Foundation Trust (Leighton Hospital in Crewe), where a ward has been developed for managing particular behaviours. During this Scrutiny Review, the issue of a providing a separate ward for patients with dementia has been explored with many of the witnesses. The vast majority of those health professionals who were interviewed showed little enthusiasm for the principle of such provision. As patients with dementia should only be in an acute hospital because they are suffering from another physical condition (other than their dementia), the most common view was that patients with dementia should be entitled to the same level of care that is available on the specialist wards that are available around the hospital. All patients should be dealt with on a ward which is relevant to their physical illness, for example, a patient with dementia in hospital for a knee replacement should be on an orthopedic ward. The proposal also raises the question as to whether wards for patients with dementia are being recreated in an acute hospital while closing beds in psychiatric units. Furthermore, it was pointed out by a health professional that:

"Dementia is so common that all staff should be able to deal with it to a certain level. It is a basic requirement".

Role of specialist dementia nurse / champion

Even though a specialist dementia ward may not be available in an acute hospital, the role of specialist dementia nurses could apply across all relevant wards. A key issue in the development of the Dementia Care Pathway is the need to have adequate staffing levels. A carer commented:

"There should be a specialist nurse who can be called on to provide care for the patient and to talk to the family".

And a representative of the Voluntary sector added:

"The best option may be for a team of specialist dementia nurses available to go to wards to support other staff".

The NHS Confederation report, 'Acute Awareness – Improving hospital care for people with dementia', quotes a carer who makes the request:

"Have a dementia lead or a specialist team: we can't expect all the hospital professionals to be specialists in dementia. After all, people are not normally in hospital because of their dementia and we need someone to treat the condition they have been to hospital for. But if staff know they can call on a team who will help them understand how the care plan can be adapted to include the needs of people with dementia too, we can improve the care of the patient and probably help them leave hospital earlier".

Regarding the delivery of Objective 8 ('Improved quality of care for people with dementia in general hospitals'), the National Dementia Strategy raises the prospect of the deployment of specialist liaison older people's mental health teams in general hospitals. The strategy document comments that:

"Specialist liaison older people's mental health teams are already advocated by the NICE/SCIE (National Institute for Health and Clinical Excellence / Social Care Institute for Excellence) guideline on dementia services. They can provide rapid high-quality specialist assessment and input into care planning for those with possible mental health needs admitted to general hospitals, including input into ongoing care and discharge planning. They will generally consist of a multidisciplinary team of three to four members of staff (part-time consultant, staff grade doctor, nurse and psychologist/ therapist) with administrative support and a base in the general hospital. They can cover the whole range of mental health problems in older adults, not just dementia. These teams can then work closely with the designated general hospital lead to build skills and improve care through the hospital. They need to have good links with the social work assessment teams based in or linked to the hospital. They are already provided in some but by no means all hospitals".

Although, liaison psychiatrists are available on the Arrowe Park site, specialist dementia nursing staff, to be deployed wherever required at a point in time, would also be beneficial. These staff could supplement ward staff when particular difficulties arose. Although dementia champions are, in theory, deployed on wards, evidence suggested that a champion was not consistently available in all relevant wards. However, it was remarked that the deployment of dementia champions wherever possible "ensures that there is more experience than in most hospitals".

RECOMMENDATION 8 The role of specialist dementia nurses
The role of specialist dementia nurses, to be deployed wherever needed in the hospital to support other acute staff, should be considered.

6.3.6 Safeguarding

The Panel Members were informed that, with regard to safeguarding, national statistics of abused older people show that 60% of the recorded incidents are against patients with dementia. Clearly, the Wirral University Hospital Trust must have and does have mechanisms in place to safeguard all patients.

There are many causes, in the general hospital, outside of dementia that can lead to cognitive impairment and agitation and there have to be appropriate systems to manage this in the general hospital. Positive comments were made regarding the aggression management team within Arrowe Park and the adult safeguarding team. Indeed, the dementia pathway identifies the need for appropriate risk assessment, training of staff and an appropriate environment leading through to identifying early warning signs and the management of aggression itself. In addition, security systems on wards to prevent patients from wandering, particularly at night when staff ratios are lower, would potentially enhance the safety of more vulnerable patients.

It is clearly the case that staff need to distinguish between patients with dementia and patients who may be elderly but just upset, suffering medication side effects or grumpy. Anecdotal evidence suggested that, in circumstances of aggression management, staff may call in security to manage a patient. The wisdom of calling in security men, who are likely to appear frightening and aggressive to a patient with dementia, was raised. The point was made that nursing staff are probably more adept at managing a patient's response.

RECOMMENDATION 9 Safeguarding
The deployment of security staff to manage patients with dementia should be avoided if at all possible. (Further recommendations for staff training and availability of experienced staff reflecting the number of patients with dementia on a ward at any one time should assist with the management of disruptive behaviours).

6.3.7 Discharge Process

Speed of discharge process
One of the principles that the Panel Members are proposing is: "If a patient with dementia is admitted to hospital, their stay in hospital should be kept to a minimum period and, while in hospital, the patient should be subject to as few moves as possible". It is fully recognised that discharge planning is a major challenge, not only for the hospital trust but also for related partner organisations.

With regard to the care of patients with dementia, a health professional commented:
"It is worth reinforcing the point to limit a stay to as short a time as possible".

However, it is fully recognised that Wirral University Teaching Hospital Trust and Wirral NHS have invested considerable time and effort on reviewing and improving the general discharge process over the last two years. Significant progress has been made in re-designing processes to enable a more efficient and effective discharge system. If a patient with dementia has to be in hospital, the work already undertaken by the Integrated Discharge Team should help. As an example, on a daily basis, appropriate staff, including the patient flow practitioner and a social worker, discuss discharge requirements for each patient on the ward from the day of admission, including gathering information about circumstances pre-admission. In the case of a patient with dementia, the process should include the carer, who needs to be involved in order to determine their needs.

However, it is inevitable that the planning process will be more difficult in more complex cases. Therefore, delays can occur. It was explained that delays may occur for a number of reasons. Once in the acute care environment there is a sense that all investigations and treatment need to be done prior to discharge, for example, occupational therapy, physiotherapy, social services assessment and so on. Professionals, families and care homes appear to have an expectation that all the issues will be resolved during the stay in hospital. In some cases, the patient cannot go home until the package of care has been increased or the residence has been changed and delays can occur whilst funding is arranged.

In order to reduce the length of stay in hospital for a patient with dementia, it was suggested that Community Psychiatric Nurses should be contacted at the earliest opportunity following admission. This would enable planning for the potential support at home to begin as soon as possible. The workload of the duty social worker and also the fact that Social Services sometimes do not get involved in the process early enough were also cited as examples of potential delays in the planning process.

Overall, evidence suggests that relatively few discharges are delayed due to waiting for care packages. However, it is possible that where this is a cause of delay, the proportion involving patients with dementia may be relatively high as they are among the more complex discharge cases. There was also anecdotal evidence, on the other side of the coin, of a family feeling under pressure to arrange for the patient to be discharged ‘too early’ in order to avoid the possibility of losing the place in the Care Home. Otherwise a longer period in hospital would have allowed a further period of occupational therapy. Nevertheless, the availability of occupational therapy should not be a reason for a delay in discharge anyway as that service should be readily deliverable in a care home.

Anecdotal evidence suggests that a key issue is that some patients are being discharged with no adequate care plan. There continue to be negative comments based on the experiences of carers. It is essential that carers are an integral part of the discharge planning process. A key issue for discharge planning is to ensure that patients are aware of the plans for their discharge as soon as possible. The aim should be to give the patient / carer an indication of discharge plans within 24 hours of admission.

A carer’s representative also made the point that the hospital should be more proactive in ensuring that, at the point of discharge, adequate physical support / care is available for the patient, particularly when the carer is elderly.

In conclusion, it should be recognised that, in the case of patients with dementia, there is a balance between the short-term gain (of needing physical support) and the long-term deficit (of being away from ‘normal’ surroundings for a lengthy period).

RECOMMENDATION 10 Discharge planning
Support is given to the principle of long-term care needs not being decided from a hospital bed. Planning for discharge from the time of arrival must involve the carer(s) with the prime objective being to discharge the patient to the residence of origin wherever possible.

Destination following discharge

A health professional informed the Panel Members:

"A stay in hospital can often 'tip' a patient with dementia into residential care. It can also sometimes be the case that the stay away from home can allow the carer to reflect that they are no longer able to cope".

Meanwhile, another added:

"In terms of discharge planning, the aim should be that no one leaves from a hospital bed and moves to a residential care bed".

And another:

"The best place for the person comes down to a balance for the individual between their physical health and their mental health".

The number of specialist care beds for people with dementia in Wirral was seen as a major issue by some of the witnesses interviewed during this Scrutiny Review. Current options available to avoid 24 hour care include the Wirral Admissions Prevention Service (WAPS) who will care for people in the community. However, there is not a HARTs service (Home Assessment Reablement Team) to support enablement specifically for the rehabilitation of patients with dementia. On the assumption that long-term decisions should not be made from a hospital bed, there need to be greater options of intermediate care. Other options at present include the rehabilitation wards at Arrowe Park (wards 36 and 25) or 24 hour care.

In terms of options for a patient with dementia, needs are more complicated and not as easy to plan for as people with physical health needs where care required tends to be more predictable. Limited specialist places in the community are available, for example, 10 tenancies at Cherry Tree House for those with a high-level need. For those in their own home, the challenges are even bigger. Support may not be available when it is most needed. It was pointed out that one potential gap in the current service is night-time support.

The impact of a stay in hospital on a person with dementia can be profound. It is sometimes the case that, after a physical illness, a patient with dementia never quite gets back to the level that they were before the illness. It is not always possible to get people back to where they were. As a result, evidence has suggested that patients with dementia are discharged too often into 24 hour care. The Alzheimer's Society Report, 'Counting the Cost', produced in 2009, estimated that, nationally, over a third of people with dementia who go into hospital from living in their own homes are discharged to a care home setting.

One officer informed the Panel Members:

"Once admitted to hospital, there is a high possibility that the patient will eventually be discharged to care and not back to their own home".

A hospital manager explained:

"Once a patient is in hospital, it is necessary to look toward the possibility of 24 hour care. There is a need to give people the choice to have appropriate packages of care. It is true that patients with dementia become more disabled in hospital because they get more confused, are more susceptible to infections, and so on. If they are turned around at the front door they may not end up in care".

One experienced health professional commented:

"There is currently a gap in the provision of interim or intermediate care beds for patients with dementia. Relatively few people go to beds provided by the Cheshire and Wirral Partnership Trust. The new bed provision at Clatterbridge looks very promising, with outside access and lots of single room accommodation. However, overall, there are a reduced number of beds for dementia services. Therefore, lower numbers of patients are going to that sort of setting. As a result, a patient is now more likely to end up in an Acute General Hospital Ward. There is now more provision of care for patients with dementia in the private sector than there use to be, but as some are very difficult cases, not everyone might want to take them on. There is also an issue regarding the provision of respite care in the community".

Meanwhile, another made a request for the future that there was:

"The need for intermediate care for mental health problems, either provided through a central service for Wirral or alternatively through a locality-based service."

It is recognised that the development of reablement and intermediate care services for older people, which will include people with dementia, is already a priority of Wirral NHS and other partners. It is understood that there are currently 13 specialist beds for patients with dementia in Wirral provided by Cheshire and Wirral Partnership Trust. Although the average occupancy rate is estimated to be 85 % (or the equivalent of 11 full-time beds), the occupancy rate does fluctuate.

Care packages

It can take time to assess the package of care that is required. The medical assessment can take a number of days before the case is passed to social care for approval and then brokerage. A further time constraint depends on the availability of an agency to pick up the care package. This, therefore, raises the question of whether services can be facilitated faster, particularly in cases where this would prevent a patient from being discharged into a care home. A more efficient process, reducing the need for large quantities of paperwork, would enable cases to be dealt with more quickly. It was reported that assistance provided by the Patient Flow Practitioners in completing the Decision Support Tool information has helped to speed up this process. One health professional commented:

"It takes a minimum of two or three weeks to get a patient through the assessment bureaucracy".

Meanwhile, another added:

"If you get a system where you have to fill in pieces of paper there will be delays".

Followed by another who said:

"The paperwork is immense. It is a hideously slow progress".

The early involvement of social workers, as well as carers, in the discharge planning process helps to mitigate against any delays occurring.

RECOMMENDATION 11 Care requirements following discharge
Appropriate discharge needs include:
- **Reducing the time taken for the care assessment**
- **Prompt availability of care packages including reablement support**

An alternative pathway for patients with dementia may involve the development of a short-term assessment unit and / or an intermediate care service.

6.4 **Staff Skills and Training**

As discussed earlier in Section 6.3.3 ('Experience on the Ward'), a common theme from many of the carers was their belief that a significant number of staff, including nursing staff, appeared to have not sufficient understanding of the requirements to care for patients with dementia. The NHS Confederation report, 'Acute Awareness – Improving hospital care for people with dementia' comments that:

"Awareness can be raised through internal training. Dementia leads play a key role in this, both by ensuring that dementia is high on the hospital training agenda and by being able to support staff who need to improve their knowledge of the condition. While it is important for professionally regulated staff to receive detailed training on dementia, any training strategy needs to include other front-line staff, ambulance crews working in patient transport, healthcare assistants, porters and catering staff. All these groups should have some knowledge and understanding of dementia".

However, it is recognised that significant effort and progress has been made by Wirral University Teaching Hospital Trust regarding staff training specifically in the care of patients with dementia. One senior health professional informed the panel that:

"There is good training for staff regarding dementia. Conflict resolution training is also included".

The National Service Framework for Older People (developed in 2001) included a standard that all areas should have an expert in older people's care. The implementation of this standard led to an audit of skills. The average trained nurse recorded a self-perception of coping with patients with dementia as very low. Since that time, the staff have been re-audited and, although self-perception has increased, it is acknowledged there was still more to do. There is recognition that, although staff need to be confident in managing the patient with dementia, many do feel uncomfortable in caring for such patients. There is a need to raise the general level of understanding of dealing with patients with dementia. Indeed, the point was made that there is such a high throughput of patients with dementia in the acute hospital, particularly the DME wards (Department of Medicine for the Elderly), that staff really must be trained in the competencies to manage this type of patient.

Nevertheless, there is no statutory requirement at all for the hospital to train non-medical staff in caring for patients with dementia. The Trust has not placed a mandatory element on the training, although Departmental managers will encourage staff to attend and Ward managers suggest the names of attendees. The interim report of the National Audit of Dementia (The Royal College of Psychiatrists, December 2010) estimates that 95% of hospitals do not have mandatory training in dementia awareness for all staff whose work is likely to bring them into contact with patients with dementia. The argument was made to the Panel Members that it would not be feasible for the dementia training to be mandatory. Trainers are not available to provide sufficient time and bigger groups of attendees would reduce the benefits of the course. There is the also the cost of releasing staff from the wards with the resultant cost of backfill for the staff.

It is important to recognise that Wirral University Teaching Hospital was the first trust in the country to obtain input from the Alzheimer's Society in providing relevant training to staff. The training enabled staff to develop coping mechanisms for managing patients with dementia. The courses, for which there was a waiting list, were delivered separately for trained nurses and untrained staff. In addition, there were courses for which the target audience was non-clinical staff such as porters and cleaners. The courses incorporated the dignity of patients, included role play and were very interactive.

Although staff on some wards have practical expertise, not all have been formally trained in caring for patients with dementia. A particular problem was described with respect to bank staff, some of whom are claimed to have limited training and experience of patients with dementia.

There is general support for the provision of dementia training and willingness to attend from many staff. However, there appears to be a difficulty in arranging for some groups of staff to attend the training sessions, for example, staff in Accident & Emergency Department (A&E), security staff, ward managers and doctors. There is anecdotal evidence that following the training, staff do not receive adequate support when they return to their wards and try to apply their training.

As one witness informed the panel:
"It is more cost-effective to prevent issues from occurring than it is to recover from them".

Evidence suggests that a major priority for the future should be training of staff. Indeed, the Dementia Care Pathway proposes that dementia training course is compulsory for certain staff groups. Although higher attendance at dementia training courses is to be encouraged, the availability of on-line training modules may be useful method to supplement the more traditional form of training that has been available.

In the longer term, the Panel Members support the principle of training in the care of patients with dementia being more fully integrated into undergraduate courses for nursing. Clearly, this can only be achieved through the support of the appropriate national bodies, such as the Nurses and Midwives Council. Therefore, qualifying bodies should be encouraged to ensure that professional training fully incorporates dementia awareness.

RECOMMENDATION 12 Staff training
Participants in training sessions regarding the care and management of patients with dementia should be expanded to include:

- **Doctors**
- **Ward managers**
- **Triage nurses**
- **Paramedics and ambulance staff**
- **Security staff**

More staff from all appropriate wards should be involved in dementia training, which could include on-line modules.

6.5 Alternatives to Hospital for Patients with Dementia

6.5.1 Caring for More Patients at Home

Increasingly, over recent years, greater emphasis has been placed on encouraging people with dementia to be at home. However, carers need to be supported for that to happen. Otherwise, there will be more carer breakdown. During the review, managing people with dementia at home was widely seen as a positive approach. However, further progress is required to avoid the problem of a person with dementia having to go into hospital when they are not ill, for example, because of carer breakdown. There has been a culture that, once in hospital, a person with dementia is more likely to be discharged into full-time care. In addition, pressure can also come from the carer who, as a result of their family member being in hospital, realises that they are not able to cope with the responsibilities of caring anymore. It is therefore difficult to ensure, that once admitted to hospital, a patient with dementia is returned to the residence from which they were admitted.

The recent Alzheimer's Society Report, 'Support. Stay. Save. – Care and support of people with dementia in their own homes' reports that, following a carers' questionnaire, it was estimated that 83% of carers and people with dementia said being able to live in their own home was very important to the person with dementia.

If there is not a service in the community to assess and support them, a person with dementia may well turn up at hospital. As a result, they are likely to be admitted. There is wide recognition that a change of environment is likely to cause problems for a person with dementia. The Panel Members were informed by a health professional that:

"It is true that patients with dementia become more disabled in hospital because they get more confused, are more susceptible to infections, and so on. If they are turned around at the front door they may not end up in care".

However, the Panel Members were informed that 60% of patients are admitted with chronic confusion. Medical staff do not know whether it will settle in a day or two. In theory, the suggestion to treat more people with dementia at home sounds like a good suggestion but, in practice, it can be difficult to separate dementia patients from those with sub-acute confusion. It is further recognised that the care for patients with dementia is very time-consuming for staff in any setting.

One health professional informed the Panel Members that:

"The question needs to be asked 'Why cannot conditions be treated in the community?'. If a patient is admitted because of their dementia it says failure in the system to me".

Meanwhile, another commented that:

"If people are acutely unwell they need to be in hospital. Once they are fit, they should no longer be in hospital. There is a need to have services in the community to support them".

The case for change was summarised by one witness:

"The feedback I receive from staff in the General Hospital is that there are a number of patients with dementia who do not need acute care but who are admitted to the general hospital around a crisis or end of life care. A culture shift will need to take place in order for this to change. This is around earlier diagnosis and pre-planning. Once the diagnosis is made we know the likely course of the illness and what challenges they are likely to face. There are currently limited community based resources to support a patient in crisis available for people with dementia".

A computerised model developed two years ago (CSED - (Care Services Efficiency Delivery) determined how best to intervene. A key message is that if you do not intervene at an early stage, subsequent intervention will not have a big impact on admissions to hospital during a period of crisis. The best option is to provide low level support at an early stage (to prevent a crisis occurring). This level of support also gets the family into the practice of accepting help. It can be the case that a person with dementia is admitted into hospital because the carer(s) did not know where to get help from.

However, some frustration was expressed as there are few services to provide a quick response to crises in Wirral. It can take a significant length of time to get packages of care set up, particularly in more complex cases. As an example, on a Friday afternoon, the easiest option is admission to Arrowe Park rather than trying to provide support services to keep a patient with dementia in their own home. Wirral NHS no longer has a Fast response Team which formerly provided support for up to 48 hours in an emergency. A witness commented to the panel:

"The most important issue is to understand the real reason for a patient being in an acute hospital. A significant number of patients are admitted into hospital because their family members cannot cope. The simpler solution is for the patient to be admitted, as there is nowhere else to take him. There is a need for rapid access mental health services".

While another added:

"Where, other than hospital or their GP, can people go in an emergency?"

And another commented:
"The system ought to be able to provide fast response to crisis, for example, what happens if a carer is taken ill? In general, the current support services are provided on a 9 to 5 basis. Can we facilitate services faster to prevent a person with dementia from having to go into care by which time care packages have to go to brokerage. This greatly extends the timescales for being able to put services in place".

However, all of the facilities and support in the community are not currently in place to enable that to happen. The links between the hospital and the community are not as robust as they need to be. There is currently no specialist dementia home care service in Wirral. It was explained that one difficulty with planning services for a person with dementia is knowing the stage of the disease and assessing how long it is possible to keep someone at home. Evidence available to the Panel Members suggested that in some areas, for example, Liverpool, there are more services to keep people with dementia out of hospital, for example, short-term care packages. The specialist home care service in Liverpool is regarded as having been very successful at keeping people in their own home. This service is an integrated service which includes health and the Community Psychiatric Nurses, who are key to the provision. Therefore, a patient has to have a definitive diagnosis in order to qualify for the service. It is possible to manage behaviours because of the close relationship between the care services and health staff. Although the Crisis Resolution Home Treatment Service exists in Wirral, patients with dementia are specifically excluded. This service, run by the Cheshire & Wirral Partnership Trust, is geared for mental health patients rather than dementia.

A senior professional commented:
"There is a case for creating a team to intensively care for patients with dementia in their own homes. The aim should be to facilitate caring at home for longer".

There are other barriers to enabling people with dementia to remain in their own home. There is a fundamental challenge which needs to be met. It is not true that it is unsafe for a person with dementia to be at home and that it is safe elsewhere. There are risks in both scenarios. Care homes are not risk-free. It was explained to Panel Members that it is important to understand that it is not risks versus safety; but risks versus another set of risks.

In the future, improved technology will help to keep people in their own homes. Although assistive technology can be very useful, it also raises particular challenges when related to patients with dementia. The client needs to have an understanding to be able to push buttons at the appropriate time. However, the use of technology such as sensors and pressure pads can be very useful. As an example, sensors were fitted in the home of a man with dementia. It was discovered that the man was getting out of bed during the night and wandering in the house in an attempt to find the fridge in the kitchen. As a result, it was possible for the man's eating patterns to be changed, which resulted in him being more settled. Assistive technology enables that detailed type of assessment.

Enhancement of services such as the development of Dementia Support Services, provided by the Alzheimer's Society and the re-design of the Memory Clinic service in Wirral, to enable better links to the voluntary sector, will enhance services available in the community. Suitable sites are also being sought in the three localities of Wirral (Bebington & West Wirral, Birkenhead and Wallasey) in order to provide a more accessible service with better signposting to further services.

There is also generic work taking place that is not aimed specifically at patients with dementia but which may also help. As an example, 'Integrated Care at Home' is being developed in each of the three localities. It will enable more of the 24 hour, seven day service for people at home. This will include up-skilling to allow the provision of intravenous therapy and so on.

On the occasions when admission to acute hospital is necessary for a person with dementia, it may not always be possible for them to be discharged back to their own home. Professional advice throughout the review was clear that long-term decisions, such as moving to a care home, should not be made from a hospital bed. Therefore, in this context, the greater availability of intermediate beds has been seen as a very positive step in order to enable quicker discharge from the acute wards, although some professionals did argue that specific mental health provision was needed. The same case was made for the provision of respite care in the community.

RECOMMENDATION 13 Crisis Response Team / Specialist Home Care Dementia Service
Recognising that any move from familiar surroundings is likely to exacerbate dementia, people with dementia should be cared for in their own home or residential / nursing home if at all possible. Therefore, Wirral NHS is encouraged to investigate the feasibility of developing a Crisis Response team and / or a Specialist Home Care Dementia Service to keep patients with dementia in a familiar environment.

6.5.2 Residential and Nursing Homes

An NHS Wirral report, ‘Implementation of the National Dementia Strategy’ estimates that, at a national level, at least 50% of long term care residents have dementia. It is understood that there are too many people with dementia in long-term care, although this figure is now starting to reduce. A witness informed the panel that approximately 15% of elderly hospital admissions come from care homes. It is frequently the case that a person who is moved to a care home will end up in hospital. For many of these patients it is not helpful in the long-term. The case was made that there is not sufficient specialist dementia care available in care homes. A health professional commented:
“The system for providing specialist medical care for care homes in the UK is very poor”.

During the review, it was claimed that, with additional support, it should be possible to reduce the number of admissions from residential or nursing homes. As an example, a patient with dementia who has a chest infection could be cared for in a residential home given WAPS (Wirral Admissions Prevention Service) support. Nursing homes must provide sufficient staffing as per Care Quality Commission regulations. Although Wirral NHS will provide advice and support, there is a legal requirement on nursing homes to provide adequate staffing levels.

In the past, much work has been done to provide support and advice to Nursing Homes in the borough. If there is a need for injections and antibiotics, WAPS (Wirral Admissions Prevention Service) are available to provide support. However, Wirral NHS is also working on a plan to further develop a service to work with nursing homes to prevent admissions. Nursing homes have nurses, but they are not specialists. Therefore, a scheme is being developed whereby Wirral NHS will support nursing homes, provide training and provide specialist skills. This project will cover both nursing and residential homes. Training is provided to nursing homes by Wirral NHS on topics such as nutritional standards and continence.

There is also an ongoing project with EMI (Elderly Mentally Infirm) to reduce medication for the elderly. One care home found that by increasing fluid intake, the number of falls and broken bones was reduced. Likewise, the aim is that by reducing medication, the number of falls can also be decreased.

In terms of the future, Quality Premiums linked to activities may help to provide incentives to care homes to provide different services.

RECOMMENDATION 14 Nursing Homes
The current work undertaken by Wirral NHS to provide support to nursing homes to enable fewer patients to be admitted to hospital is endorsed. This practice should be extended wherever possible.

Appendix 1 : Scope Document for the Dementia Scrutiny Review

Date: 1st July 2009

Review Title: 'The Care of People with Dementia in Hospital' Scrutiny Review

Scrutiny Panel Chair: Cllr Ann Bridson	Contact details: 0151 201 7310 mobile: 07759 587597
Scrutiny Support Officer: Alan Veitch	Contact details: 0151 691 8564
Departmental Link Officer: Jeanette Hughes, Department of Adult Social Services, Wirral Borough Council	Contact details: 0151 604 7226
Panel Members: Cllr Ann Bridson Cllr Denise Roberts Cllr Sheila Clarke Cllr Chris Teggin	 0151 201 7310 mobile: 07759 587597 0151 652 3309 0151 608 1154
Other Key Officer contacts: Michael Monaghan, Wirral University Teaching Hospital	

1**. Which of our strategic corporate objectives does this topic address?**

1.1 To Improve Health and Well-being for all, ensuring people who require support are full participants in mainstream society, in particular:
- To Improve support for those with mental health problems
- To Promote greater independence and choice

2. **What are the main issues?**

2.1 Management of patients with dementia in an acute hospital setting.
2.2 Impact of patients with dementia on other patients during a stay in hospital.
2.3 Are there alternative approaches which allow more patients with dementia to be cared for outside an acute hospital setting?
2.4 Is it possible to support more people with dementia in their own home?
2.5 What support is available for carers?
2.6 Is it possible to support more people with dementia in residential or nursing home rather than acute hospital?

3. **The Committee's overall aim/objective in doing this work is:**

3.1 To improve care management in an acute hospital setting for both patients with dementia and for other patients.
3.2 To identify possible alternative approaches to hospital admission for people with dementia and their carers.

4. **The possible outputs/outcomes are:**

4.1 Improved services in a hospital setting for patients with dementia.
4.2 Better experience for general patients who have interaction with patients with dementia.
4.3 Identify possible alternatives to acute hospital admission.
4.4 Ensuring that assessment and discharge of patients with dementia is effective and in the shortest possible timescale.
4.5 Reducing the number of admissions of people with dementia.
4.6 Assisting people with dementia to maintain their life skills.
4.7 Ensuring that patients with dementia are safeguarded.
4.8 Improving the experience of the carers of people with dementia

5. **What specific value can scrutiny add to this topic?**
To use the experiences of those who work closely with people with dementia (such as hospital managers, advocates, family / carers, charitable / voluntary organisations and the Older Peoples Parliament) in order to identify any changes which would lead to the outcomes listed in section 4 above.

6. **Who will the Committee try to influence as part of its work?**
6.1 Wirral University Teaching Hospital
6.2 Wirral NHS
6.3 Cheshire and Wirral Partnership NHS Foundation Trust
6.4 Department of Adult Social Services, Wirral Council
6.5 Appropriate Cabinet members, Wirral Council
6.6 Private sector residential and nursing homes

7. **Duration of enquiry?**
Aim for the final report to be available before the Health and Wellbeing Scrutiny Committee due to be held on 10th November 2009

8. **What category does the review fall into?**

Policy Review	X ☐	Policy Development	X ☐
External Partnership	X ☐	Performance Management	☐
Holding Executive to Account	☐		

9. **Extra resources needed? Would the investigation benefit from the co-operation of an expert witness?**

The review will be conducted by councillors with the support of existing officers.
However, the panel are looking for advice from people with expertise on this topic.

10. **What information do we need?**

10.1 **Secondary information (background information, existing reports, legislation, central government documents, etc).**	10.2 **Primary/new evidence/information**
10.1.1 Recent Committee reports.	10.2.1 Experience of carers / family members.
10.1.2 Relevant evidence that arose during the Hospital Discharge Scrutiny Review.	10.2.2 Experiences gathered from support groups, charitable / voluntary organisations and the Older Peoples Parliament.
10.1.3 Relevant Department of Health documents, including the National dementia Strategy.	10.2.3 Interviews with key officers.
10.1.4 Reports from other councils into similar topics.	10.2.4 Relevant statistics on diagnosis and admissions of patients with dementia.

10.3 **Who can provide us with further relevant evidence? (Cabinet portfolio holder, officer, service user, general public, expert witness, etc).**	10.4 **What specific areas do we want them to cover when they give evidence?**
Contacts may include: Carers and family members. Carers Groups Age Concern (including the Devonshire Centre) Sue Newnes (Alzheimer's Society, Wirral) Other charitable / voluntary organisations Ken McDermott and other representatives from the Older Peoples Parliament, **Wirral NHS** Tina Long (Director, Strategic Partnerships) Debbie Mayer (Acting Deputy Director, Strategic Partnerships) Jenny McGovern (Integrated Commissioning Manager) Heather Rimmer (Interim Head of Integrated Commissioning and Mental Health) **Wirral University Teaching Hospital** Michael Monaghan (Director, Nursing and Midwifery) Lesley Hutchinson (Patient Flow Manager) Marie Jeffries (Lead nurse for Medical Directorate) DME Consultants **Cheshire and Wirral Partnership NHS Foundation Trust** Peter Cubbon, Chief Executive Avril Devaney, Director of Nursing, Therapies and Patient Partnership Dr Andrew Ellis, national expert **Department of Adult Social Services, Wirral Borough Council** Jeanette Hughes, Team Manager Pete Gosling, Principal Manager	10.4.1 Current arrangements 10.4.2 Areas for improvement 10.4.3 Possible management of people with dementia outside the acute hospital setting.

11. **What processes can we use to feed into the review? (site visits/observations, face-to-face questioning, telephone survey, written questionnaire, etc).**

11.1 Discussion with family / carers and support groups, etc..
11.2 Desk-top analysis
11.3 Interviews of staff
11.4 Possible written questionnaire aimed at family / carers (similar to that produced on Hospital Stays by the Older Peoples Parliament)

12**. In what ways can we involve the public and at what stages? (consider whole range of consultative mechanisms, local committees and local ward mechanisms).**
12.1 Family and carers
12.2 Relevant organisations, for example, Older Peoples Parliament, Age Concern and Carers groups

Appendix 2 : List of Witnesses

The Panel has employed a number of methods to gather evidence:

1. Meetings / Visits with officers
A series of individual meetings has taken place at which the Panel Members could discuss relevant issues with key officers from each of Wirral University Teaching Hospital Trust, Cheshire and Wirral Partnership Foundation Trust, Wirral NHS (PCT) and Wirral Borough Council. Meetings were also held with representatives of the Third Sector. Those interviewed during the course of the review were:

Wirral University Teaching Hospital Trust (Arrowe Park Hospital)
Alison Wilkinson (Ward Manager, Ward 22 – Department of Medicine for the Elderly – DME)
Andrew Swan (Adult Protection Lead)
Chris Kennedy (Directorate Manager, Emergency Care)
Chris Turnbull (Clinical Director, DME)
Dr John Russell (Consultant, Department of Medicine for the Elderly – DME)
Lesley Hutchinson (Patient Flow Manager)
Mike Brett (Ward Manager, Ward 37 – Medical / Respiratory)

Wirral NHS
Lisa Cooper (Clinical Director, Provider Services)
Tina Long (Director of Strategic Partnerships)
Debbie Mayor (Acting Deputy Director, Strategic Partnerships)

Cheshire and Wirral Partnership Foundation Trust
Dr Andrew Ellis (Clinical Director, Adult Mental Health Services)
Dr Mike Rimmer (Liaison Psychiatrist)

Wirral Borough Council
Pete Gosling (Principal Manager, Access & Assessment, Department of Adult Social Services)
Anne Bailey (HARTS - Service Development Manager, Department of Adult Social Services)
Jeanette Hughes (Team Manager, Department of Adult Social Services)

Third Sector
Myrtle Lacey (Chief Executive, Age Concern, Wirral
Chriss Kenny (Senior Manager Care Services, Devonshire Centre
Sue Newnes (Support Services Manager, Alzheimer's Society, Wirral)
Ken McDermott (Representative of Wirral Older People's Parliament and Carer)

2. Meetings with carers of People with Dementia
During the review, Panel Members aimed to learn from the experiences of those most closely involved in caring for people with dementia. Therefore, two focus groups involving groups of carers were held as follows:
Devonshire Centre, Age Concern – 26th November 2009
Lonsdale Centre, Alzheimer's Society – 21st April 2010

3. Written Evidence
Written evidence was received from a variety of sources. This included specific evidence received by email from the following:
Sandra Wall (Wirral Older People's Parliament)
Jean Maskell (Carers Representative, Wirral LINk)
Sheila Kennedy (Member, Wirral LINk)
Keith Troughton (Merseyside Fire & Rescue Service)
Julia Simms (Head of Medicines Management, NHS Wirral)

Appendix 3 : References

Wirral documents

'Dementia Services in Wirral', Report to Social Care, Health and Inclusion Overview and Scrutiny Committee, 24th November 2008.

'A Strategy for Services for Older People with Mental Health Needs', produced by NHS Wirral and Wirral Department of Adult Social Services, April 2009

Wirral Joint Strategic Needs Assessment, 2009/10, produced by Wirral NHS

Wirral NHS document 'National Dementia Strategy', which provides a response to the National Strategy for Wirral.

'Investment to help Wirral dementia patients', Wirral Borough Council Media Release, dated 11th February 2009

'Wirral to lead the way on new National Dementia Strategy', Wirral Borough Council Media Release, dated 27th June 2008

National reports

'World Alzheimer Report 2010: The Global Economic Impact of Dementia' , Alzheimer's Disease International, dated 2010

'Dementia 2010: The economic burden of dementia and associated research funding in the United Kingdom' – A report produced by the Health Economics Research Centre, University of Oxford for the Alzheimer's Research Trust

'Living Well With Dementia: A National Dementia Strategy', Department of Health, published 2009

'Living Well With Dementia: A National Dementia Strategy – Implementation Plan', Department of Health, published 2009

'Quality outcomes for people with dementia: building on the work of the National Dementia Strategy', Department of Health, September 2010

'Acute Awareness – Improving hospital care for people with dementia', NHS Confederation, 2010.

'Counting the Cost – Caring for people with dementia on hospital wards', Alzheimer's Society, 2009

'Support. Stay. Save. – Care and support of people with dementia in their own homes', Alzheimer's Society, January 2011

'Improving Dementia services in England – an Interim Report', National Audit Office, 14th January 2010

'National Audit of Dementia', Interim Report, The Royal College of Psychiatrists, December 2010

Other Documents

'Dementia "losing out" to cancer in funding stakes', BBC website, 3rd February 2010

'Mental Health Intermediate Care team for Older Adults', Mental Health News, January 2010

Mental Health News, 'Dementia Care in an acute setting', Mental Health News, 14th July 2010 – referring to work undertaken at Leighton hospital, Crewe.

DH Care Networks website, 'CSED supporting successful Integrated Care and Support Pathway Planning (ICSPP)', 22nd February 2010

Appendix 4 : List of tables

Table	Description	Section	Page
1	Dementia prevalence on GP registers (2008/9) in Wirral	6.1.1	11
2	Projections of dementia Prevalence in Wirral for over 65's (from a base figure of 2008)	6.1.1	11
3	Objectives of the National Dementia Strategy	6.2.1	13

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Interim Report on Domestic Violence by Panel of the Health and Wellbeing Overview and Scrutiny Committee 2010/11

Committee Members

Moira McLaughlin (Chair)

Ann Bridson

Pat Glasman

Cherry Povall

Background to setting up the Panel

At the start of the 2010 municipal year, the Health and Wellbeing Overview and Scrutiny committee highlighted the area of domestic violence as one about which little firm information was known by committee members, and which they believed was a subject that was often shied away from, as being too uncomfortable to confront.

For these reasons, the committee felt it would be informative to examine the issues in more detail through a panel investigation.

A panel of 4 members was set up. Cllrs Pat Glasman, Ann Bridson and Cherry Povall expressed an interest in being part of the panel and Cllr. Moira McLaughlin agreed to act as chair.

The panel have met each month, and have been supported in their work by Gill Barr and Jayne Reid from the Family Safety Unit (FSU) of the WBC, Steve McGilvray from the Community Safety Team, Dave Swarbrick , Area Team Manager from Wallasey from CYDP, Julia Hassall Branch Head CYPD, all from the Council.

They have also been supported by Val Saunders from Wirral Women's and Children's Aid, Dave Grisenthwaite from Merseyside Police and Ann Potter from Barnardos.

The panel would like to thank each of these for their informative help and also for the work they do on a day to day basis in this very difficult area.

This report represents an interim summary of the panel's work to date and it is the intention to carry over the investigation to the next municipal year, if the next Chair and Cttee members agree.

Context of Report on Domestic Violence

The Government defines domestic violence as "Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

All forms of domestic violence stem from the abusers' desire for power and control over other family members, and although every situation is unique, there are common factors involved.

It is estimated that 1in 4 women will suffer domestic violence at some time in their lives, and though it is recognised that incidents of domestic violence are found in every socio-economic group, it is also recognised that a major contributory factor to increased risk is poverty. This is a particular concern as Wirral has some of the most deprived wards in the country within its boundaries.

In monetary terms, the cost of domestic violence is huge, at an estimated £13billion annually which breakdown as follows £3.1 B cost to the State, £1.3 B to employers and a human suffering cost of £17B (Walby 2004).

This figure is based on the cost to the criminal justice system, Healthcare, cost of treating mental illness, housing and legal costs.

Though those figures are startling, the researcher believes that is probably an underestimation, as many public services do not collect information.

The number of women supported by domestic violence services on a typical day was surveyed in Nov 2006 at being 11, 310 and this represented a rise of 50% on the 2003 figure.

See appendices of Scoping document, Graphs of wards comparisons for Wirral, list of incidents in Wards of Wirral and glossary of terms

Panel Investigation

Panel started the investigation by looking at the situation in Wirral by mapping the extent of the problem in total, as reported, and as broken down into ward.

Apart from the geographical spread, they were interested in looking at the people most affected, and factors which pre-dispose to violence being used in the home environment.

The panel then planned to investigate the impact on service provision across public and voluntary agencies, and then evaluate how they respond to the problem, both in preventative and re-active terms.

Using the recent Home Office strategy document "Violence Against Women and Young Girls", it is estimated that there are approx. 20,000 incidents of domestic violence in Wirral annually.
The Staying Safe Strategy Group in it's report further identify that 6,951 Wirral women and girls aged between 16-59 have been a victim of physical assault in the past year and 38,494 have been victims of stalking and harassment.

In a study carried out in Wirral between Sept 2009-August 2010, it was found that 31% of victims were pregnant and 33% of perpetrators have problems with alcohol

A breakdown of wards in Wirral reveal the surprising fact that though, as might be expected, Birkenhead/Tranmere has the highest number of reported incidents, Wallasey Ward has the second highest.

Reacting to Individual Incidents

Merseyside Police report 4,000 calls to incidents annually in Wirral and the Family Safety Unit (FSU) receive approx 750 reports annually of cases which are assessed as being of medium to high risk, with high risk being defined as meaning the victim is at risk of serious injury or death.

Last year the Wirral Women`s and Children Aid received 110 referrals for refuge accommodation, of which 56 were for Wirral residents. The rest were from elsewhere.

Of the referrals, only 33 were accommodated and 36% of those were Wirral residents.

When the Police are called to an incident of suspected domestic violence, they have a system of assessment. When a call is received by them, and that is the most frequent way a case is reported to them, it is referred to the Police Domestic Violence Unit. They get about 600 calls per month and they are given a priority status so that the aim is to respond within 10mins. All frontline officers have training in how to resolve the problem and arrest the perpetrator if possible.

All cases are assessed and given a score based on the presence of factors such as alcohol or drug involvement. The score is categorised into a gold, silver or bronze classification. The bronze are dealt with by means of a warning letter and silver and gold are passed on to social Services

When a suspected incident of domestic violence is identified by any of the relevant agencies such as housing providers, education, health police, social services, it is passed to FSU for formal assessment of the risk to the victim, and those most at risk are dealt with by the Multi-Agency Risk Assessment Conference (MARAC) , which has recently undergone an independent quality assurance evaluation.

This showed that a total of 9 different agencies had referred to MARAC in the last 12months, and there was a steady increase in numbers being referred.

This is viewed in a positive way as Wirral exceeds the expected referrals from non-police agencies.

Members of the panel were able to spend time witnessing how MARAC works in practice and were impressed by the number of agencies involved in the planning of interventions.

This multi-disciplinary team, which meets fortnightly, develops the planning of support services, and the agencies work together to plan the interventions through the use of Co-ordinated Action against Domestic Abuse (CAADA) and Domestic Abuse, Stalking and Harassment (DASH) protocols.

The children's assessments are carried out by social workers.
It is felt that this approach is comprehensive, robust and produces good outcomes. In performance terms, this is backed up by the fact that Wirral's FSU is judged to be one of the best performing in the country, with10% of re-referrals in a 12month period demonstrating the quality of their planning, which in the vast majority of cases is successful in avoiding recurring incidents.

Responding to issues of domestic violence

In the planning of responses to the whole issue of domestic violence, the approach deployed is in key themes which are:

1. **To intervene at an early stage to make sure that young people understand the importance of healthy relationships and respect the right to say "no"**
2. **The importance of training for professionals and frontline staff for early detection of and risk factors associated with domestic and sexual violence, and this should include all frontline staff such as educational staff, health workers, housing staff, police and social care staff.**
3. **Support for victims through the process of fleeing, protection and resettlement.**
4. **The use of new powers to help victims break the cycle of violence which include the use of different orders including the new Domestic Violence Protection Orders**

The Panel looked at how these interventions are being used in Wirral and whether the delivery was effective.

Intervention at an early stage.

The improved awareness of issues relating to domestic violence and the need to educate people, particularly young people, about what is acceptable behaviour in a relationship has led to a widespread campaign to raise awareness of it as an issue, through poster and TV advertising campaigns. Leaflets advertising help services are widely distributed in all public buildings and the Panel heard about the work being done in schools and youth services.

They were told of some innovative work being done in schools in Cheshire, and it is the panel's intention to ask the person responsible for establishing this, to come to talk to the group to see if it can inform practice in Wirral's schools.

Importance of Training

The Panel found that high importance is given to the appropriate and ongoing training of frontline staff working at all levels. This training is aimed at enabling staff to identify and support adults who are victims and children involved who may be affected by domestic abuse.

Members of the Panel invited Ann Potter from Barnardos to come to speak to them about a tool for assessment using a multi agency approach which is being developed, and used for assessing the risk of domestic violence which focuses' on the needs and risk to children in families where domestic violence is a factor.

It concentrates on regarding domestic violence witnessed by children as being harmful to them, and, because of that, it is a safeguarding issue for children's services to address.

It fits in with the existing use of CAADA –DASH, which is currently used in Wirral and focuses on the outcomes for children.

The Panel understands that, if it is in use, it should be done only after training in its use has been given to all frontline staff such as police, health, social care, education and housing staff, and it should be used in conjunction with the already existing policies of Safeguarding and the Children's and Young People's Plan.

Though it is not widely used as yet, its use is spreading, with all London boroughs now employing it, and it is widely influencing a changing approach to assessment for children.

Support for Victims.

Services to protect victims of abuse and prevent occurrence should be delivered in a co-ordinated way, and the Panel recognises that this joint approach is developing.

he FSU offers helps to victims by providing support through their staff of Independent Domestic Violence Advocates (IDVA) who support victims through the process of, for example, accessing financial help, help with re-housing and court procedures

Wirral Women's and Children's Aid give support through their advice and help line, their outreach work and the refuge and the Zero Centre, which provides a wide range of support services such as a support programme for children and young people, and emotional and practical support for women coming out of abusive relationships.

Members of the panel were able to visit the Refuge and a visit is planned to the Zero Centre

Use of new powers to break cycle of violence

To help provide protection for victims there are several different actions through the justice system and court orders that can be used.

Police are able to put a marker on an address, so that if they receive a call from that address they are able to respond more quickly.

Where there is no criminal case pending, a woman can apply for a Civil Order and it is thought that as they can be applied for very quickly (within 24hrs)they can be useful in protecting women.

Also Non Molestation Orders and Occupation Orders can also be of help and for women on low income legal aid has been available to help, although this may change in the future.

Key Areas of Concern & identified Gaps in Provision.

The Panel is concerned about the following:

Funding.

The Family Support Unit is funded through the Area Based Grant and there is a degree of uncertainty about the future funding, which if it were to be reduced, would lead to a reduction in the numbers of Independent Domestic Violence Advocates and that would have a detrimental effect on service, as they would have to move out of preventative work and concentrate on the high risk group only

Wirral Women`s and Children's Aid are concerned because the adult service is funded through Supporting People grant, which is being cut and the children's services are funded through grants from the voluntary sector and charitable donations, which again may suffer in the current economic climate.

Access to Legal Aid.

If Legal Aid aid is withdrawn from those wishing to apply for legal remedies to Domestic Violence, there is concern that, with costs for court proceedings likely to be around £800, these costs would be prohibitive. This would mean that women would either have to represent themselves, or not apply for the orders.

There is also a gap in support provision for women who enter this country legally, but on their husband's visas and therefore have no right to any service as they have no right to access public funds, if they should leave their husband. Though there is a small project in Liverpool called Sojourn for African and Asian women , there is no provision for Eastern European women, and these are an increasing number .

Gaps in provision of services for men.

Though the majority of victims of domestic violence are women, with 93% of victims being women, and 7% men, it is a significant problem in men and it is believed that the incidence is increasing.

All professionals feel that there is a particular problem of male victims not reporting because of a stigma. Of those cases that were reported, there was a particular problem identified of older males being abused by family members. However, it is also the case that younger males experience violence by partners

There is very little provision for male victims with no refuge places, no assistance of support such as those delivered through the Zero Centre and only 1 IDVA available through FSU.

It is felt that services for men are about 30years behind in development than those available for women.

Gaps in provision of services for young women.

A further area of concerns is the high incidence of violence to young women aged between16-25 who are pregnant and it is believed that 14% of women in that group are being abused.

There was a particular gap identified in service provision for young women aged between 16-18. If they are abused, they do not have the same risk assessment as adults , and that results in them not being able to access the same range of services as adults.

Problems with perpetrators of violence presenting as victims.

A further problem was identified in that, not infrequently, perpetrators of domestic violence will present as victims and will use child contact visits to make contact with their victim when those child contact visits are supervised by a family member.

On further investigation, with comparisons made to other European countries, particularly in northern Europe, it appears this does not happen there, as there are much more rigorous procedures in place to avoid this happening, by the use 2 week removal orders which are very speedily applied .

Conclusion

Though this is an interim report, only and the panel wish the work to continue, it has become obvious that the subject matter is so vast that, rather than rush to conclusions with a picture only part painted, it would be wiser to carry the work over until the next year's committee is established.

The Panel would want to continue to look at the work that the courts do and how that fits in with other agencies. They felt a visit to the Zero centre would be helpful also and they would like to hear about some of the work being done with young people around self esteem.

However even at this stage it has been possible to highlight some areas for consideration when looking at how the process can be improved, and where gaps are to be found in service. These are highlighted in the body of the report and the section above.

Panel would like to repeat the thanks to all those who have given so freely of the time in this piece of work.

Scope Document for the

Domestic Violence Scrutiny Review

Scrutiny Panel Chair: **Cllr Moira McLaughlin**	**Contact details:** 0151 644 8234
Scrutiny Officer: Lynn Lloyd	**Contact details:** 0151 691 8540 01422242017
Panel members: **Cllr Moira McLaughlin** **Cllr Ann Bridson** **Cllr Pat Glasman** **Cllr Cherry Povall**	**Contact details:** 0151 644 8234 0151 201 7310 mobile: 07759 587597 0151 630 7448 0151 343 9976
Key contacts: **Val Saunders**. Women`s Aid **Det. Insp. Dave Grisenthwaite.** Police **Ann Potter,** Barnardos.	**Contact details:** 643-9377 email:val@wwaca.demon.co.uk David.N.Grisenthwaite@merseyside.police.uk ann.potter@barnardos.org.uk
Departmental Link Officer: **Jill Barr.** Co-ordinating manager Family Safety Unit (FSU). **Steve McGilvray** Community Safety Team FSU in terms of funding with links to other issues, ie Safeguarding Boards **Dave Swarbrick**, Area Team Manager, Children's Services for Wallasey/ New Brighton **Jayne Reid,** Family Support Unit. **Julia Hassall** Head of Branch (Children's Social Care)	**Contact details:** 0151 606 5003. 0151 606 5485 0779512414. 0151 606 5440 0151 666 4293

1. An assessment of the extent of the problem in Wirral.

Broken down into:

- **a.** Geographical areas with the highest risk of incidents
- **b.** The people most affected
- **c.** Factors which pre-dispose to violence being used in the home environment
- **d.** Ways in which those at risk are identified, or could be identified in the future, in order both to prevent incidents and offer help when they do occur.

2. An investigation into the impact on service provision across the public agencies and voluntary sector.

This will include Health Providers, Police, Children's Services, Housing, Social Services for Adults, the Courts system and voluntary sector providers such as Women's Aid, Rape Crisis Centre etc.

The investigation will consider how they respond, as organisations, to identifying risk and the level of co-ordination that exists between organisations in providing a response.

In particular it will look at assessment processes, including the way in which different processes operate in different organisations, and how the assessment processes relate to different age groups, for example adults, children and 16-18 year olds. It will seek to identify any gaps in provision and also to identify what preventative work is taking place to reduce the overall level of actual incidents.

To assist us in this investigation we will be consulting initially with the Police, Barnado's, the Family Support Unit, Children and Young People's Department, the Court System and Zero Centre, and following up information provided as appropriate.

This will include visits to the Zero Centre, attendance at a meeting of Marac, and a visit to the Family Support Unit.

3. A consideration of the conclusions which can be drawn from the above.

This will include:

d. An assessment of the quality of the response, both in terms of prevention and in reaction to actual incidents.

e. An assessment of the appropriateness of a standardised assessment process with a view to removing any identified gaps in service.

f. A suggestion on what improvements can be made to what currently happens.

g. A consideration of the best way in which funding can be secured.

4. Timescale.

The aim is to produce a report for the March 2011 Committee meeting.

Geographical breakdown of referrals to WWACA April-Dec 2010

Area	Refuge referrals	Outreach	Helpline	Total
Wirral, no other info			28	28
Bebington	3			3
Bidston	1			1
Birkenhead	16	4	1	21
Bromborough	2	1	2	5
Eastham	1	3		4
Greasby	1			1
Irby	1			1
Leasowe	2			2
Meols	1	1		2
Moreton	1	4		5
New Brighton	1			1
New Ferry	3			3
Oxton	5		3	8
Pensby		1		1
Poulton	2	1		3
Prenton	2	2	1	5
Rock Ferry	5	4		9
Seacombe	2	1		3
Tranmere	3	2		5
Upton	3			3
Wallasey	6	6		12
West Kirby	2		1	3
Woodchurch	1			1
TOTAL	64	30	36	130

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Domestic Abuse

Period of Study
September 2009 – August 2010 (based on Report Date)

Data Source
IAMF (Inter agency Monitoring Form Recording System)

Introduction
This report examines generic domestic abuse trends from September 2009 – August 2010. It utilises statistics compiled from the inter Agency Monitoring Form. There three main areas of analysis are:

- Incident
- Victim
- Perpetrator

It also analyses the roles played by participating agencies in reporting, recording and taking action within the MARAC (Multi Agency Risk Assessment Conference).

Summary
What follows is a summary of the findings contained within this report:

Incident

- There have been 754 Domestic Abuse incidents in the Wirral reported to the Wirral Family Safety Unit (WFSU)) during the period September 2009 – August 2010. 219 (29%) of these incidents were repeat victims.
- 137 of these incidents are currently deemed as involving very high risk victims and therefore invoke the MARAC process.
- Birkenhead and Tranmere Ward and Wallasey Ward have by far the highest rate of Domestic Abuse cases.
- Incidents are most likely to occur between the hours of 12am and 1am and 8pm and 9pm.

Victim

- The most common victim age group is 26-40
- The most common victim ethnicity is UK White
- 29% of the victims indicated they have suffered domestic abuse previously
- 31% of victims are pregnant 19% do not have any children, 29% of one child, 29% have 2 children, 14% have 3 children and 9% have 4 children or more.
- Most WFSU clients have suffered serious and extensive abuse. 4% of the victims admitted suffering from domestic abuse for 6 years or longer.

Perpetrators

- Most of the perpetrators fall within the 26-40 age range
- 33% have problems with alcohol
- 21% have mental health problems
- 19% have drug related issues

Agency
In terms of referrals:

- 53% of referrals were from Merseyside Police (DV)
- 18% of referrals were from the Family Safety Unit
- 6% of referrals were from the Wirral NHS Trust

Client safety actions arising from MARAC

- There have been 16,719 consequential actions carried out
- WFSU carried out 47% of all actions
- 8% of all actions carried out by Children and Social Care
- 7% by Wirral NHS Trust
- 5% by Merseyside Police

1. Incidents

From September 2009 – August 2010 the WFSU received 754 domestic abuse referrals. 182 victims are repeated referrals comprising 24% of all incidents which is an 11% rise when compared with 2008-9; however 284 (38%) of records did not indicate whether the victim was a repeat referral or not, leaving 286 (38%) who were confirmed not repeat referrals.

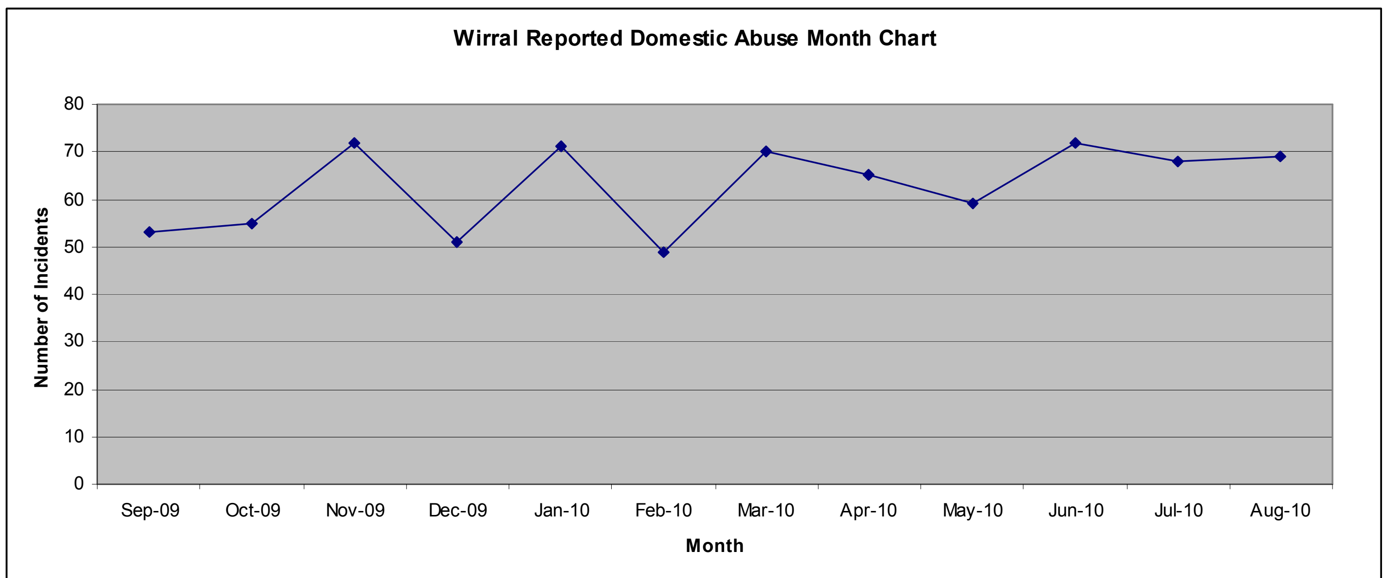
Ward	***Population***	***DV Incidents***	***Rate per 1000 Population***
Birkenhead And Tranmere	14360	188	13.09
Wallasey	15257	140	9.18
Prenton	13688	52	3.80
Rock Ferry	14203	51	3.59
Bebington	15736	43	2.73
Moreton West And Saughall Massie	14422	36	2.50
Upton	15798	36	2.28
Bromborough	14289	32	2.24
Leasowe And Moreton East	13790	28	2.03
Greasby Frankby And Irby	15596	25	1.60
Heswall	13404	21	1.57
Bidston And St James	15574	22	1.41
Eastham	13312	17	1.28
Hoylake And Meols	13154	15	1.14
West Kirby And Thurstaston	12289	10	0.81
New Brighton	14134	11	0.78
Seacombe	15482	8	0.52
Oxton	13441	5	0.37
Claughton	12903	3	0.23
Liscard	14233	2	0.14
Clatterbridge	14367	1	0.07
Pensby And Thingwall	12756	0	0.00

DV Rate Per 1000 Population
September 2009 - August 2010
9.1 to 13.1 (2)
2 to 9.1 (7)
1.1 to 2 (5)
0.5 to 1.1 (3)
0 to 0.5 (5)

NEW BRIGHTON
LISCARD
LEASOWE AND MORETON EAST
MORETON WEST AND SAUGHALL MASSIE
BIDSTON AND ST JAMES
HOYLAKE AND MEOLS
BIRKENHEAD AND TRANMERE
UPTON
OXTON
PRENTON
ROCK FERRY
GREASBY FRANKBY AND IRBY
WEST KIRBY AND THURSTASTON
BEBINGTON
BROMBOROUGH
CLATTERBRIDGE
HESWALL
EASTHAM

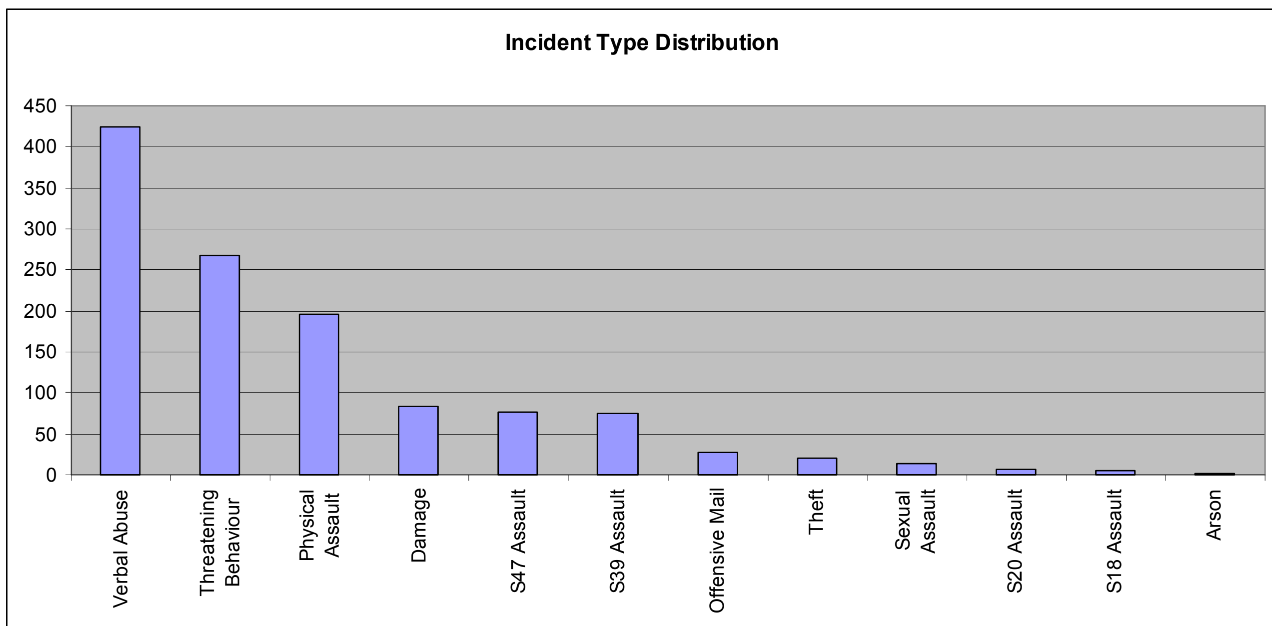
Domestic Violence Referral Rate per Population by Ward

Birkenhead and Tranmere Ward and Wallasey Ward had the highest rate of domestic abuse incidents.



Domestic Violence Referral Rate per Month

November 2009 and June 2010 were the peak months, with 72 incidents, followed by January and March with 71 and 70 incidents respectively. February with 49 had the fewest incidents. Analysis indicates that domestic abuse incidents are most likely to occur at night, particularly between the hours of 12am and 1am; and 8pm and 9pm.



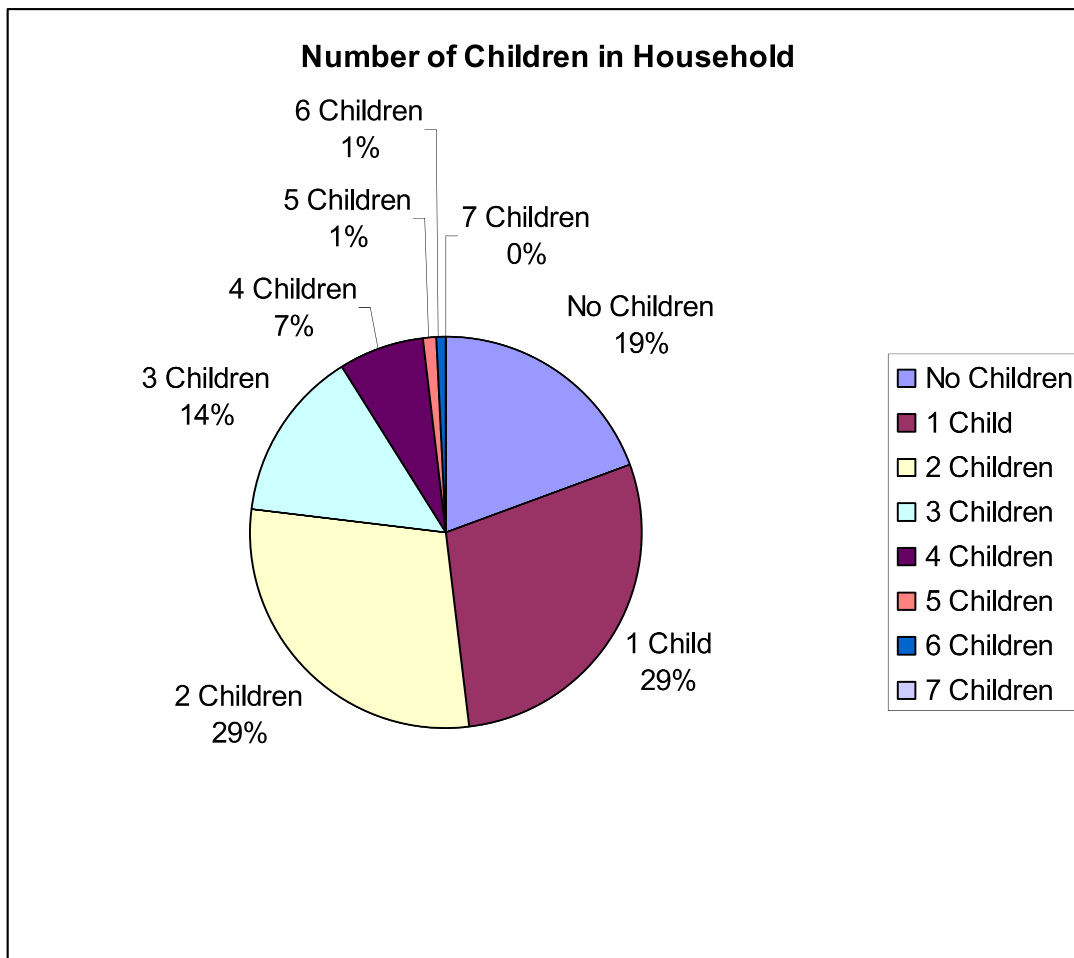
Domestic Violence By Incident Type

The top three reported incident types are verbal abuse (35%), threatening behaviour (22%) and physical assault (16%).

2. Victim

Of the 754 referrals, 704 (93%) were by female victims; the remaining 50 (7%) were male. Most WFSU clients have suffered serious and extensive abuse. 4% of the victims admitted suffering from domestic abuse for 6 years or longer.

The most common age group is 26-40 comprising 48% of all referred victims. The 19-25 and 41-64 age groups combined comprise 47% of all victims. There were 7 victims under the age of 18 and 32 victims aged 18. Analysis shows the most common victim ethnicity is UK white.



Number of Children per Household

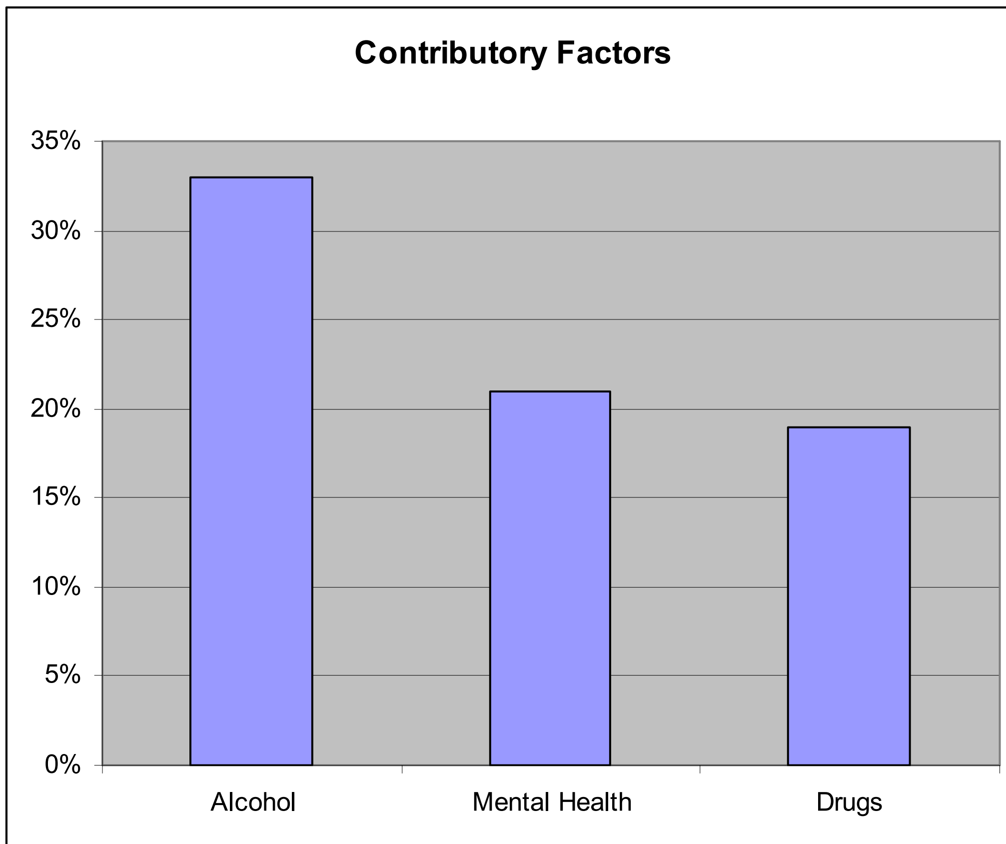
In terms of household breakdown, 19% have no children, 29% have 1 Child, 29% have 2 children, 14% have 3 children, 7% have 4 children, and the remaining 2% have 5 or more children.

3. Perpetrator

The majority of domestic abuse perpetrators are white males.

The most prevalent age range for domestic abuse perpetrators is 26-40 (52%) followed by 41-64 (25%).

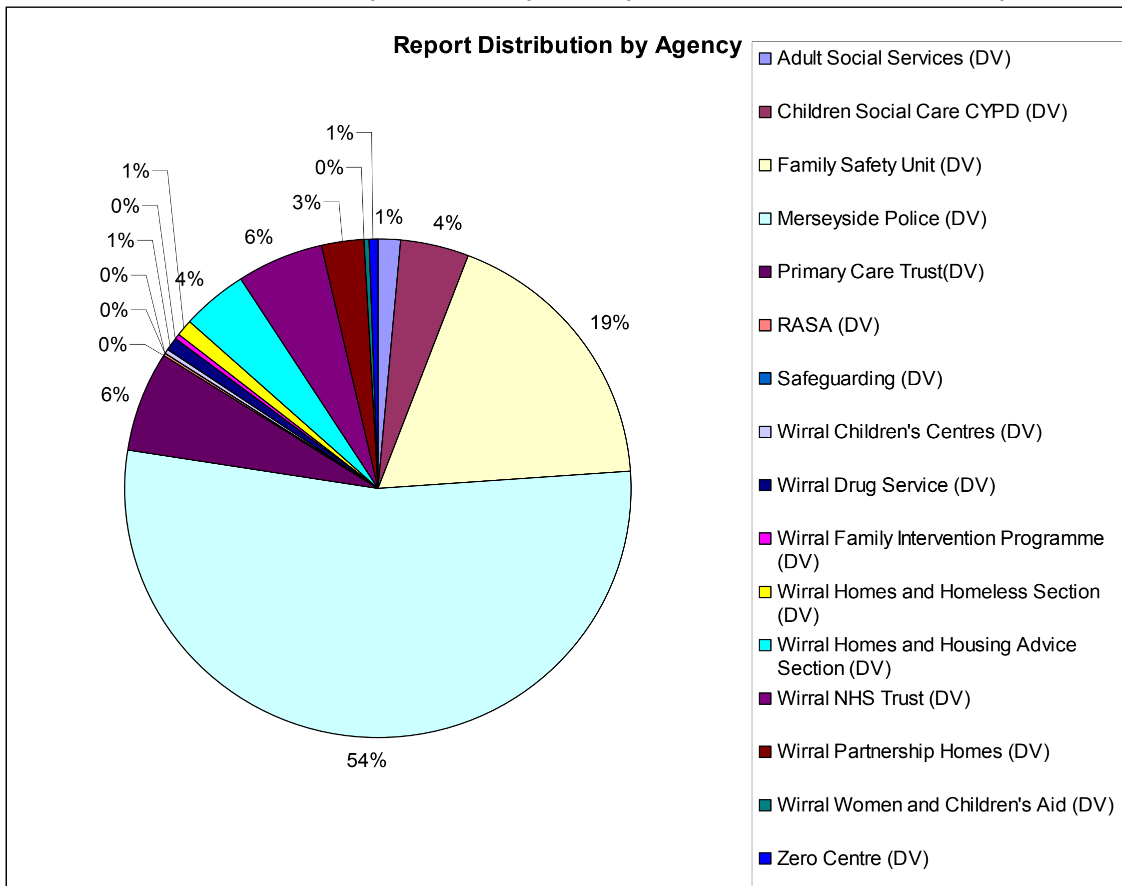
33% of perpetrators have problems with alcohol, 21% have mental health problems and 19% have drug related issues.



The Proportion of Contributory Factors Reported by Victims

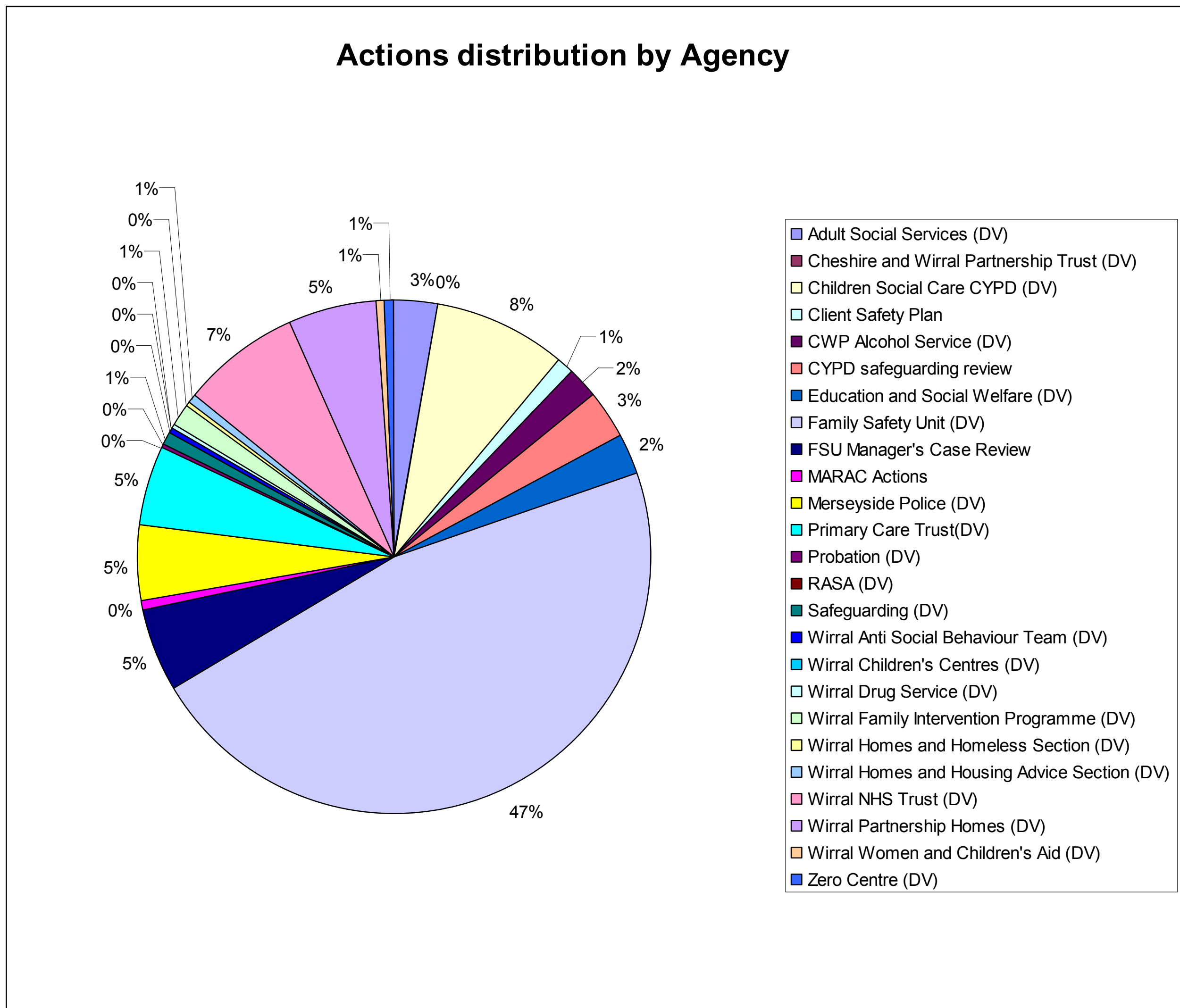
4. Domestic Abuse Reports

In terms of reporting, 16 agencies reported incidents on the IAMF. Merseyside Police reported the majority of incidents 54%, followed by the Family Safety Unit 19% and the Primary Care Trust 6%.



Domestic Abuse Actions

In terms of actions, there have been 16,719 actions carried out or an average of 22 per domestic abuse case. 47% of these were carried out by the Family Safety Unit, followed by Children Social Care CYPD 8% and Wirral NHS Trust 7%.



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Glossary of Terms

MARAC	Multi Agency Risk Assessment Conference
IDVA	Independent Domestic Violence Advocate
FSU	Family Safety Unit
NI	National Indicator
CAADA	Co-ordinated Action against Domestic Abuse
DASH	Domestic Abuse, Stalking and Harassment
RIC	Risk Identification Checklist
ACPO	Association of Chief Police Officers
CAFCASS	Children and Families Conciliation and Support Service
FCIU	Family Crime Investigation Unit

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