Public Document Pack

# Adult Social Care and Public Health Committee

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| **Date:** | **Tuesday, 2 March 2021** |
| **Time:** | **6.00 p.m.** |
| **Venue:** | Microsoft Teams |


**Contact Officer:** Daniel Sharples
**e-mail:** danielsharples@wirral.gov.uk
**Website:** www.wirral.gov.uk


# AGENDA

**1. APOLOGIES**

**2. MEMBER DECLARATIONS OF INTEREST**

Members are asked to consider whether they have any disclosable pecuniary interests and/or any other relevant interest in connection with any item(s) on this agenda and, if so, to declare them and state the nature of the interest.

**3. MINUTES (Pages 1 - 12)**

To approve the accuracy of the minutes of the meeting held on 18 January 2021.

**4. PUBLIC & MEMBER QUESTIONS, STATEMENTS AND PETITIONS**

**PUBLIC QUESTIONS**

Notice for public questions must be put in writing to the Monitoring Officer no later than midday Thursday 25 February and should be sent to committeeservices@wirral.gov.uk.

**QUESTIONS BY MEMBERS**

Questions by Members to dealt with in accordance with Standing Orders 12.3 to 12.8.

**STATEMENTS AND PETITIONS**

A member of the public may speak on up to two non-procedural items on any Agenda if notice has been given no later than midday Thursday 25 February. No speech should exceed **three minutes**. Please give notice to committeeservices@wirral.gov.uk

For petitions please give notice in advance of the meeting to committeeservices@wirral.gov.uk

**SECTION A - DECISIONS**

**5. EXTRA CARE HOUSING MODEL (Pages 13 - 28)**

**6. EXTRA CARE TENDER (Pages 29 - 34)**

**7. HEALTHWATCH (Pages 35 - 38)**

**SECTION B - BUDGET REPORTS**

**8. REVENUE BUDGET MONITORING (Pages 39 - 46)**

**SECTION C - PERFORMANCE REPORTS**

**9. ADULT SOCIAL CARE AND HEALTH PERFORMANCE REPORT (Pages 47 - 94)**

**SECTION D - REVIEWS / REPORTS FOR INFORMATION**

**10. STRATEGIC DEVELOPMENTS IN THE NHS (Pages 95 - 108)**

**11. COVID-19 RESPONSE UPDATE (Pages 109 - 116)**

**12. ADULT SOCIAL CARE AND PUBLIC HEALTH WORK PROGRAMME (Pages 117 - 124)**

# ADULT SOCIAL CARE AND HEALTH COMMITTEE

Monday, 18 January 2021
6.00 - 9.12 p.m.

| | | | |
|---|---|---|---|
| Present: | Councillor | Y Nolan (Chair) | |
| | Councillors | B Berry | S Frost |
| | | D Burgess-Joyce | P Gilchrist |
| | | K Cannon (In place of S Jones) | M Jordan |
| | | | M McLaughlin |
| | | M Collins | T Usher |
| | | T Cottier | |
| In attendance: | Councillor | J Green | |

1 **MINUTES**

**Resolved – That the accuracy of the minutes of the meeting held on 19 November 2020 be agreed.**

2 **APOLOGIES**

No apologies for absence were received.

3 **MEMBER DECLARATIONS OF INTEREST**

Members were asked to consider whether they had any disclosable pecuniary interests and/or any other relevant interest in connection with any item(s) on this agenda and, if so, to declare them and state what they were.

The following declarations were made:

| | |
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| Councillor Samantha Frost | Personal interest in Item 7 (Extra Care Housing Capital Report) as a participating member of the Planning Committee who would consider any future application. |
| Councillor Tony Cottier | Personal interest as a director of a construction company contracted by the NHS. |
| Councillor Thomas Usher | Personal interest by virtue of his employment at a local provider, Autism Together. |
| Councillor Michael Collins | Personal interests as a Governor of Wirral University Teaching Hospital, by virtue of his employment at a company providing training to the care sector and also his daughter's employment at Wirral University Teaching Hospital. |

| | |
|---|---|
| Councillor Mary Jordan | Personal interest by virtue of her employment for the NHS and involvement as a trustee for 'incubabies'. |
| Councillor Yvonne Nolan | Personal interest as a governor at Clatterbridge Cancer Centre. |
| CouncillorMoira McLaughlin | Personal interest by virtue of her daughter's employment in the NHS. |

## 4 PUBLIC QUESTIONS, STATEMENTS AND PETITIONS

The Head of Legal Services informed the Adult Social Care and Health Committee that no public questions, or requests to make a statement had been received.

**At the request of the Chair, the Committee agreed to rearrange the order of business**

## 5 STRATEGIC DEVELOPMENTS IN THE NHS

Simon Banks, Chief Officer, NHS Wirral CCG and Wirral Health and Care Commissioning, introduced the report which summarised the proposals set out in the recently published NHS England/Improvement document 'Integrating Care: Next steps to building strong and effective integrated care systems across England.' The report also set out the work in progress to respond to these proposals for Wirral as a 'place' within the Cheshire and Merseyside Integrated Care System.

The Committee was informed that the key practical changes would include the devolution of national functions to a North West level and likewise the devolution of functions from a North West level down to a Cheshire and Merseyside footprint. The idea was that the future health and care systems would be built on local authority areas, and it was felt that Wirral was in a good position to enable this. Further proposals included ensuring providers worked together collaboratively and that clinical leadership within the NHS was maintained.

It was reported that the Joint Health and Care Commissioning Executive Group was looking at what function should be retained on a 'place' level and that committee such as the Health and Wellbeing Board and Adult Social Care and Health Committees would be at the heart of the new system.

Members welcomed the emphasis on local commissioning of services and sought clarification on the footprint that different services would be delivered on.

**Resolved – That**

**(1) the work to define what a commissioning offer at 'place' level should look like, setting out what commissioning functions should be delivered in place and what would best sit with provider partnerships be noted and supported.**

**(2) the work in the creation of a provider collaborative/alliance in Wirral be noted.**

**(3) a further update report on progress be presented at a future meeting of the Adult Social Care and Health Committee.**

6 **111 FIRST**

Simon Banks**,** Chief Officer, NHS Wirral CCG and Wirral Health and Care Commissioning presented the report which provided the Committee with a summary of the implementation to date of the national "Think 111 First" project in Wirral, as well as an overview of the anticipated next steps.

It was reported that the project intended to transform the way that patients accessed urgent and emergency care by offering a single point of access. It was hoped that the project would:

- Reduce the risk of nosocomial infection through overcrowding in the Emergency Department;
- Increase the number of patients who got to the right service first time; and
- Increase staff and patient satisfaction with the 111 First service.

The Committee was advised that the project went live on 24 November and within the first ten days, 70% of all urgent referrals into the Clinical Advisory Service had been managed without referring people to the Emergency Department, in addition to fewer unheralded arrivals to the Emergency Department and shorter waiting times.

Members welcomed the project and sought further information on the targets outlined within the report and the data that these were being measured against.

**Resolved – That**

**(1) the report be noted and the implementation of phase two of NHS 111 be supported.**

**(2) a further report be submitted to a future meeting of the Adult Social Care and Health Committee, including a performance data set.**

## 7 WIRRAL EVOLUTIONS

Graham Hodkinson, Director of Adult Care and Health introduced the report which sought the continuation of delivery of adult care services within the Borough through the current provider, Wirral Evolutions.

The report outlined that Wirral Evolutions was set up as a limited company by Wirral Council in 2015 to enable the service to extend and modernise its activities and generate income in additional to the social care contract. However costs associated with day services had increased beyond the contract value leading to a review of the service as requested by Adult Care and Health Overview and Scrutiny Committee in February 2020, which included the potential for bringing services back 'in-house' to address the financial challenges currently facing the service.

It was reported that the Council had formally commenced consultation on the budget in relation to the Contract for Day Services for people with a Learning Disability, with the intention of removing the over contract spend amounting to £0.5m to bring the contract value in line with the social care budget allocation of £5.015m for 2021/22. Wirral Evolutions had discussed a range of options to modernise the current operating model, and the recommendation was that they would present these proposals to a future meeting of the Adult Social Care and Health Committee.

Members acknowledged that the quality of the service was not an issue and emphasised the need to provide reassurances and a sense of continuity to service users.

**Resolved – That**

**(1) the Council should continue to deliver Day Services through the current contract with Wirral Evolutions.**

**(2) Wirral Evolutions be invited to the Adult Social Care and Health Committee to present the company's proposals to modernise the current operating model and reduce the operating costs to ensure delivery of the service within the existing contract at the current contract price of £5.015m for 2021 to 2022.**

**(3) Wirral Evolutions be invited to the Adult Social Care and Health Committee to present quarterly reports to update the Committee on its progress, with a six-month formal review of progress against allocated spend under the contract.**

## 8 FUTURE SAFEGUARDING ARRANGEMENTS

Jason Oxley, Assistant Director of Care and Health introduced the report which outlined the proposal to step down the Merseyside Safeguarding Adults Board and establish a Local Safeguarding Adults Board in Wirral.

The report detailed how Wirral Council was currently a member of the Merseyside Safeguarding Adults Board alongside Liverpool, Sefton and Knowsley, but that following a peer review by the Local Government Association it had been decided by the existing Board members to change the arrangements to a local level, where it was felt that there was more opportunity to strengthen links with the domestic abuse strategy and services.

Members were supportive of the introduction of a local Safeguarding Board and felt it would complement the local health and social care integration agenda. It was noted that the Children's Safeguarding Board had undergone similar rearrangements and there was an opportunity for learning from those experiences.

**Resolved – That**

**(1) the establishment of a Wirral Local Safeguarding Adults Board to fulfil the statutory requirements that are currently being met and managed by the Merseyside Safeguarding Adults Board be agreed in principled.**

**(2) a further report outlining the plans to establish a Wirral Local Safeguarding Adults Board be received at a future meeting of the Adult Social Care and Health Committee.**

9 **EXTRA CARE HOUSING CAPITAL REPORT**

Simon Garner, Health and Care Commissioning Lead, introduced the report of the Director of Care and Health which outlined the funding requirements for the development of an Extra Care Housing scheme on Moreton Road, Upton.

It was reported that there were a number of these schemes across the borough, that provided 24 hour on-site care whilst also supporting independent living, which in turn reduced the need for residential and nursing care.

The previous Wirral Plan set out a target of developing 300 additional units by 2020, but national policy had resulted in delays to this. 101 additional units had been achieved, and the proposed development before the Committee alongside a further development in Rock Ferry would help to fulfil that target.

The Committee noted the considerable time required to identify and develop sites for developments such as this, and it was suggested that more regular consultation exercises could take place to identify need and to ensure that need could always be met.

**Resolved – That**

1) **payment of a grant of up to £3,685,400 to Housing 21 (H21) from the Council Extra Care Capital Programme to enable the delivery of 80 Extra Care Housing units by Housing 21 be approved.**

2) **it be noted that the council holds nomination rights and that appropriate legal agreements will be put in place to ensure that the Council's financial contribution and nomination rights are protected.**

10 **BUDGET CONSULTATION**

Graham Hodkinson, Director of Care and Health introduced the report of the Director of Resources and outlined that the report formed part of the Council's formal budget setting process and gave the Adult Social Care and Health Committee opportunity to comment on the proposals that fall within its remit, which would enable those comments to be presented for consideration by Policy and Resources Committee at its meeting in February 2021.

The report included a savings proposal through a service review of the day services for people with Learning Disabilities provided by Wirral Evolutions. The review's aim was to manage the cost of current provision through service changes with potential savings of £500,000.

Members felt that there was no need to further comment on the proposals whilst the public consultation was ongoing, and the comments the Committee made on the budget options at the previous meeting were still pertinent and should still be considered.

**Resolved – That**

**the resolutions agreed under Minute Item 19 at the previous meeting of the Adult Social Care and Health Committee on the budget options be considered by the Policy and Resources Committee as part of the budget consultation.**

11 **REVENUE BUDGET MONITORING**

Graham Hodkinson, Director of Care and Health presented the standing revenue budget monitoring report for quarter two of 2020-21 which provided members with an overview of budget performance for adult social care and health.

The Committee was informed that the projected year-end revenue forecast position was a favourable position of £0.06m which it was felt was a positive

in the context of the ongoing challenges being faced. It was explained that the favourable forecast was due to several factors including a reduction in demand for social care services in the early stages of the pandemic, alongside hospital discharges being funded by the Clinical Commissioning Group. Members were advised that the demand for services had returned but would be partially offset by further NHS and Government funding.

Members acknowledged that the Revenue Budget Monitoring report was in line with corporate reporting timetable, but felt that a budget monitoring panel should be set up to enable more timely budget monitoring.

**Resolved – That**

1) **the projected year-end revenue forecast position of £0.06m favourable, as reported at quarter 2 (Apr-Sep) of 2020-21 be noted.**

2) **a Budget Monitoring Panel be established with the Chair and Group Spokespersons to meet monthly to monitor the up-to-date financial data.**

12 **ADULT SOCIAL CARE AND HEALTH PERFORMANCE REPORT**

Jason Oxley, Assistant Director of Care and Health introduced the report, which provided a regular update on the performance of Adult Social Care and Health as requested at the meeting on 13 October 2020.

The report provided statistics relating to residential and nursing care in the borough and it was reported that there was currently a significant vacancy rate of around 15%, partly as a result of temporary closures for new admissions due to Covid-19 outbreaks or contractual issues.

The Committee discussed the care homes that had been rated inadequate by the Care Quality Commission (CQC) and the Council's ability to continue to carry out inspections during the pandemic. It was reported that there were ongoing issues with the quality improvement team accessing care settings, but that quality surveillance was still taking place through the observations of district nurses, GPs and specialist health staff alongside regular surveillance meeting.

Members discussed the reasons why care homes moved into the 'requires improvement' and 'inadequate' CQC category and how the performance of care homes could be monitored pre and post Covid-19.

**Resolved – That**

**(1) the report be noted.**

**(2) case analysis of care homes moving into the 'requires improvement' or 'inadequate' Care Quality Commission categories be included in future performance reports.**

**(3) the Assistant Director of Care and Health be requested to undertake a review of the reasons for ending reablement that were currently categorised as "other" and include the findings in future performance reports.**

**(4) the Assistant Director of Care and Health be requested to consider the use of notifiable incidents within care homes as a way of measuring their performance before and during the pandemic and report the findings back to the Adult Social Care and Health Committee.**

13 **COVID-19 RESPONSE UPDATE**

Julie Webster, Director of Public Health, introduced the report which provided the Committee with an update on the Council's Covid-19 response and the delivery of the Outbreak Prevention and Control Plan.

The report detailed the key progress made since the last update on the seven priority areas of the Covid-19 Outbreak Prevention and Control Plan which had been the main focus during lockdown, these included:

- Effective Surveillance;
- Governance and Accountability;
- Engagement and Communication;
- High Risk Settings and Communities;
- Local Testing;
- Local Contact Tracing; and
- Supporting Vulnerable People and Communities

Members were advised that the weekly infection data was still available on the Council's website, and the data showed that there was widespread community transmission in Wirral, particularly in the 20-29 year old age group. The number of cases per day was approximately 30 in December but had increased to 537 on 4th January resulting in an infection rate of 800 per 100,000 residents. The Director of Public Health outlined that whilst cases had started to reduce, the number of cases remained extremely high and the pressure on NHS and social care services remained significant.

It was reported that work was ongoing to ensure that once the national restrictions ended there was a smooth transmission into local arrangements, including robust contact tracing and the continued work of the outbreak management hub. Asymptomatic testing had been launched across the

borough following the previous meeting, and members were advised that an appointment system had since been introduced to prioritise people going into work.

Members welcomed the current communications strategy and work of the Community Champions and expressed their gratitude to the Public Health team for their ongoing work.

**RESOLVED – That**

**the report and progress made to date be noted and the ongoing Covid-19 response be supported.**

14 **DEPRIVATION OF LIBERTY RELATING TO PEOPLE WHO ARE DEEMED UNABLE TO MAKE DECISIONS ABOUT THEIR CARE AND SUPPORT NEEDS**

Simon Garner, Lead Health and Care Commissioner, introduced the report of the Director of Care and Health setting out the important context of the work of the Deprivations of Liberty (DoLS) safeguards, the issues and challenges faced during Covid-19 and providing further information on the forthcoming changes to the legislation relating to Deprivations of Liberty.

The report set out that under schedule A1 of the Mental Capacity Act 2005, the Council had powers to deprive a person in a care home or hospital of their liberty if certain statutory criteria were met such as the person being unable to consent to their treatment. The ethos of the Act was to assume the person could make their own decision and would be supported to make the relevant decision where required.

The Committee was advised of the challenges in continuing this work during the pandemic. Following the first lockdown in March 2020, all DoLS assessments were conducted remotely, other than those in exceptional circumstances where remote assessments were not able to be conducted, for reasons such as communication issues. It was reported that there had been issues whereby remote assessments had been deemed too distressing for the person being assessed.

A further update was provided on the Mental Capacity (Amendment) Act 2019 which would introduce Liberty Protection Safeguards to replace DoLS resulting in significant changes to the those who the Council had responsibility for as well as the assessment process. The introduction of the legislation had been delayed until April 2022 but the Council was still engaged in planning for its introduction.

The Committee discussed the end-of-life arrangements under DoLS and the requirement for more regular reviews under the incoming Liberty Protection Safeguards.

**RESOLVED – That**

**the report and the ongoing work to support vulnerable people within the borough be noted.**

15 **QUALITY ASSURANCE- CARE HOMES**

Jason Oxley, Assistant Director of Care and Health presented the report which set out the Council and the NHS approach to working with Care Homes to meet required national and local standards and regulations, particularly during the pandemic. The report outlined the approach that the quality improvement team undertook to improve performance to homes rated 'inadequate' or 'requires improvement' by the Care Quality Commission (CQC).

Members noted that the Committee had already held an in-depth discussion on care homes with an 'inadequate' or 'requires improvement' CQC rating when considering the Adult Social Care and Health Performance Report.

**RESOLVED – That**

the report and the ongoing work to support vulnerable people within the Borough be noted.

16 **COMMITTEE WORK PROGRAMME - ADULTS COMMITTEE**

Members considered a report of the Director of Care and Health outlining the Committee's work programme and seeking members' contributions.

The Chair outlined to the Committee that in order to enable officers to focus on the Covid-19 response, it had been agreed amongst political group leaders to have reduced agenda content for committees moving forward. Therefore only items relating to budget, Covid-19 response and Local Plan/regeneration matters would be considered by Committee.

Members acknowledged the need to reprioritise officer resource and felt it was not appropriate to propose further items for consideration.

**RESOLVED – That**

the proposed Adult Social Care and Health Committee work programme for the remainder of the 2020/21 municipal year be noted.

17 **EXTRA CARE HOUSING TENDER**

Jayne Marshall, Lead Community Care Commissioner, introduced the report of the Director of Care and Health which sought the Committee's approval of the Care and Support contract for Poppyfields Extra Care Housing Scheme to the provider outlined in Appendix D to the report.

The Committee were provided with the details of the scheme in Saughall Massie, which contained 78 self-contained flats. The care provider was to ensure 24-hour background support was available in the scheme to all residents. The report set out the procurement timescales following the tender process, and pending approval of the Committee the contract would commence on 15 March 2021.

The Chair outlined that Appendix D was exempt by virtue of paragraph 3 of the Local Government Act 1972 and the Committee would need to agree the exclusion of the Press and Public to discuss it.

**RESOLVED – That**

**(1) under section 100 (A) (4) of the Local Government Act 1972, the public be excluded from the meeting during consideration of Appendix D to the report on the grounds that it involves the likely disclosure of exempt information as defined by paragraph 3 'Information relating to the financial or business affairs of any particular person (including the authority holding the information) of Part I of Schedule 12A (as amended) to that Act. The Public Interest test has been applied and favours exclusion.**

**(2) the award of the Care and Support contract for Poppyfields Extra Care Housing Scheme to the Provider to in Appendix D to the report be approved.**

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WIRRAL

**ADULT SOCIAL CARE AND PUBLIC HEALTH COMMITTEE**

**2 MARCH 2021**

| | |
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| **REPORT TITLE** | *Extra Care Housing Model* |
| **REPORT OF** | Director of Care and Health |

## REPORT SUMMARY

This report concerns the model of Extra Care Housing in Wirral. The model sets out the standards and design requirements to provide appropriate Extra Care Housing schemes in Wirral that will support Wirral residents with eligible needs. These are needs that are assessed as eligible under the Care Act 2014.

This affects all wards.

This is a key decision.

## RECOMMENDATION/S

The Adult Social Care and Public Health Committee are recommended to agree the Extra Care Housing model for Wirral.

## SUPPORTING INFORMATION

## 1.0 REASON/S FOR RECOMMENDATION/S

1.1 The strategic priority to deliver Extra Care Housing has been both a priority for the former Wirral 2020 Plan and the Wirral Housing Strategy. A model of Extra Care Housing provides for clear expectations and standards to ensure person centred approaches to supporting Wirral residents with eligible needs. The former Wirral Plan committed to the development of 300 Extra Care Housing units by 2020. The scheme being proposed relates to that commitment. This work also supports the delivery of the current Wirral Plan 2025 'Active and Healthy Lives' theme: "Working for happy, active and healthy lives where people are supported, protected and inspired to live independently."

## 2.0 OTHER OPTIONS CONSIDERED

2.1 Not having a model may lead to issues with design and delivery of Extra Care Housing falling short of the requirements of what is needed.

## 3.0 BACKGROUND INFORMATION

3.1 Extra Care Housing is housing designed with the needs of frailer older people in mind and with varying levels of care and support available on site. People who live in Extra Care Housing have their own self-contained homes, their own front doors and a legal right to occupy the property. Extra Care Housing is also known as very sheltered housing, assisted living, or simply as 'housing with care'. It comes in many built forms, including blocks of flats, bungalow estates and retirement villages. It is a popular choice among older people because it can sometimes provide an alternative to a care home. The Strategic Housing Market Analysis identifies a need for 2,985 additional units of specialist older persons accommodation up to the period 2035. Specialist older people's accommodation is made up of age exclusive housing, sheltered, enhanced sheltered housing, Extra Care Housing and residential care and nursing care.

## 4.0 FINANCIAL IMPLICATIONS

4.1 There are no financial implications directly arising from this report. Extra Care Housing schemes will contribute to reducing future demands and cost pressures relating to more expensive forms of care. The cost of Extra Care Housing can be on average a third of the cost of residential care at Local Authority rates.

## 5.0 LEGAL IMPLICATIONS

5.1 Extra Care Housing schemes provide for people with eligible care needs and as commissioned services they are subject to contracts and in some cases nominations agreements for Wirral Council to place appropriate people into this scheme via the current Extra Care Housing allocation procedures. They are commissioned in accordance with the Council contracts procedure rules.

## 6.0 RESOURCE IMPLICATIONS: ICT, STAFFING AND ASSETS

6.1 The resource implications are the support Council staff provide to enabling developments of this type of housing, commissioning the care provision that is on site and that people with care act eligible needs access the tenancies.

## 7.0 RELEVANT RISKS

7.1 A lack of a model for Extra Care Housing could lead to insufficient Extra Care Housing schemes in Wirral of an appropriate design and build, increasing the likelihood of people having to move to residential care, as their care and health needs increase.

## 8.0 ENGAGEMENT/CONSULTATION

8.1 There has been consultation with key partners from the housing and care sector on a proposed model for Extra Care Housing in Wirral.

## 9.0 EQUALITY IMPLICATIONS

9.1 There is an existing Equality Impact Assessment (EIA) for Extra Care Housing that is scheduled for review.
https://www.wirral.gov.uk/sites/default/files/all/communities%20and%20neighbouhoods/Equlity%20Impact%20Assessments/EIA%20Assessment%202010-2014/Adult%20Social%20Services/Extra%20Care%20Housing%20allocations%20nomination%20equality%20impact%20assessment.pdf

## 10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 The content and/or recommendations contained within this report are expected to reduce emissions of greenhouse gases through design expectations. Examples can include undertaking a whole life carbon assessment of any design proposals to enable construction options to be considered to reduce embodied carbon.

**REPORT AUTHOR:** ***Simon Garner***
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email: simongarner@wirral.gov.uk

## APPENDICES

Appendix 1 – Extra Care Housing Model for Wirral

## BACKGROUND PAPERS

N/A

## SUBJECT HISTORY (last 3 years)

| Council Meeting | Date |
|---|---|
| Adult Social Care and Public Health Committee<br>Cabinet | 18 January 2021<br>16 January 2014 |

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# MODEL FOR EXTRA CARE HOUSING IN WIRRAL

WIRRAL

2021

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## Design Principles and Aims

### Overview

The Extra Care Housing Programme being developed for Wirral Council is intended to help older people and people with a learning or physical disability achieve greater independence and well-being, by giving them more choice over their care options., Extra Care Housing will help divert older people from moving into residential care and will allow the Borough to reinvest valuable resources into other services.

### Core Principles

The Transforming Care Programme is all about improving help and care services so that more people can live in the community with the right support and close to home. Extra Care Housing enables people with a disability to live in a home of their own in a designated development, with 24-hour care and support services on site.

Extra Care Housing is not intended to be a substitute for sheltered housing, flexible community support services or supported living housing. Instead, Extra Care Housing is intended to complement other types of provision, particularly for those who are unable to continue living in their own homes but wish to live more independently with the right care and support available on site. Extra Care Housing can be a community-based alternative to residential care, or other shared schemes. The dependency mix of residents will vary for each scheme.

Key features and principles that modern Extra Care Housing should include are as follows: -

a) To provide accessible specially designed housing that enables independent living for older people and those with physical or learning mental health disabilities.

b) To explore and include, where appropriate, assistive technology.

c) To enable people to live safely in their own apartments and to monitor those who have dementia or other mental health problems.

d) To provide communal facilities to allow community activities to be organised and to provide other services (e.g., a café/restaurant, assisted bathing, support to work); sensory room, communal kitchen, dining area these should be agreed for each scheme as requirements will vary.

e) To provide flexible ‘round the clock’ 24-hour emergency and unplanned care, delivered by a consistent on-site care team.

f) To provide a mixed community including those with different levels of ability, that can include the provision of apartments with different tenures and number of bedrooms.

g) To create an environment that is enabling and supports best reablement practice.

h) Facilities which enable the care and support needs of residents to be met efficiently and safely.

   To support and enable people to find privacy, comfort, support, and companionship.

i) To be a resource for the local community, both developing relationships to bring the community in as well as opportunities for tenants to integrate with activities outside of the scheme.

j) To provide support to work based and employment work placements, voluntary work opportunities and to ‘skill developing’ activities.

**Brief and Design Criteria**

It is anticipated that as Extra Care Housing could be delivered through new build, remodelling and/or conversion of existing buildings that any final design brief would have to be agreed for each scheme. It is expected that the Council and key partners are involved in the initial concept and early discussions of any scheme pre-design and pre planning to ensure schemes are developed to meet identified needs. The Council has a role in design development throughout the process, and this will help developers take account of existing and planned provision. Within this document are the concepts and criteria which Wirral wishes to see as a model to be adopted for Extra Care Housing in the Borough.

**General Principles of Extra Care in Wirral**

There are a number of overarching principles that should apply to Extra Care Housing to ensure the provision of a 'home for life' as far as is reasonably practical. In line with this, variations in core design specifications, service charges, and services on offer should be kept to an absolute minimum between tenants and leaseholders in each scheme.

In order for future provision to be successful, Wirral Council would expect the following matters to be addressed in any design and development:

a) **Visual Impairment** - consideration of lighting, colour schemes, tonal contrast, casting of shadows, audible signals, and tactile information.

b) **Hearing Impairment** - provision of hearing loops in communal spaces, use of materials to reduce reverberation, greater visual access to a person's surroundings.

c) **Accessible i.e., doors (automatic, key fob entry), lift, bathrooms, kitchen, door sensors** - consideration of space standards to accommodate this to include but not limited to floors being level with no steps and being flush at junctions. Accommodation must be accessible by wheelchairs with sufficient turning space, adapted kitchens and wet rooms.

d) **Cognitive Impairment** - to include consideration of maximising natural lighting, creating landmark features and avoiding long corridors.

e) **Location** - consideration of proximity to local shops and amenities, community facilities, transport, health services, and employment support services.

f) **Non- institutiona**l - To be domestic in style and avoid creating an institutional feel, both in terms of the built environment and also fixture and fittings used.

g) **Welcoming and easy to navigate** - The entrance should be clear and welcoming; with the building layout easy to understand, clearly signed, and private/public spaces obvious.

h) **Tenure** - consideration of a mix of both one and two bed homes which include those for affordable rent and shared ownership for people with different levels of ability. In addition, all schemes should aim to achieve a balance between high, medium, and low needs and some should consider the provision of accommodation and care for a proportion of people with dementia.

i) **Communal Facilities** - consideration of the provision of facilities such as a communal dining room, café, hairdressers, and shop which could, depending on location, also support the local community.

j) **Care and Support** - To provide flexible 24-hour care delivered by an on-site care team and to enable those who support the people who live there, to undertake tasks in a way that is efficient and can safely meet the care and support needs of residents. Every resident has to pay towards the

background support offer, regardless of how regularly they may use it. Core hours to be agreed with Wirral Health and Care Commissioning (WHCC)

k) **Service charges** - must be affordable so that individuals can afford to remain in Extra Care Housing as a home for life, rents to be agreed prior to commissioning approval.

**Specific Requirements**
On certain schemes there may be a number of specific requirements that Wirral would wish to see incorporated into an Extra Care Housing scheme such as:

a) **Flexible multi-functional rooms** - support wider community use, as well as resident use, depending on location; through the inclusion of a number of flexible use rooms capable of supporting uses such as: Hairdressing, Foot care / other clinics, Therapies / treatments / consultations, Community mentoring services / social groups hobbies / activities / clubs etc.

b) **Outdoor space** - communal gardens function on several levels, providing both stimulating views from within the building and potential for extending internal activities into the immediate surroundings. Raised beds enable elderly or wheelchair bound residents to appreciate the planting and the opportunity to contribute to gardening activities. If the site allows, an external residents drying yard can be linked to the laundry area, parking spaces.

c) **Outdoor seating** - Benches should be located at all main entrances for those awaiting transport. The design and siting of seating must also consider the requirements for a minibus drop-off under cover and to allow for the anticipated size and tracking of emergency and service vehicles, turning heads and waiting bay.

d) **Boundaries & Footpaths** – Accessible outdoor space should be enclosed, subject to design considerations, to ensure security and to avoid uncontrolled wandering. Secure wandering circuits should be integrated into the design to provide opportunities for exercise. Seating points should be strategically located to allow for resting. Sudden unguarded changes in level are to be avoided. The route to the entrance from the parking area should be level or ramped. Dropped kerbs should be provided to facilitate access from parking bays to the main entrance. All paths should avoid dead ends and provide a clear route back to their origin.

e) **External storage** - Adequate refuse, clinical waste and recycling storage must always be provided. The size and requirements for secure cycle and buggy/scooter storage must also be considered with charging facilities.

f) **Kitchen facilities** - provide kitchen facilities to enable freshly cooked meals to be provided. Kitchens to be self- sufficient and open /marketed for wider community use.

g) **Restaurant/Café** - provide a restaurant / café area for both residents and the public to use, depending on location.

h) **Laundry** - enable residents to undertake their own laundry in their flats should they wish. In addition, a small communal laundry facility to be available for residents.

i) **Privacy** - ensure ‘progressive privacy’ principles are adhered to, ensuring communal facilities are away from residents’ flats and ensuring that staff and the public do not need to walk through residents’ corridors to reach their destination. Also, keep the use of restrictive internal locking systems to a minimum.

j) **Refuse** – In addition to any planning requirement for on-site recycling, to offer refuse / recycling collection points on each floor for residents use, if possible.

k) **Assistive technology** - make best use of assistive technology in managing the scheme and delivering care and support services to residents.

l) **TV / Internet** - provide a communal infrastructure to deliver assistive technology, cable/satellite digital TV to each flat and key communal areas and WIFI in each flat and key communal/staff areas.

**Meeting specific needs**
There are a number of specific requirements in relation to meeting specific needs and these are:

a) **Dementia** - support to people with early onset/moderate levels of dementia from day one and support to severe dementia suffers as their needs increase in the longer term.

People suffering from confusion are less likely to become frustrated if they are able to clearly see and understand their surroundings.

This is often referred to as providing a visually accessible environment. For example, an environment where there are good visual clues, such as views to the outside and views from circulation spaces into communal spaces. Glazed screens and doors to communal areas enable residents to enter a room with the confidence of knowing what is going on inside.

Design features should be incorporated that will help with orientation, recognition, and familiarity. A simple floor plan should be provided to guide orientation with the help of cues and landmarks and by maximising the amount of natural light in the building, particularly where there is a change in level or direction. Smart technology can be of particular benefit to residents with dementia. For example, movement through doors can be monitored with movement (PIR) sensors without encroaching on the freedom and privacy of residents.

Each individual will respond in a different way in terms of patterns and rate of deterioration. The universal characteristics of 'home' should be recognised to create a supportive, enabling environment that might ameliorate the degenerative process.

b) **Design Principles for Short Term Memory Loss** - these include:

- A pleasant familiar domestic environment
- Domesticity in scale and character
- Space to be surrounded by personal possessions
- A simple, easily comprehensible layout
- Visual accessibility, key vistas, open plan, etc.
- Visual cues: personalizing entrances, use of color, artwork etc.
- Small scale living – cluster arrangement
- A plan to facilitate wandering
- Elimination of 'dead-end' corridors
- Security.
- Appropriate garden/amenity provision
- Integration with the community

**c) Day care and intermediate or respite care**

Wirral may also wish to commission day activities, respite care and intermediate care within an extra care scheme, but this would be determined on a site-by-site basis. Some older people with learning difficulties may wish to move into an Extra Care Housing development. Others may already be living in a specialist accommodation-based scheme for people with learning difficulties, or in supported living scheme, and may wish to remain living in these types of services. The key issue will be to give older people with learning difficulties greater choice over their housing options.

**d) Learning Disability and autism**

Extra Care Independent Living housing for people with learning disabilities does not have significantly different design issues from extra-care for older people; however, consideration should be given to the needs of:

- People with a learning disability living in a residential setting or with Carers who may need to move because of changing needs.
- People with a learning disability who need specially designed or adapted dwellings including the provision of suitably enabling assistive technology.
- People with a learning disability who need enhanced housing care and support.

- People with autism who need enhanced housing care and support.
- People with a learning disability who have complex needs.
- The ethos of Extra Care Independent Living for people with a learning disability /mental health is around enabling the person to be as independent as possible and to be able to access the community to fulfil their full potential. The service will have staff on site to respond to Assistive Technology throughout the 24-hour period and provide some pop in calls, low level prompting, some housing support tasks and organising occasional social activities.
- People will be assessed for specific hours that they require to carry out specific tasks. It is not anticipated that people will need a member of staff with them at all times as the ethos for the service is to promote independence.

**e) Long Term conditions**

Design should also accommodate the needs of residents with a typical long-term condition and health needs associated with stroke, heart disease, cancer, diabetes, mental health, brain injury, MS, and obesity.

**General Requirements**

Any development of Extra Care Housing would be expected to meet Wirral's planning policies, supplementary planning guidance and sustainable design principles. It is also expected that developments incorporate dementia friendly design principles which are tested by the University of Stirling Audit Tool. Wirral Council may conduct audits of developments utilising the Audit Tool.

Any Programme of development would be expected to be designed in consultation with the Council's Department of Social Services, Strategic Housing and Investment Team and Development Management colleagues. Any housing which is affordable would also need to have regard to the Nationally Described Space Standard. Generally, Extra Care Housing should also meet the full nationally described wheelchair accessible standards throughout.
https://www.gov.uk/government/publications/technical-housing-standards-nationally-described-space-standard

The size of each Extra Care Housing scheme will vary depending on the need of residents, the requirements of the local authority and the size of the site. Economies of scale should be achieved without detracting from the quality of life enjoyed by residents. Schemes can either be newly purpose built or can be remodelled from existing sheltered housing schemes where feasible and viable.

Extra Care Housing schemes should provide a mix of one and two bed homes; the exact number will be negotiated for each scheme; however, the bulk of units should be one bed. In addition, Wirral wishes to see a mix of tenure of extra care however the proportion will be negotiated for each scheme to reflect market conditions. The scheme will also need to comply with local planning policy on minimum affordable housing requirements.

**Dependency mix and assessment and allocations**

All people moving into Extra Care Housing must have an assessed need for care and support, eligible under the Care Act 2014, as well as a housing need. It is important to maintain a balanced level of need within each scheme in terms of levels of eligible need for the core hour support services to be able to effectively respond. Allocations into Extra Care Housing will be made through the Extra Care Housing process following an assessment by a qualified social worker. This will ensure that there is a mix of clients who have high, medium, and low care and support needs in any one Extra Care Housing scheme.

In relation to couples, eligibility would need to be determined with regard to at least one person.

**Location**

Extra care schemes must be located near good transport links and close to a wide range of community amenities and healthcare facilities. The Council's emerging Core Strategy Local Plan seeks to direct higher density residential development to urban sites within an easy walking distance of an existing town, district or local center or a high frequency public transport corridor.

**Operational Principles**
Wirral Council wish to see Extra Care Housing schemes operating in a manner which:

a) Promotes independence, healthy, active ageing, and overall general and emotional wellbeing.
b) Promotes social inclusion for residents and the local community; ensuring that older people are not left socially isolated and lonely behind their own flat door. This should be through the development of close links with the local health and social care sector, voluntary sector, and private/business sector to promote the use of the extra care scheme's facilities and services, to develop a full range/ programme of activities/therapies/treatments/services that could be provided to residents and the local community within the scheme.
c) Empowers residents to have a strong and active say in how they wish to see their scheme operating and working - including making informed decisions around provision of new services and associated costs/service charges.

**Residents**
As well as providing an environment that can provide for emotional and support needs, it is essential that the physical environment is 'enabling' in particular for those who may experience increasing care needs with the advancement of age and frailty, also and physical disabilities.

**Key Design and Specification Issues**

**Supporting impairments, disabilities, and frailty**
a) Free-swing' door closers linked to the fire alarm should be fitted to the front doors of flats and other doors regularly used by residents. Remove obstructions such as fire compartment doors, which can be held open on magnetic pads. This will avoid the hazard and frustration associated with heavy overhead door closers. Specify vision panels to doors along circulation routes and leading to communal rooms.
b) Specify handrails along both sides of circulation routes that are appropriately scored to assist way-finding for those with visual impairments. Consider the design of handrails which return to the wall to avoid snagging of clothing on their free ends, which can easily lead to a fall for a frail older person.
c) Specify appropriate ironmongery, taps etc. for older people with limited dexterity.
d) At least one stretcher sized lift should be included to accommodate long-base wheelchairs/ stretchers/coffins.
e) Wheelchair standard design should be provided throughout the building. However, consideration should be given to the fact that certain areas such as residents' individual kitchens can be designed for adaptation for people who do not use a wheelchair until a later stage in their life. This will avoid costly fit outs at the initial stage and result in a more user-friendly space for the majority of residents who will never use a wheelchair in the kitchen. Allowances for future changes should be designed in from the beginning: the construction and detailing of the building should allow for ceiling hoists to be retrofitted within flats and stud-partition walls should be reinforced for grab rails in bath and shower rooms.
f) Specify level-threshold showers. Flooding in en-suite bathrooms with flush showers has been found to be a problem frequently faced in this typology. Locate the shower away from doors and take care with building tolerances, detail a fall in the floor of the shower tray area only. Specify a shower head that can be tilted downwards and not fixed at one angle.
g) Combine shower head rails with a grab rail to avoid residents pulling the shower rails off the wall in the event of slipping.
h) Specify sockets and switches at appropriate height.
i) Generally, any ramps should, as a minimum, comply with the provisions of the Building Regulations.
**j)** Acoustics: The importance of adequate sound separation and reduction of reverberation is especially important in Extra Care schemes where some, but not all residents suffer from hearing impairments. In some cases, Building Control have relaxed the stringent reverberation requirements in corridors and stairwells based on the user group.

**Wayfinding**

a) Good use of natural light and views out are essential, particularly on circulation routes and at stair and lift landings

b) The use of clear glazed screens to communal areas greatly improves the feeling of light and space within the building and enables good visual access throughout. Floor to ceiling glazing could be introduced where it is safe to do so in order to create an open, contemporary feel.

c) Good use of colour and tonal contrast and tactile materials aid orientation. These ensure that corridors do not become monotonous and assist wayfinding. Use 'accent' colors to pick out important landmarks or entrances.

d) Recessed doors to flats and kitchen windowsills onto corridors provide a place for residents to display personal items which assist in distinguishing flats.

e) Small seating bays along corridors or overlooking interesting vistas are very popular with residents and help to create landmarks to aid orientation.

**Lighting**

a) Lighting design is crucial. A range of different luminaries and light sources should avoid glare and sharp shadows.

b) Careful design of switching and dimming will ensure that different atmospheres can be created, and different needs catered for.

c) The importance of natural lighting is strongly emphasised as this can impact moods, way finding, solar gain etc. Corridors should ideally be lit from windows or roof lights (including kitchen windows onto corridors) to avoid long, dull vistas. Consider floor voids to enable natural light to reach lower floors. Balconies and winter gardens enable natural light and views of nature and contribute to wellbeing.

d) Avoid numerous light fittings in a regimented array, which may cause a clinical, institutional appearance and avoid performance specifying lighting as BS lux levels as this will restrict the end design due to the requirement for uniformity. Balance ceiling mounted fittings with the use of wall mounted fittings and specify feature lights where appropriate with suitable lux levels, e.g.: communal lounges, winter gardens, halls etc.

e) Avoid sharp contrasts between highly lit and dark spaces, as the ability of one's eyes to adapt to different levels of light decreases with age. Specify adjustable and flexible lighting to create various atmospheres or reduce/increase lighting levels to suit an activity.

f) Install lighting along the main routes of pathways so that the garden can be used safely in the evening. Good lighting is also required to all parking areas to provide surveillance lighting and CCTV as required for security.

**Interior Design**

High quality interior design will provide atmosphere and ambiance for key spaces. Little consideration in this area can dramatically influence the success of a development. A well-considered scheme will improve kerb-appeal, provide delight and a sense of pride. Market appeal is critical in both the public and private sector for any sustainable development.

a) **Contrast** - Reduce the effects of visual impairments by incorporating colour schemes that use contrasting tones to highlight features within the building and avoid 'visual clutter'. There should be a contrast between the floor, walls, and ceiling so that those with visual impairment can have an increased awareness of spatial dimensions.

b) **Specification of finishes** - Avoid shiny surfaces, especially shiny floor surfaces, as this confuses those with visual impairment. Highly patterned floor and worktop surfaces should also be avoided as this makes objects set against them harder to distinguish, e.g. a set of keys which has fallen on the floor. Natural materials assist way finding, divide spaces, highlight level changes etc. and help create a warm and less clinical environment. Specify finishes for large spaces with higher ceilings such as lounges and dining rooms with a high acoustic absorbency, in order to reduce echoes for the benefit

of those with hearing impairments.

c) **Dividing spaces** - Different spaces, particularly within the 'community village' should be considered individually to enhance their function and create an ambiance with a combination of lighting and subdivision of space. Large areas can be subdivided into smaller, more intimate spaces by the use of screening, indoor planting, variation in ceiling height, lighting, and appropriate furnishing.

d) **Corridors** - Within corridors, create a domestic appearance with careful attention to floor finishes and choice of light fittings. Consider integrating the handrails with a dado rail and a change in paint colour or wallpaper.

e) **Orientation** - The use of colour or themes will be an important tool for assisting with way-finding. Different colour ways or use of themed wall art/photos can be adopted for different floors or areas of the building to assist visitors or residents with orientating themselves. This is particularly successful at the points where people exit from a staircase or lift.

f) **Signage** - The design of signage is paramount, and a clear strategy should be developed which outlines its hierarchy, locations, and style. Signage must comply with Part M of the Building Regulations and BS8300:2001 provides additional points to consider.

**Tenancies and nominations**

a) **Tenancy agreements** - these should be in 'easy read' formats for all prospective tenants.

b) **Mental Capacity** - Issues of capacity need to be considered in relation to the signing of tenancy agreements.

c) **Nominations agreement** - The Council fully expect that they will hold the nominations agreements for Extra Care schemes in the borough.

**Round the Clock Care Provision**

It is expected that the round the clock or 24-hour provision of care on site is commissioned by the Local Authority who are responsible for this element of extra care. There may be exceptions to this on a time limited basis where an existing housing scheme is developed to become extra care and there are existing contracts to work to conclusion. There is a requirement that the care provider is accredited by the Council and is paid at the Council's rate.

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WIRRAL

**ADULT SOCIAL CARE AND PUBLIC HEALTH COMMITTEE**

**2 MARCH 2021**

| | |
|---|---|
| **REPORT TITLE** | *Extra Care Housing re-tender - Commission of Care and Support in 5 existing Extra Care Housing Schemes* |
| **REPORT OF** | Director of Care and Health |

## REPORT SUMMARY

The purpose of the report is to notify Committee of the re-tender of the Care and Support services within the following existing Extra Care Housing (ECH) schemes in Wirral, as the contracts were due to end 31 March 2021, to be extended until 1 June 2021.

1. **Harvest Court** - is on Harvest Lane, Moreton, Wirral. It is a 40-unit scheme with a mix of 1 and 2 bedroomed apartments. Harvest Court has an on-site restaurant open 6 days a week, hair salon open 2 days a week, small self-serve shop open 7 days, and a Day Centre on-site. The housing provider is Housing 21.

2. **Willow Bank Court** - is off Gorsey Lane, Wallasey. It is a 92-unit scheme with mix of 51 1 and 2 bedroomed apartments, (20 of which are shared ownership) and 4, 1-2 bedroomed bungalows (21 of which are shared ownership). The scheme was purpose built for Extra Care in 2010 with a further 22 bungalows built in 2014. Wirral Council have 100% nomination rights for rental. The housing provider is Housing 21.

3. **Granville Court** - on Marshlands Road in a quiet cul-de-sac in the village of Wallasey. 34-unit scheme with a mix of 1 and 2 bedroomed apartments. This Extra Care setting was built in 2001. Offering a range of facilities – restaurant, hair salon and is local to public transport and amenities. There are two gardens and guest rooms on-site. The housing provider is Housing 21.

4. **Mendel Court** - is on New Chester Road in Bromborough, close to Bromborough Village. It is a 49-unit scheme, with a mix of 1 and 2 bedroomed flats. There is also a hair salon, guest room and restaurant on-site. The scheme was purpose built for Extra Care in 2011. The housing provider is Housing 21.

5. **Cherry Tree House** – is on Cherrytree Road, Moreton with 10 one-bed apartments, and is a dementia specific scheme. The housing provider is Liverpool Housing Trust.

At the point of going to Tender, all schemes are 100% occupied.

This matter affects all wards within the Borough as placement can be made from anywhere in Wirral.

**RECOMMENDATION/S**

- That Committee agrees for the procurement process to take place for the Care and Support contract in each of the Extra Care Housing schemes listed above.

- That Committee gives delegated authority to the Director of Care and Health to award the tender to the successful bidder following the tender process.

## SUPPORTING INFORMATION

## 1.0 REASON/S FOR RECOMMENDATION/S

1.1 For the care and support services to be provided to residents within the Extra Care Housing schemes.

## 2.0 OTHER OPTIONS CONSIDERED

2.1 Officers intend to procure the care provision from the established Liverpool City Region (LCR) Flexible Purchasing System, as per current regional agreements. This allows a wider choice of providers as the framework has recently been extended to attract service providers.

2.2 Offers could have chosen to do a standalone procurement exercise or to tender from the Wirral only Care and Support Framework.

## 3.0 BACKGROUND INFORMATION

3.1 The Wirral Plan: A 2020 Vision included a target of an additional 300 extra care units for older people and people with learning disabilities and/or autism, by 2020. Building on the strategic priorities within the Wirral Plan 2020, the Wirral Plan 2025 also outlines as part of the 'Active and Healthy Lives' theme, our ambition for 'happy, active and healthy lives where people are supported, protected and inspired to live independently.'

3.2 Extra Care Housing enables older people and people with a disability to live in a home on their own in a designated development, with 24-hour care and support services on site. People are enabled to live in their own accommodation with care on site for when they need to access it. Extra Care Housing will be increasingly used as an alternative to residential care.

3.3 Wirral already has 250 units of Extra Care Housing accommodation in operation (328 when Poppyfields goes live on 15 March 2021). This accommodation has been developed as an alternative to residential care and is a valued resource in the Borough.

3.4 Wirral Health and Care Commissioning are working jointly with developers and housing associations to develop Extra Care Housing schemes across the Borough to meet the future demand of Wirral residents.

3.5 The Council's expectation is that any provider of care and accommodation works to a nomination's agreement with the Council so that placements can be prioritised based on local need.

3.6 A nomination agreement sets out an agreement to allocate properties to applicants whose details are supplied by another organisation, in this case Wirral Council. For these schemes, the Council will be entitled to 100% nomination rights on the first let of a property and 100% nomination rights for subsequent re-letting of void properties.

3.7 The 24-hour provision of care and support for Extra Care Housing is commissioned by the Local Authority.

**LCR Extra Care Housing Flexible Purchasing system**

3.8 In 2018/19 Knowsley, Sefton and Liverpool jointly procured a system to purchase care and support services in Extra Care Housing. Commissioners agreed a single service specification and contract. Work continues on developing a joint performance framework, with a full set of metrics, whilst the framework was developed with commissioners from the Liverpool Tripartite agreement (Liverpool, Sefton and Knowsley), all six LCR Authorities are named parties and therefore have the option to draw down services from the framework.

Draft procurement timescales are detailed below: -

| **Week Commencing** | **Procurement Timescales** |
|---|---|
| 8 March 2021 | Window opens for mini competition |
| 28 March 2021 | Window closed |
| 29 March – 16 April 2021 | Evaluations |
| May 2021 | ASC&PH Committee notify of awards |
| May 2021 | Award Made |
| June 2021 | Contract starts |

3.9 It is proposed the duration of the Contract is for 5 Years, starting 1 June 2021, ending 31 May 2026.

3.10 The care provider is to ensure 24-hour background support is available in the scheme to all residents (Band 1). In addition to the 24-hour support, some residents will also receive additional support based on assessed level of need. These are categorised into 5 care bands as per below: -

| Band 1 | Band 2 | Band 3 | Band 4 | Band 5 |
|---|---|---|---|---|
| Between 0 and ½ hour | Over ½ and up to 5 hours | Over 5 and up to 10 hours | Over 10 and up to 15 hours | Over 15 hours |

3.11 The service will ensure that, at all times, at least one member of staff is on site, this will be kept under review dependant on the need of the tenants. This will include waking night staff, that will be required to carry out planned care tasks and respond to emergencies throughout the night.

3.12 The Council will evaluate submissions on 100% quality, as the price is set from the framework.

3.13 The Council is to advertise the schemes in one overarching commission with each scheme as a lot. Providers will be able to apply for one or more of them to a maximum of 3. This is to ensure a spread of risk across the market should any of the providers fail, and to ensure some equity within the care market to support sustainability.

3.14 All providers will be paid at agreed framework rates for Extra Care Housing.

3.15 Cherry Tree House will be procured on the LCR Supported Living Framework as this scheme is a Dementia specific scheme and attracts the Supported living framework rate.

## 4.0 FINANCIAL IMPLICATIONS

4.1 The Council is currently paying an in-year enhancement up to 31 March 2021 for providers who are paying the Real Living Wage (RLW), all the current providers within the schemes are paying the RLW.

4.2 Below, is the annual cost and overall cost of the contract for each individual scheme (based on this year's rate or £14.66 for Extra Care Housing including the RLW, and £16.76 for Supported Living based on the RLW): -

| | Annual | Contract Value 5 years |
|---|---|---|
| Mendel Court | £321,793 | £1,608,965 |
| Granville Court | £284,450 | £1,422,250 |
| Harvest Court | £370,923 | £1,854,615 |
| Willow Bank | £424,779 | £2,123,895 |
| Cherry Tree House | £359,848 | £1,799,240 |

4.3 The Council will, in the final quarter of the financial year 2020/21, undertake its annual rate and fees negotiations and the final rate will be agreed at that point.

4.4 If the successful provider does not commit to paying the RLW, they will not receive the enhanced rate once agreed by Committee.

## 5.0 LEGAL IMPLICATIONS

5.1 The commission of the services detailed in this report will need to be undertaken in accordance with The Public Contract Regulations 2015 and the Council's Contract Procedure Rules. Using the framework detailed in this report, will meet these requirements.

## 6.0 RESOURCE IMPLICATIONS: ICT, STAFFING AND ASSETS

6.1 No implications arising directly for this Procurement exercise.

## 7.0 RELEVANT RISKS

7.1 Contracts will be in breach if the procurement exercise is not completed.

## 8.0 ENGAGEMENT/CONSULTATION

8.1 A presentation will be published on the CHEST, detailing all the schemes and key points in the specification along with Procurement timescales. This will be available to providers on the Flexible Purchasing System, for care and support in Extra Care Housing.

## 9.0 EQUALITY IMPLICATIONS

9.1 Equality implications are embedded into the procurement and tender processes used as part of the application process and are taken into account when evaluating tender applications. Equalities implications are also part of the decision-making process when an award is made.

## 10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 Staff are situated on site, therefore low impact emissions as no travel is required.

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## APPENDICES

N/A

## BACKGROUND PAPERS

N/A

## SUBJECT HISTORY (last 3 years)

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

WIRRAL

**ADULT SOCIAL CARE AND PUBLIC HEALTH COMMITTEE**

**2 MARCH 2021**

| | |
|---|---|
| **REPORT TITLE** | *Re-commission of Wirral Healthwatch Service and Independent Health Complaints Advocacy Service* |
| **REPORT OF** | Director of Care and Health |

## REPORT SUMMARY

This report is to make Committee aware of the forthcoming recommission of the Wirral Local Healthwatch and the Independent Health Complaints Advocacy service.

The Local Healthwatch service has statutory functions which are set out in legalisation. The service supports local residents accessing health and care services across all wards in the borough of Wirral.

This requires a key decision as it is related to budget expenditure.

## RECOMMENDATION/S

Adult Social Care and Public Health Committee is recommended to:

1. Approve to progress the tendering of the Local Healthwatch and Independent Health Complaints Advocacy Services.
2. Give delegated authority to the Director of Care and Health to award the tender of the Local Healthwatch contract to the successful bidder.

## SUPPORTING INFORMATION

### 1.0 REASON/S FOR RECOMMENDATION/S

1.1 The Local Authority has a statutory responsibility to contract the provision of a local Healthwatch service.

### 2.0 OTHER OPTIONS CONSIDERED

2.1 As this is a statutory requirement, there has not been any alternative options considered.

2.2 We could have considered alternative contract lengths, but we wanted to secure a 5-year contract for continuity purposes.

### 3.0 BACKGROUND INFORMATION

3.1 The Health and Social Care Act 2012 sets out the functions of the Local Healthwatch as follows:

- Obtain the views of people about their needs for and experiences of local health and care services and make their views known to those involved in the commissioning, provision and scrutiny of local care services.
- Make reports and recommendations about how those services could or should be improved.
- Promote and support the involvement of people in monitoring, commissioning and provision of local care and health services.
- Represent the collective voice of patients, service users, Carers and the public on the Wirral Health and Wellbeing Board.
- Exercise Enter and View functions i.e. enter health and social care premises to observe and assess the nature and quality of those services.
- Provide information and advice to the public about accessing health and care service and promote choice in relation to aspects of those services.
- Make the views of local people known to Healthwatch England.
- Make recommendations to Healthwatch England to advise the Care Quality Commission to carry out investigations into areas of concern, where appropriate.

3.2 A summary description of the service is that the Local Healthwatch is a statutory service for people who use health and social care services and provide an independent channel for people to communicate their views on the health and care system in order to improve standards.

3.3 The Independent Health Complaints Advocacy Service supports people with health and social care complaints and signposts people to information and advice.

3.4 Healthwatch Wirral went live in April 2013. The service was re-commissioned in April 2015 with a 3-year plus 24-month contract length. The contract was due for renewal in 2020, but due to coronavirus the contract was extended throughout 2020/21.

**The Independent Health Complaints Advocacy Service**

3.5 The Independent Health Advocacy Service contract was originally awarded to Carers Federation this arrangement ceased when the contract ended in 2018, following procurement rules, the service was transferred to the incumbent Healthwatch provider in April 2018. It is intended that this service will be recommissioned in conjunction with the main Local Healthwatch commission.

3.6 The proposed contract length is 5-years with two 12-month extension options.

3.7 The provider will be a social enterprise that has an accessible Wirral base; an excellent understanding of the local health and social care service provision; proven experience in actively seeking the views and experiences of local people and evidence the ability to provide a quality service and social value impact. Tenders will be evaluated following best value principle and demonstrate that they meet the most economically advantageous tender.

## 4.0 FINANCIAL IMPLICATIONS

4.1 The Local Healthwatch contract annual budget is £170,000. The total cost of a 5-year contract would be £850,000.

4.2 The Independent Health Advocacy contract annual budget is £18,000. The total cost of a 5-year contract would be £90,000.

4.3 The budget for the service is available from the Adult Social Care budget.

## 5.0 LEGAL IMPLICATIONS

5.1 Following the Health and Social Care Act 2012, the Local Healthwatch service was established. The Local Government and Public Involvement in Health Act 2007 sets out the arrangements for patient and public involvement through the Local Healthwatch Service.

5.2 Commissioning will follow the Public Contract Regulations and the Council's Contract Procedure Rules.

5.3 An Open Procurement exercise of 30 days will take place, with the Alcatel 10 working day stand-still from contact award notices to the final signing of the contract.

## 6.0 RESOURCE IMPLICATIONS: ICT, STAFFING AND ASSETS

6.1 There are no implications as a result of this report.

## 7.0 RELEVANT RISKS

7.1 If we do not commission a Local Healthwatch service we would fail to meet our statutory requirements.

7.2 If a new provider is successful, commissioners will work with the incumbent and new provider to ensure that any disruption to service delivery is kept to an absolute minimum.

## 8.0 ENGAGEMENT/CONSULTATION

8.1 The Local Healthwatch functions are embedded in legislation and have not been consulted on.

## 9.0 EQUALITY IMPLICATIONS

9.1 The Local Healthwatch service is available to all people in the protected characteristic groups and all Wirral residents. An impact review will be completed prior to tendering.

## 10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 There are no significant environment and climate implications in relation to this service. The service provider will seek alternative solutions i.e. essential travel, to reduce generation of CO2 emissions.

**REPORT AUTHOR:** ***Carol Jones***
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## APPENDICES

N/A

## BACKGROUND PAPERS

HeathWatch Wirral Contract Award Letter (dated 1 March 2018)

## SUBJECT HISTORY (last 3 years)

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

WIRRAL

# ADULT SOCIAL CARE AND PUBLIC HEALTH COMMITTEE

## Tuesday, 2 March 2021

| | |
|---|---|
| **REPORT TITLE:** | **CAPITAL AND REVENUE BUDGET MONITORING, QUARTER 3** |
| **REPORT OF:** | **DIRECTOR OF CARE AND HEALTH** |

### REPORT SUMMARY

This report sets out the financial monitoring information for the Adult Social Care and Health Committee. The report provides Members with an overview of budget performance for this area of activity. The financial information details the projected year-end revenue and capital position, as reported at quarter 3 (Apr-Dec) 2020/21.

This matter affects all Wards within the Borough. This is not a key decision.

### RECOMMENDATION/S

The Adult Social Care and Health Committee are requested to note the projected year-end revenue forecast position of £0.036m adverse and the performance of the capital programme, as reported at quarter 3 (Apr-Dec) of 2020/21.

## SUPPORTING INFORMATION

## 1.0 REASON/S FOR RECOMMENDATION/S

1.1 Regular monitoring and reporting of the Revenue Budgets, savings achievements and Medium-Term Financial Strategy (MTFS) position enables decisions to be taken faster, which may produce revenue benefits and will improve financial control of Wirral Council.

## 2.0 OTHER OPTIONS CONSIDERED

2.1 No other options have been considered.

## 3.0 BACKGROUND INFORMATION

3.1 As at the end of December 2020 (Quarter 3), the forecast year-end position for Adult Care and Health is an adverse variance of £0.036m against a net budget of £106.627m.

3.2 The forecast had been expected to significantly deteriorate to an adverse position of approximately £1m due to steadily increasing client numbers, particularly in Domiciliary care, alongside increasing average cost of care packages. However, access to the Government's Covid-19 Tranche grant funding and grants received to support the Clinically Extremely Vulnerable (CEV) have helped to temporarily alleviate much of the in-year financial pressures.

**TABLE 1: 2020/21 Adult Care and Health – Service Budget & Forecast**

| | **Budget** | **Forecast** | **Variance** (+ Fav, - Adv) | | **Adv/ Fav** |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | % | |
| Adult Social Care Central Functions | 9,778 | 9,217 | 561 | 6% | Favourable |
| Older People Services - WCFT | 44,903 | 45,062 | (158) | 0% | Adverse |
| Mental Health & Disability Services - CWP | 48,293 | 48,428 | (135) | 0% | Adverse |
| Other Care Commissions | (148) | 182 | (330) | -223% | Adverse |
| Public Health | 215 | 13 | 202 | 0% | Favourable |
| Wirral Intelligence Service | 485 | 458 | 27 | 6% | Favourable |
| **Directorate Surplus / (Deficit)** | **103,525** | **103,360** | **166** | | Favourable |
| Support/ Admin Building Overhead | 3,577 | 3,577 | 0 | 0% | |
| Movement in Reserves | (476) | (274) | (202) | 42% | Adverse |
| **Total Surplus / (Deficit)** | **106,627** | **106,663** | **(36)** | **0%** | **Adverse** |

3.3 **Central Functions:** Favourable variance of £0.561m is mainly due to savings from employee costs from vacancies, staff not at the top of their pay scales although the budget is set assuming that this is the case and short delays in filling vacant posts.

3.4 **Older People Services:** Adverse variance of £0.158m. The main contributing factor for the deficit forecast in this area is the increased risk of non-achievement of efficiency savings approved at the start of the financial year. This pressure has been partially offset by access to Government Covid-19 monies and the CCG's responsibility to provisionally fund hospital discharges and deflections. However, since September the remit for CCG funding has reduced and the average cost of a care package has increased, placing greater financial pressure in this area.

3.5 **Mental Health & Disability Services:** Adverse variance of £0.135m. The main contributing factor for the deficit forecast in this area is the increased risk of nonachievement of efficiency savings approved at the start of the financial year. The cost of care within Mental Health & Disability Services has been partially eased due to access to Government Covid-19 monies.

3.6 **Other Care Commissions:** Adverse variance of £0.330m is caused by early intervention and prevention (EIP) commissions. Many of these commissions have been extended longer than initially anticipated due to the COVID-19 pandemic.

3.7 **Public Health:** The favourable variance of £0.202m is in relation to the Cheshire and Merseyside Public Health Partnership (CHAMPS), where responding to the Covid pandemic has led to some vacancy and project slippage. As Public Health variances cannot be utilised by Wirral Council for any other activity, a corresponding movement in reserves is shown, having the impact of fully utilising the grant in-year, which is in line with the ringfenced nature of the grant for Public Health activity. Public Health is a ringfenced grant with an annual value £29.7m and projected to be fully utilised. £6.7m of this funding supports public health activities delivered by the Council, representing a significant funding stream.

3.8 **Wirral Intelligence Team**: Favourable variance of £0.03m represents surpluses in staffing costs mainly due to staff not being at the top of their pay scales, although the budget is set assuming that this is the case, coupled with short delays in filling vacant posts.

3.9 **Movement on reserves:** The movement within reserves relates to the Cheshire and Merseyside Public Health Partnership (CHAMPS) budget as noted in 3.2.8. It should be noted that the Budget reserves position has moved from Quarter 2 (£5,864m) to Quarter 3 (-£0.476) to more appropriately reflect the controllable nature of the use of reserves by the Public Health team, as Wirral Council cannot access this funding stream.

3.10 **Pressures and Savings Statement:** The increased risk of non-achievement of the £3.75m of efficiency savings, approved at the start of the financial year and prior to the Covid-19 pandemic, are exacerbating the financial pressures. In the current circumstances, it has been difficult to forecast with confidence the likely progress toward the achievement of these savings due to the operational disruption and delays caused by Covid-19. At present and based upon savings to date, our forecast position assumes £1m of these savings will be achieved. There also continues to be

the risk of, potentially significant, increases in demand for care services as we move through the year and the impact of Covid-19 and the period of lockdown is realised. The reduced 'cost of care' burden on the revenue budget will be offset by the increased risk of non-achievement of the full £3.75m of efficiency savings. £2.75m of these savings are considered high risk of non-achievement.

**TABLE 2: 2020/21 Adult Care and Health – Subjective Budget & Forecast**

| | **Budget** | **Forecast** | **Variance** (+ Fav, - Adv) | | **Adv/ Fav** |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | % | |
| Income | (83,919) | (83,734) | (185) | 0% | Adverse |
| **Expenditure:** | | | | | |
| Employee | 5,786 | 5,291 | 495 | 9% | Favourable |
| Non Pay | 53,846 | 53,987 | (142) | 0% | Adverse |
| Cost of Care | 127,813 | 127,816 | (3) | 0% | Adverse |
| **Total Expenditure** | **187,445** | **187,094** | **351** | 0% | Favourable |
| **Directorate Surplus / (Deficit)** | **103,525** | **103,360** | **166** | 0% | Favourable |
| Support/Admin Building Overhead | 3,577 | 3,577 | 0 | 0% | |
| Movement in Reserves | (476) | (274) | (202) | 42% | Adverse |
| **Total Surplus / (Deficit)** | **106,627** | **106,663** | **(36)** | **0%** | **Adverse** |

3.11 **Income:** Adverse variance of £0.185m due to the impact of Covid-19 through clients suspending packages of care during the pandemic.

3.12 **Employees:** Favourable variance of £0.495m. There are surpluses in all areas due to vacancies, staff not at the top of their pay scales although the budget is set assuming that this is the case, coupled with short delays in filling vacant posts.

3.13 **Non Pay:** Adverse variance of £0.142m relates to early intervention and prevention (EIP) commissions. Many of these commissions have been extended longer than initially anticipated due to the COVID pandemic.

3.14 **Cost of Care:** The adverse variance of £0.03m, is not material at this level. It should be noted that the forecast was expected to have significantly deteriorated to an adverse position of approximately £1m due to steadily increasing client numbers, particularly in Domiciliary care, alongside increasing average cost of care packages. However, access to the governments Covid-19 Tranche grant funding and other grants received to support the Clinically Extremely Vulnerable (CEV) have helped to temporarily alleviate much of the in-year financial pressures.

3.15 **Capital Budget**

**TABLE 3: 2020/21 Adult Care and Health – Capital Budget and Forecast Position**

| | Budget | Forecast | Variance (+ Fav, - Adv) | | Adv/ Fav |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | % | |
| Adult Care & Health | 7,550 | 911 | 6,639 | 88% | Favourable |

3.16 Table 3 provides an update on the 2020/21 Capital Programme. Several variations have arisen since the programme was agreed in March 2020. The Covid-19 pandemic has delayed the expected programme of Assistive Technology installations and Extra Care Schemes in 2020-21. These budgets will be slipped into the next financial year (2021-22).

## 4.0 FINANCIAL IMPLICATIONS

4.1 This is the capital and revenue budget monitoring report that provides information on the forecast outturn for the Adult Care and Health Directorate for 2020/21. The Council has robust methods for reporting and forecasting budgets in place and alongside formal Quarterly reporting to the Policy & Resources Committee, the financial position is routinely reported at Directorate Management Team meetings and corporately at the Strategic Leadership Team (SLT). In the event of any early warning highlighting pressures and potential overspends, the SLT take collective responsibility to identify solutions to resolve these to ensure a balanced budget can be reported at the end of the year.

## 5.0 LEGAL IMPLICATIONS

5.1 The provisions of section 25, Local Government Act 2003 require that, when the Council is making the calculation of its budget requirement, it must have regard to the report of the chief finance (s.151) officer as to the robustness of the estimates made for the purposes of the calculations and the adequacy of the proposed financial reserves. This is in addition to the personal duty on the Chief Finance (Section 151) Officer to make a report, if it appears to them that the expenditure of the authority incurred (including expenditure it proposes to incur) in a financial year is likely to exceed the resources (including sums borrowed) available to it to meet that expenditure.

## 6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 There are no implications arising directly from this report.

## 7.0 RELEVANT RISKS

7.1 The possible failure to deliver the Capital and Revenue Budget is being mitigated by:

1. Senior Leadership / Directorate Teams regularly reviewing the financial position.

2. Availability of General Fund Balances.
3. Review of existing services and service provision.
4. Capitalisation Directive

## 8.0 ENGAGEMENT/CONSULTATION

8.1 The priorities in the Council Plan 2025 were informed by stakeholder engagement carried out in 2019.

## 9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity.

9.2 There are no equality implications arising specifically from this report.

## 10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 The Wirral Plan 2025 includes a set of goals and objectives to create a sustainable environment which urgently tackles the environment emergency. These are based on developing and delivering plans that improve the environment for Wirral residents. The performance report will include information on key areas where environment and climate related outcomes are delivered.

10.2 No direct implications. The content and/or recommendations contained within this report are expected to have no impact on emissions of Greenhouse Gases.

**REPORT AUTHOR:** Mark Goulding
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email: markgoulding@wirral.gov.uk

## APPENDICES

None

## BACKGROUND PAPERS

- 2020/21 Revenue Budget Monitor for Quarter Three (Apr - Dec)
- Capital Monitoring Quarter 3 2020/21
- Revenue Budget 2020/21 and Medium-Term Financial Plan (2021/22 to 2024/25)

**SUBJECT HISTORY (last 3 years)**

| Council Meeting | Date |
|---|---|
| **Adult Social Care and Public Health Committee** | **18 January 2021** |

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WIRRAL

## ADULT SOCIAL CARE AND PUBLIC HEALTH COMMITTEE

### Tuesday, 2 March 2021

| | |
|---|---|
| **REPORT TITLE:** | **ADULT SOCIAL CARE AND HEALTH PERFORMANCE REPORT** |
| **REPORT OF:** | **DIRECTOR OF CARE AND HEALTH** |


**REPORT SUMMARY**

The report provides an update on performance in relation to Adult Social Care and Public Health. The report has been designed based on discussions with Members and an initial draft approved by the Adult Social Care and Public Health Committee at the meeting 13 October 2020. A Committee working group requested further development of the report content in December 2020 which has been incorporated.


**RECOMMENDATION**

It is recommended that the Adult Social Care and Public Health Committee note the content of the report and highlight any areas requiring further clarification or action.

## SUPPORTING INFORMATION

## 1.0 REASON/S FOR RECOMMENDATION

1.1 To ensure Members of the Adult Social Care and Public Health Committee have the opportunity to monitor the performance of the Council and partners in relation to Adult Social Care and Public Health Services.

## 2.0 OTHER OPTIONS CONSIDERED

2.1 This report has been developed in line with Member requirements. As such, no other options were considered.

## 3.0 BACKGROUND INFORMATION

3.1 Regular monitoring of performance will ensure public oversight and enable Elected Members to make informed decisions in a timely manner.

## 4.0 FINANCIAL IMPLICATIONS

4.1 There are no financial implications arising from this report.

## 5.0 LEGAL IMPLICATIONS

5.1 There are no legal implications arising from this report.

## 6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 There are none arising from this report.

## 7.0 RELEVANT RISKS

7.1 The Council's Corporate and Directorate Risk Registers are currently undergoing revision to reflect the work in progress to update the Council Plan and the impact of COVID-19 on proposed actions and plans in 2020/21 and beyond. Information on the key risks faced by the organisation and the associated mitigations and planned actions will be incorporated into committee reporting once refreshed.

## 8.0 ENGAGEMENT/CONSULTATION

8.1 Adult Social Care and Health services carry out a range of consultation and engagement with service users and residents to work to optimise service delivery and outcomes for residents.

## 9.0 EQUALITY IMPLICATIONS

9.1 There is no impact for equality implications arising directly from this report.

## 10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 There are no environmental and climate implications generated by the recommendations in this report.

The content and/or recommendations contained within this report are expected to:
- Have no impact on emissions of Greenhouse Gases.

**REPORT AUTHOR:** **Nancy Clarkson**
(Nancy Clarkson, Wirral Intelligence Service - Head of Intelligence)
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## APPENDICES

Appendix 1: Adult Social Care and Health Performance Report

## BACKGROUND PAPERS

Adult Social Care and Public Health Performance Report Q2 2020/21
Adult Social Care and Public Health Performance Report Q1 2020/21

## SUBJECT HISTORY (last 3 years)

| Council Meeting | Date |
|---|---|
| **Adult Social Care and Health Committee** | **18 January 2021** |
| **Adult Social Care and Health Committee** | **19 November 2020** |
| **Adult Social Care and Health Committee** | **13 October 2020** |

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# Adult Social Care and Public Health Committee

## Performance Report

## 28/01/2021

WIRRAL INTELLIGENCE SERVICE

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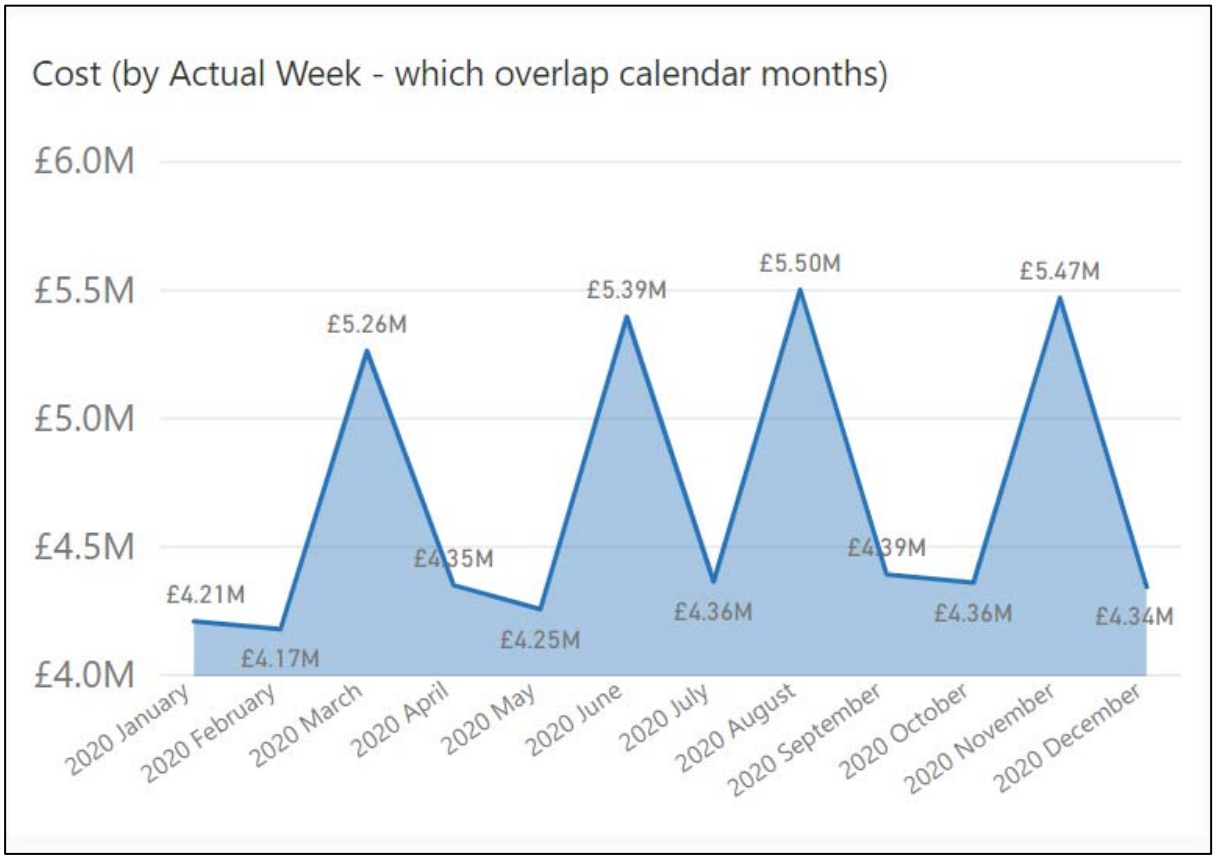
## 1.0 Introduction

The Adult Care and Health Committee have requested a set of key intelligence related to key areas within Health and Care. This report supplies that information for review and discussion by members. If additional intelligence is required further development on reporting will be carried out.

## 2.0 Care Market – Homes

### 2.1 Residential and Nursing Care - Cost and Numbers of People

The actual cost for Residential and Nursing Care over the last 12 months.

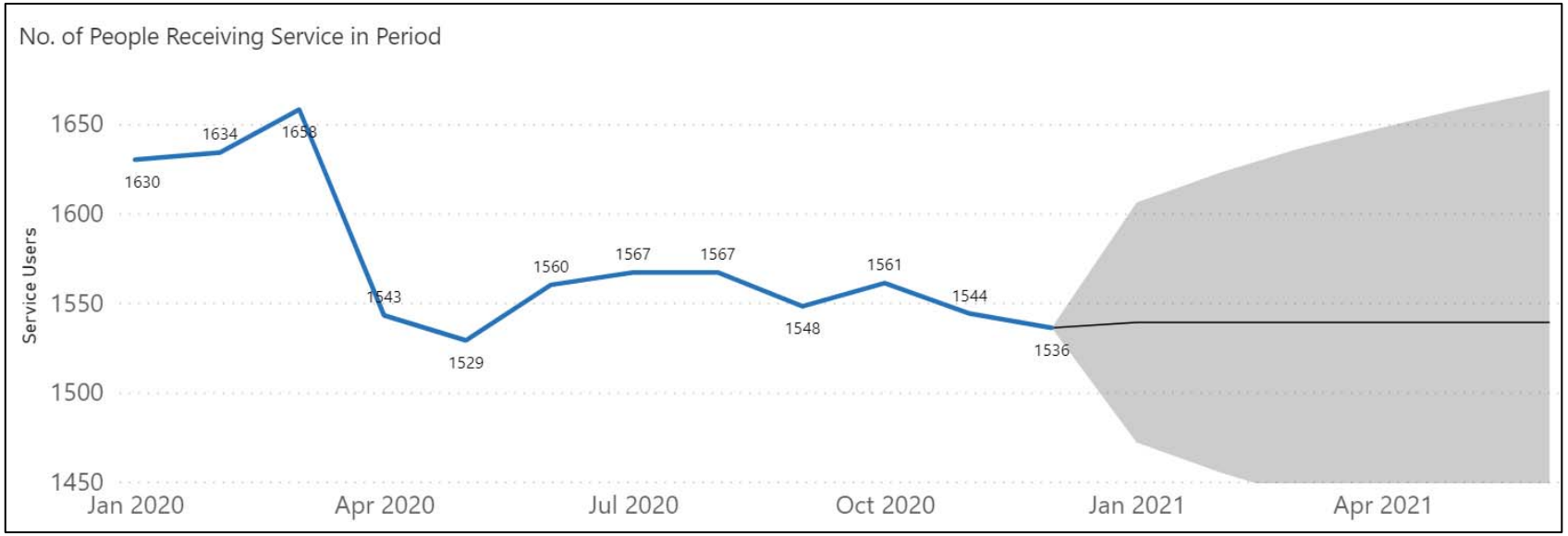


## Cost (by Actual Week - which overlap calendar months)

| Year | ActualCost |
|---|---|
| **2020** | **£56,037,399.99** |
| January | £4,205,290.12 |
| February | £4,174,434.61 |
| March | £5,259,050.01 |
| April | £4,346,392.70 |
| May | £4,252,553.92 |
| June | £5,392,079.86 |
| July | £4,359,896.51 |
| August | £5,497,454.39 |
| September | £4,388,763.49 |
| October | £4,355,795.51 |
| November | £5,466,022.78 |
| December | £4,339,666.09 |
| **Total** | **£56,037,399.99** |

The total number of people receiving residential care (that were billed) in the last 12 months.

## 2.2 Residential and Nursing Care Over Time

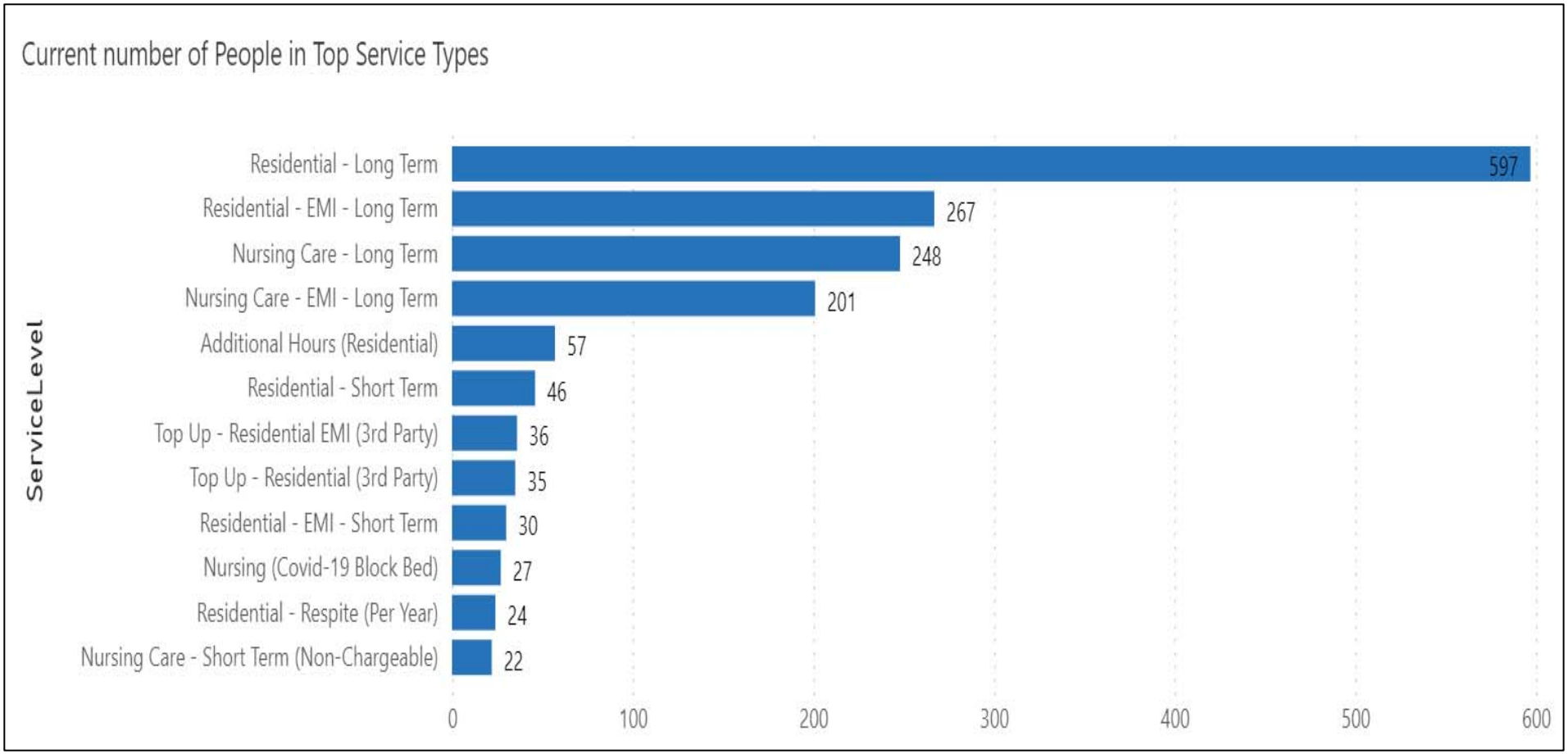



No. of People Receiving Service in Period

| Year | January | February | March | April | May | June | July | August | September | October | November | December | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2020 | 1630 | 1634 | 1658 | 1543 | 1529 | 1560 | 1567 | 1567 | 1548 | 1561 | 1544 | 1536 | **1536** |
| **Total** | **1630** | **1634** | **1658** | **1543** | **1529** | **1560** | **1567** | **1567** | **1548** | **1561** | **1544** | **1536** | **1536** |

The above line chart and table give the number of people receiving Residential and Nursing care month by month in the last 12 months. The line chart also shows a forecast in grey.

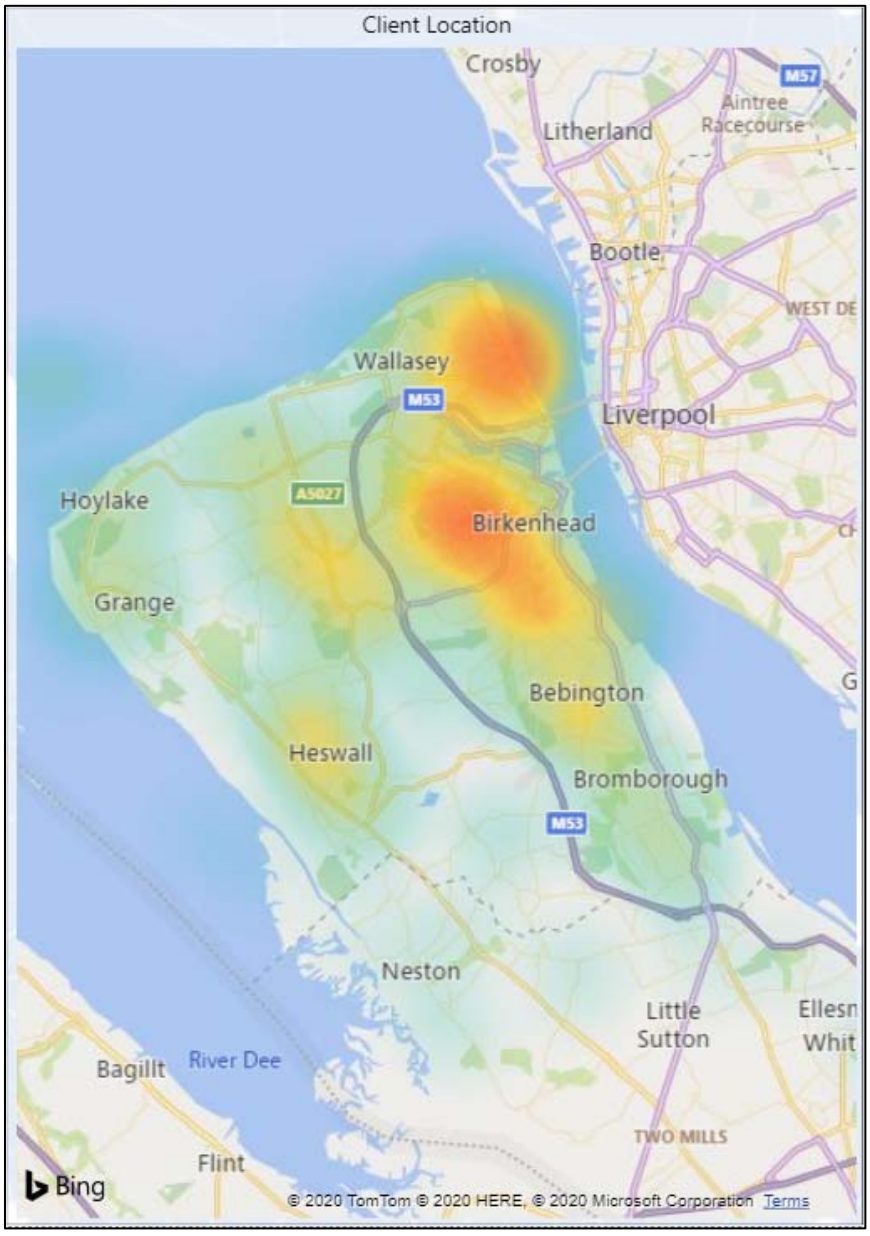
## 2.3 Residential and Nursing – Current People by Service Type



| ServiceLevel | No. of People |
|---|---|
| Residential - Long Term | 597 |
| Residential - EMI - Long Term | 267 |
| Nursing Care - Long Term | 248 |
| Nursing Care - EMI - Long Term | 201 |
| Additional Hours (Residential) | 57 |
| Residential - Short Term | 46 |
| Top Up - Residential EMI (3rd Party) | 36 |
| Top Up - Residential (3rd Party) | 35 |
| Residential - EMI - Short Term | 30 |
| Nursing (Covid-19 Block Bed) | 27 |
| Residential - Respite (Per Year) | 24 |
| Nursing Care - Short Term (Non-Chargeable) | 22 |
| Top Up - Residential (1st Party) | 22 |
| **Total** | **1460** |

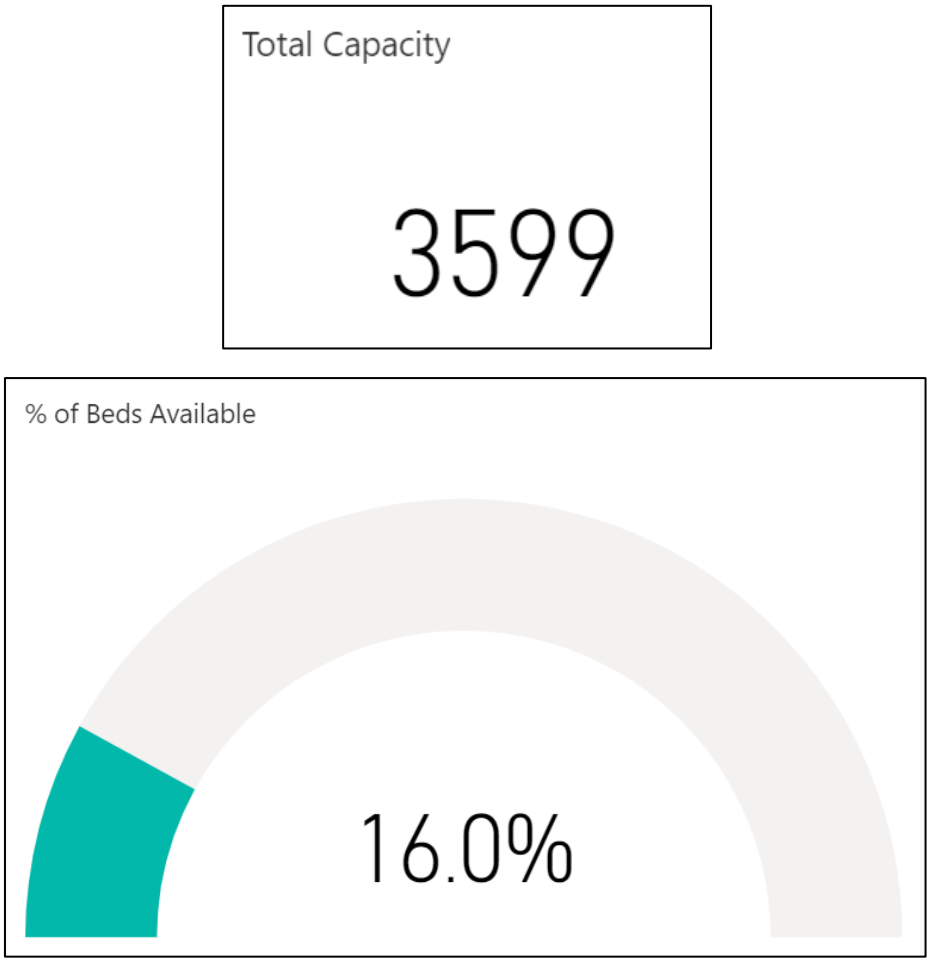
Residential and Nursing Long term and EMI (Elderly, Mental Health and Infirm) make up the bulk of the services received.

## 2.3 Residential and Nursing – People Location



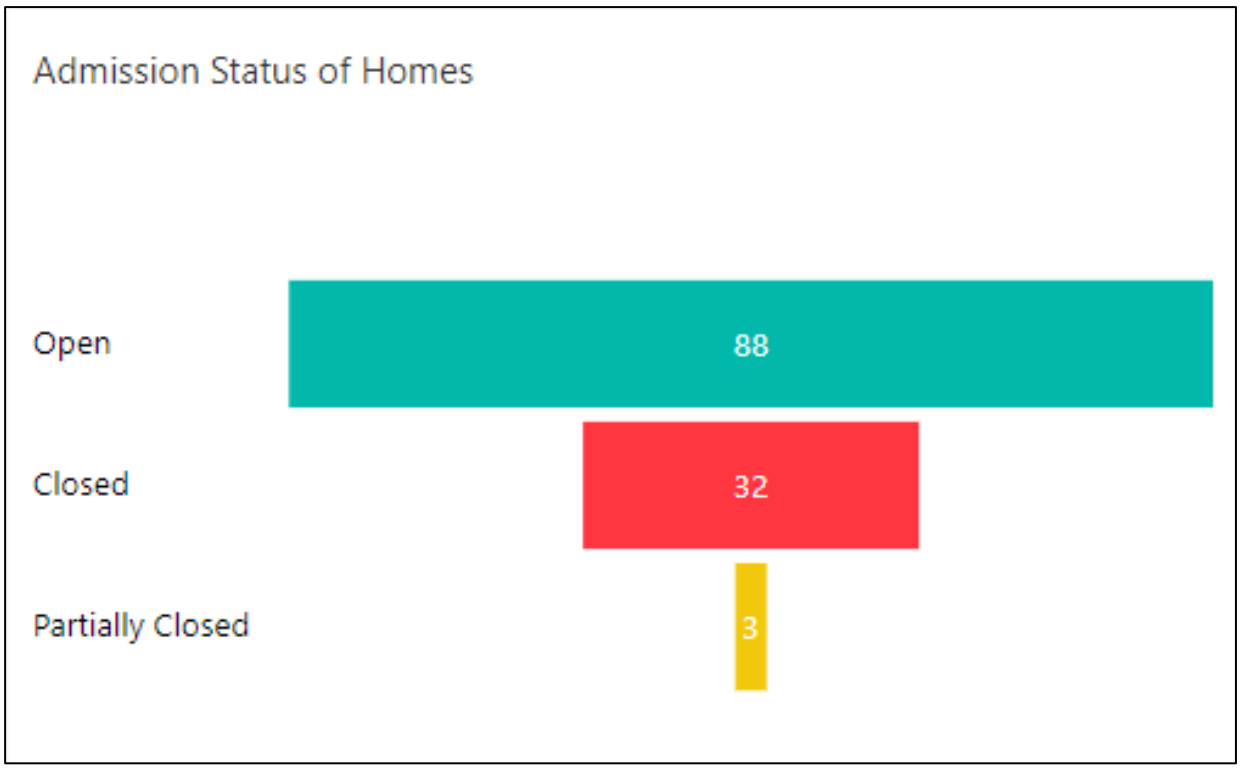

The heat map shows the care home locations.

## 2.4 Care Homes – Current Vacancy Rate




Data Source: NHS Capacity Tracker

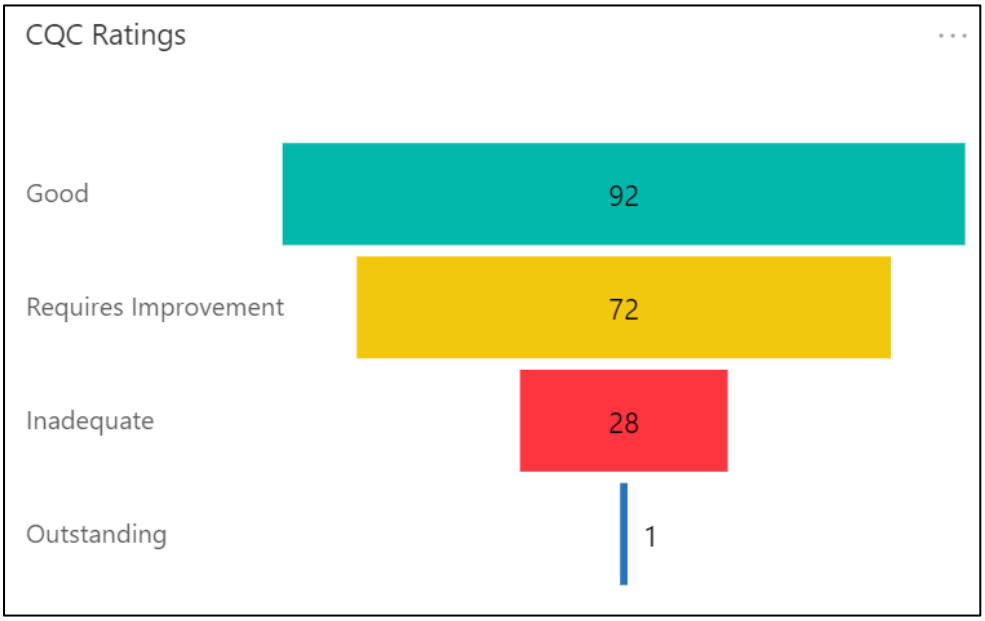
There is a capacity of 3599 places in care homes with a current vacancy rate as at 18/01/21 is 16%.




Data Source: NHS Capacity Tracker

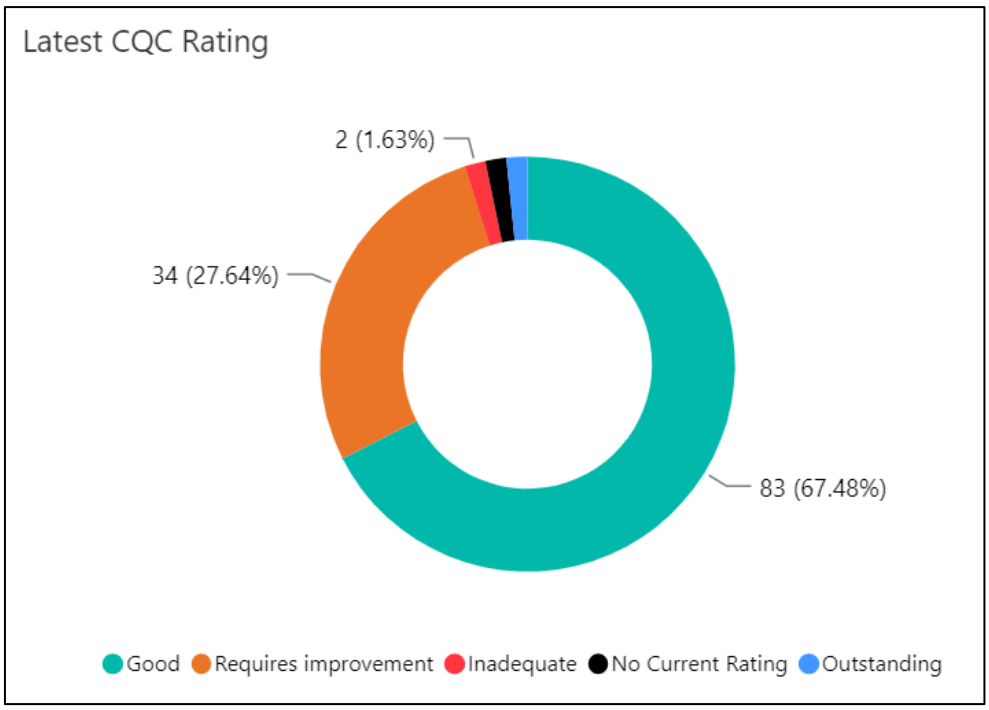
As at 18/01/21 there are currently 30 homes closed due to Covid19.

## 2.5 Care Homes – Care Quality Commission Inspection Ratings




Total number of inspections carried out since 05/01/2017 with rating information.

(Please note: homes may be inspected multiple times).

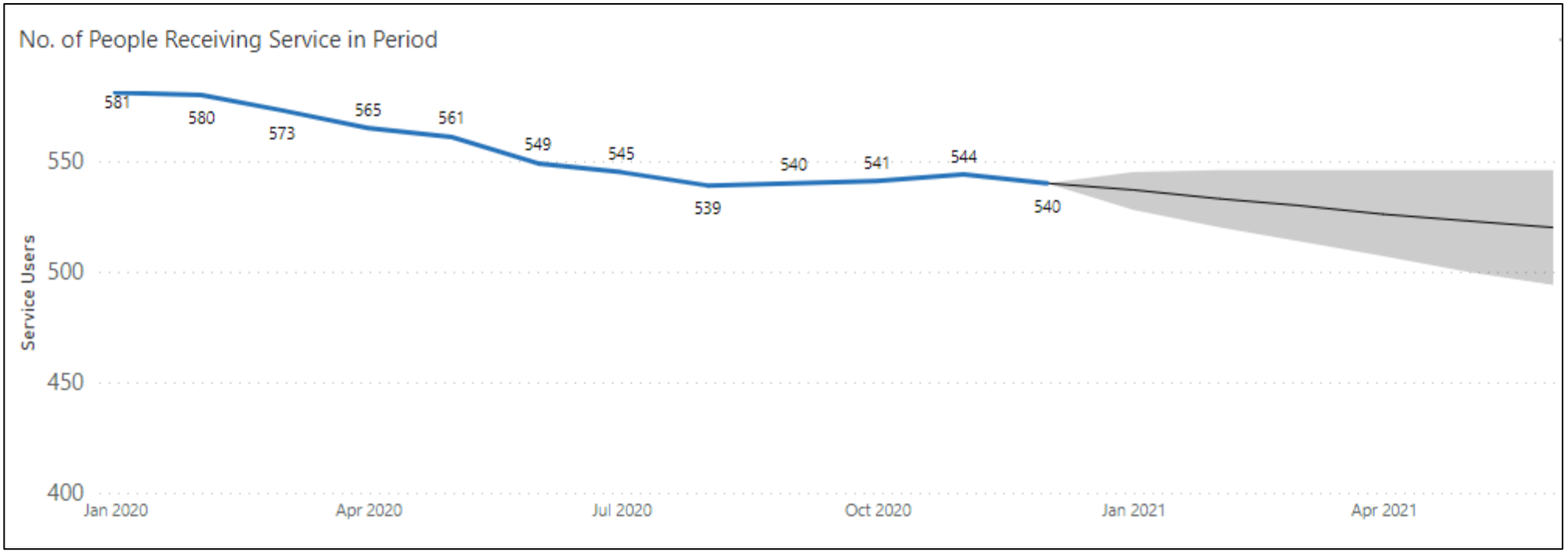



This is the current rating of the care homes based on their last CQC inspection.

The number of long-term care home placements continues to be at a reduced level, which is consistent with the intention to support people in their own homes wherever possible. Vacancy rates have continued to be higher than usual during the Covid-19 pandemic, with a high number of care homes closed to new admissions for infection control purposes. The Quality Improvement Team continue to work with care homes to reduce the number of homes with a rating of Inadequate or Requires Improvement.

## 3.0 Direct payments

### 3.1 Direct Payments – Number of People Receiving a Service



No of People Receiving Service in Period

| Year | January | February | March | April | May | June | July | August | September | October | November | December | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2020 | 581 | 580 | 573 | 565 | 561 | 549 | 545 | 539 | 540 | 541 | 544 | 540 | **540** |
| **Total** | **581** | **580** | **573** | **565** | **561** | **549** | **545** | **539** | **540** | **541** | **544** | **540** | **540** |

Data Source: ContrOCC



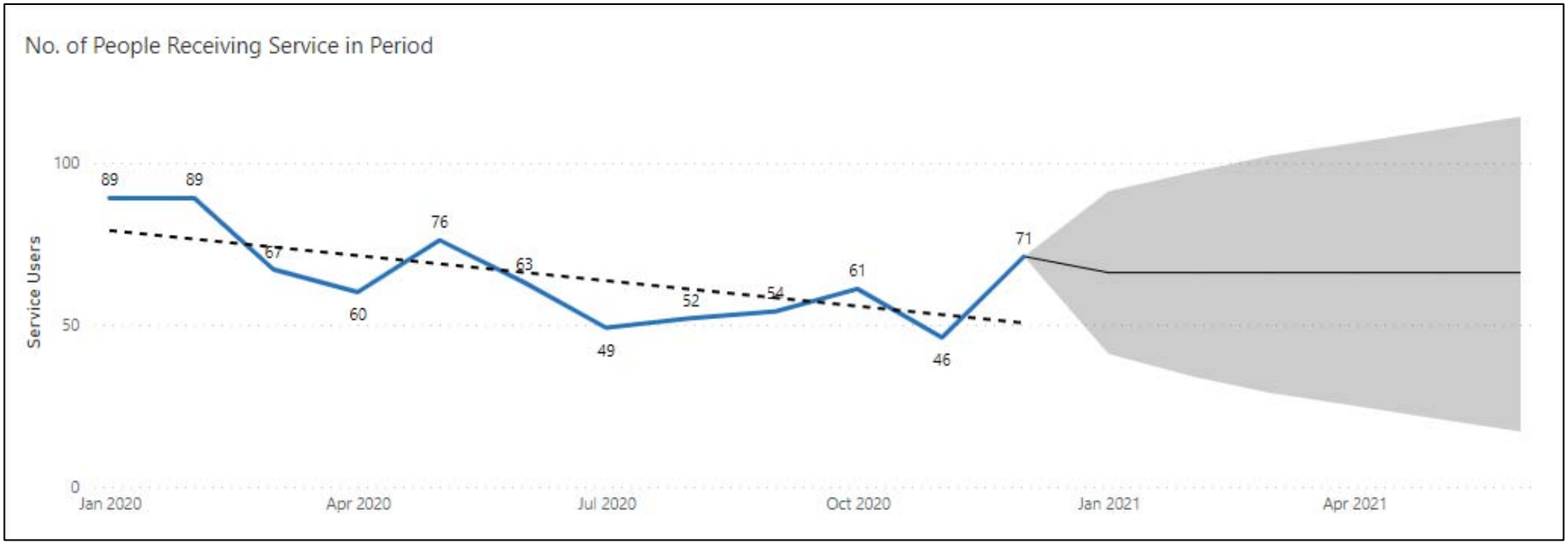
The chart and table show the number of people receiving a direct payment in the last 12 months. Data is updated monthly. The chart also indicates a projection of possible future numbers in grey.

The current number of people receiving direct payments as at 26/01/21 is 536.

There continues to be a small reduction in the number of people who arrange their support with a Direct Payment. This appears to be related to the Covid-19 pandemic. Direct Payments are a good option for people to be more in control of their care and support arrangements and the majority of Direct Payments are now made with a pre-Paid Card.

## 4.0 Care Market – Block Commitments:

### 4.1 Transfer to Assessment – Number of People



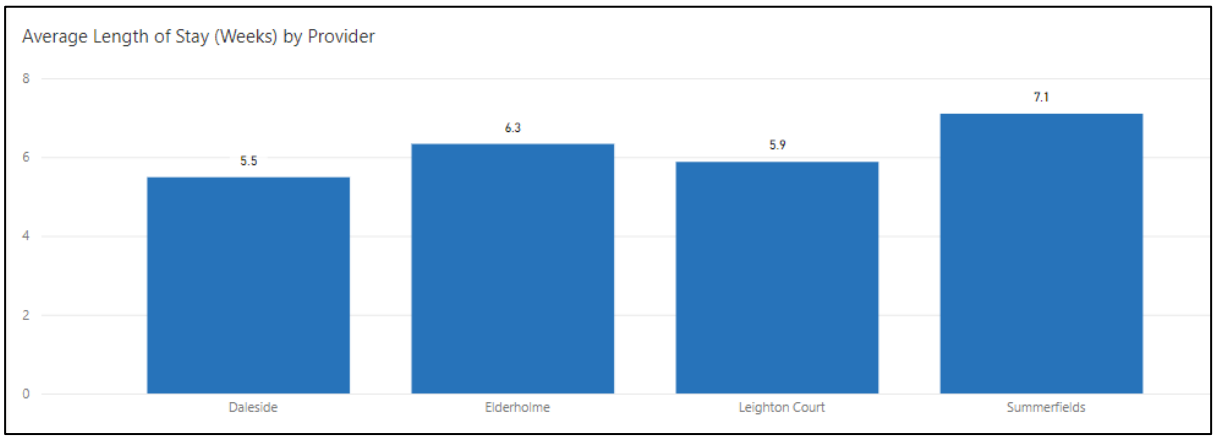

No. of People Receiving Service in Period

| Year | January | February | March | April | May | June | July | August | September | October | November | December | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2020 | 89 | 89 | 67 | 60 | 76 | 63 | 49 | 52 | 54 | 61 | 46 | 71 | **71** |
| **Total** | **89** | **89** | **67** | **60** | **76** | **63** | **49** | **52** | **54** | **61** | **46** | **71** | **71** |

Data Source: ContrOCC

These are care home beds commissioned for people being discharged from hospital who need further rehabilitation and recovery.

## 4.2 Transfer to Assessment – Average Length of Stay




Average Length of Stay (Weeks) by Provider

| Provider | Average of LOS in Weeks |
|---|---|
| Daleside | 5.49 |
| Elderholme | 6.33 |
| Leighton Court | 5.88 |
| Summerfields | 7.10 |
| **Total** | **5.92** |

Data Source: Liquid Logic

The average length of stay is shown since April 2018.

## 4.3 Transfer to Assessment – Vacancy Rate

| Table 1 - Actual Bed Days | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Nursing (Covid-19 Block Bed) | 967 | 1003 | 790 | 1008 | 1193 | 1264 | 941 | 1127 | 580 |
| Nursing EMI (Covid-19 Block Bed) | 94 | 121 | 1008 | 102 | 70 | 73 | 4 | 0 | 31 |
| Residential (Covid-19 Block Bed) | 232 | 244 | 223 | 275 | 358 | 290 | 29 | 0 | 28 |
| Residential EMI (Covid-19 Block Bed) | 550 | 424 | 336 | 273 | 230 | 179 | 377 | 408 | 300 |
| Transfer to Assess | 1913 | 2043 | 2200 | 1596 | 1619 | 1677 | 1730 | 1602 | 1517 |
| Grand Total | 3756 | 3835 | 3657 | 3254 | 3470 | 3483 | 3081 | 3137 | 2456 |

| Table 2 - Commissioned Bed Days | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Nursing (Covid-19 Block Bed) | 1680 | 1736 | 1680 | 1736 | 1736 | 1674 | 1550 | 1500 | 1562 |
| Nursing EMI (Covid-19 Block Bed) | 144 | 186 | 180 | 186 | 186 | 174 | 0 | 0 | 62 |
| Residential (Covid-19 Block Bed) | 913 | 1129 | 1110 | 1147 | 1147 | 886 | 180 | 0 | 31 |
| Residential EMI (Covid-19 Block Bed) | 630 | 651 | 630 | 651 | 651 | 630 | 651 | 630 | 461 |
| Transfer to Assess | 2831 | 2976 | 2880 | 2976 | 2917 | 1650 | 2914 | 2820 | 2914 |
| Grand Total | 6198 | 6678 | 6480 | 6696 | 6637 | 5014 | 5295 | 4950 | 5030 |

| Table 3 - % Occupancy | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Grand Total | 61% | 57% | 56% | 49% | 52% | 56% | 58% | 63% | 49% |

Data Source: WCFT

The above table shows the difference between the number of bed days commissioned compared to the actual bed days used.

Occupancy levels have been affected by temporary closures to new admissions, for infection control purposes. Additional services have been commissioned to respond to the level of need.

## 4.4 Short Breaks – Number and Occupancy Levels

Days Occupied in Week, Number of people

BY YEAR, MONTH

| Year | Number of people | Days Occupied in Week |
|---|---|---|
| **2020** | **357** | **1,765.00** |
| April | 21 | 128.00 |
| May | 18 | 116.00 |
| June | 33 | 179.00 |
| July | 36 | 189.00 |
| August | 54 | 256.00 |
| September | 61 | 306.00 |
| October | 57 | 279.00 |
| November | 39 | 163.00 |
| December | 38 | 149.00 |
| **Total** | **357** | **1,765.00** |

Occupancy Level by Date and Provider

| Date - Week Commencing | Vacancies Rate | Service |
|---|---|---|
| 06 April 2020 | 29% | Tree Vale Limited Acorn House |
| 13 April 2020 | 50% | Tree Vale Limited Acorn House |
| 20 April 2020 | 50% | Tree Vale Limited Acorn House |
| 27 April 2020 | 50% | Tree Vale Limited Acorn House |
| 04 May 2020 | 50% | Tree Vale Limited Acorn House |
| 11 May 2020 | 50% | Tree Vale Limited Acorn House |
| 18 May 2020 | 71% | Tree Vale Limited Acorn House |
| 25 May 2020 | 100% | Tree Vale Limited Acorn House |
| 01 June 2020 | 100% | Tree Vale Limited Acorn House |
| 08 June 2020 | 93% | Tree Vale Limited Acorn House |
| 15 June 2020 | 100% | Tree Vale Limited Acorn House |
| 22 June 2020 | 100% | Tree Vale Limited Acorn House |
| 29 June 2020 | 57% | Tree Vale Limited Acorn House |
| 06 July 2020 | 29% | Tree Vale Limited Acorn House |
| 13 July 2020 | 7% | Tree Vale Limited Acorn House |
| 20 July 2020 | 93% | Tree Vale Limited Acorn House |
| 27 July 2020 | 57% | Tree Vale Limited Acorn House |
| 03 August 2020 | 57% | Tree Vale Limited Acorn House |
| 10 August 2020 | 57% | Tree Vale Limited Acorn House |
| 17 August 2020 | 50% | Tree Vale Limited Acorn House |
| 24 August 2020 | 100% | Tree Vale Limited Acorn House |
| 31 August 2020 | 100% | Tree Vale Limited Acorn House |
| 07 September 2020 | 100% | Tree Vale Limited Acorn House |
| 14 September 2020 | 71% | Tree Vale Limited Acorn House |
| 21 September 2020 | 57% | Tree Vale Limited Acorn House |
| 28 September 2020 | 100% | Tree Vale Limited Acorn House |
| 05 October 2020 | 50% | Tree Vale Limited Acorn House |
| 12 October 2020 | 50% | Tree Vale Limited Acorn House |
| 19 October 2020 | 64% | Tree Vale Limited Acorn House |
| 26 October 2020 | 50% | Tree Vale Limited Acorn House |
| 02 November 2020 | 71% | Tree Vale Limited Acorn House |
| 09 November 2020 | 50% | Tree Vale Limited Acorn House |
| 16 November 2020 | 50% | Tree Vale Limited Acorn House |
| 23 November 2020 | 50% | Tree Vale Limited Acorn House |
| 30 November 2020 | 29% | Tree Vale Limited Acorn House |
| 07 December 2020 | 7% | Tree Vale Limited Acorn House |

Short Breaks services provide valuable support to people and their carers. It is usual to have fluctuating occupancy levels between short stay bookings.

## 5.0 Care Market – Domiciliary Care and Reablement

### 5.1 Domiciliary Care - Cost and Hours

| Actual Cost | Average Weekly Actuals Cost | Number of Calls |
|---|---|---|
| £27.02M | £281.50K | 2.85M |

| Number of Hours Delivered | Average No. of Weekly Hour... |
|---|---|
| 1.57M | 16.36K |

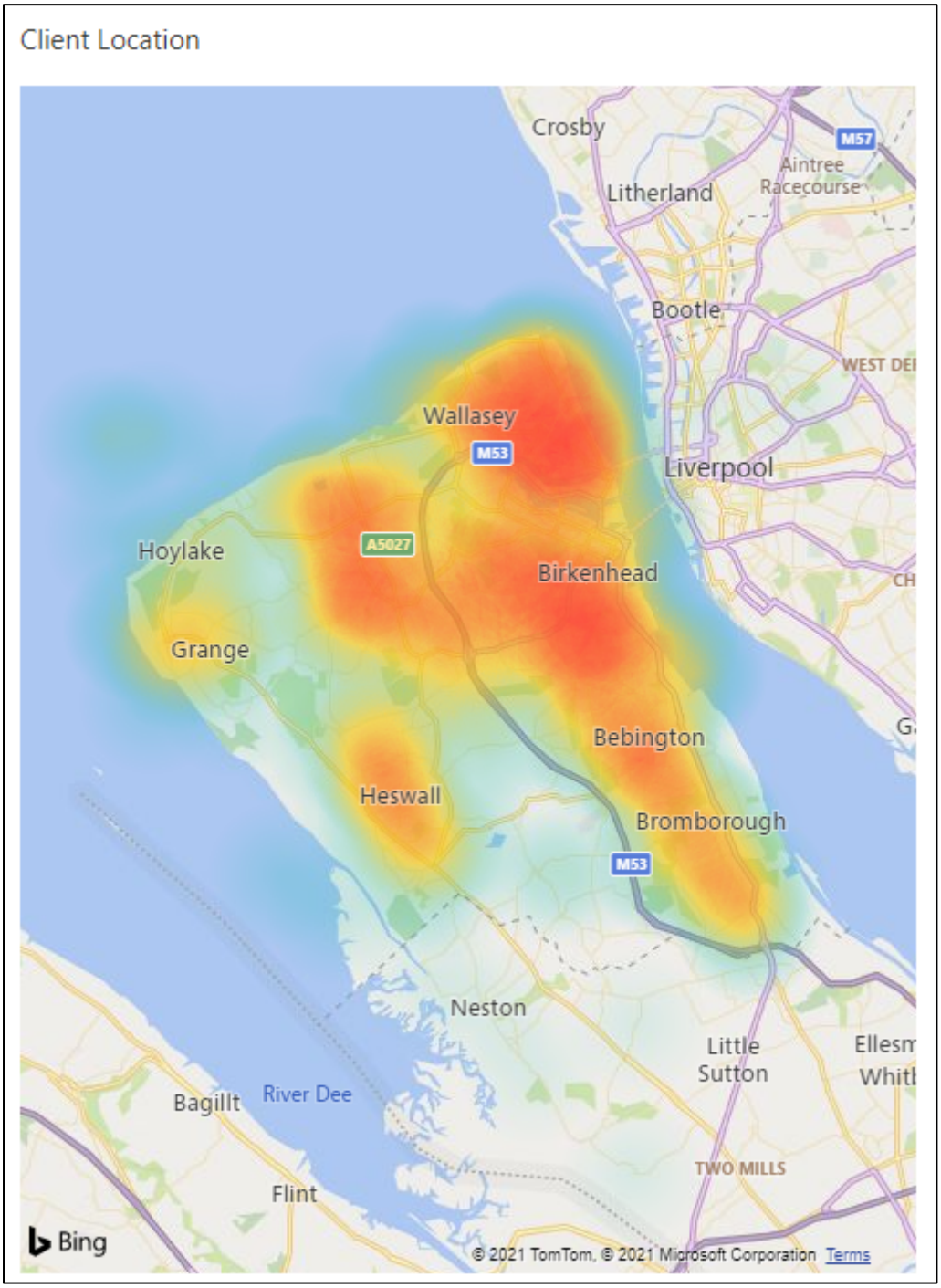
Actual Cost (with Average Line) Vs Comissioned Cost

| Year | Count of SSRef | Hours Delivered | Hours Commissioned | Actual Cost | Commissioned Cost |
|---|---|---|---|---|---|
| **2019** | **3434** | **720,064.03** | **863,749.00** | **£12,090,840.27** | **£14,174,818.36** |
| March | 1639 | 57,733.00 | 64,727.25 | £936,301.80 | £1,024,378.45 |
| April | 1852 | 86,052.88 | 96,054.75 | £1,419,649.11 | £1,577,577.75 |
| May | 1816 | 69,323.92 | 80,113.75 | £1,159,941.60 | £1,312,991.85 |
| June | 1838 | 70,019.15 | 80,324.75 | £1,180,593.88 | £1,316,966.23 |
| July | 1811 | 84,868.38 | 100,043.00 | £1,434,452.06 | £1,648,156.58 |
| August | 1743 | 66,001.78 | 80,510.50 | £1,113,722.04 | £1,325,912.04 |
| September | 1797 | 80,222.85 | 100,926.75 | £1,353,871.53 | £1,662,138.84 |
| October | 1772 | 63,628.67 | 79,908.50 | £1,072,075.88 | £1,319,241.60 |
| November | 1767 | 64,200.50 | 80,686.50 | £1,091,658.97 | £1,331,477.97 |
| December | 1791 | 78,012.90 | 100,453.25 | £1,328,573.40 | £1,655,977.04 |
| **2020** | **4224** | **850,520.27** | **1,156,223.83** | **£14,933,303.47** | **£20,221,981.12** |
| January | 1774 | 60,008.62 | 81,797.00 | £1,015,605.52 | £1,345,022.93 |
| February | 1851 | 73,645.43 | 86,175.00 | £1,235,171.51 | £1,400,001.26 |
| March | 1900 | 86,285.88 | 107,499.00 | £1,399,953.60 | £1,756,381.33 |
| April | 1808 | 69,543.25 | 85,850.25 | £1,181,227.72 | £1,461,182.01 |
| May | 1819 | 70,486.50 | 84,774.00 | £1,282,656.41 | £1,525,016.34 |
| June | 1967 | 69,597.70 | 107,590.50 | £1,284,161.87 | £1,945,434.56 |
| July | 1935 | 58,557.53 | 89,949.25 | £1,059,724.57 | £1,610,738.59 |
| August | 1994 | 74,087.62 | 114,335.75 | £1,315,940.35 | £2,047,909.48 |
| September | 1972 | 61,669.00 | 93,264.33 | £1,094,748.09 | £1,668,491.27 |
| October | 2019 | 66,575.67 | 94,624.25 | £1,184,700.13 | £1,691,276.71 |
| November | 2095 | 97,603.85 | 117,603.75 | £1,775,614.81 | £2,108,535.14 |
| December | 1922 | 62,459.22 | 92,760.75 | £1,103,798.88 | £1,661,991.49 |
| **Total** | **5876** | **1,570,584.30** | **2,019,972.83** | **£27,024,143.74** | **£34,396,799.47** |

The previous table shows the number of clients receiving Domiciliary care, month by month along with the hours delivered compared to the hours commissioned and the actual cost compared to the commissioned cost. Data is shown from 04/03/2019 to 03/01/2021.

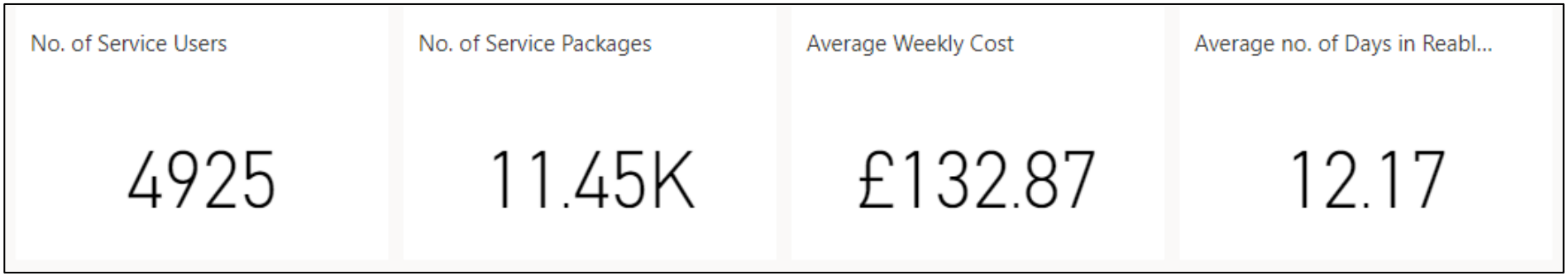
The Domiciliary Care Market continues to respond well to high levels of demand. These services support people to remain in their own home and to be as independent as possible, avoiding the need for alternative and more intensive care options.

## 5.2 Domiciliary Care – Client Location



## 5.3 Reablement – Clients, Cost and Days (since 01/04/2018):

The aim of these services is to ensure that people are supported to regain their optimum independence and mobility following an episode of ill-health. The data is shown from 1 April 2018.





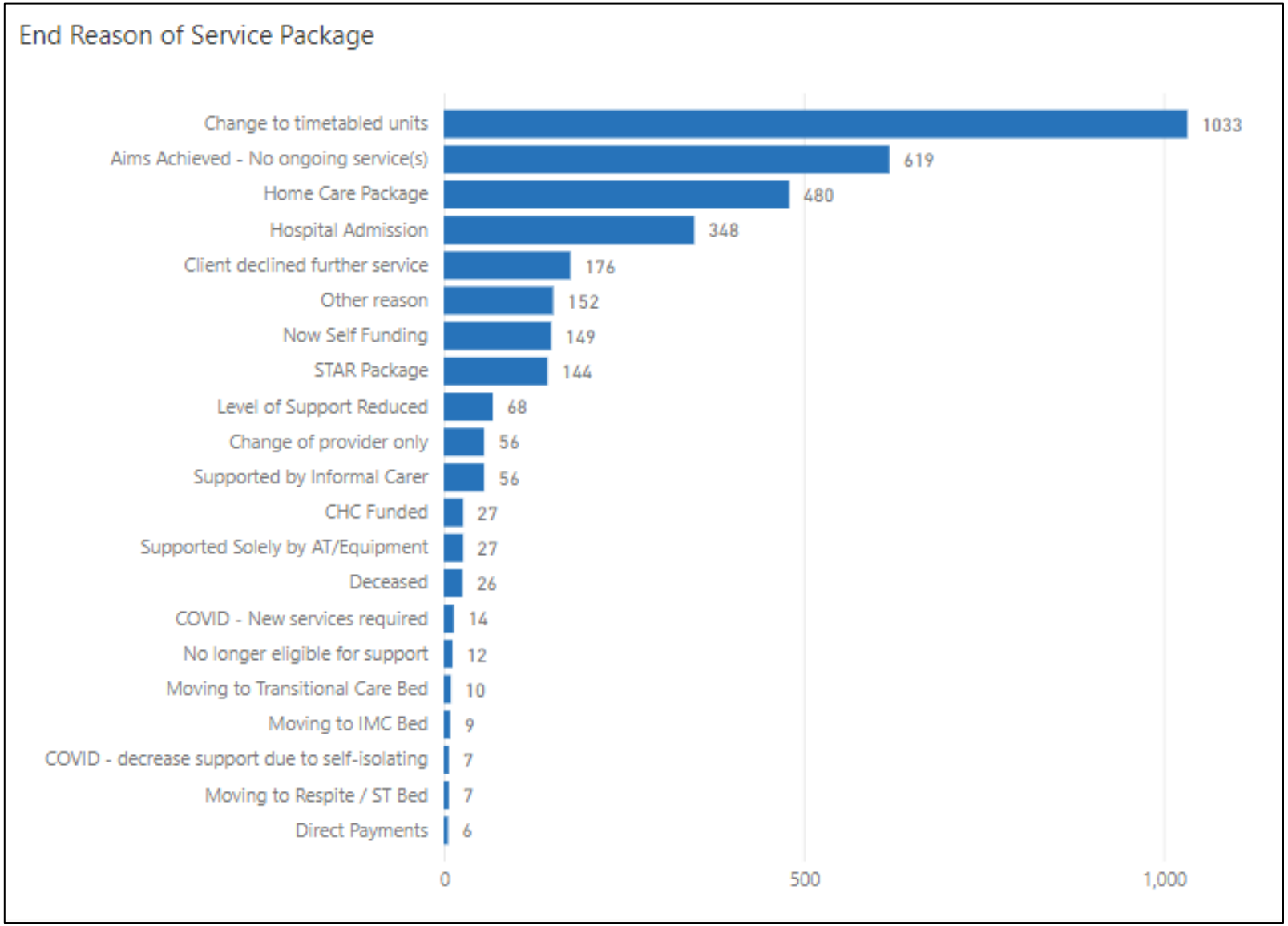

## 5.4 Reablement – Number of People

No. of People by Month Started

| Year | January | February | March | April | May | June | July | August | September | October | November | December | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2020 | 154 | 93 | 96 | 104 | 110 | 171 | 151 | 148 | 138 | 150 | 155 | 107 | **1577** |
| **Total** | **154** | **93** | **96** | **104** | **110** | **171** | **151** | **148** | **138** | **150** | **155** | **107** | 1577 |

This table shows the number of clients receiving Reablement services month by month for the last 12 months.

## 5.5 Reablement – End Reasons of Care Packages



## End Reason of Service Package

| Service Provision End Reason Description | Reablement End Reason |
|---|---|
| Change to timetabled units | 1033 |
| Aims Achieved - No ongoing service(s) | 619 |
| Home Care Package | 480 |
| Hospital Admission | 348 |
| Client declined further service | 176 |
| Other reason | 152 |
| Now Self Funding | 149 |
| STAR Package | 144 |
| Level of Support Reduced | 68 |
| Change of provider only | 56 |
| Supported by Informal Carer | 56 |
| CHC Funded | 27 |
| Supported Solely by AT/Equipment | 27 |
| Deceased | 26 |
| COVID - New services required | 14 |
| No longer eligible for support | 12 |
| Moving to Transitional Care Bed | 10 |
| Moving to IMC Bed | 9 |
| COVID - decrease support due to self-isolating | 7 |
| Moving to Respite / ST Bed | 7 |
| Direct Payments | 6 |
| Moving to Residential Care | 6 |
| COVID - decrease support- family/carer can support | 5 |
| Moving to Nursing Care | 4 |
| Moved to live with Family | 3 |
| Client left area | 2 |
| COVID - increase support- no family/carer support | 2 |
| Extension of Short Term Placement | 2 |
| COVID - change of provider for same service | 1 |
| COVID - pending CHC eligibility | 1 |
| **Total** | **3452** |

## 5.6 Reablement – Length of Stay

Length of Service by Start Month

| Year | 2 to 4 Weeks | 4 to 6 Weeks | Over 6 Weeks | Under 2 Weeks | Total |
|---|---|---|---|---|---|
| **2020** | **838** | **404** | **26** | **2182** | **3450** |
| January | 85 | 38 | 8 | 137 | **268** |
| February | 57 | 40 | | 110 | **207** |
| March | 44 | 7 | | 142 | **193** |
| April | 45 | 15 | | 135 | **195** |
| May | 64 | 18 | | 188 | **270** |
| June | 95 | 49 | 2 | 221 | **367** |
| July | 95 | 42 | 5 | 216 | **358** |
| August | 65 | 45 | 1 | 203 | **314** |
| September | 71 | 46 | 3 | 187 | **307** |
| October | 85 | 30 | 3 | 234 | **352** |
| November | 81 | 46 | 2 | 205 | **334** |
| December | 51 | 28 | 2 | 204 | **285** |
| **Total** | **838** | **404** | **26** | **2182** | **3450** |

The above table shows the number of people receiving Reablement services over the last 12 months, month on month by Length of Stay category.

Reablement services are short term to support people to regain independence and to reduce reliance on longer term care services. The data shows an increase in provision over the last half of 2020.

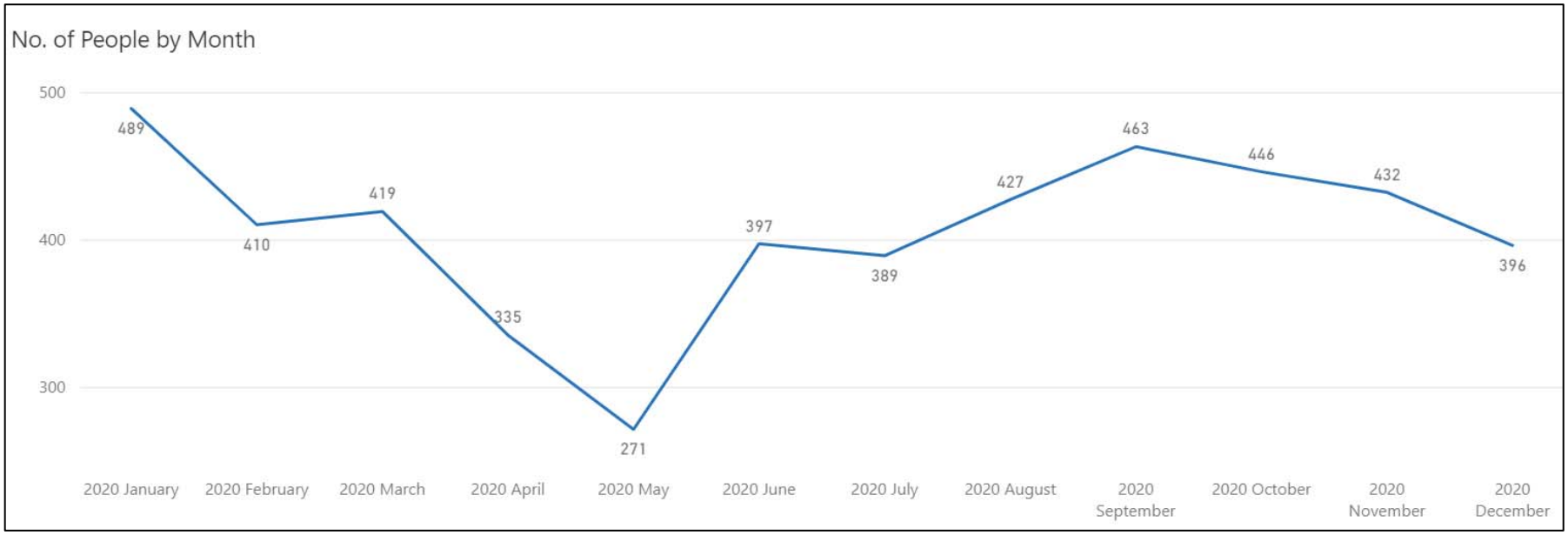
## 5.7 Brokerage – Packages by Number of People and Providers

### No. of People by Month

| Year | January | February | March | April | May | June | July | August | September | October | November | December | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2020 | 489 | 410 | 419 | 335 | 271 | 397 | 389 | 427 | 463 | 446 | 432 | 396 | **3415** |
| **Total** | **489** | **410** | **419** | **335** | **271** | **397** | **389** | **427** | **463** | **446** | **432** | **396** | **3415** |

### Number of People Waiting for Package

| Days Live Group | No. of People |
|---|---|
| 1 to 2 Weeks | 13 |
| 2 to 3 Weeks | 4 |
| 48hrs to 1 Week | 23 |
| Less than 48hrs | 25 |
| Over 3 Weeks | 8 |
| **Total** | **73** |




## No. of People by Month

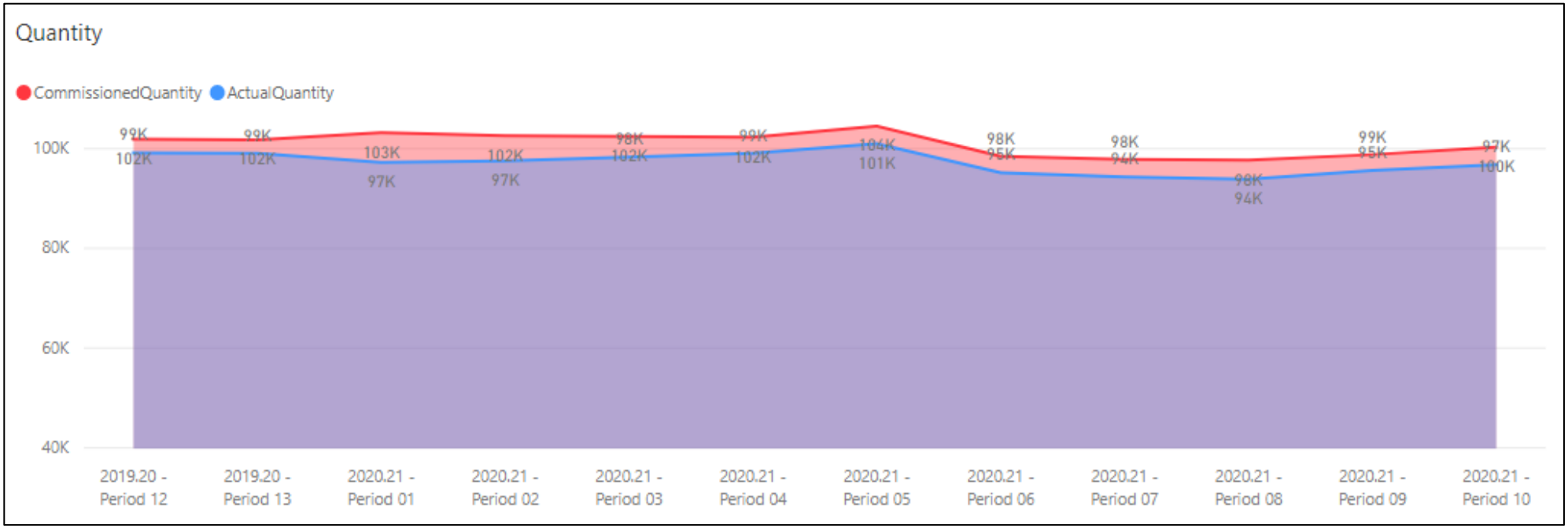
| Year | January | February | March | April | May | June | July | August | September | October | November | December | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2020 | 489 | 410 | 419 | 335 | 271 | 397 | 389 | 427 | 463 | 446 | 432 | 396 | **3415** |
| **Total** | **489** | **410** | **419** | **335** | **271** | **397** | **389** | **427** | **463** | **446** | **432** | **396** | **3415** |

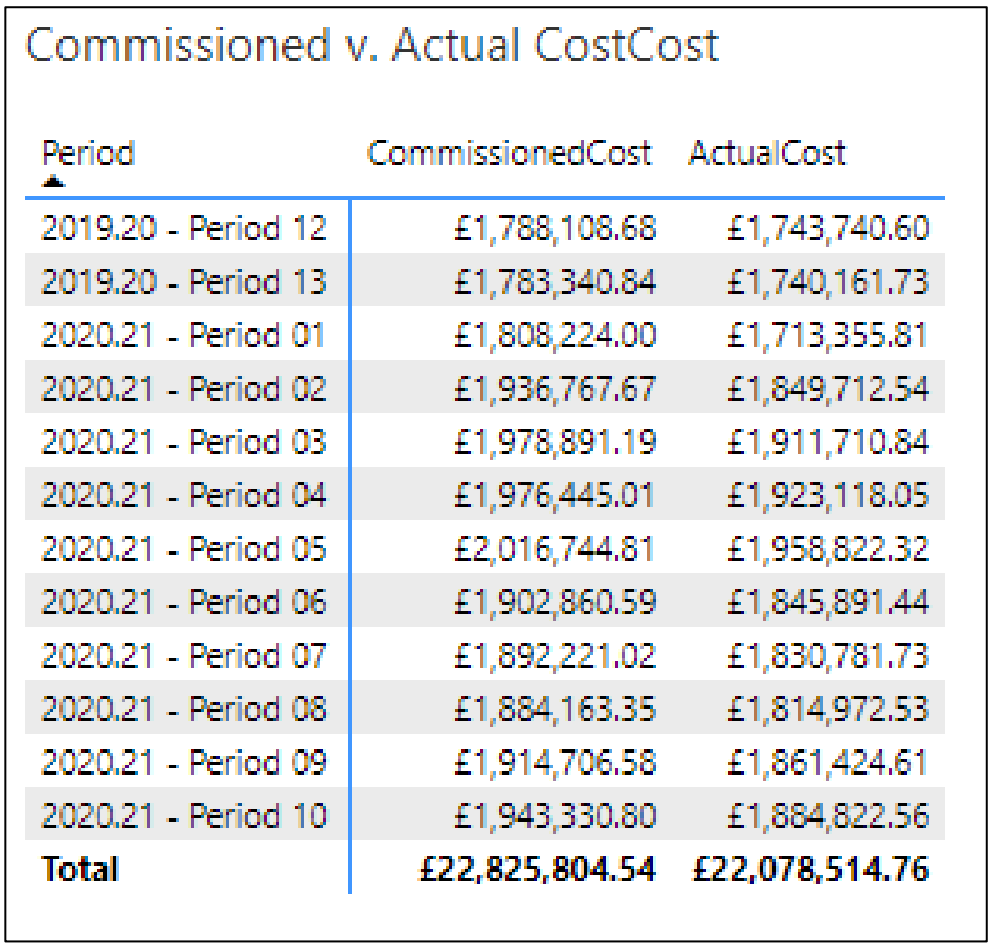
The above line chart and table show the number of people matched to home care packages month on month.

The data shows the high level of activity in the domiciliary care sector and low numbers of delays in arranging care and support. The data includes people who may be wanting to change their care provider.

## 6.0 Care Market – Specialist (Supported Living)

### 6.1 Cost

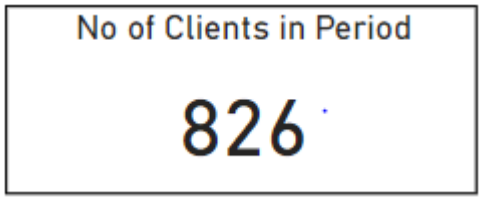


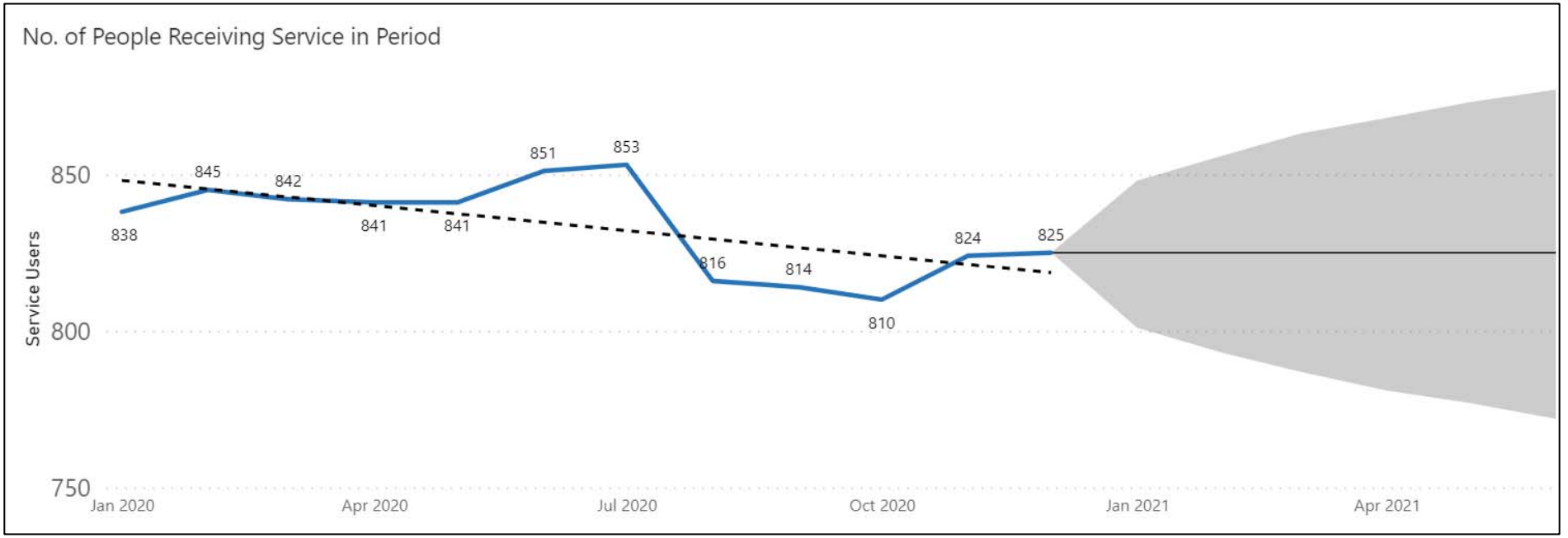



| Period | CommissionedCost | ActualCost |
|---|---|---|
| 2019.20 - Period 12 | £1,788,108.68 | £1,743,740.60 |
| 2019.20 - Period 13 | £1,783,340.84 | £1,740,161.73 |
| 2020.21 - Period 01 | £1,808,224.00 | £1,713,355.81 |
| 2020.21 - Period 02 | £1,936,767.67 | £1,849,712.54 |
| 2020.21 - Period 03 | £1,978,891.19 | £1,911,710.84 |
| 2020.21 - Period 04 | £1,976,445.01 | £1,923,118.05 |
| 2020.21 - Period 05 | £2,016,744.81 | £1,958,822.32 |
| 2020.21 - Period 06 | £1,902,860.59 | £1,845,891.44 |
| 2020.21 - Period 07 | £1,892,221.02 | £1,830,781.73 |
| 2020.21 - Period 08 | £1,884,163.35 | £1,814,972.53 |
| 2020.21 - Period 09 | £1,914,706.58 | £1,861,424.61 |
| 2020.21 - Period 10 | £1,943,330.80 | £1,884,822.56 |
| **Total** | **£22,825,804.54** | **£22,078,514.76** |

The above graph and table show the Commissioned cost against Actual costs for each 4-weekly billing period.

## 6.2 Supported Living - Number of People



No. of People Receiving Service in Period

| Year | No. of People |
|---|---|
| **2020** | **825** |
| January | 838 |
| February | 845 |
| March | 842 |
| April | 841 |
| May | 841 |
| June | 851 |
| July | 853 |
| August | 816 |
| September | 814 |
| October | 810 |
| November | 824 |
| December | 825 |
| **Total** | **825** |

The above table shows the number of people in supported living accommodation month on month.

### 6.3 Supported Living – People Locations

| Ward | No of Clients | Percentage |
|---|---|---|
| Bebington | 24 | 2.3% |
| Bidston and St James | 57 | 5.5% |
| Birkenhead and Tranmere | 104 | 10.1% |
| Bromborough | 60 | 5.8% |
| Clatterbridge | 15 | 1.5% |
| Claughton | 113 | 11.0% |
| Eastham | 16 | 1.6% |
| Greasby Frankby and Irby | 8 | 0.8% |
| Heswall | 25 | 2.4% |
| Hoylake and Meols | 21 | 2.0% |
| Leasowe and Moreton East | 36 | 3.5% |
| Liscard | 52 | 5.0% |
| Moreton West and Saughall Massie | 48 | 4.7% |
| New Brighton | 104 | 10.1% |
| Oxton | 89 | 8.6% |
| Pensby and Thingwall | 16 | 1.6% |
| Prenton | 39 | 3.8% |
| Rock Ferry | 89 | 8.6% |
| Seacombe | 34 | 3.3% |
| Upton | 10 | 1.0% |
| Wallasey | 11 | 1.1% |
| West Kirby and Thurstaston | 9 | 0.9% |
| Out of Area | 51 | 4.9% |

The above table shows the number of people in supported living accommodation by Ward.

## 6.4 Supported Living – Demographics

| Age Group | Female | Male | **Total** |
|---|---|---|---|
| Adults | 385 | 683 | **1068** |
| Older People | 64 | 104 | **168** |
| **Total** | **449** | **787** | **1236** |

Adults are between 18 and 64.

Older People are aged over 65.

There has been a small reduction in the latter half of 2020 in the number of people living in Supported Independent Living, which may be due to the Covid-19 pandemic.

## 7.0 Wirral Community Foundation Trust

### 7.1 Key Measures - monitored monthly

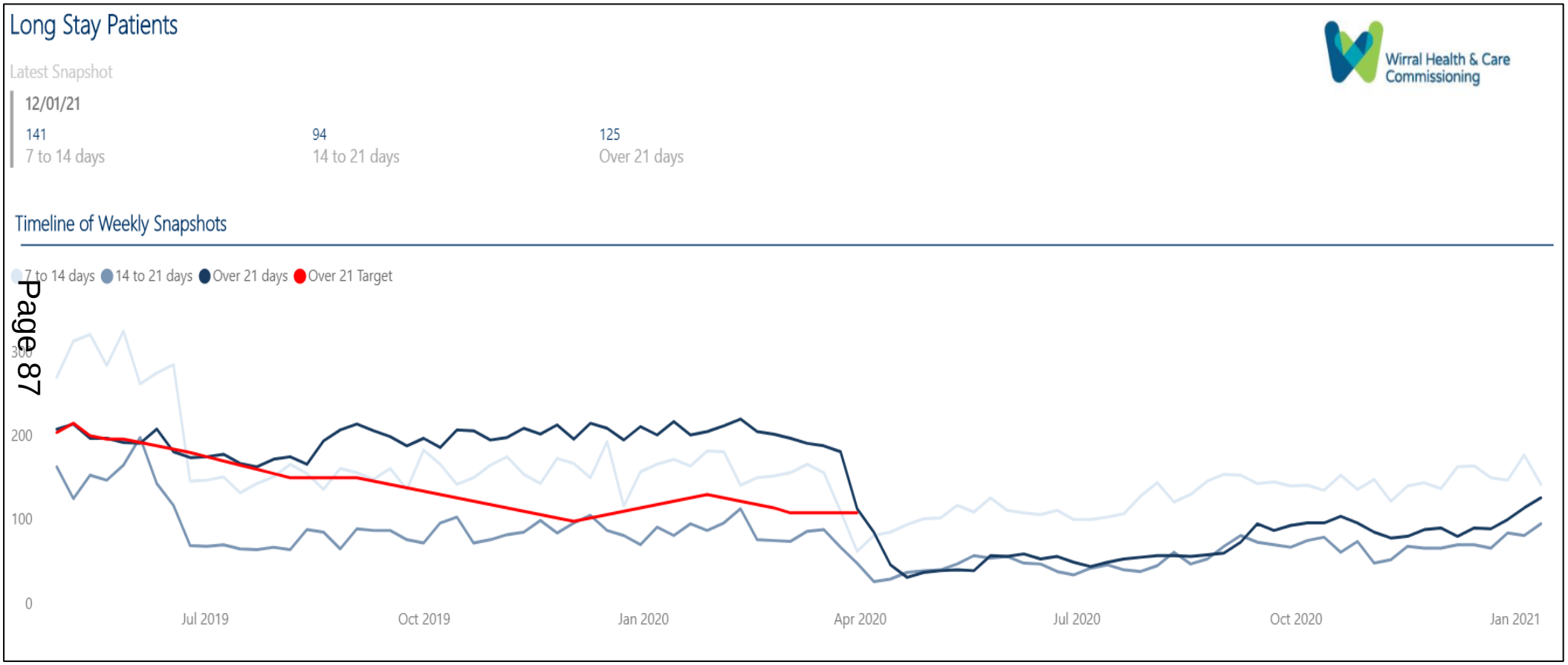
| ID | KPI Description | Green | Amber | Red | Target | Monthly Trend | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | YTD |
| KPI 1 | % of initial contacts through to completion of assessment within 28 days | >=80% | <80%<br>>=70% | <70% | 80% | 86% | 92% | 92% | 92% | 91% | 91% | 94% | 93% | 90% | 91% |
| | Total Assessments Completed within 28 Days | | | | | 233 | 227 | 341 | 333 | 306 | 320 | 342 | 301 | 260 | 1,862 |
| | Total Assessments Completed | | | | | 270 | 247 | 372 | 363 | 338 | 352 | 364 | 330 | 290 | 2,037 |
| KPI 2 | % of safeguarding concerns (Contacts) completed within 5 Days (exc. EDT) | >=99% | <99%<br>>=95% | <95% | 99% | 99.2% | 100% | 100% | 99.7% | 99.2% | 100% | 99.7% | 100% | 99.5% | 99.7% |
| | Total number of safeguarding concerns completed within 5 days | | | | | 258 | 238 | 335 | 335 | 386 | 291 | 329 | 336 | 368 | 2,876 |
| | Total number of safeguarding concerns completed | | | | | 260 | 238 | 335 | 336 | 389 | 292 | 330 | 336 | 370 | 2,886 |
| KPI 3 | % of safeguarding enquiries concluded within 28 days | >=80% | <80%<br>>=60% | <60% | 80% | 52% | 62% | 77% | 72% | 65% | 54% | 60% | 45% | 47% | 60% |
| | Total number of safeguarding enquiries closed within 28 days | | | | | 32 | 29 | 48 | 50 | 36 | 37 | 18 | 25 | 22 | 297 |
| | Total number of safeguarding enquiries closed | | | | | 62 | 47 | 62 | 69 | 55 | 69 | 30 | 56 | 47 | 497 |
| KPI 4 | % of individuals who have had an annual review completed | >=70% | <70%<br>>=60% | <60% | 70% | 68% | 72% | 71% | 67% | 68% | 70% | 71% | 68% | 64% | 64% |
| | Total number of reviews forecast to be completed | | | | | 4346 | 4571 | 4484 | 4194 | 4328 | 4450 | 4459 | 4231 | 3990 | 3,990 |

| ID | KPI Description | Green | Amber | Red | Target | Monthly Trend | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | YTD |
| | Total number of people in receipt of a long term service on 1st April | | | | | 6381 | 6348 | 6316 | 6260 | 6365 | 6355 | 6243 | 6258 | 6243 | 6,243 |
| KPI 5 | % of care packages activated (in Liquidlogic) in advance of service start date (exc. Block Services) | >=65% | <65% >=50% | <50% | 65% | 62% | 70% | 65% | 72% | 73% | 74% | 68% | 65% | 66% | 68% |
| | Total number of packages activated in advance of start date | | | | | 424 | 489 | 617 | 676 | 620 | 683 | 701 | 649 | 569 | 5,428 |
| | Total number of packages activated | | | | | 689 | 700 | 944 | 939 | 871 | 925 | 1,024 | 995 | 866 | 7,953 |
| KPI 6 | % of adults with a learning disability who live in their own home or with their family | >=88% | <88% >=70% | <70% | 88% | 94% | 94% | 94% | 94% | 94% | 94% | 93% | 93% | 93% | 94% |
| | Total number of people aged 18-64 with a learning disability living in their own home or with their family | | | | | 401 | 401 | 401 | 401 | 400 | 401 | 399 | 398 | 398 | 3,600 |
| | Total number of people aged 18-64 with a learning disability in receipt of a long term service during the year | | | | | 425 | 425 | 425 | 426 | 426 | 428 | 427 | 427 | 426 | 3,835 |
| KPI 7 | % of older people who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | >=83% | <83% >=81% | <81% | 83% | 84% | 83% | 83% | 94% | 87% | 81% | 77% | 79% | 83% | 83% |
| | Total number of people at home 91 days post discharged from hospital into a reablement service | | | | | 54 | 49 | 39 | 31 | 41 | 51 | 51 | 45 | 58 | 419 |
| | Total number of people discharged from hospital into a reablement service | | | | | 63 | 59 | 47 | 33 | 47 | 63 | 66 | 57 | 70 | 505 |

The performance data indicates that people are receiving responsive and timely services. There is a small reduction in the number of people receiving an annual review of their care and support needs.

## 8.0 Length of Stay Report

## 8.1 Long Stay Patients:



**This analysis measures 7 to 14 days, 14 to 21 days and Over 21 days by period.**

- Each of the three series decreased from 30 April 2019 to 19 January 2021, with 14 to 21 days falling the most (54%) and 7 to 14 days falling the least (36%) over that time frame.
- 7 to 14 days trended upward the most in the final period. On the other hand, 14 to 21 days trended downward the most.
- Of note, over 21 days decreased over ten consecutive periods from 11 February 2020 to 21 April 2020 (189), outpacing the overall change across the entire series.
- While Over 21 days decreased (from 11 February 2020 to 21 April 2020), 7 to 14 days and 14 to 21 days also decreased.
- Of the three series, the strongest relationship was between 14 to 21 days and 7 to 14 days, which had a strong positive correlation, suggesting that as one (14 to 21 days) increases, so does the other (7 to 14 days), or vice versa.

**For 14 to 21 days:**

- Average 14 to 21 days was 75.41 across all 91 periods.
- Values ranged from 25 (07 April 2020) to 197 (04 June 2019).
- 14 to 21 days decreased by 54% over the course of the series and ended on a promising note, decreasing in the final period.
- The largest single decline on a percentage basis occurred in 07 April 2020 (47%). However, the largest single decline on an absolute basis occurred in 11 June 2019 (55).
- The largest net decline was from 04 June 2019 to 07 April 2020, when 14 to 21 days improved by 172 (87%). This net decline was almost two times larger than the overall movement of the entire series.
- 14 to 21 days experienced cyclicality, repeating each cycle about every 45.5 periods. There was also a pattern of smaller cycles that repeated about every 18.2 periods.
- 14 to 21 days had a significant positive peak between 07 May 2019 (124) and 06 August 2019 (63), rising to 197 on 04 June 2019. However, 14 to 21 days had a significant dip between 30 April 2019 (162) and 04 June 2019 (197), falling to 124 on 07 May 2019.
- 14 to 21 days was lower than 7 to 14 days over the entire series, lower by 78.01 on average. 14 to 21 days was less than Over 21 days 90% of the time (lower by 61.46 on average).

**For Over 21 days:**

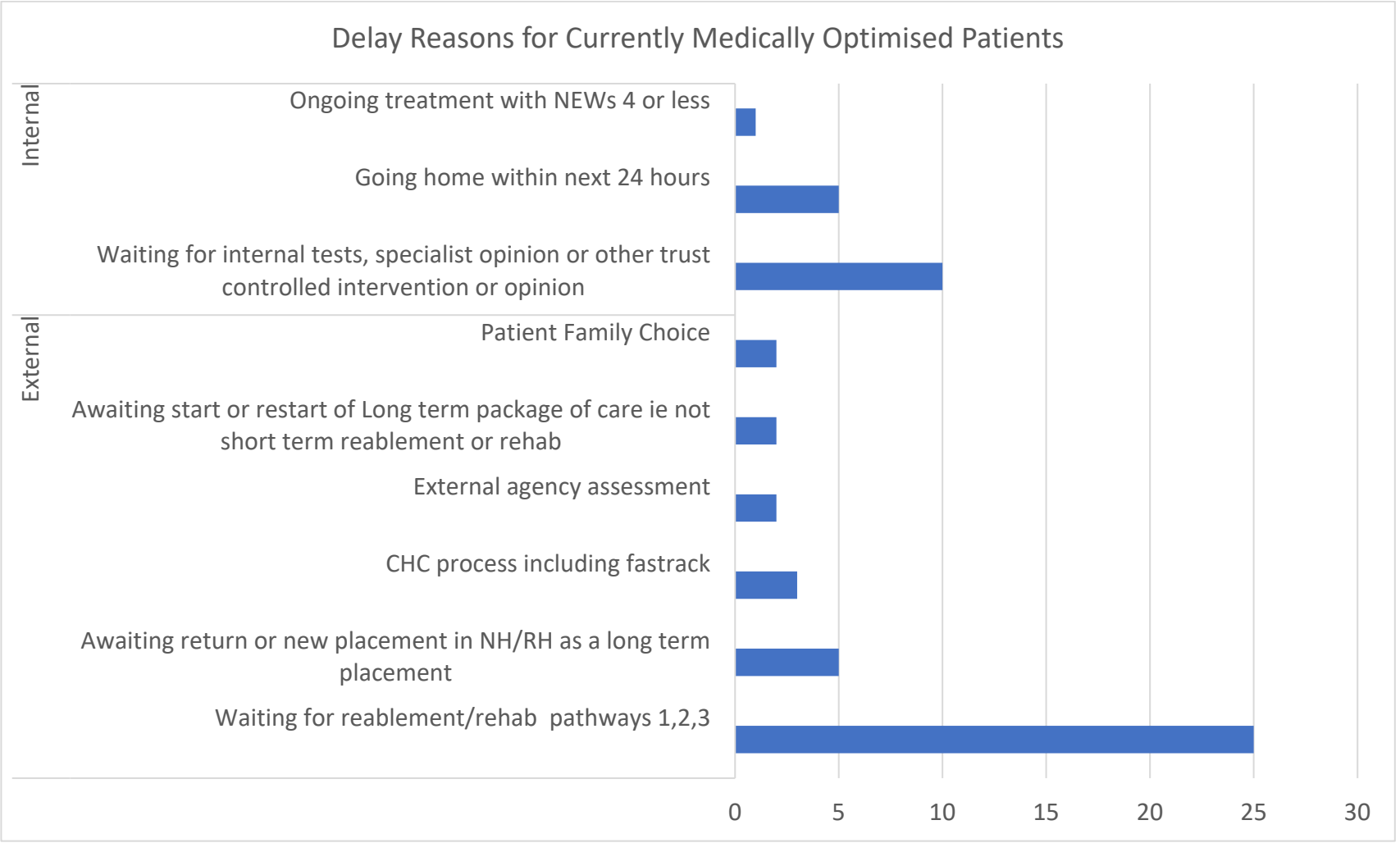
- Average Over 21 days was 136.87 across all 91 periods.
- Values ranged from 30 (21 April 2020) to 219 (11 February 2020).

- Over 21 days decreased by 46% over the course of the series and ended with a downward trend, decreasing in the final period.
- The largest single decline on a percentage basis occurred in 14 April 2020 (46%). However, the largest single decline on an absolute basis occurred in 31 March 2020 (68).
- The largest net decline was from 11 February 2020 to 21 April 2020, when Over 21 days fell by 189 (86%). This net decline was almost two times larger than the overall movement of the entire series.
- Over 21 days experienced cyclicality, repeating each cycle about every 45.5 periods.
- Over 21 days had a significant dip between 11 February 2020 and 09 June 2020, starting at 219, falling all the way to 30 at 21 April 2020 and ending slightly higher at 58.
- Over 21 days was most closely correlated with 14 to 21 days, suggesting that as one (Over 21 days) increases, the other (14 to 21 days) generally does too, or vice versa.
- Over 21 days was lower than 7 to 14 days at the beginning and end, but 7 to 14 days was lower between 25 June 2019 and 14 April 2020, accounting for 46% of the series. Over 21 days was greater than 14 to 21 days 90% of the time (higher by 61.46 on average).

**For 7 to 14 days:**

- Average 7 to 14 days was 153.42 across all 91 periods.
- The minimum value was 61 (31 March 2020) and the maximum was 324 (28 May 2019).
- 7 to 14 days improved by 36% over the course of the series but ended on a negative note, increasing in the final period.
- The largest single decline occurred in 25 June 2019 (49%).
- The largest net improvement was from 28 May 2019 to 31 March 2020, when 7 to 14 days improved by 263 (81%). This net improvement was almost three times larger than the overall movement of the entire series.
- 7 to 14 days experienced cyclicality, repeating each cycle about every 45.5 periods. There was also a pattern of smaller cycles that repeated about every 30.33 periods.
- 7 to 14 days was higher than 14 to 21 days over the entire series, higher by 78.01 on average. 7 to 14 days was higher than Over 21 days at the beginning and end, but Over 21 days was higher between 25 June 2019 and 14 April 2020, accounting for 46% of the series.

## 8.2 Delay Reasons for Medically Optimised Patients (Sum of 21 days)



| | |
|---|---|
| **External** | |
| Waiting for reablement/rehab pathways 1,2,3 | 25 |
| Awaiting return or new placement in NH/RH as a long-term placement | 5 |
| CHC process including fastrack | 3 |
| External agency assessment | 2 |
| Awaiting start or restart of Long-term package of care i.e. not short term reablement or rehab | 2 |
| Patient Family Choice | 2 |
| **Internal** | |
| Waiting for internal tests, specialist opinion or other trust controlled intervention or opinion | 10 |
| Going home within next 24 hours | 5 |
| Ongoing treatment with NEWs 4 or less | 1 |
| **Grand Total** | **55** |

## 8.3 Current External Delays

| Current External Delays | |
|---|---|
| Awaiting return or new placement in NH/RH as a long-term placement | 5 |
| Awaiting start or restart of Long-term package of care i.e. not short term reablement or rehab | 2 |
| CHC process including fastrack | 3 |
| External agency assessment | 2 |
| Patient Family Choice | 2 |

## 9.0 Better Care Fund

### 9.1 Delayed Transfer of Care - 2.67% maximum

DTOC Data collection suspended since March 2020 due to the ongoing Coronavirus crisis.

### 9.2 Residential/Nursing -5% reduction

| | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2019/20 | 30 | 32 | 25 | 48 | 33 | 31 | 30 | 47 | 29 | 35 | 39 | 40 |
| 2020/21 | **29** | **30** | **24** | **46** | **31** | **29** | **29** | **45** | **28** | **33** | **37** | **38** |

Forecast trend based on a targeted 5% reduction vs same month in preceding year.

### 9.3 Reablement (91 days)

| 91 Day Status | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| At Home 91 days + | 52 | 50 | 50 | 36 | 53 | 48 | 39 | 31 | | 51 | 51 | 45 |
| Not at Home 91 days + | 9 | 7 | 13 | 9 | 9 | 10 | 10 | 2 | | 12 | 15 | 12 |
| **Total** | **61** | **57** | **63** | **45** | **62** | **58** | **49** | **33** | | **63** | **66** | **57** |
| **% At Home 91 days +** | **85.2%** | **87.7%** | **79.4%** | **80.0%** | **85.5%** | **82.8%** | **79.6%** | **93.9%** | | **81.0%** | **77.3%** | **78.9%** |
| Target | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% |

## 10.0 Deprivation of Liberty Safeguards (DOLS)

DOLS Applications and Number of Granted Applications

| Month Year | No. of DOLS Applications | Rate per 100,000 | Granted No. of DOLS Applications | Rate per 100,000 |
|---|---|---|---|---|
| **2020** | **24375** | **528.70** | **42812** | **237.96** |
| January | 2509 | 66.98 | 4429 | 25.93 |
| February | 1597 | 53.40 | 3495 | 25.31 |
| March | 1337 | 45.06 | 3187 | 18.83 |
| April | 1721 | 43.52 | 2872 | 19.14 |
| May | 2053 | 49.69 | 3530 | 21.60 |
| June | 1996 | 52.16 | 3473 | 26.85 |
| July | 2209 | 58.64 | 3899 | 23.15 |
| August | 2336 | 53.40 | 3032 | 20.68 |
| September | 2391 | 61.11 | 4411 | 31.79 |
| October | 1951 | 58.02 | 4614 | 29.32 |
| November | 1977 | 62.35 | 3773 | 23.15 |
| December | 2298 | 65.74 | 2097 | 15.74 |
| **Total** | **24375** | **528.70** | **42812** | **237.96** |

WIRRAL

# ADULT SOCIAL CARE AND HEALTH COMMITTEE

## 2nd MARCH 2021

| | |
|---|---|
| **REPORT TITLE:** | **STRATEGIC DEVELOPMENTS IN THE NHS** |
| **REPORT OF:** | **SIMON BANKS, CHIEF OFFICER, NHS WIRRAL CLINICAL COMMISSIONING GROUP AND WIRRAL HEALTH AND CARE COMMISSIONING** |

### REPORT SUMMARY

On 26th November 2020 NHS England/Improvement (NHSE/I) published *Integrating Care: Next steps to building strong and effective integrated care systems across England*, subsequently referred to as *Integrating Care: Next steps*. This document set out proposals for legislative reform and focused on the operational direction of travel for the NHS from 2021/22 onwards. On 11th February 2021 Her Majesty's Government published a White Paper, *Integration and Innovation: working together to improve health and social care for all*, proposing legislation that would streamline and update the legal framework for health and care. On the same day NHS England and NHS Improvement (NHSE/I) issued their response and next steps in response to the White Paper.

This paper summarises the key proposals in the White Paper, *Integration and Innovation: working together to improve health and social care for all* and the response to the Government's proposals by NHS England/Improvement.

### RECOMMENDATION

The Adult Social Care and Health Committee is asked to note this report.

## SUPPORTING INFORMATION

## 1.0 REASON FOR RECOMMENDATION

1.1 The Adult Social Care and Health Committee should be informed of important policy changes in the NHS that impact upon Wirral and should also engaged in the development of a Wirral response such changes to maximise the benefit to the local population.

## 2.0 OTHER OPTIONS CONSIDERED

2.1 The options of (i) maintaining the status quo or (ii) not engaging in these national driven policy changes have been considered and dismissed as they would not benefit the population of Wirral.

## 3.0 BACKGROUND INFORMATION

### 3.1 Introduction

3.1.1 On 26th November 2020 NHS England/Improvement (NHSE/I) published *Integrating Care: Next steps to building strong and effective integrated care systems across England*, subsequently referred to as *Integrating Care: Next steps*. This document set out proposals for legislative reform and focused on the operational direction of travel for the NHS from 2021/22 onwards. It also asked for feedback on these proposals by 8th January 2021. As reported at the last Joint Health and Care Executive Commissioning Group (JHCCEG), NHS Wirral Clinical Commissioning Group (CCG) and Wirral Council provided a joint response to *Integrating Care: Next steps.*

3.1.2 On 11th February 2021 Her Majesty's Government published a White Paper, *Integration and Innovation: working together to improve health and social care for all*, proposing legislation that would streamline and update the legal framework for health and care. This paper summarises the White Paper, which can be found at: https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all.

3.1.3 On the same day NHS England and NHS Improvement (NHSE/I) issued four documents:

- Legislating for Integrated Care Systems: five recommendations to Government and Parliament
- A letter outlining the proposed changes and next steps
- A Frequently Asked Questions document
- A consultation on proposals for the NHS Provider Selection Regime

This paper summarises the first three of these documents, which can be found at: https://www.england.nhs.uk/publication/legislating-for-integrated-care-systems-five-recommendations-to-government-and-parliament/.

### 3.2 *Integration and Innovation: working together to improve health and social care for all*

3.2.1 **Key measures** included in the White Paper, *Integration and Innovation: working together to improve health and social care for all*, include:

- The NHS and local government to come together legally as part of integrated care systems to plan health and care services around their patients' needs, and quickly implement innovative solutions to problems which would normally take years to fix, including moving services out of hospitals and into the community, focusing on preventative healthcare.

- Hardworking NHS staff currently waste a significant amount of time on unnecessary tendering processes for healthcare services. Under today's proposals, the NHS will only need to tender services when it has the potential to lead to better outcomes for patients. This will mean staff can spend more time on patients and providing care, and local NHS services will have more power to act in the best interests of their communities.

- The safety of patients is at the heart of NHS services. The upcoming bill will put the Healthcare Safety Investigations Branch permanently into law as a statutory body so it can continue to reduce risk and improve safety. The Healthcare Safety Investigations Branch already investigates when things go wrong without blaming people, so that mistakes can be learned from, and this strengthens its legal footing.

- A package of measures to deliver on specific needs in the social care sector. This will improve oversight and accountability in the delivery of services through new assurance and data sharing measures in social care, update the legal framework to enable person-centred models of hospital discharge, and introduce improved powers for the Secretary of State to directly make payments to adult social care providers where required.

- The pandemic has shown the impact of inequalities on public health outcomes and the need for government to act to help level up health across the country. Legislation will help to support the introduction of new requirements about calorie labelling on food and drink packaging and the advertising of junk food before the 9pm watershed.

3.2.2 In regard to **working together to integrate care** the White Paper proposes two forms of integration which will be underpinned by the legislation: integration within the NHS to remove some of the cumbersome boundaries to collaboration and to make working together an organising principle; and greater collaboration between the NHS and local government, as well as wider delivery partners, to deliver improved outcomes to health and wellbeing for local people.

The NHS and local authorities will be given a duty to collaborate with each other. The White Paper also proposes measures for statutory Integrated Care Systems (ICSs). These will be comprised of an ICS Health and Care Partnership, bringing together the NHS, local government and partners, and an ICS NHS Body. The ICS

NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs. Both bodies will need to draw on the experience and expertise of front-line staff across health and social care. The legislation will aim to avoid a one-size-fits all approach but enable flexibility for local areas to determine the best system arrangements for them. A key responsibility for these systems will be to support place-based joint working between the NHS, local government, community health services, and other partners such as the voluntary and community sector.

Frequently, place level commissioning within an integrated care system will align geographically to a local authority boundary, and the Better Care Fund (BCF) plan will provide a tool for agreeing priorities. This will be further supported by other measures including improvements in data sharing and enshrining a 'triple aim' for NHS organisations to support better health and wellbeing for everyone, better quality of health services for all, and sustainable use of NHS resources.

3.2.3 On **reducing bureaucracy** the White Paper sets out the Government's intention to reform the existing legislation to support the workforce by creating the flexibility NHS organisations need – to remove the barriers that prevent them from working together and to enable them to arrange services and provide joined up care in the interests of service users. The White Paper states that pragmatism will be put at the heart of the system. Enabling the NHS and local authorities to arrange healthcare services to meet current and future challenges by ensuring that public and taxpayer value – and joined up care – are first and foremost. This will require changes to both competition law as it was applied to the NHS in the Health and Social Care Act 2012 and the system of procurement applied to the NHS by that legislation. These changes will enable the NHS and local authorities to avoid needless bureaucracy in arranging healthcare services while retaining core duties to ensure quality and value. This will be supported by further "pragmatic" reforms to the tariff and to remove the statutory requirement for Local Education and Training Boards.

3.2.4 The White Paper also signals intent by the Government to bring forward a number of measures to **improve accountability and enhance public confidence** in the health and care system. The de facto development in recent years of a strongly supportive national NHS body in the form of a merged NHS England and NHS Improvement will be placed on a statutory footing and will be designated as NHS England. This will be complemented by enhanced powers of direction for the Government over the newly merged body which will support great collaboration, information sharing and aligned responsibility and accountability. In addition, the Government proposes to legislate to further ensure the NHS is able to respond to changes and external challenges with agility as needed. Measures will include reforms to the mandate to NHS England to allow for more flexibility of timing; the power to transfer functions between Arms' Length Bodies and the removal of time limits on Special Health Authorities. An improved level of accountability will also be introduced within social care, with a new assurance framework allowing greater oversight of local authority delivery of care, and improved data collection allowing us to better understand capacity and risk in the social care system. The proposed measures recognise this, and the Government plans to introduce greater clarity in the responsibility for workforce planning and a clear line of accountability for service reconfigurations with a power for ministers to determine service reconfigurations earlier in the process than is presently possible.

3.2.5 The Government also intends to bring forward **additional measures** to support social care, public health and the NHS. These are designed to address specific problems or remove barriers to delivery, maximise opportunities for improvement, and have in most cases been informed by the experience of the pandemic.

These measures are not intended to address all the challenges faced by the health and social care system. The Government is undertaking broader reforms to social care and public health which will support the system in helping people to live healthier, more independent lives for longer. In particular, the Department of Health and Social Care (DHSC) recognises the significant pressures faced by the social care sector and remains committed to reform. The Government wants to ensure that every person receives the care they need and that it is provided with the dignity they deserve. The Government has committed to bringing forward proposals this year but, in the meantime, their legislative proposals will embed rapid improvements made to the system as it has adapted to challenges arising from COVID-19. Similarly, on public health, the Government's experience of the pandemic underlines the importance of a population health approach, informed by insights from data: preventing disease, protecting people from threats to health, and supporting individuals and communities to improve their health and resilience. The Government will publish in due course an update on proposals for the future design of the public health system, which will create strong foundations for the whole system to function at its best. But the measures in this legislation will address issues that require intervention through primary legislation.

In social care, integration will be enhanced through the position of social care in the ICS structure, a new standalone legal basis for the Better Care Fund and allowing 'Discharge to Assess' models to followed. A legal power to make direct payments to providers will reduce bureaucracy in providing future additional support to the sector. Finally, an enhanced assurance framework and improved data collection will improve accountability within the social care sector.

For public health, alongside the population health element of the 'triple aim', the Government intend to bring forward measures to: make it easier to secure rapid change updates in NHS England public health functions; help tackle obesity by introducing further restrictions on the advertising of high fat, salt and sugar foods; as well as a new power for Ministers to alter certain food labelling requirements. In addition, the Government will be streamlining the process for the fluoridation of water in England by moving responsibilities for doing so from local authorities to central government.

Finally, the White Paper proposes measures that contribute to improved quality and safety in the NHS, including placing the Health Services Safety Investigations Body on a statutory footing; establishing a statutory medical examiners system; and allowing the Medicines and Healthcare products Regulatory Agency to set up national medicines registries. There will also be legislation to enable the implementation of comprehensive reciprocal healthcare agreements with countries around the world.

3.2.6 In regard to **next steps**, the Government sees legislation as an enabler of change that is most effective when combined with other reforms and drivers of change within

the health and care system. As the system emerges from the pandemic, the proposed legislative measures will assist with recovery by bringing organisations together, removing the bureaucratic and legislative barriers between them and enabling the changes and innovations they need to make.

On current timeframes, and subject to Parliamentary business, the Government's plan is that the legislative proposals for health and care reform outlined in the White Paper will begin to be implemented in 2022.

### 3.3 Next Steps for the NHS

3.3.1 *Legislating for Integrated Care Systems: five recommendations to Government and Parliament* is a summary of the outcomes of the engagement exercise by NHSE/I on *Integrating Care: Next steps* as well as providing an immediate response to the White Paper. It was accompanied by a letter from Amanda Pritchard, Chief Operating Officer, NHS England and NHS Improvement, to the NHS as well as some frequently asked questions (Appendix 1).

3.3.2 The five key recommendations in the document and in the covering letter are:

- The Government should set out at the earliest opportunity how it intends to progress the NHS's own proposals for legislative change.

- ICSs should be put on a clear statutory footing, but with minimum national legislative provision and prescription, and maximum local operational flexibility. Legislation should not dictate place-based arrangements.

- The NHS ICS statutory body should be supported by a wider statutory health and care stakeholder partnership. Explicit provision should also be made for requirements about transparency.

- There should be maximum local flexibility as to how the ICS health and care stakeholder partnership is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where these work well. The composition of the board of the NHS ICS statutory body itself must however be sufficiently streamlined to support effective decision-making. It must be able to take account of local circumstances as well as statutory national guidance. Legislation should be broadly permissive, mandating only that the members of the NHS ICS Board must include a chair and CEO and as a minimum also draw representation from (i) NHS trusts and Foundation Trusts, (ii) general practice, and (iii) a local authority. As with CCGs now, NHSE/I would approve ICS constitutions in line with national statutory guidance.

- Provisions should enable the transfer of responsibility for primary medical, dental, ophthalmic and community pharmacy services by NHS England to the NHS ICS statutory body. Provision should also enable the transfer or delegation by NHS England of appropriate specialised and public health services we currently commission. And at the same time, NHS England should also retain the ability to specify national standards or requirements for NHS ICSs in relation to any of these existing direct commissioning functions.

3.3.3 The supporting letter makes reference to supporting staff through the transition to the new organisational arrangements in the NHS. It cites that NHSE/I have proposed that the NHS ICS statutory body will take on the commissioning functions that currently reside with Clinical Commissioning Groups (CCGs) alongside some of the responsibilities that currently reside with NHS England. If these proposals are passed by Parliament, this will of course impact on staff, so the letter recognises the need to ensure the implementation is right. The letter states that

> " Under these proposals we need to ensure that we support our staff during organisational change by minimising uncertainty and limiting employment changes as much as possible. We are therefore seeking to provide as much stability of employment as possible so that ICSs can use the skills, experience and expertise of our NHS people. To make the transition process as smooth as possible for you teams we will introduce an 'employment commitment' for colleagues within the wider health and care system (below board level) affected directly by these legislative proposals including where relevant CCGs, NHS England and NHS Improvement and NHS providers. "

3.3.4 The letter also references the consultation on the Provider Selection Regime, which is not covered further in this paper. This is a response to the frustration expressed in the responses to *Integrating Care: Next steps* around general competition rules and powers. The regime sets out a new approach to procurement of services, to make it easier to develop stable collaborations and to reduce some of the cost burden associated with the current regime.

3.3.5 The final commitment in the letter is to further collaboration and engagement on shaping the future state of health and care with local systems. We must therefore continue to work with our partners in Wirral and Cheshire and Merseyside to influence the implementation of this legislation and associated guidance.

## 4.0 FINANCIAL IMPLICATIONS

4.1 This report is principally for information only and as such, there are no financial implications.

## 5.0 LEGAL IMPLICATIONS

5.1 The White Paper signals the intent of the Her Majesty's Government to introduce primary legislation to further support the implementation of the NHS Long Term plan and to give ICSs statutory roles.

## 6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 There is a direct impact of these changes on staff employed by NHS Wirral CCG. It is anticipated that there will be a human resources framework from April 2021 within which these proposed changes will be managed.

## 7.0 RELEVANT RISKS

7.1 The system changes outlined in this report will have risk management frameworks as part of their implementation.

## 8.0 ENGAGEMENT/CONSULTATION

8.1 Engagement will need to take place in regard to the system changes outlined in this report.

## 9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity.

This report is for information and no EIA is required.

## 10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 None as a result of this report.

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email: simon.banks1@nhs.net

## APPENDICES

Appendix 1 Frequently Asked Questions on NHS England and NHS Improvement's Legislative Recommendations on ICSs, Version 1, 11th February 2021

## BACKGROUND PAPERS

- NHS Five Year Forward View, https://www.england.nhs.uk/five-year-forward-view/
- NHS Long Term Plan, https://www.longtermplan.nhs.uk/
- NHS Planning Guidance, https://www.england.nhs.uk/publication/delivering-the-forward-view-nhs-planning-guidance-201617-202021/
- NHS England/Improvement, Designing Integrated Care Systems (ICSs) in England, https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf
- Integrating Care: Next steps to building strong and effective integrated care systems across England, https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf
- *Integration and Innovation: working together to improve health and social care for all*, White Paper, https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all.

- *Legislating for Integrated Care Systems: five recommendations to Government and Parliament* , https://www.england.nhs.uk/publication/legislating-for-integrated-care-systems-five-recommendations-to-government-and-parliament/

**SUBJECT HISTORY (last 3 years)**

| Council Meeting | Date |
|---|---|
| **Adult Social Care and Health Committee** | **18th January 2021** |
| **Partnerships Committee** | **9th November 2020**<br>**13th January 2021** |

## APPENDIX 1 FREQUENTLY ASKED QUESTIONS ON NHS ENGLAND AND NHS IMPROVEMENT'S LEGISLATIVE RECOMMENDATIONS ON ICSs, VERSION 1, 11th FEBRUARY 2021

### 1. Why do you need to legislate for ICSs and why now?

• Legislation helps to clarify roles and responsibilities between health and care organisations, and we do not believe that existing legislation provides a sufficiently firm foundation for system working. It is only one part of the solution, but it is an important one.

• In part this is a reflection of response to the COVID-19 pandemic, which showed that collaboration is more effective than competition in protecting health and treating disease. As well as posing new challenges, the pandemic allowed the NHS and its partners to make important and beneficial changes to how they work, leading to new gains that we want to lock in for future.

### 2. How did you decide these recommendations?

• Our legislative recommendations are based on several years of 'bottom up' conversations with people who use and work in services, partners such as local government and the voluntary sector, the experience of the earliest ICSs and what they told us they need to get better results for those they serve.

• Most recently, we received thousands of responses to an invitation to comment on draft proposals set out in November and ran more than 30 sessions with stakeholders including patients groups, charities and organisations representing NHS clinicians and managers.

• It follows a clear and consistent direction of travel which also draws on the work of STPs and vanguards, through which local organisations worked more closely together. This was signposted in the *NHS Five Year Forward View*, the *NHS Long Term Plan* and many other documents in between.

• One of its central aims is to remove outstanding barriers and fragmentation that exist to partnership working, simplifying process and cutting bureaucracy that get in the way of partnership working. One of our aims is to ensure as little disruption as possible while having the greatest possible impact.

### 3. What will the recommendations mean for our patients and communities?

• We must never lose sight of the purpose, which is improving health for everyone, with better and more convenient care for those who needed, while spending every pound of public money wisely. Any organisational or legislative change should be the minimum necessary to support that ambition.

• ICSs and STPs have done great things during the past few years: improving mental health services for those at times of crisis, supporting children to get the healthiest possible start in life, and identifying and shielding the most vulnerable during the COVID-19 pandemic. Our recommendations are about making it easier behind the scenes to support people who provide health and care services to be supported do more things like these.

**4. What will they mean for commissioning responsibilities?**

• Distinct commissioning and provider responsibilities will remain in individual organisations or systems in law, even with legislative changes that place statutory NHS commissioning functions with ICSs.

• Nevertheless, we want to support commissioning functions to become more strategic and better equipped to plan how to meet the whole needs of their populations. This will also involve providers playing an enhanced role, particularly in drawing on clinical expertise to make decisions about service change and pathway redesign.

• We want to support commissioners and providers to work together, bringing together their distinct perspectives and expertise to make genuinely cross-system decisions about how we improve health and care for all citizens.

**5. What does this mean for our clinical and professional leaders?**

• Clinical and other frontline staff have led the way in working across professional and institutional boundaries and will be supported to continue to play a significant leadership role in places and systems. We will be producing advice for ICSs on embedding system-wide clinical and professional leadership at every level of governance, including through their health and care partnership.

• This should include a central role for GPs and primary care networks. As well as planned primary care representation on the NHS ICS board, clinical leaders representing primary care will sit in place-based partnerships reflecting their important part in place-based planning and local leadership.

• Experience of the earliest ICSs shows that great leadership is critical to success and can come from any part of the health and care system. To be effective, it must draw on the talents of leaders from every part of a system. The earliest ICSs developed a new style of behaviour, which makes the most of the leadership teams of all constituent organisations and empowers frontline teams, and we want to share this experience everywhere.

**6. What does it mean for local authorities?**

• Local authorities are integral partners and have an important role in the approach we are recommending to Government.

• We are recommending the statutory establishment in each ICS of a health and care partnership which brings together NHS organisations and local councils in a partnership of equals, alongside the statutory ICS bodies which will allow the NHS and local government to act as strong partners.

• We expect the devolution of more functions and resources to place-based committees to enable further local decision-making.

• One of the core purposes here is for the NHS to make a full contribution to economic and social recovery that can only be achieved in partnership with local councils. We know that this includes the full run of their work – for example, housing, leisure and employment services as well as public health and social care.

**7. How will the voluntary sector be involved?**

• The voluntary, community and social enterprise (VCSE) sector is a critical strategic partner in ICSs and brings skills and a perspective than can help improve systems' work. There are many examples of the VCSE sector playing a full role in the work of systems: providing services and understanding of local communities and their health and care needs.

• From a legislative point of view, although there would be a core mandatory membership requirement for the health and care partnership and the NHS ICS Board, local systems would be able to invite any other organisation or representative to be involved in a way that best suits their local population.

• We will be setting out further guidance and support later in 2021 to help all systems involve the VCSE sector in their work at every level.

**8. How will a statutory ICS be different from a CCG?**

• ICSs will be a different type of decision-making body from CCGs – by bringing in the perspectives and skills of a wider range of partners. We want to empower them to take the best of CCGs, but to be better equipped to respond to the whole needs of the population they serve.

• Although we propose the ICS takes on many of the CCG functions, its remit will be much broader and have a much greater system role. NHS trusts, FTs or local authorities will be full and active partners in the leadership of the ICS and could also delegate some of their functions into the collaborative arrangements in the system.

**9. Will this change accountability arrangements for NHS trusts and foundation trusts?**

• Our recommendations for ICS will not fundamentally change the core duties and functions of NHS trusts and foundation trusts to improve quality of care for patients and meet key financial requirements.

• The move towards greater collaboration will foster mutual accountability for health outcomes between NHS and other organisations at system level, drawing on the collective expertise of commissioners and providers to plan services in the best interests of local people and the wider health economy.

• To help achieve this, NHSE/I's legislative recommendations for government include new duties to support more collective decision-making in order to improve quality of care, ensure effective use of resources and take into account the health needs of the local community.

**10. How will the transition be handled?**

• We want a take a different approach to this transition: one characterised by care for our people without distracting them from the 'day job' and the critical challenges of recovery for the NHS and tackling population health.

• We also want to provide as much stability of employment as possible while NHS ICS bodies develop new roles and functions that not only improve health and care but also make better use of the skills, experience and expertise of all our NHS people.

• There will be a set of HR principles developed nationally to support this transition and these will be available in April 2021. The aim of these principles is to provide a framework for a consistent approach, including the employment commitment, but to enable local implementation, recognising the differences in systems across the country.

**11. How will creation of statutory ICSs affect those who work in CCGs and ICSs?**

• Under these proposals we need to ensure that we support our staff during organisational change by minimising uncertainty and limiting employment changes as much as possible.

• We want to take a different approach to this transition; one that is characterised by care for our people and no distraction from the 'day job' - the critical challenges of recovery for the NHS and tackling population health.

• We are therefore seeking to provide as much stability of employment as possible while NHS ICS bodies fulfil their purpose, functions and roles, and ensure they use the skills, experience and expertise of all our NHS people in doing so.

• Colleagues in CCGs will become employed by the NHS ICS body as the legislation comes into effect and the ICS becomes the statutory body. There is still a requirement for strong place based work within an NHS ICS Body which is why we think this option can provide both the necessary change but with minimal organisational change.

• NHS people within the wider health and care system (below board level) affected directly by these legislative changes, including CCGs, NHSEI and NHS providers, will receive an employment commitment to continuity of terms and conditions (even if not required by law) to enable all affected colleagues to be treated in a similar way despite a variety of contractual relationships. This commitment is designed to provide stability and remove uncertainty during this transition.

• We will promote best practice in engaging, consulting and supporting the workforce during a carefully planned transition, minimising disruption to staff.

**12. Will NHS England and NHS Improvement staff be affected?**

• For NHS England and NHS Improvement staff, this has been a long-standing direction of travel with many staff already supporting ICSs directly and some working within or alongside ICS teams. We believe this has and will continue to, create attractive opportunities, focussed on the needs of patients and communities.

• With the continued development of this policy NHS England and Improvement staff in some areas will be affected depending on which function they are performing. We have heard support for this direction of travel and are engaging colleagues to define the impact on staff as we move towards embedding current NHSEI direct commissioning functions in ICSs.

• If legislative change is agreed and if any NHS England or NHS Improvement functions are to transfer to newly created organisations or reshaped within NHSE/I as a consequence, the same employment commitment to continuity of terms and conditions would apply to those colleagues directly impacted.
• We will promote best practice in engaging, consulting and supporting the workforce during a carefully planned transition, minimising disruption to staff.

**13. Will there be a national HR framework to support the transition?**
There will be a set of HR principles developed nationally to support this transition and these will be available in April 2021. The aim of these principles is to provide a framework for a consistent approach, including the employment commitment, but to enable local implementation, recognising the differences in systems across the country.

**14. Will there be national guidance for appointments to the roles in the new NHS ICS body?**
There will be national guidance to support appointments to the new roles in NHS ICS body as specified in the legislation.

**15. How has our commitment to support staff changed since the recent engagement?**

• The reference to the employment commitment only lasting until 2022 has been removed in recognition of the different forms each transition journey is likely to take locally.

• Clarity that the commitment relates to colleagues below board level only but also applies to people in CCGs, NHSEI and NHS providers across the health and care system if they are affected by these legislation changes

WIRRAL

## ADULT SOCIAL CARE AND HEALTH COMMITTEE

### 2nd March 2021

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| **REPORT TITLE:** | **COVID-19 RESPONSE UPDATE** |
| **REPORT OF:** | **DIRECTOR OF PUBLIC HEALTH** |


**REPORT SUMMARY**

This report provides the Committee with an update on surveillance data and key areas of development in relation to Wirral's COVID-19 response and delivery of the Outbreak Prevention and Control Plan.

This matter affects all wards within the Borough; it is not a key decision.


**RECOMMENDATION/S**

The Adult Social Care and Health Committee is recommended to note the contents of the report, the progress made to date and to support the ongoing COVID-19 response.

## SUPPORTING INFORMATION

## 1.0 REASON/S FOR RECOMMENDATION/S

1.1 This report gives an overview of how we will work to Keep Wirral well and protect residents from the impact of COVID-19.

## 2.0 OTHER OPTIONS CONSIDERED

2.1 The report is for information and as such no other options have been considered.

## 3.0 BACKGROUND INFORMATION

3.1 On 22 May 2020, the government asked all Councils to develop local COVID-19 Outbreak plans. Wirral published its Outbreak Prevention and Control Plan in June 2020, setting out:

- how we will prevent transmission of COVID-19 within the community
- how we will ensure we have an effective and coordinated local approach to managing COVID-19 outbreaks across different settings within the Borough
- how we will ensure vulnerable people are protected
- how we will link with national and regional systems to ensure we get maximum benefit for the population of Wirral.

3.2 In December 2020, we published an update to this plan highlighting the progress that has been made to date along with a dynamic strategy for how we will continue to protect our communities from the impacts of COVID-19, as well as the wider effects on the health, wellbeing and livelihoods of Wirral residents. The updated plan can be found on the Wirral Council website: Outbreak Plan Dec 2020.pdf (wirral.gov.uk)

3.3 Currently we are again facing a challenging picture in relation to COVID-19 both nationally and locally. We undertake daily and weekly surveillance to understand the local picture – Up to date information on COVID-19 in Wirral is available here: COVID-19 statistics for Wirral | www.wirral.gov.uk

3.4 Due to Coronavirus cases rising rapidly across the country and growing pressure on the NHS the Prime Minister announced on the 4th January 2021, that the country would be put back into a national lockdown. Details of Current National Guidance is available here: National lockdown: Stay at Home - GOV.UK (www.gov.uk)

3.5 **Wirral Response to COVID-19**

A summary of key progress against the priority actions outlined within the Updated Wirral COVID-19 Outbreak Prevention and Control Plan is provided in the table below;

| Priority | Progress to date and Future Plans |
|---|---|
| **1) Effective Surveillance** *Ensure access to the right local* | • We have established and embedded a local surveillance system to capture local outbreak data and provide targeted support to a variety of settings through Wirral's COVID-19 Hub. The development and roll out of the |

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| *data and intelligence to inform local activity to prevent and manage outbreak* | Microsoft Dynamics software will improve the collection and reporting of data captured from local settings, and enable closer collaborative working with the Cheshire and Merseyside Hub and the regional Public Health network.<br>• We continue to hold multi-agency daily and weekly surveillance meetings at a local level to understand the epidemiology of current situations and to appropriately direct prevention and control measures, community engagement activity and target communications.<br>• We have implemented a local information system bringing together regional and local data that provides a greater understanding of what is happening in Wirral, providing intelligence to inform key decisions when responding to COVID-19. |
| **2) Governance and Accountability** *Establish robust governance structures for decision making* | • Our emergency response governance system, which oversees the Outbreak Plan and its delivery, is now fully embedded. This thread of governance and accountability works across local government teams, and includes work with Liverpool City Region neighbours, community organisations and NHS partners.<br>• Where necessary prior to national lockdown restrictions we have used legal and enforcement powers to take action against persistent non-compliance and will continue to do so in order to contain the virus. |
| **3) Engagement and Communication** *Build trust and participation through effective community engagement and communication* | • Wirral's Engagement Strategy and Action Plan has looked to recognise and support the work done by business, community and faith organisations and local people, and to gather insight to inform proactive action.<br>• Over 560 local people have now signed up to the Community Champions programme, with work ongoing to develop this offer. The Engagement HQ platform is currently being developed and will act as an interactive digital tool to gather community insight and understand what is important to our residents.<br>• We have continued to work with local community leaders within the black, Asian and minority ethnic engagement group as well as producing and promoting a range of easily accessible resources and toolkits to support our diverse local population.<br>• An Engagement and Insight-Led Communication Plan has been developed to further utilise local intelligence to inform both proactive and reactive communications internally and across the Borough. The plan will be delivered by way of an ongoing cycle of insight collection and information sharing. |
| **4) High Risk Settings and Communities** *Identify and support high risk* | • The Wirral COVID-19 Outbreak Hub facilitates regular meetings with a number of partners; including local health trusts, community infection prevention control and Merseyside Police, in order to review case data and |

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| *workplaces, locations and communities to prevent and manage outbreaks* | identify high-risk settings and cases where additional support may be needed.<br>• We have established a consistent dialogue with the specialist infection prevention and control team working with care homes, receiving daily updates on action relating to outbreak data from these settings.<br>• Our dedicated school support team are now well established and have continued to provide timely advice and guidance to schools across the Borough on a number of issues including close contact definition, isolation periods and testing.<br>• Wirral has been granted £375,000 from the Ministry of Housing, Communities and Local Government (MHCLG) Community Champion's Fund to support people shown to be most at risk from COVID-19 including those from an ethnic minority background, disabled people and other high-risk groups. This funding is for 12 months, with the successful bid developed in collaboration with leaders across the borough as part of the BAME thematic group and will be used to support a number of schemes – including in-depth analysis and training relating to 'health literacy' levels, to improve the quality, translation and accessibility of COVID-19 restriction and vaccine information, and to help people to isolate.<br>• We will continue to work with communities, organisations and groups to respond to the needs of local communities particularly at risk of COVID-19 and to safeguard vulnerable people. |
| **5) Local Testing** *Manage deployment of local testing to ensure access for the entire population* | • We have four local testing sites operating in Liscard, Bebington, Birkenhead and Heswall, maintaining good access for residents to symptomatic testing. We have continued to source additional symptomatic testing, through co-ordinated deployment of mobile testing units. We signpost residents to the full range of testing available, including ordering home testing kits, and home tests are delivered for vulnerable groups accessing respite services, in partnership with Wirral's Community Trust.<br>• As part of the LCR community testing pilot, we continue to operate four asymptomatic testing sites in New Brighton, Birkenhead, Eastham and Greasby. Access to symptom-free testing is prioritised for key workers, unpaid carers, volunteers, those requiring a test in advance of a medical appointment, and others that are unable to stay at home.<br>• There are a range of national testing programmes currently being rolled out, including expanding symptom-free testing in particular institutions and workplaces, accessible for employers of >50 staff. This extends across health, adult social care, educational settings, and other private and public sector workplaces. Wirral is |

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| | liaising with local employers to offer support with implementation of the national programme.<br>• We are currently developing plans for local community testing over the next twelve months, across the range of symptomatic, asymptomatic and outbreak categories, as one part of the wider strategy to control COVID-19. These plans will be flexible and responsive to emerging priorities, and the local and national situation, and will operate in conjunction with plans for contract tracing, supporting self-isolation, vaccination programme and the continued non-pharmaceutical interventions – hands, face, space etc. |
| **6) Local Contact Tracing** *Deploy local contact tracing to complement regional and national capability* | • Wirral Council's COVID-19 contact tracing model is now in the final stages of implementation, with locally supported contact tracing to be brought fully in-house by March 2021. This model will continue to focus on reaching high levels of cases and contacts and ensuring that no individual, group or community is underserved by the contact tracing system.<br>• A dedicated contact tracing team has now been established within Wirral's COVID-19 Hub, with over 15 new staff recruited in early 2021 and a comprehensive training programme based around the wider 'Find, Test, Trace, Isolate, Support' model to be delivered throughout February 2021.<br>• Work is ongoing, in partnership with local health trusts, to ensure that effective contact tracing is carried out for inpatients and those recently discharged from hospital – the locally supported contact tracing team will support acute and community settings to close any gaps in the identification of contacts for these types of cases.<br>• A working group, led by Wirral with attendance from Cheshire and Merseyside colleagues, has been established to discuss local contact tracing enacted through Microsoft Dynamics in order to share best practice and ensure a holistic approach to regional contact tracing.<br>• We will continue to develop our locally supported contact tracing system, working in collaboration with the National Test and Trace service, to ensure a flexible approach to evolving needs as the pandemic progresses. |
| **7) Supporting Vulnerable People and Communities** *Support vulnerable people to self-isolate and ensure that* | • We have established a group consisting of over 100 local community groups and organisations working in partnership with the local authority to deliver a range of initiatives to support local communities.<br>• The Community Connector service, operated through Involve North West, has provided a huge amount of humanitarian support throughout the pandemic. The Connectors will continue to engage with communities into 2021 with an updated action plan focusing on |

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| *services meet the needs of diverse communities locally.* | restriction adherence, vaccination, and support around the indirect impacts of COVID-19 on Wirral residents, such as dealing with debt as well as employment and housing issues.<br>• We have co-ordinated funding for local community organisations to be supported as well as facilitating the local response to support clinically vulnerable individuals with food deliveries, prescription collection and wellbeing calls.<br>• We continue to provide financial support to individuals to enable them to isolate without experiencing hardship. |

3.6 **Vaccination Programme**

The vaccination programme is progressing well in Wirral and at the time of writing, remained on track to have offered first doses to all individuals in the top four priority cohorts by 15th February 2021. These groups include residents in a care home for older adults and their carers; frontline health and social care workers; all those 70 years of age and over; and clinically extremely vulnerable individuals. The next cohorts are those 65 years of age and over and all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality. Local delivery capacity remains high with the limiting factor being vaccine supply.

## 4.0 FINANCIAL IMPLICATIONS

4.1 The delivery of the Outbreak Control Plan is funded via national grant funding as follows:

- Test and Trace Support Service Grant of £2,733,018 awarded to Wirral Council in June 2020.
- Test and Trace grant funding of £2,701,000 and £866,126 was received by Wirral Council when the Liverpool City Region was placed under the Tier 3 'very high' COVID-19 alert level restrictions in October 2020.
- Test and Trace grant funding of £1,018,320.29, was received in December 2020 in recognition of the extended time Wirral has been under COVID Alert Level: Very High prior to the implementation of National Restrictions on 5 November 2020.
- Test and Trace grant funding of £648,022, was received in January 2021 for the Period Wirral was placed in Tier 2 'high' `high COVID-19 alert level restrictions between 2 December 2020 and 29 December 2020 inclusive.
- Funding of £2,137,405 for Community Testing agreed as part of the approved Liverpool City Region Business case in December 2020.
- Funding of £375,000 was awarded in January 2021 from the Community Champions Fund allocated to support Wirral's BAME (Black and Minority Ethnic) organisations.

## 5.0 LEGAL IMPLICATIONS

5.1 There are no legal implications directly arising from this report. New powers have been provided to support enforcement activities which have been reviewed and appropriately utilised locally.

## 6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 This report is for information to Members and as a result there are no resource implications.

## 7.0 RELEVANT RISKS

7.1 It should be noted that data relating to case rates, hospitalisation and operational management of the COVID-19 response is frequently changing and as a result, some of the information contained within this report is likely to be outdated by the time of publication.

## 8.0 ENGAGEMENT/CONSULTATION

8.1 No direct public consultation or engagement has been undertaken in relation to this report. However, community engagement is a key priority in ensuring an effective response to the COVID-19 pandemic.

## 9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity. Equality considerations were a key component of the actions noted in 3.5 of this report, with information shared through the emergency response governance framework and cell structure to inform decisions and strategies. There are no further direct equality implications arising.

## 10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 There are no direct environment and climate implications arising from this report.

**REPORT AUTHOR:** **Julie Webster**
Director of Public Health,
Wirral Council
juliewebster@wirral.gov.uk

## APPENDICES

None

## BACKGROUND PAPERS

Wirral Outbreak Prevention and Control Plan December 2020

## SUBJECT HISTORY (last 3 years)

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

| | |
|---|---|
| **Adult Social Care and Health Committee**<br>**Adult Social Care and Health Committee**<br>**Adult Social Care and Health Committee** | **13th October 2020**<br>**19th November 2020**<br>**18th January 2021** |

WIRRAL

# ADULT SOCIAL CARE AND HEALTH COMMITTEE

## Tuesday 2 March 2021

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|---|---|
| **REPORT TITLE:** | **ADULT SOCIAL CARE AND HEALTH WORK PROGRAMME** |
| **REPORT OF:** | **DIRECTOR OF CARE AND HEALTH** |

### REPORT SUMMARY

The Adult Social Care and Health Committee, in co-operation with the other Policy and Service Committees, is responsible for proposing and delivering an annual committee work programme. This work programme should align with the corporate priorities of the Council, in particular the delivery of the key decisions which are within the remit of the Committee. It is envisaged that the work programme will be formed from a combination of key decisions, standing items and requested officer reports. This report provides the Committee with an opportunity to plan and regularly review its work across the municipal year. The work programme for the Adult Social Care and Health Committee is attached as Appendix 1 to this report.

### RECOMMENDATION

Members are invited to note and comment on the proposed Adult Social Care and Health Committee work programme for the remainder of the 2020/21 municipal year.

**SUPPORTING INFORMATION**

## 1.0 REASON/S FOR RECOMMENDATION/S

1.1 To ensure Members of the Adult Social Care and Health Committee have the opportunity to contribute to the delivery of the annual work programme.

## 2.0 OTHER OPTIONS CONSIDERED

2.1 A number of workplan formats were explored, with the current framework open to amendment to match the requirements of the Committee.

## 3.0 BACKGROUND INFORMATION

3.1 3.1 The work programme should align with the priorities of the Council and its partners. The programme will be informed by:

- The Council Plan
- The Council's transformation programme
- The Council's Forward Plan
- Service performance information
- Risk management information
- Public or service user feedback
- Referrals from Council

**Terms of Reference**

The Adult Social Care and Health Committee is responsible for the Council's adult social care and preventative and community based services. This includes the commissioning and quality standards of adult social care services, incorporating responsibility for all of the services, from protection to residential care, that help people live fulfilling lives and stay as independent as possible as well as overseeing the protection of vulnerable adults. The Adult Social Care and Health Committee is also responsible for the promotion of the health and wellbeing of the people in the Borough. The Committee is charged by full Council to undertake responsibility for:

a) adult social care matters (e.g., people aged 18 or over with eligible social care needs and their carers);

b) promoting choice and independence in the provision of all adult social care;

c) all Public Health functions (in co-ordination with those functions reserved to the Health and Wellbeing Board and the Overview and Scrutiny Committee's statutory health functions);

d) providing a view of performance, budget monitoring and risk management in relation to the Committee's functions; and

e) undertaking the development and implementation of policy in relation to the Committee's functions, incorporating the assessment of outcomes, review of effectiveness and formulation of recommendations to the Council, partners and other bodies, which shall include any decision relating to:

(i) furthering public health objectives through the development of partnerships with other public bodies, community, voluntary and charitable groups and through the improvement and integration of health and social care services;

(ii) functions under or in connection with partnership arrangements made between the Council and health bodies pursuant to Section 75 of the National Health Service Act 2006 ("the section 75 Agreements");

(iii) adult social care support for carers;

(iv) protection for vulnerable adults;

(v) supporting people;

(vi) drug and alcohol commissioning;

(vii) mental health services; and

(viii) preventative services.

## 4.0 FINANCIAL IMPLICATIONS

4.1 This report is for information and planning purposes only, therefore there are no direct financial implication arising. However, there may be financial implications arising as a result of work programme items.

## 5.0 LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from this report. However, there may be legal implications arising as a result of work programme items.

## 6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 There are no direct implications to Staffing, ICT or Assets.

## 7.0 RELEVANT RISKS

7.1 The Committee's ability to undertake its responsibility to provide strategic direction to the operation of the Council, make decisions on policies, co-ordinate spend, and maintain a strategic overview of outcomes, performance, risk management and budgets may be compromised if it does not have the opportunity to plan and regularly review its work across the municipal year.

## 8.0 ENGAGEMENT/CONSULTATION

8.1 Not applicable.

## 9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity.

This report is for information to Members and there are no direct equality implications.

## 10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 This report is for information to Members and there are no direct environment and climate implications.

**REPORT AUTHOR:** **Victoria Simpson**
(Victoria Simpson)
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## APPENDICES

Appendix 1: Adult Social Care and Health Committee Work Plan

## BACKGROUND PAPERS

Wirral Council Constitution
Forward Plan
The Council's transformation programme

## SUBJECT HISTORY (last 3 years)

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

**ADULT SOCIAL CARE AND HEALTH COMMITTEE**

**WORK PROGRAMME 2020/21**

**PROPOSED AGENDA FOR ADULT SOCIAL CARE AND HEALTH COMMITTEE**
**2 MARCH– Deadline for SLT – 4 FEB ( FOR SLT 10 FEB)**

| Item | Key Decision Yes/No | Lead Departmental Officer |
|---|---|---|
| KEY DECISION – EXTRA Care Tender | Yes | Jayne Marshall |
| KEY DECISION - Extra Care Housing Model | Yes | Simon Garner |
| KEY DECISION – Health Watch | Yes | Jayne Marshall |
| Performance Monitoring Report | No | Nancy Clarkson |
| Budget Monitoring Report | No | Graham Hodkinson |
| Covid Response Update | No | Julie Webster |

| Deadline for SLT | Deadline for Cleared Reports | Agenda Published |
|---|---|---|
| 4 February 2021 | 11 February 2021 | 22 February 2021 |

**KEY DECISIONS**

| Item | Approximate timescale | Lead Departmental Officer |
|---|---|---|
| Intermediate Care Bed Based Commission | June 2021 | Bridget Hollingsworth |
| Fee Setting for 2021/22<br><br>Jason Oxley/Jayne | June 2021 | Jason Oxley/Jayne Marshall/Mark Goulding |

| | | |
|---|---|---|
| Marshall/Mark Goulding | | |
| Proposals for Integrated Care Partnerships | June 2021 | Graham Hodkinson |
| Shared Lives Commission | June 2021 | Clare Hazler / Jayne Marshall |
| Early Intervention and Prevention Commission | September 2021 | Carol Jones/ Jayne Marshall |
| Advocacy | September 2021 | Carol Jones/ Jayne Marshall |
| Out of Hospital Review | September 2021 | Bridget Hollingsworth / Graham Hodkinson |

**ADDITIONAL AGENDA ITEMS – WAITING TO BE SCHEDULED**

| Item | Approximate timescale | Lead Departmental Officer |
|---|---|---|
| Public Health – Obesity | 2020/21 | Julie Webster |
| Public Health – Alcohol | 2020/21 | Julie Webster |
| Public Health – Dental Care | 2020/21 | Julie Webster |
| Public Health – Vaccinations | 2020/21 | Julie Webster |
| Domestic Abuse Strategy Update | 2020/21 | Mark Camborne/Elizabeth Hartley |
| WUTH CQC Improvement Plan | 2020/21 | Janelle Holmes/Paul Moore (WUTH) |
| Clatterbridge Cancer Centre – Site Update | 2020/21 | Liz Bishop (CCC) |

| | | |
|---|---|---|
| Commissioning Priorities and Framework | March 2021 | Graham Hodkinson |
| Domestic Abuse Strategy – Future Joint Working with Childrens | TBC | Elizabeth Hartley |
| Community Care Services Review | TBC | Graham Hodkinson |
| All Age Disability | TBC | Jason Oxley/Simon Garner |

**STANDING ITEMS AND MONITORING REPORTS**

| Item | Reporting Frequency | Lead Departmental Officer |
|---|---|---|
| Financial Monitoring Report | TBC | Shaer Halewood |
| Performance Monitoring Report | TBC | Carly Brown |
| Adult Social Care and Health Committee Work Programme Update | TBC | Committee Team |
| Social Care Complaints Report | Annual Report – January 2021 | Simon Garner ( circulated in an email to Committee) |
| Adults Safeguarding Board | Annual Report – july 2021 | Lorna Quigley |
| Public questions | Each meeting | |
| Public health report | Annually | Julie Webster |

**WORK PROGRAMME ACTIVITIES OUTSIDE COMMITTEE**

| Item | Format | Timescale | Lead Officer | Progress |
|---|---|---|---|---|
| **Working Groups/ Sub Committees** | | | | |
| Performance Monitoring Group | Workshops | Monthly from June 2021 | Jason Oxley | |
| **Task and Finish work** | | | | |
| Quality Accounts 2020/21 | Task & Finish | May 2021 | Committee Team | |

| | | | | |
|---|---|---|---|---|
| **Spotlight sessions / workshops** | | | | |
| County Lines Action Update | Workshop | 2020/21 | Paul Boyce/Tony Kirk | |
| Public Health Implications of 5G Roll Out | Workshop | 2020/21 | Julie Webster | |
| **Corporate scrutiny / Other** | | | | |
| Performance Reporting Review | TBC | TBC | TBC | |