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Health and Adult Social Care Scrutiny Committee

Agenda

Date:	**Thursday, 20th May, 2010**
Time:	**10.00 am**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

2. **Declaration of Interests/Party Whip**

   To provide an opportunity for Members and Officers to declare any personal and/or prejudicial interests or members to declare the existence of a party whip in relation to any item on the agenda.

3. **Public Speaking Time/Open Session**

Please contact	Denise French on 01270 686464
E-Mail:	denise.french@cheshireeast.gov.uk with any apologies or requests for further information or to give notice of a question to be asked by a member of the public

A total period of 15 minutes is allocated for members of the public to make a statement(s) on any matter that falls within the remit of the Committee.

Individual members of the public may speak for up to 5 minutes, but the Chairman will decide how the period of time allocated for public speaking will be apportioned, where there are a number of speakers

Note: In order for officers to undertake any background research, it would be helpful if members of the public notified the Scrutiny officer listed at the foot of the agenda, at least one working day before the meeting with brief details of the matter to be covered.

4. **Minutes of Previous meeting** (Pages 1 - 6)

To approve the minutes of the last meeting as a correct record

5. **The Cheshire and Wirral Councils' Joint Scrutiny Committee** (Pages 7 - 18)

To receive the minutes of meetings of the Cheshire and Wirral Councils Joint Scrutiny Committee held on 26 January and 12 April.

6. **Closure of Hawthorn Lane surgery, Wilmslow** (Pages 19 - 28)

To update the Committee of the work that has commenced following the Committee supporting the preferred option of dispersing the practice list.

7. **Dr Foster report - "How safe is your hospital?" - the position in Cheshire East**

To receive a verbal update

8. **East Cheshire Hospital Trust Quality Account** (Pages 29 - 56)

Due to the tight schedule in putting this report together, it has not been possible to complete the report within the normal timescales and therefore the report will be circulated in due course.

9. **Procedural items - protocol and co-opted members** (Pages 57 - 70)

To consider a report of the Borough Solicitor.

10. **"Caring Together"**

A Bacon – Programme Director East and Mid Cheshire Intergrated care, has advised the Mid Point Meeting of a range of potential changes to the geography, service models and organisational structure of health services that may occur due to a number of factors. The health and social care economy is looking at a range of options to integrated social and health care (GPs, Community, Hospital and mental health) to achieve more integrated services that enable treatment to be provided earlier and recovery delivered faster. The overall programme is known as the "Caring Together Programme" and will also respond to external changes including: the Transforming Community Services and Foundation Trust programmes and the pressure due to be placed upon public sector funding.

It was agreed that this programme would be a standing item on the midpoint meeting, so that engagement and involvement of all stakeholders is maintained and that formal consultation is used only where it is legally required or adds value.

11. **Dealing with Dementia** (Pages 71 - 112)

To consider the following items in relation to dementia:

- Building Based Services – report of the Strategic Director People;
- National Dementia Strategy, response of Cheshire East to the Strategy – presentation;
- Assistive Technology – report of the Strategic Director People;
- Carers Issues;
- Admiral Nurses

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Agenda Item 4

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Adult Social Care Scrutiny Committee**
held on Thursday, 29th April, 2010 at West Committee Room - Municipal Buildings, Earle Street, Crewe, CW1 2BJ

PRESENT

Councillor Rachel Bailey (Chairman)
Councillor G Baxendale (Vice-Chairman)

Councillors S Bentley, D Flude, S Furlong, S Jones, A Moran, J Wray, C Andrew, C Beard, A Martin and R Domleo

Apologies

Councillors W Livesley and A Knowles

23 APOLOGIES FOR ABSENCE

Apologies for Absence were received from Councillors W Livesley and A Knowles.

24 DECLARATION OF INTERESTS/PARTY WHIP

RESOLVED: That the following Declarations of Interest be noted:

Councillor D Flude, Personal Interest on the grounds that she was a Member of the Alzheimers Society and Cheshire Independent Advocacy;
Councillor A Moran, Personal Interest on the grounds that he was a member of the Mid Cheshire Hospitals NHS Foundation Trust.

25 PUBLIC SPEAKING TIME/OPEN SESSION

None

26 MINUTES OF PREVIOUS MEETING

RESOLVED

That the minutes of the meeting of the Committee held on 10 March be confirmed as a correct record.

27 MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST - QUALITY ACCOUNT

Tracy Bullock, Deputy Chief Executive/Director of Nursing, Mid Cheshire Hospitals NHS Foundation Trust (MCHFT), briefed the Committee on the draft Quality Account 2009 -2010 produced by MCHFT.

Last year MCHFT had produced a Quality Report that outlined quality areas that would be measured in 2009 – 10 and how it would take forward its aspiration to be a World Class Provider through the implementation of the five year "10 out of Ten" quality strategy. This strategy aimed to identify the top ten quality indicators and establish the measurements that would be used to monitor effectiveness against these.

The Trust had agreed a definition of Quality:

"Effective and efficient delivery, a positive experience by both service users and staff, the best possible clinical and patient outcomes".

The Trust also recognised the reduction of avoidable harm as a key imperative and had outlined a number of values –

- Commitment to quality and safety;
- Respect, dignity and compassion;
- Listening, learning and leading;
- Creating the best outcomes together;
- Every1Matters

The Trust Board had established an Executive Committee as recognition of the priority given to quality and safety. The Committee was known as QuESt (Quality, Effectiveness and Safety) and met bi-monthly, was chaired by the Chief Executive and reported to the Board of Directors.

The Quality Account listed the top ten indicators agreed in the previous year, to be progressed over five years, and outlined how progress would be monitored, measured and reported:

Outcomes

- Cardiovascular – the aim was to reduce mortality rates in patients who suffered an Acute Myocardial Infarction (heart attack) within a 30 day period. The data was not currently routinely collected but work was underway with Dr Foster (a performance benchmarking tool) to measure mortality rates and these would be reported to the QuESt Committee;
- Cancer – the aim was to improve survival rates for patients diagnosed with cancer. Monitoring would be carried out on an annual basis and measured by the Primary Care Trust and North West Cancer Intelligence Service. Survival rates would be reported to the QuESt Committee;
- Infections – the aim was to reduce the rates of healthcare acquired infections – MRSA, Clostridium Difficile and Urinary Tract Infections.

Safety

- Mortality – the aim was to reduce mortality rates by 10% in patient groups where death was not expected. A Hospital Mortality Reduction Group had been established to review health records and develop Action Plans;
- Patient Safety – the aim was to monitor and reduce the number of

consultant episodes (unnecessary patient moves) during each patient admission;
- Harm caused – the aim was to monitor and reduce the number of patients who suffered avoidable harm by 10% annually;

Experience

- Environment – the aim was to monitor and virtually eliminate mixed sex accommodation for all patients admitted to the trust (unless based on clinical need). All wards were mixed sex but bays were single sex because to introduce single sex wards would require joining services which would result in poorer outcomes. The Committee was advised that in cases where there had to be mixed sex accommodation (in bays), mobile screens were available to put around beds and there were no mixed sex toilet facilities. The maternity and gynaecology service had single sex wards;
- Patients and staff – the aim was to monitor and revise the ratio of doctors and nurses to each inpatient bed within the trust, this would be done through the use of a acuity/dependency tool to assess numbers of nursing staff required in adult inpatient wards;

Effectiveness

- The aim was to measure the percentage of the Trust budget that was spent directly on patient care;
- Readmissions – the aim was to monitor and investigate all patients who were readmitted to hospital within 7 days of discharge – the Committee was advised that readmissions were currently above the national average.

The Committee was advised that the Trust Board had read and reviewed the report relating to the Mid Staffordshire Hospital Trust and carried out a gap analysis. It appeared that there were issues at Mid Staffordshire Hospital around awareness of complaints and patient experience and also high mortality rates. At Mid Cheshire Hospital NHS Foundation Trust complaints management was perceived to be very good and the Trust Board were made aware of complaints, a Non Executive Director chaired the Patient Experience Committee, the Board were also aware of mortality rates and had identified the reduction of unexpected deaths as a priority

During the discussion the following issues/questions were raised:

- Access to drugs – in response the Committee was advised that most drugs were guided by National Institute of Health and Clinical Excellence (NICE) guidance. All drugs were funded by the PCT and drugs approved by NICE would be prescribed. If a drug was outside of NICE guidance a Complex Care Panel would sit to consider the individual case;
- Whether CT scans were available at all times particularly when access to a scan was vital in stroke cases? In response, the Committee was advised that a scan was available 24 hours a day and a scan that provided much quicker results had just been purchased;
- Were falls always reported? The Committee was advised that falls must be recorded and sent to the National Patient Safety Agency. The Trust

was a high reporting organisation following awareness raising two years ago;

- It was important to enable carers and relatives to express views, not just patients, and in response the Committee was advised that a roving kiosk was available in hospital to enable comments to be made.
- How to capture views of dementia patients and patients with learning disabilities? The Trust had been undertaking work with The Cheshire and Wirral NHS Foundation Partnership Trust to help address the needs of patients such patients and, in addition, a number of specific initiatives to introduce children and adults with learning disabilities to hospital services were planned;
- Was information sought about inpatients spiritual or religious views/needs? The Committee was advised that an Admission Document was used to ascertain the activities of a patients daily life and this included a section on spirituality and religion;
- It was noted that some targets were difficult for a hospital trust to achieve such as smoking in pregnancy and breastfeeding rates.

RESOLVED: That

1) the draft Quality Account for 2009/10 be received

2) the Committee welcomes the comprehensive information on the quality of care and services included in the report

3) the ten priorities for improvement and performance measures for 2010/11 as the basis for the Trust's five year improvement strategy be endorsed and progress be reviewed as part of the Quality Account for next year

4) attention be drawn to the following issues:

a) concern that the requirements placed upon Acute Trusts to achieve demanding targets can distract from the quality of outcomes for patients, so the focus on outcomes in the ten priorities for improvement is important

b) although the hospital operates a comprehensive patient complaints system, broader feedback about patient experience could be obtained from engaging more with their relatives, carers and visitors. Specific work aimed at helping patients with learning disabilities, in partnership with Cheshire and Wirral Partnership NHS Foundation Trust, was noted and welcomed

c) although mortality rates in patient groups where death is not expected have improved, further effort is required to ensure the Trust continues to do better in this area

d) that the Trust is investing considerable time and effort into patient safety with the aim of eliminating avoidable harm to patients including falls, and that information will be available in future to present a clearer picture of improvements achieved and priority areas for attention

e) the Trust's ongoing efforts to virtually eliminate mixed sex accommodation be supported, recognising this cannot be avoided in a number of clinical settings,

and the appointment of a Privacy and Dignity Matron to oversee improvements be welcomed

f) that despite investment, the Trust continues to have fewer doctors and nurses per bed than the national average, and also continues to rely heavily on bank/agency nurses in order to meet demand. The position with nursing staff is kept under regular review through a formal monitoring process and this is being extended to other groups of clinical staff

g) although the Trust has demonstrated year on year improvements through the National Outpatient Survey, progress over five years for the "overall rating of care" category was only one percent, and the Trust accepted that the priorities for improvement contained in the Quality Account should lead to future improvements to this figure

h) the initiatives taken by the Trust including joint working with the Central and Eastern Cheshire Primary Care Trust (CECPCT) and Cheshire East Council Adult Social Care to reduce the incidence of hospital readmissions be welcomed and it is hoped that this work will result in a reduction in readmissions to enable the Trust to be at or below the national average, rather than above

i) the target relating to reducing the rates of healthcare acquired infections is welcomed as it is noted that this can increase the length of time spent in hospital

j) issues relating to smoking cessation and breast feeding rates were noted as challenging targets that would require addressing through a partnership approach including the PCT and Cheshire East Council

5) these comments be forwarded to the Mid Cheshire Hospitals Trust for inclusion in their Quality Account and to the CECPCT and Cheshire East LINk for information.

The meeting commenced at 10.30 am and concluded at 12.20 pm

Councillor Rachel Bailey (Chairman)

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CHESHIRE EAST COUNCIL

Minutes of a meeting of the **The Cheshire and Wirral Councils' Joint Scrutiny Committee**
held on Tuesday, 26th January, 2010 at Civic Suite, Ellesmere Port Civic Hall, Civic Way, Ellesmere Port, CH65 0AZ

PRESENT

Councillor A Bridson (Chairman)
Councillor D Flude (Vice-Chairman)

Councillors C Teggin, A Dawson, P Donovan, J Grimshaw, P Lott, G Smith, R Thompson, G Watt, G Baxendale, C Beard, C Andrew and Rachel Bailey

Apologies

Councillors I Coates, S Clarke, S Jones and D Roberts

20 **DECLARATIONS OF INTEREST**

RESOLVED: That the following Declarations of Interest be noted:

Councillor C Andrew, Personal Interest on the grounds that she was a Member of Nether Alderley Parish Council;
Councillor D Flude, Personal Interest on the grounds that she was a Member of the Alzheimers Society and Cheshire Independent Advocacy; and
Councillor P Lott, Personal Interest on the grounds that she was a member of the Local Involvement Network (LINk).

21 **MINUTES OF PREVIOUS MEETING**

RESOLVED: That the minutes of the meeting of the Joint Scrutiny Committee held on 30 November be confirmed as a correct record.

22 **INTERIM CHIEF EXECUTIVE'S VERBAL UPDATE**

Dr Ian Davidson, Interim Chief Executive of the Cheshire and Wirral Partnership NHS Foundation Trust (CWP) presented an update report on current issues including:

- Older People's Service Improvement Programme, Wirral – the upgrade and refurbishment of the 2 older people's wards at Springview, Clatterbridge Hospital had been completed and now comprised Meadowbrook – a 20 bed assessment and treatment ward for people with a functional illness and Brackendale – 13 bed assessment and treatment ward for patients with an organic illness. Both wards had all single rooms with ensuite facilities and

would replace wards at St Catherine's Hospital. The Committee would be invited to the official opening in Spring;

- Greenways Learning Disability Service, Macclesfield – this was a 12 bed purpose built assessment and treatment unit for adults with Learning Disabilities which had opened in November 2009;
- Soss Moss – the proposed work at the Soss Moss site, Nether Alderley, Cheshire had received planning approval from Cheshire East Council and buildings were scheduled to be demolished on 1 March 2010;
- Learning Disability Housing Network Transfer – the network would transfer to new providers by end March 2010, CWP would not register the facilities with the Care Quality Commission;
- Financial and performance issues – CWP was still in an uncertain position in terms of levels of expected funding from commissioners from April 2010, 3 year Mental Health contracts had not been introduced at the moment for national reasons. If the current contracts were rolled forward and the rules of the operating framework for the NHS for 2010 – 11 were applied CWP was confident that financial pressures could be managed internally and efficiency savings to the level required by the operating framework could be made. It was likely that NHS Wirral and NHS Western Cheshire would roll forward existing contracts in line with the operating framework. The commissioning intentions of Central and Eastern Cheshire PCT (CECPCT) remained unclear, Pricewaterhousecoopers, who were working with CECPCT, had presented a report to the PCT Board meeting recommending a 5% cut in income across all major providers, along with a range of services and ways that providers could achieve this level of savings; however, none of this applied to services delivered by CWP.
- CWP had also not received income for services delivered in Tier 4 CAMHS (Pine Lodge and Maple Ward) since 1 September 2009 due to disputes between PCTs and Specialist Commissioners.
- Greenfields Ward, Leighton Hospital – CWP decided to close this ward before Christmas as heating was inadequate, sufficient beds were available within the CWP patch to deal with the closure. The ward remained closed although some work had been carried out with further work to be done.
- Chief Executive – the new Chief Executive, Sheena Cumiskey, would commence work on 22 February.

During the discussion the following issues/questions were raised:

- The Soss Moss proposals had generated local concern due to the isolated location with little public transport and concern about the type of patients who would be staying at the facility. The Committee was advised that the proposals did not relate to a change of use but involved bringing derelict buildings back into use, the facility would remain as low secure, patients were not locked up but often left the premises to visit friends; dialogue would continue with the local population to try to address concerns;
- Contracts with commissioners would be agreed by the deadline of end February so CWP would have a better understanding of

financial issues then, it was noted that the NHS operating framework required 3.5% efficiencies;
- Patients receiving Tier 4 services would still receive a service, the problems with non-payment to CWP seemed to have arisen from communication problems between the contract negotiating body and the commissioners with some commissioners unaware that the contract had not been paid.

RESOLVED: That

(a) the update report be received;

(b) thanks be recorded to Dr Davidson, for his contribution to the Joint Committee's work, in his role as Interim Chief Executive; and

(c) an update on the Tier 4 issues be made to the Mid Point meeting.

23 **CONSULTATION ON SUBSTANTIAL DEVELOPMENT OR VARIATION IN SERVICE - DELIVERING HIGH QUALITY SERVICES THROUGH EFFICIENT DESIGN**

The Committee considered a consultation document on a Substantial Development or Variation in Service (SDV). The consultation set out how CWP proposed to deliver high quality mental health, drug and alcohol and learning disability services:
- Changing demographics and health need – develop services based on function and need wherever appropriate rather than based on age;
- Best evidence on successful interventions;
- New models of care – continue to improve access to services, respond to new ways of working by adopting care pathways that improve patient experience in the least restrictive setting, further develop partnerships with other agencies;
- Provide services in an effective and efficient manner – reduce inefficiencies associated with under-occupied wards by having a smaller number of general acute admissions wards, develop specialist wards, make best use of highly specialist staff;
- Commissioner intentions and available resources – use facilities flexibly so as to respond to national guidance which may mean adapting current services, take opportunities to further develop and/or establish wider range of specialist services due to emerging demand.

Dr Davidson explained that the consultation questionnaire was one of a number of methods of seeking views, there were also a number of public consultation events taking place, views would be sought from user groups/support groups and also through the Engage magazine which had a distribution of hundreds and through the website.

RESOLVED: That

(a) the report be received and the proposals be confirmed as a substantial development or variation to the provision of services; and

(b) the arrangements made by CWP for public consultation on the issues and options be noted and supported.

24 CONSULTATION ON SUBSTANTIAL DEVELOPMENT OR VARIATION IN SERVICE - REDESIGNING ADULT AND OLDER PEOPLE'S MENTAL HEALTH SERVICES IN CENTRAL AND EASTERN CHESHIRE

The Committee considered a consultation document on a Substantial Development or Variation in Service (SDV) relating to in-patient services in Central and Eastern Cheshire.

The document outlined that a review of services had indicated that in future provision could be made through four in-patient wards (two older persons and two adult acute). CWP had six wards at present although one was temporarily closed. The proposal was based on further investment being made in community services and continuation of new ways of working which had resulted in effective reductions in admissions and length of stay elsewhere in the CWP patch.

Three options had been considered:

Option 1 – continue to provide services as at present from the Mental Health Units at Leighton Hospital and Macclesfield – this would not be achievable as CWP had already been given notice to vacate the Mental Health Unit at Leighton, even if it were possible, there would be clinical risks by stretching limited resources across two sites and existing wards were not capable of being redesigned to provide the environmental improvements required;
Option 2 – Provide the service currently available at Leighton elsewhere but continue to provide services from two main inpatient sites – this would create clinical risk issues if two sites were used as there would not be enough staff on duty at certain times to ensure clinical safety, this option would not be as financially efficient as option 3 and would not free up funding for community service developments;
Option 3 – provide all adult and older persons' acute mental health inpatient services from a single site – this was CWP's preferred option. Capital investment would be made to maximise the number of single rooms and ensure the provision of adequate therapeutic and day care facilities. Greater financial efficiencies would enable funding to be released for further developing community services.

After the consultation a full economic analysis would determine how a single site would be provided taking into account the financial position of the local and national health economies. A working group had been established to look at the criteria to be used when selecting a preferred location for an inpatient mental health unit. Any transport or access issues would be addressed in partnership with Cheshire East Council.

Public meetings were arranged in major towns in Cheshire East to run alongside the other SDV consultation (minute XX refers).

RESOLVED: That

(a) the report be received and the proposals be confirmed as a substantial development or variation to the provision of services;

(b) the arrangements made by CWP for public consultation on the issues and options be noted and supported; and

(c) Option 3 (the provision of services from a single site) be supported.

25 CONSULTATION ON LEARNING DISABILITY RESPITE CARE

The Committee received an update on the consultation by CWP on the eligibility for and process of assessment and allocation of Learning Disability respite care in Cheshire and the proposal to close the Primrose Avenue unit in Haslington and operate an improved single service for central Cheshire at Crook Lane, Winsford. CWP had established a Task and Finish Group who had looked at eligibility criteria and the process and allocation of health respite and suggested that the low indication of need did not suggest a shortfall of provision if Primrose Avenue were to close. There was sufficient capacity at Crook Lane to meet the current level of allocation for both units. As part of the consultation CWP had held discussions with current users of Primrose Avenue and their families to consider all the potential impacts of moving to Crook Lane.

RESOLVED: That the report be received and the proposed closure of the unit at Primrose Avenue be supported.

26 UPDATE ON IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES

The Committee considered a report on the Improving Access to Psychological Therapies (IAPT) scheme. The programme had been in place in Western Cheshire and Central and Eastern Cheshire since September 2008, which had both been chosen as Wave 1 sites in the initial rollout. National Institute for Health and Clinical Excellence (NICE) guidelines had been followed that recommended a stepped care approach to treating common mental health problems:

Step 1 – Watchful waiting, usually carried out by the GP;
Step 2 – psycho-education, including telephone treatment and computerised Cognitive Behavioural Therapy (cCBT) for people with mild psychological problems;
Step 3 – time limited CBT and time limited counselling for people with moderate psychological problems;
Step 4 – longer term interventions (up to 26 sessions) for people with complex problems;
Step 5 – psychological support to people requiring secondary care mental health services.

CWP had employed 7 new High Intensity Therapy Workers in West Cheshire and 21 in Central and Eastern Cheshire. These workers

provided high intensity Cognitive Behavioural Therapy interventions at Step 3. Both areas had Psychological Wellbeing Practitioners (PWP) who provided low intensity CBT interventions at Step 2 (7 in West and 14 in Central and Eastern Cheshire). New staff had joined existing primary care mental health teams to provide an integrated primary care psychological therapy service for Steps 2 to 4.

Central and Eastern Cheshire were also one of 12 regional pilot sites for the IAPT Employment Advisory Services to target people who were in work but struggling due to anxiety/depression or who were on sick leave from work.

Western Cheshire IAPT had completed and discharged 134 clients and returned 56 clients to work, waiting times for the service averaged between 4 – 6 weeks. In Central and Eastern Cheshire over 2000 clients had completed treatment and 233 people had been taken off sick pay and benefits, there were over 1000 people currently on the waiting list for the service.

Wirral was not an official IAPT site but the Talking Changes services commissioned by Wirral PCT worked to the principles of IAPT. The service received an average of 170 referrals a week and saw clients within Steps 2 – 4.

RESOLVED: That the update report be noted and a further update on waiting times be made to the Mid Point meeting.

27 **EVALUATION AND MONITORING OF ASSERTIVE OUTREACH CHANGES**

The Committee considered a report on the outcome of consultation on delivering the Assertive Outreach Function (AOT) from Community Mental Health Teams. The outcome of the Level 2 consultation was:

CWP must provide the same level of contracted Assertive Outtreach service based on clinical need;
Avoid disadvantaging service users of Community Mental health services;
Ensure that access to AOT remained for service users who required it within contractual service levels.

A full evaluation of the consultation was circulated at the meeting.

RESOLVED: That the consultation be noted and any comments forwarded to CWP via the Secretary by 14 February.

28 **PROTOCOL**

The Committee considered a draft Protocol that set out the working relationships between the Joint Committee and CWP particularly for identifying and responding to proposals for Substantial Developments or Variations in Service. The protocol picked up current changes in the way scrutiny and patient and public involvement operated. The revised

national guidance from the Department of Health on the conduct of NHS scrutiny was still awaited and once received would be incorporated into the protocol as necessary.

RESOLVED: that the protocol be approved and adopted subject to one amendment to paragraph 8.7 under the heading Level 3 to refer to local Ward Councillors being notified by the Secretary.

29 **PROCEDURAL MATTERS - CO-OPTION AND THE NAME OF THE JOINT COMMITTEE**

The Committee considered a report on the name of the Committee and whether to have a non-voting co-opted member from the Local Involvement Network (LINk). The Procedural Rules allowed for the appointment of a co-opted member(s) and the mid point meeting had been advised that a Sub Group was likely to be established by the 3 local LINks to focus particularly on mental health issues.

At the last meeting of the Committee, consideration had been given to changing the name of the Committee to reflect its role and responsibilities more clearly to the public. This had been considered at the mid point meeting where it was felt that, on balance, the name should remain as it was but a brief statement could be included on the Agenda front sheet and 3 Council websites describing the role of the Committee.

RESOLVED: That

(a) one non-voting co-opted place (with a named substitute) be offered to the LINks Mental Health sub group to serve until 30 April 2011;
(b) the possibility of offering further co-opted places to representatives of the LINks and/or patient or service users be considered further at the mid point meeting; and
(c) the name remain as The Cheshire and Wirral Councils' Joint Scrutiny Committee and a description of the role of the Committee be included on future Agenda sheets and on the 3 Council websites.

The meeting commenced at 2.30 pm and concluded at 4.35 pm

Councillor A Bridson (Chairman)

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CHESHIRE EAST COUNCIL

Minutes of a meeting of the **The Cheshire and Wirral Councils' Joint Scrutiny Committee**
held on Monday, 12th April, 2010 at Council Chamber, Cheshire West and Chester Council, County Hall, Chester, CH1 1SF

PRESENT

Councillor Bridson (Chairman)
Councillor D Flude (Vice-Chairman)

Councillors Teggin, Grimshaw, Lott, Roberts, Thompson, Watt, G Baxendale, C Beard, C Andrew and Rachel Bailey

Apologies

Councillors Coates, Dawson, Smith and S Jones

30 APOLOGIES FOR ABSENCE

Apologies for absence were received from Cheshire East Councillor S Jones, Cheshire West and Chester Councillors A Dawson and P Donovan (substitute Councillor P Merrick) and Wirral Councillor I Coates.

31 DECLARATIONS OF INTEREST

RESOLVED: That the following declarations of interest be noted:

- Councillor D Flude Personal Interest on the grounds that she was a Member of the Alzheimers Society and Cheshire Independent Advocacy;
- Councillor P Lott, Personal Interest on the grounds that she was a Member of the Local Involvement Network; and
- Councillor D Roberts, Personal Interest on the grounds that her daughter was an employee of the Cheshire and Wirral Partnership NHS Foundation Trust.

32 MINUTES OF PREVIOUS MEETING

RESOLVED: That the minutes of the meeting of the Joint Scrutiny Committee held on 26 January be confirmed as a correct record subject to an amendment to Minute 24 to read “(Minute 23 refers)”.

33 JARGON BUSTER

The Jargon Buster was received and noted.

34 PROCEDURAL MATTERS

The Committee considered a report of the Cheshire East Borough Solicitor on procedural matters relating to co-option, meeting venues and the appointment of Chair, Vice Chair and Spokesperson for 2010 – 2011.

The Committee's Procedural Rules made provision for co-option as follows:

"The Joint Committee may choose to co-opt other appropriate individuals, in a non-voting capacity, to the Committee or for the duration of a particular review or scrutiny".

The Committee had previously resolved to co-opt one Local Involvement Network (LINk) representative from the LINks' Mental Health Sub Group. However, the mid point meeting had subsequently been made aware that, contrary to previous expectation, such a Sub Group was unlikely to be formed for some time. The mid point meeting had therefore reviewed the position and concluded that rather than formally co-opt a LINk representative onto the Committee, a representative from the relevant LINk should be invited to attend the Committee for consideration of specific items of business and/or onto any Task/Finish Groups where appropriate. Discussions were on-going with officers of the Cheshire and Wirral Partnership NHS Foundation Trust (CWP) regarding service user/carer contributions to the Committee.

The Committee noted that meeting dates had previously been agreed and discussed venues and start times. It was agreed that most meetings would commence at 2.30pm and venues would be rotated with further discussion at the mid point meeting of specific details.

The Procedural Rules provided that the Chair and Vice Chair should be appointed annually from the elected Members of the Committee and the Chair should be held by one authority and the Vice Chair from another, the Authority that did not hold either of these positions would elect a Spokesperson.

RESOLVED: That

(a) the previous decision of the Committee to offer one co-opted place to a representative of the LINks Mental Health Sub Group be not pursued on the basis that the Sub Group is not yet in being;

(b) as the Joint Committee meets in different venues, a representative of the relevant local LINk be invited to attend each meeting with the right to speak (and the Joint Committee's Procedural Rules be amended accordingly);

(c) all LINks be notified of the dates and venues for the forthcoming year's meetings, and be supplied with an electronic copy of the agenda for each meeting;

(d) the option to co-opt LINk representatives to Task and Finish Scrutiny Review Groups in a non-voting capacity be noted;

(e) further discussions take place with officers of CWP through the Mid Point meeting concerning Service Users and Carers representation;

(f) the venues for the Joint Committee's meetings for the forthcoming year be approved as follows:

- Monday 12 July, Capesthorne Room, Macclesfield Town Hall;
- Monday 4 October, Chester or Ellesmere Port;
- Monday 10 January, Winsford Lifestyle Centre;
- Monday 4 April, Committee Room 1, Wallasey Town Hall

with a start time of 2.30 pm subject to the Mid Point meeting considering an earlier start for the January meeting and agreeing the venue for the October meeting;

(g) the position concerning the appointment of Chair and Vice Chair and the notification of Spokesperson for the forthcoming year be noted.

35 CHIEF EXECUTIVE'S UPDATE

Sheena Cumiskey, Chief Executive of the Cheshire and Wirral Partnership NHS Foundation Trust, was welcomed to her first meeting of the Committee.

She explained that due to the election purdah period it would not be possible to brief the Committee on potential service changes or consultations.

However, Ms Cumiskey was pleased to report that for the current year contracts had been resolved with the majority of commissioners and the 5% reduction across all CWP commissioned services that had been anticipated from one commissioner had not been implemented.

Actions for the forthcoming year included to further reinforce partnership working; focus on preventative work such as early intervention work with dementia sufferers that was taking place on Wirral in partnership with the Borough Council; and looking at the wider determinants of well-being again through work with partners such as Councils in areas such as housing and work with employers generally in terms of mental health awareness raising (Mindful Employer) and challenging stigma and support to staff in the work place.

RESOLVED: That the update report be noted.

36 QUALITY ACCOUNT

Ursula Martin, Associate Director Quality, Compliance and Assurance, briefed the Committee on the process for submitting a Quality Account for Cheshire and Wirral Partnership NHS Foundation Trust (CWP).

All providers of NHS services were required to publish Quality Accounts – annual reports to the public on the quality of healthcare that they delivered. Prior to publication of the finalised Quality Account in June, providers were required to share their draft Account with the commissioning Primary Care Trust (or Strategic Health Authority), the Overview and Scrutiny Committee (OSC) and the Local Involvement Network (LINk).

Ursula Martin explained that part of the process of producing a Quality Account involved identifying Priorities for Improvement which had to include at least one priority relating to each of the following categories – Safety, Clinical Effectiveness and Patient Experience. CWP had identified:

- Under the Safety Priority- 2 priorities relating to monitoring trends from Serious Untoward Incident investigations and reducing preventable falls in inpatient areas;
- Under the Effectiveness Priority – 3 priorities were identified relating to implementing the Advancing Quality programme for schizophrenia and dementia; developing systems to help identify adherence to National Institute for Health and Clinical Excellence (NICE) guidance as part of an electronic care pathway and reviewing physical health for those with a mental illness;
- Under the Patient Experience – collecting real time patient experience data and ensure that patient experience of previous Assertive Outreach service users and carers is sought and continuously monitored during the merge of this function into Community Mental Health Teams.

CWP had reviewed the quality of its past performance and could demonstrate improvements in a number of areas including:

- Improved learning from patient safety incidents by increasing reporting by 3.1% - this upward trend was encouraging and in line with best practice which suggested that organisations where incident reporting by staff was high (incidents that were of low or no harm), were safer;
- Strengthen hand decontamination compliance – almost 2500 staff had attended hand decontamination training and audits had been carried out to measure compliance;
- Increase offer of psychological intervention to service users with schizophrenia – the target was 70% and a rate of 68% had been achieved;
- Diagnosis of dementia by a specialist – almost 95% of service users referred to the Trust were diagnosed and assessed within 13 weeks;
- Increased patient experience feedback – a target of 5% had been surpassed with patients' experience through comments, compliments, concerns and complaints increasing by over 7%.

CWP was also regulated by Monitor and the Care Quality Commission. The draft Quality Account would be submitted to a Special meeting of the Committee for consideration and comment prior to publication in June 2010.

RESOLVED: that the process of producing a Quality Account be noted and the CWP draft Quality Account be considered at a Special meeting of the Committee on Tuesday 25 May.

The meeting commenced at 2.30 pm and concluded at 4.00 pm

Councillor Bridson (Chairman)

Date of Meeting : 29th April 2010

Venue : Municipal Building, Crewe

Central and Eastern Cheshire NHS
Primary Care Trust

OVERVIEW & SCRUTINY COMMITTEE UPDATE

Hawthorn Lane Surgery, Wilmslow

Background

This brief report follows on from the Mid Point Overview & Scrutiny Committee Meeting held on 29th April 2010, where a report was presented to the Committee regarding the retirement of Dr Chung from Hawthorn Lane Surgery, Wilmslow. The Mid Point Overview & Scrutiny Committee was asked to consider the options available to the PCT as a result of this retirement (Report attached Appendix A) The purpose of this update is to inform the Overview and Scrutiny Committee of the work that has commenced following the Committee supporting the preferred option of dispersing the practice list.

Actions Completed

On 19th April 2010 CECPCT sent letters to the following Practices who were most likely to be affected by the dispersion of Dr Chung's patient list:-
Alderley Edge Surgery
Chelford Surgery
Handforth Health Centre
Kenmore Medical Centre
Wilmslow Health Centre

After the liaising with the Cheshire Health Agency, and Dr Chung, the PCT have identified the following number of households in each specific area:-

Wilmslow	533
Alderley Edge	34
Altrincham	2
Crewe	1
Knutsford	14
Macclesfield	54
Stockport	1

Stockport PCT have 47 patients registered with them.

These geographical areas have then been broken down further into specific post codes, and letters were sent to each household on 10th May 2010 (copy letter Appendix B). Along with these letters, each household has also received a list of contact details of Practices which are specific to their post code, and also a

personal letter from Dr Chung. Some of the letters have been translated into Chinese for the relevant Chinese speaking patients.

Central & Eastern Cheshire PCT has liaised with Stockport PCT, and have sent a copy of the letter to them to send out to the 47 patients in the Stockport area with the relevant Practice details

Dr Chung has also identified a number of vulnerable patients on his practice list who may require additional help when registering with another practice. The PCT will work closely with Cheshire Health Agency to ensure that these specific patients have registered with another Practice prior to Dr Chung's retirement.

Included on the letter that has been sent out to patients are the details of a PCT helpline Freephone number which will be manned from 9am -5pm Monday to Friday by members of the Primary Care team. This will further support patients and Practices throughout the process.

Actions Still to be Completed
The PCT Communications team will be sending a media release to all local newspapers week commencing 31st May 2010. This will include a photograph and story of Dr Chung's retirement; and also a reminder to patients of the registration process.

The PCT will continue to offer its full support to Dr Chung and his staff, the patients currently registered with the practice and those practices with whom the patients may register with, throughout the process.

Summary
The Overview & Scrutiny Committee are asked to note the actions that have been completed following the Mid Point meeting on the 29th April 2010. A further update will be shared with the Overview & Scrutiny Committee detailing a summary position once Hawthorn Lane Surgery has closed. The final report will provide assurance that patients have successfully been re registered with neighbouring Practices.

Fran Willshaw
Primary Care Facilitator
Central & Eastern Cheshire PCT

Simon Whitehouse
Director of Primary Care
Central & Eastern Cheshire PCT

Date of Meeting: 29th April 2010

Venue: Municipal Buildings, Crewe

APPENDIX A

Central and Eastern Cheshire NHS
Primary Care Trust

OVERVIEW & SCRUTINY COMMITTEE REPORT

Hawthorn Lane Surgery, Wilmslow

Purpose of Report

The purpose of this report is to inform the Overview and Scrutiny Committee of the retirement of a single handed GP based in Wilmslow Cheshire and the options available to the PCT with regards to ensuring the continued care of the patients currently registered at this surgery. The Overview and Scrutiny Committee are asked to consider the detail included in the paper and comment on the proposals.

Background

Hawthorn Lane Surgery is CECPCT's only single handed GP practice. Dr W Chung took over the practice from Dr Zabron on 9th June 1986, and has remained a single handed GP practice until the present time. The current premises which Dr Chung practices from are not compliant with the DDA Act, and are also not compliant with either quality standards for accessibility or infection control. The current premises are leased and in view of them not being deemed suitable primary medical services it would not be advisable for the PCT to consider renewing this lease. This would therefore require the PCT to seek alternative accommodation if the GP services were to continue. The current practice population is 1204 as at the 1st January 2010, with 43 of those patients living within the Stockport PCT area. This is a very small list size when shown against an average PCT list size of 8980. The practice demographics show an exceptionally high average elderly population for the over 75's being 14.5% and for the 65-74year olds being 10.38% (taken from the Public Health Intelligence team report March 2009). This small list size needs to be taken into account when considering the options. The PCT, in its Primary Care GP Strategy, stated that it would work with GP's towards having no single handed GP Practices. This is based on extensive evidence demonstrating the benefits of having a larger Practice team to care for Patients and also the vulnerability for continuity of care that single handed practices present.

The practice has always achieved targets, including the Quality & Outcomes Framework and the Directed and Local Enhanced Services that are commissioned from them.

The PCT has been aware of the intentions of Dr Chung to retire as this had been discussed on a number of occasions. However it was only on the 22nd March 2010 that the PCT received a letter outlining that he wished to terminate his GMS Contract at the time of his retirement of the 30th June 2010. Unfortunately this does present the PCT with some very tight deadlines to ensure that this is managed in an open and transparent way. This is the reason for this report which is aimed at consulting with the Overview & Scrutiny Committee as an integral part of the process. Whilst it is appreciated that this is tight, the PCT is able to confirm that if a decision is made to proceed as detailed below that patient care will not be compromised.

APPENDIX A

GP Requirements
When dealing with this situation the PCT is advised by the Department of Health to ensure that it follows National Guidance. However it should be noted that there is no nationally agreed procedure to follow as often local circumstances are variable, and require a degree of flexibility to be shown.

National Guidance - Retirement of a provider
To qualify for NHS Pension benefits a type 1 medical practitioner (e.g. a Partner, single handed GP or a GP shareholder) must resign from any involvement in a GMS contract, PMS agreement or APMS contract. They cannot return to the NHS for at least 24 hrs.
This requires the GP to officially resign from their contract and any other NHS work for a minimum period of 24 hours. After this period they may return to NHS employment, including provider status in a GMS contract, but cannot work for more than 16 hrs a week in the first month following the break in service. Dr Chung has expressed no desire to continue to work at all as a GP after his retirement date.

Therefore, if an individual (single-handed) GP wishes to retire, the GMS contract will automatically terminate on the retirement date if succession arrangements have not been agreed. Dr Chung has made no succession arrangements preferring for the PCT to explore viable options. The PCT can agree a mutually convenient date for the termination or, if the contractor writes to serve notice, a period of 6 months notice should be given. Unfortunately due to the receipt of the notification of the retirement date of the 30 June 2010 only being received towards the end of March 2010 the PCT has no alternative but to agree to a termination date of the end of June 2010 as Dr Chung will not be in a position to provide services after this date. After the termination date the PCT is responsible for ensuring the continuity and provision of primary medical services to patients previously registered with the practice.

The PCT is responsible for ensuring continuity and provision of services to Dr Chung's patients. There is therefore, a need for a clear process on how the termination will be progressed and the PCT is committed to following the due process. However, there is not the flexibility of having a full 6 months in which to progress this situation as the PCT has agreed in principle to a mutually convenient date as detailed above. Whilst recognising that there is a challenge, the PCT is well advanced in its planning and is at an advanced state of readiness once an agreement has been reached on next steps, and is confident that patients will be managed appropriately. The PCT is keen to reach agreement with all parties that the mutually convenient date with Dr Chung can be confirmed and that plans can be implemented to manage the transition in an effective way.

Options
As the PCT is responsible for ensuring continuity and provision of services to the patients there should be a clear process on how the termination will be actioned.

APPENDIX A

The options available to the PCT would appear to be as follows:

1. **Disperse the patient list** – As already noted it was identified that 43 patients on the practice list resided within the Stockport PCT area. To compound the situation none of those patients living in the Stockport PCT area reside within any CECPCT GP Practice boundary and therefore the PCT will need to work closely with Stockport PCT to ensure these patients are accommodated. Whatever option is chosen this situation will not change as no GP practice is obliged to agree to take on a patient residing outside of its boundary. Having reviewed the list in some depth it soon became apparent that not only were there the 43 patients living in the Stockport area but a number of patients were also located near to other towns within the PCT boundary but not necessarily close to Wilmslow e.g. Macclesfield, Knutsford, It would be more sensible and safer for these patients to register with a practice much nearer to their home. After taking into account these two anomalies outlined the true list size to be taken into consideration is somewhat less than originally thought.

   The PCT should therefore identify whether there is sufficient capacity/choice within the Wilmslow area to meet the needs of Dr Chung's remaining practice list. Once capacity/choice has been identified, the PCT will need to work closely with the Cheshire Health Agency to identify the geographical areas and practices where the patients can be signposted to for registration, and ensure that a robust system is in place for this transitional period.

2. **Tender/Procurement exercise to secure a new provider for a small single handed list** – The length of time for a tender process, and also the vulnerability of having a small single handed GP practice would need to be considered. With the timescales that the PCT has, and the responsibility for the continued provision of service to those patients, this option would not be considered as viable.

3. **Provide services under a PCTMS arrangement** – The PCT would be required to have the appropriate resources (financial and physical) available to run a PCTMS practice. This option would also mean that the PCT would have the financial responsibility for the practice, and also the issue of finding alternative accommodation from which to provide the services. Again due to the time constraints and the small number of patients, this would not be a viable option.

Preferred Option

Having taken into account wider NHS Policy such as patient choice, and considering the options above, including pertinent issues such as the length of time for a tender process, the vulnerability of having a small single handed practice and the ability of the PCT to have the appropriate resources (financial and physical) available to run a PCTMS practice; it is the view of the PCT that our preferred option is option1 to disperse the list. In making this assessment the PCT has identified that there is sufficient capacity/choice within the CECPCT area to meet the needs of these patients, and that the local GP practices are keen to work with the PCT and grow their list size. Clearly enabling a patient to have choice of practice to which they can register with is a very important consideration, and care that the PCT takes seriously.

APPENDIX A

The PCT have considered the following points in this decision process:

- whether patient choice would be significantly affected in the area
- numbers of patients registered under the contract
- patient demographics – elderly, care home patients, housebound , patients with learning disabilities etc
- location of patients, such as whether patients reside in the practice area/ PCT area
- impact on local practices of list dispersal – increased workload, financial viability, capacity and workforce issues
- consultation with local practices, patients (albeit limited because of numbers and not wishing to cause unnecessary anxiety), staff (at practice), LMC, local services/agencies
- media and other stakeholder interest such as MPs and other primary care providers such as pharmacy
- PCT/ provider action plan for closing the practice e.g. outstanding bills to be settled by the contractor, notices to be displayed internally and externally, answer phone message on telephone advising callers after the practice closes usually keep on for at least one month (likely to be at PCT cost), termination of staff contracts and settlement of redundancy pay, inventory of PCT assets and removal i.e. IT equipment, logging and removing patient information (clinical system) and paper records etc
- Notifying agencies of closure i.e. Patient Advice Liaison Service (PALs), Cheshire Health Agency, Acute Trust, PCT colleagues, OOHs, NHS Choices web lead etc

Given the information already provided with regards to dates, the PCT has some very tight deadlines to follow in order to ensure that the patients can be supported to find an alternative practice with which to register with by 30th June 2010 at the latest. The practices where this is likely to have an impact on are those who share a similar practice boundary to Hawthorn Lane Surgery (listed below). However, there is also a cohort of patients who reside in the Macclesfield area. The PCT is currently working with the Cheshire Health Agency and Stockport PCT to clarify the numbers involved in each area.

The following CECPCT practices are most likely to be effected by this process:
Wilmslow Health Centre
Kenmore Medical Centre
Handforth Health Centre
Chelford Surgery
Alderley Edge Surgery
Macclesfield Practices

All practices listed have an open list and are accepting new patients.

Progress to date
The following progress has been made to date. The PCT Trust Board agreed on 30th March 2010, to delegate the responsibility to Simon Whitehouse, Director of Primary Care, to progress the preferred option once an agreement has been reached. Also as a part of the statutory process the PCT have consulted with the Local Medical Committee (LMC) on 7th April 2010. The LMC, who represent the GPs in Cheshire and their interests in all relevant political and managerial settings at both national and local level were also fully supportive of

this process, and of the preferred option. The LMC informed the PCT that after careful consideration of the options available they agreed that the dispersal of the practice list would be the best option, especially given the unique circumstances of the practice population and where they reside.

The PCT is now looking to the Overview & Scrutiny Committee to comment on the detail contained in this report and would welcome any further advice and guidance that the Committee may have to support and endorse this sensitive process to ensure the minimum disruption to the patients involved, many of whom have been with Dr Chung for a considerable length of time.

Next Steps
The PCT must consider our statutory duty under the NHS Act 2006, to consult with, and involve, the public and patients in any developments or variations to services. Section 242 of the NHS Act gives particular responsibilities to PCT's to involve and consult with all affected patients or their representatives on:

(a) the planning of the provision of these services
(b) the development and consideration of proposals for changes in the way those services are provided, and
(c) decisions to be made by that body affecting the operation of those services

World Class Commissioning sets out challenging requirements for the PCT to ensure that our process for public consultation is robust and accessible. This is obviously a significant change to the delivery of primary medical services to these patients and we should be demonstrating that we are seeking to ensure that the patients are not disadvantaged. Equally we should be aware that the patients may be getting improved services in collaboration with local clinicians and partner organisations. Members are asked to consider the patient list size and the agreed approach towards larger GP Practice teams when considering the issue of consultation.

The PCT will need to enter into discussions with local practices to assist in the registration of these patients. The PCT are therefore planning to write to all patients that are registered with Hawthorn Lane Surgery and within this communication the PCT will include details of the relevant practices to which the patients residing in the appropriate town will be able to register. Included in the letter will also be an 0800 number which will enable the patients to ring the PCT directly to discuss any concerns and queries which they may have.

The PCT communications team will also include an article in all of the local newspapers as a part of the process which will inform the patients of the procedures to re-register etc. As a matter of courtesy and to proactively facilitate this process, the PCT will also be contacting those practices which are likely to be affected by the patient list being dispersed (listed above), and would expect that they will work collaboratively with the PCT to integrate those patients.

The PCT will obviously be offering its full support to Dr Chung and his staff, the patients currently registered with the practice and those practices with whom the patients may

register with. The PCT will closely monitor the process, ensuring that the transition period for patients is as seamless as possible.

The PCT will provide action plans and timescales for dispersing the practice list, ICT, premises, finances and communications.

The PCT is confident that all of the above issues will be addressed in a comprehensive manner and will allow for the final option to be implemented with the minimum of disruption.

Action Required/Next Steps
In order for the PCT to now progress further with the dispersing of the patient list in a timely and supportive manner, we are asking for the endorsement and support of the Overview & Scrutiny Committee.

Once the PCT receives any recommendations and the endorsement from the Overview & Scrutiny Committee around the proposed changes to the Health Services provision for the patients in Wilmslow, the following actions will commence.

- Having already liaised with the Health Agency regarding the patient population and geographical areas, letters will go out to all head of households explaining the forthcoming retirement and closure of Hawthorn Lane Surgery, and the options for re registration available to them in their neighbourhood. Dr Chung has also provided a personal letter to his patients which also includes a copy written in Chinese, and these will be sent out at the same time as the PCT letters. These letters will include an 0800 patient help line number.

- The PCT Communications team will send a media release to all local newspapers that cover the current practice area informing them of the closure.

- During this process the PCT Primary Care team will have a range of support measures in place to ensure that the patients, Dr Chung and Hawthorn Lane Surgery, and also the practices with whom the patients will re-register are fully supported.

The Overview & Scrutiny Committee are asked to comment on the detail contained within this paper and provide a clear recommendation to the PCT with regards to next steps

Fran Willshaw
Primary Care Facilitator

Simon Whitehouse
Director of Primary Care

16 April 2010

Central and Eastern Cheshire NHS
Primary Care Trust

APPENDIX B

Universal House
ERF Way (off Pochin Way)
Middlewich
Cheshire
CW10 0QJ

Tel: 01606 275303
Fax: 01606 835541

7 May 2010

Dear Patient(s)

Re: Retirement of Dr Chung and closure of Hawthorn Lane Surgery, Wilmslow

This letter is to inform you and your family that, as of the 30 June 2010, Dr Chung is retiring from General Practice. The Practice operates as a single handed Practice and, as such, Hawthorn Lane Surgery will be closing on this date.

Central & Eastern Cheshire PCT is responsible for ensuring the continuity and provision of GP services to Dr Chung's patients and, as part of that responsibility, we are writing to advise you what you need to do to register with another Practice in your area.

As a patient of Dr Chung you and your family have a number of choices where you can register. Included with this letter is a list of GP Practices local to you, who are accepting new patients. To help you make this important choice we have included the NHS Choices website on the list and this provides more information on the individual Practices. However, some Practices have their own website and details of these can also be found on the NHS Choices website.

Once you have made a decision about which GP Practice you wish to register with, you will need to contact your chosen Practice. They will then inform you of the registration process. Once you have registered your family's medical records will be transferred automatically.

I am sure that, as a patient of Dr Chung, you will join us in wishing him a very happy and healthy retirement. Dr Chung has written a personal letter to you and a copy can be found on the reverse of this letter.

For any further assistance, or if you have any queries please the ring the PCT on **Freephone 0800 5877888** Monday to Friday from 9am until 5pm.

Yours sincerely

Simon Whitehouse
Director of Primary Care

HAWTHORN LANE SURGERY

23 Hawthorn Lane
Wilmslow
Cheshire SK9 5DD
Tel: 01625 523902
Fax: 01625 522112

18th March 2010

Dear Patient

Some of you would have already suspected that I will be retiring from General Practice this year and I can now confirm that the date is 30th June 2010.

I have been privileged to take over this practice from my predecessor Dr Zabron and a number of respected general medical practitioners before him on 9th June 1986. The past 24 years has been a long unmitigated job satisfaction and I thank all of you for the loyalty and friendliness that you bestowed on me and my staff over the years.

It is ironic that a fervent believer in the virtues of single-handed practice like me should patronize the closure of the last remaining single-handed practice in East Cheshire but I have no doubt you will find alternative excellent primary care service in the area.

Detail information on other practices in the area has been enclosed by the PCT for your information.

I wish you all the best for the future.

Yours sincerely

Dr W K Chung

Agenda Item 8

East Cheshire NHS Trust

EMT
OVERVIEW AND SCRUTINY COMMITTEE
20 MAY 2010

Report of	Bernie Salisbury Director of Nursing and Patient Care Standards
Paper prepared by	Bernie Salisbury Director of Nursing and Patient Care Standards
Subject/Title	Draft Quality Account
Background papers (if relevant)	Quality Account Toolkit (Department of Health)
Purpose of Paper	To give an overview of quality performance in 2009/10 and describe priorities for improvement in 2010/11
Action/Decision required	For the Overview and Scrutiny Committee, PCT and LINks to consider and offer an opinion to be included on page 20
Identify NHSLA and CQC Standards to which this report relates:	CQC Outcomes 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 16, 17 and 21.
Link to: ➢ **Trust's Strategic Direction** ➢ **Corporate Objectives**	To continuously improve the patients experience
Resource impact	
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	

East Cheshire NHS Trust

1 PURPOSE OF THE PAPER

1.1 The purpose of this paper is to explain what a 'Quality Account' is.

1.2 The Quality Account for 2009/10 is attached and the needs consideration and comment by the Overview and Scrutiny Committee, PCT and LINks

2 INTRODUCTION

2.1 There is a legal requirement under the Health Act 2009 for all bodies who provide NHS Services to produce a Quality Account and for this first Quality Account to be produced by June 2010.

2.2 The toolkit issued by the Department of Health provides guidance on the production of a Quality Account and the attached report is based on that guidance.

2.3 A Quality Account consists of three separate parts. Part 1 is a statement on quality from the Chief Executive Officer and sign off by the Chairman and Chief Executive Officer on behalf of the Board. Part 2 describes priorities for improvement and Part 3 is a review of 2009/10 in terms of quality performance.

3 QUALITY ACCOUNTS – WHAT ARE THEY AND WHAT ARE THEY FOR?

3.1 Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of services they provide. The public, patients and others with an interest will use a Quality Account to understand:

- the organisation's commitment to quality services;
- what are our priorities for improvement for the coming year;
- what we are doing well;
- how we have involved service users, staff and others with an interest in our organization in determining those priorities for improvements.

3.2 Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

3.3 A Quality Account must include:

- a statement from the Chief Executive Officer summarising the quality of NHS services provided;
- a statement from the board for which the format and information required is set out in regulations;
- the priorities for quality improvement for the coming financial year;
- the specific requirements in the statutory instrument relating to audit, commissioning research, data quality, coding and information governance.
- a review of the quality of services in our organization expressed in terms of the three domains of quality: patient safety, clinical effectiveness and patient experience.

4 HOW SHOULD QUALITY ACCOUNTS BE PUBLISHED

4.1 Quality Accounts must be published on the NHS Choices Website by 30th June and for future years hard copies of the previous two years Quality Accounts must be made available on request.

East Cheshire NHS Trust

5 ASSURANCE

5.1 The Trust Board is accountable for the Quality Account, therefore, the members of the Board must assure themselves and state publicly within the document that the information presented is accurate.

5.2 The Trust Board will receive a draft copy of the Quality Account for comment after EMT on the 10th May.

5.3 The Quality Account will be agreed at Safety Quality and Standards Committee on the 25th May and finally signed off at the Trust Board meeting of the 27th May.

5.4 To provide further assurance the lead Primary Care Trust (PCT), Local Involvement Network (LINK) and Overview and Scrutiny Committee must all be offered the opportunity to comment on the report ahead of publication and a statement, if offered, must be presented in the Quality Account.

5.5 The National Quality Board has commissioned a piece of work involving the Department of Health and Monitor to consult upon and develop a form of third party assurance of Quality Accounts which subject to consultation will be introduced in 2011.

6 QUALITY ACCOUNT 2011/12

6.1 From July 2010 a plan for 2011/12 account will be devised including wider patient, staff and public involvement for priority setting for next year.

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East Cheshire NHS
NHS Trust

QUALITY ACCOUNT 2009/2010

CONTENTS

PART 1

SUMMARY STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

2009/10 has been a very successful year for the Trust in many ways and I would wish to start by giving our thanks to the staff at the Trust for the service they have given over the last 12 months. Their dedication is appreciated by the Board, especially during the period of extreme bad weather during the winter months.

The Trust is ever mindful of patient quality and safety and our focus on infection control has seen a significant reduction in Clostridium difficile and the lowest levels of MRSA bacteraemia since the introduction of the target several years ago. The Care Quality Commission reinforced this success with the outcome of their unannounced visit confirming that the Trust was meeting its obligations under the hygiene code.

The Trust Board recognises its role in placing quality and safety at the centre of what it does. The Board adopted its quality strategy in July 2008 and this is being refreshed for the 2010/11 financial year.

As part of this commitment £292,000 has been spent in 2009/10 to ensure that single sex accommodation can be achieved within the Trust so that patients can retain their privacy and dignity whilst being cared for.

The Trust has been recognised for its progress in a number of areas. Our stroke service was highly recommended in the national patient safety awards. The Trust was also identified as one of five hospitals in the North West to become Tier 2b paediatric allergy centres as part of the Department of Health best practice pilot across the region. This involves hospital consultants working closely with GPs and community health colleagues for example school nurses. We have also been named as one of the top 5 hospitals for quality of care by CHKS, a commercial company working within the NHS.

The standardised mortality rate at the Trust compares favourably and has been reducing further during the year

These achievements have been made against a challenging financial backdrop and the Trust has completed its financial recovery plan in 2009/10 which allows the Trust to enter 2010/11 with confidence having registered with the Care Quality Commission without conditions and focusing now on working with partners to deliver services in a more integrated way allowing a move to Foundation Trust status as required by the Department of Health.

We very much hope you enjoy reading this document and that it gives a feel for the real achievements made during the year for the benefit of our patients.

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF QUALITY ACCOUNTS

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

In preparing these accounts, Directors are required to take steps to satisfy themselves that:

- The Quality Account present a balanced picture of the NHS Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data, quality standards and prescribed definitions, and is subject to appropriate scrutiny and review;
- The Quality Account has been prepared in accordance with relevant requirements and guidance.

The Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Kathy Cowell
Chairman

John Wilbraham
Chief Executive

PART 2

PRIORITIES FOR IMPROVEMENT IN 2010/2011

INTRODUCTION

The Trust has a significant number of quality and safety improvement initiatives underway.

These include requirements from the Primary Care Trust who commission our services, standards from the Care Quality Commission as well as the Trust's own internal Quality Strategy.

The Primary Care Trust set out their requirements in the contract in a Quality Schedule. These standards are monitored monthly by the Primary Care Trust. The commissioners also provide funding for achievement of specific initiatives called Commissioning Quality Initiatives (CQuin). There are 9 CQuin initiatives.

The Trust registered with the Care Quality Commission (CQC) from the 1st April 2010. The Care Quality Commission registers NHS Trusts with or without conditions. The Trust was registered without conditions.

The CQC have 16 quality standards. These standards describe the outcomes that patients should expect. Through 2010/11 we have a programme of audits in place to provide assurance that we continue to achieve these outcomes.

Since 2008 the Trust has had its own Quality Strategy that focused on 10 areas, 5 in improving patient safety and 5 on the patient experience.

Our achievements in all of these areas are described in Part 3.

The Quality Strategy agreed in 2008 has been updated and now has 31 aims. This will support continuous improvement through the coming years.

The Trust Board has agreed the following statements as underpinning principles for continuing to improve the care we give to patients:

- Do me no harm (safety)
- Make me better (clinical effectiveness)
- Be nice to me (patient experience).

THE PRIORITIES

In order to focus our efforts on continuous improvement the following 10 areas are identified as priorities. The Individual Performance Indicators are listed in Appendix 2.

DO ME NO HARM (safety)

Aim:- To reduce the number of falls sustained by patients within our care and to improve the care of patients who attend or are admitted to hospital following a fall.

Measured by:- Nine performance indicators.

Monitored by:- Monthly reports internally and annually by Royal College of Physicians organisational audit for falls and bone health.

Reports to:- Trust Board monthly via Chief Executive's Report.

Aim:- To protect patients within our care from hospital acquired infection.

Measured by:- Four performance indicators including a continued reduction in Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (Cdiff).

Monitored by:- The Director of Infection Prevention and Control weekly and monthly by the Board.

Reports to:- Infection Control Committee and Trust Board through the Chief Executive's Report monthly.

Aim:- To reduce the impact of medication errors on patients within our care.

Measured by:- Eight performance indicators.

Monitored by:- Quality Strategy Steering Group.

Reports to:- Medicines Management Group and Trust Board monthly via Chief Executive's Report.

MAKE ME BETTER (clinical effectiveness)

Aim:- To reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE) for patients within our care.

Measured by:- Two performance indicators.

Monitored by:- Monthly returns to the Department of Health.

Reports to:- Trust Board monthly through the Chief Executive's Report and quarterly to the Primary Care Trust.

Aim:- To deliver evidence based interventions to patients within our care with a diagnosis of acute myocardial infarction, heart failure, pneumonia, stroke or undergoing hip or knee surgery.

Measured by:- Two performance indicators.

Monitored by:- North West SHA Advancing Quality Team.

Reports to:- Trust Board monthly through the Chief Executive's Report.

Aim:- To support the timely and effective discharge of patients within our care to the most appropriate setting of an expected discharge date and providing timely information to GPs.

Measured by:- Seven performance indicators

Monitored by:- Monthly by the Primary Care Trust.

Reports to:- Trust Board monthly through the Chief Executive's Report.

BE NICE TO ME (patient experience)

Aim:- To ensure that patients within our care are treated in privacy with dignity and respect.

Measured by:- Four performance indicators including the provision of same sex accommodation unless it is clinically justified.

Monitored by:- Executive review of daily information. Local and national patient surveys and complaints and monthly by the Primary Care Trust.

Reports to:- Trust Board via the Chief Executive's Report on breaches of same sex accommodation and Privacy and Dignity quarterly to the Board by the Patient Experience Report.

Aim:- To ensure that our patients' concerns and complaints are listened to, are investigated appropriately and acted upon and lessons are learnt.

Measured by:- Five performance indicators including a process to ensure lessons have been learnt.

Monitored by: Patient Experience Group.

Reports to:- Trust Board monthly via the Chief Executive's Report and quarterly by Patient Experience Report.

Aim:- To develop all of our staff to ensure that they act as a role model; take personal responsibility; have the courage to speak up and make their voices heard and to deliver care in the best interests of the patient and their families.

Measured by:- Performance indicators as identified in the project plan.

Monitored by:- Project Steering Group monthly.

Reports to:- Executive Management Team monthly and 3 times a year to the Trust Board.

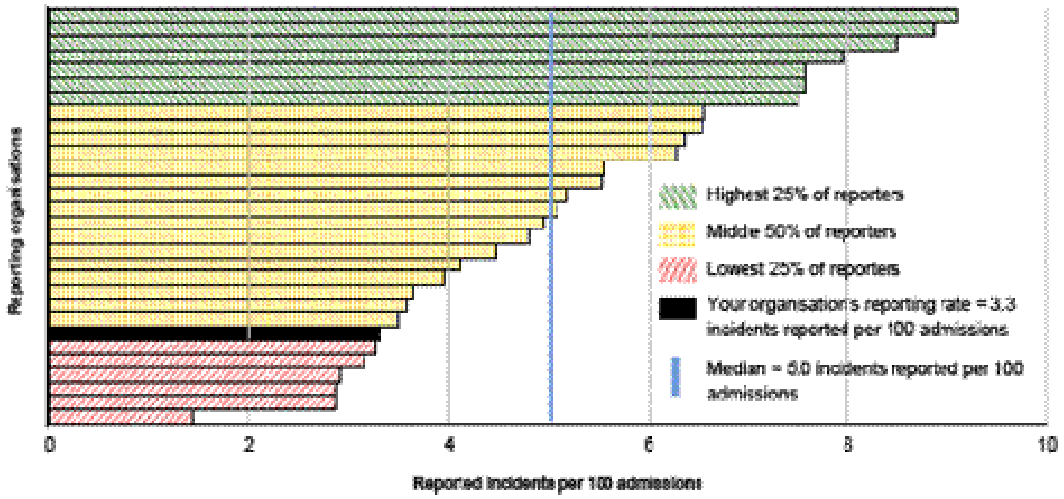
INCIDENT REPORTING

Most incidents that occur are minor. Organisations that report more incidents usually have a more effective safety culture. The following table is the Trust's performance between April and September 2009 and is lifted directly from the National Patient Safety Agency website.

Are you actively encouraging reporting of incidents?

The comparative reporting rate summary shown below provides an overview of incidents reported by your organisation to the National Reporting and Learning System (NRLS) between 1 April 2009 and 30 September 2009. 605 incidents were reported during this period.

Figure 1: Comparative reporting rate, per 100 admissions, for 30 small acute organisations.



Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are. So:

- Encourage staff to report things that go wrong. Don't shoot the messenger!
- Make it easy to report and provide feedback. Make reporting useful!
- Use national comparative data from the NRLS to better understand the reporting and learning culture in your organisation.
- Review steps your organisation can take to make reporting matter.

Tips to help you: *Act on reporting: five actions to improve reporting; Questions are the answer! Seven questions every board member should ask about patient safety at:* www.nrls.npsa.nhs.uk

Aim:- To improve incident reporting and be in the highest 25% of reporters.

Measured by:- Two performance indicators.

Monitored by:- Clinical Risk Management Group monthly.

Reports to:- Trust Board monthly through the Chief Executive's report.

PART 3

REVIEW OF QUALITY PERFORMANCE

INTRODUCTION

In order for NHS bodies to be compared the content of this first section of Part 3 is prescribed in the Statutory Instrument – The National Health Service (Quality Accounts) Regulations 2010 No: 279.

REVIEW OF SERVICES

East Cheshire NHS Trust was established in 2002 providing a wide range of acute health services to the population of Eastern Cheshire, with a catchment area of approximately 200,000, and the borders of the neighbouring areas of Stockport, High Peak and North Staffordshire.

The Trust consists of three hospitals at Macclesfield, Knutsford and Congleton in Cheshire.

East Cheshire NHS Trust provides a full range of general acute secondary care hospital services through a Clinical Business Unit (CBU) structure. These are Surgical Services, Outpatient Services, Medical Services and Women's and Children's Services.

The Clinical Business Units are led by Clinical Directors who are senior consultants supported by Associate Directors who manage the service.

There are also a number of support services that contribute to the efficient running of the organisation such as Governance, the Estate and Facilities function, Human Resources and Financial Support.

There is a performance management process in place for internal and sub-contracted services. This process provides assurance on the quality of service that is delivered. Trust Board reports throughout the year demonstrate this process.

The income for East Cheshire Trust was 82.9 million for 2009/10 million from our main commissioners (Central and Eastern Cheshire PCT) and 15.5 million from other local Primary Care Trusts.

PARTICIPATION IN CLINICAL AUDITS

NATIONAL AUDITS

During 2009/10 the Trust took part in 17 national audits out of 26 (65%) and 1 national confidential enquiry out of 4. Information about national clinical audits is forwarded directly to lead consultants by the organising body eg Royal Colleges. The lead clinician decides if it is appropriate for their service to be involved.

The following audits were those that the Trust did participate in with the number of cases submitted to each audit as a percentage of the number required by the terms of the audit or enquiry.

- NNAP: neonatal care (1478/3414) 43%
- ICNARC CMPD: adult critical care units
- NLCA: lung cancer
- NBOCAP: bowel cancer
- DAHNO: head and neck cancer
- MINAP (inc ambulance care): AMI & other ACS 100%
- Heart Failure Audit (N=44)
- NHFD: hip fracture
- TARN: severe trauma

- Adult cardiac interventions
- National Sentinel Stroke Audit (n=40-60) 100%
- National Audit of Dementia: dementia care (n=40) 100%
- National Falls and Bone Health Audit (n=60) 100%
- National Comparative Audit of Blood Transfusion: changing topics (n=50) 100%
- National Mastectomy and breast reconstruction Audit.
- National Oesophago-gastric Cancer Audit
- RCP Continence Care Audit (n=34/40) 85%

National Confidential Enquiries

Emergency and elective surgery in the elderly.

The following audits were those that the Trust could have participated in.

- NNAP: neonatal care
- NDA: National Diabetes Audit
- ICNARC CMPD: adult critical care units
- National Elective Surgery PROMs: four operations*
- CEMACH: perinatal mortality
- NJR: hip and knee replacements
- NLCA: lung cancer
- NBOCAP: bowel cancer
- DAHNO: head and neck cancer
- MINAP (inc ambulance care): AMI & other ACS
- Heart Failure Audit
- Pulmonary Hypertension Audit
- NHFD: hip fracture
- NAPTAD: anxiety and depression
- TARN: severe trauma
- NHS Blood & Transplant: potential donor audit
- Adult cardiac interventions
- National Kidney Care Audit (2 days)
- National Sentinel Stroke Audit (n=40-60)
- National Audit of Dementia: dementia care (n=40)
- National Falls and Bone Health Audit (n=60)
- National Comparative Audit of Blood Transfusion: changing topics
- British Thoracic Society: respiratory diseases
- College of Emergency Medicine: pain in children; asthma; fractured
- National Mastectomy and Breast Reconstruction Audit
- National Oesophago-gastric Cancer Audit

National Confidential Enquiries:

- Parenteral nutrition,
- Emergency and Elective Surgery in the Elderly,
- Surgery in Children,
- Peri-Operative Care Study

EAST CHESHIRE NHS TRUST AUDITS

Audits are carried out in a number of ways. To test whether patients receive the care they expect we carry out local audits eg patient's view of cleanliness on wards and the hand washing of staff.

Clinical audits are also carried out by clinical staff with the support of the Audit Department. These audits focus on compliance with clinical standards such as National Institute for Clinical Excellence

(NICE) guidance. During 2009/10 144 audits of this type commenced. The audits support our compliance with standards and identify areas for improvement. The priorities of which are set out in Part 2 of the Quality Account.

In addition to both local and clinical audits the Trust commissions time from a NHS consortium (termed internal audit) who carry out audits for the Trust Board to provide assurance that the Trust is working to the standards expected. Two examples of this type of audit would be the prevention of infection and assessing the process and the evidence for registration with the Care Quality Commission.

RESEARCH

The Trust works as part of a research network helping to improve the current and future health of the population it serves.

In 2009/10 496 patients have been recruited to participate in research approved by a Research Ethics Committee. This exceeded all requirements. As a comparison 275 patients were recruited in 2008/09.

There is a rigorous ethics process applied both to the study itself and the recruitment process. Patients have all the information they need and actively have to consent to take part in any study.

COMMISSIONING FOR QUALITY AND INNOVATION (CQuin)

Central and Eastern Cheshire Primary Care Trust provide specific funding for certain initiatives. For 2009/10 this related to the management of patients with alcohol problems and the provision of electronic discharge information for GPs.

The development of the alcohol pathway aims to ensure that patients treated within the Trust with alcohol related conditions are appropriately assessed and referred to alcohol support services. In this way the local health services can support individuals who want to address their alcohol issues as well as treating them for the consequence of these issues. The alcohol CQuin monitors the Trust in agreeing the pathway between professionals, training staff in the use of the pathway and then delivering the screening, advice and initial interventions detailed within the pathway.

The improvement of discharge arrangements specifically relating to estimating a discharge date within 24 hours of admission and ensuring share care and continuing health care assessments were completed in a timely way.

The financial amount for achievement of these outcomes was £600,000.

CARE QUALITY COMMISSION

In February 2010 the Trust received an unannounced visit from the Care Quality Commission in relation to the Hygiene Code.

Three inspectors visited wards of their choosing and were very rigorous in checking standards of hygiene and infection control.

The Trust was pleased to be found compliant with the Hygiene Code.

In April 2010 the Trust was required to register with the Care Quality Commission. The Trust is now registered with no conditions attached to that registration.

The ratings for 2009/10 are not yet available. In 2008/09 the Trust was given a rating of ‘fair’ for quality and ‘good’ for resources.

DATA QUALITY

All Trusts are required to send to the Department of Health (via the Secondary User Service) a complete and valid data set for each individual episode of patient care when patients are admitted, attend an outpatient clinic or attend the Emergency Department. The data quality of these records is assessed and benchmarked. The data is assessed for "completeness" (ie, all required fields filled) and "validity" (ie, all the data items are valid). All scores for each type of patient activity are then combined to present an overall percentage score

The Trust submitted records during 2009/10 (April 2009 – February 2010) to the Secondary User Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

98.9% for admitted patient care (national score 97.2%).
99.8% for Out Patient Department care (national score 96.5%).
97.2% for Accident and Emergency care (national score 90.9%).

The percentage of records in the published data which include the patients valid General Medical Practice Code was

100% for admitted patient care.
100% for Out Patient Department care.
100% for Accident and Emergency care.

INFORMATION GOVERNANCE TOOLKIT ATTAINMENT LEVELS

Ensuring information about patients and staff is kept confidentially and only shared on a need to know basis is critical to good governance.

The Information Governance Toolkit is an assessment document that supports the checking of systems and processes.

The assessment has also been the subject of a separate audit to ensure that the findings are robust. The scores are rated using red, amber and green. For 2009/10 East Cheshire Trust scored 72% (green).

CLINICAL CODING ERROR RATE

The Trust was subject to the payment by results clinical coding audit during the reporting period and the error rates were as follows:

- Primary diagnosis incorrect 12.67% * (2008/09 9%, 2007/08 13.6%).
- Secondary diagnosis incorrect 4.88% (2008/09 7.5%, 2007/08 11.5%).
- Primary procedures incorrect 2.47% (2008/09 14%, 2007/08 16.8%).
- Secondary procedures incorrect 7.95% (2008/09 4%, 2007/08 24.7%).

* High number of Healthcare Resource Group changes related to paediatrics and availability of discharge summaries - this is now resolved.

HOSPITAL STANDARDISED MORTALITY RATE (HSMR)

The Hospital Standard Mortality Rate is a calculation that provides hospitals with a benchmark in relation to death in hospitals. A rate below 100 in the 'relative risk' column shows performance better than the benchmark

Dr Foster Intelligence Hospital Standardised Mortality Rates

Rolling 12 month HSMR

The Hospital Standardised Mortality Rate (HSMR) for the 12 months from Jan 08 to Sep 2009. This data was produced from the national system as at 9th March 2010

Time Period	Deaths	Expected	Difference > More <Less	Relative Risk	Confidence Limit Low	Confidence Limit High
Jan 08 - Dec 08	732	710.1	>21.9	**103.1**	95.7	110.8
Feb 08 - Jan 09	733	716.1	>17.2	**102.4**	95.1	110.1
Mar 08 - Feb 09	727	724.1	>3.1	**100.4**	93.2	108.0
Apr 08 - Mar 09	747	732.3	>14.9	**102.0**	94.8	109.6
May 08 - Apr 09	735	730.1	>5	**100.7**	93.5	108.2
Jun 08 - May 09	718	736.4	<18.4	**97.5**	90.5	104.9
Jul 08 - Jun 09	697	735.6	<38.6	**94.8**	87.8	102.1
Aug 08 - Jul 09	692	736.5	<44.4	**94.0**	87.1	101.2
Sept 08 - Aug 09	684	724.0	<39.9	**94.5**	87.5	101.8
Oct 08 - Sept 09	680	730.3	<49.5	**93.1**	86.3	100.4
Nov 08 - Oct 09	667	731.8	<64.8	**91.1**	84.4	98.3
Dec 08 - Nov 09	649	728.3	<79.3	**89.1**	82.4	96.2
Jan 09 - Dec 09	645	732.8	<87.8	**88.0**	81.4	95.1

The benchmark figure is always 100 with values greater than 100 representing performance worse than the benchmark and values less than 100 representing performance better than the benchmark. The Trust has shown a continuous reduction in HSMR.

QUALITY STRATEGY

The Trust's Quality Strategy focused on 10 areas on patient safety and 5 on improving the patient experience.

The following were the areas of focus:

- Advancing Quality by introducing a more systematic approach to the following conditions acute myocardial infarction, community acquired pneumonia, hip and knee replacements.
- Reducing health care acquired infections.
- Reducing hospital acquired pressure sores.
- Reducing inpatient falls.
- Reducing serious medication errors.
- Improving Customer Care.
- Improving the monitoring of patients to check for early deterioration.
- Improving privacy and dignity.
- Improving record keeping.
- Improving patient nutrition.

There has been improvement in 8 of the 10 areas over the year as demonstrated below. Two of the areas that require quantifiable changes are the reduction of falls and medication errors and these are priority areas for 2010/11 as described in Part 2 of this Quality Account.

REDUCING HEALTH CARE ACQUIRED INFECTIONS

Over the period the Trust has continued to make good progress in reducing Health Care acquired infections.

The number of MRSA bacteraemias has fallen progressively over the last 5 years.

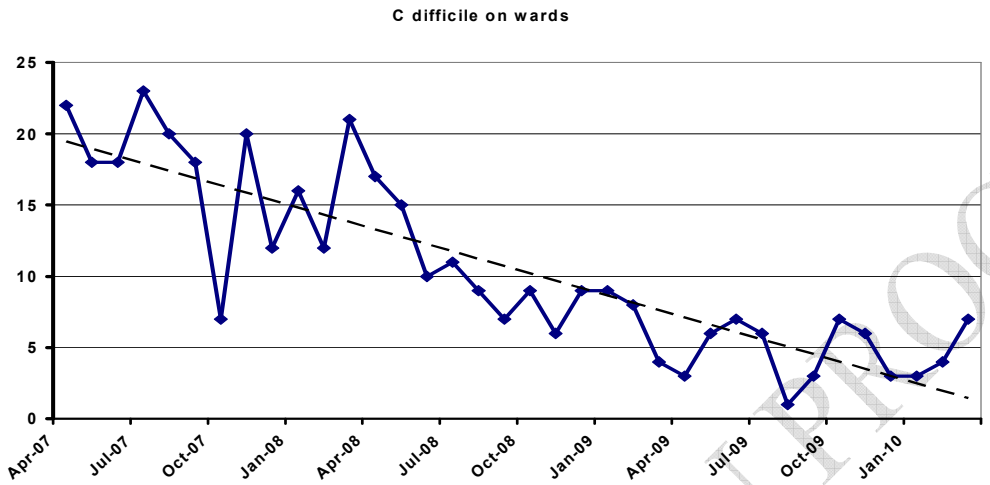
Year	Cases of MRSA bacteraemia
2005 – 2006	21
2006 – 2007	15
2007 – 2008	14
2008 – 2009	14
2009 – 2010	9

A maximum of 10 MRSA bacteraemias was set for the East Cheshire area. A total of 9 cases has been recorded, 7 cases were recorded in the hospital and 2 developed in the community. All cases were followed up by a root cause analysis and discussion with the relevant clinicians. In 4 of the cases intravenous cannulation was the probable cause. This was the most common theme and therefore is a priority area for 2010/11.

A maximum trajectory of 127 Clostridium difficile cases was set by the Strategic Health Authority for 2009-10. However, as we had had only 114 cases in 2008-9, the Trust set its own internal maximum of 67 cases to match that of the Strategic Health Authority for 2010-11. In the year 2009-10 there were 55

cases of Clostridium difficile in the hospital, against the trajectory of 67, representing a reduction in cases of more than 50% over the previous year. The improvement may be ascribed largely to improved cleanliness, particularly in relation to commodes and toilet areas, as well as to better antibiotic prescribing.

The number of Clostridium difficile infections on the wards has been falling for several years. Three years ago there were new cases seen almost on a daily basis, whereas now there may be only 1or 2 a week.



REDUCING HOSPITAL ACQUIRED PRESSURE SORES

Pressure sores are graded from numbers 1 – 4; 1 being reddening of intact skin to 4 being a serious wound. In agreement with the Primary Care Trust a planned reduction of all grades was targeted for the Medical and Surgical Clinical Business Units. Across the whole Trust there were 22% less pressure sores and none of the most serious kind. A further 5% reduction has been targeted against the actual numbers for 2010/11.

REDUCING INPATIENT FALLS

The reduction of patient falls has proved challenging. Despite devising a strategy and action plan; raising awareness with staff, patients and relatives via a leaflet and training; monitoring risk assessments on patients and purchasing movement alarms a reduction in patient falls has not occurred.

In addition functional electrical stimulation (FES) was introduced in neuro-physiotherapy. FES is recommended by the National Institute for Clinical Excellence (NICE). It speeds up the patient's recovery and reduces the risk of falling. This service has been officially recognised by the North West Strategic Health Authority as an example of innovative practice.

Reduction in falls has been identified as a priority area for 2010/11. Key performance indicators have been agreed and these will be monitored by the Quality Strategy Implementation Group monthly and by the Royal College of Physicians audit on falls and bone health. A more focused approach has been actioned working directly with 2 wards to implement falls prevention and management. The Project Office has also been engaged to support progress in this area.

REDUCING MEDICATION ERRORS

The vast majority of medication errors are minor. Medication errors can be classified as prescribing, dispensing or administrative errors. Progress in reducing errors has not been as expected. A detailed

study was undertaken in this complex area to improve our understanding of the issues. The conclusions and action plans of this study have outlined a number of areas of work that is now being taken forward by the new Chief Pharmacist. The Project Office has also been engaged to support progress in this area.

An internal audit identified concerns about the storing and dispensing of controlled drugs. Significant improvement has now been made in this area and practice is monitored to ensure high standards are maintained.

IMPROVING CUSTOMER CARE

During this period the sixth National Inpatient Survey was received.

The Trust was in the top 20% for the following areas:

- Choice of hospital – being offered a choice of hospital for your first appointment when referred to see a specialist.
- Length of wait – feeling you waited right amount of time on waiting list to be admitted.
- Changes to admission dates – not having admission date changed by the hospital.
- Not feeling threatened – not feeling threatened by other patients or visitors during your stay.
- Quality of food – rating hospital food as good.

The Trust was in the lowest performing 20% for the following two areas:

- Hand washing by doctors.
- Hand washing by nurses.

Considerable work has been undertaken to address these issues. This has been demonstrated in the reduction in health care acquired infections and improvements in the "committed to being clean audits" which ask for patients views on hand washing.

FORMAL COMPLAINTS

The following table shows the number of formal complaints received by the Trust, the severity of those complaints and the response times.

	KPIs	Qtr 1	Qtr 2	Qtr 3	Quarter 4			Total Year to Date	Total 2008/9
Formal Complaints					**Jan**	**Feb**	**Mar**		
Medicine		10	11	12	2	9	12	56	72
Surgery		10	10	14	3	3	7	47	43
Women & Children's		4	4	8	2	1	3	22	13
Outpatients		2	3	3	0	1	3	12	4
Corporate Division		0	0	0	0	0	0	0	1
Pathology		1	1	0	0	0	0	2	0
Nursing & Patient Care Standards		0	0	1	0	0	0	1	1
No. Of Complaints Received by PCT re ECNHST		0	2	0	0	1	0	3	
No. Of Complaints Referred to the Ombudsman		1	0	1	2	4	0	8	
No. Of Complaints Upheld									
Level of Severity of Complaints									
High - Risk score of 15+				0	0	0	0	0	

Medium - Risk score of 9-15				0	0	0	0	0	
Low - Risk score of 1-8		28	29	38	7	14	25	141	
Performance against Targets									
Contact with complainant within 48 working hrs of receipt of complaint	100%	100%	100%	100%	100%	100%	100%	100%	
Response to complainant within agreed timescale	100%	100%	100%	97%	100%	100%	100%	99%	98%

Learning lessons from complaints is a priority for the organisation. The following are examples where improvements have been made:-

Patient passports for patients with learning difficulties have been developed and introduced to ensure that individual's needs are clear and information is available to Doctors, Nurses and Administrative Staff in an easy to read format to optimise levels of support for the patient during the patient's journey. This has been developed with patients with learning disabilities and their carers and has been really well received.

A review of systems took place within the Emergency Department and improvements were made so that the time taken from the initial patient x-ray to the result was reduced.

A change was made to telephone lines within Customer Care to allow easier access to the service.

Laminated notices have been placed in the entrance to Congleton Hospital stating the start and finish times of the phlebotomy service. Queue numbers are available for patients arriving early to ensure they are seen in chronological order.

A family was invited to the documentation 'lean' event in order to share their experience and contribute to the improvement.

A rapid improvement event in Stroke Services was held in March 2009. The purpose of the event was to look at how processes could be improved to provide best practice for stroke patients.

The 40+ members of staff were inspired to make several service improvements. The Acute Stroke Unit and the Stroke Rehabilitation Unit were combined so that stroke care is provided in the same unit by the same staff. One of the most significant pieces of work to come out of the event was the creation of the stroke oracle data base. Thus database records and reports on all vital care information so that patient safety issues can be identified and addressed immediately. The Trust received recognition for the database which was "highly commended" in the National Patient Safety Awards 2010.

The following table shows the improved performance against key indicators.

Sentinel Audit 06,08 and Oracle

9 Key indicators	**2006**	**2008**	**Jan-Mar 2010 (of discharges to early April)**
Swallow screening <24 hours	89	90	90
Brain scan <24 hrs admission	31	38	89
Physio < 72 of admission	59	77	98
OT < 4 days of admission	34	80	100
Weighed during admission	53	79	96
Mood assessed during admission	56	32	93

Rehab goals set by MDT	76	95	93
Antiplatelet < 48 hrs	38	81	75 (<24)
90% stay on stroke unit	59	62	85
Average LOS			23
Admitted straight to Stroke unit (of discharges to date)			64

IMPROVING THE MONITORING OF PATIENTS TO CHECK FOR EARLY DETERIORATION

Prior to April 2009 a tool that enhanced the assessment of patients and checked for early signs of a deteriorating clinical condition was only used in certain areas. Further training and support has been given to staff and the tool is now fully implemented across all wards. The Healthcare Community reaped the benefit of a new way of working with the development of the Emergency Floor which co-located the Emergency Unit and the Medical Admissions Unit adjacent to the Emergency Department (ED). This has resulted in faster assessments for patients and a reduction in the number of medical emergency admissions.

IMPROVING PRIVACY AND DIGNITY

Extensive building alterations have been undertaken throughout the year. £292,000 has been spent on enhancing the layout in clinical areas and increasing the number of bathroom and toilet facilities. Unless clinically necessary patient care is now delivered in same sex accommodation.

Staff training has been a real focus over the year and privacy, dignity and respect is included in induction and mandatory training programmes. To improve access for staff the Royal College of Nursing Dignity DVD is also available on the Trust intranet with a privacy and dignity workbook to test your knowledge.

Following an impact assessment in the Physiotherapy Department the following service improvements have been made.

- More space for wheelchair users in the waiting area.
- Leaflets including information on chaperoning.
- Communication box for patients and visitors to offer feedback.
- New, better fitting curtains purchased and privacy screens in rooms.

A number of visits were also undertaken by LINk (formerly Patient and Public Involvement Forum) following the development of its Enter and View Strategy.

2009/10 saw a further development of Christie at East Cheshire to provide oncology services in a pleasant and accessible environment and to avoid the need for patients to travel to Manchester for chemotherapy treatment.

IMPROVING RECORD KEEPING

A rapid improvement event was held in September 2009 focusing on improving care documentation used by nurses. The aim of the event was to agree with nursing staff an approach to standardising documentation.

Ensuring timely and accurate recording of information maximises the quality of care for patients ensuring that patients receive the right care in the right place at the right time. The revised admission document and care plans have been launched in May 2010. The paperwork is easier for nurses to complete and

reduces duplication thereby ensuring that documentation can be completed quickly and patients get the care they need sooner.

Internal audit undertook an audit of records, the recommendations made have been actioned ensuring the Trust is meeting the required standards for the Care Quality Commission registration.

IMPROVING PATIENT NUTRITION

A multidisciplinary event took place during 2009/10 to focus on patient nutrition and a number of improvements have subsequently been implemented. The assessment of patients being screened using the Malnutrition Universal Screening Tool (MUST) increased from 30% to 70%. A greater emphasis on non-clinical activities not taking place at mealtimes and increased volunteer support to give additional assistance in the timely distribution of meals and help for individual patients. In addition a 'top tips' nutrition newsletter was issued to staff.

NATIONAL PATIENT SAFETY AGENCY PATIENT ENVIRONMENTAL ACTION TEAM ASSESSMENTS (PEAT)

Assessments for the environment, food provision and privacy are undertaken and scores awarded by hospital for each element. The results range from poor to excellent. The following assessment took place in February and March 2010.

SITE NAME	ENVIRONMENT SCORE	FOOD SCORE	PRIVACY AND DIGNITY SCORE
Congleton War Memorial Hospital	Good	Excellent	Good
Knutsford and District Community Hospital	Good	Excellent	Good
Macclesfield District General Hospital	Good	Good	Good

STATEMENTS FROM LOCAL INVOLVEMENT NETWORKS (LINK), OVERVIEW AND SCRUTINY COMMITTEE (OSC) AND PRIMARY CARE TRUST (PCT)

In *High Quality Care for All,* published in June 2008 Ministers set out the Governments vision for putting quality at the heart of everything the NHS does. The key component of the new Quality Framework would be a requirement for all providers of NHS services to publish Quality Accounts. The aim of the Quality Account is to improve public accountability and to engage Boards in understanding and improving quality in their organisations.

The Primary Care Trust, Local Involvement Networks (LINk) and the Overview & Scrutiny Committee (OSC) have important roles in the development of these accounts and maximising their success.

This Quality Account has been reviewed by the Central & Eastern Primary Care Trust and Western Cheshire Primary Care Trust, LINk and the OSC.

Their comments are documented below:-

LINk	Local Involvement Networks
OSC	Overview and Scrutiny Committee
PCT	Primary Care Trust

APPENDIX 1
GLOSSARY

TERM	ABBREVIATION
Clostridium difficile	Cdiff
Methicillin Resistant Staphylococcus Aureus	MRSA
Care Quality Commission	CQC
Commissioning Quality Initiatives	CQuin
Venous Thromboembolism	VTE
Clinical Business Unit	CBU
Primary Care Trust	PCT
National Neonatal Audit Programme	NNAP
National Diabetes Audit	NDA
Intensive Care National Audit and Research Centre	ICNARC
Case Mix Programme Dataset	CMPD
Patient Reported Outcome Measures	PROMS
Confidential Enquiry into Maternal and Child Health	CEMACH
National Joint Registry	NJR
National Lung Cancer Audit	NLCA
National Bowel Cancer Audit Programme	NBOCAP
DAta for Head and Neck Oncology	DAHNO
Myocardial Ischaemia National Audit Programme	MINAP
Acute Myocardial Infarction	AMI
Acute Coronary Symdrome	ACS
National Hip Fracture Database	NHFD
National Audit of Psychological Therapies for Anxiety and Depression	NAPTAD
Trauma Audit and Research Network	TARN
National Institute for Clinical Excellence	NICE
Hospital Standardised Mortality Rate	HSMR
Advancing Quality	AQ
Acute Myocardial Infarction	AMI
Patient Environmental Action Team	PEAT
Functional Electrical Stimulation	FES
Emergency Department	ED
Local Involvement Networks	LINk
Overview and Scrutiny Committee	OSC
Accident and Emergency	A and E
Minor Injuries Unit	MIU
International Normalised Ratio	INR
General Practitioner	GP
CHKS - Name of Company	CHKS
Heart Failure	HF
Malnutrition Universal Screening Tool	MUST

APPENDIX 2
KEY PERFORMANCE INDICATORS

To reduce the number of falls sustained by patients within our care and to improve the care of patients who attend or are admitted to hospital following a fall.

- To have in place a Falls and Bone Health Policy that includes falls prevention and reduction
- 95% of older patients who attend A and E or MIU following a fall receive a falls and bone health screening and appropriate referral or signposting for appropriate management
- 95% of older patients admitted with a fragility fracture receive a falls and bone health assessment and have a falls management plan for inpatient and post discharge care
- To have personnel are in post with job descriptions that give a commitment to the management of falls and bone health for the roles of Falls Lead/Coordinator, Consultant in Geriatric Medicine and Fracture Liaison Nurse
- To achieve the six standards for hip fracture care as recommended in "The care of patients with a fragility fracture" (blue book) which summarises best practice in the care and secondary prevention of fragility fractures.
- Reduction in overall inpatient falls rate per 1000 bed days against 2008/09 baseline of
- Reduction in overall injurious inpatient falls rate per 1000 bed days against 2008/09 baseline of
- Increase prescribing of antiresorptive therapy against 2008/09 baseline of
- Reduction in number of deaths in hospital for patients with a hip fracture against 2008/09 baseline of

To protect patients within our care from hospital acquired infection.

- To implement best practice in accordance with Saving lives
- No more than 4 MRSA Bacteraemia
- No more than 50 Clostridium Difficile (internal target, 63 for PCT)
- No more than 72 MRSA isolates (internal target)

To reduce the impact of medication errors on patients within our care.

- Year on year reduction of medication errors
- A reduction in percentage of patients on warfarin with an INR greater than 6
- A reduction of patients receiving low molecular weight heparin outside protocol limits.
- A reduction in percentage of patients needing antidote to overdose of midazolam
- A reduction in percentage of patients needing antidote to overdose of opiates
- 100% accuracy of insulin prescriptions.
- % antibiotics administered on time for elective patients
- % antibiotics discontinued on time for elective patients

To reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE) for patients within our care.

- 100 % of patients receiving a VTE risk assessment on admission to hospital
- 100% of patients, who are at risk, are treated using NICE guidance

To deliver evidence based interventions to patients within our care with a diagnosis of acute myocardial infarction, heart failure, pneumonia, stroke or undergoing hip or knee surgery.

- Improve all scores on an ongoing basis
- To be in the top 25% hospitals in the North West for all care bundles

To support the timely and effective discharge of patients within our care to the most appropriate setting of an expected discharge date and providing timely information to GPs.

- 85% patients to have an expected date of discharge set within 24 hours admission / definitive diagnosis
- 100% of patients discharged from wards 10 and 11 have a share care assessment
- 100% of patients are advised how to take their medicines and any possible side effects
- 100% of patients are provided with clear written or printed information about their medication
- 75% of the Continuing Healthcare Assessments are completed by the Trust within 5 working days of being triggered by the screening checklist
- 100% of patients referred for Continuing Health Care Assessments to receive an information leaflet and complete consultation checklist
- 100% of discharge summaries to be issued within 24 hours of discharge

To ensure that patients within our care are treated in privacy with dignity and respect.

- To eliminate mixed sex accommodation unless clinically justifiable
- 80% front line staff receive Privacy and Dignity training
- Decrease of 5% in the number of patients sharing bathroom and toilet facilities as measured by the National Patient Survey
- The Trust will be in the top 20% of Trusts for 'Treated with Dignity and Respect' as measured by the National Patient Survey

To ensure that our patients' concerns and complaints are listened to, are investigated appropriately and acted upon and lessons are learnt.

- 100% of complaints are acknowledged with 2 working days
- 100% of internal complaints are answered within 25 working days
- 100% of complaints that cross organisational boundaries are answered within agreed timeframes
- 60% staff are trained in customer care training
- Evidence of learning and improvement

To develop all of our staff to ensure that they act as a role model; take personal responsibility; have the courage to speak up and make their voices heard and to deliver care in the best interests of the patient and their families.

- KPIs to be agreed by the project steering group.

To be in the highest 25% for incident reporting

- Top 50% by end of 2nd Quarter.
- Top 25% by end of 4th Quarter.

CHESHIRE EAST COUNCIL

REPORT TO: Health and Adult Social Care Scrutiny Committee

Date of Meeting:	20 May 2010
Report of:	Cheshire East Borough Solicitor
Subject/Title:	Cheshire East and Central and Eastern Cheshire Primary Care Trust - Protocol.

1.0 Report Summary

1.1 This report sets a draft protocol to formalise arrangements between the Health and Adult Social Care Committee and Cheshire East and Central and Eastern Cheshire Primary Care Trust

2.0 Recommendations

2.1. That the Committee consider and determine whether any arrangements for co – option should apply for the forthcoming year

2.2 That the attached Protocol setting out the working relationships between the Committee and Central and Eastern Cheshire Primary Care Trust be approved.

3.0 Reasons for Recommendations

3.1 To clarify roles on the committee and improve governance arrangements.

4.0 Wards Affected

4.1 All

5.0 Local Ward Members

5.1 All

6.0 Policy Implications including - Climate change - Health

6.1 None

7.0 Financial Implications for Transition Costs (Authorised by the Borough Treasurer)

7.1 None

8.0 Financial Implications 2009/10 and beyond (Authorised by the Borough Treasurer)

8.1 Not known at this stage.

9.0 Legal Implications (Authorised by the Borough Solicitor)

9.1 None

10.0 Risk Management

10.1 None identified

11.0 Background and Options

11 **Co – Option**

Under the Council's Constitution, Scrutiny Committees may appoint non voting co – opted Members for a specific period of time, or with regard to specific issues under consideration. Any person appointed under these arrangements will be entitled to participate fully in the work of the Committee concerned.

This Committee on 20 January 2009 considered a report on co-option which sought views on whether to progress co-option further. In considering the issue Members were advised that there were a number of points to take into account:

- Liaison with other organisations could be achieved without having permanent co-option including involving organisations in Task and Finish

Panels that were looking at a specific issue;

- It was important to have "balance" on the Committee;
- If the Committee was to pursue co-option it would need to consider from
  which sectors to seek representation together with the term of office to be applied and whether to have substitution arrangements;
- How to handle potential conflicts of interest.

The predecessor County Council Committee did have a scheme of co – option which involved one representative each from Cheshire Association of Local Councils; Cheshire Carers; Age Concern; Cheshire Disabilities Federation; and Citizens Advice Bureau (Vale Royal). It is not known at this stage whether any of these bodies would be interested in taking up a co – opted place on the Committee.

Since then, Members have encouraged the development of working relationships in particular with Cheshire East LINK, given the complementary responsibilities which that body and the Committee have for the review of health and adult social care activities in the area.

The Committee in January 2009 resolved that -

(a) no action be taken on permanent co-option to the Committee for the time being; and
(b) further consideration be given to this matter in approximately twelve months time.

Accordingly Members are invited to consider further whether to make any co – opted Member appointments (non – voting) to the Committee for the year, and if so, the basis on which these arrangements should be made.

12. **Protocol**

Given the statutory responsibilities placed upon Health Overview and Scrutiny Committees for scrutiny of the NHS, many Committees have found it helpful to adopt a Protocol with Health partners governing the working arrangements between them. The main point of contact for this activity in Cheshire East is the CECPCT as the commissioner of health services for the area. Accordingly the attached document has been produced, which sets out the respective roles and responsibilities, and how the relationship between the Committee and the PCT should work in practice. The draft has been considered and welcomed by the Midpoint meeting, and a similar Protocol has already been agreed between the Cheshire and Wirral Councils Joint Scrutiny Committee and the Mental Health Partnership NHS Foundation Trust.

In particular, the Protocol sets out guidance for identifying and responding to Substantial Developments or Variations in Services (SDV's) proposed by the NHS. If a proposal is considered to be an SDV, statutory obligations on public consultation arise for the NHS and for this Committee to consider and respond to the proposed changes. It is therefore an important aid towards ensuring that SDV's (and proposals with a lesser but still significant impact) are dealt with properly.

The Protocol reflects the current legal framework for the conduct of Health scrutiny, and conforms to the previously issued National Guidance for this work. Some time ago the Department of Health promised to publish an updated version of the national document but this is still awaited. When the new National Guidance is available, the Protocol will have to be further reviewed to ensure it continues to comply with the Department of Health requirements.

If approved by the Committee, the Protocol will need to be formally agreed by the CECPCT.

DRAFT

CHESHIRE EAST COUNCIL AND CENTRAL AND EASTERN CHESHIRE PRIMARY CARE TRUST

OVERVIEW AND SCRUTINY COMMITTEE

PROTOCOL

1 Introduction

1.1 The Health and Social Care Act 2001 and associated regulations give local authorities the power to review and scrutinise health services through their overview and scrutiny committees. This complements their existing power to promote the social, economic and environmental well-being of local areas. The role of local authorities is to contribute to health improvement and reducing health inequalities in their local area. Health services are to be viewed in their widest sense and will include Adult Social Care and other services provided by the local authority and in partnership with the NHS. Local authorities will be channels for the views of local people.

1.2 Health scrutiny is the democratic element of the new system for patient and public involvement. This includes Local Involvement Networks (LINks), Independent Complaints and Advocacy Services (ICAS) and Patient Advice and Liaison Services (PALS). In addition, the NHS is required to make arrangements to consult with and involve the public in the planning of service provision, the development of changes and in decisions about changes to the operation of services.

1.3 The two main elements of health overview and scrutiny are:

- Formal consultation on substantial developments or variations to services.
- A planned programme of reviews with capacity to respond to issues raised by Cheshire East Local Involvement Network ("LINk") and other bodies.

1.4 The functional responsibility for the overview and scrutiny of health provision and services in Cheshire East lies with the Health and Adult Social Care Scrutiny Committee of the Council ("the Committee"). The main point of contact for NHS scrutiny is Central and Eastern Cheshire Primary Care Trust (*the PCT"), which reflects the PCT's responsibilities for commissioning and providing health services in the area. Scrutiny of the Mental Health and related services provided by the Cheshire and Wirral Partnership NHS Foundation Trust is undertaken separately by a Joint Scrutiny Committee of Cheshire East, Cheshire West and Chester and Wirral Borough Councils.

2 Policy Statement

Members of the Committee, the PCT and organisations for patient and public involvement, will work together to ensure that health scrutiny improves the provision of health services and the health of local people.

3 Aims of Health Scrutiny

- To improve the health of local people by scrutinising the range of health services.
- To secure continuous improvement in the provision of local health services and services that impact on health.
- To contribute to the reduction of health inequalities in the local area.
- To ensure the views of patients and users are taken into account within a strategic approach to health care provision.

4 Principles

4.1 Overview and scrutiny of health services is based on a partnership approach.

4.2 Overview and scrutiny is independent of the NHS.

4.3 The views and priorities of local people are central to overview and scrutiny, and patients and their organisations will be actively involved.

4.4 The overview and scrutiny approach is open, constructive, collaborative and non confrontational. It is based on asking challenging questions and considering evidence. Recommendations are based on evidence.

4.5 Overview and scrutiny works seamlessly with other elements of the patient and public involvement system and with the Local Strategic Partnership.

4.6 Overview and scrutiny will consider wider determinants of health and use wider local authority powers to make recommendations to other local agencies as well as the NHS.

4.7 Overview and scrutiny recognises that there will be tensions between people's priorities and what is affordable or clinically effective, and that local health provision takes place within a national framework of policies and standards.

4.8 The impact of health overview and scrutiny will be evaluated.

5 The Role of the Committee

5.1 In the course of a review or scrutiny the Committee will raise local concerns, consider a range of evidence, challenge the rationale for decisions and propose alternative solutions as appropriate. It will need to balance different perspectives, such as differences between clinical experts and the public. All views should be considered before finalising recommendations.

5.2 The Committee will not duplicate the role of advocates for individual patients, the role of performance management of the NHS or the role of inspecting the NHS.

5.3 The Committee has no power to make decisions or to require that others act on their proposals. The NHS must respond to recommendations of the Committee and give reasons if they decide not to follow these.

6 Organisations to which Health Scrutiny Applies

6.1 NHS bodies subject to overview and scrutiny include any Strategic Health Authority, Primary Care Trust (PCT), and NHS Trust that provides, arranges or performance manages the provision of services. The Committee's main focus will be on services commissioned or provided by the PCT and where appropriate the complementary activities of local authorities and other agencies.

6.2 The Local Government and Public Involvement in Health Act 2007 introduced a new procedure "the Councillor Call for Action (CCfA)" which provides elected Ward Members with a formal means to escalate matters of local concern to an Overview and Scrutiny Committee. Although this is seen as a measure of "last resort" it can lead to recommendations being made to the Council concerned and/or other agencies. The CCfA is one of a number of changes designed to provide Overview and Scrutiny Committees with greater powers to work more closely with Partners and across organisational boundaries. It is likely that any CCfA which is concerned with NHS services will be referred to the Committee in the first instance.

6.3 Similar statutory provisions under the Local Democracy, Economic Development and Construction Act 2009 have also been made to require valid Petitions to be considered at a Local Authority meeting. Each Local Authority is required to make a "Petition Scheme" to determine how such petitions will be handled. Should either a CCfA or a formal Petition be received which relate to health services, the Secretary of the Committee will liaise in the first instance with the PCT, to assist the Chair and Spokespersons of the Committee to determine how to proceed.

7 Matters that can be Reviewed and Scrutinised According to Regulations

7.1 Overview and scrutiny powers cover any matter relating to the planning, provision and operation of health services. Health services are as defined in the NHS Act 1977 and cover health promotion, prevention of ill health and treatment.

7.2 Issues that can be scrutinised include the following:

- Arrangements made by local NHS bodies to secure hospital and community health services and the services that are provided
- Arrangements made by local NHS bodies for the public health, health promotion and health improvement including addressing health inequalities.

- Planning of health services by local NHS bodies, including plans made in co-operation with local authorities setting out a strategy for improving both the health of the local population and the provision of health care to that population.
- The arrangements made by local NHS bodies for consulting and involving patients and the public.
- Any matter referred to the committee by a LINk.
- Any appropriate matter raised by a Councillor Call for Action or a Petition.

8 Substantial Developments or Variations in Services

8.1 The PCT or the NHS Trust responsible will consult the Committee on any proposals it may have under consideration for any substantial development of the health service or any proposal to make any substantial variation in the provision of such services.

8.2 This is additional to discussions between the NHS Trust and the appropriate local authorities on service developments. It is also additional to the NHS duty to consult patients and the public. Guidance indicates that solely focusing on consultation with the Committee would not constitute good practice.

8.3 The Committee has the responsibility to comment on

- Whether as a statutory body the Committee has been properly consulted within the public consultation process
- The adequacy of the consultation undertaken with patients and the public
- Whether the proposal is in the interests of Health Services in the area

Arrangements relating to PCTs

8.4 As the PCT leads the commissioning process will usually be responsible for undertaking formal consultations for services which it commissions. Where services span more that one PCT, they will agree a process of joint consultation. The board of each PCT will formally delegate the responsibility to a joint PCT Committee. This should act as a single entity and will be responsible for the final decision on behalf of the PCTs for which it is acting.

8.5 Where the proposal impacts across the Strategic Health Authority (SHA) or several SHAs the relevant PCTs with lead commissioning responsibility may wish to invite the SHA to coordinate the consultation. Responsibility for decisions on any service revision remains with the PCTs.

Substantial developments or variations ("SDV's") – explanation

8.6 Substantial developments or variations are not defined. The impact of the change on patients, carers and the public is the key concern. The following factors should be taken into account:

- Changes in accessibility of services such as reductions, increases, relocations or withdrawals of service
- Impact on the wider community and other services such as transport and regeneration and economic impact
- Impact on patients – the extent to which groups of patients are affected by a proposed change
- Methods of service delivery – altering the way a service is delivered. The views of patients and LINks are essential in such cases.

8.7 The first stage is for the Committee (acting initially through its Chair and Spokespersons) to decide whether or not the proposal is substantial. This initial assessment is conducted at three levels:

Level One

When the proposed change is minor in nature, eg. a change in clinic times, the skill mix of particular teams, or small changes in operational policies.

At level one, the Committee would not become involved directly, but would assume that the LINk is being consulted.

Level Two

Where the proposed change has moderate impact**,** or consultation has already taken place on a national basis. Examples could include a draft Local Delivery Plan, proposals to rationalise or reconfigure Community Health Teams, or policies that will have a direct impact on service users and carers, such as the "smoke free" policy. Such proposals will involve consultation with patients, carers, staff and the LINks, but will not involve

- Reduction in service
- Change to local access to service
- Large numbers of patients being affected

The Committee will wish to be notified of these proposals at an early stage, but would be unlikely to require them to be dealt with formally as an SDV. A briefing may be required for the full Committee or through the Chair and Spokespersons, and the Local Ward Councillors concerned will be informed of the proposal by the Secretary. The Committee will wish to ensure that the LINks and other appropriate Organisations have been notified by the PCT or NHS Trust concerned.

Level Three

Where the proposal has significant impact and is likely to lead to –

- Reduction or cessation of service
- Relocation of service
- Changes in accessibility criteria
- Local debate and concern

Examples would include a major Review of service delivery, reconfiguration of GP Practices, or the closure of a particular unit.

The Committee will normally regard Level Three proposals as an SDV, and would expect to be notified at as early a stage as possible. In these cases the Committee will advise on the process of consultation, which in accordance with the Government Guidelines would run for a minimum 12 weeks period. The Trust will make it clear when the consultation period is to end. The Committee would consider the proposal formally at one of their meetings, in order to comment and to satisfy the requirement for the Overview and Scrutiny Committee to be consulted in these circumstances.

8.8 Officers of the PCT or other NHS Trust will work closely with the Committee during the formal consultation period to help all parties reach agreement.

8.9 The Committee will respond within the time-scale specified by the PCT. If the Committee does not support the proposals or has concerns about the adequacy of consultation it should provide reasons and evidence.

Exemptions

8.10 The Committee will only be consulted on proposals to establish or dissolve a NHS trust or PCT if this represents a substantial development or variation..

8.11 The Committee does not need to be consulted on proposals for pilot schemes within the meaning of section 4 of the NHS (Primary Care) Act 1997 as these are the subject of separate legislation.

8.12 The PCT/other NHS Trust will not have to consult the Committee if it believes that a decision has to be taken immediately because of a risk to the safety or welfare of patients or staff. These circumstances should be exceptional. The Committee will be notified immediately of the decision taken and the reason why no consultation has taken place. The notification will include information about how patients and carers have been informed about the change and what alternative arrangements have been put in place to meet the needs of patients and carers

Report to Secretary of State for Health

8.13 The Committee may report to the Secretary of State (SoS) for Health or, as appropriate, to Monitor for their consideration when it is not satisfied with the consultation or the proposals. *Referral should not be made until the NHS body concerned has had the opportunity to respond to the Committee's comments and local resolution has been attempted.*

8.14 Specific areas of challenge include:

- The content of the consultation or that insufficient time has been allowed
- The reasons given for not carrying out consultation are inadequate

NB 'inadequate consultation' in the context of referral to the SoS means only consultation with the Committee, not consultation with patients and the public.

or

- Where the Committee considers that the proposal is not in the interests of the health service in its area.

8.15 In response to a referral the SoS may:

- Require the local NHS body to carry out further consultation with the Committee.
- Make a final decision on the proposal and require the NHS body to carry out the decision.
- Ask the Independent Review Panel to advise him/her on the matter.

9 Developing a Programme of Reviews

9.1 The Committee will produce an annual overview and scrutiny plan in consultation with the PCT and the LINks.

9.2 The plan will consider the range of health services including those provided by the local authority and partnership arrangements with the NHS.

9.3 The plan will be based on the views and priorities of local people.

9.4 The plan will have the capacity to take into account issues that may be raised through the work of the LINks.

9.5 The plan will be realistic, based on the capacity of the Committee and the NHS bodies to undertake meaningful reviews.

9.6 The following factors should be taken into account when planning a programme:

- It is a local priority that can make a difference.
- The topic is timely, relevant and not under review elsewhere.
- If the topic has been subject to a national review it should be clear how further local scrutiny can make a difference.
- There is likely to be a balance between;
    - Health improvement and health services,
    - NHS and joint services,
    - Acute services and primary/ community services.
- It may be thematic, e.g. public health, homelessness or services for older people that might impact on the health of local people, or a service oriented priority.
- It should contribute to policy development on matters affecting the health and well being of communities.

9.7 There are a number of methods for scrutiny, including formal reports to the Joint Committee or Reviews conducted by smaller “Task and Finish” Review Panels appointed by the Committee with specific terms of reference.

Sections 10 to 16 apply to both consultation on substantial developments or variations and reviews or scrutiny.

10 Provision of Information

10.1 The PCT or appropriate NHS Trust will provide the Committee with such information about the planning, provision and operation of health services as it may reasonably require in order to discharge its health scrutiny functions. Reasonable notice of requests for information or reports will be given.

10.2 Confidential information that relates to and identifies an individual, or information that is prohibited by any enactment will not be provided.

10.3 Information relating to an individual can be disclosed, provided the individual or their advocate instigates and agrees to the disclosure.

10.4 The local authority may require the person holding information to anonymise it in order for it to be disclosed. The Committee must be able to explain why this information is necessary.

10.5 The PCT will provide regular briefings for Committee Members on key issues.

10.6 In the case of a refusal to provide information that is not prohibited by regulation, the Committee may contact the relevant NHS performance management organisation, which should attempt to negotiate a speedy resolution.

11 Attendance at Meetings

11.1 The Committee may require any officer of the PCT or other NHS Trust to attend meetings to answer questions on the review or scrutiny.

11.2 Requests for attendance will be made through the Chief Executive of the Trust concerned.

11.3 The Committee will give reasonable notice of its request and the date of attendance. The Committee will provide the officer with a briefing on the areas about which they require information no later than one week prior to the attendance.

11.4 If the scrutiny process needs to consider health care provided by the independent sector on behalf of the NHS, it will consider the issue through the lead commissioning body, generally the PCT. The NHS will build into its

contracts with independent sector providers a requirement to attend a review or scrutiny or provide information at no cost to the Committee.

11.5 The Chair or non-executive Directors of the PCT or other NHS Trust cannot be required to attend before the Committee. They may, however, wish to do so if requested.

11.6 Local independent practitioners such as GPs, dentists, pharmacists and opticians may be willing to attend the Committee but cannot be required to do so. Local independent practitioners may be willing to attend at the request of the PCT. An alternative source of information may be the Local Medical Committee or appropriate professional organisations.

12 Reporting

12.1 In their reports the Committee will include:

- An explanation of the issues addressed
- A summary of the information considered
- A list of participants involved in the review or scrutiny
- Any recommendations on the matters considered
- Evidence on which the recommendations are based.
- Where appropriate, recognition of the achievements of the PCT and/or NHS body concerned.

12.2 The Committee will send draft reports to the PCT and other bodies that have been the subject of review to check for factual accuracy.

12.3 The report is made on behalf of the Committee and there is no requirement for the Cabinet or the full Council to endorse it. However the report will be sent to the Cabinet and full Council and, if required, a briefing will be arranged to identify the main implications.

12.4 If the Committee request a response from the PCT and/or another NHS Trust this will be provided within 28 days. If a comprehensive response cannot be provided in this time, the Trust(s) concerned will negotiate with the Committee to provide an interim report, which will include details of when the final report will be produced.

12.5 The response will include:

- The views on the recommendations
- Proposed action in response to the recommendations
- Reasons for decisions not to implement recommendations

12.6 Copies of the final report and the response will be widely circulated and made publicly available.

13 Conflict of Interest

13.1 The Committee must take steps to avoid any potential conflicts of interest arising from Members' involvement in the bodies or decisions they are scrutinising.

13.2 Conflict of interest may arise if councillors or their close relatives are:

- An employee of an NHS body, or
- A non-executive director of an NHS body, or
- An executive member of another local authority
- An employee or board member of an organisation commissioned by an NHS body to provide goods or services.

13.2 These councillors are not excluded from membership of overview and scrutiny committees but must follow the National Code of Conduct for Members regarding participation and as necessary seek advice from the Monitoring Officer of the Council where there is a risk of conflict of interest.

13.3 Executive (Cabinet) Members and Cabinet Assistant Members of Cheshire East Council are excluded from serving on the Committee in any capacity.

14 Liaison between the Committee and the Local Involvement Network (LINk)

14.1 The Committee will develop an appropriate working relationship with the Cheshire East LINk.

- The LINk may refer issues to the Committee, which must take these into account. If issues are not urgent they may be considered when planning future work programmes.
- The Committee will where appropriate advise the LINk of actions taken and the rationale for these actions.
- The outline and process of a scrutiny review will be discussed with members of the LINk.
- One or more LINk representatives shall be eligible for appointment as non – voting Co – Opted Members of the Committee, either fully or for the duration of a particular Scrutiny or Review. The Committee will decide how these arrangements will operate.

15 Conclusion

15.1 This Protocol was considered and adopted by the Committee on 20 May 2010 [and is endorsed by the PCT]

CHESHIRE EAST COUNCIL

REPORT TO: CABINET

Date of Meeting:
Report of: **Phil Lloyd – Head of Adult Services**
Subject/Title: **Dementia Strategy - Building Based Services Review**
Portfolio Holder: **Councillor Roland Domleo**

1.0 Report Summary

1.1 This report contains recommendations for the further implementation of the Council's approach to the Redesign of Adult Social Care Services and to its strategy for Dementia Services, which was agreed by the Cabinet at its meeting on 16th June, 2009.

1.2 In particular, it recommends the Cabinet to decide that a Procurement exercise should be undertaken to commission consultants (it is hoped, in partnership with Central and Eastern Cheshire Primary Care Trust) to develop costed options for the development of new facilities to meet the needs of Older People suffering from Dementia.

2.0 Decision Requested

The Cabinet is recommended to decide:-

2.1 To note the further work described in this report which has been taken forward to progress the implementation of the Cabinet's policy of gradually developing more specialised provision for those with Dementia, and of reducing over time the extent of the Council's reliance upon institutional, building based services.

2.2 To agree that negotiations should be undertaken with Central and Eastern Cheshire Primary Care Trust (CECPCT) to seek their support for consultants to carry out an exercise to develop specific proposals for how Cheshire East Council and the CECPCT should provide services for older people suffering from dementia in the area in the future.

2.3 To agree, subject to the outcome of those negotiations, that a procurement exercise should be undertaken to secure the services of consultants.

2.4 To acknowledge that any capital and revenue implications which arise from the proposals generated by this exercise, will be presented in a further report to the Cabinet, setting out the options and their potential impact upon the financial situation of the Council.

2.5 To agree that an exercise should be undertaken to gather the views of existing and recent service users (and their carers) of Cypress House, a Community Support Centre in Handforth, around the option of closing that provision, both to contribute to the re-commissioning of resources

for the creation of new specialist services, and to address its significant under-utilisation.

2.6 To request that a report be made to the Cabinet setting out the views expressed during that exercise and the proposed response to them.

3.0 Reasons for Recommendations

3.1 There are a number of reasons for the recommendations made in this report.

3.2 First and foremost, the Council's objective must be to secure better services for users and their carers. Cheshire East has an older population than the average English Local Authority. It can therefore be anticipated that the needs of older people with Dementia will become an increasing focus of strategic attention. Moreover the expectations of service users and carers are changing significantly, rendering some of our old service responses no longer relevant. It will be crucial for the Council to respond to those changes appropriately.

3.3 The Council is committed to developing its response to the National Dementia Strategy. A specific group to focus attention upon Services for Older People has been established as part of the Health and Wellbeing Thematic Partnership of the Local Strategic Partnership. A key deliverable from that group will be a joint commissioning strategy in relation to Services for Older People. The commissioning of services for Older People with Dementia will necessarily be a key part of that overall joint commissioning strategy.

3.4 The Redesign of Adult Social Care Services is one of the big Transformation projects of Cheshire East Council. A fundamental element within that Redesign is a shift away from reliance upon Building Based Services. As a Council we have inherited some traditional service provision. A key transformational challenge is to develop service solutions which are relevant to today's needs, rather than the needs of yesterday.

3.5 The Council is required to make effective use of its assets and its staff and to deliver Value for Money. In that context, it cannot ignore significant under-utilisation of resources, which arises as potential service users turn away from old fashioned provision.

3.6 More specifically, the Council's revenue budget for 2010/2011, as agreed by Full Council at its meeting on 25th February, 2010, requires the Adult Services of the People Directorate to deliver a reduction of £750,000 within its Provider Services. The recommendations contained within this report are fundamental to the delivery of that agreed reduction.

4.0 Wards Affected

4.1 All wards could be affected by these proposals

5.0 Local Ward Members

5.1 n/a

6.0 Policy Implications including - Climate change
- Health

6.1 These proposals are in line with the Council's approach to the redesign Adult Services and the further development of our approach to the National Dementia Strategy as it affects building based services.

7.0 Financial Implications for Transition Costs (Authorised by the Borough Treasurer)

7.1 None.

8.0 Financial Implications 2009/10 and beyond (Authorised by the Borough Treasurer)

8.1 This strategy is designed to improve outcomes for users while delivering the challenging budget set for Adult Services involving an overall reduction of £2.995M in 2010/11 before corporate procurement reductions are allocated out. These reductions which form part of the 2010/11 budget specifically include a reduction of £750k in respect of Provider services Building Based Services. The rationalisation of one centre will help to achieve the targeted savings for one element of the 2010/11 budget. The cost of the commission to develop proposals will be funded from Social Care Reform Grant.

The capital cost of provision of new facilities will potentially be shared with partners and also part funded through the realisation of land and buildings where current provision is located – some of which is prime development land. Longer term capital and revenue implications will be presented as part of the options appraisal and will then be fed into the Council's medium term financial strategy and future budget setting exercise.

9.0 Legal Implications (Authorised by the Borough Solicitor)

9.1 The proposals contained within this paper will enable the Authority to continue into the future to comply with its statutory duty to meet the needs of persons with a critical or substantial need for community care services under Section 47 National Health Service and Community Care Act 1990.

9.2 There is no statutory requirement for consultation in respect of the possible closure of Cypress House. However, it is appropriate to seek the views of affected service users and for these to be taken into account before any final decision is taken as to closure. Any consultation must contain four elements, known as the Sedley Requirements (R v Brent London Borough Council, ex parte Gunning (1985)

84 LGR 168) and it would be good practice for these principles to be followed in this matter. The Sedley Requirements are as follows:

1 The Consultation must be at a time when proposals are still at a formative stage
2 The proposer must give sufficient reasons for any proposal to permit of intelligent consideration and response
3 That adequate time must be given for any consideration and response
4 That the result of the consultation must be conscientiously taken into account in finalising any proposals

9.3 It should further be noted that it was stated in R (Madden) v Bury MBC [2002] EWHC 1882 (Admin) that consultation will be held to be inadequate if the residents are not given the true reason for the closure and for why one home was favoured to remain open rather than another. Therefore in seeking the views of affected users and carers of Cypress house it is important that they be provided with full information as to why it has been selected for possible closure in preference to any of the other Community Support Centres.

9.4 The Authority has a duty under the Disability Discrimination Act 2005 to take into account the impact of these proposals upon affected service users and to carry out an Equality Impact Assessment before reaching any final decision to substantially vary service provision.

9.5 The Local Authority is permitted to work jointly with other bodies to provide services to its residents. However, there are restrictions in respect of some of the work that can be undertaken jointly e.g. procurement exercises and therefore officers will seek legal advice in respect of the specific options that are identified for future joint working.

10.0 Risk Management

10.1 As with all major transformation projects, risks will be identified and mitigating actions taken. A risk register will be maintained by the Steering group implementing this project.

11.0 Background and Options

11.1 The Council's internal Provider Service has already undergone significant transformation in line with the redesign of Adult's Social Care and its underpinning principles of addressing changing demand, maximising efficiency, and responding to personalised needs. The overarching strategy for the Internal Provider Service has been to redefine its core purpose to deliver services in the following areas:

- Reablement to improve outcomes and reduce care costs.
- Specialist Services for Long Term Conditions (e.g. Dementia / Complex Needs).
- Back up & benchmark for Market Failure.

11.2 On 16 June 2009 Cabinet agreed that the recommissioning of the Council's Community Support Centres (CSCs) is fundamental to its implementation of the National Dementia Strategy. To that end it further agreed that the development of new and enhanced services at Lincoln House in Crewe should *constitute the first phase* of the Council's implementation plan, with services currently provided at Santune House being transferred to Lincoln House and Santune House closing. As the agreed approach continued the report indicated that other CSC's would be considered at a later stage to help address capacity issues which in turn, helps to maximise the quality of the project delivered. It should be noted that there are no permanent or long-term residents in the Council's Community Support Centres.

The report also noted specifically that, "Cypress House at Handforth and Mountview in Congleton- will be considered as the impact of the social care re-design process becomes apparent". This impact is now apparent and is outlined in this report.

11.3 The Report noted that the CSCs have begun to show their age in recent years. Their service offer is a traditional one and it is building based. The buildings themselves have not been updated and they now require very significant investment if they are to be brought up to modern standards. There are few en-suite rooms in any of our Centres. Older People are obliged to share communal bathroom facilities. Few today would tolerate those arrangements if they were staying in a hotel. Additionally, Health and Safety requirements are proving more and more difficult to meet. It is hardly surprising that potential service users have been increasingly turning away from this old-fashioned provision. In recent years, the take up of short stay care in the CSCs has been declining, with consequent increases in unit costs.

11.4 The increasing availability of Direct Payments and Individual Budgets has also had an impact, and can be expected to have an increasing impact over time. More and more Older People and their families are becoming able to make arrangements for their own for short stay care and daytime occupation. It can be anticipated that fewer and fewer of them will want to make use of traditional, institutional settings.

11.5 The approach agreed by the Cabinet was to close those CSCs which were particularly problematic and which were located very close to another CSC or a significant facility like extra care housing, and to recycle the resources (subject to the approval of a robust Business Case) into the development of new services, particularly for Older People with dementia. The report also noted specifically that, "Cypress House at Handforth and Mountview in Congleton – will be considered, as the impact of the social care redesign process becomes apparent". This impact is now apparent and is outlined in this report.

11.6 The future model involves integrating and rationalising current facilities and part of this work will be to determine the final shape of provision. However, current thinking suggests a model on the following lines:

- Two main specialist centres for Dementia – i.e. 1 each in the north and south of the Borough.
- Two main specialist centres for Adults with Severe and Complex Conditions – i.e. 1 each in the North and South of the Borough.
- New facilities to provide both short stay residential and nursing care in seamless, integrated and co-located services between the Council and PCT.
- Investment in Telecare / Assistive Technology for individuals to remain safely in their own homes for longer, to be funded from existing resources.
- Investment and acknowledgment for carers and respite, to be funded from existing resources.
- Maximising use of underutilised external provision.
- Maximising use of Extra Care Housing developments in the Borough.

11.7 As noted earlier the Council is already aware that its current provision of Community Support Centres is, to some extent, struggling to respond to user needs and expectations. This is reflected in the current usage of the centres. The level of vacancies across all 5 centres has averaged 21% (i.e. 37 beds) over the last year. In some centres occupancy has peaked at just 58%.

Existing provision and average usage for 2009/10 are:

	Total Capacity	**Aver. bed use**	**Aver. vacant beds**
Bexton Court , Knutsford	23 beds	80% (18)	5
Cypress House, Handforth	31 beds	69% (21)	10
Hollins View, Macclesfield	40 beds	65% (26)	14
Mountview , Congleton	36 beds	68% (25)	11
Lincoln / Santune, Crewe	45 beds	64% (29)	16
Total:	175 beds	119 beds	56

11.8 Current figures indicate an average demand of 119 beds.. The net effect of this under usage is heavily subsidised individual beds which are neither economical nor competitive. A more efficient use of resources could be achieved by meeting the demand in less centres whilst still allowing for peaks in activity.

12.0 Which is the most appropriate Centre to close?

12.1 A public consultation exercise was carried out by the former County Council to establish an appropriate strategy to address this issue and the closure of some Centres was concluded to be the solution. The consultation emphasised the value placed on specialist dementia services and the need to articulate the vision for alternative services of the future before any closures took place. This feedback has informed the revised proposals, together with

learning from the project at Lincoln House which has illustrated the costs of reproviding specialist dementia facilities in the current buildings as an alternative to new purpose build accommodation.

12.2 Whilst Bexton Court is the smallest centre it has a Service Level Agreement in place with CECPCT for the 18 bedded Tatton Ward and until they find a location for this service its closure could have a considerable impact on the Intermediate Care Strategy. That is our key, joint strategy for ensuring smooth transition from hospital to the community. Bexton Court is also a specialist centre for dementia providing a service for all Cheshire East Borough Council and some residents of Cheshire West and Chester Council (CWAC).

12.3 Cypress House is the next smallest of the centres with 31 beds, of which 7 are purchased by CECPCT for Intermediate care . The PCT has been consulted and would be able to relocate these beds to under-occupied provision at Hollinsview in Macclesfield and for those with dementia at Bexton Court. Evidence shows that service users are already accessing these services from the Handforth locality

12.4 During the last twelve months, the remaining 24 beds were used by 255 service users. Of these, the equivalent of 2 beds were used by 46 carers to access respite care using the one call system (an instant access service for carers). Service users are no longer restricted to the use of in house provision to meet their short term respite needs and some of this demand could be met by alternative local provision using individual budgets. Ten former services users are now resident in the Oakmere, the nearby Extra Care Housing facility. The proximity of Oakmere as a modern facility is relevant to the proposals in this report, as it demonstrates commitment to investment in an area before proposed withdrawal of facilities

12.5 The demand for core services – reablement, complex care and crisis Response - could be absorbed in the remaining Community Support Centres pending new build accommodation.

12.6 Cypress House also provides day care to 38 service users. Those who are assessed as still requiring this service would be relocated either to Redesmere Day Care in Redesmere Road, Handforth,Wilmslow or community activities at Oakmere Extra Care Housing in Spath Lane, Handforth. Cypress House and Redesmere are currently only averaging 50% and 49% attendance respectively and the proposal is to amalgamate those services.

It is therefore proposed that consideration be given to the possibility of closing Cypress House, as the preferred centre, with users enabled to access similar services at other facilities as part of migrating to the future model because

- It involves a loss of the least number of beds
- Its services can be re-provided in the remaining centres/services

- There is alternative local provision in the new Extra Care Housing scheme and day centre.
- There are alternative independent providers of short stay residential care in the vicinity.
- All the current community support centres are utilised by Cheshire East citizens from throughout the borough.

12.7 The current sale value of Cypress House has been estimated on the basis of current and alternative use and this will generate a capital receipt, once the building has been declared surplus and sold. In addition, the centre has a net revenue budget of £760K some of which will be realised as an annual saving once users and some staff have been relocated to other more effective provision. The remaining staff would be redeployed, but it must be acknowledged that for some redundancy may be the outcome. The closure would therefore provide the opportunity to enhance staffing levels where appropriate at remaining centres to deliver a more intensive level of support, in line with the emerging model of dementia care, while still achieving efficiencies for the Council.

12.8 This would partly meet the revenue saving target included within the 2010/11 budget. It is requested that any capital receipt should be taken into account in developing the business case for the development of new facilities. The cost of redundancies would be funded from an earmarked corporate fund against which this development has already been identified as a potential claim. The Council needs to carry out an exercise to ascertain the views of, and address the impact on, affected users and carers and this will be undertaken immediately. An Equality Impact Assessment will also be carried out. The Cabinet will be asked to make a final decision in the summer of 2010 when the results of the above exercises are available.

13.0 Overview of Year One and Term One Issues

13.0 n/a

14. Access to Information

The first Cabinet Report on Dementia Strategy is available on http://moderngov.cheshireeast.gov.uk/ecminutes/Published/C00000241/M00002477/$$ADocPackPublic.pdf

The background papers relating to this report can be inspected by contacting the report writer:

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AT Strategy Proposal – May 2010

Summary

- This is a proposal to introduce an Adult Social Care wide strategy to support the integration of assistive technology into support planning for vulnerable people.

- Assistive technology is (A.T.) is, "any item used to increase, maintain or improve the functional capabilities of individuals with cognitive, physical or communication disabilities" (Palmer, 2008). This includes telecare which is the use of monitors or sensors to alert a remote carer to an individual's need. For further information on what this equipment is, please see the attached information sheets, "How can assistive technology help me?" and "Telecare Sensors". A visit to a demonstration flat to see the equipment working can be arranged on request.

- Assistive technology has a prominent role in government agendas. Cheshire East has already developed some systems to support the use of some technologies. A recent reprocurement exercise has provided a substantial reduction in revenue costs and there are some options detailed regarding charging policy in respect of assistive technology including suspending charges to customers for telecare.

- Preventative agenda: assistive technology has the potential to raise the level at which some people need social care. Information for the general public is the key to assistive technology's role in prevention and through development links with the third sector, this can be supported by the use of self-assessment and mediated assessments using internet based tools. This will link in to the Cheshire East Council's Information Gateway.

- Reablement: technologies, such as the Just Checking lifestyle assessment system, can support effective assessment and prevent unnecessary admissions to care placements. Assistive technology can also support people to regain skills which can help them to remain in their own home and increase their independence. By providing telecare support before assessing for and allocating a budget for an individual's personal support the council will reduce the amount spent on supporting vulnerable individuals. Assistive technology is already an integral part of reablement with benefits currently being realised by customers and commissioners.

- People requiring ongoing support can be assisted by technology, which reduces their dependence on physical support and can prevent the need for future support should their needs increase over time. For example, people requiring prompting to take their prescribed tablets may benefit from a medication dispenser. This would alert them at the exact time they need to take their medication, reduce the risk of

overdoses by limiting access to only the tablets that are due to be taken and alerts support staff if the dispenser is not used within a set period of medication being due.

- The main obstacle to integrating assistive technology into practice is knowledge and up to date information. Developing a dedicated assistive technology team, who would link into assessment teams directly, would help embed assistive technology into everyday practice. This approach, taken by a number of local authorities to date in the UK, would enable the council to maximise the benefits that assistive technology can bring to the local population and commissioners.

- The projected financial impact of the proposal is based on independently evaluated practice in the UK. Detailed figures are provided and a five year plan is provided which estimates that for an investment of £1,495,000 the savings realisation to local authority services would be £3,700,000. Cheshire East's own impact evaluation is underway.

- Joint working with health colleagues, other statutory services and the 3rd sector has the potential to bring a number of benefits to local people and the synergies for services as a whole are potentially significant. A good example of this is Telehealth, which has a growing evidence base with government currently supporting a number of pilot schemes in England. Rigorous evaluation by the Department of Health of 3 local authority wide pilot schemes is underway and due to be published later in the year. We will look to build upon initial discussions with health colleagues in the PCT and agree funding on an invest to save basis.

Introduction

Across social services departments in the UK there has been a drive, (linked to a number of government agendas) towards the use of assistive technology to support people in their own homes. The basis of the agenda has been research in older people's services to suggest that the use of technology can enable people to stay outside of permanent care (Nursing or Residential Homes) for longer than if no equipment is used (for example; Woolham, 2006). There are three major positive aspects to such support for the use of assistive technology for older people:

- research suggests that people want to stay in their own home for as long as possible
- supporting people with technology is less costly than an admission into permanent care
- recruitment difficulties are managed as less staff-intensive support can be provided through the use of technology

To this end central government introduced the Preventative Technology Grant (PTG), which was rolled out to local authorities in 2006 (initially as a 2 year programme) to pump-prime the use of assistive technology and develop systems to support the provision of assistive technology for older and disabled people. This gave local authorities the opportunity to test the premise that assistive technology could improve services, support people in their desire to remain in their own homes, and save money, without having to remove resources from already overstretched budgets.

Cheshire County Council took up this challenge and used telecare in services for people aged 65 and older. As part of social care redesign in Cheshire East assistive technology is now available to all customers of the council aged over 18. The evaluation of the work in Cheshire supported the premise that assistive technology is effective at keeping people independent at home and has proved popular with carers (Cheshire County Council Telecare Newsletter February 2008). It was decided in 2006 that the PTG should be used solely for those over 65 years, due to the performance indicators that were associated with the use of the grant monies relating to 'older people'. The decision not to include under-65s was not universally made in other local authorities.

Within local authority-run learning disability services in Cheshire, assistive technology was introduced early in 2006 in a pilot scheme and then rolled out countywide following positive outcomes and evaluation of the work. Although this work within learning disability services represents one of very few examples where assistive technology has been successfully implemented, there has been long standing government support for the idea: Ivan Lewis (Minister for Care Services) stated that assistive technology is important in "meeting the aspirations and demands of people with learning disabilities" when launching Advance Housing's (2007) Report, "Gadgets, Gizmos and Gaining Independence".

An evidence base for the use of assistive technology to support vulnerable people is evolving gradually, and the systems through which technology can be integrated into social care are beginning to develop in the light of the ongoing research and evaluations of pilot schemes.

The recent Department of Health publication Use of Resources in Adult Social Care: A guide for local authorities cited North Yorkshire County Council as an example of good practice in telecare; they estimate that where telecare is used there is a 38% reduction in the care package costs saving £1.1 million in social care costs among 330 people. A report, Telecare: a crucial opportunity to help save our health and social care system (published by the University of Leeds in August 2009) with a foreword by Andrew Lansley CBE MP the then Shadow Secretary of State for Health concluded there is a compelling case for further investment in telecare, "It (telecare) *can* be investment to save. It *can* eliminate common risks to health and wellbeing. It *can* enhance the quality of life. **It *should* be a simple decision".**

The potential of this technology appears to be greater than the current level of commissioning. Only 7% of customers with a social care package, living in their own home have telecare installed at present. The barriers to further take up of technology amongst vulnerable people in Cheshire East are to do with knowledge amongst commissioning and provider staff, customers and carers. With increased awareness, information and assessment skill the impact and the benefits can be substantial to all stakeholders.

In contrast, Essex County Council has 16,000 telecare users (7% of the total population aged 65 and over) and its evaluation states that for every £1 spent on telecare £3.82 is saved on traditional support and where telecare can replace services the saving rises to £12.60 based on every £1 spent.

Current Telecare Service in Cheshire East

The existing telecare service is available to all customers aged over 18. In line with equipment provision under the Chronically Sick and Disabled Persons Act 1970 the telecare equipment itself is provided free of charge. There is a charge to customers receiving the telecare service which relates to the monitoring of the sensors by the call centre and the availability of responders to visit people in their homes within 60 minutes of an alert, 24 hours per day 365 days per year. The current charge is £9.81 per week which customers are financially assessed for.

Telecare monitoring and response is available at no charge to customers receiving intermediate care (this is a 6 week limited service).

There is a list of equipment that care managers and occupational therapists can select based on their assessment of an individual.

Assessors have a basic 2 hour training session in one of the demonstration flats and have some information to refer back to in their work. There is a telecare element to the training programme for reablement workers, raising their awareness of the issues and encouraging them to consider technological solutions to assessed needs.

Customers are set up with a lifeline unit which is connected to the telephone line, the appropriate sensors are installed and a keysafe unit is provided so that responders have access to the property in an emergency. There are approximately 260 telecare installations in Cheshire East at present.

Supporting People funding currently supplies telecare connections with a pendant alarm to around 1500 vulnerable people who pay rent to registered social landlords in Cheshire East. These units are not compatible with some of the additional telecare sensors and functions. Where a customer has one of these lifeline connections but requires additional sensors the system needs to be changed through assessment with a new lifeline unit and keysafe arrangement being put in place.

Reprocurement

Cheshire East Council has recently undertaken a telecare procurement exercise. All telecare equipment is provided to those customers who have critical and substantial needs at no cost and there is no charge to that individual for the installation, maintenance or withdrawal of the equipment. This policy is under pinned by legislation (Chronically Sick and Disabled Person's Act, 1970). Under the current contract customers are financially assessed for a weekly charge (£9.71) which relates to the link from telecare equipment to the call centre and the availability of a worker to visit them (within an hour of an alert) in their home if this is required. Cheshire East pays this £9.71 per week to the contracted provided for each lifeline unit in a person's home, irrespective of the number of sensors linked up the lifeline unit. The only exception to this charging policy is people who have telecare support provided under intermediate care are not charged at all for as long as they are supported through intermediate care (up to six weeks) for this service.

The recent reprocurement exercise sought to consolidate the number of providers of telecare (from 3 currently) allowing that organisation to develop economies of scale and to ensure equity of service across the council area as the service develops further as well as ensuring best value for Cheshire East as a commissioner and for our customers. Under the proposed new contract (starting in July) there will be one provider for the Cheshire East area and the charge for the monitoring and response service will reduce significantly to £1.05 per week, a reduction of £8.66 per week, just under 90% of the current price.

This reduction in cost provides a number of options for charging in the future:

- Continue to charge out to customers the full cost of monitoring and response through telecare (the council currently raises approximately a third of this cost through its fairer charging policy). Given the amount involved the process of administering the charge will be close and may exceed the amount gained from charging.
- Suspend the charge for telecare monitoring and response. It is anticipated that this policy would lead to a greater uptake of telecare services (including cost of additional equipment and installation charges), but this would be affordable under the current yearly spend on telecare. Additionally, as investing in telecare use brings cost avoidance benefit to the council as a commissioner of social care, offering telecare at no charge would represent an investment in respect of social care services as a whole rather than just a cost. Suspending a charge for an emerging high profile service would also be a 'good news story' for citizens of Cheshire East; evidencing the council's commitment to supporting vulnerable people to remain in their own home and supporting citizens at a time of financial stress for many.
- Suspend the charge for telecare monitoring and response for specific time periods or services. Offering a free service through reablement would link into the offer of domiciliary support which is offered free of charge for up to 6 weeks. Telecare monitoring and response could be offered free of charge to all customers for a set period (for example, 6 weeks from the start of their service) irrespective of whether they are accessing reablement. This approach would encourage uptake of telecare (which brings its own benefits to customers and commissioners) and would be affordable within the current spending on telecare.

The new contract includes support for a number of new pieces of assistive technology equipment that will assist carers in particular.

Beyond the 3 year contract (July 2013 onwards) the costs of telecare provision may rise so any Cheshire East policy position would need to ensure that the council retained the option of charging for this service.

Equipment is procured through the national Buying Solutions framework agreement for telecare. This joint NHS and local authority organisation ensures best value pricing for telecare products.

Prevention

Prevention has, over the last few years, become a major part of the government's agenda for social care. The Putting People First Concordat (2007) emphasised the move towards personalisation and asserted that, "telecare to be viewed as integral not marginal". 'Putting People First - the whole story' (DH, 2008) followed this up with an emphasis on universal services and prevention, moving away from the focus on eligibility criteria. The use of assistive technology (which includes, but is not limited to telecare) has been shown to prevent or delay the need for support and care from services (evidenced in evaluations of assistive technology initiatives in West Lothian, Northamptonshire, Northern Ireland, Aberdeenshire and others) and therefore is valuable as an integral part of services available to everyone.

The increasing number of older people is forecast to put serious pressures on care services in the future. In Cheshire, the number of people over 65 is set to increase by over 20% by 2015 and those over 85 is forecast to increase by more than 27% in the same period. Whilst the predicted increased need in learning and physical disabilities and mental health needs is less severe, numbers are projected to increase. Investing in preventative measures is one way of softening the impact of these demographic changes whilst raising the quality of life of people in the local area as a whole. Assistive technology can raise the level at which some people need physical support from others and will work as part of an integrated package of services to support individuals with greater needs.

The key to engaging people with technology that will help them maintain their independence is providing knowledge about what is available. There have been a number of initiatives in the UK looking to give the general public information about assistive technology and access to technology which may increase independence, reduce reliance on others and avoid the need for people to receive personal care services. For example, in Leicestershire the Signal project (a multi agency project led by the local authority and Age Concern) fitted a bus out with various assistive technologies, which then toured market places, shopping centres and community centres. By marketing these visits, the project gave people the opportunity to see equipment at first hand without specifically seeking it out or speaking to the social services department. People visiting the bus were given information about where they could buy the equipment and contact numbers for further information and advice. Within Leicester City Council, social services and libraries combined forces to sell a number of free standing pieces of assistive technology at the issue counter in the city council's libraries.

In Cheshire East the roll out of Independent Living Centres provides an opportunity to showcase, assess for, and through the linked retail outlets sell assistive technology, sitting alongside their role in exhibiting more equipment that may increase independence and mobility. Exhibiting assistive technology products, with expertise available on site, will increase knowledge and uptake of products that meet preventative goals with a small investment from the

social care budget. People will pay for the equipment themselves and remain outside of the authority's community services department, whilst having a route into further support and assessment if this is required.

An extension of this work would be a web-based assessment, which would be able to recommend assistive technology as well as other equipment aimed at making everyday living easier. One such product is ADL Smartcare: this has a self assessment module enabling people to go online, assess themselves with regard to particular activities, and follow links to purchase equipment that has been recommended. Cheshire Peaks and Plains Housing Trust have developed a self assessment computer programme for assistive technology which is available in a number of languages and has a touch screen option.

A number of local authorities use the ADL Smartcare product with positive results. For example, Birmingham City Council have purchased a licence agreement following a trial and evaluation that found, compared to an Occupational Therapist's assessment, that the tool produced an exact match outcome in 39% of cases and a partial match in 10% of cases. In a further 21% of cases there was a recommendation that the user seeks a professional assessment, and of the remaining 30% none of the recommendations put users at risk and provide generally appropriate outcomes. There is currently a larger scale evaluation of the tool being undertaken at Manchester University.

A web-based tool could be made available from a link on the local authority website, and for people without access to the internet at home, ILCs and library and other council internet access points could be used to access an assessment. For those people who do not have friends or relatives to assist them with an assessment and are not able to access a computer in their locality, a link with a third sector organisation could develop a mobile assessment service using a laptop for a modest financial outlay.

Working in partnership with other statutory agencies as well as the third sector may have preventative value. For example, Cheshire's Fire Service provides free smoke alarms to any property (calling door to door) and identify people who are over 65 and at risk of falls or needing social care intervention to Age Concern 'Safe at Home' scheme. They are able to provide leaflets and limited services as part of their Supporting You service. However, they would be able to refer people for an online assessment. There are many other agencies (acute and primary care trusts, police, housing services, etc.) that come into contact with members of the public, some of whom may benefit from the opportunity to complete a self assessment and discover products which could improve their daily lives. Such a consortium approach is underway in Staffordshire, where a number of agencies are able to pass on basic referrals to each other, with a focus on prevention of future health and social care needs. Staffordshire County Council are investigating a tool developed by the Kings College London which is able to identify those most at risk of intensive health and social care interventions, enabling services to focus their efforts where they will be most effective.

The potentially rich information from any online assessments would be available to community services, and represents something of much greater depth and value than the information currently used as the basis for the prediction of need. The data could be used to inform future planning and commissioning decisions, enabling longer term planning with increased confidence.

Links are planned with representatives from third sector organisations and customers. With information and training provided to these groups, they will be in a position to inform others and advocate for the increased use assistive technology. New accessible information is being produced for customers, carers and other professionals which will tie in with the new contract provider.

The impact of such a preventative approach would be shared by health colleagues as well as community services. An approach in tandem with health services would result in reductions in admissions to A&E, non-elective surgery, as well as reduced pressure on GPs' and district nurses' time. Falls and health conditions generally have an impact on social care services too and prevention would be positive for community services as well, not to mention the population as a whole. Telecare has been identified as a priority for the NHS as part of fall prevention strategies in the NHS Operating Framework Prevention Package for Older People, so there may be potential to share some of the costs associated with this approach with health colleagues.

Measuring the impact of a preventative approach is difficult and putting a cost saving along side this is even more complex. A long term evaluation consisting of an analysis of the rate of referrals to social care services, adjusted for the changing demography would be revealing. A 'Social Return on Investment' model may be a more sophisticated approach to evaluating the costs and benefits of such an approach. Examples of some outcome measures might be the number of people over 65 presenting at A&E or having unplanned surgery as a result of a fall would be another appropriate measure. Both of these outcomes can be measured in terms of service impact as well as in terms of their impact on individual lives.

Bradford Metropolitan District Council's investment in the ADL Smartcare product has resulted in a 60% saving on the costs of Occupational Therapy assessment by using Social Care Advisors, who have used the product (under the guidance of an Occupational Therapist) to assess individuals and, where appropriate, provide equipment. Lincolnshire County Council have taken a similar path using the ADL Smartcare product and their waiting list for assessment and equipment has been considerably reduced following this implementation.

The **potential annual costs** of this approach for Cheshire East would be:

Subscription to ADL Smartcare	**£10,000** (per year)
Training for third sector partners to assist with assessment	**£1,000**
0.5 WTE assessment facilitator (?employed by third sector)	**£10,000** (per year)
Computer equipment to support on line assessment	**£3,000**
0.1 WTE (1/2 day 'surgery' every week at alternate venues) assistive technology assessor for surgeries based in ILCs	**£4,000** (per year)
Total	**£28,000**

The potential impact on OT assessments has not been factored in: there have been initial discussions with the OT service about how the integration of such a product into their own assessment system might work.

Reablement

The reablement approach is defined by the Department of Health as "re-abling people so that they achieve their potential in terms of a stable level of independence with the lowest appropriate level of ongoing support or care." The plan to expand the reablement approach alongside intermediate care services in Cheshire East to all adult care is an opportunity to draw further benefit from the use of assistive technology. A period of reablement provides an opportunity to further assess the needs that an individual has, support him or her to regain abilities and develop a robust plan of care that will provide the ongoing support that that person really needs. Technology supports all three of these aims and can reduce the need for direct support to be provided for specific tasks or for a 'just in case' risk management approach.

Assessment
Lifestyle monitoring systems (such as the Just Checking system) inform an in depth assessment of an individual's needs; identifying issues or risks over a 24 hour period, enabling support plans to target care where and when it is needed, and providing a baseline of activity for review in the future.

Staffordshire County Council looked at the increasing number of people with dementia who were keen to stay in their own home. Alongside this aim they saw that new solutions would be needed to take the pressure off home care budgets, residential placements, carers, and to prevent hospital admissions. They invested in 12 Just Checking systems for assessment purposes and a Department of Health evaluation of their set-up in 2008 found positive outcomes. 21 cases were evaluated that were Critical and Substantial (generally they were referred for residential care) and following assessment from the monitoring system, 8 were more accurately reassessed within a lower category of risk than had been initially identified. 13 were able to remain at home: this carries notional savings from the proposed Residential Care placement. Each Just Checking system costs just under £800 per year to purchase and run.

An alternative package to a permanent care placement, following a Just Checking assessment might be:
3 daily calls at £12 an hour
7 days a week costing £252
2 days at day services approximately £25 a day
Total £302 (£148 a week notional saving over a £450 per week placement)

When multiplied by the 70% (13 of 21) of the total group then the impact could be hugely significant. The other 8 had their admission to registered care delayed by 8 weeks with associated savings. Mapping this experience into Cheshire East, of those 21 people the savings would be upwards of £100,000 per year after charging is taken into account. 21 assessments is a conservative estimate of what 2 Just Checking systems could do in a year. The following link provides a Local Gov TV presentation regarding this initiative: http://www.justchecking.co.uk/media/tv/staffordshire.asp

A number of local authorities (for example; Birmingham and Manchester City Councils) use the equipment systematically in their authorisation process; people who have been assessed as needing a permanent 24 hour placement are expected to have had a Just Checking assessment prior to requesting authorisation.

Support to regain abilities

Technology can enable people to regain control over aspects of life that they had lost. For example, with the support of a lifeline based bogus caller system, someone with reduced confidence or cognition can take charge of opening their front door, making their own decisions about who they let in. A video doorbell can give people with reduced mobility similar control over who they let into their home, rather than leaving the door on the latch or giving other people keys. Medication reminders and dispensers can give people back control over their own medication.

A review and evaluation of the use of medication dispensers undertaken by the University of Birmingham evidenced a number of positive outcomes associated with the use of dispensers, suggesting that the benefits are greatest for people with dementia. Based on data collected in Worcestershire, the review was able to forecast net savings of between £236 and £4,592 in care costs per service user. The work reports slightly less robust data for Sandwell, which gave a notional saving of £142,950 per year, based on 82 service users avoiding home care visits and care home admission. There are advanced meetings taking place with the Co-op Pharmacy chain to develop a robust medication dispenser service which is open to all customers of the council via social care assessment. A Cheshire East wide pilot scheme is currently proposed with a view to rolling out the service in 2011.

Ongoing support

People with a diagnosis of dementia can continue to live at home where the risk of them leaving the property without support has been identified, using memo minders (to remind them not to leave the house without support) or door sensors (to alert a nominated carer to respond). People at risk of falls can continue to choose to live alone, with risks being managed by sensors that will produce emergency alerts should someone fall.

Research from the University of Reading looked at the costs of substituting care with assistive technology for older people and found that this is a cost effective approach. Whilst the replacement of care with technology is controversial and has ethical aspects which need strong consideration based on individual circumstances, the research found that savings associated with this approach, “can often fund the provision of a maximum AT package that includes non-essential AT to enhance quality of life.” This indicates that genuine notional savings can be achieved using AT to support vulnerable people in Cheshire. Aberdeenshire’s (2008) evaluation (which was completed by Robert Gordon University) reported a 14 month saving of £301,600 on reduced use of home care, based on an investment of £172,263.46 (£85,198.46 equipment and installation & £97,065 project management costs).

Links with Supporting People funded Telecare Support

Cheshire East's Supporting People team is, in line with recent government policy, in the process of requesting the disaggregation of community alarm costs from its total allocation to housing providers. This will provide an opportunity in the future to link these connections with the provision of assistive technology in health and social care within Cheshire East. In the intervening time staff working on assistive technology will share information with Supporting People staff to ensure our strategies develop in tandem.

The assistive technology strategy has strong links with and is integral to a number of other strategies in Cheshire East:

Dementia Strategy – The project manager for assistive technology has been heavily involved in the development of the Dementia Strategy facilitated by CSED at the Department of Health. There are a number of strands of assistive technology that are particularly appropriate for people with a diagnosis of dementia.

Money has been secured to provide equipment for a demonstration lounge at the new dementia respite facility in Crewe. People with a diagnosis of dementia and their carers will be able to have a demonstration of the equipment as well as being able to try it out, the aim being to encourage them to use equipment in their own homes.

A recent development is that pager systems are now an option for carers supporting people in their own home. For example; a man with dementia who is at risk of falls due to disorientation at night time has a sensor alerting his carer who sleeps in the room next door that he is out of bed. This has enabled the carer to improve the amount and quality of their sleep as they do not have to have 'one eye open' in case the cared for person gets out of bed.

A lifestyle monitoring system is available for any customer where there are concerns about the levels of activity (particularly at night time) in their home. Care managers have online access to the charts produced and the result has often been that the vulnerable person is safe to remain in their own home and does therefore not need to move out into more expensive residential or nursing care.

Carers Strategy – a recent evaluation of the impact of telecare installations on carers in Scotland 'A Weight off my Mind', found that all the carers found that telecare had a positive effect on their lives in respect of their caring role and had even enabled some carers to remain in employment.
Within Cheshire East any customer living in the community can have telecare which is linked into a 24 hour, 365 day a year response service. This enables some carers to step back from their caring role in the knowledge that a

service is in place which will address any emergencies promptly (within 1 hour currently, this will shortly be reduced to within 45 minutes), day or night. When a customer is provided with a lifestyle monitoring system carers are generally given online access to the charts produced and the result has often been a reduction in their stress levels, with people being reassured that their family member or friend is safe and they are able to focus their visits on spending quality time with their loved one rather than needing to frequently check that they are ok.

Palliative Strategy – at present palliative social workers need to refer to the council to access assistive technology support for the people they are supporting. With suitable training and set protocols this process can be changed so that palliative social workers can have direct access to assistive technologies; reducing the workload for community teams and providing more responsive services to customers.

Learning Disability Strategy – Cheshire East has successfully introduced assistive technology into its own support services for people with learning disabilities and a number of individual support packages. Through an integrated approach to assessment and support planning Cheshire East has been able to support the outcomes an individual wishes to achieve through a combination of assistive technology and staff support, with an appropriate response to an alert, triggered by the technology, being a crucial aspect of measuring success. A proposal has been developed for a worker to support the further assistive technology developments in learning disability services, linking in to the current project team working on learning disability packages under Jacqui Evans.

Domestic Violence Strategy – there is potential for assistive technology to provide improved risk management for people supported through Cheshire East's Domestic Violence Strategy which is under discussion at present. This paper from the Journal of Assistive Technologies highlights some of the possibilities.

Falls Strategy – falls are a major issue for both health and social care services, which is increasing as demography of Cheshire east evolves. The number of people who are predicted to attend Accident and Emergency departments in Cheshire East as a result of a fall in the next 15 years is due to rise by 56% (POPPI data; www.dh.gov.uk). Assistive technology has a role in falls management and there are discussions taking place around targeting people with packages of assistive technology (falls detectors, bed sensors, and movement detectors) who are evaluated as being at risk of falls and associated complications through the Wilmslow Group, led by the PCT.

Children's Service & Transition Strategy – assistive technology is not currently used in children's services, and this group is missing out on some positive outcomes for people and commissioners of services. As children with disabilities come through transition the package handed over to adult services should be more cost effective if assistive technology has been introduced at an earlier stage.

Operational Assistive Technology Strategy

A strategy that systematically provides ready access to these (and other) technologies can bring benefits to service users, carers and local authority budget holders. Therefore RAS allocations and individual budgets need to take account of assistive technology, with strong efforts being made to assert the value of such technology to service users, carers and care managers/ brokers who can be initially sceptical.

There is a policy decision to be made if individual budgets are allocated based on the assessed use of assistive technology; should customers be allocated funds to buy the equipment themselves or should equipment be purchased for them separately, with a budget allocated alongside the provision of technology. The latter option may be most effective initially, given the lack of knowledge amongst many stakeholders, with a longer term aim of informing customers so that in the future they are able to purchase equipment from their allocations themselves.

The assessment for assistive technology is crucial in obtaining the best outcomes from the use of technology. Within older people's services care managers and occupational therapists have received some training on the specific telecare equipment (limited to one manufacturer) offered through the existing Cheshire Telecare contract and will refer service users to the housing trusts (who fit the equipment) with recommendations for equipment required. The housing trust workers then visit the service user (sometimes with the care manager) and assess them and their property with regard to the equipment available (for which Cheshire East pays them a fee). This can result in telecare existing alongside the care plan rather than as an integral part of it, people being assessed for equipment (by people with no specific social care training) rather than having their needs met and risks managed, and there is potential for over-provision as the payment structure for the housing trusts is based on how much equipment they fit.

In the learning disability service, before the reorganisation of Cheshire's local authorities, a project officer (who is a qualified social worker) assessed people, linking with the care manager, for assistive technology. The project officer had a broad range of equipment that he was able to draw on to offer bespoke solutions for individuals. Connections to call centres were arranged where necessary and connections could be set up to link to other phone numbers (e.g. mobile phones, pagers, etc). This style of approach has proved to be successful both in terms of benefits to people with learning disabilities and budget savings. A Department of Health evaluation of the work in learning disability services in Cheshire (which is about to be published) identified positive outcomes of this model, both in terms of outcomes for service users and savings. Annual revenue savings of £404,000 resulted from an annual investment of £100,800. The savings include cashable savings resulting from a review of current provision, although this level of cashable savings is not expected to continue once reviews have been completed.

Many other local authorities and PCTs (Cambridgeshire, Coventry, Norfolk, Leicester City, Leicestershire, Northamptonshire and Aberdeenshire) have a specific Assistive Technology Team which assesses and provides equipment to service users in the area. This approach encourages assessors to develop their knowledge of available technology in a rapidly changing marketplace as there is no need to provide a menu of equipment which the local authority is prepared to fund. Decisions can be made on a case by case basis, depending on the benefits to the user and cost effectiveness of the solution. This expertise is developed within the authority and can be spread to care managers through ongoing information and training, improving their practice and knowledge. Tighter control can be kept on the budget for assistive technology, and the costs and administration involved in paying outside agencies for this work is reduced. The assessors also have a responsibility to keep up to date with the rapidly evolving technology (and evidence associated with it) to ensure the best outcomes for service users and commissioners. This arrangement encourages innovation in a developing field, rather than setting limits to the technology that can be used by outside agencies.

Having workers within individual commissioning teams with a specific assistive technology focus may be more flexible and bring benefits when compared with the current arrangements. However, the long term aim should be to embed consideration of assistive technology into care managers' practice. Kent County Council have adopted this strategy, using project officers within care management teams to inform and develop practice around assistive technology, whilst maintaining the long term aim of care managers being able to effectively assess people with regard to assistive technology in the future. Internet access to the ADL Smartcare tool for care managers would also support this aim, bringing together preventative and active strategies to support vulnerable people.

The current situation where only a project and performance manager is in post, limits the impact that assistive technology can have. Additional staff will be able to cascade information and new technological developments to individual commissioning staff, take on assessments for technology with colleagues in provider services (including reablement) as well as in individual commissioning and develop links with colleagues outside Cheshire East (for example, health and the third sector).

The **potential annual costs** of this approach for the council would be:

1 FTE Project & Performance Manager	**£45,000**
2 FTE Assistive Technology assessors @ Grade 8 **(additional)**	**£73,000**
1 FTE Administrative Support @ grade 3 **(additional)**	**£18,000**
Training budget for AT	**£5,000**
Computer equipment to support assessment & programming	**£3,000**
5 Just Checking systems & web subscription	**£7,000**
100 medication dispensers	**£20,000**

Assistive technology equipment	**£100,000**
Preventative Strategy Total **(additional)**	**£28,000**
Total (of which **£119,000 is additional funding**)	**£299,000**

Potential revenue savings would be (total year 1 benefits accrued in year 2):

Just Checking use (based on Dept of Health Staffs evaluation data)	**£250,000**
Med Dispenser use(based on 100 service users saving £500 per person; conservative estimate based on University of Birmingham evaluation)	**£50,000**
Assistive technology equipment use in older people's services (based on £60,000 spent & Aberdeenshire evaluation data)	**£105,000**
Assistive technology equipment use in learning disability services (based on £40,000 spent & Cheshire's Dept of Health evaluation)	**£108,000**
Unknown potential value of a preventative approach (to be evaluated)	**£?**
TOTAL	**£513,000+**

Projecting these figures over a 5 year period and taking a conservative approximation that savings associated with older people will end, on average, after a full financial year, the **total spend will be £1,495,000** and the **savings realisation would be £3,700,000.**

Evaluation

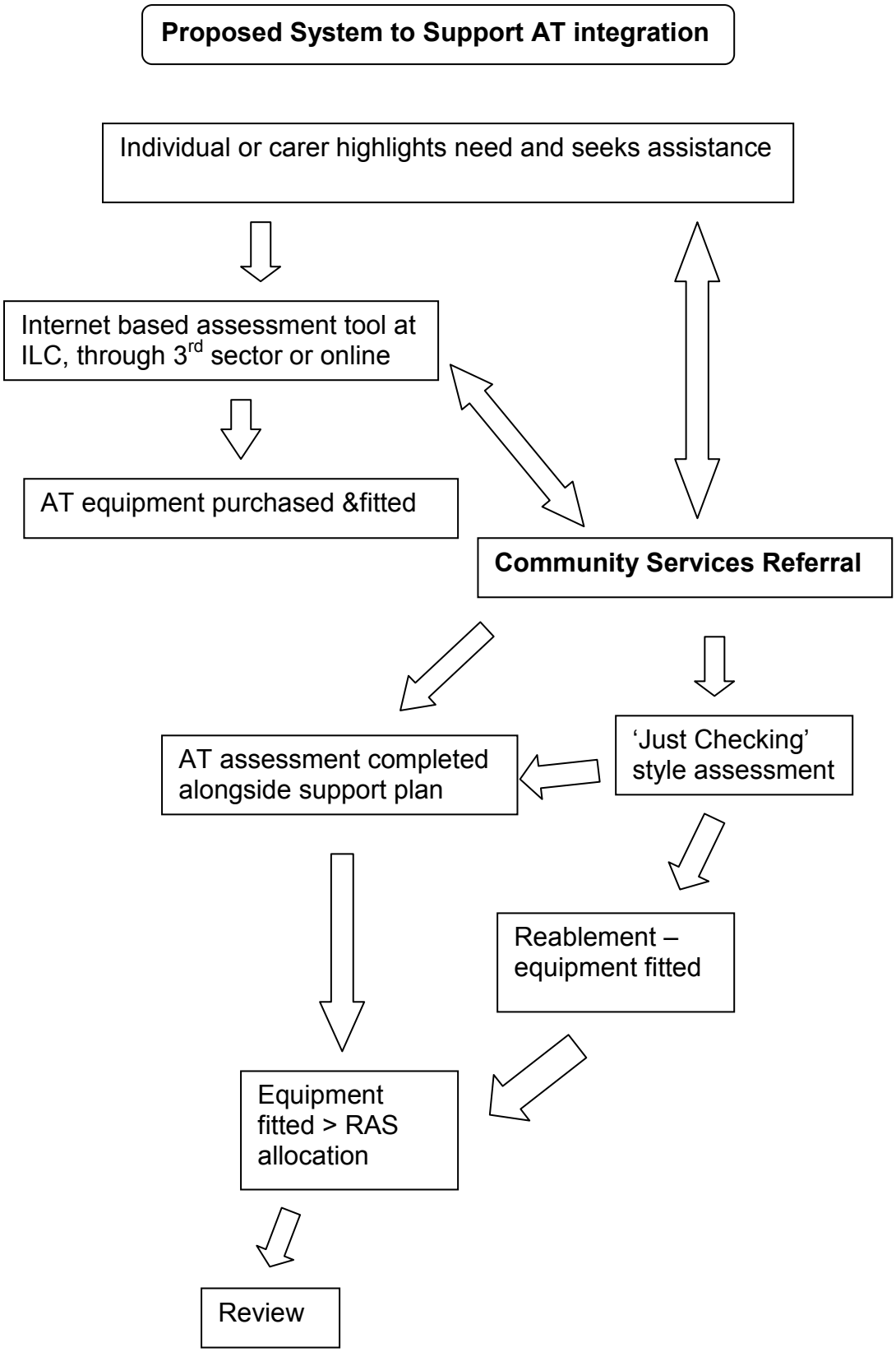
The evaluation of the impact that assistive technology has had within Cheshire East to date has been positive. The majority of carers surveyed in 2008 reported that they valued the service, felt that telecare had helped keep the person they were caring for at home for longer and believed that it provided independence. A number of case studies have been compiled which illustrate both the value to individuals in terms of independence and to the authority as a commissioner, in terms of money committed to support vulnerable people.

A more systematic approach to measuring the benefits has been adopted as part of the reablement evaluation. This system is currently being refined to take account of the financial impact of assistive technology only by using the resource allocation system as a base. Additionally, in the future referrers will be asked what the impact on the individual and the support package would be if assistive technology was not available. The aim of this work is to enable commissioners to put a value on technology in the context of support to inform future commissioning decisions. For example; Essex County Council believes that for every £1 they spend on telecare they save at least £3.82.

Telehealth

Telehealth is the delivery of health-related services and information via telecommunications technologies. Practically this involves patients having equipment in their home which they (or a carer) use to take readings (such as blood sugars, oxygen saturation and blood pressure) which are then transmitted via a phone line to a call centre. The call centre has preset acceptable parameters for each reading (arranged for individuals by their health professional) and will produce an alert when the readings fall outside of the preset limits. The nominated health professional (normally a community nurse) is then contacted and will make the appropriate intervention.

Kent County Council have invested heavily in Telehealth equipment and systems; they have taken the view that the investment benefits social care as well as health services – strong links between health and social care agencies was found to be essential and led to positive outcomes for both service users and commissioners. There were substantial savings for health; there was more than a 75% reduction in acute care costs over a 6 month period. There are three Whole System Demonstrator Projects funded through the Department of Health in Kent, Newham and Cornwall which will provide robust evidence on all the outcomes associated with the use of Telehealth technologies. The Department of Health is piloting individual health budgets I a number of sites across the country and this could in the future be compatible with local authority individual allocations and be spent jointly on services such as Telehealth. There have been small scale pilots to date in Cheshire (Chester and Vale Royal areas) which have been broadly positive and set the scene for what is possible given an ongoing commitment to Telehealth.


Proposed System to Support AT integration
Individual or carer highlights need and seeks assistance
Internet based assessment tool at ILC, through 3rd sector or online
AT equipment purchased &fitted
Community Services Referral
'Just Checking' style assessment
AT assessment completed alongside support plan
Reablement – equipment fitted
Equipment fitted > RAS allocation
Review

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How can assistive technology help me?

The aim of social care support for vulnerable people in Cheshire East is to help people be as independent as possible and help them remain in their own home for as long as possible.

These objectives can be compromised by a number of issues:

- **Difficulties in obtaining a true assessment of night time needs**; for example, where you perhaps have some memory problems and there are concerns about your safety as a result of confusion at night time. One option could be to organise a period of assessment at a community support centre; however, taking you out of your known environment may provide an artificial idea of how you would manage at home and may be unsettling for you. The lack of options available for a comprehensive assessment of your abilities in your home, can lead to risk adverse support decisions; for example an admission to permanent care.
- **Risk management concerns**; for example, if you have a level of confusion and have been mixing up prescribed medication, and may be at risk of under or overdosing, then a traditional response may be to arrange support calls to prompt you with your medication. This intervention takes away something that you may wish to do for yourself and makes you dependent on support. Whilst support calls will be arranged to fit in with your routine and needs, you would need to stay at home to wait for someone to visit to watch beginning you take your medication, limiting your choices.
- **Limited opportunities to promote greater independence;** where you may develop difficulty with certain tasks you may be reluctant to have someone else physically help you or wish that you did not need someone else to assist you for reasons of dignity. Just providing the traditional response of physical support to increasing need may make you less independent, reducing your control over your life.

Electronic assistive technology (which includes telecare) can play an important role in combating these issues and achieving the stated aims.

How can technology help?

<u>Reminding you about important things</u> - alerts can jog your memory about taking your medication at the right time and a dispenser can ensure that you take the right medication at the right time. Alerts can also be programmed with a familiar voice to ask for identification when you open the front door, remind you to visit the doctor or even to send a card for your niece's birthday. Certain clocks can make sure that you know whether it is daytime or night time so that you have a point of reference for what comes next in your daily routine.

Case Examples:

A man with dementia who needed to take a number of medications at different points throughout the day had support staff visit his home to prompt him to take his medication at the correct time. He was frustrated at having to wait for staff to be there when he was capable of taking his own tablets, so he switched to using a medication dispenser. This unit beeps and has a flashing light to indicate that medication needs to be taken and only the tablets that he is due to take are visible and available to him from the dispenser (alleviating any risk of overdosing). If he doesn't remove the tablets from the dispenser within 15 minutes of the allotted time a carer is notified and can respond if assistance is required. *He is much happier with this arrangement, with support workers calling only when he really needs them and values the greater independence the dispenser gives him*.

A woman with a diagnosis of dementia, living in sheltered accommodation was reported to be leaving her flat during the early hours of the morning (thinking it was daytime). A memo minder unit was placed next to her front door with a message from her daughter recorded on to it saying to her mother that she shouldn't go out as it is night time. When she opens the front door at night time the movement of the door triggers the voice recording. *This has been effective in encouraging her not to leave her flat during the night time without any need for emergency alerts or staff to respond. The alternative would have been for this lady to give up her flat and go into residential care which she (supported by her family) did not want to do.*

Products:

Pivotell Medication Dispenser

Tab time products

Mem-X

Memo Minder

Tunstall Lifeline Units

Day Night Clock

Staying safe in your own home – Your home can be fitted with items which will trigger an alert if there is smoke or a rapid rise in temperature detected (suggesting a fire in the home). Carbon monoxide or water on the floor which may indicate a flood can also be sensed automatically. Alerts can be set up so that someone is contacted immediately and can take action to help you, preventing more serious results. If you are concerned about answering the front door and worry about bogus callers a system can be set up so that by pressing a button someone can talk you through answering the door on a speaker phone, making sure that the person at the door is someone you can let in to your home. If you may be at risk should you leave your home without someone being with you, equipment can be installed to produce an alert if you leave the house, with staff available to guide you back to your home.

Case Examples:

A woman living on her own with a diagnosis of dementia had some telecare fitted to manage a number of identified risks in her home. She had a heat rise detector fitted in her kitchen, flood detectors in her bathroom and kitchen where she also had a heat rise detector. Two weeks after the equipment was installed there was an alert from her heat rise detector in the kitchen followed by an alert from the smoke detector. Staff at her local call centre received the alert and tried to speak to her via the loud speaker on her lifeline unit but received no reply. They contacted the fire service who attended and put out a fire in the kitchen which had started in the cooker. The woman herself had been distressed and confused by the incident and had stayed in the kitchen trying to stop the smoke alarm from beeping. She was rescued from her home uninjured with only cosmetic damage to her property. *Without the telecare fitted managing the risks to her health and safety she would have been assessed as needing to go into permanent care which she (supported by her family) were desperate to avoid.*

A young woman with a learning disability wanted to move out of her parents' property to live on her own but there were concerns about her safety in the house and she was not confident about opening the front door to people she didn't know. A telecare package was fitted which comprised a smoke alarm, carbon monoxide detector, flood sensor and a bogus caller button placed next to the front door. Every time the doorbell rang she pressed the bogus caller button and the call centre (who were aware of her situation and needs) talked her through asking for identification from people she didn't know and giving her the confidence to say no to people at the

door if she wanted to. She moved into a flat in 2008 and has been living there ever since with low key support and has grown in confidence when the doorbell rings so that she now only uses the button if she feels uncomfortable answering the door. *The telecare package enables her to live independently and provided confidence to both her and her parents to make it happen.*

Products:

Telecare smoke alarm

Telecare carbon monoxide detector

Telecare flood detector

Telecare temperature extremes sensor

Telecare bogus caller button

Helping you to be independent – If you have difficulty bending down to switch plug sockets on or off by using a remote control this can be done automatically, saving energy and reducing the likelihood of a fall. Lights that come on automatically when you approach them or when you get out of bed can help you see at night time, reducing the risk of a trip or fall as you look for your slippers or the main light. Sensors can be placed in the bath to make sure that the bath temperature is just right and so that the bath isn't overfilled. Hot water dispensing units mean that people can make a hot drink without having to fill and carry a kettle or pour boiling water, reducing the likelihood of an accident. Sensors can even be installed to ensure that continence needs can be managed during the night time.

Case Studies:

A man with a tremor and weakness to one side of his body had been assessed as unable to manage to make a cup of coffee for himself as he could not fill or carry a kettle and risked scalding himself whilst pouring the boiling water. The impact for him was that he was reliant on staff support visits for a hot drink which he found frustrating. Staff supporting him found a hot water dispenser in the Argos catalogue which dispensed a cup full of hot water at the touch of a button. *He is now able to make himself a hot drink as and when he likes as there is no pouring or tipping required. He is pleased with the dignity it gives him as he is not dependent on staff for this basic need.*

A man with an acquired brain injury was keen to return to independent living following a period of intensive rehabilitation. As a result of his injury he had some short term memory difficulties, was occasionally unsteady on his feet and was unable to gauge temperature. He was set up with a telecare to manage the risk of falls and medication reminders to ensure that he took his tablets at the right times during the day. Due to his balance problems he needed to have a bath rather than a shower so he was also provided with a bath level and temperature sensor. That meant he was able to bathe independently and managed the risks of him scalding himself whilst bathing. *The equipment provided meant that he was able to return home where he had a small amount of support rather than requiring assistance 24 hours per day. The independence he gained from his package of support is highly valued by him and has enabled him to regain some sense of control over his life.*

Movement sensitive lights

Tefal One Cup Hot Water Dispenser

Remote Control Plug Sockets

Telecare Continence Sensor

Making sure that help is there when you need it - If you have had a slip, trip or a fall at home previously or if this is a concern there are a number of ways that others can alerted automatically to a problem. For example, should you have a fall by pressing a pendant alarm someone of your choosing would be immediately notified, reassuring you though a speaker phone that help will be there quickly. Alternatively by wearing a fall detector an alert would be sent automatically if you were to fall and not get up within 5 seconds. Night time falls can be managed by a sensor placed under the mattress which will produce an alert if someone gets out of bed at night and doesn't return within a set time (which is up to the person themselves), indicating a problem. Falls that result in a fracture (which are less than 10% of all falls) are a significant predictor of admission in to permanent care (Tinetti, 1997) and mortality (Keene, 1993). Confidence is a big factor in the likelihood of a fall (Simpson et al, 1997) and by knowing that if a fall does happen someone will be there to assist the assurance that leads to confidence while walking will follow. Also by identifying more minor falls, the issues underlying why the person is falling (e.g. medication compliance, postural hypotension, etc) can be addressed. If someone has certain forms of epilepsy a sensor can be placed under the mattress to detect a seizure and alert someone to provide the appropriate support.

Case Examples:

A woman living on her own and receiving daily domiciliary support had reported having two night time falls in a short period of time. There was no obvious cause for these falls and support workers had also reported that she was reluctant to eat when they assisted her to prepare a meal at tea time. A reassessment led to consideration of whether this woman needed to move on to permanent care. The woman herself expressed her wish in the strongest terms to remain in her own home. She had a bed sensor placed under her mattress which produced an alert if she was out of bed for more than 15 minutes at night time which managed the risk of a night time fall. She also had a lifestyle monitoring system installed as part of the reassessment which showed that she was moving around in the kitchen half an hour before the daily support called to assist with her tea time meal. It became clear that she was able to prepare food for herself and was doing so before the support worker arrived. The reluctance to eat was not an indicator of a general increase in needs as had been assumed. *Three years later this woman is still living independently in her own home with support tailored to her needs.*

A young man with a diagnosis of epilepsy received 24 hour support due to the risk of a seizure at any point in the day. He found this support very frustrating, limiting and unnecessary, feeling that he had no privacy in his own home. He was provided with an epilepsy sensor to manage the risk of a seizure in bed, a bed sensor to manage the risk of a seizure when he got up at night time and a fall detector to wear during the day which would manage the risk of a daytime seizure. Appropriately skilled responders are available to support him within 30 seconds of any alert. *He no longer requires a support worker to be physically with him at all times and appreciates time on his own providing him with privacy and dignity.*

Products:

Tunstall pendant alarm

Tunstall Lifeline unit

Tunstall bed sensor

Tunstall fall detector

Emfit epilepsy sensor

Help you keep in touch with family and friends – If you find remembering or dialling telephone numbers difficult, phones are available with speed dial

buttons where photos can be shown. So by simply pressing the photo of a particular person on your phone you can dial their number. Some telephones can be configured to automatically answer calls from pre-programmed numbers via a speaker phone so that you never miss calls from friends and family. Calls can be answered by using a portable button which switches the telephone to loudspeaker mode, so you don't have to leave your chair to answer a call. Adaptors and specialist phones are available if you have a hearing impairment.

Products:

Picture phone

Easy Answer Desktop Mobile Phone

Doro HandleEasy 326gsm Mobile Phone

Ensure a full assessment of need – If you have a degree of confusion and are concerned that you are not coping in your own home, a lifestyle monitoring system can be temporarily be installed. This will produce a real time (with a 6 minute delay) chart of movement in each room of a property, providing a 24 hour representation of your activity to inform a 360 degree assessment of your needs.

Case examples:

A woman living on her own with a diagnosis of dementia had had a fall at home which resulted in a hospital admission. In hospital she had been disorientated and there were concerns expressed by her family and professionals about whether she would be able to return home. She expressed her wishes to return home and was provided with a telecare package including a fall detector, bed sensor and heat rise detector. She was also provided with a lifestyle monitoring system following a discussion about what it was and the information that it would provide that enabled her family and the care manager to view a chart of movements within her property over a 24 hour period. *The monitoring system indicated that she was active around the house as expected during the daytime and slept well at night, with no evidence of the disorientation that she experienced in hospital. She remains at home where she is settled and content.*

A man living on his own who had a diagnosis of Alzheimer's disease and had recently had to sell his car as a result of his increasing confusion. As his memory was poor he struggled to remember that he had sold the car and was often spotted

outside his house searching for his car, sometimes in the early hours of the morning. His family were very concerned and felt that it might be time for him to go into permanent care. As part of his support package and following a lengthy discussion about the technology he was provided with a memo minder which was placed next to his front door which activated a message from his daughter reminding him that the car had been sold and suggesting that he stay inside when it is night time. He was also provided with a lifestyle monitoring system which enabled his family and care manager to look at activity in the house over a 24 hour period. *The monitoring system showed that he was no longer leaving the house in the early hours of the morning and that he was reasonably active during the day. He remained in his own property and his family who all lived at least 2 hours drive from his house purchased their own monitoring system as they had valued the reassurance provided by being able to look at the activity in the house regularly.*

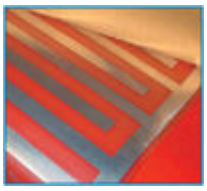
Products:

Just Checking lifestyle monitoring system

TELECARE SENSORS (from Tunstall Telehealthcare; please note hyperlinks will direct to their website)

Personal health and well-being

Bed/Chair Occupancy Sensor - provides an early warning by alerting that the user has left their bed or chair and not returned within a preset time period, indicating a potential fall. The sensor can also be programmed to switch on lights, helping people find their way to and from bed easily.



Enuresis Sensor - Placed between the mattress and sheet, this sensor provides immediate warning on detection of moisture, allowing effective action to be taken. The sensor eliminates the need for carers to make physical checks, promoting dignity and independence.

Epilepsy Sensor - This state of the art sensor monitors the user's vital signs including heart rate and breathing patterns to detect a range of epileptic seizures. The sensor eliminates the need for carers to make physical checks, promoting independence and dignity.

Fall Detector - 8,000 older people fall every day in the UK. Tunstall's fall detector can provide valuable peace of mind by automatically detecting a serious fall and raising an alert to the monitoring centre or designated carer.

Medication Dispenser - Provides an effective solution to support medication compliance by automatically dispensing medication and providing audible and visual alerts to the user each time medication should be taken. If the user fails to access the medication, an alert is raised to the monitoring centre or designated carer.

Reminder messages - The reminder functionality of the Lifeline Connect+ informs the user about key information, for example a family member can record a message to remind the user to take a their medication at a particular time. If the user hasn't confirmed receipt of the message, an alert will be raised with the monitoring centre, who can proactively call the user to check everything is alright.

Fast PIR (Movement Detector) - A wireless movement detector that has been enhanced to enable its use the new features of the Lifeline Connect+, including Virtual Sensors and ADLife. It can also be used as part of an intruder alarm and for both activity and inactivity monitoring.

PIR (Movement Detector) - A wireless movement detector that can be used for both activity and inactivity monitoring, for example, to check if a person has got out of bed or visited the kitchen.

Pressure Mat - Monitors movement in a specific area, for example to monitor if someone has got of bed or left the house.

Property Exit Sensor - As 40% of people with dementia are prone to walking about, this sensor specifically monitors for people leaving a building at unusual times of day or night. It can also detect if a main exit door has been left open and can be linked to external lighting to provide added protection.

Pull Cord (Radio) - To raise alerts in areas where personal triggers are unlikely to be worn e.g. positioned next to the bed. A wired version is also available.

Radio Frequency Identification (RFID) Buttons - Providing dignity in care for laundry management.

Minuet Watch - This has been developed to help encourage telecare users to wear their personal triggers throughout the day. By combining an alarm button with a high quality watch, users are more likely to wear it and as a result will be provided with additional protection as their ability to raise an alarm is increased.

Personal Trigger (Radio) - Amie & Gem - Worn round the neck, on the wrist or attached to an item of clothing, personal triggers enable a call for help to be raised anywhere in the home or garden. Both operate on the 173MHz frequency.

Personal Trigger (Radio) - Amie+ & Gem+ - Enhanced to operate on the 869MHz dedicated social alarm frequency, enabling maximum reliability. Click here to view the wearing options and easy press adaptors for the Amie+ and Gem+.

Environmental monitoring

Carbon Monoxide Detector (wireless) - Warns of dangerous CO levels which otherwise could go undetected, providing unrivalled levels of accuracy and reliability.

Flood Detector - Provides an early warning of flood situations, such as taps being left on.

Gas Shut Off Valve - When combined with the natural gas detector, this solution automatically cuts off the gas supply to an appliance when a leak is detected.

Natural Gas Detector - Provides an early warning of dangerous levels of gas. Can be linked to the Gas Shut Off Valve to automatically cut the gas supply off, if a leak is detected.

Smoke Detector (wireless) - Enhanced with new features such as auto low battery reporting, only one battery for ease of management and accreditation to the very latest standard for smoke detectors.

Heat Detector - The wireless Heat Detector provides additional protection against the risk of fires in rooms where smoke detectors are unsuitable e.g. kitchen.

Temperature Extremes Sensor - Monitors for low and high temperature extremes in addition to rate of rise of temperature. Helps minimise the risks associated with changes in temperature including the build up of heat in a kitchen and the risk of sustained periods of cold weather.

X-10 Controllers - Can be used in conjunction with the Bed/Chair Occupancy and Property Exit Sensors in order to switch on lights when a sensor is activated.

Safety and security

Bogus Caller Button - Fixed near the door, this button will provide reassurance in the event of an unexpected caller.

Arm/Disarm Trigger - Allows users to protect their property by arming the intruder functionality on vacating their dwelling, and then disarming it in the same way as they re-enter.

Zoning Button - Allows users of intruder alarm functionality to zone the downstairs of their property e.g. at night. This means that users will not need to 'beat' the zoning delay time before the system arms therefore users can take as much time as required to walk up the stairs without needing to panic.

Sensory impairments

DDA Solution - Tunstall's DDA Solution combines a pager, transmitter, under pillow pad and optional flashing beacon to provide visually impaired people with additional support and protection by ensuring they are immediately alerted when an alarm is raised.

DDA Vibrating pager - When a telecare sensor is activated, the Lifeline sends a signal to the DDA transmitter, which alerts the wearer by vibrating an LED.

DDA Pager charger including pillow alert - The DDA pager charger is required to charge the pager. The cradle also links to a vibrating under pillow alert and when the pager is in the cradle, it automatically vibrates when an alarm is raised.

DDA Flashing beacon - The beacon works with the pager and flashes to indicate when a telecare alarm has been raised