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Health and Adult Social Care Scrutiny Committee

Agenda

Date:	**Thursday, 10th March, 2011**
Time:	**9.30 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 statement to be made 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 - 8)

To approve the minutes of the meeting held on 6 January 2011.

5. **North West Ambulance Service** (Pages 9 - 18)

To consider a presentation by Sarah Byrom and Dave Kitchin of the North West Ambulance Service on:

- Response times in Cheshire East;
- Foundation Trust application;
- Serious and untoward incidents.

A summary document on the Foundation Trust application is attached for reference.

6. **Adult Services Charging Policy Review** (Pages 19 - 62)

At the last meeting of the Committee, Members considered a report on a review of the adult services charging policy. The Committee resolved that they receive a report back on the outcomes of the consultation and the attached report to Cabinet gives the outcomes and recommendations.

7. **Adult Services Transport** (Pages 63 - 106)

At the last meeting of the Committee, Members considered a report on a review of adult services transport. The Committee resolved that they receive a report back on the outcomes of the consultation and the attached report to Cabinet gives the outcomes and recommendations.

8. **Rationalisation and Temporary Closure of Buildings in Adult Services** (Pages 107 - 110)

To consider a report of the Director of Adults, Community, Health and Wellbeing

9. **Government proposals for "Local Accounts"** (Pages 111 - 118)

To consider a report of the Performance, Standards and Information Manager.

10. **Public Health White Papers: Council's response to consultation** (Pages 119 - 146)

To consider the report of the Chief Executive

11. **The Cheshire and Wirral Councils Joint Scrutiny Committee** (Pages 147 - 160)

To receive the minutes of the meetings of the Joint Scrutiny Committee held on 11 October 2010 and 10 January 2011.

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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, 6th January, 2011 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor B Silvester (Chairman)
Councillor C Beard (Vice-Chairman)

Councillors C Andrew, G Baxendale, S Bentley, D Flude, S Furlong, S Jones, M Lloyd, A Moran, A Thwaite and C Tomlinson

Apologies

Councillors D Bebbington and W Livesley

81 **ALSO PRESENT**

Councillor R Domleo, Portfolio Holder for Adult Services
Councillor O Hunter, Cabinet Support Member for Adult and Health Services

82 **OFFICERS PRESENT**

Fiona Field, Central and Eastern Cheshire Primary Care Trust
Mike O'Regan, Central and Eastern Cheshire Primary Care Trust
Lucia Scally, Adults, Community, Health and Wellbeing Department
Jill Greenwood, Adults, Community, Health and Wellbeing Department
Allison McCudden, Adults, Community, Health and Wellbeing Department
Urvashi Bramwell, Policy and Performance Team
Mike Flynn, Scrutiny Team
Ross Paterson, Scrutiny Team

83 **DECLARATION OF INTERESTS/PARTY WHIP**

RESOLVED: That the following declarations of interest be noted:

- Councillor D Flude – personal interest as a Member of the Alzheimer's Society and Cheshire Independent Advocacy.
- Councillor S Jones – personal interest as a Member of the Alzheimer's Society.

84 **FORWARD PLAN**

This item was withdrawn.

85 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no members of the public present who wished to speak.

86 **MINUTES OF PREVIOUS MEETING**

RESOLVED: That the minutes of the meeting of the Committee held on 11 November 21010 be confirmed as a correct record.

87 **ADMIRAL NURSES**

Members received a presentation by Ted McGuiness from Dementia UK, on the role of Admiral Nurses.

Admiral Nurses are specialised mental health nurses who work with the carers of people with Dementia. They work within an integrated nursing role which involves the carers and the families of people suffering from dementia, and they provide education, training, practical advice and emotional support amongst many other services to the families and carers.

Admiral Nurses works in partnership with NHS Trusts and Dementia UK. They work using a best practice model to ensure high quality support and services for carers and people with dementia. All of their nurses are highly trained and receive continuous training and development in partnership with Dementia UK.

After consideration of the presentation the following points were raised:

- How the organisation was funded, and whether there were opportunities for Admiral Nurses to work with other agencies. It was explained that the organisation is funded by sponsorships, and their structure is similar to that of the Macmillan Cancer Trust, in that their nurses are NHS or Social Care staff who are also supported by the charity.

- Further clarification was sought on the costs to patients and carers, and also whether the trained Admiral mental health nurses were able to get access to development opportunities. It was confirmed that are no costs for the patient or carer, and Admiral Nurses do have development opportunities within their academy, with Dementia UK providing most of the training in this area.

- Whether nurses would be trained initially as a mental health nurse, following which they could apply through the appropriate channels such as through the NHS and partnerships to become Admiral Nurses.

- Whether the PCT and the Council should consider a pilot scheme to examine the impact of Admiral Nursing availability in the area.

- Councillor Flude undertook to raise the possibilities at the Cheshire and Wirral Council's Joint Scrutiny Committee.

RESOLVED: That

1. Ted McGuiness be thanked for a most interesting presentation;

2. The possibility of setting up a pilot scheme for Admiral Nursing in the Cheshire East area be investigated with Central and Eastern Cheshire Primary Care Trust and a further report be made to this committee in due course.

88 **DR FOSTER HOSPITAL GUIDE - MORTALITY RATES**

The Committee was advised that the Dr Foster report for the period April 2009 – March 2010 published in November had highlighted that Mid Cheshire Hospitals NHS Foundation Trust had a higher than expected Hospital Standardised Mortality Ration (HSMR) for the year. Although the Committee had considered a report on the previous year's performance, Members felt that further information on the latest findings by Dr Foster should be provided. This was supported by the PCT, and it was hoped that representatives from the Hospital would be able to attend the next meeting.

RESOLVED: That a report and explanation concerning the Dr Foster data on the Hospital Standardised Mortality Rate (HSMR) be provided by Mid Cheshire Hospital foundation Trust at the next meeting.

89 **THE WILLOWS DAY CARE - UPDATE**

Mike O'Regan explained that a level 2 consultation was undertaken in November and the conclusion was that the Willow Day Care Centre in Macclesfield should be closed. Officers reassured the committee that everyone at this centre will be assessed and cared for despite its closure.

After consideration of the update provided to the Committee, the following points were raised:

- That despite the issues going to consultation, people were concerned that the closure is going to happen anyway and this may raise false hopes for the public.

- Removing the "social" aspect of care for people with mental health problems and moving towards more personalised care may lead to people becoming isolated.

- Relating to the movement of social care to more personalised care, Mike O'Regan explained that for some people a social environment is very useful and rewarding. However for others, this environment can become too comfortable and prevent people from progressing and moving on. He gave assurances that this would be done with as limited upheaval to people as possible.

- It was encouraging that the various service providers were now cooperating and working together to address these complex issues.

- The extent to which there was scope for the Voluntary Sector to offer support and services particularly with regard to the social care dimension. However the potential risks of people falling through the net due to the complexity of mental health issues was noted, and provision must be made to guarantee that the voluntary sector which is increasingly taking up these services is properly regulated.

- That care is only successful if provided by trained professionals and concerns that reliance on the voluntary sector required careful planning and preparation, and the necessary professional input.

RESOLVED: That the Report be received.

90 **PROPOSED CHANGES TO MENTAL HEALTH SERVICES IN CENTRAL AND EASTERN CHESHIRE - RISELEY STREET LEARNING DISABILITIES HEALTH RESPITE SERVICE, MACCLESFIELD**

Background information on this issue was provided to the committee by Mike O'Regan and Fiona Field. It was explained that a level 2 consultation had been carried out in November, in which some issues have been raised with regards to the Respite Centre in Winsford, which had been flooded.

Currently there was a proposal to close the facility at Primrose Avenue. The proposal was made as the three sites that were operating were running at around 40-45% occupancy. After consultation with legal advisors the decision was made to have a further 4 week consultation on the proposed closures at both Riseley Street and Primrose Avenue.

A change of wording in the report was noted by committee as it should have read; “discussed” rather than “accepted in principle” on page 12 of the Agenda.

The committee was asked to note the reasons for the further consultation on the proposals, which once completed will be taken back to the CECPCT Board for consideration.

After consideration of the issues, the following points were raised:

- Whether Cheshire West and Chester Council had commented on the proposals, given that service users from their area were also affected. It was understood that the relevant Overview and Scrutiny Committee would consider the issues at a meeting in the next week.

- It was explained that work was being carried out to ensure the best possible outcome and that there would be the capacity within the system for everyone who currently requires care, however the level of future referrals was expected to be low.

- Primrose Avenue is viewed as not being fit for purpose and would have been closed as originally planned if it were not kept open as a necessity due to the flood at Crook Lane that prevented its closure.

RESOLVED: That the Report be received and the position with regard to further consultations noted.

91 **ADULT SERVICES - CHARGING AND TRANSPORT CONSULTATIONS**

The Committee received a presentation by Allison McCudden on two Adult Services’ consultations currently taking place on Charging and Transport.

It was stated that this review will address inequality between people who pay their full contribution toward a Direct Payment and those who have services purchased for them by the council at subsidised prices.

The presentation outlined the major proposals of the review and explained the planned charging mechanisms, whilst giving charging case examples

in the form of a table, to emphasise how people in varying circumstances would pay for their care.

Committee was informed that the consultation runs from 2nd November 2010 and had been extended until 31 January 2011. Cabinet will meet in February 2011 to discuss the outcomes, with any changes likely to be implemented in April with more possibly phased in over the year.

After consideration of the presentation, the following points were raised:

- Concerns over the closing down of information centres at bus stations, which would deter people from moving around independently, without the necessary advice and information services.

- That the current "dial a ride" system is working extremely well and should be supported. Clarification was sought over what will replace the Integrated Transport System when it ceases in March.

- Officers should ensure that the press and public are made fully aware that there is an extension of the consultation period until the end of January, and that other suitable venues, perhaps more centrally located in Cheshire East should be explored, with Sandbach being suggested due to its good transport links.

- The extent to which there would be competitive pricing, and also that the reduced bus service to Leighton Hospital could create difficulties for members of the public accessing the hospital.

RESOLVED: That the Report be received and a further report be made in due course on the outcome of the public consultations.

92 **CARE QUALITY COMMISSION - ASSESSMENT OF ADULT SOCIAL CARE**

The committee was invited to consider the report to Cabinet on 18 January on the Care Quality Commission's assessment of adult social care services in Cheshire East covering the period April 2009 to March 2010. This would be the last report by CQC in this format, as assessments were moving to a more outcomes and improvement focus in the future. The Government had published an "Outcomes Framework" last November as the basis for the new approach.

Lucia Scally reported to committee on the main outcomes, which scored the Council positively as "performing well" across the seven areas covered by the assessment.

After consideration of the report the following points were raised:

- Concern over problems in dealing with mental health referrals, only half of which were completed. This was partly due to incompatibilities between the Council's PARIS and the ICT systems operated by mental health services, and assurances were needed that this will improve.

- The Report from the Care Quality Commission commented very favourably on the Council's key strengths, particularly in areas of safeguarding dignity and respect and that the section entitled "areas for improvement" set out clearly the main issues which the Council and it's Partners would have to address in the following year.

- That there needs to be improvement in the way services are integrated across authorities, especially in relation to information and communication.

- In terms of "Areas for Improvement" it would be beneficial if the committee could have future reports on progress. Members also felt that a development event on this subject would be beneficial.

RESOLVED: That the Report be received, and a further Report be made in due course on progress with the areas for improvement and the new outcomes framework.

93 **PUBLIC HEALTH WHITE PAPER**

Urvashi Bramwell explained that the White Paper, together with associated consultations on Public Health Outcomes, Funding and Commissioning would be considered in detail at the Member Development event arranged for 28 January.

The deadlines for responses were 8 March for the Public Health White Paper, and 31 March for the associated consultations. The views of the Scrutiny Members on the issues would be included in the Council's response, to be considered following the Member development event at the Midpoint meeting on 10 February.

RESOLVED: That the Report be received.

The meeting commenced at 10.00 am and concluded at 12.23 pm

Councillor B Silvester (Chairman)

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North West Ambulance Service NHS
NHS Trust

your lifeline to health care

Delivering the right care, at the right time, in the right place

North West Ambulance Service
Summary Consultation Document

Seeking your views on our plans for becoming an NHS Foundation Trust

Consultation Period
10 January 2011 - 1 April 2011

Introduction

North West Ambulance Service NHS Trust is applying to become an NHS Foundation Trust. We believe that over time this will bring real benefits to patients, staff and the public we serve. The Government White Paper 'Equality and Excellence: Liberating the NHS' published in July 2010 outlines the commitment for all NHS Trusts to become Foundation Trusts.

We believe that becoming a Foundation Trust will give us the right platform to deliver our future vision of ambulance services in the North West, building on our excellent service delivery and quality of care. We feel that providing our communities and partners with the opportunity to be more involved in shaping the future of our services, is key to our success.

About the North West Ambulance Service

The North West Ambulance Service (NWAS) is the largest ambulance service in the country providing 24 hour, 365 days a year accident and emergency services to those in need of emergency medical treatment and transport. Our highly skilled staff provide life-saving care to patients in the community and take people to hospital or a place of care if needed. We also provide non-emergency patient transport services for those who require transport to and from hospital and are unable to travel unaided because of their medical condition or clinical need.

Alongside the other emergency services we also work to ensure the safety of the public and treatment of patients in the event of a major incident. We also play an important role in advising patients and the public about staying safe and healthy.

Did you know?

- The North West Ambulance Service was established on 1st July 2006, by the merger of ambulance trusts from Greater Manchester, Cheshire and Merseyside, Cumbria and Lancashire
- We currently employ over 5,100 staff
- The Trust Headquarters is in Bolton, and there are four main Area offices in Liverpool, Carlisle, Broughton and Bury
- There are 114 ambulance stations distributed across the region and three 999 Control Centres
- We receive around one million emergency calls, and carry out three million patient journeys per year, including over two million non-urgent patient transport journeys for patients travelling to hospitals and healthcare centres for treatment
- Our annual expenditure budget in 2009/10 was £240 million, of which 70% was invested in our staff
- 2009/10 saw the delivery of a major workforce expansion programme involving the recruitment of 300 people and the further training of an additional 270 frontline staff
- In 2009/10, we received 440 letters of thanks from patients, relatives and friends, as well as businesses, hospitals, clubs and employers
- The Trust has over 1500 community first responders, who are local community volunteers who work with the Service to provide immediate life saving care to patients whilst an ambulance is on the way
- The Trust has 450 volunteer car drivers who play a key role in helping us take patients to and from their hospital appointments
- We have set up 402 public defibrillator sites to assist victims of heart attacks and since April 2010 we have trained over 1250 members of the public in basic life support
- The Trust has a Bronze Investors in People award demonstrating our commitment to staff

What is a Foundation Trust?

Foundation Trusts are still part of the NHS and subject to NHS standards, performance ratings and systems of inspection. They operate according to NHS principles – free care, based on need and not ability to pay. The difference with a Foundation Trust is that it is run locally, with local people as members, having a say in how they wish their services to be developed.

Foundation Trusts enable local people to become involved in the democratic process of influencing how their health services are shaped in the future. The Trust invites local people to become members and who then elect representatives to serve on a Council of Governors. The Trust is held to account by the Council of Governors for its performance and the Council will work with the Board of Directors to influence how services are developed and provided in the future.

An organisation called 'Monitor' authorises and regulates Foundation Trusts. Monitor is an independent official body which supervises NHS Foundation Trusts on behalf of the Government to make sure they operate in the public interest. Trusts must meet a set of very rigorous standards before Monitor decides whether or not to approve them as a Foundation Trust. Trusts have to demonstrate, for example, that the organisation is well run, that their finances are in order and that they have sustainable service plans that meet local needs.

Why do we want to become a Foundation Trust?

At a time of great economic challenge, the need to ensure we use public sector resources effectively is paramount.

We believe becoming a Foundation Trust will give us the very best opportunity to deliver our future vision to provide a high quality clinical service which meets the needs of our patients and the public across the North West, whilst making the very best use of our resources.

The financial stability which comes with Foundation Trust status will enable more effective longer term planning and investment to really make our plans happen.

Local accountability will mean we are making and delivering our plans in true partnership with you – our stakeholders.

What do we think are the main benefits to NWAS and its users?

Freedom to design services that meet community needs: NHS Foundation Trusts have more freedom from central Government control to work with communities to design services to meet their needs.

Greater financial freedoms: New financial freedoms will allow us to keep any surplus funds to invest in better facilities and services for patients.

Much more involvement for staff and the public to have their say in developing services: Members will have a real opportunity to participate and influence our ambulance service.

The opportunity to have a voice as a Governor of the organisation. Members will be able to stand for election as a Governor of the NHS Foundation Trust. Governors will appoint the Chair and Non-Executive Directors of the Trust. They will have a bigger say in how the ambulance service is run.

Support for staff and improvement to their working lives: Staff will benefit from better access to training and development opportunities through longer term investment. Staff, as both members and governors, will also have a greater influence on decision making and the future planning of services.

Strengthening local partnerships: More opportunities to work in closer partnership with other organisations and communities to provide joined up services for patients and the public across health and social care.

Our Vision and Values

Vision: We will deliver a high quality service to patients ensuring we deliver the right care, at the right time and in the right place.

Our Aims

Quality of Care – Effective, Safe, Clean and Caring

Communities – In partnership with our communities

Infrastructure – Delivering today, developing for the future

Best Value – Efficient, innovative and productive

Staff – A fully engaged workforce working together for patients and communities

Corporate objectives are developed for each of the strategic aims which enables us to measure progress. The strategic aims also reflect the organisational values which are outlined next.

Our Values

The values we commit to are:

- Patient focus
- Honesty
- Respect
- Listening
- Professionalism
- Confidentiality
- Fairness
- Learning
- Challenge
- Collective Responsibility
- Self awareness

Our Plans for the Future

Building on our achievements, the Trust has developed its future plans for the next five years to achieve the vision and strategic aims, and to support the delivery of the 'right care, at the right time and in the right place'.

The key work programmes within the plans are as follows:-

- Modernising the Emergency Service, to ensure high quality and efficient delivery which meets the needs of our communities and achieves performance standards set nationally and agreed with our commissioners.
- Modernising the Patient Transport Service, to ensure high quality and efficient services which meet patients' needs and performance standards agreed locally with our commissioners.
- Developing further the role of NWAS as a key partner and service provider in an integrated emergency and urgent care system across the North West.
- Developing even stronger plans to meet our responsibilities under the Civil Contingencies Act (2004) for when a major emergency occurs.

We will make sure our patients receive the **RIGHT CARE** by:

Ensuring that our staff have the right set of skills to treat the different conditions and illnesses of our patients, from A&E support staff to Advanced Paramedics.

Having the confidence that our patients have the best possible outcomes by improving the way we monitor patient care and treatment.

Making sure that our ambulances are thoroughly clean and our staff have the highest levels of hygiene when caring for patients.

Giving staff access to electronic patient information to support the treatment of patients, and to ensure the safe and effective handover of patients to other health services.

Tailoring the care we provide to be sensitive to a patient's individual needs whether these are health, social or cultural needs.

Improving our patient transport services to ensure that they meet the medical needs of our patients.

We will make sure we deliver care at the **RIGHT TIME** by:

Improving even further our call prioritisation to ensure our response times reflect more accurately the patient's clinical needs.

Making the best use of our valuable resources (staff, vehicles, buildings) to achieve our response times and deliver more equitable access to communities across the varied geography of the North West.

Improving the timeliness and flexibility of our patient transport services for patients attending hospital appointments.

We will make sure our patients receive care in the **RIGHT PLACE** by:

Putting in place systems so we know how busy hospitals are and where best to take patients, ensuring they are seen in the best place for their needs as quickly as possible.

Treating more patients in their home when this is appropriate and safe to do so, avoiding unnecessary trips to accident and emergency departments.

Taking more patients to specialist treatment centres for treatment such as stroke, head injuries or heart conditions.

Ensuring patients have timely access to safe transport between places of care.

How we will be run

Each NHS Foundation Trust needs to establish its governance arrangements – a system of running the organization, to ensure it is fully accountable to its members. Current legislation requires all NHS Foundation Trusts to have Members, a Council of Governors (with a majority of Governors elected by the public members) and a Board of Directors.

We see membership as providing an exciting opportunity to engage with and involve our local communities. As a Foundation Trust we will engage positively with our members and governors to seek their feedback and views on future priorities and developments. Our members will be formed from our staff, the public we serve and the volunteers who support us from across the whole North West region. Through our Council of Governors we will aim to build and sustain a wide consensus about the services we provide and our future direction

Members

Members will be able to:

- Have a say
- Help raise awareness of ambulance services across the North West
- Represent the views and needs of the local community
- Vote in the election for the Council of Governors
- Stand for election to the Council of Governors
- Influence proposed changes to services and future plans for development
- Be a volunteer

It will be up to individual members to determine the level of involvement they wish to have. This might include:

- Simply opting to receive information and vote for Governors
- Participating in discussion groups, surveys and consultation events
- Seeking election as a Governor

There will be two categories of members – public and staff. An individual can only belong to one category. Every member will be eligible to elect representatives to our Council of Governors.

Public Constituency

Members of the public who live in the North West can become a member of the Trust. We are proposing that our public membership will be open to anyone aged 16 or over.

We want to try and ensure we have public members representing the diversity and geography of the North West and aim to attract at least 5,000 people by September 2011.

To reflect the key role that volunteers play in the delivery of our services, we are proposing that a class within our public constituency will be dedicated to our volunteers, ie Community First Responders, Volunteer Car Drivers. This will mean that the Trust will have an overall public membership with a volunteer group within it.

Council of Governors

The Council of Governors represents the interests and views of the membership, including local people, staff and partner organisations. It will have important responsibilities including the appointment and removal of the Chairman. Staff and Public Governors are elected from the membership.

Public Governors

We propose that we will have 20 elected public Governors.

The public constituencies reflect the electoral boundaries of the counties and will be divided as follows:

- Cheshire
- Cumbria
- Greater Manchester
- Lancashire
- Merseyside

Each County will have four Public Governors, one of which will represent volunteers. This will mean of the 20 Public Governors, five will represent the volunteers.

Staff Governors

The staff constituency is divided into four classes with each class generating a number of staff governors as follows:

- State Registered Paramedics, Qualified Ambulance Technicians and Trainee Paramedics – 4 staff governors
- Patient Transport Service and High Dependency Service Staff (including managers) – 3 staff governors
- Emergency Control Centre Staff (including managers) – 2 staff governors
- Support staff and managers not included in one of the above categories – 2 staff governors

Appointed Governors

We propose to offer one seat on our Council of Governors to each of the following partner organisations.

- Commissioner organisations (this is a legal requirement)
- Local Authorities nomination to be invited from the North West region of the Society of Local Authority Chief Executives (SOLACE) (this is a legal requirement)
- Institutes of Higher Education, nomination to be invited from the Institutes awarded contract for delivery of paramedic diploma
- St John Ambulance
- The British Heart Foundation

Board of Directors

The Board of Directors will be responsible for the strategic and day to day management of the Trust. It is proposed the Board of Directors will comprise:

- Six Non-Executive Directors (including the Chairman)
- Five Executive Directors

The Executive Directors will include the Chief Executive, Director of Finance, a registered medical practitioner and a registered nurse or midwife.

What happens next?

Have Your Say, we want to hear your views on our plans. We will need your comments back by 1 April 2011.

There are different ways in which you can have your say:

Complete our feedback form
Fill in the questionnaire on page 11 of this document and send it to the following address:

FREEPOST RSLG-RBSA-YGJE
North West Ambulance Service NHS Trust
Ladybridge Hall Education & Training Centre
399 Chorley New Road
Bolton
BL1 5DD

By letter
If you would like to provide more detailed views and comments then we welcome these in writing to the address above.

By email
communications@nwas.nhs.uk

By telephone
0845 112 0 999

In person
We will be holding consultation events across the North West. These will be advertised locally and are on our website at www.nwas.nhs.uk

Invite us to your meetings
We welcome invitations to attend local meetings to discuss these proposals. If you would like to invite a representative from the Trust to come to your meeting please contact:

Sarah Smith
Assistant Director Corporate Communications
Sarah.smith@nwas.nhs.uk
01204 498400

The consultation document and this summary document are being widely distributed across the North West and will be made available for local people, our staff, local authorities including Health Overview and Scrutiny Committees, Local Involvement Networks, Primary Care Trusts, NHS Trust, Emergency Services, Voluntary and Community Groups. Further copies of the documents are available on our website or via communications@nwas.nhs.uk

Become a Member

We want as many people as possible across the North West to become one of our members. Membership is free, and it is easy to join. Simply complete the attached membership form and return it by freepost FREEPOST RSLG-RBSA-YGJE, North West Ambulance Service NHS Trust, Ladybridge Hall Education & Training Centre, 399 Chorley New Road, Bolton BL1 5DD, contact membership@nwas.nhs.uk or visit our website at www.nwas.nhs.uk

Next Steps

- All comments must be received no later than 1 April 2011. Any comments received after this date cannot be considered as part of this consultation.
- The Trust will consider all comments received.
- After the end of consultation we will produce a report setting out the comments that have been received and how these will influence our plans to become an NHS Foundation Trust.
- This report will be published on our website (www.nwas.nhs.uk) and will also be available on request from June 2011.

Timetable

Our proposed timetable is as follows:

1 April 2011	End of Consultation
June 2011	Publication of consultation feedback
October 2011	Secretary of State for Health approves application and commends it to the Independent Regulator (Monitor)
November 2011	The Independent Regulator (Monitor) commences its scrutiny of the application by the Trust
March 2012	North West Ambulance Service NHS Trust is authorised as an NHS Foundation Trust

Contact Details and Further Information

If you would like additional copies of this document, copies of our full Consultation document, or copies in other languages and formats (Large Print, Audio Tape, Braille), please write to: FREEPOST RSLG-RBSA-YGJE, North West Ambulance Service NHS Trust, Ladybridge Hall Education & Training Centre, 399 Chorley New Road, Bolton, BL1 5DD

Have your say (feedback form – tear out)

Your views are important to us, and we would like to know what you think about our proposals to become a Foundation Trust. The deadline for you to reply is Friday 1 April 2011. **Simply complete and return this form via the Freepost address.**

Question	Mark with (X)	Additional comments
Q1: Do you agree with our vision and strategic aims?	☐ Yes ☐ No	
Q2: Do you think our values are the right ones?	☐ Yes ☐ No	
Q3: Do you agree with our plans for the next five years?	☐ Yes ☐ No	
Q4: Do you agree that 16 should be the youngest age to become a member?	☐ Yes ☐ No	
Q5: Do you agree with the proposed public constituencies?	☐ Yes ☐ No	
Q6: Do you agree with our proposals for volunteers having a separate class in the public constituency?	☐ Yes ☐ No	
Q7: Do you agree with the proposals for staff membership?	☐ Yes ☐ No	
Q8: Do you agree with the proposed role of the Council of Governors?	☐ Yes ☐ No	
Q9: Do you agree with the number of public Governors within each county?	☐ Yes ☐ No	
Q10: Do you agree with the proposal to have separate Governors for volunteers?	☐ Yes ☐ No	
Q11: Do you agree with our proposals for Staff Governors?	☐ Yes ☐ No	
Q12: Do you agree with the proposals for who our Partner Governors will be?	☐ Yes ☐ No	

Question	Additional comments
Q13: If there is one thing you would like us to change to improve our service, what would it be?	
Q14: Is there anything else you would like to say about our future plans or application to be a Foundation Trust?	

Are You:

☐ Member of public ☐ NWAS staff
☐ Partner organisation
☐ NWAS volunteer ☐ Other,

please state.....

Thankyou for taking the time to comment on our proposals. If you wish to become a member, please complete the form overleaf.

Name .....
Address .....
.....
Postcode .....
Telephone .....
Email .....

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glue strip

Freepost RSLG-RBSA-YGJE
North West Ambulance Service NHS Trust
Ladybridge Hall Education & Training Centre
399 Chorley New Road
Bolton
BL1 5DD

Membership form

We want as many people as possible across the North West to become one of our members.

Membership is free, and it is easy to join. Simply complete this form and send it back to us by Freepost or contact membership@nwas.nhs.uk or visit our website at www.nwas.nhs.uk

You must be 16 years or older to become a member. If you are a member of our staff, you do not need to complete this form – information will be sent to you separately.

The information you provide here will be held on a database so that we can keep you up to date on membership issues. This information will remain confidential and held in accordance with the Data Protection Act (1998).

Your Details Fields marked with * are mandatory

*Title .....
*Telephone (home/work) .....
*First name .....
Mobile .....
*Last name .....
*Date of birth .....
*Address .....
.....
*Postcode .....

We would prefer to send you information about the Trust and membership issues by email

Email address .....

If you would prefer to receive this by post, please tick here ☐

About you

We want to involve the whole community and build a membership that is representative of the North West region. The following information will help us know if we are achieving this.

Gender (please tick) Male ☐ Female ☐

Ethnicity (please tick)

White
White British ☐
White Irish ☐
White Other ☐

Asian / Asian British
Indian ☐
Pakistani ☐
Bangladeshi ☐
Other ☐

Chinese ☐

Mixed
White and Black Caribbean ☐
White and Black African ☐
White and Asian ☐
Other ☐

Black / Black British
Caribbean ☐
African ☐
Other ☐

Other Please state
.....

Do you consider yourself to have a disability? Y ☐ N ☐

Do you have any specific requirements (eg: mobility, hearing loop, sight aids, interpreter)?

Please state here .....
.....

Getting involved

All members will receive regular information about the Trust and its services. If you want to get more involved, below are a number of ways in which you can (please tick as many as apply):

I would be interested in: Tick as many as apply ☐
Receiving regular information about the Trust ☐
Taking part in surveys, consultations and questionnaires ☐
Attending meetings or events Volunteering for the Trust ☐
Standing for election to the Council of Governors ☐

Your Areas of Interest

Is there a particular area of service you are interested in?

Emergency Services ☐ Education and Training ☐
Patient Transport Service ☐ Clinical Governance ☐
Volunteers ☐ Equality and Diversity ☐
Health and Safety ☐ Service Development ☐

Public register

We are required to keep a public register of our members. If you DO NOT wish your name to be included, please tick this box. ☐

I would like to become a member of North West Ambulance Service NHS Trust which is applying to become a Foundation Trust. ☐

Signature .....

Date .....

Thank you for applying to be a member of our Trust. We look forward to working with you in the future.

Please return this form to the Freepost address overleaf

For more information about membership write to:

FREEPOST RSLG-RBSA-YGJE
North West Ambulance Service NHS Trust
Ladybridge Hall Education & Training Centre
399 Chorley New Road
Bolton
BL1 5DD

Email: membership@nwas.nhs.uk
Phone: 0845 112 0 999
Visit our website www.nwas.nhs.uk

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Freepost RSLG-RBSA-YGJE
North West Ambulance Service NHS Trust
Ladybridge Hall Education & Training Centre
399 Chorley New Road
Bolton
BL1 5DD

Glossary of Terms

A&E
Accident and Emergency, in the UK, a common name for the emergency department of a hospital.

Civil Contingencies Act
The Civil Contingencies Act (2004) is a United Kingdom Act of Parliament that establishes a coherent framework for emergency planning and response ranging from local to national level. It also replaces former Civil Defence and Emergency Powers legislation of the 20th century.

Community First Responder
A Community First Responder (CFR), is a person available to be dispatched by an ambulance control centre to attend medical emergencies in their local area. These are normally, although not exclusively members of the public.

Emergency care
Emergency care is provided by ambulance crews when 999 is dialled and is continued by staff in A&E departments upon arrival.

Executive Directors
The Executive Directors form part of the Board of Directors as well as the Executive Management Team and are responsible for all aspects of the Trust's business, including finances and performance.

Non-Executive Directors
The Non-Executive Directors (NEDs) are voting members of the Board of Directors however they do not form part of the Executive Management team.

Urgent Care
Urgent care is the range of responses that health and care services provide to people who require - or who perceive - the need for urgent advice, care, treatment or diagnosis.

Patient Transport Service
The Patient Transport Service of the North West Ambulance Service provides non-emergency transport to and from hospital for those patients who are unable to travel unaided because of their medical condition or clinical need.

Primary Care Trust (PCT)
PCT's have responsibility for the healthcare needs of their local community; their aim is to improve the health of and address health inequalities in their communities. They receive budgets from the Department of Health to commission and provide primary care and community services across the local area and to commission hospital and ambulance services.

Public Defibrillator Sites
An automated external defibrillator or AED is a portable electronic device that automatically diagnoses the potentially life threatening cardiac arrhythmias of ventricular fibrillation and ventricular tachycardia in a patient and is able to treat them through defibrillation, the application of electrical therapy which stops the arrhythmia, allowing the heart to re-establish an effective rhythm. They are located in public places eg. workplaces and shopping centres for the public to use whilst waiting for the ambulance to arrive as they highly increase a patients chance of survival if used quickly.

Strategic Health Authority
NHS Strategic Health Authorities (SHA) are part of the structure of the NHS. Each SHA is responsible for enacting the directives and implementing policy as outlined by the Department of Health at a regional level. In turn each SHA area contains various NHS trusts which take responsibility for running or commissioning local NHS services. The SHA is responsible for strategic supervision of these services.

Voluntary Car Drivers
Voluntary Car Drivers supplement the Patient Transport Service by taking patients to and from hospital appointments on a voluntary basis.

Triage
Triage is a process of prioritising patients based on the severity of their condition

Your opinions are important to us. If you have any views about this document or if you would like to receive this document in large print, braille, on audio tape, or in an alternative language, please contact us.

Arabic

اذا كنت تحتاج لهذه الوثيقة بلغة اخرى او بشكل آخر يرجى الاتصال بنا

Chinese

如果您需要本文件任何其它语言或格式的文本，请直接与我们联系。

Gujarati

જો તમને આ દસ્તાવેજ બીજી કોઈ ભાષા કે સ્વરૂપમાં જોઈતો હોય, તો કૃપા કરીને અમારો સંપર્ક કરો.

Polish

W celu otrzymania niniejszego dokumentu w innym języku lub formacie, należy się z nami skontaktować.

Somali

Haddii aad ku rabto xaashadan luqad ama qaab kasta oo kale fadlan nala soo xidhiidh.

Urdu

اگر آپ کو یہ تحریر کسی اور زبان یا فارمیٹ میں درکار ہو تو ہم سے رابطہ کریں۔

Trust Headquarters

Ladybridge Hall
Chorley New Road
Bolton
BL1 5DD
Tel: 0845 112 0 999 (local rate)
Minicom: 0151 260 8628
Email: nwasenquiries@nwas.nhs. uk
Website: www.nwas.nhs.uk

Photography courtesy of Jason Locke

For further information visit the website, email or call

0845 112 0 999

(charged at local rate)

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Agenda Item 6

CHESHIRE EAST COUNCIL
REPORT TO: Cabinet

Date of Meeting: 14 March 2011
Report of: Adult and Community Health & Wellbeing
Subject/Title: Adult Services Charging Policy Review
Portfolio Holder Cllr. R Domleo

1.0 Report Summary

1.1 A formal consultation on Adult Services Charging Policies and Scheme of Delegated Commissioned Care Charges occurred between 2 November 2010 to 31 January 2011, to seek views on options available to increase income to enable reinvestment in front line services. This consultation addressed the inequity between commissioned care service charging and personalised services.

1.2 A summary of the consultation responses, Equality Impact Assessment and proposed Scheme of Delegated Charges is attached to this paper. The full detailed responses to consultation are available on the Cheshire East Council website and the Members page within Adult Services Intranet.

1.3 In summary, people generally accepted that there would be an increase in care costs but were not happy to see this set at 100% of disposable income as a contribution. Many people objected to the charging policy outright and felt income could be generated through alternative means such as officer pay or council tax increases. Increases to flat rate fees for Transport and Meals were generally accepted as having to increase to protect valued services.

2.0 Decision Requested

2.1 Agreement to set the Scheme of Delegated charges (including flat rate fees for Transport) at a suitable level to remove significant subsidy from commissioned care prices. This to include Council overhead costs and enable the recovery of additional income from customers who can afford to pay, whilst ensuring the level of charges provide Care4CE with competitiveness in the open market.

2.2 Note that customers will continue to have the choice to meet their needs in the open market through a personal budget as an alternative to choosing commissioned care services.

2.3 To levy a one-off administrative charge (approx £400 to cover the costs of administrative and legal time) for deferred charge agreements.

2.4 To apply interest at contract end to deferred debt at base rate plus 5%, capped at 8% whilst base rate is below 7.5%, then base plus 1%, in accordance with statutory guidance.

2.5 Approval to maximise the use of Direct Debit for income collection. Offering this as the preferred payment option in new cases and applying an administrative fee to those who could pay via Direct Debit but chose to pay through alternative methods.

2.6 Approval to maximise the use of the Empower processes as the primary method of receiving a Direct Payment and as the single option to new service users unless in exceptional cases and where legally required to commission services on behalf of the customer.

2.7 Agreement to move to a process where the Council encourages net payments to care providers through revised contract terms, thus reducing Council overheads in income collection.

2.8 Agreement to introduce a one-off charge for the administration of managed individual personal budgets by the Council, should the Council's provider service (Care4CE) move to be able to trade independently, and for signpost access to Third Sector support, where the customer can reasonably afford to pay a suggested charge of £25.

2.9 Approval to explore options to streamline the Council's Appointeeship and Deputyship system via electronic banking/Empower processes and to introduce a moderate annual fee for administration of the service where possible from interest gained on accounts.

2.10 Approval to remove subsidy from the Non-Residential charging formula taking account of the strong public view not to increase this to 100%. This is currently set at 90% of disposable income taken as a maximum charge. It is proposed this moves to 97%, from 9th April 2011, however the impact of this change should be reviewed again at 2012/13 to consider a move to 100% of disposable income as a charge from April 2012, subject to Cabinet approval.

2.11 To consider the strong public opinion to the Council's proposal to extend the Non-Residential Charging policy to include strategically commissioned care services for carers and to withdraw this proposal from consideration.

2.12 Agree to extend the Non-Residential Charging policy to recipients of Independent Living Funds subject to guidance on the continuation of this funding.

2.13 Agree to revise and tighten the disability expenditure assessment framework to ensure consistent and fair application and to account for personal budgets which cover many disability costs reducing the dual funding in this area.

2.14 Approval to review the structure of charges within Extra Care Housing by mid-year 2011; to move away from banded average charges to actuals based on hourly provision, aligned to hourly home care charges. To protect those people who receive no care services in their own right (partners of service users or people who have made a life-style choice), at their current contribution through transition and as part of the full review of charges to introduce a Health & Wellbeing charge.

2.15 The hot meals unit price to the customer will remain at the current level of £3.25 per meal whilst the contract is reviewed due to the reduction in demand for commissioned hot meals and increased private sales. To agree that care managers from April 2011 offer a personalised service to new customers directing people through the open market for their provision of meals, with support as required, only commissioning meals in exceptional circumstances and where legally required to do

so. Adult Services will support ineligible Hot Meals service users to access private purchased meals, Extra Care Housing Restaurant, brokerage, re-ablement services to promote independence, IT training to facilitate on-line ordering, personal budget via Empower Card removing the need for cash transactions or assisted technology for checking on safety of customers who have no other services.

2.16 To charge customers for the actual number of double handed staff hours of care commissioned subject to the means test, removing inequity between those who choose commissioned care and those who have their care provided through a personal budget where subsidy is already removed.

3.0 Reasons for Recommendations

Customer Impact:

3.1 Adult Services support approximately 4000 people in the community.

3.2 Moving to 97% of disposable income as a contribution would affect:

- 53% (2139) people are not able to contribute towards their care services and will feel no impact of these proposals unless receiving meals or transport services.
- 7% (280) are paying the full cost due to high capital and are likely to see a 7% increase in their charges. These people could be supported to access alternative care from the open care market if that is their choice.
- 36% (1416) people are paying an assessed contribution towards their care and are likely to see on average a 4% increase (£1.58 per week per person on average).

3.3 Deferred Charges

- Approximately 3 new deferred arrangements are made each week - from April 2011 each new deferred agreement would include an administrative charge to cover the costs to the Authority of land registry searches, legal charges being placed, renewed and removed, legal and administrative time..
- One deferred charge contract is due to be settled per week on average, applying interest on the 1st day due rather than 56 days after the contract end would encourage prompt settlement of new and existing agreements (subject to legal advice).

3.4 Admin Charges

- Approximately 300 Corporate Appointeeships and 20 Deputyship cases are managed by Adult Services where the customer is not able to manage their own finances. The proposal is to modernise banking processes to make efficiencies and to attract interest on accounts and to levy an annual fee of around £25 per annum on appointeeship accounts once the review is completed.
- Around 2 people every 4 weeks are referred onto brokerage services for assistance to arrange their own care. These are people who can afford to fund their care privately due to high capital. It is proposed Adult Services levy an administrative charge of £25 per person for signposting to a service which the Council funds.

3.5 Flat Rate Charges

- 7% (289) people receive a commissioned hot meal at a charge of £3.25 per meal. The Council incurs the costs of invoicing and income collection averaging out at a cost to the Authority of £6 per meal. 210 people are likely to be ineligible for the meals service as they receive no other care service. Removing ineligible users would force a full review of the contract. As demand for commissioned meals has declined over the year, the actual cost per meal to the council by the provider will be reviewed to £5.91, to be implemented from January 2011 in line with the contract terms and conditions. It may be possible to negotiate an equalisation of price with the current provider to around £5.25 per meal for a private meal (currently costing £5.77) and a commissioned meal cost to the Council. There is no incentive for an eligible individual to purchase their hot meal directly from the provider whilst the cost through the Council remains at £3.25. To facilitate choice and personalisation via alternative providers would require Cabinet approval to increase the cost of a commissioned meal to £5.25 (subject to negotiation with the current contractor).
- 10% (420) people use Adult Services Commissioned Transport to and from day care. The proposal is to increase the flat rate charge from £2 to £4 per one way trip. Consultation showed people to be willing to pay up to £4.55 per one way trip. The future of fleet transport and associated unit price is detailed in a separate paper for Cabinet consideration.

3.6 As government funding is reduced at a time when greater demands are placed on social care services, many local authorities are looking for ways to raise additional income.

3.7 Other Local Authorities such as Liverspool, Manchester, Lancashire and Warrington are consulting on their charging policies. The Council's nearest neighbour, Cheshire West and Chester revised their non-residential charging policy in 2010, moving to recover 100% of disposable income as a contribution.

3.8 Cabinet expect Adult Services to raise an additional £450k in income in the 3 years from 2010/11 through to 2012/13 (phased £100k/£150k/£200k). These targets are part of the existing 2010/11 Medium Term Financial Strategy that has been rolled forward. The proposals for 2011/12 include a further increase of income for the Adults service of some £500k, over and above the policy that commenced in 2010/11, requiring £650k of additional income to be generated during 2011/12. This report details how £510k will be generated during 2011/12, with further work in hand to detail how the balance of £140k will be generated.

3.9 A major strand of achieving these targets will be moving from commissioned care packages to personal budgets for new and existing service users, as consulted on in 2008/09 "The Personalisation of Services".

4.0 Wards Affected - All

5.0 Local Ward Members - All

6.0 Policy Implications :

- **Adult Services Fees and Charges Policy:** To be prepared following consultation and Cabinet approval of changes.
- **Public Information**: in accessible format for all. Brokerage exists to assist customers to access alternative services where needed.
- **Whole System Commissioning**: Children's, Adults Services and Health – welfare benefit advice and information to ensure maximum take up of benefits through partnership working.

7.0 Financial Implications 2010/11 and beyond (Authorised by the Borough Treasurer)

7.1 The anticipated savings or additional income from implementing these changes are set out below:

£185,000	Removing subsidy from commissioned care prices, although some people may choose to purchase their care privately and so this figure would reduce.
£165,000	Move to 97% of disposable income as a client contribution
£60,000	Application of administrative charges on deferred debt
£100,000	Annual welfare benefit increase
£510,000	Total full year effect

7.2 Transport charges will generate a further £200,000 income towards transport saving targets subject to current volume of customers being maintained, it is anticipated that some people will choose to find alternative transport due to the price, others will be reviewed and provided with alternative transport in accordance with a programme of transition. This income target is accounted for within the £800k reduced cost of providing transport that the Adults service is required to deliver in 2011/12.

7.3 Meals charges remaining at £3.25 per meal will cost Adult Services a further £52k net per annum on top of the current £104k net costs based on current volume, for a full year which will impact on the meals saving target of £100k. This additional cost will need to be met from elsewhere within Adult Services. It is anticipated that the trend for people choosing to purchase directly from their current supplier will continue and will result in the contract for meals becoming unviable early in 2011/12 as the volume reduces to an unsustainable level.

8.0 Legal Implications (Authorised by the Borough Solicitor)

8.1 Section 17 of the Health and Social Services and Social Security Adjudications Act 1983 gives councils a discretionary power to charge for certain non-residential services. The charge can be set at any level that the authority considers reasonable, subject to complying with other legislation in respect of charging and trading.

8.2 The current guidance in respect of charging is contained in 'Fairer charging policies for home care and other non-residential social services: Guidance for Councils with Social Services Responsibilities' issued in September 2003. Under this guidance a local authority is required to consult if considering changing its charging policy.

8.3 Statutory guidance is issued by the Department of Health in "Charging

for Residential Accommodation Guidance" which is applied to all long or short term residential/nursing care commissioned services in England.

8.4 The changes being proposed to the Charging Policy comply with statute and the relevant guidance.

8.5 Cabinet should satisfy itself that the consultation undertaken has abided by Case law which states that consultation must contain four elements:

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

8.6 In order to comply with the final requirement (as set out in the previous paragraph) for proper consultation, members of cabinet should ensure that they have familiarised themselves with the views expressed during the consultation period and ensure that those views are taken into account in any decision made.

8.7 When a Local Authority is considering amending policies it should assess the actual or likely affect of its policies on the community in respect of gender, racial and other equality issues. To ensure that these issues have been considered and appropriately taken into account, an Equality Impact Assessment has been completed before presenting the recommendations to Cabinet. A copy is attached and, as with the consultation, Cabinet should ensure that the results of that assessment are taken into account when making its decision.

9.0 Risk Management

9.1 There is a risk of vulnerable people refusing services due to the cost of care. Adult Services would ensure that the financial assessment is fair and affordable within the individuals means and will offer financial assessment review where someone falls into debt or where someone appeals their charge assessment following established processes.

9.2 Some individuals may be unable to pay their care costs by Direct Debit as they operate a basic bank account. Individuals will be supported through the Empower processes which will offer a solution in most cases.

9.3 Long term care charges will be implemented at a point when the financial systems within Adult Services change to facilitate new payment and charging processes – these processes require testing and there is a risk that these revised charges may not be implemented within year.

Name: Phil Lloyd
Designation: Director of Adults, Community, Health & Wellbeing
Tel No: 01270 686553
Email: phil.lloyd@cheshireeast.gov.uk

SCALE OF FEES AND CHARGES 2011/2012

SERVICE				2010/11	2011/12		Refer to
				Current Charge	Proposal	Increase	Example
				£	£	%	
ADULT SOCIAL CARE							
	CHARGES NOT SUBJECT TO ASSESSMENT						
	Community Meals	Hot Meals		3.25	3.25	0%	
	Occasional Charges						
		Visiting Officer, relatives/guests of residents and flatlet tenants					
			Overnight Stay	9.95	10.85	9%	
			Breakfast	2.25	2.95	31%	
			Dinner / Main Meal	3.95	5.50	39%	
			Tea / Snack	2.95	3.58	21%	
	Day Centres for Children						
		Playgroup Session		1.60	1.74	9%	
	Transport to and from Day Centres	Charge per one way trip		2.00	4.00	100%	
	Meals for Clients						
	Adults - for meals in Day Centres						
	Elderly People - for meals in Community Support Centres, Day Centres						
	Children - for day care (inc nurseries/playgroups)						
		Breakfast	For a light breakfast	1.25	1.95	56%	
			For a full cooked Breakfast	1.95	2.95	51%	
		Dinner	For a light meal	1.75	2.75	57%	
			For a full meal	3.25	5.50	69%	
		Tea	For a light meal	1.75	2.75	57%	
			For a high tea	2.25	3.58	59%	
	CHARGES WHICH ARE SUBJECT TO AN ASSESSMENT OF MEANS						
	Community Based Services	Home Care 60 mins		19.80	20.34	3%	
		Home Care 45 mins		14.85	15.87	7%	
		Home Care 30 mins		9.90	11.40	15%	
		Home Care 15 mins		4.95	6.93	40%	
		Building Based Day Care (per session)		32.00	35.00	9%	
		Building Based Day Care for Complex Needs (per session)		32.00	52.00	63%	3
		Building Based Day Care for Dementia (per session)		32.00	40.00	25%	
	Mental Health Sessional Support	Up to 3 hours per day		11.87	16.00	35%	
		Up to 6 hours per day		23.74	32.00	35%	

		Up to 9 hours per day		35.61	48.00	35%	
		Waking Night Service (per night)		94.00	125.08	33%	
		Sleep in Service (per night)		69.00	45.44	(34%)	
	Extra Services Housing (per week)	Band 1	0 - 2.25 hrs per week	18.36	30.51	66%	2
		Band 2	2.5 - 10 hrs per week	137.97	152.55	11%	
		Band 3	over 10 hrs per week	237.49	284.76	20%	
		Well-being Charge		n/a	20.34	New	
		Hourly Rate to be introduced at mid-year to replace banding		n/a	20.34	New	
	Supported Living	24 hour care services (internal networks) per week		315.00	741.00	135%	3
		Charges for Telecare Service (per week)		1.05	1.14	9%	
	Residential Services	Long / Short Stay Residential Care (per week)	Basic Residential	376.73	410.64	9%	Revised charges to be implemented in year 2011/12 in line with introduction of revised financial system
			Residential EMI	467.10	509.14	9%	
		Long / Short Stay Nursing Care (per week)	Nursing	433.07	472.05	9%	
			Nursing EMI	467.10	509.14	9%	
		Learning Disability Respite Care (per week)		503.44	993.28	97%	1
	Family Placement	Day Care - support to multiple users	3 hr session	11.87	16.00	35%	
		In Carer's home	6 hr session	23.74	32.00	35%	
			9 hr session	35.61	48.00	35%	
		Day Care - one to one support	3 hr session	17.79	31.27	76%	
		In either Client's or Carer's home	6 hr session	35.58	62.55	76%	
			9 hr session	53.37	93.82	76%	
		Carer Boards in (per night)		28.42	38.37	35%	
		Day Care lunch		3.11	3.45	11%	
		Day Care tea		1.54	1.75	14%	
		Day Care high tea		2.02	2.25	11%	
		Residential Care (per week)	Standard Rate	321.44	389.48	21%	
			Enhanced Rate	344.47	417.38	21%	
		Short Stay Residential (per day)	Standard Rate	45.92	130.54	184%	1
			Enhanced Rate	49.21	139.90	184%	
	NEW CHARGES	Deferred Charge Agreement (one off)		-	400.00	n/a	
		Interest on Deferred Debt		1%+base	base + 5%	n/a	
		Admin Charge for Appointeeship (annual)		-	25.00	n/a	
		Admin Charge for referring a full cost payer to Brokerage (one off)		-	25.00	n/a	

Charging Examples for Scheme of Delegated Charges 2011/12

Example 1: Tim has Learning Disabilities, he is 34 years of age and lives at home with his Mum and Dad. He receives respite care 2 weeks in the year.

Tim's Income	**Weekly Income**
Income Support	£107.10
Disability Living Allowance (Care)	£71.40
Disability Living Allowance (Mobility)	£49.85
Total Income	£228.35
LESS the money Tim keeps:	
DLA Care	£71.40
Housing/Council Tax	£10.00
Personal Allowance	£22.30
DLA Mobility	£49.85
Tim's weekly contribution to Respite	**£74.80**

The standard charge for Learning Disability Respite is proposed at £993.28 per week. Tim can afford to contribute £74.80 pw.

Example 2: Mrs Brody is 80 years of age, she is fairly able but her memory is not so good, she has decided recently to sell her property and move to Extra Care Housing to receive her care and support into the future. Mrs Brody has £200,000 capital following the sale and re-investment in her new apartment. Her carer calls for 10 minutes every day, 7 days a week.

Mrs Brody's weekly Income	**Weekly Income**	**Current Standard Charge per week**	**Moving in line with Home Care hourly rate of £19.80**
State Retirement and private pension	£230.00		
Attendance Allowance	£47.80		
Total Income	£277.80		
What Mrs Brody can pay:			
Current Standard Charge		£18.36	
Moving in line with Home Care hourly rate for 1hr 20 mins of care per week.			£24.40 approx.

Because Mrs Brody has more than £23,250 in capital, she is viewed as able to pay the standard charge for the service which is proposed at Band 1 = £30.51 pw.

Example 3: Susan has Learning Disabilities, she is 25 years of age and lives in a Supported Living Network in her own tenancy. She attends Day Care 5 days a week.

Susan's Income	**Weekly Income**	**Current Policy of 90%**	**Increasing % of Disposable Income by 5%**	**Increasing % of Disposable Income by 10%**
Income Support & SDP	£160.75			
Disability Living Allowance (Care)	£71.40			
Disability Living Allowance (Mobility)	£49.85			
Total Income	£282.00			
LESS the money Susan keeps:				
Standard amount for ordinary living costs plus 25% (protected)	£133.88			
Housing/Council Tax	0			
Night-time Disregard	0			
DLA Mobility	£49.85			
Disability Costs (protected)	£10.00			
Susan's weekly disposable income.	£88.27			
What Susan can pay:				
90% of Disposable Income		£79.44		
If this changes to 95% of Disposable Income			£83.85	
If this changes to 97% of Disposable Income				**£85.62**
If this changes to 100% of Disposable Income				£88.27

The standard charge for Network Support is proposed at £741.00 per week. The charge for Day Care for complex needs is proposed at £52.00 per session.

Susan has been supported to travel in a shared vehicle through the network – she uses some of her Disability Living Allowance (Mobility) to pay for this service.

Susan can afford to pay up to £88.27 per week towards her Network and Day Care.

Adult Services Charging Consultation Report

Consultation Period : 2 November 2010 – 31 January 2011

Summary of Responses

Charging Consultation

Background

Council's throughout the UK are currently under severe financial pressure. This pressure is the result of two significant factors. Firstly, Local Authorities have seen a substantial reduction in the money they receive in grant funding from the Government. Secondly, financial pressure grows year on year due to the rising elderly population and increased demand for care. This problem is exacerbated in Cheshire East because our population is significantly older than the national average.

Cheshire East Council is projecting an over-spend of £9.2m in Adult Services alone (2010/11), despite stringent efficiency measures.

Councils throughout the country are looking at ways to alleviate these financial pressures. Many of them are looking to do this by changing what people pay for care services. The aim of the Charging Consultation carried out by Cheshire East is to explore proposals for doing this. These measures include looking to close the gap between the charges service users pay for commissioned care services and the real cost of that commissioned care service. It also involves looking at new charges that could be introduced to offset the administrative costs the Council pays for certain tasks (e.g. Deferred Charge Agreements and Appointeeships).

The impact of changes will primarily be in the community provision offered to around 4000 customers. Many people will be unaffected by these changes because they are entitled to a free service (66%), some (19%) will see a small change as the % of disposable income as a charge moves from 90% potentially all the way to 100%. Others (8%) paying a flat rate fee may see their charges increase. Full cost or standard charge (7%) will see the greatest increase but would be able to purchase care services from the open market at competitive prices.

Consultation Process

The Charging consultation period ran from 2 November 2010 - 31 January 2011. Throughout this 3 month consultation period, numerous steps were taken to involve and inform those likely to be affected by the changes to the Charging

arrangements, including service users, carers, families, and organisations representing the former groups.

Following feedback at the first event written examples of the effects of the changes were given to the public. The number of examples was also increased during the course of the events following further dialogue and a further consultation event was arranged at the request of the people of Knutsford.

Below is a list of the methods used to provide information about the proposals and the opportunities in which people were given to have their say:

- Public Meetings (listed below)
- Letters in invoices to service users
- Website information
- Formal Consutlation events with Presentations
- Facilitated meetings at all day care centres (listed below)
- Consultation specific email account for feedback and responses
- Postal address for open comment and letters
- Individual meetings and telephone conversations
- Poster campaign
- Discussion and engagement with third sector and support groups.
- Presentation to Over-view and Scrutiny Committee on consultation process.
- Briefing to Central and Eastern Primary Care Trust.
- Individual responses to specific letters of concern
- Helpline for people to understand the impact on themselves.

List of formal public consultations

Date	***Location***	***Number of Attendees***
25th November	Nantwich	11
30th November	Sandbach	5
1st December	Middlewich	13
6th January	Crewe	18
7th January	Wilmslow	10
19th January	Macclesfield	35
21st January	Poynton	10
27th January	Knutsford	25

List of facilitated meetings at Day Care Centres

Informal meetings were also held at day centres across Cheshire East in order to get the thoughts of social care customers. People unable to attend the public events were also able to attend.

Date	*Location*	*Number of Attendees*
7th December 2010	Hollins View	Macclesfield (5)
13th December 2010	Peatfields	Macclesfield (6)
13th December 2010	Cheyne Hall	Nantwich (4)
7th January 2011	Mount View	Congleton (15)
11th January 2011	Redesmere Centre	Handforth (33)
13th January 2011	Carter House	Congleton (30)
17th January 2011	Hilary Centre	Crewe (35)
19th January 2011	Mayfield Centre	Macclesfield (11)
24th January 2011	Stanley Centre	Knutsford (30)
24th January 2011	Macon House	Crewe (20)
25th January 2011	Salinae House	Middlewich (30)
25th January 2011	Hilary Centre second event	Crewe (20)

Letters and emails received: 8

<u>General Questions Raised at Consultation Meetings</u>

A number of important questions were posed during the course of the consultation about the process. We have tried to answer the key ones below as they are more general in their nature and were repeatedly raised at different events.

What have you done to reduce the Council's administrative costs?

Since the inception of Cheshire East Council in 2009, Adult Services has realigned care services into 4 Local Independent Living Teams, reduced staff costs by £1.7m, reviewed Care4CE services achieving £2m efficiencies over the past two years, worked with providers of care to identify efficiencies in 2010/11, accessed other funding opportunities for care providers and reduced provider costs through review. Next year will bring further cost efficiencies in business processes.

Why should social care users be the ones to pay?

Wherever possible people are offered re-ablement services for up to six weeks free of charge to improve independence and avoid the need for on-going care services.

Cheshire East is very aware of the burden that is already placed on customers of its social care services and their families and carers. However, the Council has no choice but to act on the financial pressures it faces. An important point to stress is that no one will be asked to pay more than they can reasonably afford and those who do feel commissioned care services are too expensive, the Council can assist them to find alternative, cheaper options in the open market.

All Local Authorities must apply something known as Fair Access to Charging Criteria. These are Government guidelines that ensure that there is some uniformity over charging across the country. It also ensures that social care service users have enough money to live on. However, Council's do have some discretion over some elements of charging. This is the reason for this consultation.

The Council is committed to keeping Council Tax rises at or below inflation until 2013. Council Tax equates to 26% of all Cheshire East Council funding (£177m). The only other area where the Council has flexibility to raise revenue is in charging. The average annual charges paid per head in Cheshire East is £155, the national average is £210 despite Cheshire East being amongst the wealthiest areas in the UK. 30% of charges per year are for Social Care, 23% for Children's Services, 18% for Places Directorate, 11% for Leisure and 18% for other areas.

Can you explain why Adult Services current financial position is so bad?

The problem of the social care budget keeping track with the demands of an ageing population and growing demand for services has been an unremitting problem in Cheshire and in the UK generally. Cheshire East Council has taken substantial steps to try and mitigate this impact. However, the cut in funding from central government means further measures need to be taken.

Why are people punished for working hard and acquiring savings?

It is a national principle laid out by the Government that social care users should pay for services if they can afford to do so. This is long-established in Cheshire East and before that in Cheshire County Council and supported by national policy.

Was the consultation a done deal?

An example comment making this point was:

> *"Felt it was a pointless. Crazy cuts are going to happen; this is looking at which deck chair to throw off the Titanic first."*

The Council recognises something needs to be done about its budget shortfall. It formulated these charging proposals to help tackle this. However, ultimately Councillors will decide whether the proposals are adopted at a meeting of full Council on 14 March 2011. This will be done by taking into account the views expressed at the consultation events which are reflected in this report. No decision will be taken before this meeting.

Why did Councillors not attend more of the public events?

Although Councillors were not able to attend as many events as they would have liked they are very keen to listen to the concerns of the people of Cheshire East and in particular users of social care services. The feedback received during this consultation period will be crucial to how Councillors determine the way ahead for Cheshire East.

Why are social care services not spread out fairly across the Borough?

The Council has a statutory duty to ensure the social care requirements are met of people with critical or substantial needs. The Council has been assessed as achieving this by the Care Quality Commission. The Council also has a duty to deliver these services in as cost effective a way as possible. This means it has had to look at ways to deliver better and more efficient services which inevitably has meant shifts in care provision. However, the Council is committed to making the most of its resources for all service users in Cheshire East.

Charging Questions

General charging questions

1. **The main issue for the Council within this charging consultation is bringing what it charges closer to the cost of providing a service. Do you think the Council is right to do this? /**
2. **If the Council does proceed with the increases in charges there will be very little impact on those who pay no charges at present. The main impact will be on those who pay full charge for their care with a lesser impact on those who make a contribution to the cost of their care. If charge increases go ahead is this the right way to proceed in your view?**

Note: As the discussion dealt with a range of issues related to these subjects it was felt more useful to deal with these questions together.

A subsidy is the difference between the cost to the Council of providing a unit of care and the unit price of that care to the customer.

Removing the subsidy from care prices is likely to affect service users currently paying the full cost of care services, for example if they have capital in excess of £23,250 (at 2010/11), if they are paying a charge within a band of care houses (e.g. Extra Care Housing), if they have sufficient income to be able to pay the current full costs of their services or if they pay a flat rate charges for Meals or Transport.

The subsidy will also affect the following areas:

Extra Care Housing:
Extra Care Housing is a supported living service, where people live in their own apartment within a complex offering night and day time care. Maximum charges are based on average hours within bands of care and are subject to the individuals ability to pay through a financial assessment:

Flat Rate Charges
Adult Services currently provide hot meals and transport services to eligible people. These services are deemed to be normal living expenses and therefore are not subject to means testing but are charged for at a standard rate which everyone pays.

Transport. Adult Services currently support 420 individuals with transport provision to and from their Day Care service costing £1.6m per annum. The flat rate charge to the customer is £2.00 per one-way trip, but the cost to the Council is £9 per trip. The Transport provision is subject to consultation and one of the options is to remove significant subsidy from the flat rate charge.

Hot Meals. Hot meals are currently provided to 328 people. The Authority pays £4.78 per meal and recovers £3.25 in a flat rate charge for each meal, leaving a subsidy of £1.53 per meal. The proposal is to remove the subsidy and support people to purchase the meal directly from the provider at the true cost or support people to receive their meals in a different way, for example using the Restaurant facility in Extra Care Housing.

Many respondents expressed frustration at the rises the Council was suggesting. A good number felt that the most vulnerable people in society were being targeted when costs should be shared elsewhere (e.g. by raising Council Tax). This point was also affirmed by Cheshire East LINk. A regular question was what the Council had done to reduce its own costs by cutting bureaucracy as well as jobs (particularly amongst senior staff). Representative comments were:

> *"If Cheshire East looked at their own high levels of management and got rid of them or those paid £100k per annum took a cut then the £9 million overspend would be easily paid off"*

> *"I feel that the most vulnerable in society are being attacked."*

Other people felt that the Council had no choice but to increase charges because of its financial position.

> *"If people have the money and are able to contribute then they should contribute."*

One group stated that they felt that this should be done in a phased way so that customer's did not feel a heavy impact immediately. Other concerns raised included whether people on the borderline of paying for social care would particularly suffer e.g.

> *"Moving the cost burden to those who make a full contribution is not the right or fair way to proceed. It disproportionately penalises those who have modest savings."*

One individual raised the question whether this was part of a transition process into private care.

In Cheshire East LINk's formal response to the consultation they felt that the proposal was reasonable particularly because it did not affect those who could not afford to pay. However, there was concern expressed over 'borderline' cases where they felt the effect on these people should be minimised.
Note: Cheshire East LINk is an independent network of people and organisations who want to improve health and social care services in the borough. (http://www.celink.org.uk/)

3. If you consider that some subsidy from the Council should remain, where do you believe the subsidy should remain?

Although this was one of the first questions asked at the public events the debate tended to focus on other areas such as the proposed raising of charges instead of this subject. Where it was discussed, people felt that care services should be charged at a rate appropriate to their cost but not at full cost. One person made the comment that;

> *"We need transparency about what's right for each individual customer group. There should be no cross subsidy as it's dangerous to heavily subsidise some services."*

Other issues raised included whether removing the subsidy from some services would prevent some people accessing that care. There was also a fear expressed that personal care might be difficult to find on the open market.

A formal letter from Harvest Housing addressed issues relevant to people in Extra Care Housing. It states, "…Reducing subsidy, introducing administration fees (yet to be defined) plus the introduction of a new Health and well being charge may make the units financially unsuitable for potential and current residents placing further pressures on the current care system…."

Specific Charging Questions

1. What do you think of the Council's proposal to move the percentage of disposable income considered for a charge from 90% to 95 or 100%?

Notes: This proposal is likely to affect those currently paying an assessed contribution towards care services. The Council's Non-residential charging policy has to meet certain requirements set by the Department of Health. However, there are elements within the formula which the Council is able to review. The Council wishes to review the percentage of disposable income taken as a contribution of the charging formula.

The Council's non-residential charging formula currently first looks at weekly income (including welfare benefits but excluding earned income)

- It then deducts a standard disregard according to age for daily living costs plus 25%. This is set by the Department of Health.
- It then deducts any weekly Housing Costs and Council Tax that is paid, which is not covered by benefits.
- It then calculates and deducts any Disability Related Expenditure an individual has, which is not being covered in disregarded income or provided in their care package.
- The remaining amount is the person's weekly disposable income.
- The Council currently takes 90% of this disposable income as a maximum contribution towards care services.

The effect of increasing the percentage of disposable income as a contribution by 5 or 10% without any changes to unit prices on service users :

	Numbers of service users affected	
	90% to 95%	**90% to 100%**
No effect as already paying the maximum service charge	196	196
Less than £1 pw increase	485	216
up to £5 pw increase	470	272

up to £5 increase	13	180
up to £6 increase	6	133
up to £10 increase	0	3
TOTAL	**1594**	**1594**

Analysis of public responses:
This question arguably provoked the strongest reaction at both the formal and informal consultation events. Many attendees felt that it was going too far to increase the percentage of disposable income taken to 100%. It was felt that this was akin to 'treating people like babies' and this took away their human rights. It was also felt that service users should not be 'treated like cash cows'. Cheshire East LINk felt that the calculation should remain at 90%. However, a number also accepted the current financial position of the Council and felt that some increase was fair (to 95%). It was even raised at one event that there should be a transition to 100% if it meant the financial difficulties could be tackled earlier.

> *"I can't see it as attractive to have to contribute extra money. But I will give a bit more as I feel as an individual that we need to make a contribution."*

However, there were views in total contradiction to the proposal. At the Knutsford Consultation Event, in particular, it was felt that the 90% was too high to begin with. One person offered the observation;

> *"A percentage increase should not be implemented in a time of recession."*

A further comment was:

> *"I strongly do not agree with the proposal to move to 95% or 100%. Other costs are rising fast and steeply, and as my disabilities increase, it is more costly to keep warm, and manage daily living."*

Many people also questioned how the formula for disposable income was calculated. They felt that it was impossible to take all factors into account when assessing this (e.g. presents for grandchildren, holidays, Xmas etc). One member of the public queried why the Government had the right to determine what someone's disposable income was.

2. **Do you think the Council is right to:**
    a. **Apply a one-off administrative charge to Deferred payment agreements.**
    b. **charge interest immediately and at a rate similar to other local authorities rather than waiting 56 days and charging only base rate plus 1%.**

Notes: The Council currently offers what is in effect an interest free loan to people who enter into long term care leaving their property vacant. The customer is required to pay what they can from their weekly income, deferring the rest of the charge to be collected either when the property sells or when the contract with the Council ends. The Council secures the debt with a Legal Charge on the property, which means it cannot be sold without the Council being notified and collecting the debt owed.

The Council's proposal is to apply a one-off administrative charge to deferred debt to cover the cost of land registry search, legal and administrative time in setting up Deferred Charge Agreements and of applying/lifting the Legal Charge on the property. The Council is also proposing charging interest from the end of the contract rather than the current practice of 56 days after the end of the contract at base rate plus 1% (2.5%) and wishes to review the interest rate currently applied with the intention of increasing the rate in line with other Councils.
A number of other Councils apply a charge for arranging Deferred Charges - these charges range from £75 to £500 one off charges. Other Councils apply interest of up to 8% on deferred debt.

Analysis of public responses:

a) A large number of individuals felt that the administrative charge was fair. This was predominantly because they felt individuals were currently gaining from the fact that they didn't need to sell their house: a benefit unjust to everyone else. An example comment was:

"If they are deferring and they have capital I think this is reasonable."

Nevertheless, people felt that the charge should not be excessive, but should be proportionate to the costs incurred by the Council. There were also a few participants who felt that it was not fair to put additional charges on service users at all and that Council Tax should be increased instead.

b) Many individuals again felt that an interest charge was fair. They also agreed with the ending of the 56 day waiting period. One comment was,

"You show me a bank that gives you 56 days grace."

A few individuals felt that the interest charge would be excessive because of the time it might take to sell someone's home. An alternative concept was put forward of asking a customer to sell their home after a period of time (say two years). However, the Council has no rights under law to force a sale. A further comment was that if the Council introduced this measure it should be done in a transparent way.

Cheshire East LINk strongly disagreed with proposal (a) and disagreed with proposal (b).

3. Do you think the Council should apply an administrative charge when managing someone's money of their behalf (e.g. Appointeeship or Managed Personal Budgets?)

Notes: The Council provides the Appointeeship or Managed Personal Budget service to people who lack capacity or are considered too vulnerable to manage their own income themselves (e.g. benefit payments). The Council is seeking to modernise this service and introduce an administrative charge for money management services. Only people who can afford to pay and who choose to have the Council provide their care will be asked to contribute subject to their means.

Analysis of public responses:

Some individuals expressed the view at the events that the Council should implement this proposal. However, there were concerns about the vulnerability of the client group and whether it might be better to absorb these costs into Council Tax or by cutting costs in other areas for instance. A representative comment was:

> *"I don't feel that charging the disabled or elderly is the right way to maximise income. You should be looking at other areas of the Council instead of targeting vulnerable people"*

Again the level of the charge was an important consideration.

4. Do you think the Council is right to charge people who can afford to pay, a fee for brokerage?

Notes: The Council provides brokerage support to a rapidly increasing number of people. This is where we support people to make their own care arrangements (under a direct payment). The Council considers that this increases independence and affords people access to a greater variety of care to meet their needs. There are, of course, a number of people for whom this is not

possible and the Council would continue to make arrangements to care for this group (for example, people who need long term residential or nursing care).

Analysis of public responses:

Limited discussions were had at the events about this question. However, a slight majority of people felt that the proposal was unfair because it advanced charging vulnerable people who had limited capacity to speak for themselves. Again, a fear was expressed that this was part of a privatisation of social work. Some did feel that the proposal was reasonable, however. One remark was:

> *"No one gets something for nothing. So yes, not unfair to ask people to pay charge"*

One other issue that was raised was the impact the policy would have on 3rd sector organisations. Brokerage is currently provided by Age Concern and CCIL (Cheshire Centre for Independent Living) in Cheshire East. There were concerns it would adversely affect their income if their customers dropped as a result of the charge.

Cheshire East LINk expressed general concerns with the availability and costs of brokerage services which it was felt that this would do nothing to address.

5. The Council wishes to pay its contribution towards personal budgets through the Empower Card as this eliminates much costly administration. Do you think this is the right thing to do?

Notes: The Empower Card is a brand new way to purchase social care services using a personal budget. It works like a bank debit card and is loaded with the Council's financial contribution to an individual's care and any extra monies they contribute. They can use this to make purchases and to monitor their spending. This can be tracked via the internet or they can choose to receive paper statements on a quarterly basis. The Council can also use the system to monitor that an individual's spending is meeting their care needs. It is not possible to make cash withdrawals on the card or to go overdrawn on it.

Analysis of public responses:

This question prompted a large amount of debate possibly because there was a specific presentation on this and also because it captured the imagination.

A sizeable majority of people felt that the Empower Card was a very positive development because it helped reduce the administrative costs of sending out an invoice. A comment at the Nantwich event was:

"The Empower Card is not a worry and the idea works well"

Many people felt that it was a more modern approach to tackling the issue of managing personal budgets.

However, a number of linked issues were raised regarding the card. One of these concerned the card's management. It was felt that the card might be open to abuse from disreputable carers/ or family members. Two individuals felt that the card allowed the Council too much knowledge of peoples spending and that there was an element of "big brother" about it. A further issue leading on from this was that the card singled people out in some way. One person voiced:

"Why should you have to know everything?"

An oft-repeated concern was how older people or those lacking mental capacity would take to the card. Comments included:

"Some older people still don't like chip and pin and need alternatives as well."
"So the mentally disabled are going to be forced to use Empower?"

People wanted to know how a customer with these needs would be helped with the process.

6. In some situations the care provider may be willing to collect a contribution directly from customers and the Council will pay the rest of the cost directly to the provider. This process eliminates costly administration. Do you think this is the right thing to do?

Analysis of public responses:

Most people felt that this proposal made sense although a couple of additional issues were raised. One of these concerned the fear that the care provider might pass the costs of their increased administration (the fact they now had to chase customers for money) on to service users.

"Care costs could go up for the extra administration. It could be more streamlined for the Council, but is it for the provider? Will this cost be passed on to the user?"

One individual also wondered if the system might be open to fraud as providers might bill the Council over and above the true cost.

"This assumes care provider submits correct claims which might not always be so"

7. The Council wishes to change its approach to assessing carers for services when the cared for person refuses services, so that there is a financial assessment and a full welfare benefit check. Do you think this is the right thing to do?

Notes: This will affect Carers currently using the free three hour home care service only. The Council currently offers three hours home care per week free of charge to carers where the cared for person refuses to accept services themselves. The Council is considering whether to continue to offer this service although recognises that this provision helps to support carers in their caring role.

This question provoked heated comment. The vast majority of people felt that this proposal was unfair because carers were burdened enough although generally people felt carers ought to be offered a welfare benefit check. There was anxiety that penalising carers might have a knock on effect on service users. A typical statement was:

"Things are usually financially difficult for carers so not too sure about this"

"…do not tamper with the current policy or you risk further isolating an already vulnerable group of carers."

A further question mark was raised against the comprehensiveness of the proposed financial assessment and whether it could truly capture all of a carer's costs. A similar point was raised for the question on the service user's financial assessment. However, people did feel that the offer of a welfare benefit check for carers was very worthwhile.

8. The Council is looking to amend the charging policy to enable the collection of an Independent Living Fund contribution should this be necessary in the future. Do you think this is the right thing to do?

Notes: Some people with severe needs currently receive a benefit called Independent Living Funds - these funds are currently subject to national review by the Department for Work and Pensions and Department of Health. This is a national scheme that makes money available to enable disabled people to live independent lives in their community rather than in residential care. The ILF is no longer accepting any new applications.

The Council does not charge anyone who receives these funds and is proposing amending the charging policy to enable future charges to be collected subject to the continuation of the fund. Council's will have to adhere to guidance on how these funds will be managed in the future. The Council is simply seeking to amend the charging policy to allow for charging of Independent Living Fund recipients subject to further instructions on how the money is to be managed next year. Currently, people in receipt of Independent Living Fund pay approximately £89 per week towards care purchased with Independent Living Funds. Any charge levied by the Council would come out of this ILF charge so no-one would be disadvantaged.

Analysis of public responses:

There was little discussion over this question mainly because people did not understand the Independent Living Fund and the reasoning behind the question. Almost everyone speaking from a position of knowledge agreed that it made sense to adopt this proposal. This was a question around a technicality which would have little impact on service users overall.

THE IMPACT OF CHARGING PROPOSALS - Summary

If you are assessed as :	Nil Charge	Assessed Charge	Capital over £23,250
Removing Subsidy from Care Prices	No Impact	Impact only for those who can afford to pay.	Will pay more towards commissioned care or be signposted to purchase care independently with support.
Removing subsidy from charging policy	No Impact	All people paying an assessed contribution will see an increase depending on the percentage agreed from consultation.	No Impact as already paying the price of the care. May choose to purchase care independently with support.
Both the above options together	No Impact	All people paying an assessed charge would see an increased contribution within their means.	Would pay more toward commissioned care or be signposted to purchase care independently with support
Administrative Charges	No Impact	Can choose to purchase additional services subject to means, to help with care arrangements.	Can choose to purchase additional services to help with care arrangements.
Carers Charges	No Impact	Will be offered a benefit check and may be required to contribute towards services commissioned directly for them, subject to means test.	Will be charged for commissioned services or be signposted to services to help access services independently.
Independent Living Fund Charges	No Impact	No Impact	Would not be entitled to ILF

Overall Summary

The Charging proposals provoked a wide range of reactions. Many people sympathised with the Council's financial position, others felt that social care service users were already in an economically and emotionally vulnerable position and should not be penalised further. They felt that a Council Tax rise or cuts in bureaucracy and staffing should be explored instead. There was also debate over whether the assessment of what is essential and what is disposable was potentially flawed.

In general, reaction was split on whether additional charges should be implemented. However, it was clear that people did not want an assessment to

be introduced for carers. Inevitably the proposals have proved controversial particularly at a time of economic hardship for many people.

What next?

This report has been sent to all attendees who requested it at the formal and informal consultation events. It has also been made available on the Cheshire East website.

The next step is for Councillors to consider its findings at full Council on 14th March 2011. This is a public meeting which anyone may attend. Questions can be logged before this meeting in order to give time for the answer to be researched (if the question requires technical information which would need to be investigated). A full summary of views can be found at the Cheshire East Council website.

Cabinet decision will be communicated to those affected as soon as possible.

Further comments about the consultation process can be made to the Cheshire East Consultation and Participation Team cpu@cheshireeast.gov.uk or by telephone at 01270 371376. You can also write to the Consultation and Participation Team, Floor 4, Delamere House, Crewe, CW1 2LL.

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Department/Service	Adult Services	**Equality Impact Assessment Form Template**		
Ref **See Appendix 1**	**ADU**	Officer responsible for the assessment	Alison McCudden	
Name of policy procedure function being assessed	**Adult Services Charging Policy**		Start date of assessment	04/02/11
Are there are any other policies or procedures associated or linked with this one.	• Financial Assessment Procedure			
Briefly describe the aims, objectives and outcomes of the policy / procedure / function	The proposed changes to charges involve making modifications to a number of areas. These can be summarised to include closing the gap between the standard charge set for services and the true, unsubsidised costs of the service. It also involves looking at new charges that could be introduced to offset administrative costs in a number of areas (e.g. Deferred Charge Agreements and Appointeeships).			
Who is intended to benefit from this policy –procedure – function?	Council Tax payers by increasing the size of the income that comes into the Council from charges. Provides equity between commissioned care service charges and personalised budget charging. Enables reinvestment of savings into front line services, contributing to maintaining service delivery able to meet growing demand.			
What factors could contribute to or detract from the outcomes?	▪ Problems in implementing the revised charging arrangements ▪ Rejection of the proposals by Council ▪ Miscalculation in the real income the changes generate (as factors at work are often complex)			
Who are the main stakeholders in relation to the policy – procedure- function? (Please consider key equality groups)	• Service Users and Carers • External provider services. • Care4CE			
Who is responsible for the policy – procedure –	Alison McCudden			

Please indentify any impact (Positive / Negative) this policy, procedure, function or service will have on the following protected characteristics:			
Age - Is there an impact?	**YES**		Comments/Actions: Cheshire East has a larger elderly population than both England and the North West. There are 68,400 people aged 65+ in Cheshire East or 18.9% in comparison to an average of 16.6% for the North West and 16.3% for the country. Correspondingly, Cheshire East has a small percentage of young people; 22.9% aged under 20, compared to 24.3% for the North West and 23.9% for England. Within Cheshire East in general the rural areas show the greatest proportion in both losses of young people and gains in older people. The Macclesfield area has the largest population and highest number of people aged 65+. Attendees at the Charging Events can be banded as following. 65+ 10 44-64 26 18-44 11 No further age related issues were raised as a result of consultation except ability to pay. This is a significant problem for older people. According to the national Help the Aged Document 'Lifting Pensioners out of Poverty': "Almost one in four pensioners lives in poverty (2.5 million), with over half of poor pensioners living in severe poverty (56 per cent or 1.4 million). In addition, almost one in three pensioners lives in near poverty (3.8 million)." According to official statistics, in the last year alone an additional 300,000 pensioners were forced into poverty.

			It is likely that the effect of the charging policy is to put pressure on those who can afford to pay, to pay more. However, service users are financially assessed according to ability to pay (under Government Fairer Charging Guidance) and so should not ever be asked to contribute more than they can afford to do. The Empower Card which has age related issues connected with it will be dealt with by a separate equality impact assessment.
Carers – Is there an impact?		**No**	Comments/Actions: The Office of National Statistics estimates that 10% of the population are likely to be carers i.e. 36,500 people in Cheshire East. There are 70,100 people over the age of 65 in Cheshire East and 8,016 of these may be carers. Of these approx 1,300 are likely to be in poor health themselves and 2,400 may be providing 50 or more hours of care per week. Only 740 carers are recorded as having had an assessment with Cheshire East Council of their needs as carers during the last year. (Cheshire East Carers Strategy 2010). One of the proposed changes was the implementation of a financial assessment on carers. This would affect carers currently using the free three hour home care service only. Many carers expressed the view in the consultation for this question that they were under enough financial and psychological pressure at the moment and that this proposal could only add further to it. However, it is now unlikely that this proposal will be implemented. The other aspects of the charging proposals have less effect on carers because this would involve increasing charges on the

<table>
<tr><td></td><td></td><td></td><td>cared for (only if they can afford to pay). It is likely that there will be some knock on effects on carers particularly where they must manage the budgets of those lacking in capacity. However, these are not deemed of extra significance compared to the main impact on the service users themselves.</td></tr>
<tr><td>Disability - Is there an impact?</td><td>Yes</td><td></td><td>Comments/Actions:

The majority of service users in Cheshire East Adult Services are those with a Physical Disability (55.3%). The next largest group is those with a Mental Health Disability which is almost half as much (23.9%). Learning Disability clients make up only 14.6% of community service users. 6.4% of customer’s have a Visual Impairment [note older people are no longer taken to be a separate client group}

<table>
<tr><th>Client Type</th><th>Total Service Users</th><th>%</th></tr>
<tr><td>Physical Disability</td><td>3331</td><td>55.3</td></tr>
<tr><td>Mental Health</td><td>1441</td><td>23.9</td></tr>
<tr><td>Learning Disability</td><td>879</td><td>14.6</td></tr>
<tr><td>Other Vulnerable</td><td>206</td><td>3.4</td></tr>
<tr><td>Null</td><td>148</td><td>2.5</td></tr>
<tr><td>Substance Abuse</td><td>17</td><td>0.3</td></tr>
<tr><td>Visual Impairment</td><td>384</td><td>6.4</td></tr>
<tr><td>Total</td><td>6022</td><td>100.0</td></tr>
</table>
Note for table and graph: all categories are mutually exclusive except visual impairment. The data also shows the main client type so if a person also has other needs, these are not included in these statistics.

Thus, the nature of social care as such (with the exception of substance abuse) is that all service users will have some form of</td></tr>
</table>

			disability even if this is a result of old age. Note: attendee disability was not one of the questions captured by the event feedback forms. Change in disposable income: Statistical analysis has shown that the effect of the move from 90% of disposable income to 95% or 100% is likely to be monetarily small with most people seeing a £1-5 increase on charges each week. However, as was stressed at the consultation events, this increase could nevertheless have a real impact on service users. Factors related to the extra expenditure required if someone has a disability are included in the essential income calculation. This might include: • Excess Heating Costs • Gardening labour • Cleaners • Extra loads of laundry • Continence issues • Extra personal care • Community Alarm maintenance • Disability related equipment Individual Changes: The change which would bring administrative charges for appointeeships and brokerage is likely to impact on those lacking in mental capacity. The deferred payment charge on property will impact those who have to go into residential or nursing care. This is likely to happen because the person has suffered a loss of mental capacity or because of physically disability. The increase in transport charges is picked up by transport EIA.

			The increase in charges for hot meals is likely to affect those who are physically disabled. It is likely that the effect of the charging policy is to put pressure on those who can afford to pay, to pay more. This is a particular problem for disabled people. The Leonard Cheshire Disability Review 2009 found disabled people were facing increasing levels of poverty, with 42% of respondents stating they were struggling to live on their income, up from 33% in 2007. However, service users are financially assessed according to ability to pay (under Government Fairer Charging Guidance) and so should not ever be asked to contribute more than they can afford to do. This means although there will be an impact on service user's particularly just about the Council threshold this should not be excessive. Nevertheless, the general principle of increasing charges on those with care needs will necessarily impact disproportionately on the vulnerable is the case as a result of the very principle of charging for care services. This is national issue to do with how the care system is currently set out by Government.
Gender (Including pregnancy and Maternity, Marriage)?		**No**	Comments/Actions: According to the Mid-2009 population estimates from the Office for National Statistics the current resident population of Cheshire East is circa 362,700. This is split between 184,500 females and 178,200 males (50.9% and 49.1%). This is approximately the same as the gender split in the North West and for England as a whole. There is a much larger ratio of females to male service users in Cheshire East. This can largely be explained by the differences

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>in life expectancy between the sexes.

Service Users by Sex
<table><tr><th>Sex</th><th>Total:</th><th>%</th></tr><tr><td>M</td><td>2206</td><td>36.6</td></tr><tr><td>F</td><td>3816</td><td>63.4</td></tr><tr><td>Total:</td><td>6022</td><td>100</td></tr></table>
19 men and 26 women indicated their gender on the consultation feedback forms. There were no gender related issues which were raised during these events.</td>
</tr>
<tr>
<td>Gypsies & Travellers - Is there an impact?</td>
<td></td>
<td>No</td>
<td>Comments/Actions:

Cheshire East Caravans - July 2010 (source LILAC)

<table><tr><td>All Caravans</td><td>139</td></tr><tr><td>Authorised Sites</td><td>119</td></tr><tr><td>Unauthorised Sites</td><td>20</td></tr></table>
Due to the transient nature of the Gypsy and Traveller community it is difficult to ascertain the exact numbers of this section of the community within Cheshire. It is considered an important and significant minority group however.

The impact of this policy on this protected characteristic is neutral. The plan to use empower card flexibly may have a beneficial impact.</td>
</tr>
<tr>
<td>Race – Is there an impact?</td>
<td></td>
<td>No</td>
<td>Comments/Actions:</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>White people are the overwhelming racial group within Cheshire East. Nevertheless there is a significant proportion of people who are neither white British or Irish. This amounts to a total of 20,800 people or (6.1%), with 13,000 (3.8%) being non white.

Ethnic Minorities (estimated for 2009 ONS)
<table>
<tr><th></th><th>Cheshire East</th><th>England</th><th>Cheshire East %</th><th>North West %</th><th>England %</th></tr>
<tr><th></th><th>Unitary Authority</th><th>Country</th><th>Unitary Authority</th><th>Region</th><th>Country</th></tr>
<tr><td>All Ethnic Groups</td><td>360,700</td><td>51,092,000</td><td>100.0</td><td>100.0</td><td>100.0</td></tr>
<tr><td>White</td><td>347,600</td><td>45,082,900</td><td>96.4</td><td>92.1</td><td>88.2</td></tr>
<tr><td>Mixed</td><td>3,300</td><td>870,000</td><td>0.9</td><td>1.2</td><td>1.7</td></tr>
<tr><td>Asian or Asian British</td><td>5,000</td><td>2,914,900</td><td>1.4</td><td>4.4</td><td>5.7</td></tr>
<tr><td>Black or Black British</td><td>2,000</td><td>1,447,900</td><td>0.6</td><td>1.1</td><td>2.8</td></tr>
<tr><td>Chinese or Other Ethnic Group</td><td>2,700</td><td>776,400</td><td>0.7</td><td>1.1</td><td>1.5</td></tr>
</table>

The impact of this policy on this protected characteristic is neutral.</td>
</tr>
<tr>
<td>Religion & Belief- Is there an Impact?</td>
<td></td>
<td>No</td>
<td>Comments/Actions:

Cheshire East as a whole has a far greater percentage of people who stated that they were Christian in the census than in England as a whole. This is a pattern which is a feature of much of the North West of England. Perhaps, the main reason for this is the lack of racial diversity apparent in the general population.</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cheshire East has an equal amount of Buddhists to the North West average, half as many Hindu’s and Jewish people and significantly less Muslims.

<table>
<tr><td></td><td>Cheshire East</td><td>England</td><td>Cheshire East</td><td>England</td></tr>
<tr><td></td><td>Unitary Authority</td><td>Country</td><td>Unitary Authority%</td><td>%</td></tr>
<tr><td>All People</td><td>351,817</td><td>49,138,831</td><td>100.0</td><td>100.0</td></tr>
<tr><td>Christian</td><td>282,432</td><td>35,251,244</td><td>80.3</td><td>71.7</td></tr>
<tr><td>Buddhist</td><td>551</td><td>139,046</td><td>0.2</td><td>0.3</td></tr>
<tr><td>Hindu</td><td>617</td><td>546,982</td><td>0.2</td><td>1.1</td></tr>
<tr><td>Jewish</td><td>562</td><td>257,671</td><td>0.2</td><td>0.5</td></tr>
<tr><td>Muslim</td><td>1,375</td><td>1,524,887</td><td>0.4</td><td>3.1</td></tr>
<tr><td>Sikh</td><td>170</td><td>327,343</td><td>0.0</td><td>0.7</td></tr>
<tr><td>Any other religion</td><td>593</td><td>143,811</td><td>0.2</td><td>0.3</td></tr>
<tr><td>No religion</td><td>42,757</td><td>7,171,332</td><td>12.2</td><td>14.6</td></tr>
<tr><td>Religion not stated</td><td>22,760</td><td>3,776,515</td><td>6.5</td><td>7.7</td></tr>
</table>

The impact of this policy on this protected characteristic is neutral.</td>
</tr>
<tr>
<td>Sexual Orientation -Is there an impact?</td>
<td></td>
<td>No</td>
<td>Comments/Actions:

In the NWDA’s Report (North West Development Agency) “Improving the Region's Knowledge Base on the LGB&T population in the North West” it was estimated that 34,500 LGB’s were living in the County of Cheshire. When adjusted for predicted population growth and split proportionately for the Cheshire East area, the number can be stated as being 12,311</td>
</tr>
</table>

<table>
<tr><td></td><td></td><td></td><td>for 2009. This equates to circa 3.4%. If this ratio is also adopted for Cheshire East service users (which is currently 6022 - 30 September 2010), this would be 205.

The impact of this policy on this protected characteristic is neutral.</td></tr>
<tr><td>Transgender - Is there an impact?</td><td></td><td>No</td><td>Comments/Actions:

The North West Development Agency has estimated that the number of transsexual people in the North West in 2009 as between 600-700. Using this proportion for Cheshire East means that there would be circa 32-37 transsexual people. Although the NWDA does note that this is a, “conservative estimate because it covers only those who are seeking, those who intend to seek and those who have undergone gender re-assignment and gender recognition (i.e. transsexuals), and does not include those not seeking recognition”. There are no current service users who are known to be transgender.

The impact of this policy on this protected characteristic is neutral.</td></tr>
<tr><td>Other socio-economic disadvantaged groups (including white individuals, families and communities) Is there an impact?</td><td></td><td>No</td><td>Comments/Actions:

The areas with the lowest average household income, Cheshire East, 2007

<table>
<tr><td>Region (Lower Super Output Area)</td><td>Ward</td><td>Paycheck – Average Income</td></tr>
<tr><td>Central & ValleyL1</td><td>Delamere</td><td>£21,900</td></tr>
<tr><td>East CoppenhallL3</td><td>Maw Green</td><td>£22,200</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td>West Coppenhall & GrosvenorL4</td><td>Grosvenor</td><td>£23,100</td></tr>
<tr><td>Macclesfield Town EastL5</td><td>Macclesfield Hurdsfield</td><td>£23,600</td></tr>
<tr><td>AlexandraL1</td><td>Alexandra</td><td>£23,700</td></tr>
<tr><td>West NantwichL1</td><td>Barony Weaver</td><td>£23,800</td></tr>
<tr><td>Wilmslow Town Dean Row & HandforthL4</td><td>Handforth</td><td>£23,900</td></tr>
<tr><td>Congleton EastL3</td><td>Congleton North</td><td>£24,200</td></tr>
<tr><td>St BarnabasL4</td><td>St Barnabas</td><td>£24,300</td></tr>
<tr><td>East CoppenhallL2</td><td>Maw Green</td><td>£24,400</td></tr>
</table>

Service users are financially assessed according to ability to pay (under Government Fairer Charging Guidance) and so should not ever be asked to contribute more than they can afford to do. This means although there will be an impact on service user's particularly just about the Council threshold this should not be excessive.
</td></tr>
<tr><td>Please give details of any other potential impacts of this policy (i.e. Poverty & deprivation, community cohesion, environmental)</td><td>Yes</td><td></td><td>Comments/Actions:
This policy is likely to decrease disposable income for social care service users although within a designated limit.</td></tr>
<tr><td>Could the impact constitute unlawful discrimination in relation to any of the Equality Duties</td><td></td><td>No</td><td>Comments:
Although impacts have been detected these concern the general principle of social care charging and do not introduce any new emphasis on current policy.</td></tr>
<tr><td>Does this policy – procedure – function have any effect on good relations between the council and the</td><td>Yes</td><td></td><td>Comments:
Charging is always likely to be a contentious area and the consultation events showed the strength of peoples feeling</td></tr>
</table>

community			concerning the measures.
Do you require further data/information/intelligence to support decision making?		**No**	Comments: (please note if you answer yes or no you will still be required to complete the Data Methods/Collection to Support Decision Making Section)
Please specify any question(s)/issues/concerns/actions identified as a result the assessment. What needs to be done?			Comments • Communication, information and support for vulnerable people and their carers.

Data Methods/Collection to Support Decision Making		
Please indicate what methods of research, information and intelligence will be/have been used e.g. consultation, reports, comparisons with similar organisations	Internally Activity data has been analysed to determine how much extra income each measure is likely to generate in comparison to the potential impact on service users.	Externally Comparisions with Other Local Authorities have been made to determine where charging policies are set and currently subject to consultation and change.
Please state who will be/who was involved/engaged/consulted	Internal (Staff/Members/Service/Dept) Members Social Care staff	External (stakeholders/service users/partners) All stakeholders, service users, carers and community support groups
Please indicate any significant expected costs & resource requirements for completing the		

data collection		

Equalities Impact Assessment (EIA) Action Plan: Making Changes					
REF	Action	Responsible Person/s	Action Deadline	Tasks	Progress
	Notify customers of charge impact and ensure no-one is left not able to afford care.	Client Finance	By end of April 2011		
	Review Extra Care Housing charging structure	Lynn Glendenning	By September 2011		
	Review Hot Meals contract as will become unviable due to low volume	Alison McCudden	By September 2011		
	Monitor income against targets	Patrick Rhoden	On-going through year		
Please state the date the policy/procedure/function will be reassessed? (generally 1-3 yrs)			Comments/Date:		

Signed (Service Manager) ……. Date…….

Signed (Head of Section) …….. Date…….

Once you have completed this section please email it to the Equality and Inclusion Team. The Equality and Inclusion Team will convene a quarterly meeting of the Fairness and Inclusion Group (FIG) who will quality check our EIA's to ensure we have considered everyone. We plan to send approximately 2-5% of our completed EIAs Forms to the (FIG).

Quarterly Progress and monitoring

REF	Action	Progress	Completed

Once you have completed your progress report, please email it to the Equality and Inclusion Team. Make a copy of the progress report template so you can present an update in three months time.

Once you have completed your quarterly progress report, please email it to the Equality and Inclusion Team

Measuring Impact & Reporting

Ref	Action	Impact	Outcome	Review Date
	The changes that you have made to remove the gaps you have Identified (simply cut and paste these from the action plan).	What has been the overall impact of making the particular changes? (could include wider community involvement in policy development or greater use of service by diverse communities).	What are the concrete results of having changed your policy or service? Could include improved service use, reductions in complaints or increased satisfaction. These will be based on detailed data and should outline how the changes have brought about improvements for different communities and groups	

Once you have completed your impact report, please email it to the Equality and Inclusion Team. The Equality and Inclusion Team will prepare an annual report for Corporate Management Team and Cabinet on our progress.

Appendix 1

Service Reference Index

Service Reference Index			
Safer & Stronger – **SSC**	Regeneration – **REG**	Planning & Policy – **PAH**	Legal & Democratic Services – **LAD**
Children & Families – **CHI**	Adults – **ADU**	Health & Wellbeing – **HWB**	Human Resources & Organisational Development – **HROD**
Policy & Performance – **PAP**	Corporate Improvement - **CI**	Environmental – **ENV**	Borough Treasurer & Head of Assets – **BTA**

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Agenda Item 7

CHESHIRE EAST COUNCIL

REPORT TO: Cabinet

Date of Meeting: 14 March 2011
Report of: Adult and Community Health & Wellbeing and Places Directorate
Subject/Title: Adult Services Transport
Portfolio Holder: Cllr R Domleo

1.0 Report Summary

1.1 Adult Services Portfolio Holder approved initially a 2 month public consultation from November to end of December 2010 on the future of Adult Services transport provision and associated client charges. This consultation period was extended at public request to the end of January 2011.

1.2 A full report on the consultation process and responses is attached to this report. General feedback is that people value the door to door transport service, particularly the safeguarding aspects (escorts and physical assistance to and from vehicle) and would be happy to pay more for a similar service.

1.3 Adult Services are committed to ensure that no individual will have commissioned transport withdrawn without an appropriate alternative solution being available to them to meet their eligible unmet transport needs.

2.0 Decision Requested

2.1 Approval is sought for Adult Services and Places to begin a phased programme from April 2011, to move away from Strategically Commissioned Adult Transport provision over the next two financial years. This extended timescale is to mitigate against corporate cost impacts, customer safe transition and to enable the market and support services to fully develop to aid a safe transfer. Adult Services recognise that there may be a need to retain a small element of strategically commissioned transport for those individuals in exceptional circumstances who cannot be supported to travel through alternative transport options.

2.2 To agree that no new Adult Services eligible transport needs will be met through strategically commissioned transport, unless in very exceptional circumstances and where legally required to do so.

2.3 For Places Directorate and Adult Services to work closely to develop a range of mitigating measures and alternative provision - detailed at item 3.

2.4 For Adults Services to set the fee for commissioned transport to £4 per one-way trip from 9th April 2011(representing a £2 per trip increase) bringing

additional income of £200k based on current transport user numbers which will taper as demand reduces. The average amount people felt they would be happy to pay from consultation equates to £4.55 per one-way trip. Adults with mobility issues receive a welfare benefit which should be used to pay toward transport. Within disregarded income, people have an amount protected for transportation and all eligible customers would also have concessionary travel passes.

2.5 For re-investment of savings amounting to £473,400 (2011/12 – see Section 7 below for full details) to be made to develop transport support services, develop concessionary travel and to cover the likely demand on personal budget expenditure. Future years investment would then be determined by demand on provision.

3.0 Reasons for Recommendations

3.1 Transport is one of a very limited number of discretionary areas within the Adults Social Care part of the budget with transport only very rarely fitting the criteria as an assessed Social Care need under the Critical and Substantial criteria that is applied under Fair Access to Care. Adult Services do have a duty to ensure a critical or substantial unmet need for transport to access care services is met.

3.2 Strategically Commissioned transport does not meet the requirements of personalisation, limiting choice and flexibility. The Department of Health requires everyone with eligible community social care needs to receive their services through personal budgets by the end of 2012.

3.3 In view of the Council's scarce resources and budget pressures there is a need to ensure equity in funding, taking account of welfare benefit income that many Adults receive associated with mobility issues paid by the Department for Work and Pensions through Disability Living Allowance Mobility or Motorbility schemes and statutory concessionary travel for eligible people. All service users have a small amount of protected income from which to meet some transport costs. Where someone has insufficient to meet their eligible transport needs, Adult Services has a duty to provide a personal budget to meet eligible unmet transport need.

3.4 Care managers from April 2010 should follow the tightened Adult Services Transport Policy in new and review cases, which is in line with personalisation and assessed eligibility for transport support or funding. The emphasis is on individuals making their own arrangements through mobility income and personal budgets ensuring more choice and flexibility and with support as required.

3.5 During the first 12 months there will be a focus on market development to scope and develop a range of services as follows:

- Appropriate alternative transport options in the private market (including community transport and accessible buses)

- Developing volunteer services with Third Sector
- Accreditation of accessible taxis
- Accessible buses
- Concessionary travel for carers
- Escorted door to door travel options
- Companion travel passes or Empower Companion card.
- Empower Card payment processes across a range of transport provision.
- Developing a travel planning, booking and coordination role
- Third Sector support for individuals to find suitable transport to meet their need.
- Safeguarding pathway underpinned by training and awareness to be developed and embeded for operators.
- Extending Independent Travel Training.
- Scoping rural transport issues and examining options.
- Ensuring tariffs are moderate for client group.

3.6 Proposed programme:

LILT Area	Timeline	Reason
Crewe/Nantwich	April - June 2011	Greatest amount of transportation, densely populated and greatest opportunity for market development.
Macclesfield	July - Sept 2011	Developing the Northern area as above.
Congleton	Oct - Dec 2011	Smaller, more disperse client group Often travelling greater distance.
Wilmslow	Jan - March 2012	An area where the transport market needs greatest development.
RURAL Areas	2012 onward	Looking at cross boundary partnerships And extending voluntary services.
Complex Needs	2011 onward	Recognising that there may be some People, exceptionally who cannot move from a Strategically commissioned transport Service.
Withdrawal of Strategically Commissioned Transport	By March 2013	In all but very exceptional cases.

3.7 Adult Services will continue a review of ineligible transport provision, through the application of the Adult Services Transport Policy, by supporting those with mobility income or no eligible transport need to independent travel.

4.0 Wards Affected

4.1 All

5.0 Local Ward Members

5.1 All

6.0 Policy Implications including - Climate change - In line with Total Transport objectives. **- Health**

6.1 Adult Services Transport Policy to reflect Cabinet agreement for no new Commissioned transport services from April 2011 unless in exceptional circumstances and where legally required to do so.

6.2 To ensure Concessionary Travel Policies reflect the anticipated greater demand on concessionary travel by service users and carers/escorts to meet the personalisation agenda requirements.

6.3 To ensure Public Information and Communication is available in accessible format, with support available to assist customers with individual queries or support/transport planning needs.

6.4 A phased approach to the transformation of Adult Services transport is less likely to impact on corporate costs as the programme is extended across 2 years.

7.0 Financial Implications (Authorised by the Borough Treasurer)

7.1 Adult Services transport budget is £1,470k (2010/11) against expenditure of £1,592k delivering commissioned transport to 420 adults to and from their day care provision through Integrated Transport shared services fleet vehicles (40 mini-buses) or hired transport. The transport budget reduced by £200k this financial year which has been met through in year efficiency savings although Adult Services project an overspend this financial year of £120k.

7.2 Adult Services have an efficiency challenge to save a gross amount of £1.3m over the next two years. This is made up of a MTFS roll forward of £500k in 2012/13 associated with the shift towards personalisation giving service users greater control and independence and £800k in 2011/12 emanating directly from the Efficiency group held on 16th September 2010. Charging for Transport currently generates £250k Income, based on the current level of customers this year, which is anticipated to increase by a further £200k through increased charges in 2011/12 subject to the volume of customers being retained. There is a risk that these income targets will not be met as service users opt to access different transport options and income decreases.

7.3 There will be a requirement to reinvest some of the savings into concessionary travel (£50k), travel planning service (£23.4k) and 30% of current spend set aside to meet personalisation anticipated demand (£400k) - the draw on this resource will be monitored and reviewed within the first 12 months. This reinvestment will be met primarily by the income generated from transport charges and where there is a short fall, should volume of custom decline, the service will have to look elsewhere to achieve the required savings.

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7.4 Gross expected savings over 2 years of £1.3m (£500k met through client charges and £800k from service withdrawal to alternative transport options). The Council's MTFS contains a reduction to the Adults transport budget of £800k in 2011/12 with any savings over and above this being reinvested in 3 areas as outlined below. There is an unknown risk in meeting these saving targets in year associated with pace of market development and the 2 year programme of transformation. Additional capacity is available within the transport budget to cover the risk if there is a shortfall in 2011/12, although should the need arise compensating one-off savings will need to be found from elsewhere across the Adults Directorate to make good this temporary shortfall.

7.5 A contingency reserve of £400k to be set aside to be drawn against as needed, to meet anticipated demand on Individual Commissioning personal budget growth associated with meeting eligible unmet transport needs in line with Adult Services statutory duty to meet Fair Access to Care critical or substantial care need, representing a 30% reinvestment to front line services. This can be put toward saving targets if not fully needed in year. Where an individual with eligible transport needs has insufficient income to meet their transport needs associated with receiving their care, Adult Services would make up the difference through a personal budget - there may be a requirement, therefore to redirect some savings to Individual Commissioning for increases to personal budgets associated with unmet eligible transport needs

7.6 Reinvestment of £50k to concessionary travel. This represents a prudent assessment of the financial impact of service users making their revised journey using existing passes – with the consequential recharge from the bus companies to the Council rising by this amount. This reinvestment would be reviewed within year one to establish impact and likely ongoing demand.

7.7 There is an identified need to negotiate a jointly funded Gr.7 post within Places Directorate for transport planning services offered to Adults and Childrens Services (80/20 split) - **£23,400 pa** from Adult Services and £5,873 pa from Childrens.

7.8 A short summary table is detailed below, detailing the current budget forecasts, the anticipated delivery during 2011/12 and the current shortfall in overall terms in 2012/13, which will be reviewed over the coming year to ensure an overall balanced position in 2012/13.

	£000	£000
2010/11 Base Budget		1,470
Additional Income From Service Users from 2011/12		200
		1,670
Individual Commissioning Contingency Investment	(400)	
Transport Planning Post (shared cost)	(23)	

Concessionary Travel Investment	(50)	
		(473)
Available		1,197
2011/12 Budget Reduction		(800)
2012/13 Budget Reduction		(500)
Net Shortfall		(103)

7.9 Transport staff redundancy to be costed and met by corporately agreed processes.

7.10 The move away from strategically commissioned transport by Adult Services will have an impact across the Transport Fleet and in particular those vehicle costs shared, where Children's Services currently benefit from making use of the fleet, thereby realising economies of scale through sharing costs with Adults. The programme of Adult Services transformation over two years is likely to mitigate the financial risk for Children's Services. However early indications are that this could increase costs by **£200k** across the Transport Fleet for those services used by Children's Services. These increased costs are subject to review and discussion through contract and other negotiations, including how the additional costs, should they arise, be funded from either Places or Children and Families. The outcomes of further work in this area will be monitored and reported on regularly through 2011/12.

8.0 Legal Implications (Authorised by the Borough Solicitor)

8.1 The Local Authority has a duty to carry out assessments under Sec. 47(1) NHSCCA 1980 where an individual has come to the knowledge of the authority and they may be in need of community care services. If this assessment highlights a substantial or critical need for a service that the local authority has a duty to provide and their transport needs are also assessed as critical or substantial, then the need for transport must be reflected in the care package. In this case, the Local Authority does not have to provide transport itself but can provide funding through the individuals personal budget to enable them to access the services elsewhere.

8.2 If the transportation is not required to access a service which the local authority has a duty to provide, then the need for the transport would still be there but it would not be a critical or substantial need. In this case, the local authority would not be required to provide or fund that service.

8.3 In order to comply with the legal requirements for proper consultation, the decision maker should ensure that he has familiarised himself with the views expressed during the consultation period and ensure that those views are taken into account in any decision made.

9.0 Risk Management

9.1 The impact on Children's Services Special Education Needs transport unit costs is likely to increase significantly should Adult Services withdraw transport offer.

9.2 Given Adult Services need to meet critical or substantial unmet transport need, the risk should the market not respond at an appropriate pace with alternative appropriate provision would bring a need for greater investment in Individual Commissioning funds to meet needs through personal budgets.

9.3 Impact on Adult Services Individual Commissioning staff to ensure smooth transition from fleet to alternative provision.

9.4 Timescales for transition may extend over two years as the market responds.

9.5 There may be a need to retain a very small commissioned transport element for individuals with very complex transport needs which cannot be met in any other way - these needs may possibly be met through fleet retained by Childrens' Services.

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Adult Services Transport Consultation Report

Period of Consultation : 2 November 2010 – 31 January 2011

Summary of Responses

Background

Within a challenging financial context the council is faced with maintaining statutory provision to meet critical or substantial care need, reviewing discretionary provision and addressing the national directive of personalisation, developing the market place to provide greater choice, flexibility and control for customers in meeting their care needs through personal budgets. The national directive for Local Authorities is to provide services in the community in a personalised way, offering this choice, control and flexibility to customers from a range of traditional and innovative services – every Local Authority is required by the Department of Health to offer community care services in a personalised way to all customers by 2012.

In the current economic climate, all local authorities in the UK are experiencing severe and increasing budget pressures. Cheshire East Council are dealing with a reduction in grant funding from the government, a higher than average growing elderly population, more demands for social care and an over-spend projected at £9.2 million in Adult Services alone for 2010/11.

Cheshire East Council is committed to developing services that are flexible and suitable for all and aims to bring control and choice to adult transport arrangements. Those who can travel independently will be supported to, and those who need to remain travelling with the same level of service and support because of their critical or substantial needs will be given the option of equal and alternative transport arrangements to meet their assessed mobility needs in order to access care services.

Summary

Adult Services transport budget is £1.4m (2010/11) and is used to deliver transport to 420 adults across East Cheshire to and from their day care provision using fleet transport vehicles (43 mini-buses) or hired transport.

As a discretionary service, the current cost per one way trip to the council is £9 and the cost to the transport user is £2. One of the proposals to the Transport Consultation is to reduce the gap between the cost and charge of transport services.

This consultation aims to involve the views of service users, carers, key external stakeholders, representative bodies, voluntary organisation and the wider public ensuring that these are taken into account when exploring a number of options and proposals of meeting the Personalisation agenda and budget challenges.

The consultation period should be seen as a process of dialogue and debate; and an opportunity for people to ask questions and offer their views and opinions for consideration.

This document summarises the feedback received through the consultation processes evidencing the key themes from the public meetings, other open comments and the statistical feedback from the Transport survey.

Consultation Process

The consultation period originally ran between 2nd November 2010 and 31st December 2010. However, following feedback it was decided to extend the formal period for consultation around Transport until 31st January 2011, (and to add another public meeting date) and so the date of the cabinet decision was put back to March, 2011 respectively.

Throughout the 3 month consultation period, numerous steps have been taken to involve and inform those who will be affected by changes to Transport provision, including service users, carers, families, and organisations representing the former groups.

Below is a list of the methods used to provide information about the proposals to Adult Services Transport and the opportunities in which people were given to have their say;

- Public Meetings (listed below)
- Transport questionnaire; Online and accessible (paper copy with assistance to complete offered by Day Centre Staff)
- Website information
- Presentations
- Facilitated meetings at all day care centres (listed below)
- Consultation specific e-mail account for feedback and responses
- Postal address for open comment and letters
- Individual meetings and telephone conversations
- Poster campaign
- Discussion and engagement with third sector and support groups
- Individual responses to letters of concern
- Briefing of Over-view and Scrutiny Committee
- Briefing of Link, Learning Disability Partnership Board and Forums, Older People Network, Carers Interagency Group, Central and Eastern Primary Care Trust.
- Meetings with Drivers and Attendants
- Liaison with Unison and Transport Services Management

Public consultations (N = number of attendees)

1st December 2010	Transport Consultation 1	Middlewich	N = 23
1st December 2010	Transport Consultation 2	Middlewich	N = 7

21st January 2011	Transport Consultation	Knutsford	N = 9

The consultations followed a set format with presentations from senior officers on specifics of the consultation and Personalisation. There was variation within each meeting depending on the number of attendees and whether it was suitable to have group discussions around tables before the question and answer session. Questions and comments from the meetings were recorded and these will be fed into the report.

Facilitated meetings at Day Care Centres (N = number of attendees)

7th December 2010	Hollins View,	Macclesfield	N = 5
13th December 2010	Peatfields,	Macclesfield	N = 6
13th December 2010	Cheyne Hall,	Nantwich	N = 4
7th January 2011	Mount View,	Congleton	N = 15
11th January 2011	Redesmere Centre,	Handforth	N = 33
13th January 2011	Carter House,	Congleton	N = 30
17th January 2011	Hilary Centre,	Crewe	N = 35
19th January 2011	Mayfield Centre,	Macclesfield	N = 11
24th January 2011	Stanley Centre,	Knutsford	N = 30
24th January 2011	Macon House,	Crewe	N = 20
25th January 2011	Salinae House,	Middlewich	N = 30
25th January 2011	Hilary Centre	Crewe	N - 20

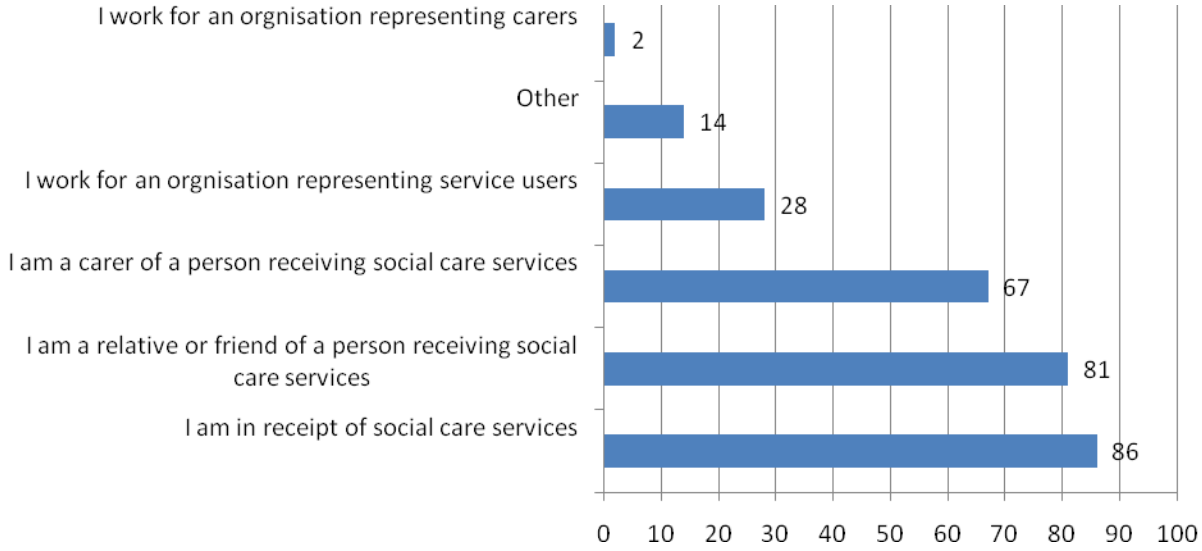
Discussions at Day Care Centres were approached in an informal manner to give service users and their carers an opportunity to absorb the information and to ask questions and give feedback; notes were taken from each of these discussions and are fed into this report.

Responses to the Transport Questionnaire

A total of 250 questionnaire responses were received during the consultation period (2nd November 2010 – 31st January 2011) via the online survey and the accessible (paper) version of the survey. These responses have been evaluated and summarised, along with the additional comments received from this feedback method.

Question 1

Which of these statements best describe your situation?

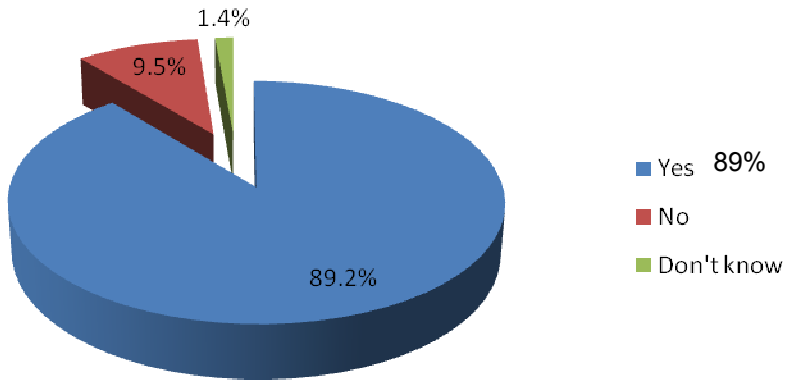


Additional comment;

Respondents were able to choose more than one option here, so the results are presented as numbers and not percentages. The chart shows that the greatest level of response was received from those receiving social care services or from those who are related to or friends with those receiving care services.

Question 2

If you are in receipt of social care services, do you also use the Council's fleet mini-bus transport service to get to and from day care?

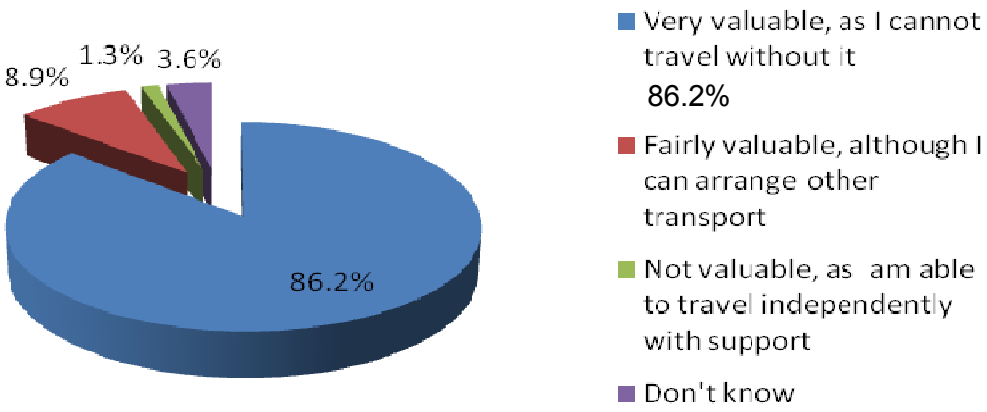


Additional Comment;

There were 222 responses to this question. This chart shows the great proportion of respondents who use (or are representing a service user who uses) the fleet transport service to travel to and from their day care provision (89%).

Question 3

How valuable is the social care fleet mini-bus service to you?

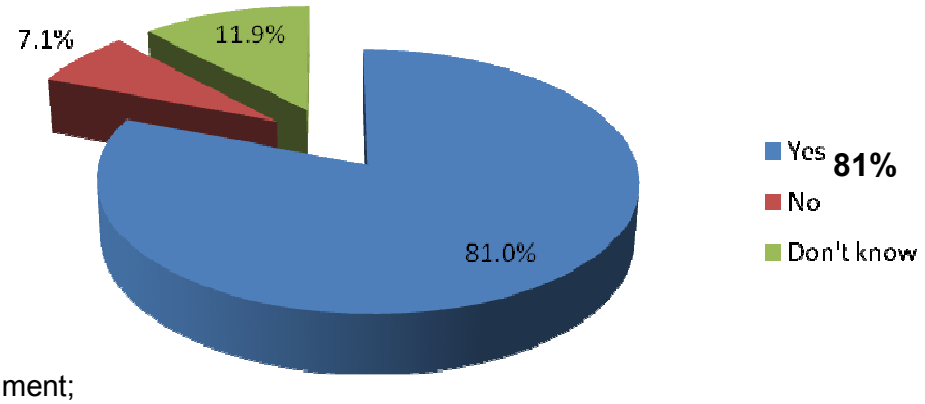


Additional Comment;

There were 224 responses to this question. The vast majority of responses indicate that respondents find the transport provided by the council very valuable and are as are unable to travel independently (82.6%)

Question 4

The Council is currently reviewing the way it provides its minibus service which gets people to and from day care. Options being considered instead are offering people dial-a-ride, specialist taxis or providing a bus pass for a carer in order for them to travel with you (the cared for). Do you think these changes would have a major impact on you?

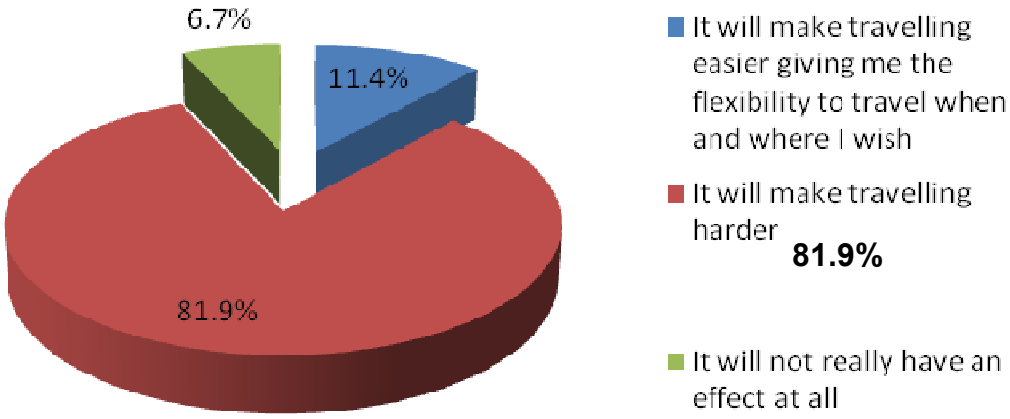


Additional comment;

There were 210 responses to this question. The chart shows the high proportion of respondents who felt the changes to transport provision would have a major impact to them and their lives (81%).

Question 5

How will moving from Social Care fleet mini-bus to another suitable form of transport affect you?



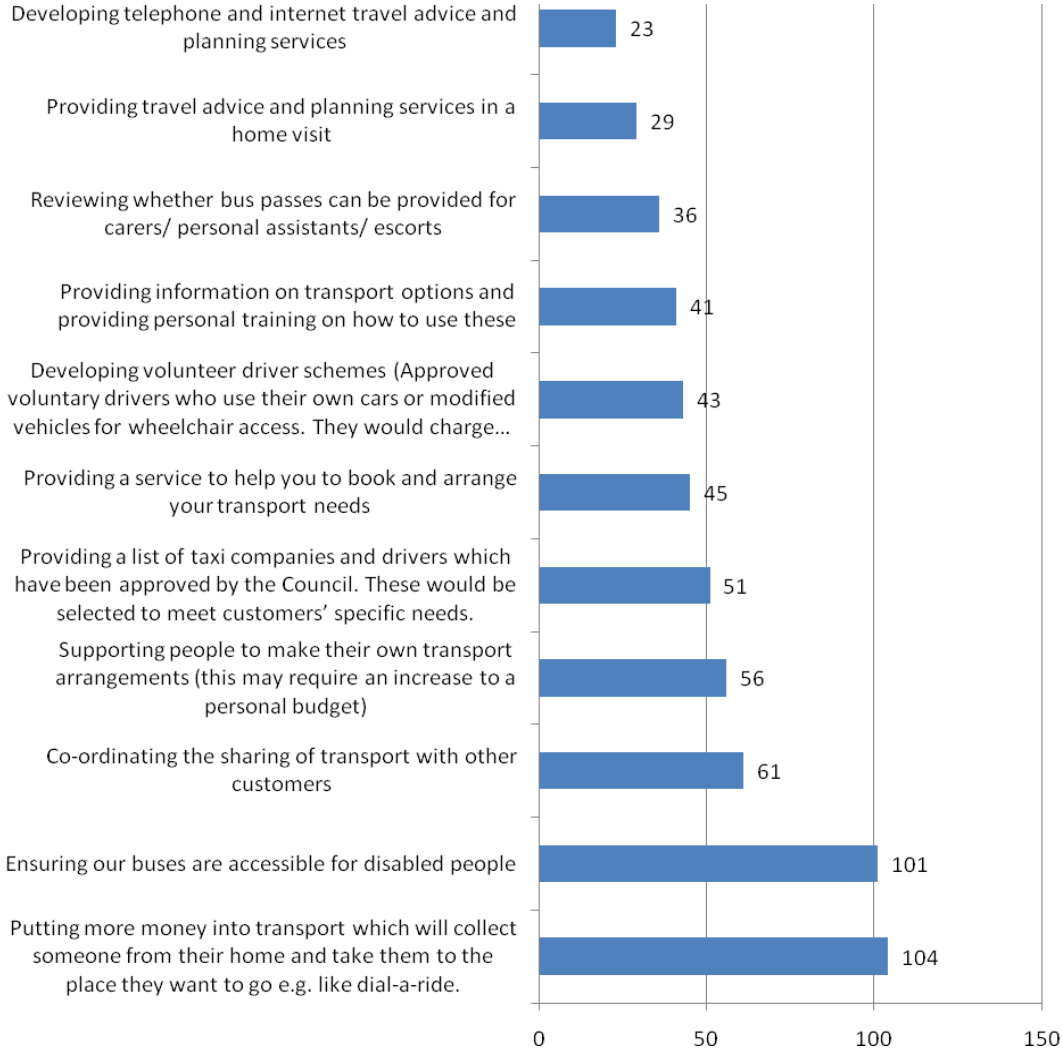
Additional comments;

There were 210 responses to this question. A small percentage of respondents (11.4%) indicated that moving away from fleet transport would make travelling easier for them and increase their independence and flexibility to travels when and where they want. An even smaller percentage (6.7%) reported that moving away from fleet transport would have virtually no effect on them, while a great proportion of respondents reported that moving away from fleet transport arrangements would make travelling harder (81.9%)

Question 6

The Council is exploring the following range of options to help people with their transport needs. Please indicate which options you feel would help you. You may choose more than one:

The chart shows the number of people who indicated which options they would find most helpful to their situation;



Additional feedback from respondents;

The current system is the best option
Currently not enough public transport links – especially in rural areas
Public transport is expensive
Happy to travel with assistance
New system will lose experienced staff and established relationships with staff
Happy to use taxis
Transport must cater for disability; wheelchair friendly and with escorts
Travel time could be reduced
More flexibility
Could lead to isolation without the same support

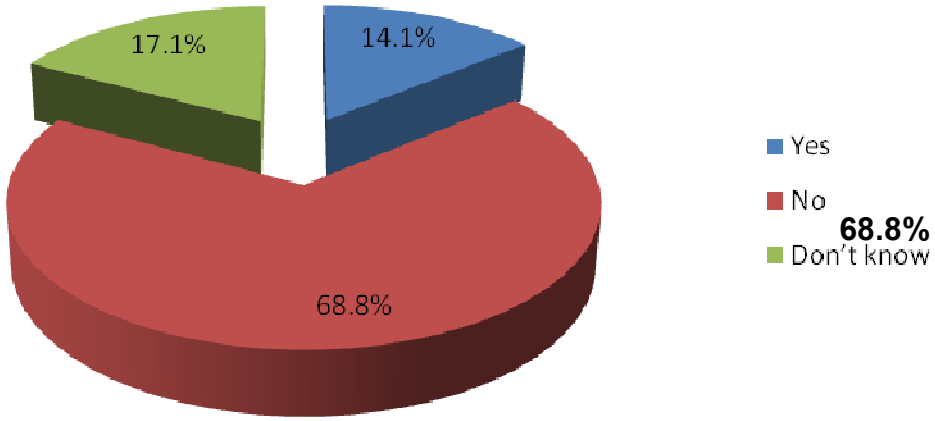
More information is needed

Additional comments;

The greatest feedback was in support of options to put more money into transport provision such as s dial-a-ride, or to improve disabled access to public transport such as busses.

Question 7

If you were supported with information and advice, would you be able to arrange and finance your own transport needs?



Additional feedback from respondents;

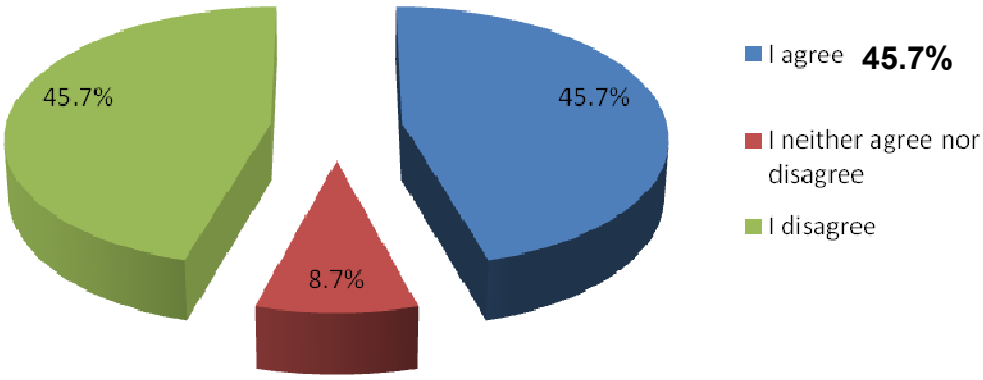
Too costly; cannot afford to pay more
Too confusing
Would prefer to keep fleet transport
Would need assistance
Unable to organise effectively given age and disability/communication difficulties
Suitable for some but not others
Need similar transport arrangements

Additional comments;

There were 205 responses to this question. While the majority of respondents indicated that they would not be able to arrange and finance their transport needs, the qualitative feedback to this question sheds some light on the reasons behind these responses. Some respondents mentioned that they cannot afford to pay more for their transport provisions whilst some mentioned that due to the nature of their disability they would be unable to cope with the task of arranging transport for themselves.

Question 8

As a result of increasing financial pressures on local authorities, it is unlikely that the Council will be able to continue to subsidise the social care fleet minibuses at the current level. Read the following statement and select the statement which best meets your view. "Given the current financial pressures on national and local government I understand why the charges might need to be increased for my transport services and I accept the situation"

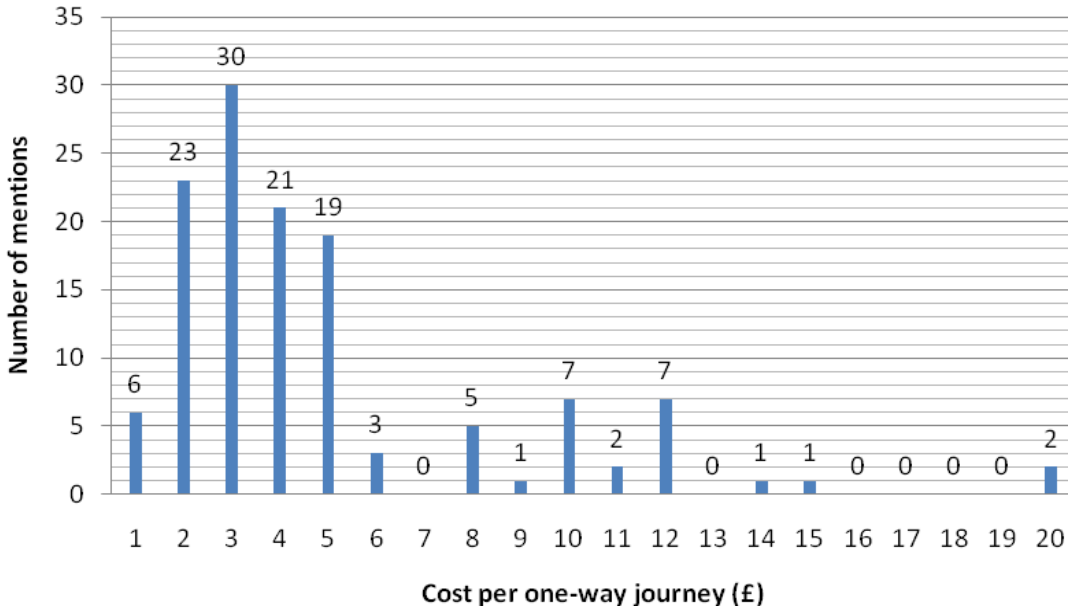


Additional comments;

There were 208 responses to this question. An equal proportion of respondents indicated that they agreed or disagreed with the statement presented.

Question 9

What is the maximum charge per one-way trip that you think is reasonable for using the social care fleet minibus service? Please enter an amount to the nearest pound (£)



Additional Comments;

This is a key question as evidences what people think is a fair price to pay for the transport provision they receive. The graph shows the number of people who indicated what they thought was a fair price for their journey (each way). These figures have been rounded to the nearest pound. The most recurrent cost indicated by respondents is £2 and £3 per one-way journey, while the average cost indicated per one-way journey is **£4.55.**

However many respondents indicated that the length of their journey should be a determinant in the costing of that journey.

Question 10

Please rate the following service in order of priority to you; 1 = Most Important and 6 = least important.

The results have been analysed and here is the ranking for each service;

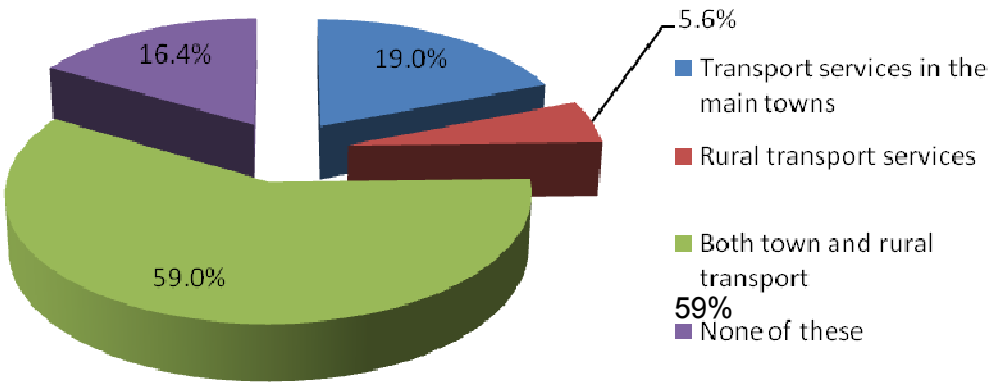
Service	**Rank of Importance**
Transport	1
Day Care Services	2
Carer Respite Services	3
Home Care Services	4
Family Based Care	5
Reablement	6

Additional comments;

Although the data gathered was not complete enough to allow for statistical analysis, the key message of the information has been represented in the table. Transport and Day Care Services came out as the top most important services to respondents in the survey sample.

Question 11

Thinking about transport services in general, which of the following options do you consider to be most important?



Additional feedback;

There were 195 responses to this question. The graph shows that a greater proportion of respondents equally valued the importance of transport services in both towns and rural areas of Cheshire East.

Qualitative Feedback – Key Themes

The feedback gathered from the public meetings, facilitated discussions at the day care centres, and open comments from the surveys and by letter and e-mails have all been analysed together. We have also received responses from organisations supporting service users and their carers and this feedback has also been fed into the qualitative analysis of this report. A more comprehensive response was received from UNISON, and this response has been included as an Appendix document; (see Appendix A).

From this analysis there have been six common and re-occurring themes that encapsulate the opinions and feedback of all the people who were involved in the consultation process.

The key themes are;

1. Safeguarding
2. Support
3. Funding
4. Consultation Process
5. Personalisation
6. Service Availability

Key Theme 1 – Safeguarding

Many people raised concerns over the safeguarding of service users. It was felt by some that the most vulnerable people were being ‘attacked’ in this transport consultation; and that those who are likely to be most affected were unable to speak up for themselves.

Concerns were raised about how particular service users and user groups may be unable to travel independently given the nature of their condition, and about how their safety would be compromised in doing so. It was noted that although the new transport proposals may be suitable for some service users, they would not be suitable for others.

Queries were raised as to how the council would ensure the quality of new transport arrangements. This was focused on whether the staff of bus or taxi companies, would have the correct level of training to enable them to support service users in an appropriate way. Also if these staff would be CRB checked, and if the services they provide would be reliable.

Some quotes:

"You are targeting the most vulnerable in society and their carers"

"Taxi drivers do not have the right training and knowledge i.e. first aid"

"These vulnerable people cannot travel independently''

"Taxi drivers will need CRB checking"

CEC Response/Action;

Officers recognise the need to reassure that vulnerable people will not be left without proper transport provision, the Council proposes developing a range of transport options with transport operatives being accredited to a specific level and trained in the needs of our customers. We recognise that removing cash transactions and introducing concessionary travel for escorts and carers will assist vulnerable people to travel safely. The Council recognises that there will be a number of service users who will require specialised, commissioned transportation.

Key Theme 2 – Support

A large number of people expressed their concerns about the level of support that would be available to services users given the new transport proposals. The main concern was that those who needed an escort to travel would be unable to travel if escorts were not provided. Additional concerns were that service users would lose the door to door support they receive from the fleet bus drivers.

Some people were concerned about the growing level of pressure that transport changes would bring to both service users and carers and whether provisions would be made to support the most vulnerable through these changes.

Some people were concerned for services users who do not have family or friends who could help and support them to find new transport arrangements.

Some quotes:

"People need more care than just a taxi collecting them and delivering them home"

"I wouldn't get the same help from a taxi driver"

"What about those who do not have family to help them?"

CEC Response/Action;

The Council recognises the valuable service offered by fleet drivers and attendants in ensuring customers are safely escorted to and from the vehicles and into their homes. It is proposed, through accreditation and training that a like for like service is developed.

Key Theme 3 – Funding

Much concern was raised over the cost of the proposed transport services. People felt that they would not be able to afford to pay more for their transport to and from day care. People who already operate tight personal budgets felt that an increase in transport costs would mean that some would be left unable to travel to day care services at all.

While many people expressed that they would be willing to pay more to keep the same transport service they receive now. Or that they were happy to pay more for transport, they just wanted to know how much more it would cost them.

Others wanted to know if they could spend their Disability Living Allowance more flexibly on other services and if personal budgets or mobility allowance would be increased in line with increased travel costs.

Many people commented that they felt cuts should be made elsewhere instead of community transport, which would affect the most vulnerable. There were also suggestions about setting a fixed price based on length of journey.

Some quotes;

"Cuts should be made elsewhere, not the handicapped"

"I believe the contribution I already make to transport is high"

"I'm happy to pay more but I'd like to know how much"

CEC Response/Action;

It is expected that people with mobility income will use that income to meet their transportation needs similarly for those with Motorbility vehicles. Where there is a shortfall and a customer cannot afford to meet their critical or substantial care or transport needs the Council has a duty to provide the funding to meet the shortfall.

Key Themes 4 – Consultation Process

Whilst most people felt the consultation was an important opportunity to find out more about the proposed changes to Transport provision, there were concerns about the integrity of the consultation process. Some viewed the process and associated proposals as a *fait accompli*.

Comments were also made concerning the timing and location of the public events. More specifically, some had difficulty locating the venues and the events were scheduled to occur at the same time the fleet buses would be dropping off service users.

Others reported a lack of publicity and communication, with their attendance being attributed to 'word of mouth'. Others deemed the distribution of invitation letters via service users for their parents and carers to read as inappropriate.

Some also expressed their disappointment at the absence of an elected member to participate in the discussions. Although attendees felt they had the opportunity to express their views, there was some scepticism as to what, if any, impact they would make.

Some quotes:

"It looks quite obvious that the outcome is a foregone conclusion but yet again people in offices are making decisions which will drastically affect the lives of service users".

"This consultation is meaningless, we won't be listened to."

CEC response/action:

Cllr Domleo, Portfolio Holder for Adult Services approved a consultation process with decisions to be made by Cabinet following full consideration of the views of the public. The Council has attempted to provide a range of opportunities for people to have their say and can demonstrate 359 people have attended consultation events, 220 have submitted completed questionnaires, the Council has received 33 letters on the subject along with 11 emails.

Key theme 5 - Personalisation

Some were sceptical about the motives for implementing Personalisation, perceiving it to be a cost cutting exercise, with the authority relinquishing their responsibility for care and support (including transport provision) onto the service user, their families and carers. Others questioned why service users had to consider Personalisation if they were happy with the traditional services currently received. Some felt that the quality of life of some service users would be negatively affected by the personalisation agenda and the concept of giving more choice and control, when routine and consistency were of paramount importance to them.

Questions were also raised relating to the number of service users who were using the Empower Card and its suitability and appropriateness. Concerns were raised relating to the Empower Card and Personal Budgets, with some feeling they were not appropriate for many services users, their families and carers. One issue of particular note, was the perceived increase in the administrative burden on families and carers.

Some quotes:

"The Empower Card and personalisation is useless for my son – he cannot manage this himself".

"What is a Personal Budget?"

CEC response/action:

Personalisation is a national directive from the Department of Health which requires all Local Authority social care to be offered in a personalised way by 2012. The Council has developed an innovative system to deliver personal budgets in a cost effective way in the Empower Card which is continuing to be developed. There are a range of options available to individuals in the way they operate the Empower Card system – a personal Empower Card, a companion card which can be operated by a carer or relative, a managed account with a care provider or a virtual account managed by the Council. It is felt that these options will enable most of our customers to benefit from the programme.

Key theme 6 - Service Availability

There were concerns that the proposed transport options would not be available in all areas of Cheshire East, with particular concern being raised by those living in rural areas and those residing close to the border with the neighbouring authorities. There was also concern that there was already a lack of suitable local private transport alternatives which were accessible with adequately trained staff and escorts to accommodate the diverse needs of those individuals requiring adult social care transport.

The future of Cheshire East Councils Day Centres was also raised with attendees feeling that the proposed transport changes would have ramifications on the future of day care services. There was real concern that Day Care Services would be next to face cuts.

Concerns were also raised about the potential environmental impact of an increased number of taxis, minibuses and private cars which would be required to transport service users to and from day care if the fleet transport service ceased to exist.

Some quotes:

“You listed Dial-A-Ride but when I have contacted them they said they could not provide a service at the same time on a daily basis”

“Families are concerned that this is the start of cuts to services such as Day Care.”

CEC response/action:

The Council recognises that the transport market needs to develop to meet the needs of all social care customers and that the provision is not there currently. Considerations to a range of services to meet a variety of needs across the Cheshire East footprint have been identified. The consultation process has not highlighted any further options which the Council feels it has not already captured.

Reviewing transport does not mean that Day Care services are at risk, however as personalisation rolls out people may opt to have their care needs met in a different

way and if this happens in numbers then building based provision would need to be reviewed.

Next Steps

Cheshire East Cabinet will consider a report from Adult Services on 14th March 2011, once the recommendations have been agreed by Corporate Management Team and Overview and Scrutiny Committee.

An Equality Impact Assessment will accompany the decision making process as well as this summary report and example correspondence.

This summary document will be posted on the Cheshire East Council website together with full comments from consultation and the summary report will be distributed to those people who have provided contact details.

Department/Service	Adult Services	**Equality Impact Assessment Form Template**	
Ref **See Appendix 1**	**ADU**	Officer responsible for the assessment	Alison McCudden
Name of policy procedure function being assessed	**Adult Services Transport Policy**	Start date of assessment	04/02/11
Are there are any other policies or procedures associated or linked with this one.	• Personalisation - Assessment		
Briefly describe the aims, objectives and outcomes of the policy / procedure / function	April 2010 review: • Introduce Personalisation for Transport for those with an eligible unmet need only. • Move away from strategically commissioned Transport by 2012/13 unless in exceptional cases.		
Who is intended to benefit from this policy –procedure – function?	The change in policy is required under the Personalisation agenda and will bring about cost savings. As such it will benefit the citizens of Cheshire East as well as service users by giving them greater choice and control.		
What factors could contribute to or detract from the outcomes?	▪ Culture change required within Adult Services to move away from commissioned transport. ▪ Service User/carer expectations. ▪ Availability of suitable alternative transport provision across CEC and rural borders. ▪ Suitable discretionary concessionary travel policy to support personalisation. ▪ Resources available for individual reviews to support users through change. ▪ Independent Travel Training use. ▪ Risk of corporate cost implcations. ▪ Saving targets in Places Directorate for Integrated Transport Service.		

			▪ Saving targets in Adult Services for commissioned Transport.
Who are the main stakeholders in relation to the policy – procedure- function? (Please consider key equality groups)			• Service Users and Carers • LD Partnership Board and Forum • Carers Interagency Group • Older People Forum and Senior Voice, • North West Ambulance Service and PCT • External provider services. • Disability Information Bureau • Staff and Members
Who is responsible for the policy – procedure – function?			• Adult Services Senior Management Team.
Please indentify any impact (Positive / Negative) this policy, procedure, function or service will have on the following protected characteristics:			
Age - Is there an impact?	**Yes**		Comments/Actions: Cheshire East has a larger elderly population than both England and the North West. There are 68,400 people aged 65+ in Cheshire East or 18.9% in comparison to an average of 16.6% for the North West and 16.3% for the country. Correspondingly, Cheshire East has a small percentage of young people; 22.9% aged under 20, compared to 24.3% for the North West and 23.9% for England. Within Cheshire East in general the rural areas show the greatest proportion in both losses of young people and gains in older people. The Macclesfield area has the largest population and highest number of people aged 65+. The major issues for people of different ages with regards to the

			transport policy tend to involve issues regarding physical condition such as ability to get on transport, safety on transport. As such these are dealt with under the disability section of this EIA. Economic issues which are often a problem for older people are dealt with in the economic deprivation section.
Carers – Is there an impact?	**Yes**		Comments/Actions: The Office of National Statistics estimates that 10% of the population are likely to be carers i.e. 36,500 people in Cheshire East. There are 70,100 people over the age of 65 in Cheshire East and 8,016 of these may be carers. Of these approx 1,300 are likely to be in poor health themselves and 2,400 may be providing 50 or more hours of care per week. Only 740 carers are recorded as having had an assessment with Cheshire East Council of their needs as carers during the last year (Cheshire East Carers Strategy 2010). It may bring about health and safety concerns for the carer regarding the service user for instance concerning whether they have arrived safely at an establishment (by use of public transport, taxi or minibus etc). Proposed action include: - Ensuring that carer's are not put under undue pressure to provide transport to a service user. - Ensuring sufficient measures are in place e.g. check-in system that health and safety concerns are managed within an acceptable level of risk - Travel Training programme - Safeguarding awareness and training for operators.
Disability - Is there an impact?	**Yes**		Comments/Actions:

The majority of service users in Cheshire East Adult Services are those with a Physical Disability (55.3%). The next largest group is those with a Mental Health Disability which is almost half as much (23.9%). Learning Disability clients make up only 14.6% of community service users. 6.4% of customer's have a Visual Impairment [note older people are no longer taken to be a separate client group].

Client Type	Total Service Users	%
Physical Disability	3331	55.3
Mental Health	1441	23.9
Learning Disability	879	14.6
Other Vulnerable	206	3.4
Null	148	2.5
Substance Abuse	17	0.3
Visual Impairment	*384*	*6.4*
Total	**6022**	100.0

Note for table and graph: all categories are mutually exclusive except visual impairment. The data also shows the main client type so if a person also has other needs, these are not included in these statistics.

- The Government Report, "Improving the Life Chances of Disabled People", states that disabled people experience a number of areas of disadvantage. This includes that; they are more likely to live in poverty, they are less likely to have educational qualifications, they are more likely to be economically inactive, more likely to experience problems with housing and more likely to experience problems with transport.

			Transport is listed as disabled people's biggest challenge in this document. It also states there should be, "increased local authority accountability for making sure that all aspects of disabled people's transport needs are taken into account." "Disabled people travel a third less often than the general public and over a third of those who do travel experience difficulties, the most common being getting on or off trains or buses." - The Government 'Putting People First' document set out the pathway for all Councils to move towards the personalisation of social care. It is a consequence of this approach that the Council is reconsidering its provision of fleet transport. This is because in order for individuals to have greater choice over how their care needs are met there must be flexibility of transport. However, the aim of this policy is to react to predicted future demand and grow the external transport market. Current demand is not there at present for alternative services. In the longer term this approach may mean greater choice and control for people who are disabled. This may significantly positively impact on their lives. Major issues from transport consultation: - Impact: 81% of respondents to the survey felt that a change in provision would have a major impact on their lives. 11.4% felt that moving away from fleet transport would make travelling easier for them. - Ability for disabled to arrange transport: 11.4% of respondents indicated that this was important. However 68.8% of respondents in the survey indicated that they would not be able to finance or arrange their own transport even with assistance.

			The Council expects to invest to develop assistance for the public with transport planning and accessing the appropriate transport to meet their need. It will be important to ensure that these resources are sufficient to assist those lacking in capacity. Transport is considered within a review of care. - Cost of transport: e.g. public transport, taxis. Note: 45.7% of those who completed the survey said they understood why transport costs might need to be increased which was exactly balanced by those who disagreed with the increase. It is expected that with the change in provision that the service user will incur increased costs e.g. use of minibus, taxi, public transport. However, these increased costs will be factored into the individual's personal budget less the contribution the customer is able to make. Service users currently pay £2 to receive transport to and from a day centre. Many service users stated that they would not be able to afford an increase in transport costs due to their already stretched budgets. However, some also expressed the view that they would be prepared to pay more. The Council expects that people with mobility income will be able to use it to meet their transport needs. If there is a shortfall the Council has a duty to meet eligible unmet transport needs through a personal budget where the customer has critical or substantial care or transport needs. Where someone has a mobility vehicle their needs should be met by that resource. - Availability of transport: Concerns were expressed at the consultation events that it might be difficult to obtain transport to care services particularly from rural locations.

			The Council wishes to use a range of transport options for service users and develop the market over a 2 year period. However, it has acknowledged that provision is not currently available and that the market must develop. The Council must ensure that there is a 'phasing out' of the fleet system as capacity is built.. - Ability of transport to cater for people with disability: (101 service users indicated that this was necessary for buses in the survey). Transport companies must have a commercial interest in adapting their vehicles to cater for disabled people. These vehicles must also be available at the appropriate times e.g. when transport to day centres is required. A scoping study is required of interest of companies in adaptations. The Council must also ensure that there is a gradual 'phasing out' of the fleet system as capacity is built elsewhere. - Staffing: Loss of staff who understand the needs of service users. Attendees at the events expressed concerns as to whether staff from other transport options would be sufficiently well trained to support service users. For instance, in seeing them to their door, in operating a key safe. One example quote was "*"Taxi drivers do not have the right training and knowledge i.e. first aid".* There were also concerns over whether staff would be CRB checked. The Council aims to develop a robust accreditation system and training to provide a like for like quality of staffing by transport providers. However, some key issues remain. These include increased costs to ensure assistance 'to the

			door and other safeguards. There is also a lack of knowledge of the commercial interest firms will have in taking on this work and the associated costs that may go with it. Further research needs to be done to gauge these factors - Health and Safety: Concerns were expressed that people lacking in mental capacity might have their safety compromised by using alternative transport methods. For instance, if a service user was taken by taxi and deposited outside their home with no way for them to get into it, how a service would react to an unusual event in their day to day public transport journey e.g. getting on the wrong bus accidentally. Safeguarding measures are to be factored into each individual solution. The Council aims to carefully assess the capabilities of each service user to gauge which method of transport is most suitable. However, the other aspect of ensuring safety is the training of transport staff e.g. bus drivers. It should be recognised that risk cannot be eliminated nor is this desirable because service users would miss out on the many benefits greater independence can bring. For instance, building confidence, better integration into the community etc. It is expected that each service user will have their transport options reviewed as a result of this process and that careful monitoring will occur of how the user's suitability for this option.
Gender (Including pregnancy and Maternity, Marriage)?		**No**	Comments/Actions: According to the Mid-2009 population estimates from the Office for National Statistics the current resident population of Cheshire East is circa 362,700. This is split between 184,500 females and

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>178,200 males (50.9% and 49.1%). This is approximately the same as the gender split in the North West and for England as a whole.

There is a much larger ratio of females to male service users in Cheshire East. This can largely be explained by the differences in life expectancy between the sexes.

Service Users by Gender

<table>
<tr><th>Sex</th><th>Total:</th><th>%</th></tr>
<tr><td>M</td><td>2206</td><td>36.6</td></tr>
<tr><td>F</td><td>3816</td><td>63.4</td></tr>
<tr><td>Total:</td><td>6022</td><td>100</td></tr>
</table>

This impact on this protected characteristic is neutral. No issues were uncovered through research or at the consultation events.</td>
</tr>
<tr>
<td>Gypsies & Travellers - Is there an impact?</td>
<td></td>
<td>No</td>
<td>Comments/Actions:

Cheshire East Caravans - July 2010 (source LILAC)

<table>
<tr><td>All Caravans</td><td>139</td></tr>
<tr><td>Authorised Sites</td><td>119</td></tr>
<tr><td>Unauthorised Sites</td><td>20</td></tr>
</table>

Due to the transient nature of the Gypsy and Traveller community it is difficult to ascertain the exact numbers of this section of the community within Cheshire. It is considered an important and significant minority group however.</td>
</tr>
</table>

<table>
<tr><td></td><td></td><td></td><td>The change in transport provision would not impact on the gypsy and traveller community because of the location of traveller sites in rural locations. Taxis and minibuses must be available for appropriate service users. Cost of transport must also be factored into the financial assessment process.</td></tr>
<tr><td>Race – Is there an impact?</td><td></td><td>No</td><td>Comments/Actions:

White people are the overwhelming racial group within Cheshire East. Nevertheless, there is a significant proportion of people who are neither white British or Irish. This amounts to a total of 20,800 people or (6.1%), with 13,000 (3.8%) being non white.

Ethnic Minorities (estimated for 2009 ONS)
<table>
<tr><th></th><th>Cheshire East</th><th>England</th><th>Cheshire East %</th><th>North West %</th><th>England %</th></tr>
<tr><th></th><th>Unitary Authority</th><th>Country</th><th>Unitary Authority</th><th>Region</th><th>Country</th></tr>
<tr><td>All Ethnic Groups</td><td>360,700</td><td>51,092,000</td><td>100.0</td><td>100.0</td><td>100.0</td></tr>
<tr><td>White</td><td>347,600</td><td>45,082,900</td><td>96.4</td><td>92.1</td><td>88.2</td></tr>
<tr><td>Mixed</td><td>3,300</td><td>870,000</td><td>0.9</td><td>1.2</td><td>1.7</td></tr>
<tr><td>Asian or Asian British</td><td>5,000</td><td>2,914,900</td><td>1.4</td><td>4.4</td><td>5.7</td></tr>
<tr><td>Black or Black British</td><td>2,000</td><td>1,447,900</td><td>0.6</td><td>1.1</td><td>2.8</td></tr>
<tr><td>Chinese or Other Ethnic Group</td><td>2,700</td><td>776,400</td><td>0.7</td><td>1.1</td><td>1.5</td></tr>
</table>

This impact on this protected characteristic is neutral. No issues were uncovered through research or at the consultation events.</td></tr>
</table>

<table>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Religion & Belief- Is there an Impact?</td><td></td><td>No</td><td>Comments/Actions:

Cheshire East as a whole has a far greater percentage of people who stated that they were Christian in the census than in England as a whole. This is a pattern which is a feature of much of the North West of England. Perhaps, the main reason for this is the lack of racial diversity apparent in the general population. Cheshire East has an equal amount of Buddhists to the North West average, half as many Hindu’s and Jewish people and significantly less Muslims.

<table>
<tr><td></td><td>Cheshire East</td><td>England</td><td>Cheshire East</td><td>England</td></tr>
<tr><td></td><td>Unitary Authority</td><td>Country</td><td>Unitary Authority%</td><td>%</td></tr>
<tr><td>All People</td><td>351,817</td><td>49,138,831</td><td>100.0</td><td>100.0</td></tr>
<tr><td>Christian</td><td>282,432</td><td>35,251,244</td><td>80.3</td><td>71.7</td></tr>
<tr><td>Buddhist</td><td>551</td><td>139,046</td><td>0.2</td><td>0.3</td></tr>
<tr><td>Hindu</td><td>617</td><td>546,982</td><td>0.2</td><td>1.1</td></tr>
<tr><td>Jewish</td><td>562</td><td>257,671</td><td>0.2</td><td>0.5</td></tr>
<tr><td>Muslim</td><td>1,375</td><td>1,524,887</td><td>0.4</td><td>3.1</td></tr>
<tr><td>Sikh</td><td>170</td><td>327,343</td><td>0.0</td><td>0.7</td></tr>
<tr><td>Any other religion</td><td>593</td><td>143,811</td><td>0.2</td><td>0.3</td></tr>
<tr><td>No religion</td><td>42,757</td><td>7,171,332</td><td>12.2</td><td>14.6</td></tr>
<tr><td>Religion not stated</td><td>22,760</td><td>3,776,515</td><td>6.5</td><td>7.7</td></tr>
</table>

Religious requirements may mean a service user requires increased flexibility in transport arrangements e.g. to coincide with trips to places of workshop, to ensure transport occurs at appropriate times (e.g. not interfering with times of prayer). The</td></tr>
</table>

			change in transport provision is likely to benefit this protected characteristic in the longer term as the market grows and caters for a greater range of individual needs.
Sexual Orientation -Is there an impact?		**No**	Comments/Actions: In the NWDA's Report (North West Development Agency) "Improving the Region's Knowledge Base on the LGB&T population in the North West" it was estimated that 34,500 LGB's were living in the County of Cheshire. When adjusted for predicted population growth and split proportionately for the Cheshire East area, the number can be stated as being 12,311 for 2009. This equates to circa 3.4%. If this ratio is also adopted for Cheshire East service users (which is currently 6022 - 30 September 2010), this would be 205. This impact on this protected characteristic is neutral. No issues were uncovered through research or at the consultation events.
Transgender - Is there an impact?		**No**	Comments/Actions: The North West Development Agency has estimated that the number of transsexual people in the North West in 2009 as between 600-700. Using this proportion for Cheshire East means that there would be circa 32-37 transsexual people. Although the NWDA does note that this is a, "conservative estimate because it covers only those who are seeking, those who intend to seek and those who have undergone gender re-assignment and gender recognition (i.e. transsexuals), and does not include those not seeking recognition". There are no current service users who are known to be transgender. This impact on this protected characteristic is neutral. No issues

<table>
<tr><td></td><td></td><td></td><td>were uncovered through research or at the consultation events.</td></tr>
<tr><td>Other socio-economic disadvantaged groups (including white individuals, families and communities) Is there an impact?</td><td></td><td>No</td><td>Comments/Actions:

The areas with the lowest average household income, Cheshire East, 2007

<table>
<tr><th>Region (Lower Super Output Area)</th><th>Ward</th><th>Paycheck – Average Income</th></tr>
<tr><td>Central & ValleyL1</td><td>Delamere</td><td>£21,900</td></tr>
<tr><td>East CoppenhallL3</td><td>Maw Green</td><td>£22,200</td></tr>
<tr><td>West Coppenhall & GrosvenorL4</td><td>Grosvenor</td><td>£23,100</td></tr>
<tr><td>Macclesfield Town EastL5</td><td>Macclesfield Hurdsfield</td><td>£23,600</td></tr>
<tr><td>AlexandraL1</td><td>Alexandra</td><td>£23,700</td></tr>
<tr><td>West NantwichL1</td><td>Barony Weaver</td><td>£23,800</td></tr>
<tr><td>Wilmslow Town Dean Row & HandforthL4</td><td>Handforth</td><td>£23,900</td></tr>
<tr><td>Congleton EastL3</td><td>Congleton North</td><td>£24,200</td></tr>
<tr><td>St BarnabasL4</td><td>St Barnabas</td><td>£24,300</td></tr>
<tr><td>East CoppenhallL2</td><td>Maw Green</td><td>£24,400</td></tr>
</table>

Some attendees at the events felt that Personalisation was a mechanism in which the Council forced service users both to contribute more to their care and spend more time planning it. Service users currently pay £2 to receive transport to and from a day centre. Many service users stated that they would not be able to afford an increase in transport costs due to their already stretched budgets. However, some also expressed the view that they would be prepared to pay more.</td></tr>
</table>

			It is likely that the effect of the transport policy is to put pressure on those who can afford to pay, to pay more. However, service users are financially assessed according to ability to pay (under Government Fairer Charging Guidance) and so should not ever be asked to contribute more than they can afford to do. This means although there will be an impact on service user's particularly just about the Council threshold this should not be extreme. The assessment process must take into account the cost of transport in a particular area e.g. costs in rural locations may be significantly higher.
Please give details of any other potential impacts of this policy (i.e. Poverty & deprivation, community cohesion, environmental)	**Yes**		Comments/Actions: It is likely that this policy will bring about increased road traffic as individuals make a variety of ways to day centres rather than by using fleet vehicles.
Could the impact constitute unlawful discrimination in relation to any of the Equality Duties		**No**	Comments:
Does this policy – procedure – function have any effect on good relations between the council and the community	**Yes**		Comments: This policy has proved highly contentious and may have a significant impact on relations between the community and the council
Do you require further data/information/intelligence to support decision making?	**Yes**		Comments: A phased programme of transition is proposed, including a detailed analysis of current service users and individual reviews. No eligible person will have their commissioned transport service removed without an appropriate

			alternative transport solution being in place. (please note if you answer yes or no you will still be required to complete the Data Methods/Collection to Support Decision Making Section)
Please specify any question(s)/issues/concerns/actions identified as a result the assessment. What needs to be done?			Comments • Measure and review market developments • Ensure costs of alternative transport are moderate for service group. • Safeguarding referral pathways, training, advice and support. • Robust accreditation including enhanced CRB

Data Methods/Collection to Support Decision Making		
Please indicate what methods of research, information and intelligence will be/have been used e.g. consultation, reports, comparisons with similar organisations	Internally	Externally
Please state who will be/who was involved/engaged/consulted	Internal (Staff/Members/Service/Dept)	External (stakeholders/service users/partners)
Please indicate any significant expected costs & resource requirements for completing the data collection		

Equalities Impact Assessment (EIA) Action Plan: Making Changes

REF	Action	Responsible Person/s	Action Deadline	Tasks	Progress
1	To ensure that sufficient resources are put into transport planning for service users. This should meet the needs of a full range of audiences e.g. those with learning disabilities, those with hearing impairments etc.	Chris Williams	From April 2011 to March 2013		
2	Ensuring that transport needs are fully factored into the financial assessment process. This includes ensuring that the location/needs of each individual are carefully assessed. This is of particular importance to those in rural locations. Taking account of motorbility or mobility resources available to the customer.	Jacqui Evans	From April 2011 to March 2013		
3	To ensure procedures are in place to carefully identify an individual's option for travel and that	Jacqui Evans	From April 2011 to March 2013		

	this is reviewed regularly to ensure it still fits in with their capabilities and wishes				
4	To ensure if the policy is implemented that a transition from fleet transport happens in a gradual way only removing supports when suitable alternatives are available for the individual. This includes both in staff training, quantity of vehicles and facilities of vehicles for disabled people	Places and Adult Services Jointly	From April 2011 to March 2013		
5	For procedures to be put in place to guarantee training of external transport staff and CRB checking. Accreditation should be regularly reviewed on the basis of inspection and incident reporting.	Places and Adult Services Jointly	From April 2011 to March 2013		
6					
Please state the date the policy/procedure/function will be reassessed? (generally 1-3 yrs)			Comments/Date:		

Signed (Service Manager) ……. Date…….

Signed (Head of Section) …….. Date…….

Once you have completed this section please email it to the Equality and Inclusion Team. The Equality and Inclusion Team will convene a quarterly meeting of the Fairness and Inclusion Group (FIG) who will quality check our EIA's to ensure we have considered everyone. We plan to send approximately 2-5% of our completed EIAs Forms to the (FIG).

Quarterly Progress and monitoring

REF	Action	Progress	Completed

Once you have completed your progress report, please email it to the Equality and Inclusion Team. Make a copy of the progress report template so you can present an update in three months time.

Once you have completed your quarterly progress report, please email it to the Equality and Inclusion Team

Measuring Impact & Reporting

Ref	Action	Impact	Outcome	Review Date
	The changes that you have made to remove the gaps you have Identified (simply cut and paste these from the action plan).	What has been the overall impact of making the particular changes? (could include wider community involvement in policy development or greater use of service by	What are the concrete results of having changed your policy or service? Could include improved service use, reductions in complaints or increased satisfaction. These will be based on detailed data and should outline how the changes have	

		diverse communities).	brought about improvements for different communities and groups	

Once you have completed your impact report, please email it to the Equality and Inclusion Team. The Equality and Inclusion Team will prepare an annual report for Corporate Management Team and Cabinet on our progress.

Appendix 1

Service Reference Index

Service Reference Index			
Safer & Stronger – **SSC**	Regeneration – **REG**	Planning & Policy – **PAH**	Legal & Democratic Services – **LAD**
Children & Families – **CHI**	Adults – **ADU**	Health & Wellbeing – **HWB**	Human Resources & Organisational Development – **HROD**
Policy & Performance – **PAP**	Corporate Improvement - **CI**	Environmental – **ENV**	Borough Treasurer & Head of Assets – **BTA**

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CHESHIRE EAST COUNCIL

REPORT TO CABINET

Date of Meeting: 14 March 2011
Report of: Phil Lloyd, Director of Adults, Community, Health and Wellbeing
Subject/Title: Rationalisation and Temporary Closure of Buildings in Adult Services
Portfolio Holder: Cllr Roland Domleo

1. Report Summary

1.1 The Cabinet Report of 19 July 2010 outlined a range of options for delivering the same level of service from fewer buildings in Adult Services. In particular, the report referred to the possible closure of 291 Nantwich Road and the transfer of services to the nearby Hilary Centre. The matter was discussed at the Overview and Scrutiny Committee on 12 August 2010 and it was noted that those affected by the proposals would be consulted and a recommendation be brought to Cabinet.

1.2 At Cabinet on 18 October 2010 Cabinet noted 'that as a result of discussions with users of 291 Nantwich Road, it is not proposed to close that facility at this stage but to re-examine the future of that building in March 2011'.

1.3 This report details the outcome of that re-examination and puts forward a proposal for the future of the building.

1.4 The new proposals are to be considered by the Overview and Scrutiny Committee on 10 March 2011.

2 Decision Required

2.1 Cabinet agree to the closure of 291 Nantwich Road once the remaining groups have transferred to the Oakley Centre.

2.2 Cabinet agree to the recommendation that 291 Nantwich Road be declared surplus to the service requirements of the Adult, Community, Health and Wellbeing Directorate when it has been vacated and authorise officers to take the necessary actions to implement the proposals.

2.3 That the property be then appropriated to the management of the Assets Manager and consideration be given to the use of the property by other Services within the Council or otherwise.

3. Reasons for Recommendation

3.1 It is considered good practice (and has been Government policy for many years) to move mental health day services, where possible, away from day

centres and to locate them in more socially inclusive settings. Examples of such settings are libraries, community centres, colleges and leisure centres. Nearly all mental health services and groups across Cheshire East are now located in such settings.

3.2 However it has been recognised that service users in Crewe have an attachment to 291 Nantwich Road and have shown a reluctance to share a building with other groups.

3.3 Lunchtime meetings to consult with service users have been held regularly over the last six months and, as a consequence of the views expressed, have identified a room at the Oakley (Leisure) Centre in West Street which will become available daily to mental health service users by early summer. Whilst providing a dedicated space for them, it will also provide the opportunity to branch out and share some facilities with other community groups and the general public.

3.4 At the final consultation meeting on 28 January 2011, service users agreed to this plan as an acceptable alternative to remaining at 291 Nantwich Road.

3.5 Unrelated groups using the building for occasional meetings in the evening will also be able to relocate to either the Oakley Centre or Hilary Centre.

3.6 291 Nantwich Road will then become surplus to requirements in the Adult Community Health and Wellbeing Directorate.

4. Wards Affected

Crewe South, North, East and West.

5. Local Ward Members

Crewe South	Cllrs. Flude, Cannon and Howell
Crewe East	Cllrs. Conquest, Martin and Thorley
Crewe North	Cllrs. Beard, Bebbington and Jones
Crewe West	Cllrs. Cartlidge, Parker and Weatherill.

6. Policy Implications – including Climate Change and health

6.1 Rationalisation of buildings reduce carbon impact without impact on service level.

6.2 No direct impact on individual health, following satisfactory conclusion to consultation with service users.

7. Financial Implications

7.1 The current 2010/11 non staffing budget for 291 Nantwich Road is £20,500 of which approximately £10,000 relates to the physical premises, which will be a full saving that has been factored into delivery of the Adult's 2011/12 budget.

Staffing savings have already been achieved following the restructure of day services. The remainder of the non pay budget of £10,500 will be utilised in running the new facility at the Oakley Centre,

8. Legal Implications

8.1 There is no statutory requirement for consultation in respect of the possible closure of a Community Support Centre. 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. Therefore, the discussions that have taken place with service users in respect of the proposed changes at 291 Nantwich Road appear to fulfil the councils duty in respect of them.

8.2 Enquiries made by the Legal Department in respect of staff employed by the council to work at 291 Nantwich Road suggest that all staffing issues have been dealt with and therefore there are no outstanding legal implications in respect of this issue.

9 Risk Management

9.1 The risk arising from this proposal is a delay in release of the room at the Oakley Centre but the closure of 291 Nantwich Road would not take place until an alternative suitable venue was found or there was no further demand for the service.

10. Background Options

10.1 These are detailed in Cabinet reports 19 July 2010 and 18 October 2010.
http://moderngov.cheshireeast.gov.uk/ecminutes/Published/C00000241/M00003094/$$ADocPackPublic.pdf

http://moderngov.cheshireeast.gov.uk/ecminutes/Published/C00000241/M00003098/$$ADocPackPublic.pdf

10.2 Since then there has been considerable consultation with those directly affected and the new proposals have been accepted as acceptable to them.

11. Access to Information

11.1 The background papers relating to this report can be inspected by contacting the report author.

Put in l inks to Cabinet reports mentioned in the text

Name. Sandra Shorter
Designation Head of Care4CE
Tel. No. 01270 685717
Email Sandra.shorter@cheshireeast.gov.uk

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CHESHIRE EAST COUNCIL

REPORT TO: Health and Social Care Scrutiny Committee

Date of Meeting:	10th March 2011
Report of:	Sue Crompton – Performance, Standards and Information Manager
Subject/Title:	Government Proposals for 'Local Accounts'
Portfolio Holder:	Cllr Roland Domleo

1.0 Report Summary

1.1 The Government has announced changes to the way that council adult social care services are assessed. Previously, councils were assessed each year by the Care Quality Commission (CQC) and through the council's performance against a list of national targets (the National Indicator Set) published annually. Both the Annual Performance Assessment by the CQC and the National Indicator Set are to end.

In their place, the government has put forward proposals to replace these with the following:

> Local Account
> This would be a document published by the council on how it believes it has made progress on achieving its goals for adult social care over the past year.
>
> Outcome Measures
> These will be published nationally each year on how each council has performed against a number of different measures so that both councils and local people can compare progress on outcomes that are being achieved. These would also be published within the Local Account.

The aim of these proposals is to support transparency at the local level by providing a means for councils and citizens to scrutinise progress against priorities and outcomes achieved.

1.2 The final proposals will be published by the Government in April 2011. Whilst there may be changes to the details of the proposals, it is highly likely that the framework for Local Accounts and Outcome Measures will be a part of the final proposals.

Therefore, implementation of Local Accounts and Outcome Measures within Cheshire East will be required. The key aim of local

implementation is to ensure that the Local Account and supporting measures reflect the priorities of local people in a way that is meaningful to them. This will be achieved through the involvement of local people, councillors and key partners in the planning and production of the Local Account.

2.0 Decision Requested

2.1 The committee notes the proposals for Local Accounts and Outcome Measures and that final proposals from the Government are due to be published in April 2011.

2.2 The committee notes the proposals for local implementation of the Local Account and gives its views on how this should be taken forward.

3.0 Reasons for Recommendations

3.1 The Local Account and Outcome Measures form part of proposals on Government requirements of councils with Adult Social Care responsibilities.

3.2 The Local Account and Outcome Measures will become a key means of local transparency and accountability of Health and Adult Social Care services.

4.0 Wards Affected

4.1 All wards

5.0 Local Ward Members

5.1 Council wide.

6.0 Policy Implications including - Carbon reduction - Health

6.1 No implications for carbon reduction.

6.2 This report is relevant to Health as the Local Account and Outcome Measures will reflect integrated working and joint responsibility in these areas for the achievement of better outcomes for individuals.

7.0 Financial Implications (Authorised by the Borough Treasurer)

7.1

8.0 Legal Implications (Authorised by the Borough Solicitor)

8.1

9.0 Risk Management

9.1 Any associated risks from the final proposals will be managed through the Local Account Steering Group.

10.0 Background and Options

10.1 The proposals put forward by the government for **Local Accounts** are:

- They will be self-assessed and published by the council. They would be based on the progress it has made in achieving the quality and outcomes priorities during the past year;

- They might include a statement from the council's board, or the proposed Health and Wellbeing Board, on their quality and outcome priorities and how these have been taken forward over the year;

- They include a description of how the council is working with other partners locally in support of shared outcome priorities (for example, the NHS);

- A potential requirement that the account is signed off by the Local Involvement Network, or proposed HealthWatch. They might include a statement on their perspective on the council's progress and the extent to which local people have been actively engaged in prioritisation and planning; and,

- They include a selection of data and measures which demonstrate the objectives chosen locally, and the progress made during the past year.

- The first Local Account is expected to relate to 2011/12.

- Quality assurance of Local Accounts would be through a system of peer review whereby councils would review one another's accounts, challenge poor practice and share expertise. The Local Government Association and Local Government Improvement and Development (previously IDeA) are currently developing the peer review process. The Government is also considering whether the local HealthWatch could have a more formal role in assuring the Local Account or acting as a signatory.

10.2 The proposals put forward by the government on **Outcome Measures** are:

- Outcome Measures under four 'Outcome Domains' which align with the Outcome Frameworks for the NHS and Public Health:

    1. Promoting personalisation and enhancing quality of life for people with care and support needs

2. Preventing deterioration, delaying dependency and supporting recovery
3. Ensuring a positive experience of care and support
4. Protecting from avoidable harm and caring in a safe environment

- There will be no national targets for these outcome measures
- They will be published annually
- Intended for councils to consider for benchmarking their results, and to help local people to judge progress.

Please see Annex A for the full list of proposed outcome measures.

10.3 Proposals for Local Implementation

A Local Account Steering Group is to be formed to oversee the planning and production of the Local Account which includes representation from the PCT. This group which will look at the following areas:

- Engagement with key partners e.g. NHS, Local Involvement Network (LINk), Third Sector;
- Review existing consultations and plan specific consultation with local people on the Local Account and Outcome Measures;
- Produce recommendations on the content and format of the Local Account to the Directorate Management Team and to Health and Adult Social Care Scrutiny Committee;
- Plan the production of the Local Account and develop associated procedures.

11.0 Access to Information

11.1 The Government proposals on Local Accounts and Outcome Measures are part of the Department of Health consultation document 'Transparency in Outcomes: a framework for adult social care':

http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_121509

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

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Annex A
Local Government Proposals for Local Accounts
Health and Adult Social Care Scrutiny Committee – 10th March 2011

Proposed Outcome Measures from April 2011

1: Promoting personalisation and enhancing quality of life for people with care and support needs

Overarching measure:	
Social care-related quality of life	Source: Adult Social Care Survey
Outcome measures:	
The proportion of people using adult social care services who have control over their daily life	Source: Adult Social Care Survey
Carer-reported quality of life	Source: Carers' Survey
People with long-term conditions supported to be independent and in control of their condition	Source: NHS GP Patient Survey
Proportion of adults with learning disabilities in employment	Source: Council data
Proportion of adults in contact with secondary mental health services in employment	Source: Mental Health data
Supporting quality measures:	
Proportion of people using social care who receive self-directed support	Source: Council data

Annex A
Local Government Proposals for Local Accounts
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2: Preventing deterioration, delaying dependency and supporting recovery

Overarching measure:	
Percentage of emergency admissions to any hospital in England occurring within 28 days of the last, previous discharge from hospital	Source: NHS Hospital Episode Statistics
Outcome measures:	
Admissions to residential care homes, per 1,000 population	Source: Council data
Older people discharged from hospital to rehabilitation or intermediate care, who are living at home 91 days after discharge	Source: Council data
Emergency bed days associated with multiple (two or more in a year) acute hospital admissions for over 75s	Source: NHS Hospital Episode Statistics
The proportion of people suffering fragility fractures who recover to their previous levels of mobility / walking ability at 120 days	Source: National Hip Fracture Database
Supporting quality measures:	
Delayed transfers of care	Source: NHS hospital data
Proportion of council spend on residential care	Source: Council data

Annex A
Local Government Proposals for Local Accounts
Health and Adult Social Care Scrutiny Committee – 10th March 2011

3: Ensuring a positive experience of care and support

Overarching measure:	
Overall satisfaction with local adult social care services	Source: Adult Social Care Survey
Outcome measures:	
The proportion of carers who report that they have been included or consulted in discussions about the person they care for	Source: Carers' Survey
The proportion of social care users and carers who express difficulty in finding information and advice about services	Source: Adult Social Care Survey and Carers' Survey

4: Protecting from avoidable harm and caring in a safe environment

Overarching measure:	
Percentage of adult social care users who feel safe and secure	Source: Adult Social Care Survey
Outcome measures:	
Acute admissions as a result of falls and falls injuries for over 65s	Source: NHS Hospital Episode Statistics
Proportion of adults in contact with secondary mental health services in settled accommodation	Source: Mental Health data
Proportion of adults with learning disabilities in settled accommodation	Source: Council data
Supporting quality measures:	
Percentage of all referrals to adult safeguarding services which are repeat referrals	Source: Council data

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CHESHIRE EAST COUNCIL

Health and Adult Social Care Scrutiny Committee

Date of Meeting:	10th March 2011
Report of:	Erika Wenzel, Chief Executive
Subject/Title:	Public Health White Papers: Council's response to consultation

1.0 Report Summary

1.1 This report presents Scrutiny with draft responses to the three government consultations on the Public Health White Paper, for their consideration and input. The consultations are:

- Healthy Lives, Healthy People: Our Strategy for Public Health in England
- Healthy Lives, Healthy People: Transparency in outcomes
- Healthy Lives, Healthy People: Funding and commissioning routes for public health

2.0 Recommendations

2.1 That Scrutiny considers the attached draft responses to the three consultations on the Public Health White Paper, and provides comments/ amendments.

2.2 That officers be authorised to develop and finalise the responses based on Scrutiny's input, ready for submission to the Portfolio Holder.

3.0 Reasons for Recommendations

3.1 The deadline for responses is 31st March 2011.

4.0 Wards and Local Ward Members Affected

4.1 The health reforms have application to the council as a whole - all wards and ward members are affected.

5.0 Policy Implications

5.1 The public health reforms, as discussed in these consultation papers, has relevance for the Sustainable Community Strategy. The reforms will influence the council's methods of achieving the strategy's aims.

6.0 Financial Implications

6.1 These consultation papers discuss the health premium, to determine the formula that will be used to financially reward councils for achieving good public health outcomes. The council's response to these papers therefore has relevance for future income.

7.0 Legal Implications

7.1 There are no legal implications for the submission of a response to government consultation.

8.0 Risk Management

8.1 There are no risk management implications for the submission of a response to government consultation.

9.0 Background and Options

9.1 A summary of each government paper's main points is provided with each response, attached.

9.2 The Public Health White Paper was issued on 30th November 2010, and provides the basis for the transfer of responsibility for public health from PCTs to local authorities by 2013.

9.3 The *Transparency in outcomes* consultation document sets out proposals to put in place a new strategic outcomes framework for public health at national and local levels.

9.4 The *Funding and commissioning routes for public health* consultation document consults on which organisation should be the lead commissioner for specific services and on aspects of funding, such as how the health premium should work.

10.0 Attachments

Paper 1: Cheshire East Council Response to Consultation - Healthy lives, Healthy people: Our strategy for public health in England

Paper 2: Cheshire East Council Response to Consultation - Healthy lives, Healthy people: Transparency in Outcomes

Paper 3: Cheshire East Council Response to Consultation - Healthy lives, Healthy people: consultation on the funding and commissioning routes for public health

11.0 Access to Information

Further information relating to this report can be gained from:

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March 2011 **Paper 1**

Cheshire East Council Response to Consultation

Healthy lives, Healthy people: Our strategy for public health in England

On 30th November 2010, the Government released the white paper *'Healthy Lives, Healthy People: The strategy for public health in England'.* The paper states its aim as 'putting local communities at the heart of public health' and outlines an approach it believes 'will empower local communities, enable professional freedoms and unleashing new ideas based on the evidence of what works, while ensuring that the country remains resilient to and mitigates against current and future health threats'. It outlines the Government commitment to:

- protect the population from serious health threats;
- help people live longer, healthier and more fulfilling lives;
- improve the health of the poorest, fastest.

Earlier health papers and reports have guided the Government's approach, including Sir Michael Marmot's '*Fair Society, Healthy Lives'* report, '*A Vision for adult social care: Capable communities and active citizens'* and *'Equity and excellence: Liberating the NHS'.*

The white paper is separated into five sections:

- Seizing opportunities for better health
- A radical new approach
- Health and wellbeing throughout life
- A new public health system with strong local and national leadership
- Making it happen

Summary of key points

- The paper confirms that local authorities will be tasked with improving public health, fighting obesity, alcohol and drug abuse, smoking, and sexually transmitted diseases.
- The Director of Public Health will be the strategic leader for public health and health inequalities in local communities, working in partnership across public, private and voluntary sectors.
- There will be a renewed focus on bringing health work into early years, schools and unemployment initiatives.
- There will be ring-fenced budgets for public health. These are to be determined, but authorities may receive bonus payments for delivering on obesity and smoking targets.

- The guiding principle is 'reach across and reach out' – reach the root causes of poor health and reach out to people most in need.
- The support to be provided by local authority public health teams will need to be responsive, resourced, rigorous and resilient.

Consultation questions and responses

a. Role of GPs and GP practices in public health: Are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?

GPs can have substantial impact on the public health agenda as set out in Healthy Lives, Healthy People. However this will require a fundamental rethink about the way contracts by the NHS Commissioning Board are designed, the way in which delivery of public health outcomes are incentivised and the way in which GPs and GP practices become part of the wider public health delivery system.

The primary influence on GPs will be through the contracts they agree with the NHS Commissioning Board. Delivery of the wider public health agenda needs to be a fundamental part of these contracts, and not added as an afterthought. The public health agenda will then have a firm foundation nationally. In addition, all areas of Public Health England's responsibility will have broad coverage. These contracts should be based on sound evidence which is clearly communicated to GPs.

Additionally, at local levels much can be achieved by GPs' contributing to the development of the local Health and Wellbeing Strategies, agreeing priorities and delivery mechanisms designed to deliver best outcomes for communities.

All GP practices, in addition to all the GP consortia, must continue to have regular contact with Public Health England and governmental bodies. This should ensure that they receive consistent information and national guidance on the operational duties of all agencies involved in the Public Health Service in England. All GPs, including those that don't play an active role within their consortium, will need to receive information on national policy and their public health commitments, via the consortium.

Robust monitoring and accountability for commissioning and delivery of public health services are currently not in place. There is an assumption that GPs and GP Practices have a good understanding of public health and the needs of the population they are serving. Predominantly GPs and Practices are focused upon disease or special interests and often fail to recognise wider determinants. Building the capacity to address public health commitments should be a priority for consortia.

b. Public health evidence: What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

Availability and use of good sound data will be a core requirement for an evidence-based public health system. Public health information and intelligence is essential to ensure that the limited resources within the public health service, both monetary and personnel, are targeted to protect the population from serious health risk and to reduce inequalities in health. The prioritising of health risks and inequalities will be dependent on the availability of accurate local and national health statistics and data. Currently this information is made available by Regional Public Health Observatories, Primary Care Trusts, Local Authorities and Joint Strategic Needs Assessments.

The government's proposal to alter the Public Health Service in England must include and consider how to make information and intelligence available, readily accessible and accurate. Local government and GP consortia will require reliable data available in order to make informed decisions on local health priorities.

Improving access, quality and utility of data, and clarifying accountability and data sharing protocols will be a will be a major piece of work requiring robust standards. Various issues currently exist – for example the quality of practice information and disease registers is variable, and often practice systems are incompatible and practice information is difficult to access.

Work also needs to be undertaken urgently to understand what data is currently available, and how it can best be integrated at both local and national level. This should be followed up by a systematic approach to data integration.

Work in this area will need to be sufficiently resourced – requirements may currently be underestimated.

Utility of data has to be enhanced by underpinning it with good analysis. This will mean enhancing the skills pool and making best use of the skills available, for example by pooling resources.

Some thought is required on how public health professionals located in Local Authorities will have access to practice information including disease registers, Quality Outcomes Frameworks and population demographics. Mortality and morbidity information on certain data bases are only accessible to NHS employees through secure NHS systems which are used for needs assessments, equity audits and planning of services. This will need to be addressed with guidance.

Data quality is also a key issue under the new arrangements, where 'any willing provider' may provide a service. A fundamental requirement for good and reliable data is good quality entry at source. Data-keeping and quality requirements should form a key part of contracts with service providers, to prevent the data issue of 'garbage in, garbage out'.

c. Public health evidence: How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?

Establishment of the National Institute for Health Research (NIHR) School for Public Health Research, and also of the Policy Research Unit on Behaviour and Health will go a long way to bridge the gap in this critical area. Capacity in each of these areas is likely to be scarce and scattered, therefore grouping to create cohesive units is essential. Effort will need to be focused at a national level to provide support and guidance from a central source. It will therefore be important to give both the NIHR and PRUBH a strong head start so that they are well positioned to meet the needs locally and nationally.

In the medium to long term local organisations will need to create and enhance this capability locally if they are to effectively tackle public health in a comprehensive way.

It will be essential to consider the root causes of poor health and health inequalities before they can be tackled. NIHR should be responsible for compiling and communicating research knowledge, successful policy modelling and professional experiences to improve health and reduce inequalities. This research will provide an insight into behavioural science, which is important in order to understand why health inequalities still exist within English society. People often have the knowledge of what is a healthy lifestyle but they choose not to practice their knowledge. The wider determinants of health include socio-economic status; education; housing; environment; workplace, society. All of these factors will have an influence on the health of an individual and their life expectancy. Research will also inform about cost effectiveness, which will be achievable if the limited available resources are used consistently to address the current gaps in health outcomes.

Research and policy modelling will need to be translated into practical advice. For example, a recent ‘Health Inequalities Toolkit’ provided practical assistance in addressing health inequalities, enabling national research to be applied locally.

d. Public health evidence: What can wider partners nationally and locally contribute to improving the use of evidence in public health?

Requiring the use of evidence in all that we do on public health will contribute considerably to an increase in the use of evidence across the public health system. At a practical level this will also mean publicising good practice examples, promoting the use of robust methodologies and rewarding best practice.

All partners should make evidence more easily and publicly available, both nationally and locally, and practitioners and commissioners should seek the use of evidence. This will assist in developing the culture of using evidence in public health.

It is important, however, that the focus and use of evidence does not become a trap and paralyse practitioners to indecisiveness and inaction, or impose an excessive burden on practitioners.

- Partners should ensure that a lack of direct evidence does not necessarily prevent an informed proposal from going ahead as a pilot, for example, provided the pilot undergoes thorough monitoring and evaluation – innovative approaches are to be encouraged.
- Partners should similarly consider whether spending many weeks or months undertaking extensive research and analysis and writing hefty reports prior to implementing an initiative is cost-effective, or whether it in fact stifles activity. The level of evidence-gathering undertaken needs to be appropriate to the scale of the activity.
- Partners should ensure that people with the correct skills are available to perform the different functions in using evidence – compilation of data, policy analysis, and application of public health expertise. This can greatly improve the efficiency of the process.

The knowledge and skills offered by national and local partners will be essential in order to tackle the inequalities in public health. Central and local government public health professionals will be able to contribute their knowledge and skills based on their previous experience. Partners could include both voluntary and commercial sector organisations and educational establishments, which will have an interest in promoting public health. They will have their own evidence base and experience of what has been successful within public health research. It will be important that health messages to the public are consistent, and if more partners are involved it will widen the spread of the message.

Distribution and communication of evidence and how this is understood by populations is a key role for local authorities, and could be supported by partner organisation such as Cheshire and Merseyside Public Health Network and sharing research from partners such as Age Concern, MIND, Macmillan, and the Roy Castel Foundation.

e. Regulation of public health professionals: We would welcome views on Dr Gabriel Scally's report. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialists?

Local authorities traditionally have many practitioners that work in the wider field of health and wellbeing, rather than in healthcare-based public health. Regulation or registration is a positive way of recognising the role of these practitioners in public health.

The voluntary registration could be administered by the Chartered Institute of Environmental Health (CIEH) which has a history in protecting and promoting public

health and preventing ill health through controlling the spread of disease. Historically environmental health practitioners have played an important role in controlling infectious diseases, and as the wider determinants of public health have been identified, it has been responsible for administering national environmental influences such as clean air legislation. In 2007 environmental health professionals were responsible for implementing the most important public health legislation to date, the smoke free legislation in England. Many environmental health practitioners consider themselves to be public health specialists with recognised public health qualifications. They are dedicated professionals who lead existing initiatives within local authorities to promote public health, as well as working in partnership with Primary Care Trusts. The role of this profession will be vital in the government's plan for the future of the public health service. It is important that the invaluable contribution that environmental health practitioners play in improving public health and reducing inequalities is recognised by the government.

March 2011 **Paper 2**

Cheshire East Council Response to Consultation

Healthy lives, Healthy people: Transparency in Outcomes

Summary

This consultation document sets out proposals to put in place a new strategic outcomes framework for public health at national and local levels.

The consultation is seeking views on the overall structure and scope of the framework and the range of outcomes and measures within it, including views on those measures that should be incentivised.

The proposed Outcomes Framework is guided by a set of principles. The Framework will:

- Use indicators which are meaningful to people and communities
- Focus on major causes and impacts of health inequality, disease, and premature mortality
- Take account of our legal duties in particular under equalities legislation and regulations (Equalities Act 2010)
- Take a life course approach
- As far as possible, use data collated and analysed nationally to reduce the burden on local authorities

The Outcomes Framework should have three purposes:

- To set out the Government's goals for improving and protecting the nation's health, and for narrowing health inequalities through improving the health of the poorest, fastest;
- To provide a mechanism for transparency and accountability across the public health system at the national and local level for health improvement and protection and inequality reduction; and
- To provide the mechanism to incentivise local health improvement and inequality reduction against specific public health outcomes through the 'health premium'.

The Public Health Outcomes Framework should be a consistent means of presenting the most relevant, available data on public health for national and local use.

The Public Health Outcomes Framework is linked with the NHS and Adult Social Care Outcomes Frameworks, which are explored in this consultation document.

The proposed Outcomes Framework will be based on a high level vision for public health, which will be supported by 5 key domains for public health outcomes that reflect national, local and community level actions. There are also a set of indicators that sit under the vision and each domain.

Vision

"To improve and protect the nation's health and to improve the health of the poorest, fastest"

Proposed indicators for the overall vision:

- Healthy life expectancy
- Differences in life expectancy and healthy life expectancy between communities

It will be supported by 5 key domains for public health outcomes that reflect national, local and community level actions. There is also a set of indicators that sit under the vision and each domain.

These domains will need to be delivered through actions that are evidence based, can be measured, and which can be used by the public to hold local services to account for improvements in health.

Domain 1: Health protection and resilience

Protect the population's health from major emergencies and to remain resilient to harm.

Proposed indicators:

- Comprehensive, agreed, inter-agency plans for a proportionate response to public health incidents are in place and assured to an agreed standard. These are audited and assured and are tested regularly to ensure effectiveness on a regular cycle
- Systems failures identified through testing or through response to real incidents are identified and improvements implemented
- Systems in place to ensure effective and adequate surveillance of health protection risks and hazards
- Life years lost from air pollution as measured by fine particulate matter
- Population vaccination coverage (for each of the national vaccination programmes across the life course)
- Treatment completion rates for TB
- Public sector organisations with a board approved sustainable development management plan

Domain 2: Tackling the wider determinants of health

Tackling factors which affect health and wellbeing and health inequalities.

Proposed indicators:

- Children in poverty
- School readiness: foundation stage profile attainment for children starting Key Stage 1
- Housing overcrowding rates
- Rates of adolescents not in education, employment or training at 16 and 18 years of age
- Truancy rate
- First time entrants to the youth justice system
- Proportion of people with mental illness and or disability in settled accommodation
- Proportion of people with mental illness and or disability6 in employment
- Proportion of people in long-term unemployment
- Employment of people with long-term conditions
- Incidents of domestic abuse
- Statutory homeless households
- Fuel poverty
- Access and utilisation of green space
- Killed and seriously injured casualties on England's roads
- The percentage of the population affected by environmental, neighbour, and neighbourhood noise
- Older people's perception of community safety
- Rates of violent crime, including sexual violence
- Reduction in proven reoffending
- Social connectedness
- Cycling participation

Domain 3: Health improvement

Helping people to live healthy lifestyles, make healthy choices and reduce health inequalities.

Proposed indicators:

- Prevalence of healthy weight in 4-5 and 10-11 year olds
- Prevalence of healthy weight in adults
- Smoking prevalence in adults (over 18)
- Rate of hospital admissions per 100,000 for alcohol related harm
- Percentage of adults meeting the recommended guidelines on physical activity (5 x 30 minutes per week)

- Hospital admissions caused by unintentional and deliberate injuries to 5-18 year olds Number leaving drug treatment free of drug(s) of dependence
- Under 18 conception rate
- Rate of dental caries in children aged 5 years (decayed, missing or filled teeth)
- Self reported wellbeing

Domain 4: Prevention of ill health

Reducing the number of people living with preventable ill health and reduce health inequalities.

Proposed indicators:

- Hospital admissions caused by unintentional and deliberate injuries to under 5 year olds
- Rate of hospital admissions as a result of self-harm
- Incidence of low-birth weight of term babies
- Breastfeeding initiation and prevalence at 6-8 weeks after birth
- Prevalence of recorded diabetes
- Work sickness absence rate
- Screening uptake (of national screening programmes)
- Chlamydia diagnosis rates per 100,000 young adults aged 15-24
- Proportion of persons presenting with HIV at a late stage of infection
- Child development at 2 - 2.5 years
- Maternal smoking prevalence (including during pregnancy)
- Smoking rate of people with serious mental illness
- Emergency readmissions to hospitals within 28 days of discharge
- Health-related quality of life for older people
- Acute admissions as a result of falls or fall injuries for over 65s
- Take up of the NHS Health Check programme by those eligible
- Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed

Domain 5: Healthy life expectancy and preventable mortality

Preventing people from dying prematurely and reduce health inequalities.

Proposed indicators:

- Infant mortality rate
- Suicide rate
- Mortality rate from communicable diseases
- Mortality rate from all cardiovascular disease (including heart disease and stroke) in persons less than 75 years of age
- Mortality rate from cancer in persons less than 75 years of age

- Mortality rate from Chronic Liver Disease in persons less than 75 years of age
- Mortality rate from chronic respiratory diseases in persons less than 75 years of age
- Mortality rate of people with mental illness
- Excess seasonal mortality

Consultation questions and responses

1. How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?

Good partnership working across different partner organisations, communities and individuals will be key to delivering public health outcomes. It is therefore important to make sure that barriers to collaborative working are minimised. An equitable reward system is needed, that ensures all agencies are recognised for their contribution. Commissioning and contracting arrangements should recognise the contributions of all agencies involved in achieving positive outcomes.

Clear lines of accountability will be required. The outcomes need to be specific, measured, relevant, timely, targeted and achievable. They will need to be reviewed and refined.

The single outcomes framework for all partners will encourage collaborative working.

There are a number of indicators which are not easily measured in the short term. Others have no technical definition or are not properly defined. This could create perverse incentives for some organisations.

Further work is required - it would be helpful to make data available at a more local level e.g. Lower Super Output Area, Middle Super Output Area, so that the outcomes can be judged by citizens and communities who may (or may not) recognise the outcomes reported.

2. Do you feel these are the right criteria to use in determining indicators for public health?

These appear to be the right criteria to use in determining indicators for public health. It is important however to revisit the indicators periodically and to refine the system in light of experience. Ongoing refinement in light of practical experience is to be welcomed, but we should avoid radical overhauls on a regular basis.

The outcomes are likely to be long term – application of the health premium should bear this in mind when assessing progress.

Outcomes should also bear in mind that it is sometimes difficult to measure interventions, but this does not necessarily mean that they are ineffective. Innovative means may need to be used to provide evidence of effectiveness.

It is important to use indicators which are meaningful to partners and the public.

Standardisation across the country is important to allow for comparisons.

3. How can we ensure that the Outcomes Framework, along with the Local Authority Public Health allocation, and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?

It is difficult to design a system that ensures that all actions contribute fully to health inequality reduction. Reduction in inequalities in health and wellbeing is a corner stone of the government's health reforms and as such all systems and processes should be structured to reward progress in delivering the expected improvements. In so doing it is likely that some areas will make more progress than others and this is unavoidable.

The focus should be to continue to reward delivery of outcomes where possible, rather than rewarding activity. This will allow for innovation in the means of achieving those outcomes.

The Outcomes Framework should require a clear audit path, with clear accountability to clarify that a commissioned activity has been targeted toward desired outcome.

Local Authorities will become mainly responsible for achieving health outcomes, but influence in this area does not lie solely with the public health service or partners within the Health & Well-being Board. Key determinants may rest with industry, government and the public themselves. Accountability of the outcomes will be a challenge to achieve between these different sectors.

4. Is this the right approach to alignment across the NHS, Adult Social Care and Public Health Frameworks?

We believe that it is. The alignment of the three frameworks ensures that public health is an integral component of commissioning for all commissioning organisations. This also promotes an area based approach, with the outcomes frameworks aligned so that associated agencies are all working towards shared outcomes.

5. Do you agree with the overall framework and the domains?

Structuring the Framework around the five domains is a useful way of designing the outcomes framework, but it is essential that the Framework is robust as a stand-alone public health outcomes framework.

Although there is some overlap between the domains, there is the capacity to work across the domains.

The use of an outcomes framework would provide a logical and comprehensive approach to realising outcomes within a 2-5 year timeframe. There is also the capacity to work towards intermediate objectives.

6. Have we missed out any indicators that you think we should include?

We welcome the inclusion of a wide variety of indicators within the outcomes framework. Some gaps exist, but development of indicators within the framework should not be rushed, and different agencies might contribute to this over time.

Development of local Health and Wellbeing strategies, Local Inequalities Plans and local JSNAs will all be able to contribute to identification of additional indicators to enrich the Framework - this opportunity should not be missed.

Some important aspects of public health are hard to measure. It may be better to use themes, with some further work undertaken to devise more robust indicators.

7. We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?

The framework should provide a breadth of indicators to cover all the domains comprehensively, which this framework aims to do. Healthy life expectancy for men and women is a fundamental deficit measure and we see this as an important outcome measure.

While it is useful to have this level of detail in the structure of the framework, it is not necessary to expect all agencies to measure all or many of these indicators. Agencies should be able to choose a basked of indicators that reflect their local public health priority and collect, monitor and report only the relevant indicators on a regular basis. The selection of the indicator would reflect its significance to achieving the desired outcome.

A number of key dimensions, for example asset and deficit indicators, performance and vigilance indicators need to be considered when designing measures to support this approach. Consideration to all-age indicators and breakdown is needed.

Examples of asset indicators:

- % reporting coping on current income/confident in ability to receive financial help in a crisis
- % Redundant in past year who found a new job or entered education or training or took up regular volunteering work
- % reporting recommended levels of recreational exercise
- % reporting participation in local groups and/or frequency of meeting people outside own household

- % reporting positive mental wellbeing (WEMWBS or equivalent measure of life satisfaction for all age)
- % reporting positive evaluation of functioning in local area (i.e. ability to influence local decisions, sense of belonging in local area, feeling safe at home at night)

8. Are there indicators here that you think we should not include?

It is more important to understand how the indicators included will be measured before considering if they will be included. The indicator needs to be appropriate and easily measured.

9. How can we improve indicators we have proposed here?

Indicators can be improved by being specific and ensuring the indicator is measurable and appropriate. For example: life years lost from air pollution as measured by fine particulate matter (Domain 1). Many authorities will not have the necessary equipment in place to measure particulate matter; it is also difficult to quantify life years lost from air pollution, as this is subjective.

A more appropriate indicator would be 'To reduce the number of Air Quality Management Areas' over a specific time frame. This work will already be measurable and this would then ensure that all partners would contribute to reaching this outcome.

10. Which indicators do you think we should incentivise through the health premium? (Consultation on how the health premium will work will be through an accompanying consultation on public health finance and systems).

The framework should use composite indicators to set the baseline, based on an index of multiple determinants. Incentives should reward progress against that baseline using both composite and individual indicators. This system would allow the flexibility locally to address the multiple causes of inequality in local communities.

This system would also allow a focus on the key areas which affect health e.g. smoking, cancer, obesity, alcohol, etc. Timescales for these indicators are important but need to be realistic and SMART.

11. What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?

As suggested earlier, it is important to align the three Public Health, NHS and Social Care Frameworks. We can see benefit in sharing domains to assess successful integration of activities to achieve outcomes that span more than 1 domain.

While we approve of the sharing of this domain, we will require a more joined-up approach between local authority and GP consortium commissioning, for example by giving key responsibility to GPs to improve quality and public health responsibilities.

Public health outcomes are needed within the NHS Outcomes Framework as well as within the Public Health Service.

12. How well do the indicators promote a life-course approach to public health?

This will become more apparent as we all begin to use the framework and integrate it within our plans and activities to address the complex public health issues.

The indicators should be presented as a life course 'model'.

A composite indicator based on an index of multiple determinants would also be a useful measure.

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March 2011 **Paper 3**

Cheshire East Council Response to Consultation

Healthy lives, Healthy people: consultation on the funding and commissioning routes for public health

Summary

This further consultation document under the public health white paper consults on which organisation should be the lead commissioner for specific services and on aspects of funding, such as how the health premium should work.

Public health services will be funded by a new ring-fenced public health budget, separate from the budget managed through the NHS Commissioning Board. Public Health England (PHE) will fund public health activity through:

- allocating funding to local authorities;
- commissioning services via the NHS Commissioning Board; or
- commissioning or providing services itself.

The paper describes the flows of the public health budget from the Department of Health (DH) across the system. Decisions as to how services would be best commissioned will determine how much funding flows through different parts of the system. The majority of the public health budget will be spent on local services, either commissioned via the NHS Commissioning Board (who may choose to pass the responsibility down to GP consortia) acting on behalf of Public Health England, or led by local authorities through the ring-fenced grant.

The paper asks whether the proposed health and wellbeing boards, which will provide a mechanism for bringing together discussions about investment in cross-cutting services such as social care primary prevention, are the right place to bring together ring-fenced public health and other budgets.

The government claims that the reforms, alongside the ring-fenced budget, will open up opportunities for local government 'to take innovative approaches to public health involving new partners. The Department of Health expects that local authorities will want to contract for services with a wide range of providers and incentivise and reward those organisations for improving health and wellbeing outcomes and tackling inequalties'. The Department 'would encourage and expect that local authorities, where possible and appropriate, should be commissioning on an any willing provider/ competitive tender basis'.

On a national level, Public Health England will directly fund and commission some services, such as any national campaigns; directly provide some services, for example the functions currently carried out by the Health Protection Agency; and directly provide

some activity which will be exercised locally, for example via the local networks of Public Health England Health Protection Units.

There will also be some commissioning at a sub-national or a supra-local level. The paper says that these would be services that are specialised in nature, such as services for victims of sexual violence and for vulnerable groups. They could be commissioned as part of Public Health England, or local authorities could choose to adopt supra-local arrangements for commissioning certain activities for which they are responsible.

Public Health England in some cases will ask the NHS to take responsibility for commissioning public health interventions or services funded from the public health budget. These will include population interventions such as screening programmes, that are most effectively delivered as part of a wider pathway of care. It is assumed that most NHS commissioning for public health will occur via GP consortia.

Consultation questions and responses

1. **Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?**

We consider that it is, as this would provide the board with oversight of all funding activity relating to prevention, health protection and health and wellbeing of the whole population. It would also provide transparency and a partnership approach to priority setting, with consultation prior to final decision making. Ultimate responsibility for the budget should rest with the Director of Public Health.

Another advantage is that local people will have access to information held by the board, which informs commissioning decisions. There will also be transparency for local people on public health spending and outcomes achieved.

2. **What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?**

It will be necessary for councils to consider of their constitution and financial policy that informs procurement practice.

The best solution may be to use the Chest to allow potential providers to bid or make expressions of interest. However, it is also important that commissioners are able to stimulate local enterprise solutions that build community capacity and wellbeing.

Councils are well placed to further develop existing relationships with the Voluntary, Community and Faith Sector. Building public health capacity is a core part of workforce

development. This will ensure that providers are supported in providing health and wellbeing services that are commissioned.

There are barriers which may hinder the involvement of third sector organisations and small independent organisations, such as lack of resources, skills, and time. Full cost recovery means the third sector are disadvantaged against larger organisations. Sharing expertise and skills with these organisations will minimise barriers and allow them to compete in the tender process.

3. How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

The priorities for public health will need to be taken into account by the NHS Commissioning Board, GP Consortia and the Health and Wellbeing Board. The Director of Public Health and public health professionals will therefore need to be responsible for ensuring that priorities are taken into account when commissioning decisions are made, and that strategic decisions encompass regional, sub regional and local issues.

It will be essential that local needs and experiences also shape universally commissioned services. In addition to gaining and interpreting local data, it will be necessary to gather information on the experiences of citizens and patients.

4. Is there a case for Public Health England to have greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?

There is a case for Public Health England and local authorities to commission services currently provided under the GP contract. This could align services - such as screening and child health surveillance - with existing services which councils provide such as child protection, safeguarding and child health. This would create an opportunity to gather information around the individual in a holistic approach to health and wellbeing.

Clusters using multi-sectoral public health data could be used to compare matched populations.

5. Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?

When commissioning, there is often insufficient representation from each community. Representatives from communities that are less visible, and people from minority groups need to be included.

The policy should state that commissioners should actively seek representation from hard-to-reach communities. It should also ensure that a quality criterion is applied, and that continuous evaluation and systematic audit is included.

6. Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?

Yes, but will health visitors will experience a change in their ways of working, as some of their responsibilities will shift to local authorities. We await further clarification in this area.

Clarification is required for public mental health, regarding who commissions Child and Adult Mental Health Services and drug and alcohol services if responsibilities are transferred to the local authority.

7. Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to:
a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and
b) reduce avoidable inequalities in health between population groups and communities?
If not, what would work better?

Yes - we think the proposed primary routes for commissioning will be the best way. This will allow local authorities and Public Health England to work together on issues that have relevance for both bodies.

Under this arrangement, PHE will require resources and appropriately skilled staff to enable them to identify forthcoming issues and to advise councils. PHE will also need to be flexible enough in its approach to allow councils to apply the advice according to local population needs.

It is also important that all commissioning bodies have clarity about who is commissioning a service. With so many different commissioning routes possible, there is the potential for some services to 'fall through the cracks'. For example, with public health for children under 5, there are roles for the NHS Commissioning Board, Public Health England, local authorities, and combinations of these groups. The government will need to ensure full guidance is provided.

8. Which services should be mandatory for local authorities to provide or commission?

The services included in Table A, public health funded activities.

9. Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?

The following conditions should be placed on the grant:

- Outcomes should be linked to the Joint Health and Wellbeing Strategy and outcomes framework for social care and public health
- The Director of Public Health should be responsible for the ring fenced budget to ensure the money is spent on the priorities determined by public health data and evidence-based interventions.
- Local accountability should be held by the Health and Wellbeing Board to meet desired outcomes.

10. Which approaches to developing an allocation formula should we ask ACRA to consider?

Any approach to developing an allocation formula should bear in mind the need for the formula to be transparent, and to reflect local authority responsibilities, population data and population needs.

11. Which approach should we take to pace-of-change?

The approach that should be taken will depend upon the amount of funding to be transferred from the PCT to the local authority. We will need to consider the impact of this locally, and upon current contractual arrangements.

12. Who should be represented in the group developing the formula?

- Public health commissioners
- GPCC commissioners
- Local authority commissioners
- Voluntary / Community / Faith Sector
- Health Watch
- Council members
- GPs
- Public health observatories

13. Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?

The health premium should be awarded where the goals in the outcomes framework have been achieved, and local outcomes identified by local need have been accomplished. This will need to be set locally, for various levels of achievement, therefore encouraging authorities to improve.

Consideration will also need to be given for short, medium and long term outcomes.

The health premium should relate mainly to reducing health inequalities, improving health and wellbeing in areas of disadvantage and deprivation.

14. How should we design the health premium to ensure that it incentivises reductions in inequalities?

Payment should be made on the reduction in the base rate of health inequalities for each area. This should be in a staged approach with the premium increasing according to the decrease in health inequalities, based on the achievement of milestones.

15. Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?

Yes – this would be a good method of providing incentives, but there may be other ways of doing this that are not solely financial. This should be further considered and consulted upon.

Health Improvement Budgets should be set according to local need with the added incentives to increase funding from other means. Innovation, quality and prevention needs to be part of the development work which may not attract extra money from the onset.

16. What are the key issues the group developing the formula will need to consider?

The formula should reward local authorities who demonstrate:

- Behavioural change in their communities
- Sustained improvement measures
- Continuous monitoring and evaluation
- Links with JSNA analysis through observatories providing accurate data
- Improvements in the wider social determinants of health e.g. in housing, income, employment, education
- Sustainable impact of large scale change initiatives on communities and services
- Early intervention and prevention
- Building on strengths, assets and resilience of individuals and communities to bring about change

- Production of baseline data and well-being analysis that informs strategic direction and service development, with a wellbeing focus
- The use of asset and deficit indicators.

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CHESHIRE EAST COUNCIL

Minutes of a meeting of the **The Cheshire and Wirral Councils' Joint Scrutiny Committee**
held on Monday, 11th October, 2010 at Vauxhall Suite, Ellesmere Port Civic Hall, Civic Way, Ellesmere Port, CH65 0AZ

PRESENT

Councillor D Flude (Chairman)
Councillor P Lott (Vice-Chairman)

Councillors D Beckett, C Andrew, C Beard, A Dawson, J Grimshaw, W Livesley, D Roberts, G Smith, R Thompson, G Watt, B Silvester and J Salter

56 ALSO PRESENT

Councillor C Tomlinson – Cheshire East Council;
Councillor R Wilkins – Wirral Borough Council.

57 APOLOGIES FOR ABSENCE

Apologies for absence were received from Wirral Councillor A Bridson (substitute - Councillor R Wilkins) and Cheshire East Councillor S Jones (substitute - Councillor C Tomlinson).

58 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; and
- Councillor D Roberts, personal interest on the grounds that her daughter was an employee of the Cheshire and Wirral Partnership NHS Foundation Trust.

59 MINUTES OF PREVIOUS MEETING

RESOLVED: That the minutes of the meeting of the Committee held on 12 July 2010 be confirmed as a correct record.

60 OFFICERS PRESENT

Avril Devaney, Cheshire and Wirral Partnership NHS Foundation Trust
Ros Francke, Cheshire and Wirral Partnership NHS Foundation Trust
Dr R Parhee, Cheshire and Wirral Partnership NHS Foundation Trust
Denise French, Cheshire East Council

61 **CHIEF EXECUTIVE'S UPDATE**

The Committee considered the Chief Executive's update report on the following items:

- Primrose Avenue – following the consultation period the proposals to close Primrose Avenue Respite Unit had been reconfirmed by the Board of the Cheshire and Wirral Partnership NHS Foundation Trust (CWP) and were to be re-presented to the Cheshire East Learning Disability Management Group on 16 October for reconfirmation. All service users' health respite needs would be reassessed and a needs assessment for carers also undertaken; this process would be done jointly with social care staff. A decision around implementation dates would be taken in November;
- Soss Moss – this former hospital site had now been renamed the Alderley Unit and had planning permission for 45 low secure beds. The CWP Board had confirmed that Dane Ward (a 15 bed low secure service for adult males with mental health needs currently provided from the Millbrook site, Macclesfield Hospital) would transfer to the first building to be constructed which would be a purpose built 15 bed low secure unit. Most patients staying at the unit would be longer term and the environment was more suitable with space for activities and more facilities available. All safeguarding standards had been met. A meeting with local Parish Councils had been held to provide information and answer queries and a further meeting would be held in the new year. It was expected that the unit would be completed by 4 April 2011;
- Medical Director – a jobshare appointment had been made to the post of Medical Director, and Dr Andy Cotgrove and Dr Anushta Sivananthan had been appointed and taken up the post at the beginning of August;
- Annual Report 2009/10 and Annual Plan Summary 2010/13 – this was now available on the website.

RESOLVED: That:

- the update be received;
- a report be submitted to the next meeting of the Committee on definitions of low secure units, the types of services provided and the service users who access such services;
- a visit be arranged to the Alderley Unit in the new year; and
- a progress report be submitted to the next meeting on the integration of the Assertive Outreach Function into Community Mental Health Teams.

62 **28 RISELEY STREET, MACCLESFIELD - DECOMMISSIONING OF LEARNING DISABILITY RESPITE SERVICES**

The Committee considered a report on a Level 2 Substantial Development or Variation in Service. The proposal was to decommission learning disability respite services currently delivered at 28 Riseley Street, Macclesfield.

The Central and Eastern Cheshire Primary Care Trust (PCT) had notified CWP of a reduction in income and in order to manage this reduction had worked with CWP to evaluate all services commissioned by the PCT and provided by CWP.

All services had been reviewed using the same criteria and, using this prioritisation process, it was proposed that the respite provision at Riseley Street cease to be provided.

There were a range of respite options for people with learning disabilities living in central and eastern Cheshire – residential bed based services provided by CWP at Primrose Avenue, Crewe (due for closure), Crook Lane, Winsford and Riseley Street, Macclesfield. The Council's social care team also provided respite at Warwick Mews, Macclesfield and Queen's Drive, Nantwich. People with learning disabilities were also able to access direct payments to choose their own provision.

The proposed closure of Primrose Avenue had been subject to a consultation process and as part of the overall planning for the changes, had also confirmed eligibility criteria for health respite services provided by CWP. This agreed eligibility criteria and assessment process would be used to review the needs of all existing respite service users starting in September 2010. Respite services provided by CWP in central and eastern Cheshire would then be allocated on the basis of the outcome of this assessment process and the resources available. Transitional arrangements would be put in place to enable a mix of health and social care respite to be provided by CWP for an agreed period of time.

There were a small number of people affected by the closure of Riseley Street and this had enabled personalised consultation and future planning based on their needs, to be done.

A report on this issue had also been submitted to Cheshire East's Council OSC.

During discussion of the item the following points were raised:

- There was concern that there would be no learning disability respite in Cheshire East Borough and whether there would be a detrimental impact on the existing provision at Winsford; in response, Members were advised that outcomes tended to be better if services were accessed in the community, rather than building based, and such services were available. If social care respite was required this would be provided (by other partners such as the Council), it was only health respite that would no longer be available;
- Who would monitor private provision? In response, the Committee was reminded of the role of the Local Involvement Network who had powers to inspect provision through their Enter and View powers. Also the Care Quality Commission's role was to regulate providers and anybody who wished to could provide feedback to them on provision;
- People may have to travel further to access respite and carers/friends would have further to travel to visit their family member. The Committee was advised that as the number of people affected was small any travelling issues on individuals would be picked up through the individual assessment process.

RESOLVED: That the closure of the service at Riseley Street be noted.

63 **THE WILLOWS, MACCLESFIELD - PROPOSED CLOSURE**

The Committee considered a report on the proposed closure of The Willows, Macclesfield.

The Central and Eastern Cheshire Primary Care Trust (PCT) had notified CWP of a reduction in income and in order to manage this reduction had worked with CWP to evaluate all services commissioned by the PCT and provided by CWP. All services had been reviewed using the same criteria and, using this prioritisation process, it was proposed that The Willows be closed.

The Willows offered day services to patients already under the Care Programme Approach (CPA) of a Community Mental Health Team (CMHT). The service was provided to up to 115 patients in and around Macclesfield and was not accessed by service users from other areas. The services offered included social skills training, computer literacy and horticulture and the operation of a small print workshop, all of which were offered in conjunction with external agencies. All the services offered were available through other agencies such as the Council and service users would be supported to access these services. Service users had been advised of the potential closure at an early stage to enable them to access courses starting in September if they wished. The building belonged to the Council.

The proposed closure had also been discussed at the Cheshire East Overview and Scrutiny Committee.

RESOLVED: That the proposed closure and alternative arrangements for service users be noted.

64 **THE MILLBROOK UNIT, MACCLESFIELD - CONSOLIDATION OF MENTAL HEALTH INPATIENT SERVICES**

The Committee considered a report regarding the consolidation of mental health inpatient services at the Millbrook Unit, Macclesfield.

A public consultation exercise had been carried out by the Cheshire and Wirral Partnership NHS Foundation Trust on behalf of Central and Eastern Cheshire Primary Care Trust about consolidating Adult and Older People's services from two sites to one in Central and Eastern Cheshire. The results of the consultation exercise suggested broad approval to centralise onto a single site, support for continuing to develop new ways of working which would enable a reduction in inpatient beds and the expansion of community services and making investments to improve the patient environment.

A number of changes were proposed:

- Closure of the mental health inpatient unit at Leighton Hospital and transfer of services to either Millbrook Unit, Macclesfield or Bowmere Hospital, Chester. There would be three acute inpatient wards at Millbrook and adaptations made to Bowmere to accommodate extra services;
- The overall impact on inpatient beds was a reduction of 4; there would be no changes to bed numbers in Wirral during the implementation of the changes;

- CWP remained committed to improving the patient environment in South East Cheshire and the re-provision project team would report on the options for delivering this in March 2011.

RESOLVED: That the update report be noted.

65 QUALITY ACCOUNT - QUARTERLY REPORT

The Committee considered the Quality Quarterly Report which set out progress against each of the quality priorities identified in the Quality Account for 2009/10.

All priorities identified for Patient Safety had been achieved for the first quarter and were on track for the remainder of the year. For patient related performance CWP was performing on track or better when measured against key national priorities apart from in relation to the average length of stay which had increased. All targets for achieving quality improvement and innovation goals were also on course. Targets relating to patient safety and patient experience were also achieved. Members suggested that in future more ambitious targets may be needed and were advised that future targets would be more challenging.

One area of concern was around the average length of stay (measured in days). The aspiration of the Trust was for this average to show a reduction but the actual position showed an increase from 18 days in April to 24 in July. It was important that a service user's care and treatment was in the least restrictive environment possible and the Crisis Resolution Home treatment team facilitated the earliest discharge possible. The average length of stay would be monitored by the Trust's Performance and Compliance Sub Committee.

It was noted that medication errors and certain self harm incidents had increased along with minor injuries; Members were advised that minor injuries meant issues that could be dealt with on site without any need to go to Accident and Emergency. Members requested that more information was included in future on what was meant by medication errors and self harm incidents so it was clear whether there were any significant issues in these areas. It was noted that the Trust's Suicide Prevention Strategy was currently being revised and would be considered at a future meeting.

RESOLVED: That the report be noted.

66 TRANSFORMING COMMUNITY SERVICES PROGRAMME

The Committee considered a report on the Transforming Community Services programme as set out below:

- In Central and Eastern Cheshire all provider services currently run by the Primary Care Trust (PCT) would transfer to the East Cheshire Hospital Trust, apart from some physiotherapists for the Learning Disability service who were to transfer to the Cheshire and Wirral Partnership NHS Foundation Trust (CWP);
- In Wirral the provider services of the PCT would transfer to a social enterprise/community trust;
- In Western Cheshire the provider services of the PCT would transfer to CWP.

In each case the main changes related to how the services were be managed and service users should not experience any impact.

The proposals were currently under consideration by the Strategic Health Authority prior to implementation on 1 April 2011.

RESOLVED: that the current position be noted.

67 APPOINTMENT OF A CO-OPTED MEMBER

The Committee considered a report on the appointment of a co-opted Member.

The Committee's Procedure Rules provided for the Committee 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 considered co-option and had agreed that further discussions should taken place with officers of CWP, through the mid point meeting, regarding Service User and Carers representation.

The mid point meeting in September discussed the matter and expressed a preference for a service user rather than a carer to take up a co-opted place. CWP would be happy to progress this by contacting the patient members of the Patients and Public Involvement (PPI) Group to seek volunteers interested in taking up a co-opted place. If a number of volunteers came forward, the PPI Task Force would be invited to assess the applications so as to put forward one person to serve as a co-opted member of the Committee together with one named substitute. A co-opted member would not have voting rights. In accordance with the National Code of Conduct for Members, the co-opted member would not be able to be a Member of the CWP Foundation Trust Board. This process could be carried out during autumn with the formal appointment being made at the next meeting on 10 January.

RESOLVED: That approval be given to the procedure set out in the report to appoint one non-voting co-opted Member and one named substitute onto the Committee to represent the interests of service users.

68 WHITE PAPER - LIBERATING THE NHS

The Committee considered a report on the key points outlined in the NHS White Paper – Liberating the NHS: Equity and Excellence.

The White Paper contained 4 key themes:

- Patients would be given more information and choice;
- Health outcomes would be improved to among the best in the world;
- Doctors would be empowered to deliver results – by being put in charge of what services best met the needs of local people;
- Unnecessary bureaucracy would be removed, waste cut and the NHS made more efficient.

The White Paper proposed the abolition of Strategic Health Authorities, by 2012, and Primary Care Trusts, by 2013. GP consortia would be introduced to take over responsibility for commissioning most NHS services. A new independent body – the NHS Commissioning Board – would be established to allocate and

account for NHS resources, lead on quality improvements and promote patient involvement and choice. Responsibility for public health would be transferred to local authorities and a new consumer champion would be introduced known as HealthWatch.

RESOLVED: That the update on the NHS White Paper be received.

The meeting commenced at 2.30 pm and concluded at 4.00 pm

Councillor D Flude (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, 10th January, 2011 at Winsford Lifestyle Centre, The Drumber, Winsford CW7 1AD

PRESENT

Councillor D Flude (Chairman)
Councillor P Lott (Vice-Chairman)

Councillors D Beckett, A Bridson, C Beard, A Dawson, J Grimshaw, W Livesley, D Roberts, G Watt and B Silvester

Apologies

Councillors S Jones, G Smith, C Povall and J Salter

69 **ALSO PRESENT**

Councillor W Clements, Wirral Borough Council, substitute member for Councillor C Povall
Mr P Hough (Co-opted Member)

70 **DECLARATIONS OF INTEREST**

RESOLVED: That the following Declarations of interest be noted:-

- Councillor Flude - personal interest on the grounds that she is a member of the Alzheimer's Society and Cheshire Independent Advocacy.
- Councillor D Roberts - personal interest on the grounds that her daughter is an employee of the Cheshire and Wirral Partnership NHS foundation Trust (CWP).

71 **OFFICERS PRESENT**

Mike O'Regan, Central and Eastern Cheshire Primary Care Trust (CECPCT),
Avril Devaney, Andy Styring and Michelle Bering (Cheshire and Wirral Partnership NHS Foundation Trust (CWP),
Mike Flynn and Ross Paterson (Cheshire East Council Scrutiny Team)

72 **MINUTES OF PREVIOUS MEETING**

RESOLVED: That the minutes of the meeting of the Joint Committee held on 11 October 2010 be confirmed as a correct record.

73 **CHIEF EXECUTIVE'S UPDATE**

The Committee considered the Chief Executive's Update Report which had been tabled. The report covered the following issues:

- Transforming Community Services; in West Cheshire work is progressing with the transfer of community services, from Western Cheshire PCT to CWP. Furthermore, NHS Wirral is proposing to go ahead with its plans to establish a Community Trust, and this will function as an entirely separate organisation from 1 April 2011. Community Services in Central and Eastern Cheshire would transfer to East Cheshire Hospitals Trust on the same timescale.

- The CWP is scheduled to move the clinical services from Leighton Hospital to the Millbrook unit by 19th January 2011. Procedures are also in place to assist carers who may have difficulty with transport to visit their relatives in Millbrook. The situation concerning patient and carer travel would continue to be monitored. Concerns were raised over the availability of public transport between Crewe and Macclesfield, which could create difficulties for members of the public. It was also proposed that Members should visit the Millbrook site.

- The CWP plans to renew its Suicide Prevention Strategy by April 2011.

- Work is underway at Bowmere to construct an outside garden for the ward, for people with dementia. This is in partnership with Kings Fund under the Enhancing the Healing Environment Scheme.

- The Committee was also advised that the progress report on the integration of the Assertive Outreach Function was due to be considered by the CWP Board at the end of January, following which it would be circulated to the Committee and considered at the next meeting.

RESOLVED: That the Report be received and a visit to the Millbrook Site be arranged.

74 **PROPOSED CHANGES TO MENTAL HEALTH SERVICES IN CENTRAL AND EASTERN CHESHIRE - RISELEY STREET LEARNING DISABILITIES HEALTH RESPITE SERVICE, MACCLESFIELD**

The committee considered a report from Mike O'Regan of Central and Eastern Cheshire Primary Care Trust on the proposed closure of Riseley Street Respite Service.

It was explained to the Committee that a level 2 consultation had been carried out in November, which raised issues regarding the respite centre in Crook Lane, Winsford. The Centre had recently been flooded which had created difficulties in offering alternative services for users at both Riseley Street and Primrose Avenue in Crewe which had also been subject to a consultation on closure.

The consultations had been launched as the three sites collectively were running at around 40-45% occupancy levels. Following legal advice the decision was made to have a further 4 week consultation on the proposed closures, covering the issues at all of the sites. The implications had been considered in detail at the Cheshire East Health and Adult Social Care Scrutiny Committee.

After consideration of the report, the following points were raised;

- Concerns were expressed over the numbers of people who are assessed or actually need respite care and over the possible confusion about the local boundaries from which people can access respite care. The proposed changes also raised questions about payment, as NHS facilities were provided free of charge, whereas service users transferring to Social Care respite facilities could be charged. The arrangements intended to deal with this were explained in detail.

- A change of wording in the report was noted by committee in that it should read; "discussed" rather than "accepted in Principle" on page 10 of the Agenda.

RESOLVED: That the Report be received and a further report be made in due course on the outcome of the consultations.

75 **UPDATE ON CONSULTATION ON THE PROPOSAL TO CLOSE THE WILLOWS DAY SERVICES, MACCLESFIELD**

The committee considered a report on this issue from Mike O'Regan.

It was explained that following a level 2 consultation which had been conducted in November, it was decided that the Willows day care centre in Macclesfield should be closed.

The Committee was informed that everyone in the centre would be assessed and alternative care provided where required in view of the closure.

Service users had been consulted in individual meetings to advise them and their care plans had been reviewed accordingly. Service users were disappointed about the closure and felt they had benefitted from the services provided at the Willows. However, CWP felt the service was social care rather than health care and such provision was not made available elsewhere in the Trust. Also, services provided at the Willows were accessible via other mainstream providers.

It was expected that the Willows service would close in mid January 2011; the impact of the changes would be monitored and service users would be supported to access mainstream services.

The Cheshire East Health and Adult Social Care Scrutiny Committee had also considered the issues and had noted the outcome of the consultations. The Committee had raised the question of whether the services at the Willows could be provided in different ways using the Voluntary Sector. The Committee had also asked that the possibility of setting up a pilot scheme for Admiral Nursing (which offered specialist nursing for dementia patients) in the area should be investigated jointly with the Primary Care Trust. The Cheshire West and Chester Scrutiny Committee would consider the report on the Willows later in the day.

RESOLVED: That the Report be received and the issues related to Admiral Nursing be considered at the next Mid Point meeting.

76 **PUBLIC HEALTH STRATEGY**

The committee received a presentation by Michele Bering which gave an overview of the new Public Health White Paper and its implications for the CWP and the populations it serves.

The presentation focused on the shift of emphasis from simply treating people, to promoting and maintaining well being, with importance being placed on all organisations working together to achieve this goal.

The presentation also addressed what the CWP are already doing in terms of the public Health Agenda and the various core functions which they carry out, including; Strategic development and project

work, teaching, training and health promotion, and direct clinical work to support access to Primary and Acute Secondary Care.

During the discussion the following points were raised:

- How the funding required to support the promotion of good health and the prevention of illness was going to be found and what the impact on other current services would be. It was explained that the money would be sourced from the existing budgets, and also through the redesigning of the Trust's internal structure in order to facilitate these changes and fund the services.

- In addition improvements in the training of staff would lead to efficiencies being made. It was explained that there was a change of emphasis now towards prevention, to encourage people into trying to improve their health rather than just treating people for health problems. The Trust would also be delivering services in different ways in the future, better to meet the new requirements.

- Concerns over the way in which the quality of these services would be measured and monitored, and where the controls would come from.

- It was explained that the Government's White Paper proposals envisaged the setting up of a Public Health Board nationally, and Health and Wellbeing Boards in each Council area, which would oversee the new arrangements.

- Concerns that the money for funding the CWP's service is not ring fenced, and therefore the success of the new approach would be dependent on effective prioritisation and target setting, and careful monitoring of the impact of new initiatives as they were brought into effect.

- Confirmation from a commissioning perspective, that funding would allow the priorities identified nationally to be pursued and tailored to address local need.

RESOLVED: That Michele Bering be thanked for her presentation, and that the implications for the Trust be noted.

77 **APPOINTMENT OF A CO-OPTED MEMBER**

The Joint Committee's Procedural Rules provide that it "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."

Following consideration at the Mid-Point meeting, CWP had circulated the Patients and Public Involvement members of the Trust, as a result of which Mr Phil Hough (carer member) had applied to become a Co – opted Member of the Committee.

The Chairman welcomed Mr Hough to the meeting, and he outlined his background as a carer, and his activities and experience both in CWP and more widely in the NHS.

RESOLVED: That Mr Phil Hough be appointed as a non-voting co-opted member on the Joint Committee, initially for the remainder of the municipal year.

78 **FUTURE MEETING DATES**

RESOLVED: That the following dates for future meetings be agreed:

- 11 July 2011;
- 10 October 2011;
- 23 January 2012;
- 16 April 2012.

All meetings to start at 2.00pm, venues to be confirmed.

The meeting commenced at 2.00 pm and concluded at 3.20 pm

Councillor D Flude (Chairman)