Wiltshire Council
Where everybody matters

AGENDA

Meeting:	**Cabinet**
Place:	**Kennet Room - County Hall, Trowbridge BA14 8JN**
Date:	**Tuesday 4 April 2017**
Time:	**9.30 am**

Please direct any enquiries on this Agenda to Yamina Rhouati, of Democratic Services, County Hall, Trowbridge, direct line 01225 718024 or email Yamina.Rhouati@wiltshire.gov.uk

Press enquiries to Communications on direct lines (01225)713114/713115.

All public reports referred to on this agenda are available on the Council's website at www.wiltshire.gov.uk

Membership:

Cllr Baroness Scott of Bybrook OBE	Leader of the Council
Cllr John Thomson	Deputy Leader and Cabinet Member for Communities, Campuses, Area Boards and Broadband
Cllr Fleur de Rhé-Philipe	Cabinet Member for Economic Development, Skills, Strategic Transport and Strategic Property
Cllr Laura Mayes	Cabinet Member for Children's Services
Cllr Jonathon Seed	Cabinet Member for Housing, Leisure, Libraries and Flooding
Cllr Toby Sturgis	Cabinet Member for Strategic Planning, Development Management, Strategic Housing, Operational Property and Waste
Cllr Dick Tonge	Cabinet Member for Finance
Cllr Jerry Wickham	Cabinet Member for Health (including Public Health) and Adult Social Care
Cllr Stuart Wheeler	Cabinet Member for Hubs, Heritage and Arts, Governance and Support Services
Cllr Philip Whitehead	Cabinet Member for Highways and Transport

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Public Participation

Please see the agenda list on following pages for details of deadlines for submission of questions and statements for this meeting.

The full constitution can be found at this link. Cabinet Procedure rules are found at Part 6.

For assistance on these and other matters please contact the officer named above for details

Part I

Items to be considered while the meeting is open to the public

Key Decisions Matters defined as 'Key' Decisions and included in the Council's Forward Work Plan are shown as

1 **Apologies**

2 **Minutes of the previous meeting** *(Pages 5 - 16)*

To confirm and sign the minutes of the Cabinet meeting held on 14 March 2017, previously circulated.

3 **Minutes - Capital Assets Committee** *(Pages 17 - 20)*

To receive and note the minutes of the Capital Assets Committee held on 14 March 2017.

4 **Declarations of Interest**

To receive any declarations of disclosable interests or dispensations granted by the Standards Committee.

5 **Leader's announcements**

6 **Public participation and Questions from Councillors**

The Council welcomes contributions from members of the public. This meeting is open to the public, who may ask a question or make a statement. Questions may also be asked by members of the Council. Written notice of questions or statements should be given to Yamina Rhouati of Democratic Services by 12.00 noon on Thursday 6 April 2017. Anyone wishing to ask a question or make a statement should contact the officer named above.

7 **Wiltshire End of Life Care Strategy** *(Pages 21 - 82)*

Report by Carloyn Godfrey, Corporate Director.

8 **A350 Chippenham Phase 3 and M4 Junction 17 Improvement contract award** *(Pages 83 - 100)*

Report by Dr Carlton Brand, Corporate Director

9 **Urgent Items**

Any other items of business, which the Leader agrees to consider as a matter of urgency.

Part II

Items during consideration of which it is recommended that the public should be excluded because of the likelihood that exempt information would be disclosed

10 **Exclusion of the Press and Public**

This is to give further notice in accordance with paragraph 5 (4) and 5 (5) of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 of the intention to take the following item in private.

To consider passing the following resolution:

To agree that in accordance with Section 100A(4) of the Local Government Act 1972 to exclude the public from the meeting for the business specified in Item Number 11 because it is likely that if members of the public were present there would be disclosure to them of exempt information as defined in paragraph 3 of Part I of Schedule 12A to the Act and the public interest in withholding the information outweighs the public interest in disclosing the information to the public.

Reason for taking item in private:

Paragraph 3 - information relating to the financial or business affairs of any particular person (including the authority holding that information).

11 **A350 Chippenham Phase 3 and M4 Junction 17 Improvement contract award - Part II** *(Pages 101 - 120)*

Report by Dr Carlton Brand, Corporate Director

Our vision is to create stronger and more resilient communities. Our priorities are: To protect those who are most vulnerable; to boost the local economy - creating and safeguarding jobs; and to support and empower communities to do more themselves.

CABINET

DRAFT MINUTES OF THE CABINET MEETING HELD ON 14 MARCH 2017 AT THE KENNET ROOM - COUNTY HALL, TROWBRIDGE BA14 8JN.

Present:

Cllr Baroness Scott of Bybrook OBE, Cllr John Thomson, Cllr Fleur de Rhé-Philipe, Cllr Laura Mayes, Cllr Jonathon Seed, Cllr Toby Sturgis, Cllr Dick Tonge, Cllr Jerry Wickham, Cllr Stuart Wheeler and Cllr Philip Whitehead

Also Present:

Cllr Jon Hubbard, Cllr Richard Gamble, Cllr Richard Clewer, Cllr Alan Hill, Cllr Glenis Ansell, Cllr Chris Caswill, Cllr Ian West and Cllr Bill Moss

26 **Apologies**

There were no apologies made. All members of the Cabinet were present.

27 **Minutes of the previous meeting**

The minutes of the meeting held on 7 February 2017 were presented.

Resolved

To approve as a correct record and sign the minutes of the meeting held on 7 February 2017

28 **Declarations of Interest**

There were no declarations of interest.

29 **Leader's announcements**

The Leader welcomed all those present and reminded the meeting that the proceedings would be webcast for live broadcast.

30 **Public participation and Questions from Councillors**

The Leader drew the meeting's attention to the questions and statements received for this meeting as circulated in the Agenda Supplement together with the Cabinet members' responses.

The Leader invited Caroline Brown and Gisella Norman to address the meeting with their questions regarding the siting of a mobile phone mast in Bradford-on-

Avon. In response to the issues raised, including the implications on the conservation area, public health and insurance considerations, the Leader requested that officers arrange to meet with the parties to clarify the position of the Council. It was noted that a statement had also been received from Emma Darling on the same matter.

31 **Performance Management and Risk Outturn Report: Q3 2016/17**

Councillor Dick Tonge presented a report which provided an update on third quarter outturns against the measures and activities compiled and reported through the council's website via the Citizens' Dashboard and other key measures, as well as latest outturns on the council's strategic risk register.

In presenting the report, Councillor Tonge, and other Cabinet members, drew attention to areas where performance had improved such as: increasing usage of leisure centres and libraries; reductions in residual waste created; and increases in employment in the County.

In response to an issue raised by Councillor Jon Hubbard, officers agreed to consider how the wording in relation to the risks associated to safeguarding could be more sensitively worded.

Resolved

To note updates and outturns:

1. **Against the measures and activities ascribed against the council's key outcomes.**

2. **To the strategic risk register.**

Reason for Decision:

The performance framework compiles and monitors outturns in relation to the outcomes laid out in Wiltshire Council's Business Plan. The framework is distilled from individual services' delivery plans. In doing so, it captures the main focus of activities of the council against each outcome.

The strategic risk register captures and monitors significant risks facing the council: in relation to significant in-service risks facing individual areas, in managing its business across the authority generally and in assuring our preparedness should a national risk event occur.

32 **Wiltshire Council 2016 staff survey outcomes**

Councillor Stuart Wheeler presented a report which provided an overview of the 2016 staff survey results, highlighting key messages and priorities arising. The results had also been reported to the Staffing Policy Committee on 1 March 2017.

Issues highlighted in the course of the presentation and debate included: how the Council had responded to the areas of further development highlighted in the survey; the increased response rate, and the measures taken to reach non-office-based staff and the importance of good management in engaging staff in developing and maintaining a positive work culture.

Dr Carlton Brand, Corporate Director pointed out that Wiltshire Council was rated by Glassdoor to be the number council to work for.

Resolved

To note the content of the corporate staff survey report and priorities arising.

Reason for Decision:

Cabinet have requested to be kept updated regarding staff survey outcomes and trends, particularly regarding staff engagement, recognising that the ability to deliver business plan outcomes relies on having an engaged workforce.

33 **Report on Treasury Management Strategy 2016/2017 – Third Quarter ended 31 December 2016**

Councillor Dick Tonge presented a report which enabled Cabinet to consider the performance of the Council in the period to the end of the quarter against the parameters set out in the approved Treasury Management Strategy for 2016/2017.

In response to a question raised by Councillor Jon Hubbard, it was noted that whilst it was not unexpected for there to be an underspend on the capital programme; that the issues he raised would be considered by officers when projecting capital spend in future periods.

Resolved

To note that the contents of this report were in line with the Treasury Management Strategy.

Reason for Decision:

To give members an opportunity to consider the performance of the Council in the period to the end of the quarter against the parameters set out in the approved Treasury Management Strategy for 2016/2017.

34 **Adoption Chippenham Site Allocations Plan**

Councillor Toby Sturgis presented the report which informed Cabinet of the Inspector's Report into the examination of the Chippenham Site Allocations Plan and his conclusions regarding legal compliance and soundness; sought approval that the Chippenham Site Allocations Plan, as amended by the Main

Modifications in the Inspector's Report and other Additional Modifications that have arisen during the examination or been made in the interest of accuracy and consistency, be recommended to Council for adoption; and sought approval for the Associate Director for Economic Development and Planning, in consultation with the Associate Director for Legal and Governance and the Cabinet Member for Strategic Planning, Development Management, Strategic Housing, Operational Property and Waste, to undertake the final stages associated with the formal adoption by the Council of the Chippenham Site Allocations Plan.

In presenting the report, Councillor Sturgis referred to the history of the development of the plan and the importance of having a sound plan to lead development in the area. He also praised the work of the officers in developing the plan.

The Leader drew attention to the questions and answers circulated in the agenda supplement, and invited Councillor Chris Caswill to ask any supplementary questions.

In response to a supplementary question from Councillor Caswill, Councillor Sturgis stated that the issues of traffic flows had been considered at the examination, and that the Inspector had found the plan to be sound.

In response to a supplementary question from Councillor Caswill, Councillor Sturgis stated that there was the willingness to work with local business Wavin on their concerns about the road access to the nearby development area. Additionally officers stated that Wavin was aware of the issue, as recorded in the information submitted in their recent planning application, and that a solution was possible.

In response to a supplementary question from Councillor Caswill, officers stated that the Inspector had requested the addition of the text related to alternative traffic measures if a link road was not deliverable as part of the development. It was also acknowledged that previously submitted plans accompanying the Rawlings Green planning application would likely have to be resubmitted taking the Inspector's findings into account.

Resolved

i) To note the content of the Inspector's report into the examination of the Chippenham Site Allocations Plan (Appendix 1) and his conclusions regarding legal compliance and soundness and accepts the modifications in the Appendix of the Inspector's report, which the Inspector considers are necessary to make the plan sound in accordance with legislation;

ii) To recommend to Council that the Chippenham Site Allocations Plan, as amended as set out in (i) above and attached at Appendix 2, including the Additional Modifications set out in Appendix 3, be adopted as part of the development plan for Wiltshire.

iii) To delegate authority to the Associate Director for Economic Development and Planning in consultation with the Associate Director for Legal and Governance and the Cabinet Member for Strategic Planning, Development Management, Strategic Housing, Operational Property and Waste for the Policies Map to be amended in line with the modifications identified in (ii) and for further minor textual changes to be made to the Chippenham Site Allocations Plan prior to publication in the interests of accuracy and consistency.

iv) Following approval of Council, agrees that the Associate Director for Economic, Development and Planning in consultation with the Associate Director for Legal and Governance and the Cabinet Member for Strategic Planning, Development Management, Strategic Housing, Operational Property and Waste, undertakes the final stages associated with the formal adoption and publication of the Chippenham Site Allocations Plan.

Reason for Decision:

The Chippenham Site Allocations Plan will form part of the Council's Policy Framework. In accordance with the Local Government Acts 1972 and 2000, and the Council's constitution it must first be approved by Cabinet before it is adopted by Council. As the document has been found sound by the Inspector its adoption by the Council would help ensure up to date planning policy is in place at Chippenham and provide effective policies to ensure the sustainable development of Chippenham.

35 **A303 Amesbury to Berwick Down Road Scheme**

Councillor Fleur de Rhé-Philipe presented a report which informed Members of the route options appraisal methodology and outcome selected by Highways England to take to public consultation; sough to confirm the Council's response to the public consultation; and asked Cabinet to note the resource and financial implications for the Council with regard to this road improvement scheme.

The Leader invited Dr Andy Shuttleworth, Chair of Winterbourne Stoke Parish Council who had submitted a statement as circulated in the Agenda Supplement; Henry Colthurst; and Councillor Ian West, local division member, to address the meeting.

Issues discussed in the course of the meeting included: the impacts of the various proposals; the history or previous proposals and the views of various stakeholders.

In presenting her report, Councillor Fleur de Rhé-Philipe emphasised that plans were at the initial stage and it was important for the Council to express its support in principle to enable a more detailed plan to be consulted on. It was at that point, she hoped, that further improvements could be sought to mitigate the

concerns of the community. However a delay at this time could jeopardise the project which currently had central government funding attached to it.

In response to some of the matters raised in the course of the debate, Councillor Fleur de Rhé-Philipe proposed two additional resolutions to clarify the Council's position.

Following a debate, the Cabinet;

Resolved

1. **To note the contents of this report**

2. **To agree the proposed response to Highways England for this options appraisal and route selection public consultation**

3. **To note the additional potential financial implications arising as a result of this scheme, which will require more detailed discussion as the preferred route is established.**

4. **To restate the Council's support in principle for the proposal from HE to bring about substantial improvements to the a303 at Stonehenge by building a dual carriageway and tunnel, subject to the comments listed in Appendix 1 of the report presented.**

5. **To welcome the input from the local community and any technical and information support they can supply.**

Reason for Decision:

The case for dualling the A303 between Amesbury and Berwick Down has long been established through promoting economic growth in the South West, increasing safety, improving connectivity with neighbouring regions and protecting and enhancing the environment Highways England have assessed approximately 60 historic routes and identified the 2.9km tunnel with a bypass either North or South of Winterbourne Stoke as the better performing and more deliverable route. Whilst there are several issues which will require resolution as the design is further developed, on the whole officers believe that both options are capable of addressing the transport, economic, heritage and community issues associated with the A303. They will also enable the timeframe dictated by the Development Consent Order (DCO) process to be met, achieving start on site by March 2020.

36 **Wiltshire Council's Housing Board Annual Report**

Councillor Jonathon Seed invited Councillor Richard Clewer, Chair of the Housing Board, to present the annual report to Cabinet in accordance with the terms of reference of the Board.

In presenting the report, Councillor Clewer highlighted some of the successes of the Board and the future challenges ahead. In response to a question from Councillor Laura Mayes, Councillor Clewer stated that independent members of the board were appointed following an interview as part of an open recruitment process, and that these members tended to come from a housing professional background. It was suggested that subject to meeting national requirements, the number of properties awaiting reletting be reconsidered to ensure that the figures related to those properties available for relet and not those which were not available due to refurbishments or other works taking place.

Resolved

To note this Annual Report.

Reason for Decision:

Wiltshire Council's Housing Board's Terms of Reference require an Annual Report to be presented to Cabinet.

37 **Sub Regional Independent Fostering Framework**

Councillor Laura Mayes presented the report which sough Cabinet's agreement for the Council to continue to collaborate with other regional local authorities and join the new South West Framework Agreement for the procurement of Independent Fostering Agency (IFA) placements for looked after children and young people from 1 April 2017 to 31 March 2021, with an option to extend, subject to fee negotiations.

Resolved

To approve Wiltshire Council to continue to collaborate with other regional local authorities and join the new South West Regional Independent Fostering Agency Framework for placements for looked after children and young people from 1 April 2017 to 31 March 2021, with an option to extend, subject to fee negotiations.

Reason for Decision:

There are currently no other procurement options available once the existing framework contract term ceases. Should the Authority not join the new framework then the procurement of independent fostering placements will be off contract with the risk of uncontrolled spend and non-compliance. The Authority will be unable to hold providers to agreed fees, resulting in a risk that the cost of placements will continue to increase year on year, which will clearly impact on the placements budget.

Sub-regional working has proven helpful in terms of bringing consistency to some aspects of IFA provision.

The participating Local Authorities aspire to work with IFA providers who are

delivering good outcomes for children and young people.

38 **Care Home Tender - Contract Awards**

Councillor Jerry Wickham presented a report which requested that Cabinet awards contracts for block and framework care home beds as recommended in Appendix 1 of the report presented and taken under Part II of the meeting. Councillor Wickham also requested that Cabinet authorise the Council to go out to tender again for Nursing and Residential Framework beds due to the current tender process generating a reduced number of bids and a shortfall in the above provision.

In response to a question, it was noted that some smaller providers could receive additional support to access the tender process.

Following a short discussion, and after considering the information in the part II report, the meeting;

Resolved

1. **To approve the award of the block and framework contracts as recommended in Appendix 1 as presented in the Part II paper.**

2. **To approve the undertaking of a re-tendering exercise for further Block Nursing, Framework Nursing and Framework Residential Services in order to address the potential shortfall in the required level of service provision; and**

3. **To delegate authority to the Corporate Director following consultation with the Cabinet Member for Adult Care, Public Health and Public Protection to approve in consultation with the Cabinet member for finance for the award of contracts within the approved budget**

Reason for Decision:

Awarding block and framework contracts will secure better rates and better availability of care home beds in Wiltshire. This supports budget management and gives greater control on spend. The contracts place requirements on providers with regard to the quality of care that they provide and also with regard to the speed of assessment and admissions. This supports the health and well-being of individuals, and the health and social care system as a whole.

39 **Governance arrangements for the prioritisation of Community Infrastructure Levy (CIL) spending**

Councillor Toby Sturgis presented a report which sought agreement for the process for prioritising the spending of the strategic funds raised through Community Infrastructure Levy (CIL) and reviewing the Regulation 123 List to ensure open and transparent decision making in the allocation of strategic funds.

In response to a question from the Leader, it was clarified that Cabinet would make the final decision at the end of the process.

Resolved

(i) To approve the process for the review of the Regulation 123 List and prioritising the spending of strategic funds raised through the Community Infrastructure Levy as set out in Appendix 2; and

(ii) Agrees that for 2017, the next step would be to prioritise projects for funding consistent with the current Regulation 123 List.

Reason for Decision:

To assist with the effective operation of CIL and ensure open and transparent decision making in the allocation of strategic CIL funds.

40 **Urgent Items**

There were no urgent items.

41 **Exclusion of the Press and Public**

Resolved

To agree that in accordance with Section 100A(4) of the Local Government Act 1972 to exclude the public from the meeting for the following items of business because it is likely that if members of the public were present there would disclosure to them of exempt information as defined in paragraph 3 of Part I of Schedule 12A to the Act and the public interest in withholding the information outweighs the public interest in disclosing the information to the public.

Reason for taking the item in private:

Paragraph 3 – information relating to the financial information or business affairs of any particular person (including the authority holding that information)

No representations had been received as to why these items should not be held in private.

42 **Care Home Tender - Contract Awards (Part II)**

The content of the report was noted.

43 **Governance arrangements for the prioritisation of Community Infrastructure Levy (CIL) spending**

The content of the report was noted. It was further noted that the document presented was not in fact confidential and would be made available with the agenda papers for this meeting.

Councillor Alan Hill suggested that the governance arrangements for the prioritisation of CIL was an area that would benefit from involvement by Scrutiny. The Leader explained that whilst it was up to the Overview and Scrutiny Management Committee to set its workplan the Cabinet would be happy to suggest that the Committee include the matter of community and non-executive councillor involvement in the governance arrangements as part of its considerations of legacy issues to the new Council.

44 **Porton Business Plan**

Cllr Fleur de Rhé-Philipe presented the report which sought the Cabinet's endorsement of the proposed business plan to achieve the long term vision for growing high value activity in the defence and health/life sciences sectors at this centre of excellence; and recommended delegated authority be given to officers to finalise and enact the plan.

Resolved

To endorse the Porton Science Park Business Plan and delegate authority to the Associate Director, Economic Development and Planning, in consultation with the Leader of the Council, and the Cabinet Member for Economic Development, Skills, Strategic Property, to finalise the plan and undertake those activities that may be required, working in partnership with the Porton stakeholders in particular Dstl and PHE, to establish a suitably constituted company which will take forward and implement the vision for the Science Park.

Reasons for Decision:

To continue Wiltshire Council's support of Porton Science Park in partnership with Dstl and PHE.

45 **Procurement of housing repairs and maintenance service**

Councillor Jonathon Seed presented the report which outlined the proposed actions and timeframes for procuring new contracts for the Repairs and Maintenance service for the upkeep and improvement of the Council's Housing Stock for the next 5-10years.

Resolved

1. **To approve, in principle, the process that will be followed in order to deliver the required outcomes, including the various stages that will be undertaken and how suitable contractors can be selected.**

2. **To note that all options for delivery of services considered within the report in Appendix 1, in light of the report's conclusions, agrees in principle:**

   i. **To progress with the enlargement of the DLO to take on all responsive repairs and voids work, and look to recruit a new managerial structure to lead and co-ordinate this service**

   ii. **To extends the current partnership contracts with Ian Williams, British Gas and Wessex Electrical for a further two years and then look to migrate some of these services to the DLO, subject to a further review; and**

   iii. **That a further report will be presented to Cabinet in June 2017 with costings and potential savings in support of the above**

Reason for Decision:

On average Wiltshire Council plans to spend some £12m from the Housing Revenue Account (HRA) each year on the repairs and maintenance of the housing stock. This includes all emergency and day to day repairs, works to void properties, gas servicing, electrical testing, lift maintenance, as well as replacement works and meeting the Decent Home Standard.

The majority of this work is currently out-sourced through 4 main contracts and these are either ending or up for extension, so key decisions on how these services are delivered in the future will need to be made. A Repairs and Maintenance (R&M) Steering Group including members of the Housing Board has been formed to advise on progress through a number of stages in order to advise the future of both service delivery models and the most effective route to deliver the required service outcomes.

(Duration of meeting: 9.30 am - 12.43 pm)

These decisions were published, earlier, on the 17 March 2017 and will come into force on 27 March 2017

The Officer who has produced these minutes is Yamina Rhouati of Democratic Services, direct line 01225 718024, e-mail Yamina.Rhouati@wiltshire.gov.uk

Press enquiries to Communications, direct lines (01225) 713114/713115

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Wiltshire Council
Where everybody matters

CABINET CAPITAL ASSETS COMMITTEE

DRAFT MINUTES OF THE CABINET CAPITAL ASSETS COMMITTEE MEETING HELD ON 14 MARCH 2017 AT THE KENNET ROOM - COUNTY HALL, TROWBRIDGE BA14 8JN.

Present:

Cllr Baroness Scott of Bybrook OBE, Cllr John Thomson, Cllr Fleur de Rhé-Philipe, Cllr Toby Sturgis and Cllr Dick Tonge

Also Present:

Cllr Stuart Wheeler and Cllr Chris Caswill

76 **Apologies and Substitutions**

All members were present.

77 **Minutes of the previous meeting**

The minutes of the meeting held on 17 January 2017 were presented.

Resolved

To approve as a correct record and sign the minutes of the meeting held on 17 January 2017.

78 **Leader's Announcements**

There were no leaders announcements.

79 **Declarations of interest**

There were no declarations of interest.

80 **Public Participation and Questions from Councillors**

The Leader drew attention to the questions submitted by Marilyn Mackay, and to the answers circulated in the agenda supplement.

In response to a follow up question raised at the meeting from Councillor Chris Caswill, it was clarified that it was expected that the infrastructure requirements arising from the Rawlings Green application would be met by the developer, but that the Inspector had requested information as to what steps would be taken if this was not the case.

81 **Wiltshire Growth Deal Update**

Councillor Fleur de Rhé-Philipe presented the report which provided Cabinet Capital Assets Committee with an update on the development and delivery of Wiltshire Growth Deal projects and provide detail on the outcome of the Growth Deal round 3 bid.

The Leader welcomed the update particularly in relation to funding for Wiltshire College which would enable further improvements to their estate.

Resolved

1. To note the progress of Growth Deal projects; and

2. To note the outcome of the round 3 bid.

82 **Compulsory Purchase Order (CPO) Powers**

The Leader invited Councillor Stuart Wheeler to present a report which sought delegated authority to officers to establish the Council's process for carrying out the compulsory purchase of land to ensure the timely delivery of infrastructure, regeneration projects and development sites.

In presenting the report, Councillor Wheeler set out the main considerations and emphasised the importance of having a clear procedure in place should it be required.

Resolved

(i) To note the main considerations for the Council in relation to compulsory purchase powers.

(ii) To delegate authority to the Associate Director for Economic Development and Planning in consultation with the Associate Director for Legal and Governance and, the Associate Director for Finance to establish the Council's process for carrying out the compulsory purchase of land to ensure the timely delivery of infrastructure, regeneration projects and development sites.

83 **The Maltings and Central Car Park - Update**

🔑 Cllr Fleur de Rhé-Philipe presented the report which updated Members on the current status of the Central Car Park & Maltings regeneration scheme, and sought delegated authority to progress the project.

In presenting her report, and prior to consideration of exempt information in part ii of the agenda, Councillor Fleur de Rhé-Philipe reminded the meeting that the project would be in receipt of monies from the Growth Fund which would enable progress on the matter.

Resolved

To delegate authority to the Associate Director of Economic Development and Planning in consultation with the Cabinet Member for Cabinet Member for Economic Development, Skills, Strategic Transport and Strategic Property to proceed as advised in the exempt report considered at this meeting.

84 **Urgent items**

There were no urgent items.

85 **Exclusion of the Press and Public**

Resolved

To agree that in accordance with Section 100A(4) of the Local Government Act 1972 to exclude the public from the meeting for the following items of business because it is likely that if members of the public were present there would disclosure to them of exempt information as defined in paragraph 3 of Part I of Schedule 12A to the Act and the public interest in withholding the information outweighs the public interest in disclosing the information to the public.

Reason for taking the item in private:

Paragraph 3 – information relating to the financial information or business affairs of any particular person (including the authority holding that information)

No representations have been received as to why this item should not be held in private.

86 **The Maltings and Central Car Park - Update (Part ii)**

The meeting considered the content of the report.

87 **Professional Services Framework**

Councillor Stuart Wheeler presented the report which described the procurement process that will be followed to establish a framework of providers for the delivery of capital building projects, and requested authority from the Cabinet for the execution of contracts on that basis.

Resolved

1. **To note the Property related Professional Services Framework, which was entered into in 2012, will expire in November 2016; and**

2. **To delegate authority to the Associate Director for People and Business Services, in consultation Associate Director for Corporate Services and Procurement, Associate Director for Legal Services and Section 151 officer with their respective Cabinet Members, to enter into a procurement for the provision of Consultancy Services in support of delivery of the Council's ambitious Building Programme across the Wiltshire.**

(Duration of meeting: 1.00 - 1.21 pm)

These decisions were published on the 17 March 2017 and will come into force on 27 March 2017.

The Officer who has produced these minutes is Will Oulton of Democratic Services, direct line 01225 713935, e-mail william.oulton@wiltshire.gov.uk

Press enquiries to Communications, direct line (01225) 713114/713115

Wiltshire Council

Cabinet

4 April 2017

Subject: **Wiltshire End of Life Care Strategy**

Cabinet Member: **Cllr Jerry Wickham – Cabinet Member for Health (including Public Health) and Adult Social Care**

Key Decision: **No**

Executive Summary

Wiltshire's End of Life Care (EoLC) Strategy sets out our local vision for EoLC which is personalised, well co-ordinated and empowers patients to make informed choices about their care.

This refreshed strategy reinforces our commitment to improving and developing end of life care and support services.

It adopts a community approach to end of life care that integrates clinical, psychological, spiritual and social efforts in recognition that death, dying, loss and care take place in everyday life.

A range of factors influenced this refreshed strategy development: national and local guidelines and policies, best practice models, feedback from patients and insights from health and social care professionals.

The key objectives are to embed the recommendations from the National Palliative and End of Life Care Partnership ambitions framework, which builds on the 2008 Department of Health (DH) Strategy for End of Life Care.

Since this strategies predecessor in 2014 we have made significant progress and have worked collaboratively with our providers to implement a range of innovative end of life care services.

Continuing to learn and enhance work in a joined-up manner across health, social care and the voluntary sector will be fundamental to our approach as we move forward.

The improvement in service delivery that is expected from this strategy will require ownership and leadership from across the system in partnership with carers, patients, families and others that are important to them.

The draft strategy was shared with members of the Healthwatch Wiltshire readers' panel and was used to inform the version of the strategy used in the wider public engagement.

We heard from 91 people in total with public meetings in Salisbury, Royal Wootton Bassett and Bradford on Avon in November 2016. The feedback received will help shape ongoing work and service developments.

An Implementation Plan will now be developed by the End of Life Programme Board following approval of this Strategy.

This will outline the prioritised actions to be implemented within the next three years.

Proposal

For cabinet to adopt the End of Life Care Strategy

Reason for Proposal

To reinforce our commitment to improving and developing end of life care and support services across Wiltshire and to embed the recommendations from the National Palliative and End of Life Care Partnership ambitions framework, which builds on the 2008 Department of Health (DH) Strategy for End of Life Care.

Carolyn Godfrey, Corporate Director

Wiltshire Council

Cabinet

4 April 2017

Subject: **Wiltshire End of Life Care Strategy**

Cabinet Member: **Cllr Jerry Wickham – Cabinet Member for Health (including Public Health) and Adult Social Care**

Key Decision: **No**

Purpose of Report

1. To seek cabinet's endorsement of the Wiltshire End of Life Care Strategy.

Relevance to the Council's Business Plan

2. The EoLC strategy supports the council's business plan to create stronger more resilient communities by adopting a community approach to end of life care, and by protecting those who are most vulnerable.

Main Considerations for the Council

3. To adopt the refreshed Wiltshire End of Life Care Strategy.

Background

4. Wiltshire previous EoLC strategy comes to an end in 2017. This refreshed strategy reinforces our commitment to improving and developing end of life care and support services.

Overview and Scrutiny Engagement

5. The EoLC strategy and implementation plan will be made available for consideration by Health Select Committee, with the Committee's next meeting sheduled for 27 June 2017.

Safeguarding Implications

6. All organisations involved in end of life care will follow relevant safeguarding procedures.

Public Health Implications

7. None identified

Procurement Implications

8. Where in delivering the aims of this strategy it involves the award of contracts with providers these will be undertaken by the Strategic Procurement Hub in collaboration with a range of applicable stakeholders and in accordance with the council's Procurement and Contracts Regulations.

Equalities Impact of the Proposal

9. The consultation document for the End of Life strategy highlighted some potential areas equality to be addressed going forward. For example, white writing within the strategy document on a colour background can be difficult for some people to read, particularly people with a visual impairment, and some participants felt that the graphs were difficult to understand.

10. Members of the public thought that there was a lack of focus on unpaid carers, and respondents felt that some consideration of people from different cultures, religions and those without a religion would be beneficial.

11. Feedback from the consultation process will be actively used to shape the ongoing work and service developments of the Wiltshire End of Life Care Programme Board. An Implementation Plan will now be developed by the End of Life Programme Board following approval of the strategy which will outline the prioritised actions to be implemented within the next three years.

Environmental and Climate Change Considerations

12. Not applicable

Risks that may arise if the proposed decision and related work is not taken

13. The Strategy requires updating. Not taking this decision will mean that the EoLC Strategy will be out of date. There is a risk that decisions taken outside of a strategy could be conflicting.

14. There's an additional reputational risk of operating without a strategy and council decisions being questioned.

Risks that may arise if the proposed decision is taken and actions that will be taken to manage these risks

15. There is a risk that the strategy could be challenged in the future. The already done in consultation involving stake holders mitigates this risk as far as possible.

Financial Implications

16. There are no additional Financial commitments identified within this refreshed strategy.

Legal Implications

17. There are no additional legal commitments identified within this refreshed strategy.

Conclusions

18. Our commitment to EoLC in Wiltshire should be maintained and built upon through the adoption of this refreshed strategy and through the future development of a three year implementation plan.

Report Author: Kate Blackburn, Consultant in Public Health
Kate.Blackburn@wiltshire.gov.uk, gail.warnes@nhs.net,

09/03/2017

Appendices

- End of Life Care Strategy 2017-2020
- Public Health Engagement on the Wiltshire End of Life Care for Adults Strategy 2017-2020

Background Papers

None

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Wiltshire's End of Life Care Strategy For Adults 2017 to 2020

Strategy prepared by:

- Gail Warnes, End of Life Commissioning Manager, Wiltshire Clinical Commissioning Group
- Kate Blackburn, Public Health Consultant, Public Health, Wiltshire Council
- Jeremy Hooper, Public Health Scientist, Wiltshire Public Health

Contents

> *How people die remains in the memory of those who live on.*

Dame Cicely Saunders (1918–2005) founder of the modern hospice movement

Foreword

On behalf of Wiltshire Council and the NHS Wiltshire Clinical Commissioning Group, we would like to welcome you to our joint, refreshed, End of Life Care strategy for adults.

The provision of Palliative and End of Life Care for our patients represents one of the most challenging areas of health and social care practice, but also one of the most rewarding for the professionals involved. No two patients are the same, and we are privileged to be able to support and care for patients and their carers at this unique time in their lives. But we only have one chance to get it right.

It is vital that in addition to effective clinical practice we are also developing approaches to end of life care that include a focus upon improving health and wellbeing in the face of life-threatening/limiting illnesses, caregiving and bereavement, and actively involve patients in their own end of life care concerns.

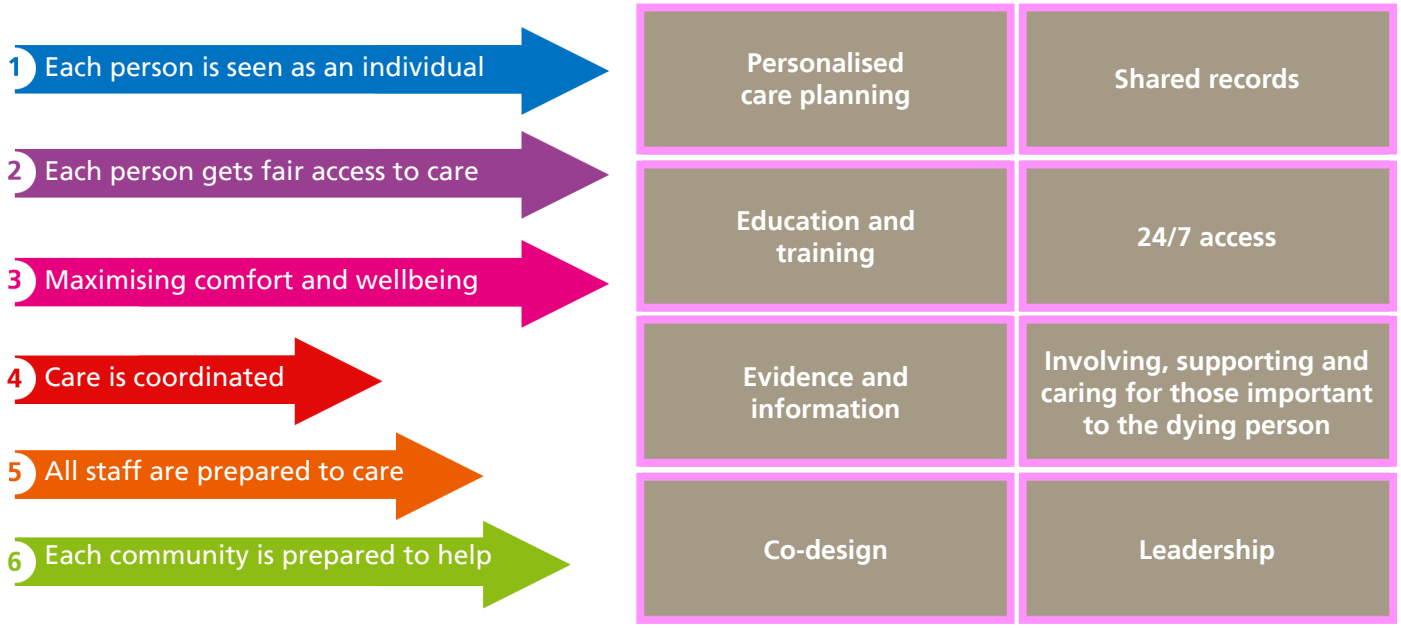
Wiltshire's End of Life Care Strategy sets out the local vision for end of life care which is personalised, well co-ordinated and empowers patients to make informed choices about their care. Our vision is that all patients at end of life, together with those closest to them, are able to express their needs and wishes, and that as far as clinically appropriate and practically possible, these needs and wishes are met.

This refreshed strategy reinforces our commitment to improving and developing end of life care and support services. It adopts a community approach to end of life care that integrates clinical, psychological, spiritual and social efforts in recognition that death, dying, loss and care take place in everyday life within the family and community. We will seek to raise awareness of death, dying, loss and care and provide a compassionate approach to end of life care which incorporates sustainable networks of care that adapt and are flexible depending on need and demand.

We will respond to national and local guidelines and best practice models, and listen to patients, carers and families so that we can continually enhance the quality of our services. This strategy builds on its predecessor that was first published in 2014. Since this time we have made significant progress and have worked collaboratively with our providers to implement a range of innovative end of life care services. Partnership working has remained key for many years in delivering improvements in End of Life Care across Wiltshire. Continuing to learn and enhance work in a joined-up manner across health, social care and the voluntary sector will be fundamental to our approach as we move forward.

This strategy clearly aligns with the aims of the Wiltshire Better Care Plan which is to provide more specialist care for the patient in their own home and community and take active steps to enhance the wellbeing and independence of the service user.

In September 2015, the National Palliative and End of Life Care Partnership published a national framework for local action 2015-2020[1] . This national framework for action sets out six 'ambitions' – principles for how care for those nearing death should be delivered at local level and eight principles which are the foundations to build and realise the ambitions:



Responsibility for implementing the ambitions of the new framework spans the commissioner and provider spectrum, putting onus not just on CCGs, but on providers, NHS England, Public Health England, local councils, and third sector organisations to take action, monitor progress and influence change.

Acknowledging this, Wiltshire's refreshed End of Life Care Strategy sets out our aspirations for the coming years. We are also committed, in an environment where resources are constrained, to make best use of those available and to deliver value for money. This includes seeking the best experience possible for both patient and carers in the palliative period. As far as the patient's clinical condition allows, the aim is to deliver real choice for patients and meet their wishes, where possible, in the last phase of their life.

By working together to implement this strategy we are confident that we can continue to make a really positive difference to improved end of life care in Wiltshire.

Thank you

Dr Peter Jenkins
Chair, Wiltshire Clinical Commissioning Group

Frances Chinemana
Acting Director for Public Health, Wiltshire Council

End of Life Strategy on a page

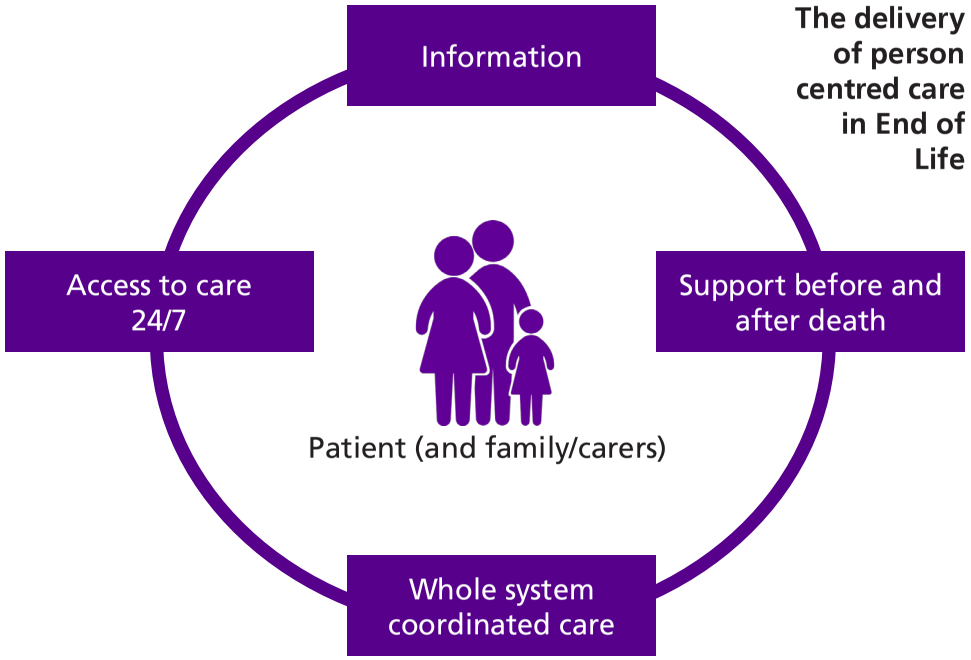
Vision: Our vision is that the patient and their family/carer receive the care and support that meets their identified needs and preferences through the provision of information, education and support and in the delivery of high quality, timely, effective individualised services. Ensuring respect and dignity is preserved both during and after the patient's life

Priorities

- 24/7 accessible and appropriate high quality care
- Informed choice for patients and families
- Patient and family centred care.
- Integrated end of life care through further partnerships between all services and communities in recognition that end of life care requires a community approach
- Flexibility of services
- Value for money for services
- Empower individuals to plan for their end of life care
- Improve patient and family experience
- Skilled and competent providers delivering high quality end of life care
- Encourage and support people to think and plan for end of life at the earliest opportunity
- Support the people of Wiltshire to be cared for and die in their preferred place of care
- Reduce inappropriate transfers of care from all settings and faster discharge from hospital

What we are doing

- 72-hour service
- Enhanced Discharge Service
- Electronic Palliative Care Co-ordination systems
- Hospice @ Home
- Wiltshire Dying Well Community Charter
- Education and training
- Treatment Escalation Plans
- Advance Care Plans
- Community pharmacies



What we want to achieve

- Increase in advance care plans and Treatment Escalation forms
- Increase engagement with communities about end of life so that those affected by dying and death do not feel abandoned and socially isolated
- Reduction in emergency admissions to hospital of patients who are approaching end of life
- Increase in satisfaction of bereaved families and more support for them in times of crisis
- Increase in people who die in their preferred place
- Reduction in number of hospital bed days of patients wishing to die at home
- Improved care at home

Wiltshire's Aim

Our overarching vision for End of Life Care has remained unchanged for several years, along with our core values, goals and ways of working.

We want to make sure that the highest quality end of life care services are available, through integrated services which embed best practice to meet individual need, so that people at the end of their lives have a 'good death'. In addition we want to adopt a community approach to end of life care that integrates clinical, psychological, spiritual and social efforts to ensure that social isolation and stigma are reduced.

Effective and compassionate care and support will be in place for people who are approaching the end of life so that they can have a dignified, peaceful and supported end of their life. Carers and families will be supported through this time and after their loved one has passed away.

We want to ensure that people are given the support and information that helps them to make a clear choice about where and how they are cared for, supported and die. To make it possible for health and social care services to enable their wishes to be met as far as the patient's clinical condition allows.

Introduction

Wiltshire's End of Life Care Strategy was first published in 2014 and set out a three-year plan for the continued development of End of Life Care for Wiltshire residents. It is now considered to be an opportune time to revisit the strategy, to build upon achievements, and reaffirm our priorities for the next three years so that we will continue to enhance and improve End of Life Care services for the local population, at the individual, family and community level.

End of Life Care is an enduring priority at both national and local levels. At a national level, this is reflected by the fact that personalised and coordinated care are two areas identified in the Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020[2].

At a local level, we remain committed to pursuing continuous improvement and identifying new innovations to drive developments in our services. This strategy has been jointly developed by Wiltshire CCG and Wiltshire Council. It seeks to strengthen elements of our previous End of Life Care Strategy and ensure that many of the commitments and aims to continue to remain relevant.

A range of factors influenced our refreshed strategy development, including national and local guidelines and policies, best practice models, feedback from patients and insights from health and social care professionals. The key objectives of this strategy are also to embed the recommendations from the National Palliative and End of Life Care Partnership ambitions framework, which builds on the 2008 Department of Health (DH) Strategy for End of Life Care[3].

It details the current understanding of need, reflects upon progress since the publication of the 2014 strategy, service provision within Wiltshire and the future plans to further develop integrated end of life care for adults. The improvement in service delivery that is expected from this strategy will require ownership and leadership from across the system in partnership with carers, patients, families and others that are important to them.

This strategy acknowledges the importance of current collaborative arrangements between the statutory, community and voluntary sector agencies and recognises that going forward these arrangements need to be strengthened further through local and regional strategic planning. This strategy will be implemented through the End of Life Programme Board and will report to Wiltshire's Clinical Commissioning Group Governing Body and Wiltshire Council's Health and Wellbeing Board.

Defining End of Life

The General Medical Council (2010)[4] has defined End of Life in the manner described below, and the National Institute for Health and Care Excellence adopted the same definition in their Quality Standard for End of Life Care for Adults[5], which was published in 2011.

Patients are 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

1. advanced, progressive, incurable conditions
2. general frailty and co-existing conditions that mean they are expected to die within 12 months
3. existing conditions if they are at risk of dying from a sudden acute crisis in their condition
4. life-threatening acute conditions caused by sudden catastrophic events.

General Medical Council (2010:8)

As noted in NICE's (2011) Quality Standard[6], "defining when a person needs end of life care is individual and dependent on the person's perspective and that of their health and social care professional".

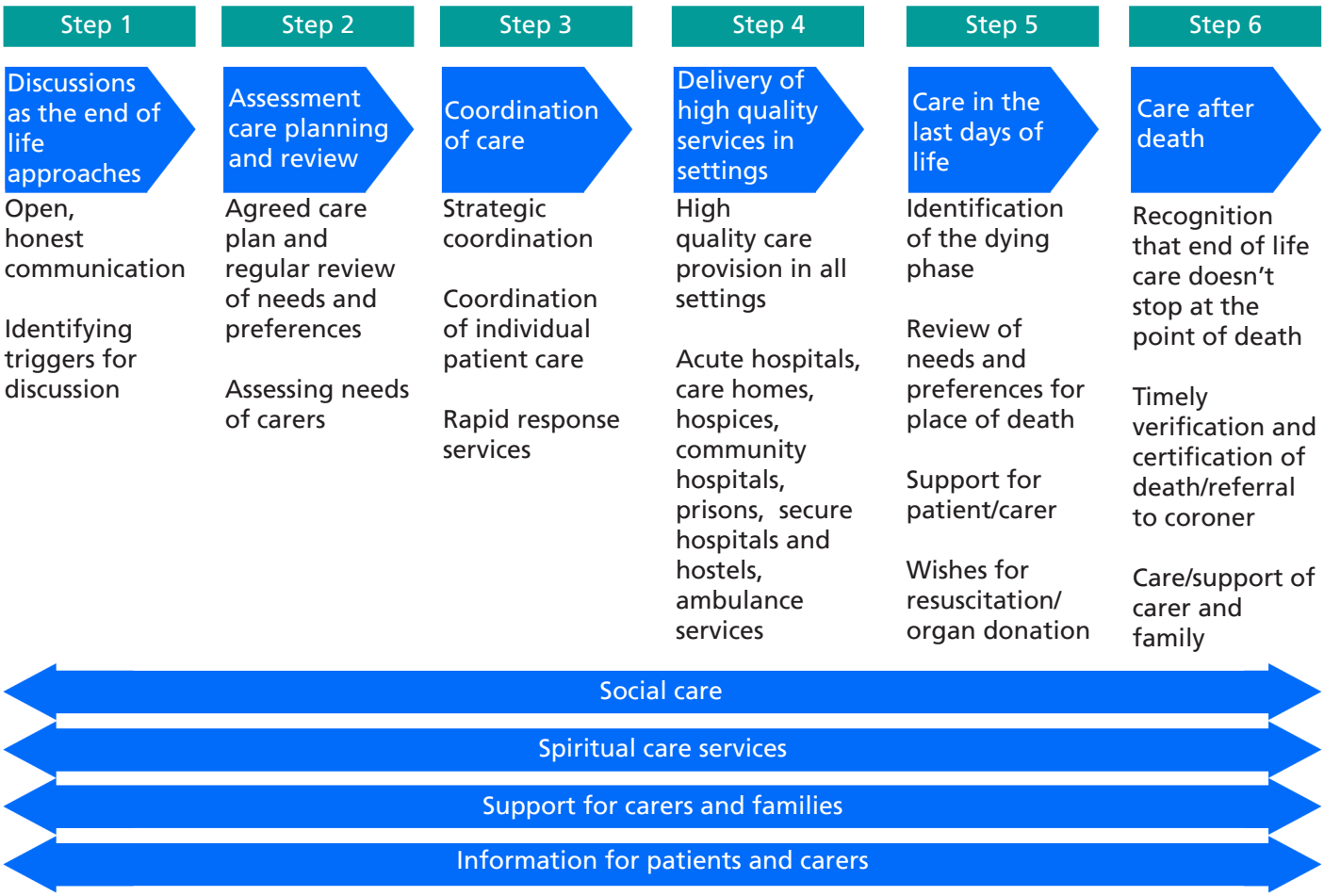
As a result of the complexities associated with identifying when individuals enter the end-of-life phase, many patients will require access to End of Life Care services for a period of time that is greater than a year.

National End of Life Policy

Wiltshire endeavours to keep abreast of, and be responsive to, national strategy, policy and relevant guidelines on end of life care.

Involving people, carers, families and others who are important to them in decisions about their end of life care and improving access to high quality care closer to home at end of life are both key issues for policy.

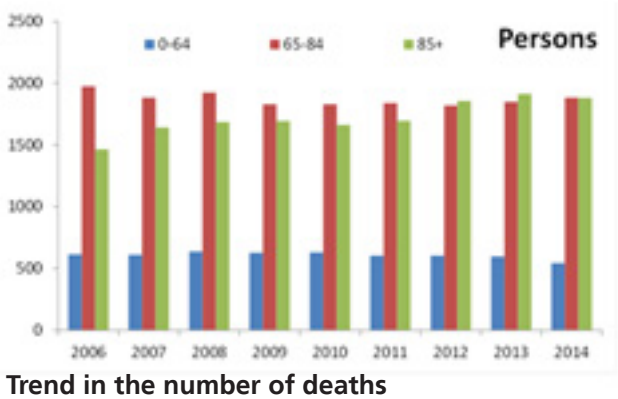
The Government's mandate[7] to the NHS Commissioning Board in 2013 stated that one of the objectives is to 'pursue the long-term aim of the NHS being recognised globally as having the highest standards of caring, particularly for older people and at the end of people's lives'.



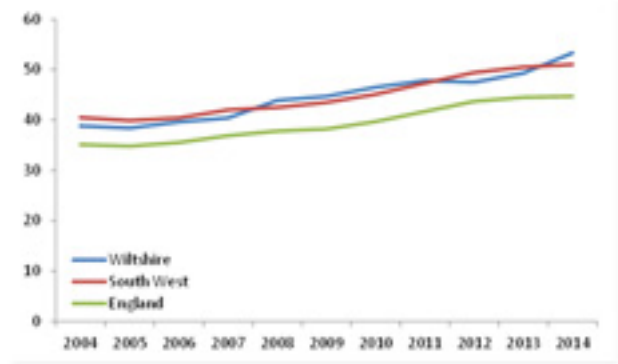
Source: The National End of Life Strategy (DH 2008)

Included in Annex 1 are brief commentaries on some fundamental areas of guidance which have also had an influence on this strategy's development.

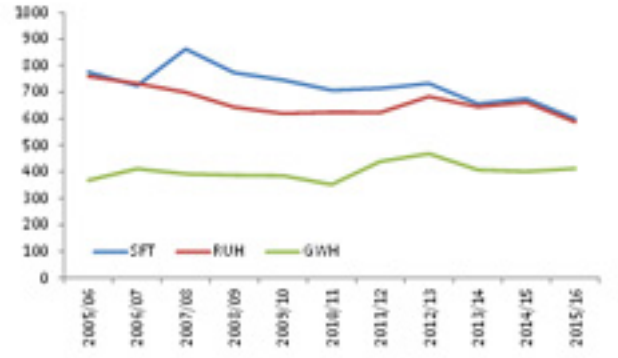
> *"[The carers] knew what to do, what to expect ... [and] were more confident in looking after someone who was dying. They cared for the family as well as the patient."*
>
> **Healthwatch Wiltshire Evaluation of 72-hour pathway**



Trend in the number of deaths



Annual trend for the percentage death in the usual place of residence



Trend in the number of deaths at the 3 main acute trusts

"The Palliative care nurses were so professional and helpful – I really felt supported."

Healthwatch Wiltshire Evaluation of 72-hour pathway

National and Local Context

The What We Now Know Report[8] (reflected in Annex 2) illustrates the needs of the national population for End of Life Care:

- There are changing trends in the age of death, with increasing numbers of deaths in people aged 85 and over and a decreasing trend in people aged 65 to 84. The older age group has a greater likelihood of frailty and multiple illnesses
- 36.2% of deaths in England are in the 85 and over age group. Approximately 50% of all female deaths occur in women aged 85 and over, and 30% of all male deaths.
- Although 70% of the public say they are comfortable talking about death, most haven't discussed their end of life wishes or put plans in place.
- Home is the preferred place of care and death for the majority of people and most do not change this preference. However, a substantial minority do not make home their first choice or change their minds.

The population of Wiltshire in 2016 is approximately 475,870. This is predicted to rise to 492,630 by 2021 . Wiltshire's population is also aging, with the percentage of over 65 year olds predicted to rise from 20.6% in 2016 to 22.3% by 2021.

Around 4,000 Wiltshire residents die each year. The majority of deaths occur in adults over the age of 65, following a period of chronic illness. Information suggests there has been a decline in the percentage of deaths happening in hospital from around 55% in 2006 to around 40% in 2014 which correlates with the percentage of deaths in a hospice or at home increasing.

More detailed end of life demographics is captured under Annex 2.

Wiltshire's End of Life Care Strategy will link closely with a number of other key strategies and work programmes including the Dementia Strategy, Cancer Strategy and Carers Strategy.

Wiltshire's Strategy

The End of Life Care Strategy is a refresh to reaffirm the vision and direction of travel for end of life care in Wiltshire. The work has and will continue to be taken forward by making the best use of existing resources within the system. Delivering the strategy, building on the work to date will need the development of a multiagency plan and will require resources in terms of staff, technology etc within and across organisations to work differently.

The strategy is underpinned by the principle of an active and compassionate approach to end of life, that ensures respect for, and dignity of, the patient and their family and carers. The continuing key priorities are:

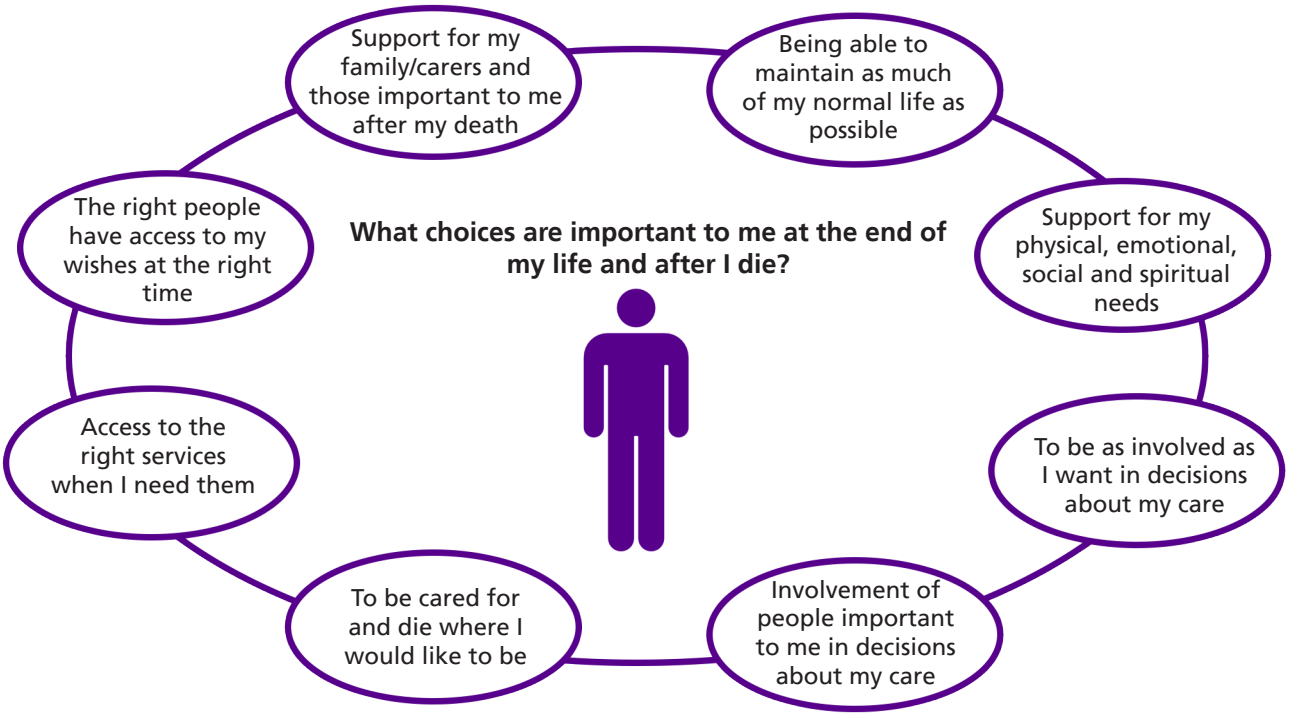
- For individuals to be able to access appropriate high quality care at all times.
- For individuals, families and carers to have access to information, education and support to inform decision making and choice relating to end of life care
- To ensure informed choice for patients, carers, families and others who are important to them.
- To provide patient, carer and family centred care.
- To develop a community approach to end of life care which include health promotion, prevention and harm reduction and reduces the risks of social isolation and stigma.
- To have flexibility of services.
- To provide value for money for services.
- To ensure individuals are empowered to plan for their end of life care.
- To improve the experience for patients, carers, families and others who are important to them.
- To ensure all providers are skilled and competent in delivering high quality EOL care.
- To encourage and support people to start thinking and planning for end of life at the earliest opportunity and whilst they are well able to contribute to decisions affecting their future care.
- To support the people of Wiltshire to be cared for and die in their preferred place of care.
- To reduce inappropriate transfers of care from all settings.

Patient and Public Perspectives

We are committed to hearing the voices and stories of patients in order to find out what is working well and identify areas for development. They help to reveal how progress in recent years has improved services and the quality of care for patients.

We intend to work with providers to ensure that feedback from patients who are approaching the end of life and their carers, families and others who are important to them is captured in a sensitive and meaningful way to ensure that it can be used to make continual improvements in the services which are offered and can help to inform commissioning decisions in the future.

> *"So nice they didn't rush away [after the person had died]… but they stayed until they felt you were ready to cope"*
>
> **Healthwatch Wiltshire Evaluation of 72-hour pathway**



Exploring the Experience of End of Life Care

The Patients Association[9], on behalf of Wiltshire CCG, carried out a project to help understand the experience end of life care from relatives of people who had died in Wiltshire in 2014.
The project had three elements:

- a review of the large-scale Office for National Statistics (ONS) Survey for Bereaved People in relation to data for Wiltshire;
- a specifically designed semi-structured questionnaire for relatives of those who had died within the last year in Wiltshire;
- a small number of telephone interviews with relatives.

Forty people replied to the 17-question survey either by paper or online with 10 telephone interviews with people who had replied to this survey, to provide additional depth and insight into the survey findings.

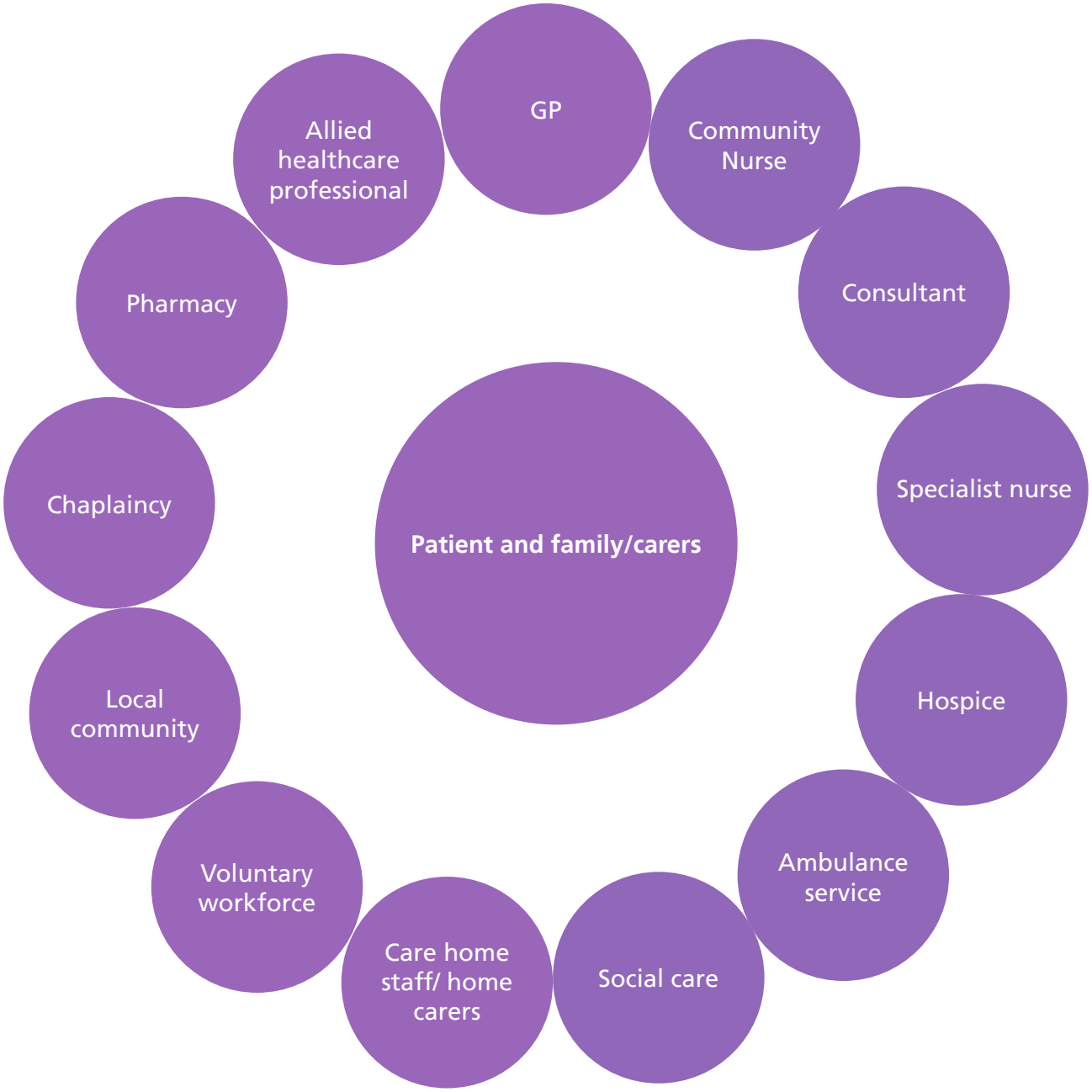
Most respondents to the Patients Association survey rated their relative's end of life care highly, with 24 people saying that care overall in the last three months before death was Outstanding or Excellent; 10 rating it Good; three Fair and two Poor.

The report concluded with 7 recommendations that the CCG, its partners on the End of Life Programme Board and the health community in Wiltshire more generally, review and use the learning from the relatives to help develop future programmes of improvement.

End of Life Care in Wiltshire

Services

End of Life Care is provided by a range of professionals and services and is delivered in a range of settings across Wiltshire. Bearing this in mind, collaborative working is of fundamental importance in order to meet patients' needs and wishes during the final stages of their lives. Mechanisms to support effective joint working across the local healthcare economy are frequently explored.



The range of health, social and voluntary sector providers involved in End of Life Care

The Wiltshire End of Life Programme Board, which meets bi-monthly, brings together representatives from local providers of end of life care services (including hospices, hospitals and community services) and commissioners to explore issues which span organisational boundaries in order for solutions to be collectively established and taken forward. There is also patient representation at this forum to help to ensure that patients' voices guide service developments and changes.

Outlined in Annex 3 are the key End of Life Care services which are currently commissioned in Wiltshire.

What we are doing

The Better Care Fund (BCF)

72Hour Service

The Better Care Fund pilot schemes provide us with the extended opportunity to improve the delivery of more integrated end of life care designed around individual need. Work to date has included creating local integrated community teams to change the way care is delivered locally, to be more proactive and reduce dependence on acute hospital provision and to enable health and social care resource to be placed around needs of individual.

We have made good progress through the Better Care Fund's 72hr pathway concepts. In order to better support the needs of those with End of Life care needs, two of Wiltshire's hospices (Dorothy House Hospice Care and Prospect Hospice) delivered a pilot for a 72 hour rapid response enhanced End of Life care service, to provide care at home, up to 24 hours a day for up to 72 hours. This has recently commenced at Salisbury Hospice.

The aim of the 19-week pilot was to establish demand, capacity and process for an enhanced service for people with End of Life Care needs. It was designed to prevent inappropriate admissions to hospital and increase timely discharge from hospital, thus reducing unnecessarily prolonged stays.

Each hospice provided a skilled hospice at home carer that was available 24 hours a day (if required) to support any patients within the last year of life who have been assessed as medically stable for discharge or to remain at home with appropriate support.

To enable a seamless service across Wiltshire, the pilot integrated closely with out-of-hours medical services and the existing Urgent Care @ Home service. Joint working with Medvivo enabled the service to be integrated and coordinated across the area.

The service was delivered to 191 people between December 2014 and December 2015. Prospect Hospice supported 101 people, while Dorothy House Hospice Care provided care to 90 people.

Enhanced Discharge Service

Following the successful evaluation of the Hospice at Home 72 hour pilot, but taking into account the ongoing needs of our patients when admitted to hospital, Dorothy House Hospice Care have started a rapid discharge service in collaboration with the Royal United Hospitals Bath NHS Foundation Trust (RUH) and again funded through the Better Care Plan.

This service provides up to 24 hours of care, 7 days a week to facilitate timely discharge for Wiltshire end of life patients who are in the RUH. Whilst this service can only be accessed through the RUH palliative care team we are positive about how this service will help more of our patients to leave hospital quicker to be at home with family and friends.

> *"I hope to have something similar for me"*
>
> **Healthwatch Wiltshire Evaluation of 72-hour pathway**

Electronic Palliative Care Co-ordination Systems (EPaCCS)

The End of Life Care Strategy (2008)[10] identified the need to improve co-ordination of care, recognising that people at the end of life frequently received care from a wide variety of teams and organisations. The development of Locality Registers (now Electronic Palliative Care Co-ordination Systems known as EPaCCS) were identified as a mechanism for enabling co-ordination.

EPaCCs enable the recording and sharing of people's care preferences and key details about their care at the end of life. EPaCCs enables details of a person's illness and their wishes to be shared to improve coordination of care and allow people's choices to be known to emergency and out-of-hours services. EPaCCs, through SystmOne, is being used in Wiltshire GP practices, hospitals, hospices and community services. Plans are also being developed to extend access to ambulance services.

Hospice @ Home Service

Hospice at home is an integral component of community end of life care bringing the skills, ethos and practical care associated with the Hospice movement into the home environment, putting the patient and those who matter to them at the centre of the care.

Hospice at home services aim to enable patients with advanced illness to be cared for at home, and to die at home if that is their preference. Care may be provided to prevent admission to, or facilitate discharge from, inpatient care for crisis management or for longer periods of care. Care may support times of rapid change, or may be for longer periods of support.

Care is intended to be of the highest possible standard to enhance the quality of life of patients, while supporting carers and families. Hospice at home often works in partnership with many other health and social care professionals to achieve this.

It provides personal care and support for patients and their carers and is recognised to be an important component of End of Life Care service provision which supports patients to remain in their own homes. The needs of the carers are an integral part of the service which aligns with the recognition that emergency services may be more likely to be needed if carers feel unsupported.

The Hospice at Home teams, provided by all 3 of Wiltshire's Hospice providers, work closely with other professionals and organisations in order to meet patients' needs and wishes during the final stages of their lives.

Wiltshire Dying Well Community Charter

Wiltshire's End of Life Programme Board has prioritised developing a Wiltshire Dying Well Community Charter. This will set out to outline a visible commitment by individuals, communities and organisations, working together to support the community we all live in, the people with a life limiting illness, their carers, families and all those who are important to them.

The Charter is a nationally led idea, but the ideas and commitments within it need to be ones that many local organisations will recognise as important and valid for our local community of Wiltshire.

A partnership group has been established to understand how we could best create a Wiltshire Charter as there is more to do to engage communities in the end of life so that those affected by dying and death do not feel abandoned and socially isolated. Importantly, that care for one another at times of crisis and loss is not simply a task for health and social care services but is everybody's responsibility.

Education and Training

We recognise that staff need to have high quality training and support to enable them to care effectively for patients who are approaching the end of life. Wiltshire CCG has a website page dedicated to providing details of our providers that deliver End of Life Care training.

Wiltshire's Community care provider is also providing training for staff who work in care homes, primary care professionals and those who work for agencies who provide community care, and includes areas such as communication skills, advance care planning and Treatment Escalation Plans.

> *"I am so grateful this service exists and that we were able to access it"*
>
> **Healthwatch Wiltshire Evaluation of 72-hour pathway**

Treatment Escalation Plans (TEP)

Treatment Escalation Plans, to improve the experience of patients, carers, families and others who are important to them, was launched across Wiltshire in December 2014. The aim is to ensure the wishes of patients and their families are communicated between health providers. This was developed as part of the multi-agency End of Life Programme Board and involved patient representatives, hospital and hospice staff and GPs.

The implementation of the plan is being supported by an education programme for staff and information for patients, carers, families and others who are important to them. Patients who have a Treatment Escalation Plan will be able to discuss the plan at any stage with health professionals and the plan can be altered to mirror the potential changing wishes of patients. Extensive detail to further support the implementation of TEP and to hopefully increase the number of patients in Wiltshire who are able to die in their preferred place, is captured on Wiltshire CCG's website.

Advance Care Plans

The National Council of Palliative Care states that:

"Advance care planning (ACP) is a voluntary process of discussion about future care between an individual and their care providers, irrespective of discipline. If the individual wishes, their family and friends may be included. It is recommended that with the individual's agreement this discussion is documented, regularly reviewed, and communicated to key persons involved in their care. An ACP discussion might include:

- *the individual's concerns and wishes,*
- *their important values or personal goals for care,*
- *their understanding about their illness and prognosis,*
- *their preferences and wishes for types of care or treatment that may be beneficial in the future and the availability of these."* [11]

Wiltshire's community services are currently piloting an advance care plan and the evaluation of this, in its current format, is due early 2017 in order this can be formally launched and embedded into practice.

Community pharmacies

A number of community pharmacies, including some which operate a 100 hour per week service, provide an Emergency Access Drugs Service. The pharmacists provide up-to-date information and advice on prescription writing and dispensing to support carers and relatives obtaining supplies of medicines needed for end of life care.

Next steps

In order to continue to deliver our end of life strategy and realise the benefits for patients, their carers and their families a more detailed implementation plan will be developed each financial year by the End of Life Care Programme Board. The plan will work to ensure best use of the existing resources, building on what has been done to date and develop specific project mandate(s) to take collaborative improvement work forward to ensure overall delivery of this strategy.

How we will continue to measure progress

To achieve our aims, we must recognise patients approaching the end of life, record their wishes and provide care to enable those wishes to be met, where the patients clinical condition allows. End of life is not a condition and measurements of cause of death have to be interpreted from conditions that you would expect to be palliative towards the end.

Therefore, to determine whether we are achieving this we will need to measure progress by the following performance indicators:

- Increase in advance care plans
- Increase in Treatment Escalation forms
- Increase in patients registered on GPs palliative care register
- Reduction in emergency admissions to hospital of people who are approaching end of life care
- Increase in satisfaction of bereaved families
- Increase in people who die in their preferred place
- Reduction in emergency admissions of people who are approaching the end of their lives from Care Homes
- Reduction in number of hospital bed days of patients wishing to die at home.

As highlighted in this strategy, End of Life Care has been a key area of focus for many years in Wiltshire and there is a strong commitment to pursuing continuous improvement.

Significant progress has been made in recent years in terms of improving the care of individuals who are approaching the end of life and their carers, and there are a range of high-quality services across the local healthcare economy. However, there are still important areas for development which need to be focussed on in the coming years and these are reflected in our reaffirmed commitment to the priorities which are set out in this strategy.

We are committed to continuing to listen to the needs, wishes and preferences of our local population and will use the feedback that we receive to shape ongoing work and service developments.

This strategy provides a vision and direction for end of life care service planning and delivery with the priorities described in this strategy revealling where we think we need to be focussing in the coming years.

To continue the drive for high quality end of life care in Wiltshire, an Implementation Plan will be developed by the End of Life Programme Board following approval of this Strategy. This will outline the prioritised actions to be implemented within the next three years and will take into account the responses from public engagement activities. This will encompass specific outcomes, activities and deadlines. Developing such an implementation plan will help to ensure that momentum is maintained and that the right progress is achieved in a timely manner.

Annex

Annex 1

Department of Health (2008)[12]
End of Life Care Strategy: Promoting High Quality Care for All Adults at the End of Life

The aim of this strategy was to "make a step change in access to high quality care for all people approaching the end of life" (DH 2008:10). The strategy identified 12 key areas, listed below, together with associated actions and recommendations.

1. Raising the profile
2. Strategic commissioning
3. Identifying people approaching the end of life
4. Care planning
5. Coordination of care
6. Rapid access to care
7. Delivery of high quality services in all locations
8. Last days of life and care after death
9. Involving and supporting carers
10. Education and training and continuing professional development
11. Measurement and research
12. Funding

The Department of Health's Strategy highlighted the need to consider the entirety of the patient journey. The End of Life Care Pathway presented in this strategy is shown below, and the relevance and value of drawing upon this when developing services is still recognised.

National Institute for Health and Care Excellence (NICE) (2011)[13]
Quality Standard for End of Life Care for Adults

This NICE quality standard defines clinical best practice within this topic area and covers all settings and services in which care is provided by health and social care staff to all adults approaching the end of life. It does not cover condition-specific management and care or the clinical management of specific physical symptoms.

The quality standard for end of life care for adults requires that services are commissioned from and coordinated across all relevant agencies, including specialist palliative care provisions as well as the voluntary sector and encompasses the whole end-of-life care pathway. An integrated approach to provision of services is fundamental to the delivery of high-quality care to people approaching the end of life and their families and carers.

The standard includes specific, concise quality statements, of which there are 16 relating to the areas listed below.

- Identification
- Communication and Information
- Assessment, Care Planning and Review
- Holistic Support
- Coordinated Care
- Urgent Care
- Specialist Palliative Care
- Care in the Last Days of Life
- Care After Death
- Workforce

Actions for End of Life Care: 2014-16[14]

The National Palliative and End of Life Care Partnership, made up of statutory bodies including NHS England, the Association of Directors of Adult Social Services, charities and groups representing patients and professionals, developed a framework for action.

The document is one component of a wider ambition to develop a vision for end of life care beyond 2015. To work in partnership with all those in health and social care and ensure that living and dying well is the focus of end of life care, wherever it occurs. This framework is aimed at health, social care and community leaders. It builds on the Department of Health's 2008 Strategy for End of Life Care and responds to an increased emphasis on local decision making in the delivery of palliative and end of life care services since the introduction of the Health and Social Care Act 2012.

Leadership Alliance for the Care of Dying People; one Chance to Get it Right (2014)[15]

The Leadership Alliance for the Care of Dying People (LACDP) developed a new approach for the care of those in the last few days and hours of life. A range of organisations were involved in the development of the approach; the membership of the LACDP included regulatory bodies, professional colleges, national quality organisations, commissioning organisations, charities and academic institutions.

The report sets out five Priorities for Care, outlined below, which apply when it is thought that a person may die within the next few days or hours. These are transferable across settings and should be adopted and delivered regardless of where someone dies. The primary focus is on the needs and wishes of the dying person and their loved ones, who should be at the centre of decision-making regarding treatment and care. The Priorities will be monitored and reviewed, and there is the expectation that they will be revised and developed, based on feedback and findings of new research.

The Priorities for Care align with NICE Quality Standard for End of Life Care for Adults (2011).

Priorities for Care of the Dying Person

The Priorities for Care are that, when it is thought that a person may die within the next few days or hours…

1. This possibility is recognised and communicated clearly, decision made and actions take in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly
2. Sensitive communication takes place between staff and the dying person, and those identifies as important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
5. An individual plan of care, which included food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion

Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020[16]

The National Palliative and End of Life Care Partnership, made up of statutory bodies including NHS England, the Association of Adult Social Services, charities and groups representing patients and professionals has developed a framework for action in making palliative and end of life care a priority at local level.

The Ambitions for Palliative and End of Life Care framework, is aimed at local health and social care and community leaders. It builds on the Department of Health's 2008 Strategy for End of Life Care and responds to an increased emphasis on local decision making in the delivery of palliative and end of life care services since the introduction of the Health and Social Care Act 2012.

This national framework for action sets out six 'ambitions' – principles for how care for those nearing death should be delivered at local level:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help

The framework identifies measures such as personalised care planning and shared electronic records that are needed to realise each of the six ambitions, and calls on Clinical Commissioning Groups, Local Authorities and Health and Wellbeing Boards to designate a lead organisation on palliative and end of life care and to work collaboratively to bring people together to publish local action plans based on population based needs assessments.

Care of dying adults in the last days of life (NICE) (2015)[17]

This NICE guideline was produced in response to the removal of the Liverpool Care Pathway and the recommendations set out by the One Chance to Get it Right Report.

The guideline is intended for all healthcare professionals and other care providers who might be involved in the care of a person who is nearing death in any NHS setting. It is specifically aimed at non-specialists working in primary care or in care homes, and healthcare professionals working in a wide range of clinical specialties who do not have specialist level training in end of life care. It also provides a baseline for standards of care in settings that specialise in caring for people who are dying, such as non-NHS palliative care units and hospices.

This guideline provides recommendations to help healthcare professionals to recognise when a person is entering the last days of life or may have stabilised or be improving even temporarily; to communicate and share decisions respectfully with the dying person and people important to them; and to manage hydration and commonly experienced symptoms to maintain the person's comfort and dignity without causing unacceptable side effects.

The Choice in End of Life Care Programme Board's Whats important to me; A Review of Choice in End of Life Care (2015)[18]

This report identifies the issues people approaching the end of their lives are currently facing and offers a blueprint for how greater choice in end of life care can be achieved. The Choice in End of Life Care Programme Board was commissioned to provide advice to Government on how the quality and experience of care and support for adults at the end of their life, and those close to them, can be improved with greater and better choices. It provides advice on the steps that should be taken to ensure greater choice in end of life care for everyone when they need it, focused around 'a national choice offer' – meaning what should be offered to each person who needs end of life care.
The report also mentions the models of care that have been created for end of life care.

- Commitment to deliver choice in end of life care by April 2020.
- A new right in the NHS constitution for everyone to be offered choices.
- 24/7 end of life care for people being cared to be in place by 2019.
- A clear policy by the Government to make access to social care fast and free.
- More honest and open communication about issues to do with end of life.
- Better support for health and care professionals involved in end of life care.
- Improving awareness of end of life care amongst the public.

Department of Health (2016)[19]
The Government Response to the Review of Choice in End of Life Care

The Government commissioned the Review of Choice in End of Life Care (published February 2015) to provide independent advice on improving the quality and experience of care for adults at the end of their life, their carers, families and others who are important to them, by expanding choices. The Review found that people want to be given the opportunity to make choices relating to their end of life care, but they want their choices to be real choices, based on high quality end of life care services being available in all areas of the country and in all settings.

The Review made 30 recommendations.
In July 2016, the Government published their response to the Review. The response confirms that the Government accepts the recommendations of the Review. It goes on to outline the actions the Government are taking, led by organisations across the health and care system, to meet their ambition for all people to have high quality, personalised end of life care built around their needs.

The Response details the 6 commitments that the government has made to the public to end variation in end of life care across the health system by 2020. These are:

- honest discussions between care professionals and dying people
- dying people making informed choices about their care
- personalised care plans for all
- the discussion of personalised care plans with care professionals
- the involvement of family and carers in dying people's care
- a main contact so dying people and their families know who to contact at any time

The Government conclude that their vision is one of transformation and transparency for end of life care.

Annex 2

Need and Trends in Deaths

National

A review of the Liverpool Care Pathway was undertaken to find out why its implementation was unsuccessful. The What We Now Know Report illustrates the needs of the national population for End of Life Care:

- There are changing trends in the age of death, with increasing numbers of deaths in people aged 85 and over and a decreasing trend in people aged 65 to 84. The older age group has a greater likelihood of frailty and multi- morbidities.
- 36.2% of deaths in England are in the 85 and over age group. Approximately 50% of all female deaths occur in women aged 85 and over, and 30% of all male deaths.
- Population-based studies exploring patterns in the place of death in England between 1993 and 2010 found:
    - Hospital remains the most common place of death
    - An increase in home and hospice deaths mirrors the decrease in hospital deaths in cancer since 2005, and a reversal of British trends in deaths suggest that the National End of Life Care Programme made a difference in end of life care.
    - The proportion of deaths in inpatient hospices increased slightly among people with cancer and non-cancer (0.4% and 0.3%, respectively).
- Although 70% of the public say they are comfortable talking about death, most haven't discussed their end of life wishes or put plans in place.
- Home is the preferred place of care and death for the majority of people and most do not change this preference. However, a substantial minority do not make home their first choice or change their minds.
- Among high-quality studies and excluding outliers, estimates of a preference for dying at home ranged 31% to 87% for patients (nine studies), 25% to 64% for carers (five studies), 49% to 70% for the public (four studies).
- 20% of patients in the ten studies that examined preferences over time changed their preference for place of care or death as their illness progressed.
- A retrospective cohort study of 970 people using hospice services in South West England found that:
    - 75% of people using hospice services who had completed advance care planning (ACP) achieved their choice of place of death.
    - 11% of people using hospice services who had completed ACP died in hospital compared with 26.5% of those who had not completed ACP
    - The preferred place of death for people in hospices in South West England varied between those with cancer and non-cancer diagnoses.

Wiltshire

Around 4,000 Wiltshire residents die each year. The majority of deaths occur in adults over the age of 65, following a period of chronic illness. We live in an ageing society and it is important to understand the trends in mortality in order to understand need and to plan ahead. Figure 1 shows the trend in the number of deaths in three age bands.

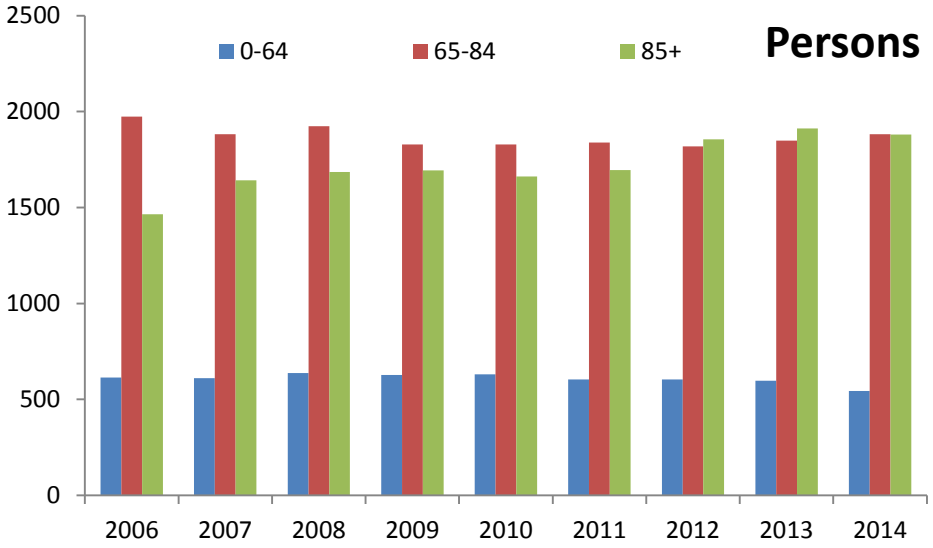


Figure 1

The number of deaths for those aged under 65 is fairly constant. In 2012 the number of deaths for those aged 85 and over was greater than for those aged 65 to 84. This trend has been seen nationally but in England and Wales there are still a greater number of deaths within those aged 65 to 84.

In Wiltshire we see a slight difference between the males and females. Figures 2 and 3 show the trend in the number of deaths by age band for males and females.

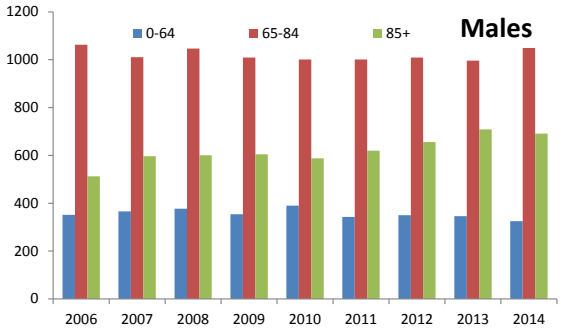


Figure 2 – Trend in the number of Males deaths by age band

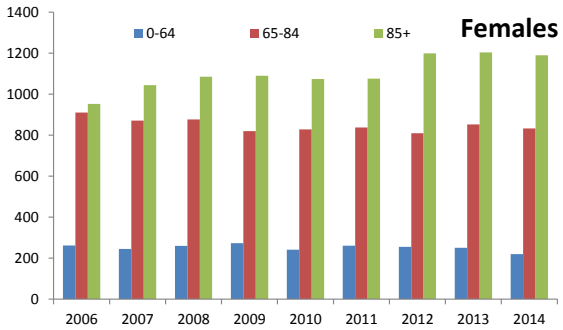


Figure 3 – Trend in the number of Female deaths by age band

In females the trends for both those aged 85 and over and those aged 65 to 84 are consistent with the national picture with increased numbers dying aged over 85 and reducing in the 65 to 84 year olds. In males there is a rise in the number of deaths in people aged 85 and over but deaths in those aged 65 to 84 are fairly consistent and substantially higher than the older age band.

There is little variation between the 3 CCG Groups in the number of percentages of deaths for those aged 85 or over

Preferences for Place of Care and Place of Death

National

The British Social Attitudes Survey, 7% said they would prefer to die in hospital, compared to two-thirds (67%) who would prefer to die at home. The South West survey found that these wishes differed slightly for those who were cancer patients compared to non-cancer patients.

Wiltshire

This data for Wiltshire is currently unavailable for all patients as the database being used at present is not recording this information in sufficient quantities. However, with the GP TPP system being used for EPaCCs, this information should be available going forward as the GPs already input a large amount of information regarding patients at end of life into their database, although at present it is not collated. It should be noted that people do also change their minds regarding their preferred place of death and this needs to be monitored as well.

However, for those looked after by Community Services (in own home), between August 2013 and July 2014, 92% of clients died in their place of choice. 84% had home as their preferred place of death.

Place of Death trends

National

The PRISMA survey across seven European countries determined people's preferences for place of death if faced with a serious illness such as cancer, had less than one year to live, and circumstances allowed them to choose. At least two thirds would prefer to die at home (69% across the seven countries,64% in England). Hospices and palliative care units are the second most common preference (20% across the seven countries. 29% in England).

Place of Death by Demographics

At the beginning of the 20th century it was common for people to die at home, but as the century progressed the rate of home deaths fell while the rate of hospital deaths increased.

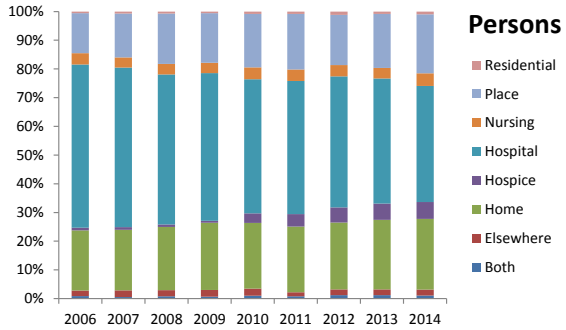


Figure 4 – All Age, All Cause Trend in Place of Death

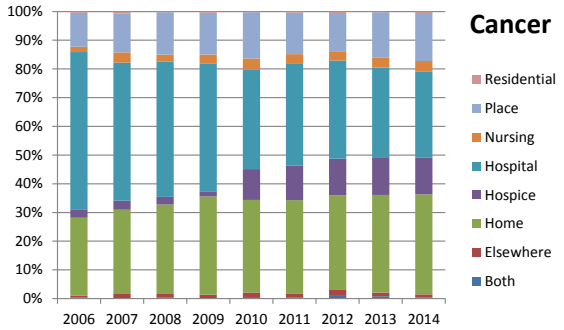


Figure 5 – All Age, Cancer Trend in Place of Death

Figure 6 – Trend in Place of Death for those Aged 0 to 64

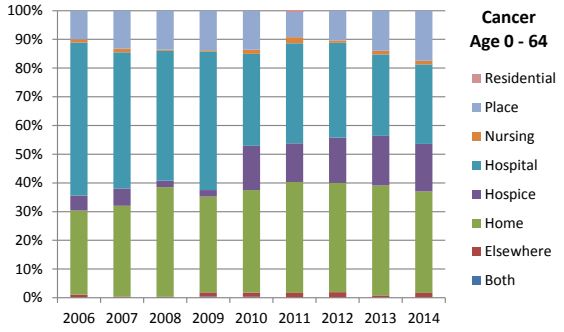


Figure 7 – Trend in Place of Death for those Aged 0 to 64

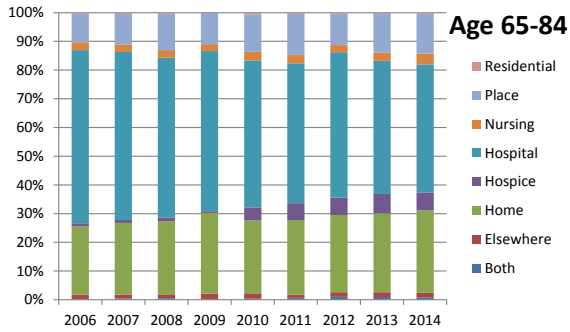


Figure 8 – Trend in Place of Death for those Aged 65 to 84

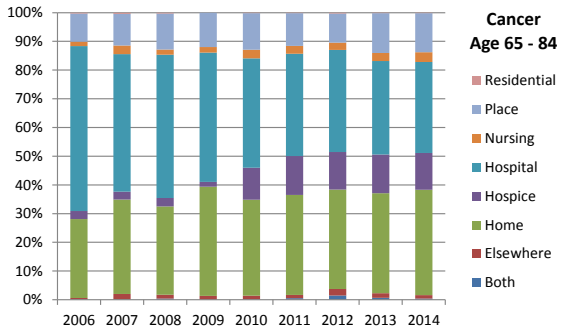


Figure 9 – Trend in Place of Death for those Aged 65 to 84

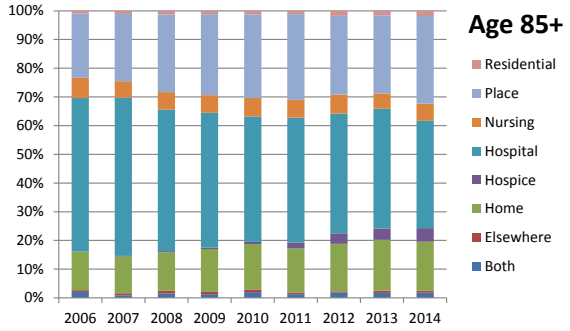


Figure 10 – Trend in Place of Death for those Aged 85+

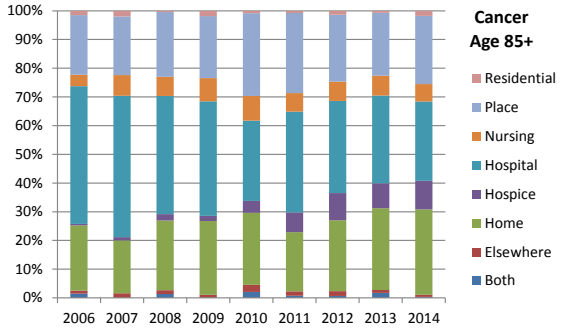


Figure 11 – Trend in Place of Death for those Aged 85+

This shows the decline in the percentage of deaths happening in hospital from around 55% in 2006 to around 40% in 2014. For patients with Cancer the reduction is even greater from around 55% to around 30%. We also start to see the percentage of deaths in a hospice increasing, as is deaths at home. The percentage of deaths in a Residential or Nursing home has remained constant at around 5%.

Place deaths are those which we are unable to identify as home, or other communal establishment, the percentage of deaths in this group has risen from around 10% to around 20%. There are also differences by age bands, the percentage of those dying at home is greater in the 0 to 64 age group consistently around 30%. For those aged 65-84 the percentage dying at home has increased to close to 30%, while for those aged 85 and over the percentage it is still less than 20%

There is also variation by Gender and Figures 12 and 13 show the trend in place of death for males for all causes and cancer, while Figures 14 and 15 show the female trend.

Figure 12 – Trend in the place of death, Males

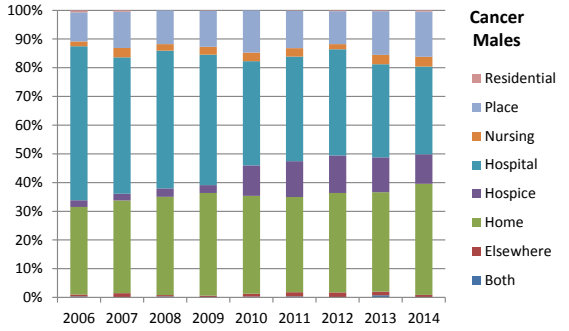


Figure 13 – Trend in the place of death, Males

Figure 14 – Trend in the place of death, Females

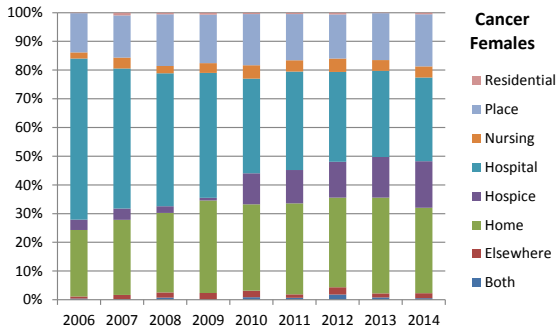


Figure 15 – Trend in the place of death, Females

The percentage of males dying at home or in hospital is greater than that for females. The percentage of females dying in hospital has also dropped by more than for males. The percentage of females dying in a nursing or residential home is greater than that for males.

Geographical Location

To analyse variation across the county we have looked at the trend in place of death for the CCG Groups. Figures 16, 18 and 20 shows the trend in place of death for all causes for the 3 CCG Groups while figures 17, 19 and 21 show the trend for deaths from Cancer.

Figure 16 – Trend in Place of Death for NEW

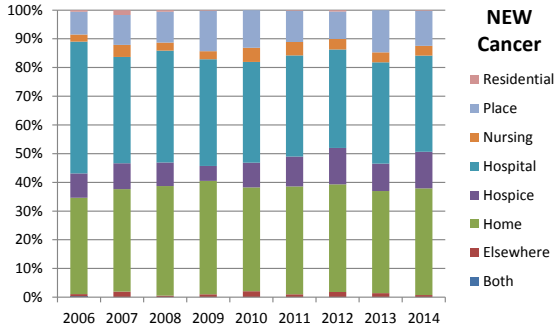


Figure 17 – Cancer Trend in Place of Death for NEW

Figure 18 – Trend in Place of Death for SARUM

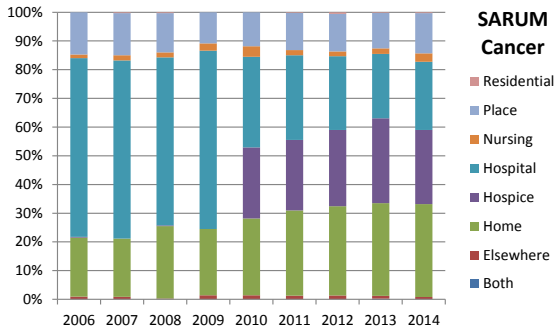


Figure 19 – Cancer Trend in Place of Death for SARUM

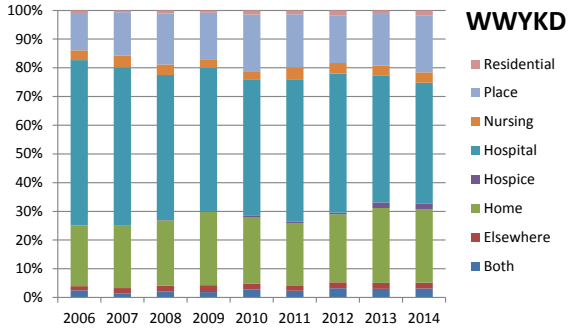


Figure 20 – Trend in Place of Death for WWYKD

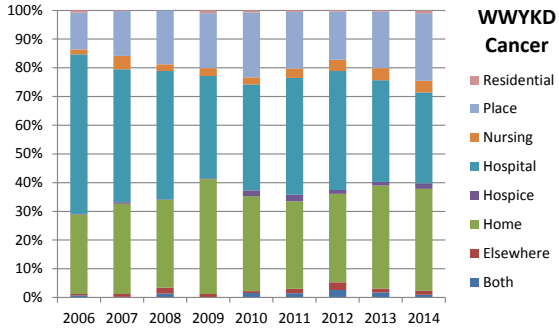


Figure 21 – Cancer Trend in Place of Death for WWYKD

The figures show a wider degree of variation in the 3 areas, NEW is closest to the Wiltshire average with a steady increase in the percentage of deaths at home with a reduction in the percentage of deaths in hospital. There is a small but growing percentage of deaths in a Hospice and this is larger for deaths from Cancer.

In SARUM the percentage of deaths in a hospice jumped from almost nothing to just under 10% for all deaths in 2010 and around 25% of deaths from cancer. This jump in hospice deaths was taken directly from hospital deaths and therefore suggests all that may have changed is the coding.

In WWYKD there are a very small percentage of deaths in a hospice for all deaths and cancer deaths, however there are a higher percentage of deaths in care homes and deaths at home also appear a little higher than the others.

For Community Areas, analysis of place of death of Wiltshire residents was carried out using data about those who died in 2012 and 2013 whilst being cared for by Integrated Teams. Initial analysis has been carried out according to the Office for National Statistics conventions which categorises deaths at care homes (LA and non-LA) and religious establishments as deaths 'at home'.

However, from postcode analysis it can be ascertained that sometimes a care home is a temporary residence. For this reason, the data presented here is split into 6 categories:

- homes;
- care homes and religious establishments as usual places of residence;
- care homes and religious establishments as temporary residences
- Wiltshire's Community hospitals;
- acute hospitals
- hospices

Deaths classified as happening elsewhere and deaths due to external causes, where the setting cannot be managed, are excluded from the analysis in line with ONS conventions.

Deaths at usual residence

CCG Level

The End of Life Care Profiles includes an indicator which measures the percentage of deaths in a person's usual place of residence. Figure 22 shows the annual trend for the percentage death in the usual place of residence for Wiltshire, the South West and England.

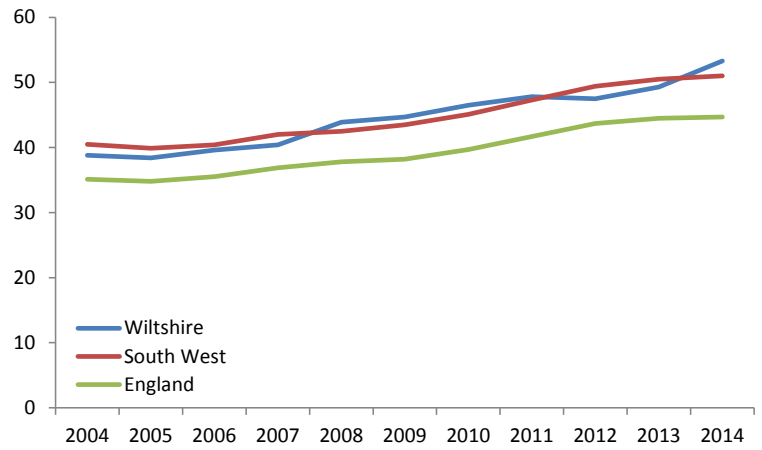


Figure 22

Wiltshire and the South West are around the same percentage and higher than the percentage in England. The percentage in Wiltshire has risen from just under 40% in 2004 to over 50% in 2014. To look at this locally within Wiltshire we have looked at the data in the Primary Care Database and refined the methodology to show the Wiltshire percentage of deaths where the place of death is the same as the usual place of residence or the place of death is coded as home. The trend by CCG Group and for Wiltshire is shown in Figure 23.

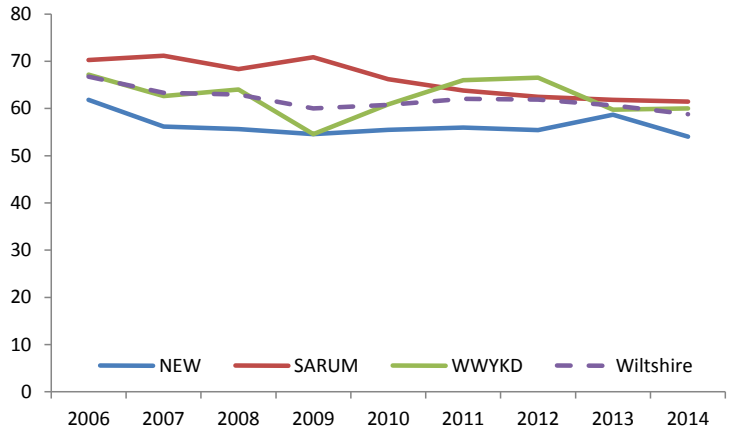


Figure 23

There is a generally a decreasing trend except in WWYKD where the trend was increasing until 2012 when it dropped and has not yet recovered. NEW has been consistently lower than the Wiltshire average. SARUM has also recently been above the Wiltshire average.

The national indicator count those coded as home and those in a care home which may slightly overstate the true percentage as it will include people temporarily in a care home. The local method looks at the address of the place of death and checks it is the same as the usual place of residence. In addition if the place of death is coded as home then this is also included as the usual place of residence.

Hospital Care in the Last Year of Life

National

Information comes from various surveys and audits. The main findings are:
Hospice patients who had advance care planning (ACP) spent significantly less time in hospital. The average time spent in hospital in the last year of life was 18.1 days for people with ACP compared to 26.5 days for those without. The average length of stay for people who die in hospital is 12.9 days.

Wiltshire

The majority of people die in hospital and it is therefore important that quality end of life care is provided. Figure 24 shows the trend in the number of deaths at the 3 main acute trusts which serve the Wiltshire population.

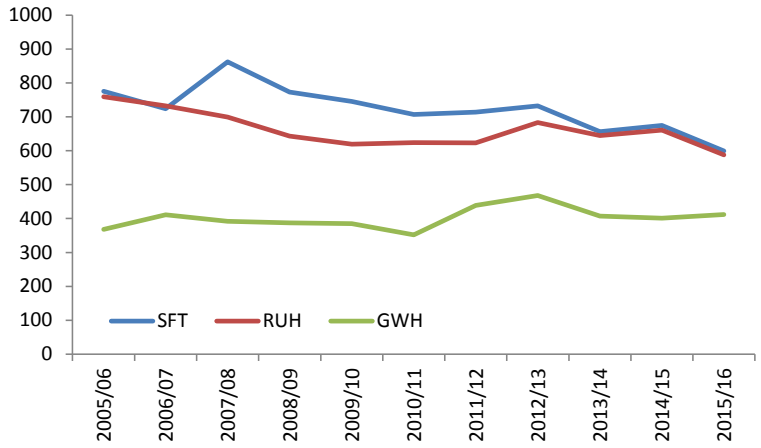


Figure 24

There has been a steady decline in the number of deaths of Wiltshire patients at both RUH and SFT, while admissions have increased by over a quarter. At GWH the number of admissions has almost trebled which is why we see an increasing number of deaths. The crude rate of deaths per spells shows a steady downward trend. Figure 25 shows the percentage of spells which receive palliative care from a specialist team in hospital by 10 year age band and hospital.

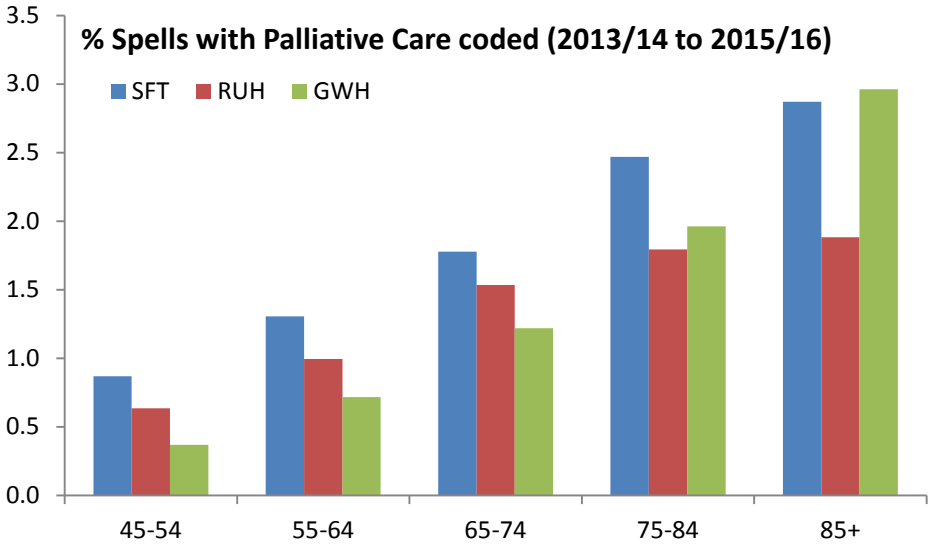


Figure 25

To be able to code palliative care within the hospital data the trust must have a specialist palliative care team. The proportion of spells with palliative care increases with age. As Salisbury FT has a linked hospice it may explain the increased proportion of spells with palliative care. Figure 26 shows the trend in the number of admissions with palliative care coding by hospital for the 3 main providers in Wiltshire.

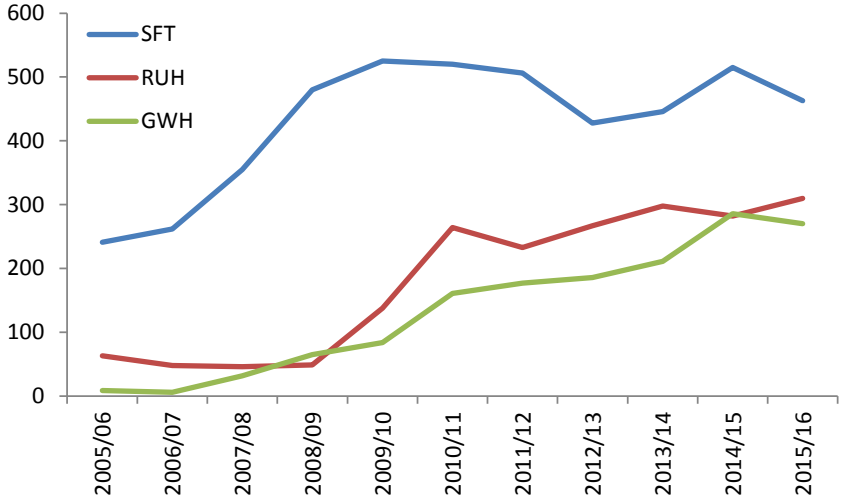


Figure 26

The number of spells at Salisbury was initially much higher than the other 2 trusts but Salisbury seems to have been steady at between 400 and 500 for the last 8 years while Bath and Great Western continue to see growth in numbers.

The earlier analysis looked at all admissions, for which palliative care represents only a very small proportion of admissions, we now look at admissions for neoplasm's which are more likely to involve palliative care in hospital in the later stages of the disease. Figure 27 shows the trend in the proportion of palliative care admissions which relate to neoplasms.

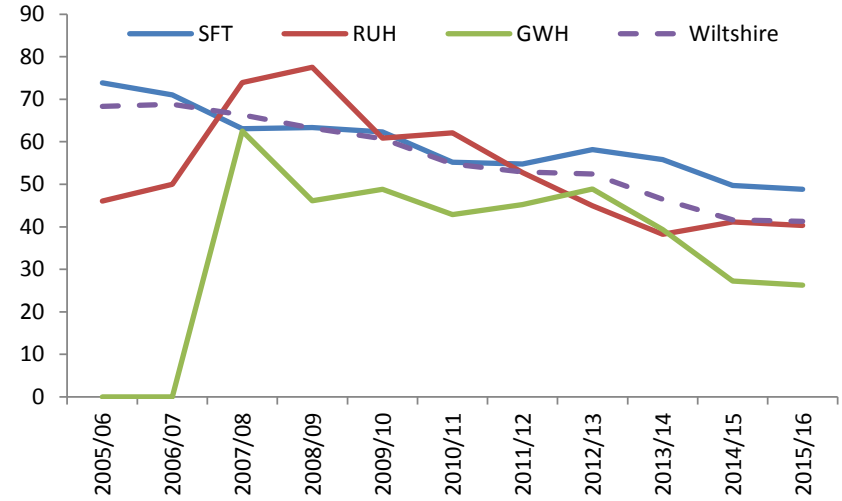


Figure 27

For Wiltshire this shows a reduction from around 70% to around 50%, while the 3 hospitals show variation historically they seem to have generally converged around the Wiltshire Average. This suggests palliative care is being used in hospital for a wider range of conditions.

Social Care in the Last Year of Life

National

Individuals with highest social care costs had relatively lower hospital costs, irrespective of age

- 24.9% received social and hospital care during the last year of life, 64.7% received only hospital care, 2.9% received only social care and 7.5% received neither
- 27.8% of people who died received some form of local authority-funded social care
- On average 14.9% of people who died had some residential or nursing care service in the last year of life
- In the final month before death 24.4% received social care (50% more individuals used care homes in the final months before death than 11 months previously)
- 51.9% of those aged 95 and over had some form of social care compared to only 6% of those under 55

Wiltshire

The above data was obtained from areas that either could already link health and social care data or could set up a linkage process. The data collected by Dr Foster will be linked if possible to social care data. At present, persons are not flagged up in social care as on an end of life care pathway. Going forward, for future this could be linked up as part of the Single View of the Patient work.

Specialist Palliative Care

The national survey of patients accessing specialist palliative care finds that nearly half of all people accessing specialist palliative care in the community died at home while less than a quarter dies in hospital. Figure 28 compares the percentage of 2012 deaths in Wiltshire against the national percentage of people accessing specialist palliative care services taken from the National Survey undertaken by the National Council for Palliative Care

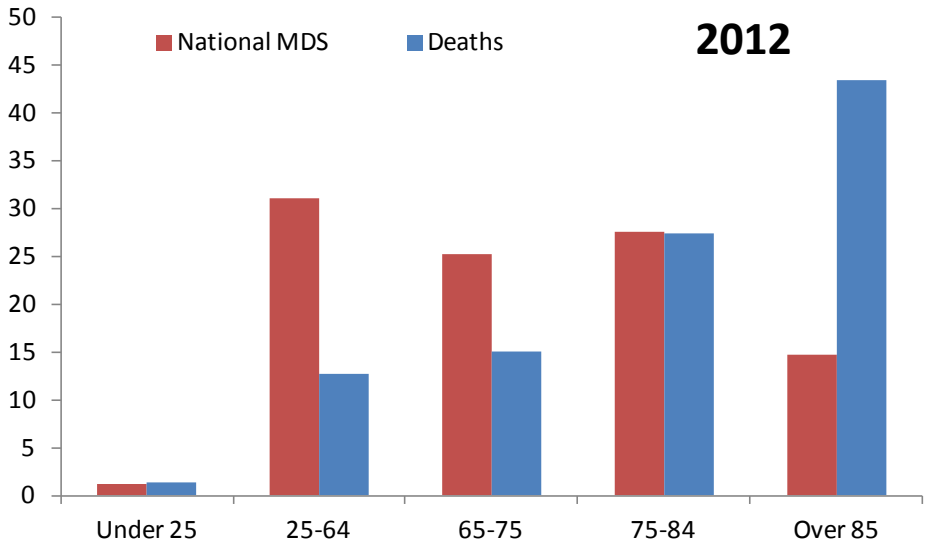


Figure 28

Most people nationally accessing specialist palliative care services are under 75 while most of the people who died were over 75. We have requested a local dataset for people in Wiltshire accessing specialist palliative care services.

Primary Care and Community Services in the last year of life

National

The national primary care snapshot audit in End of Life Care 2010/11 of the provision of EoLC based on use of Palliative Care/GSF Registers in primary care for 502 GP practices in 15 PCTs and 7,200 case notes, over a two-month period found 27% of people who died were included on the palliative care register and of these 23% had a non-cancer diagnosis. Most significantly though it found that those people included on the palliative care register were more likely to receive well-co-ordinated care (handover to out-of-hours, anticipatory prescribing, etc) and more likely to have been offered an advance care planning discussion and to die in their preferred place of choice.

Wiltshire

We can get an indication of the numbers of people registered as EOL on the quality and outcomes framework (QOF), which is part of the General Medical Services contract for general practices. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. From 58 GP Practices within Wiltshire, with 474,987 patients 708 are on the palliative care register (QOF for April 2012 to March 2013), however 30 practices did not participate in the palliative care QOF. This could mean they had no patients requiring palliative care, or that they chose not to participate in the QOF.

Integrated Teams

For the period August 2013- July 2014:

- 298 people on the ePEX EoL registers died. This is EoL care patients being cared for in their own homes by the community health staff.
- 92% died in their place of choice. 84% had home as their preferred place of death.
- There were 15,846 contacts recorded as palliative Care (with 1814 patients).
- If contacts for syringe drivers and fast track care were added this increases to
- 16,778 contacts for 1,836 patients.
- If all contact with patients with a malignancy diagnosis were included the figures were 24,024 contacts with 2,169 patients.
- There were 1547 deaths of patients on the Neighbourhood Teams caseload; 624 of these had received palliative care (40%), the 298 on the register account for 19%.
- The advanced care plan data is the weakest data area as it is entered at the time the patient is recorded on the end of life register, and often gets subsequently overlooked and is rarely updated. For those same 298 patients we are showing 31 with advanced care plans completed, 7 declined, 9 in progress with 251 still showing as not yet offered. There is no advanced care plan data for those not on the register.

Care Homes in the Last Year of Life

National

Areas with high percentages of hospital deaths have the lowest percentages of care home deaths. A qualitative study interviewing 63 care home residents over a year found that core to older people's ability to discuss end of life care is their acceptance of being in a care home, the involvement of family members in making decisions and the extent to which they believed they could influence decision making within their everyday lives.

Wiltshire

Wiltshire has a significantly lower percentage of hospital and hospice deaths than England as a whole, and significantly higher home and care home deaths (NEoLCIN, 2014). Further qualitative information may be gleaned from a survey of residents in care homes.

Quality of Care

National

National Survey of Bereaved People (VOICES): England, 2015

The National Bereavement Survey (VOICES) was commissioned by the Department of Health and administered by the Office for National Statistics (ONS). The key results for 2015 were:

- 3 out of 4 bereaved people (75%) rate the overall quality of end of life care for their relative as outstanding, excellent or good; 1 out of 10 (10%) rated care as poor.
- Overall quality of care for females was rated significantly higher than males with 44% of respondents rating the care as outstanding or excellent compared with 39% for males.
- 7 out of 10 people (69%) rated hospital care as outstanding, excellent or good which is significantly lower compared with care homes (82%), hospice care (79%) or care at home (79%).
- Ratings of fair or poor quality of care are significantly higher for those living in the most deprived areas (29%) compared with the least deprived areas (22%).
- 1 out of 3 (33%) reported that the hospital services did not work well together with GP and other services outside the hospital.
- 3 out of 4 bereaved people (75%) agreed that the patient's nutritional needs were met in the last 2 days of life, 1 out of 8 (13%) disagreed that the patient had support to eat or receive nutrition.
- More than 3 out of 4 bereaved people (78%) agreed that the patient had support to drink or receive fluid in the last 2 days of life, almost 1 out of 8 (12%) disagreed that the patient had support to drink or receive fluid.
- More than 5 out of 6 bereaved people (86%) understood the information provided by health care professionals, but 1 out of 6 (16%) said they did not have time to ask questions to health care professionals.
- Almost 3 out of 4 (74%) respondents felt hospital was the right place for the patient to die, despite only 3% of all respondents stating patients wanted to die in hospital.

Wiltshire
This data is now available at CCG level, however the data is only available for some questions covering overall quality of care, dignity and respect and support for the carer.

- Overall, and taking all services into account, 46.3% of those sampled (CI 41.6-51.0%) rated care in the last 3 months of life as excellent/outstanding compared to an England percentage of 43.2% (CI 42.7-43.7%). This is not significantly different.
- Responses for other areas are below, with ratings according to whether they are significantly higher than the England average (green), no significant difference (amber) or significantly lower (red):

Question	Area	Number	Weighted Percentage and Confidence Intervals
Support for Carers & Family			
Were you or his/her family given enough help and support by the health care team at the actual time of death?- 'Yes,definitely'	Wiltshire	428	59.5 (54.8-64.1)
	England	39,604	59.8 (59.3-60.3)
After he/she died, did staff deal with you or his/her family in a sensitive manner?- Yes	Wiltshire	418	94.7 (92.0-96.5)
	England	38,560	93.5 (93.3-93.8)
Looking back over the last three months of his/her life, were you involved in decisions about his/her care as much as you would have wanted?- 'I was involved as much as I wanted to be'	Wiltshire	429	82.7 (78.7-86.0)
	England	39,121	77.9 (77.5-78.3)
Dignity & Respect			
Overall, do you feel that the care he/she got from the district and community nurses in the last three months was excellent?- 'Excellent'	Wiltshire	192	80.3 (73.9-85.4)
	England	19,037	78.6 (78.0-79.2)
Overall, do you feel that the care he/she got from the GP in the last three months was excellent?- 'Excellent'	Wiltshire	347	82.3 (77.9-86.0)

	England	30,959	72.4 (71.9-72.9)
During his/her last hospital admission, were he/she always treated with dignity and respect by Doctors?- 'Always'	Wiltshire	250	54.9 (48.7-61.0)
	England	24,396	57.9 (57.2-58.5)
During their last hospital admission, were he/she always treated with dignity and respect by Nurses?- 'Always'	Wiltshire	271	48.8 (42.9-54.8)
	England	26,679	49.9 (49.3-50.5)

Table 2: Wiltshire Quality of Care, Dignity and Respect

We can see that, apart from involvement in care and care from GPs in the last 3 months of life, the Wiltshire percentages are not significantly different from England as a whole (although low numbers means wide confidence intervals). It is interesting to note however, that when care during hospital admission is considered, the percentage drops for both Wiltshire and England.

Ethnic Groups

National

Population projections suggest that the numbers and proportions of people from black, Asian and minority ethnic (BAME) groups will continue to increase in the UK and they will represent a larger proportion of older people. Review of the literature reported unmet needs and/or disparities in palliative and end of life care for BAME groups.

Minority ethnic groups with non-cancer conditions and those with lower socio-economic status achieve lower rates of home death.

Compared with people with cancer and aged under 50, people with cancer and aged over 80 are less than half as likely to be prescribed strong analgesics.

Deprivation

Wiltshire

In addition to diagnosis there may be other inequalities related to age, ethnicity, culture, and sexuality, place of death and location of residence. There are differences in the proportion of deaths at home and in a care home, Figure 29 shows the trend by deprivation quintile.

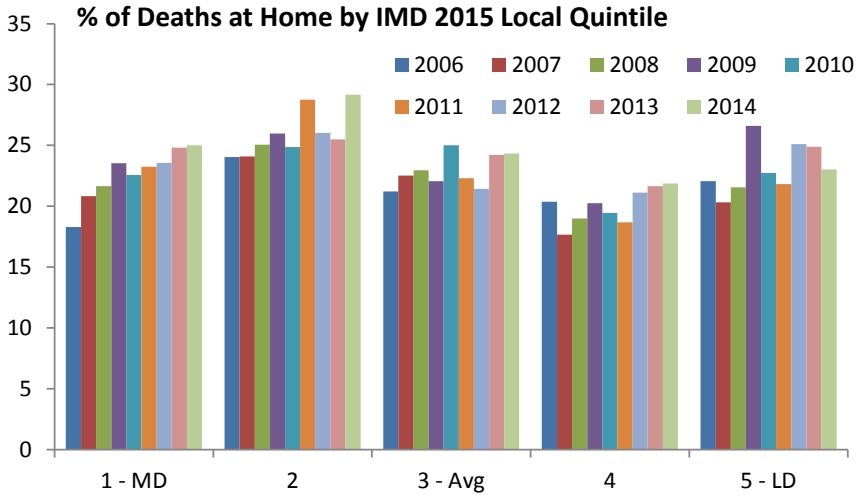


Figure 29

The variance is small by deprivation quintile but while in the least deprived quintile did initially increase they have now peaked, while in the least deprived quintile the proportion continues to rise. There is little variation when analysed by CCG Group but there is still variation within the Clusters, Figure 30 shows the proportion of deaths at home or in a care home by CCG Cluster and Group for 2012-14.

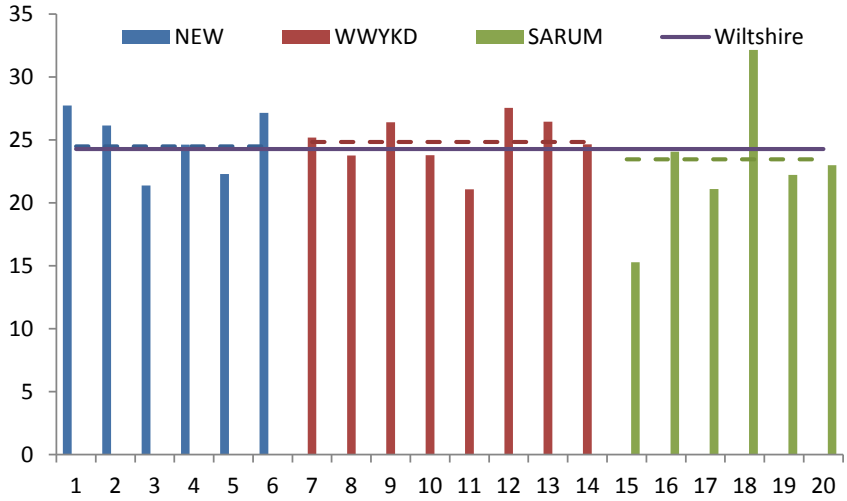


Figure 30

The proportion in NEW and WWYKD is generally around the Wiltshire Average and the majority of clusters within these groups are above the Wiltshire average. SARUM is slightly lower than the Wiltshire Average with all but 1 cluster above the Wiltshire average.

Ethnic Group
At present the percentage of non-white British people over 65 in the population is 0.8%:

	Wiltshire		South West		England	
	Number	%	Number	%	Number	%
White	84,836	99.2	1,024,632	99.0	8,250,504	95.3
Mixed/multiple ethnic grp	176	0.2	2,577	0.2	33,849	0.4
Asian/Asian British	260	0.3	4,396	0.4	236,275	2.7
Black/African/Caribbean/ Black British	158	0.2	3,097	0.3	114,575	1.3
Other ethnic group	58	0.1	742	0.1	25,326	0.3
Total	85,488	100	1,035,444	100	8,660,529	100

Table 3: Ethnic Group Wiltshire, South West and England

End of life profiles

The End of Life Care Profiles present indicators by Local Authority and CCG, to help commissioners and providers understand the end of life care needs of their populations.

The Wiltshire local authority profile was published in 2012 (http://www.intelligencenetwork.org.uk/EasySiteWeb/GatewayLink.aspx?alId=52494) while the CCG profile (http://www.endoflifecare-intelligence.org.uk/end_of_life_care_profiles/ccg_profiles) was published in April 2014. These provide a snapshot of Wiltshire's position compared to England. They can be used to benchmark and review Wiltshire's position over time.

The main points of interest contained in Wiltshire's profiles are:

- Wiltshire's population is older than England.
- There is a higher proportion of deaths in Wiltshire in older age groups than the England averages.
- Significantly more people in Wiltshire die at home / care home, and less in a hospital/hospice than the England average.
- Apart from liver disease deaths which are significantly lower, people in Wiltshire are dying of similar conditions in similar proportions to England.
- Terminal admission characteristics are similar to England.
- The number of care home & beds is similar to England.

Annex 3 – End of Life Care Services in Wiltshire

Hospices

Our hospices provide holistic end of life care for people with life limiting illnesses, supporting them to die in their preferred place of care. They attend to the physical, emotional, psychological and spiritual needs of people approaching the end of their life through day services, as an inpatient facility or at the patient's home. They offer a range of services for their patients, carers, families and others who are important to them that include clinical, nursing and therapy services, alternative therapies, counselling, respite care, chaplaincy, welfare and financial advice.

Currently the CCG provides funding to three hospices: Dorothy House Hospice Care in Winsley, Bradford-on-Avon, Prospect Hospice in Wroughton, Swindon and Salisbury Hospice to cover the south of Wiltshire.

Hospitals

It has been identified that given a choice most people would prefer to die at home, however for a substantial percentage the reality is that they will die in hospital, following an unplanned admission. Given this fact, it is essential that hospital teams develop effective skills and knowledge to communicate effectively with patients at the end of life and their families and identify their preferred place of death and DNACPR preference. Improved communication skills and earlier identification of people at the end of life attending A&E or following an unplanned admission will enable hospital staff to mobilise community services to support these patients to die in their preferred place, thus reducing the number of people who die in hospital when it is not their preference.

Provision of an appropriate care environment conducive to achieving a dignified death is also vital for those people actively dying in hospital where it is totally inappropriate to move them to another care setting.

Community Hospitals

There are 3 local community hospitals in Wiltshire who provide inpatient services for patients who choose to die within a community hospital setting within well equipped, supportive environments.

Care Homes

Most people admitted to a nursing or residential home will usually be approaching the end of their life and will die there. Caring for residents at the end of their life will therefore be core care provided by care home staff. To ensure that the Wiltshire population is well served with a high standard of end of life care, care home staff in Wiltshire need to be trained in planning end of life care and managing the dying phase. This can be complicated by the fact that there is a high turnover of nursing /residential home staff and a general lack of experience in providing end of life care.

GPs

Caring for people nearing the end of their lives is part of the core business of general practice. The GP and the primary care team are central to the delivery of end of life care in the community, working closely with health and social care professionals from across the interface of primary, community, secondary, voluntary and social care to support the terminally ill in their preferred place to die with dignity and be symptom free. GPs hold regular multidisciplinary team meetings with health and social care to review and update the care provided to people at end of life.

The GP is generally ‘known’ by a patients carer, family or others who are important to them and is best placed to help co-ordinate providers in EOL care delivery and initiate difficult conversations about prognosis, identifying preferences for care and death and DNACPR instructions. Care of the dying challenges general practice to respond with the best that the profession has to offer – clinical expertise, considered professionalism, personalised care and human compassion.

Out of Hours
Out of hours primary care is provided by Medvivo who have a large multidisciplinary team. Medvivo use a combination of GPs and Nurse Practitioners to deliver our face-to-face OOH service. Most of our GPs are local, working in daytime practice in Wiltshire and its neighbouring counties. Our Nurse Practitioners all have advanced clinical assessment, diagnostic and prescribing skills in addition to many of the practical skills often required during an OOH consultation. It operates 1830-0800 weekdays and 1830 Friday – 0800 Monday over weekends.

Community Nursing
End of life care is one of the core services provided by Community nurses who work closely with GPs, care homes and hospices, delivering EOLC to terminally ill people in their usual place of residence. Community nurses are often with patients during the dying phase. They play a pivotal role in the planning and co-ordination of end of life care and often provide supportive visits.

Third Sector
The third sector (charities other than hospices) provide important end of life services to the Wiltshire population in their own home. Wiltshire CCG commission Marie Curie to provide a planned night sitting service.

Social Care
Social care professionals pay a key role in the delivery of the end of life strategy for clients, carers and families. The assessment and support planning process delivers choice and control to the dying person to enable them to achieve an end of life which is in line with their needs and wishes. Wiltshire Council commissions a range of care and support, including care homes and domiciliary care, to meet the care and support needs of those who are nearing the end of their life for those who meet the eligibility criteria for funded social care. Information, advice and signposting to care and support options is also available to those who fund their own social care.

It is acknowledged that carers are key to enabling those who wish to die at home to do so. All carers are entitled to a carers assessment and Wiltshire Council commissions services which offer information, advice and a range of support for carers to enable them to maintain their own wellbeing.

South West Ambulance Service (SWAST)
SWAST clinicians are aware of the complexity of patients at the End of Life and the services available to refer patients as required as often 999 can be the first point of call for a deteriorating situation and it is important for the organisation to understand the most appropriate care required.

Community pharmacies
Wiltshire Community pharmacies currently provide an Emergency Access Drugs Service. This is a local enhanced service under which a select group of community pharmacies stock and supply a defined group of palliative and urgent care medicines. A number of these pharmacies operate a 100 hour per week service. The pharmacists involved can provide up to date information and advice on prescription writing and dispensing in order to reduce the number of difficulties experienced by carers and relatives in obtaining supplies of medicines needed at end of life.

Anticipatory prescribing
Anticipatory prescribing is essential to patients in the community with a terminal illness who have been assessed by a qualified healthcare professional as actively deteriorating and are in the last few weeks or days of life. Providing a good death at home is a vital part of modern General Practice but presents unique problems for the Primary care Team especially during the out of hours period when access to the patient's own General Practice and regular pharmacy may not be possible. Anticipatory prescribing is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms and is based on the premise that although each patient is an individual with individual needs, many acute events during the palliative period can be predicted and management measures put in place in advance.

Bereavement

Cruse Bereavement provides support before and after the death of a loved one. The service recognises that the support needs to respond to individual needs, and may include practical guidance, social activities and befriending to reduce loneliness and isolation.

Glossary of terms

Advance Care Plan (AcP)	A voluntary process of discussion about future care between an individual and their care providers, irrespective of discipline. It is recommended to document the discussion
Best practice models	A method or technique that has consistently shown results superior to those achieved with other means, and that is used as a benchmark. In addition, a 'best' practice can evolve to become better as improvements are discovered
Carer	A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support
End of Life	Patients are 'approaching the end of life' when they are likely to die within the next 12 months. this includes patients whose death is imminent (expected within a few hours or days) and those with: (a) advanced, progressive, incurable conditions (b)general frailty and co-existing conditions that mean they are expected to die within 12 months (c) existing conditions if they are at risk of dying from a sudden acute crisis in their condition (d)life-threatening acute conditions caused by sudden catastrophic events
NICE	The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. NICE's role is to improve outcomes for people using the NHS and other public health and social care services.
Palliative care	Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care: • provides relief from pain and other distressing symptoms • affirms life and regards dying as a normal process • intends neither to hasten or postpone death • integrates the psychological and spiritual aspects of patient care; • offers a support system to help patients live as actively as possible until death • offers a support system to help the family cope during the patient's illness and in their own bereavement • uses a team approach to address the needs of patients and their families • enhances quality of life and may also positively influence the course of illness • is applicable early in the course of illness, in conjunction with other • therapies that are intended to prolong life, and includes those investigations needed to better understand and manage clinical complications Palliative care can be provided by a range of health and social care staff and may be done alongside treatment intended to reverse particular conditions (World Health Organisation)
Treatment Escalation Plan (TEP)	A TEP form is a way of your doctor recording your individual treatment plan, focusing on which treatments may or may not be most helpful for you. A variety of treatments can be considered

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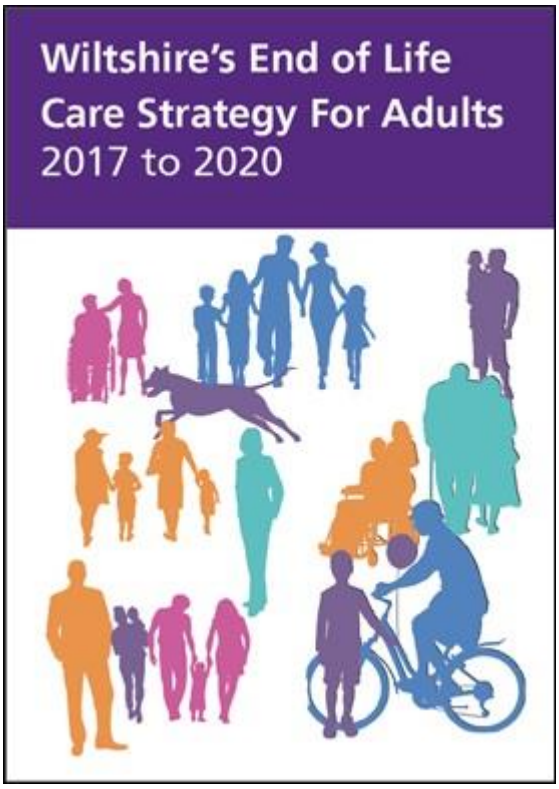
healthwatch Wiltshire

Public Engagement on the Wiltshire End of Life Care for Adults Strategy 2017-2020

An independent voice for the people of Wiltshire

Contents

Background



About four thousand people die each year in Wiltshire. Most are older people who had been living with a chronic condition. Compared to ten years ago, more people in Wiltshire are dying at home or in a hospice, and fewer in hospital. Care to support people at the end of life is provided by a range of services including hospitals, hospices, care homes, pharmacies, social care agencies, charities, GPs and community services.

NHS Wiltshire Clinical Commissioning Group (CCG) and Wiltshire Council are refreshing the Wiltshire End of Life Care Strategy, and are interested to hear what people think is important in end of life care. This will help them to develop their plans for end of life care in Wiltshire.

Healthwatch Wiltshire was asked by NHS Wiltshire CCG and Wiltshire Council to help gather public feedback on the draft strategy. The feedback will be used to shape the plan for delivering services in the future.

What we did

1. Pre-engagement

The draft strategy was shared with members of the Healthwatch Wiltshire readers' panel (volunteers who read and comment on documents). Nine volunteers fed back with a variety of comments, covering readability, content and potential areas for further work. This feedback was shared with the strategy authors, and was used to inform the version of the strategy used in the wider public engagement.

2. 'Starting a Conversation' events

Healthwatch Wiltshire facilitated three public events called, 'Starting a Conversation about End of Life Care'. At each event, a representative from NHS Wiltshire CCG explained the strategy and plans for end of life services in Wiltshire and answered questions from members of the public. There was also an opportunity for people to feed their views and experiences into discussions in small groups and a chance to visit information stalls held by different organisations which deliver services and support to Wiltshire people at the end of their life (and their families).

"Your voice is our voice"

3. Online questionnaire

An online questionnaire was hosted on the NHS Wiltshire CCG website between 16th November and 13th December 2016. People who were unable to attend the events were encouraged to complete the online survey.

4. Other opportunities to provide views and experiences

Healthwatch Wiltshire work with Dorothy House Hospice on user involvement. The User Advisory Group kindly agreed to look at the strategy and how it links with that of the hospice. Salisbury Area Board Health and Wellbeing Group also provided its views about end of life care. We also examined issues around end of life care raised with us by members of the public as part of our ongoing monitoring of the quality of services.

Who we spoke to

We heard from 91 people in total.

We held public meetings in Salisbury, Royal Wootton Bassett and Bradford on Avon in November 2016. These were attended by members of the public and professionals from various organisations providing services to people at the end of life.

Table 1: Breakdown of engagement numbers

Venue	Members of the public	Health and Social Care professionals	Healthwatch Wiltshire staff and volunteers
Salisbury	9	8	5
Royal Wootton Bassett	7	10	8
Bradford on Avon	5	10	7

5 people fed back on the strategy and end of life care in the county through the online questionnaire.

10 members of the Dorothy House User Advisory Group reviewed the strategy and fed back to us. 7 members of the Salisbury Area Board Health and Wellbeing Group also fed back about end of life care.

"I feel better informed and have a better understanding of the objectives of the strategy."

Engagement participant

We asked people these questions:

General

- If you are at the end of life, or caring for someone who is, what is most important to you?
- What needs improving now?
- What support does an unpaid carer caring for someone at the end of life need?

Format of strategy

- How easy is the strategy to read? Is it clear?
- Do you feel more informed about end of life care after reading the strategy/ coming to the event today?

Content of strategy

- Is what Wiltshire Council and NHS Wiltshire CCG are doing, and intend to do, right to ensure good end of life care in Wiltshire?
- In terms of the strategy and end of life care, what else could they be doing in the next 3 years? (Do you think there is anything missing from the strategy?)
- Are the success measures right for the strategy? Anything else they should measure?
- What actions do you think need to happen for the strategy to be successful?

Other feedback

- Do you have any other comments on the strategy?
- Do you have any other comments on end of life care?

We used our wider and previous engagement to add to the general feedback about end of life care. People raise things that they feel are important or missing from current services with us through our monitoring of the quality of services and investigations into particular topics, such as dementia.

What people told us

1. Feedback on the strategy format

There was mixed feedback on the format of the strategy. Some people felt that it was clear and well presented, while others found it more difficult to read. This may reflect the variety of people who participated, some members of the public and some members of health or social care organisations.

A number of people questioned who the strategy was aimed at, and did not feel that the public was the target group for this document. Acronyms and jargon were not always explained.

"It is a nicely presented, clear document."

Engagement Participant

"Too much management speak."

Engagement participant

Members of the public felt that it was written from the perspective of professionals and providers, viewing the public as patients, rather than everyone as people.

The size of the document was mentioned as too large by a number of groups and individuals, with one describing it as "overwhelming". Participants also felt that it was difficult to look at online and assumed it would be expensive to print out. Participants said that they wanted a simplified or easy read version or summary. They said what they would find most useful would be a two-page document which included sign-posting to services (based on what was offered through the strategy) and phone numbers to access them. The 'Strategy on a page' (page 6 of the draft document) was designed to be an accessible, simple to read summary of the strategy. Some groups liked this section and found it helpful in understanding the strategy, while other people felt that this was too wordy and did not contain the information that they would want from a public version.

"A short easy read version for the public is needed."

Engagement participant

"The strategy is just a professionally presented document laying out lots of good intent but with little accountability... I notice that it is not marked "draft"... I wonder if anything we say will be taken into consideration?"

Engagement participant

Feedback was also received about the way some of the information was laid out. For example, white writing on a colour background can be difficult for some people to read, particularly people with visual impairments. Some participants felt that the graphs were difficult to understand.

2. Feedback on the strategy content

People felt that the strategy lacked information on what would happen next, including targets and concrete actions, and who would be accountable for these. At the meetings, the commissioners emphasised that the public feedback would be used towards the creation of an implementation plan. However, there was an expectation from the public that a strategy would include this information.

"Overall the Wiltshire end of life strategy lacks warmth and a simple vision statement."

Engagement Participant

"The Wiltshire vision is clear and reinforced throughout the document."

Engagement participant

Members of the public thought that there was a lack of focus on unpaid carers, although reference is given to the Carers Strategy.

Respondents felt that some consideration of people from different cultures, religions and those without a religion would be beneficial.

3. Feedback about the success measures or "what we want to achieve"

"Success measures should be measured by an impartial outside body."

Engagement participant

Most participants agreed that the goals laid out in the strategy as "what we want to achieve" (page 6 of the draft strategy) were admirable and good goals. However, there were questions about how they would be prioritised, and delivered.

Questions were asked about how improvements could be made given the current shortages of trained staff.

People thought that the goal of increasing the number of advanced care plans and treatment escalation plans was only worthwhile if the use of them was also monitored. They felt that the true test was whether they were used and successfully enabled peoples' choices to happen. They considered the care to be more important than just having the paperwork in place.

"The emphasis should be on people, not policy."

Engagement participant

A reduction in complaints about providers of care involved in end of life services was also suggested as a goal for the strategy.

"All is dependent on the communication skills, kindness and dedication of the staff delivering the end of life care."

Engagement participant

"The strategy is actually rather short on strategic actions to be taken to achieve the stated goals."

Engagement participant

"It was good to read the patient/family/carers are the focus and especially they would continue to listen to the needs of the local population."

Engagement participant

4. What is important to people at the end of their life?

People who took part in the engagement identified a number of areas which were important to people who were at the end of life and their unpaid carers:

- Symptom control (especially controlling pain).
- Being treated with respect and dignity.
- Choice – about the location where end of life care is provided and ensuring individual wishes around particular care options are respected
- Information – provided in an accessible manner for patients and carers, covering what is available (that the person is eligible for) and what they can expect. Every group said that online information was insufficient, and hard copy and face to face information was also vital.
- The importance of having early discussions about individual wishes, and decisions such as Power of Attorney, and Advance Care Planning. This was especially mentioned in relation to people who are living with dementia.
- Support for unpaid carers and family members, including a single key person supporting a person at the end of life and their unpaid carers, coordinating all the professionals involved in care and able to signpost to other sources of support.
- High quality staff with end of life training and the ability to put it into practice.
- Continuity of care from clinical professionals and domiciliary carers.
- Good communication between professionals and with the patient and family.

Many of these are areas that fall within in the draft strategy priorities. However, these are also combined into the aims in the current (2014-2016) strategy. We know that there are people for whom these aims are not always achieved. People who took part in the engagement identified areas that they thought could be improved:

1. The 'visibility' of death and the societal view of dying, and the encouragement of early discussions about peoples' wishes and options;
2. Recognition that someone is coming to the end of their life, so information/services/support can be accessed without delay;
3. Availability of domiciliary care, and responsiveness of systems to adapt to reflect changing circumstances requiring changes in the amount of care (both especially raised in relation to Continuing Health Care, but also more generally);
4. More communication and collaboration between services and less duplication across services;
5. Communication with family members and dying patients, especially those with disabilities or who are otherwise potentially isolated;
6. Patient and carer access to information held about them by professionals;

7. The number of people with dementia referred for end of life or palliative care services;
8. Waiting lists for services, such as bereavement counselling;
9. Availability of end of life and caring skills training for unpaid carers (for those willing to be involved in this role);
10. More support for unpaid carers so that they can spend time with the dying person, not spend their time and energy doing the caring tasks (for those who want it);
11. Support locally for carers, as travelling long distances to access support groups deters people who don't want to spend a lot of time away from their loved one and the effort of travelling was perceived as undoing any of the benefit from support groups;

12. Inconsistency of services across the county, with not everyone able to access all services;
13. Access to medications, including out of hours, especially for people who are without their own transport or otherwise unable to go to pharmacies themselves, and information on pharmacies stocking end of life medications;
14. Inclusion of professionals from beyond health and social care as part of caring communities, such as religious leaders (where appropriate), housing staff, postal workers and solicitors involved in end of life planning;
15. Anticipatory prescribing of equipment as well as medication.

Some of the feedback we received related to areas beyond Wiltshire, for example the difficulties people face in completing national forms to claim benefits, and the content of national media. Representation of resuscitation in films and on TV may create unrealistic expectations of success. The cost of arranging Lasting Powers of Attorney were also mentioned.

Local people strongly felt that people needed to have earlier conversations about death and dying, within families and in the wider community. Suggestions were made of having end of life champions in local communities.

There were also concerns that any changes happening in health and social care (either within the strategy or beyond it) were more about cost-cutting than about patient welfare. People felt unclear as to how the strategy fits with other developments in health and social care, such as Sustainability and Transformation Plans. For those attending the meetings, this was explained in response to questions. People were interested where funding came from for end of life care. Concerns were raised as to how parts of the strategy could be implemented until personal health budgets were in place, especially as it was felt that these were "in their infancy".

Positive feedback was received about hospice provision, including the outreach and hospice at home services.

Feedback from participants at the meetings included how useful they found the information about services that was available from the information stands.

Challenges

The timescale for this project has been tight. Delays in preparing the draft strategy and online questionnaire meant we weren't able to publicise the events and opportunity to feedback online as much as we wanted. We invited stand holders and asked our volunteers to share information in their communities before the strategy was available, and started publicising to the voluntary and community sector and the wider public a fortnight before the first event, before the survey was online. Obviously, this is not ideal, as people who may have wanted to feed in may not have been able to do so at a convenient time. This may have contributed to the low response rates.

Many of the people who participated through the engagement had not had the opportunity to read the strategy in advance. This meant that they were not able to feed back in depth on the content and format of the strategy, but were still able to share their views about end of life care and what is important to patients and unpaid carers.

Recommendations

1. Commissioners should consider the priorities and concerns raised by the people involved in the engagement when finalising the implementation plan.
2. Once the strategy and implementation plan has been finalised, commissioners should produce a short, accessible document for the public. This should also include signposting information for patients or carers to access services.
3. Future engagement on health and social care related strategies needs to consider how to make the strategy easily available to participants in advance of engagement, to give people an opportunity to read it properly and then be able to comment.

Acknowledgements

Many thanks to the members of the public and organisations who attended the events and shared their feedback. Further thanks to the organisations who shared information at the events, and who publicised the project. We are also grateful to the organisations who invited us to their events to discuss the strategy. Thanks to the members of the Healthwatch Wiltshire Readers' Panel for their comments and Healthwatch Wiltshire volunteers who helped facilitate the events.

Definitions

End of life

"People are considered to be approaching the end of life when they are likely to die within the next 12 months, although this isn't always possible to predict. This includes people whose death is imminent, as well as people who:

- have an advanced incurable illness such as cancer, dementia or motor neurone disease
- are generally frail and have co-existing conditions that mean they are expected to die within 12 months
- have existing conditions if they are at risk of dying from a sudden crisis in their condition
- have a life-threatening acute condition caused by a sudden catastrophic event, such as an accident or stroke".

[*Source: NHS Choices*[(1)]]

Unpaid carer

Healthwatch Wiltshire uses the term unpaid carer to describe anyone who provides care to another person, outside of a professional role. This includes adult carers who are caring for another adult (such as a spouse, relative or friend), parents who are caring for a child who has additional health needs, and young people (including children) who have a caring role.

About Healthwatch Wiltshire

Healthwatch Wiltshire is the independent consumer champion for health and social care in Wiltshire. It has an important role in assessing the quality of health and social care services today and influencing the design of services for tomorrow. We want to make sure that the people who use these services have a say in how they are shaped and that their overall views and experiences are heard and taken seriously.

healthwatch Wiltshire

(1) www.nhs.uk/Planners/end-of-life-care/Pages/what-it-involves-and-when-it-starts.aspx

Why not get involved?

Visit our website: www.healthwatchwiltshire.co.uk

Email us: info@healthwatchwiltshire.co.uk

Phone us: 01225 434218

Write to us: Unit 5, Hampton Park West, Melksham, SN12 6LH

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Wiltshire Council

Cabinet

4 April 2017

Subject: **A350 Chippenham Phase 3 and M4 Junction 17 Improvement contract award**

Cabinet Member: **Councillor Philip Whitehead – Highways and Transport**

Key Decision: **Yes**

Executive Summary

The A350 provides an important strategic north-south link through western Wiltshire. It forms the main connection for Chippenham and the west Wiltshire towns to the M4. High traffic volumes, particularly during peak periods, results in congestion, safety problems, delays and unpredictable journey times at some locations on the Chippenham Bypass and at the M4 junction.

Tenders have been invited for two improvement schemes for this route. The M4 Junction 17 Improvements, and A350 Chippenham Phase 3.

The procurement of the contracts has followed a two stage process. Following the publishing of the Official Journal of the European Union (OJEU) notice, 14 firms (made up of medium and larger companies), expressed an interest via the supplying southwest portal.

Based on the evaluations by a team of Council highways officers, with the Corporate Procurement team acting as moderators, it was concluded that the initial submissions from all of the potential bidders were good and they were invited to submit tenders for the schemes.

There were six contractors who submitted tenders for the A350 Chippenham Phase 3 scheme and five for the M4 Junction 17, which have been assessed in terms of cost and quality, using Price/Quality considerations of 70/30 described in the tender documentation.

The detailed scoring and financial information is contained in a confidential report to be considered in Part 2 of this meeting.

Proposal

To approve the award of contract for the A350 Chippenham Phase 3 and for the M4 Junction 17 Improvement Works following consideration of the information contained in the Part II report

Reasons for Proposal

(i) There is a need for a specialist contracts to be awarded to deliver these two important improvement schemes on the A350.

(ii) Following a procurement exercise in accordance with the 'Restricted Procedure' tenders were submitted and have been assessed in terms of price and quality.

(iii) The most advantageous tender for the Council, taking into account quality and price, should be accepted in accordance with the procurement procedures. The detailed scoring and financial information is contained in a confidential report to be considered in Part 2 of this meeting.

Dr Carlton Brand, Corporate Director

Wiltshire Council

Cabinet

4 April 2017

Subject:	**A350 Chippenham Phase 3 and M4 Junction 17 Improvement contract award**
Cabinet Member:	**Councillor Philip Whitehead – Highways and Transport**
Key Decision:	**Yes**

Purpose of Report

1. To seek approval to award contracts for A350 Chippenham Phase 3 and M4 Junction 17 Improvement Works.

Relevance to the Council's Business Plan

2. The Council's highways contract helps meet the priorities of the Council's Business Plan, including:

    - Outcome 1 – Wiltshire has a thriving and growing economy
    - Outcome 3 – Everyone in Wiltshire lives in a high quality environment
    - Outcome 6 – People are as protected from harm as possible and feel safe

Background

3. The A350 provides an important strategic north-south link through western Wiltshire. It forms the main connection for Chippenham and the west Wiltshire towns to the M4. High traffic volumes, particularly during peak periods, results in congestion, delays and unpredictable journey times at some locations.

4. Lack of investment on the A350 has the potential to constrain delivery of new homes and new employment opportunities in strategic sites around Chippenham. Worsening congestion will potentially hinder economic growth in all the towns within the A350 growth zone.

5. Two improvement schemes have been identified for implementation:

    (i) M4 Junction 17 Improvements
    (ii) A350 Chippenham Phase 3

6. These schemes build on the previous investment to improve the A350 north of Chippenham as part of the Department for Transport (DfT) Pinch Point funding and the A350 Bumpers Farm scheme implemented last year.

7. The purpose of the new schemes is to:

    (i) Improve connectivity between Chippenham and the West Wiltshire towns, with reduced journey times

(ii) Reduce queue lengths and delays;
(iii) Reduce frequency of personal injury collisions;
(iv) Facilitate housing and employment growth;
(v) Protect the strategic role of the A350;
(vi) Reduce queue lengths on the M4 off-slips and prevent them from backing onto the M4 mainline;
(vii) Minimise delays at the junction specifically on the M4 off-slip eastbound in the AM peak and M4 off-slip westbound in the PM peak;
(viii) Reduce the total amount of collisions and accidents that occur at the junction;
(ix) Improve the capacity of the junction to mitigate congestion impacts of future development.

8. The Outline Business Cases for the proposals were considered by the Swindon and Wiltshire Local Enterprise Partnership (SWLEP) Board at its meeting on 11 May 2016, when it was agreed to proceed to a Full Business Case. The schemes were also considered by the Council's Cabinet Capital Assets Committee on 13 September 2016, when the outline cash flow proposals for delivery of the schemes were discussed.

9. In order to develop the Full Business Cases for the schemes it was necessary to obtain tenders for the work to enable the costs to be identified in more detail. It is intended that the schemes will be considered by the SWLEP Board on 25 May 2017, with a view to the Business Cases being approved and construction starting this summer.

M4 Junction 17 Improvement

10. This junction has been the subject of several collisions on the M4 where traffic queues have backed up from the westbound off-slip road onto the main carriageways of the motorway. Entering the circulatory carriageway from the slip roads can be difficult because of high circulatory speeds of vehicles.

11. The proposed scheme is intended to address these issues, and comprises the installation of signal control at the entrances to the roundabout on the eastbound and westbound off slip roads of the M4, as well as the A429 northern approach and A350 southern approach, with modern signal controller and the installation of cut loop detectors on the approach to the stop lines in order to detect traffic build-up and queue length. The circulatory carriageway and the slip road surfaces are also to be resurfaced.

12. As this route is highly traffic sensitive any road closures will generally have to be undertaken at night, and the traffic management will need careful consideration to allow free passage of traffic at all other times.

13. The scheme has been awarded £0.5 million funding from the Growth Deal. Detailed discussions are taking place with Highways England who is responsible for the motorway and slip roads and the opportunity is being taken to include some of its maintenance works in the scheme in order to reduce disruption to road users and to share costs.

A350 Chippenham Phase 3

14. The proposed scheme represents the third phase of the A350 Chippenham Bypass dualling to improve capacity on this section of the A350. The sections of the route being dualled as part of this scheme are:

    (i) the northern approach to Chequers Roundabout (including construction of a second road bridge);
    (ii) the section from Chequers Roundabout to South Cepen Park Roundabout (including improvements to the geometry of the South Cepen Park Roundabout to address safety concerns at that junction), and
    (iii) the section between Brook Roundabout and Badger Roundabout.

15. The scheme was successful in being awarded £7.1 million as part of the first round of Growth Deal funding. It will increase the existing single carriageway capacity by constructing a new northbound carriageway, with the southbound traffic running on the existing carriageway. This will include the construction of a second road bridge across the Pudding Brook immediately south of Chequers Roundabout, the installation of drainage with a sustainable drainage system, street lights, signage, safety barriers, full depth construction of 1.4 kilometres of carriageway and alterations to the existing roundabouts.

16. As this route is highly traffic sensitive some road closures will have to be undertaken at night, and the traffic management has required careful consideration in order to allow free passage of traffic at all other times and keep delays to the minimum.

17. Utility company's equipment in the area of the works has been diverted prior to commencement on site. Measures have also been undertaken to ensure that the environmental requirements are met to enable a start on site this summer.

Main Considerations for the Council

18. The procurement for the two schemes has been carried out at the same time in order to reduce procurement costs and to provide an attractive package for bidders. The first stage was for bidders to submit information to enable them to be considered for inclusion on a list to be invited to tender.

19. The second stage was for tenderers to be issued the Invitation to Tender (ITT) documents, which had to be completed and returned by the closing date of 28 February 2017. The tender documents included both price and quality elements which are taken into account in awarding the contract.

    Pre Qualification Questionnaire

20. Following the issue of a Prior Information Notice (PIN), the Pre-Qualification Questionnaire (PQQ) was made available to potential bidders. The PQQ requested information about the bidder, including financial information, business and professional standing, health and safety, equal opportunities and diversity, environmental management, quality management and previous experience.

21. Following the publishing of the PIN in the Official Journal of the European Union (OJEU) notice, 14 firms (made up of both medium and larger companies), expressed an interest via the supplying southwest portal. The returned PQQs were assessed in accordance with the process set out in the document, and were scored by a panel of Council officers to identify a list of organisations to be invited to tender.

22. In compliance with the Public Contract Regulation 2015, all of the documents (the PQQ and the Draft Tender Documents) were made available to the potential bidders. This was to allow them to view the documents, and the requirements of the Council, to allow an informed decision to be made on whether to submit a completed PQQ.

23. By 19 December 2016, which was the deadline to receive completed PQQs, 14 firms had submitted documents. All of the submitted PQQs were of good quality, with the bidders all potentially capable of carrying out the works. Financial checks confirmed that there were no major concerns identified in connection with the potential bidders.

24. Based on the evaluations by a team of Council highways officers, with the Corporate Procurement team acting as moderators, it was concluded that the scores of the PQQs were very close, and there was a case for inviting all of the companies to submit a bid, whilst understanding that some may not wish to or decline as a result of workload elsewhere.

Invitation to Tender

25. The updated tender documents were issued to the selected list of bidders on 17 January 2017 for return by 28 February 2017. The tender documents included a Price List and a Quality Questionnaire.

26. The Quality Questionnaire has questions in connection with:

- The Management Arrangements
- Programme
- Methodology

27. The tenderers had to complete the Bill of Quantities of items which reflected the work to be procured through the contract.

28. It was indicated that the assessment would be based on 70% price and 30% quality.

Quality Assessment

29. The Quality Questionnaires were assessed and scored by a panel comprising Heads of Service and other staff who have extensive experience of the type of work being undertaken through the contract. The weightings given to each aspect of the Quality Questionnaire and the tender assessment procedure are described in **Appendix 1**.

30. The Quality Scores were calculated for each tenderer by dividing their initial quality scores awarded by the panel by the highest initial quality score. Thus the tenderer with the highest initial quality score from the Quality evaluation was awarded a score of 100.00% and all the others are awarded Quality Scores pro rata to their initial quality scores (rounded to two decimal places).

31. The outcome of the tender quality assessment is reported in the Part 2 item to be considered at this meeting.

Price Assessments

32. Tenderers completed and submitted a Bill of Quantities which contained a schedule of rates and items for the work required under the contracts. This included a mixture of rates for different types of measured work, fixed sums for particular identified elements of work, and on-costs and multipliers to be applied in certain circumstances. These rates were used to price a summary of items which represented the work anticipated through the contracts.

33. The lowest value calculated from the price assessment was awarded 100%. The cost scores for all the other tenderers were calculated by dividing the lowest value by each tender value in turn.

34. The outcome of the price assessment is reported in the Part 2 item to be considered at this meeting.

Comparison of Bids

35. The tender assessment process has recognised the vital importance of delivering cost-effective works, but has also recognised the importance of the quality of the work to be carried out by the contractor. Consequently, bids have been evaluated on a 70/30 Price/Quality basis in order to reflect the relative importance of these two aspects.

36. The quality and price scores of the tenderers were combined to determine the preferred contractors. The full details of the assessment are described in the Part 2 item to be considered at this meeting.

Next Stages

37. Following a decision to award the contract there will be a ten day standstill period during which other tenderers may make a legal challenge to the award of the contract.

38. Subject to the outcome of the decision by Cabinet, and assuming no legal challenge is received, the intention is to complete the Full Business Case so that the SWLEP Board can consider the funding of the scheme at its meeting on 25 May 2017.

39. There will be a significant amount of preparatory work for the successful bidder (or bidders) in arranging the necessary plant, resources and equipment to enable a start on site in the summer. However, final approval will be subject to the decision of the SWLEP in May.

Overview and Scrutiny Engagement

40. A Swindon and Wiltshire Local Enterprise Partnership Joint Task Group has been established. This Group acts as a critical friend, developing an overview of strategies and plans and providing independent scrutiny of the work of the SWLEP Board and Joint Strategic Economic Committee (JSEC) and comprises four elected Councillors from each of the two Unitary Authorities. It is an essential element of assuring democratic accountability for the use of public funds.

41. Although it is planning to monitor the implementation of projects in future, the Swindon and Wiltshire Local Enterprise Partnership Joint Task Group has not specifically considered this report therefore cannot offer any further comments.

Safeguarding Implications

42. None.

Public Health Implications

43. The layout and condition of roads and junctions can have serious safety implications. The proposed improvements are intended to reduce collisions and improve safety for all road users.

Corporate Procurement Implications

44. The procurement has followed the Restricted Procedure, which is a two stage process, with the relevant OJEU notices and procedures being complied with.

45. The Council's Procurement Team has been actively involved in the process and has monitored the procurement and tender assessment processes to ensure they are carried out properly to reduce the risk of a legal challenge at a later stage.

46. The scope and details of the new contracts take into account a number of factors, including the type of work required and the need to make them attractive to bidders by reducing the risks and providing a procurement process that is easily understood, clear and fair.

47. The detailed scoring and financial information on the tender assessment is contained in a confidential report to be considered in Part 2 of this meeting.

Equalities Impact of the Proposal

48. The successful tenderer has been required to demonstrate good practice in terms of employment policies and practices, and conform to the Council's standards and behaviours framework. The tenderers' employment policies have been taken into account in assessing the tenders.

Environmental and Climate Change Considerations

49. The effects of climate change are likely to have significant effects on the highways network as was seen in the flooding in recent years, and the consequent damage to the roads, footways and drainage systems. The proposed schemes have been developed and designed to improve the condition of the network and help build resilience into the highway infrastructure.

50. The schemes include improvements to the street lighting and the use of energy efficient equipment. The tender assessment process for the new highways contract has taken into account the environmental policies of the tenderers in the quality assessments.

Risk Assessment

51. There are significant risks associated with construction of major highway works, especially in terms of health and safety, and in financial and reputational risks to the Council. The appointment of suitable contractors for this work is important in reducing and managing these risks.

Risks that may arise if the proposed decision and related work is not taken

52. Not proceeding with the schemes would result in increasing traffic delays and increased collisions. It is important that the works proceed for the reasons described in this report, and set out in the business case.

53. There could be a risk of increased collisions, claims and public dissatisfaction if highway improvements are not delivered effectively, or are delayed.

Risks that may arise if the proposed decision is taken and actions that will be taken to manage these risks

54. There is a risk that, despite the stringent procurement procedure and assessment processes, the selected contractor does not meet expectations and performance is not as good as anticipated. These potential issues, especially with regard to safety, are well understood, and comprehensive site supervision and contract management is being put in place to manage those risks.

55. The risks associated with implementing the schemes have been significantly reduced by the advance work carried out to facilitate the works, particularly in connection with public utilities equipment and environmental factors. There remain some financial risks associated with these types of contract, but the supervision arrangements and contract procedures to be followed should enable these to be managed.

56. There is a risk that there could be a legal challenge to the contract award. There is a ten day standstill period following award during which this could happen. The processes followed in procuring the contract have followed the required procedure in order to reduce this risk.

Financial Implications

57. Both schemes represent a significant investment in improving the highways network, and have substantial benefits as demonstrated in the previously prepared Outline Business Cases. The financial position will be reviewed as part of the consideration of the Full Business Case for the SWLEP Board, but the indications are that both schemes represent good value for money, with significant economic benefits.

58. The work to be carried out by the contractors is well defined and the schemes have been designed in considerable detail in order to reduce risks and obtain the best price. Advanced work has been carried out to facilitate the early implementation of the scheme, and to avoid costly delays.

59. The assessment of the tenders has included financial considerations. A weighting of 70% has been given to the cost elements, compared to 30% for quality, which reflects the importance of achieving value for money through the contracts.

60. The A350 Chippenham Bypass Phase 3 scheme (Badger to Brook and Chequers Roundabouts) was successful in achieving an allocation (£7.1 million) as part of the first round of Growth Deal funding. The project was originally profiled to be delivered over three years, between 2017/18 and 2019/20. In September 2016, the Cabinet Capital Assets Committee (CCAC) agreed to cashflow the scheme in order to accelerate delivery, enabling the scheme to be completed in 2018/19.

61. The M4 Junction 17 Improvements scheme was successful in achieving a Growth Deal allocation (£0.5 million) as part of the second round of Growth Deal funding. The project was originally profiled to be delivered in 2019/20. In September 2016, CCAC agreed to cashflow the scheme in order to accelerate delivery, enabling the scheme to be completed in 2017/18. Highways England will be contributing to the funding of the scheme.

62. The early delivery of these projects can send a strong message to Government of Wiltshire Council's ability and reliability in relation to Growth Deal delivery.

63. The financial implications of the award of the contracts are discussed in the Part 2 report which will be considered at this meeting.

Legal Implications

64. The Council is the local highway authority and has a duty to maintain the highways network and related infrastructure. The proposed schemes will help to improve the capacity and safety of the highway network. Highways England is responsible for the motorway network and there has been close liaison with them regarding the proposed works at Junction 17.

65. The schemes are within highway land, and no additional land acquisition or permissions are required. A legal agreement is being put in place with Highways England to enable the M4 Junction 17 scheme to be delivered by this Council and to allow the Council's contractor to carry out the necessary works on the motorway network. No further legal agreements are required to deliver the schemes.

66. It is important that the procurement process and contract award have followed the correct processes in order to avoid legal challenges during the process, which could delay or prevent the start of construction.

Options Considered

67. Not proceeding with the schemes would result in increasing traffic delays and increased collisions. There could be a risk of increased collisions, claims and public dissatisfaction if highway improvements are not delivered effectively, or are delayed.

68. The procurement process has identified the most suitable contractors for the work. Awarding the contract to one of the unsuccessful tenderers would not represent value for money and could result in a legal challenge.

69. The tenders submitted for the contracts have been assessed in terms of price and quality in accordance with the agreed procedure, and the most suitable tenderer has been identified.

Conclusions

70. The result of the assessment to identify the preferred contractors is described in the Part 2 item to be considered at this meeting. The most advantageous tender for the Council, taking into account quality and price, has been identified in accordance with the procurement procedures.

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The following unpublished documents have been relied on in the preparation of this Report:

None

Appendices:

Appendix 1 – Tender Assessment Procedure

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APPENDIX 1

TENDER ASSESSMENT PROCEDURE

1. Tenders will be evaluated by the Employer on the basis of both quality and price as set out in this document. If awarded, the Contracts will be awarded to the Tenderers submitting the most advantageous tender evaluated using the criteria set out in these instructions.

2. Submissions will be evaluated will be evaluated separately against the following award criteria;

   Quality 30%
   Price 70%

QUALITY ASSESSMENT

3. Evaluation of the Quality Submission will be undertaken by the Employers Representative and Consultant Representative and they will ensure that the selection process is conducted in a fair and non-discriminatory manner.

4. Each tender submission will first be assessed on the quality score, based on the criteria from Table 1 below against the quality questions in the Contract Documents.

5. The quality questions are:

   1. Organogram

   The Tenderer shall provide an organogram identifying the proposed structure to successfully deliver the project with suitable levels of resource.

   The organogram should include the key staff, including those based on site as part of the delivery team and support staff located elsewhere providing overall support. Key stakeholders, work gangs and sub-contractors used in the delivery of the works should also be identified.

   (1 side of A3 only)

A description of each key member of staff identified on the organogram shall be provided. The details are to include their; skills, experience and qualifications necessary to successfully deliver the role they have been identified to undertake.

Please note that this is not required for the labour resource identified in the organogram.

(1 side of A4 for each member of staff)

2. Programme

The Tenderer shall provide a programme of the works identifying the necessary tasks required to undertake the works in accordance with the contract documents provided as part of this tender.

The Tenderer shall ensure the information shown is in accordance with Clause 31.2 of the NEC3 ECC form of contract.

(1 side of A1 only – ensuring each task and any associated text is clearly visible)

Please Note: This can be a 'rolled up' version of the Contractor's programme required to be submitted in accordance with Contract Data Part Two

3. Methodology

The Tenderer shall provide a project specific methodology as to how they would provide the works in accordance with the contract documents, ensuring it is line with the programme provided in Question 2.

For operations identified on the programme, the Tenderer should state how they plan to do the work, identifying the principal Equipment, labour and other resources which they plan to use.

In addition to the above, the Tenderer should also demonstrate how they would address traffic management, sustainability of materials, public liaison and any other elements that they feel are relevant to the project identified.

(4 sides of A4 maximum)

Table 1 – Scoring Criteria:

Assessment	Mark	Interpretation
Excellent	***5***	*Exceeds the requirement.* *Exceptional demonstration by the Tenderer of how they will meet this requirement by their allocation of skills and understanding, resources and quality measures. Response identifies factors that demonstrate added value, with evidence to support the response.*
Good	***4***	*Satisfies the requirement with minor additional benefits.* *Above average demonstration by the Tenderer of how they will meet this requirement by their allocation of skills and understanding, resources and quality measures. Response identifies factors that demonstrate added value, with evidence to support the response.*
Acceptable	***3***	*Satisfies the requirement.* *Demonstration by the Tenderer of how they will meet this requirement by their allocation of skills and understanding, resources and quality measures, with evidence to support the response.*
Minor Reservations	***2***	*Satisfies the requirement with minor reservations.* *Some minor reservations regarding how the Tenderer will meet this requirement by their allocation of skills and understanding, resources and quality measures, with limited evidence to support the response.*
Serious Reservations	***1***	*Satisfies the requirement with major reservations.* *Considerable reservations regarding how the Tenderer will meet this requirement by their allocation of skills and understanding, resources and quality measures, with little or no evidence to support the response.*
Unacceptable	***0***	*Does not meet the requirement.* *Does not comply and/or insufficient information provided to demonstrate how the Tenderer will meet this requirement by their allocation of skills and understanding, resources and quality measures, with little or no evidence to support the response.*

Table 2 – Quality Assessment Weighting:

Part 1 - Quality Questions	**Weighting**
Q1: Organogram	30
Q2: Programme	35

Q3: Methodology	35
Total mark for Quality	**100**

6. The weighted score for each question response is derived by multiplying the mark out of 5 by the weighting of the individual section. Thus a score of 4/5 for question 1 results in a weighted score for that section of 24.00% (4/5 x 30% = 24.00%). If a Tenderer were to score 5/5 for every question, the sum of all their weighted scores would be 100.00%, since the sum of the questions weightings is 100.00%.

	Q1	Q2	Q3	Total Mark	Total Score
Tender A	12	7	21	40	50.63
Tender B	30	21	28	79	100.00
Tender C	24	21	21	66	83.54
Tender D	18	28	14	60	75.95

e.g. Tender A: 40/79 * 100 = 50.63

7. The sum of all the weighted scores is therefore equal to the Tenderers Quality score out of 100. These ***Quality Scores*** are carried forward to the Quality + Cost evaluation (see later).

8. Any Tenderer with an aggregated quality score of less than 60% may have their Financial Submission withheld by the Employer.

PRICE ASSESSMENT

9. Evaluation of the Financial Submission will be firstly based on the tendered price for the bill of quantities in Volume 4. The lowest tendered total will be given 85 marks with all other scored pro-rata; a worked example is shown below;

	Price (£)	Score

Tender A	2,535,000	73.76
Tender B	3,575,000	52.31
Tender C	2,200,000	85.00
Tender D	2,775,000	67.39

10. The direct fee percentage, subcontract fee percentage and people fee percentage submitted by each Tenderer for the works will be ranked. The lowest tendered percentage for each fee will be given 5 marks with all others scored pro-rata (total of 15 marks); a worked example is shown below.

11.

	Direct Fee %	Score	Sub contract fee %	Score	People Overheads fee%	Score	Total Score
Tender A	11.0	4.55	7.5	4.00	7.5	4.00	12.55
Tender B	10.0	5.00	6.0	5.00	6.0	5.00	15.00
Tender C	13.0	3.85	9.0	3.33	9.0	3.33	10.51
Tender D	12.0	4.17	12.0	2.50	9.0	3.33	10.00

12. The *final price score* for each tendered shall be the aggregated scoring of the bill of quantities and fee percentages. A worked example is shown below:

	Bill of Quantities Score	Fee Score	Aggregated Price Score
Tender A	73.76	12.55	86.31
Tender B	52.31	15	67.31
Tender C	85.00	10.51	95.51
Tender D	67.39	10.00	77.39

13. All cost scores shall be rounded to two decimal places.

QUALITY AND PRICE COMBINATION

14. The *final assessment* of each compliant tender will be based on the aggregated score for the Quality/Price submission based on a ratio of 30:70. (Quality score x 30% + Price score x 70%). The Tenderer receiving the highest combined

Quality/Price score shall be awarded the Contract. The table below shows a worked example.

15. Quality Scores are calculated for each Tenderer by dividing their *initial quality scores* by the *highest initial quality score*. Thus the Tenderer with the ***highest initial quality score*** from the Quality evaluation is awarded a score of **100.00%** and all the others are awarded Quality Scores pro rata to their *initial quality scores* (rounded to two decimal places).

	Quality Marks	Best Quality Score (Q)	Aggregated Price cost	Best Tender Mark (P)	Combined Score (Q*0.3)+(P*0.7)
Tender A	72	86.75%	86.31	90.37%	89.28%
Tender B	62	74.70%	67.31	70.47%	71.74%
Tender C	83	100.00%	95.51	100.00%	**100.00%**
Tender D	73	87.95%	77.39	81.03%	56.72%

In this example Tender C is the successful submission.

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