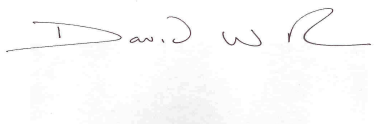
Public Document Pack

Health Policy and Performance Board

Tuesday, 7 June 2011 at 6.30 p.m.
Council Chamber, Runcorn Town Hall



Chief Executive

BOARD MEMBERSHIP

Councillor Ellen Cargill (Chairman)	**Labour**
Councillor Joan Lowe (Vice-Chairman)	**Labour**
Councillor Dave Austin	**Liberal Democrat**
Councillor Sandra Baker	**Labour**
Councillor Mark Dennett	**Labour**
Councillor Margaret Horabin	**Labour**
Councillor Martha Lloyd Jones	**Labour**
Councillor Chris Loftus	**Labour**
Councillor Andrew MacManus	**Labour**
Councillor Carol Plumpton Walsh	**Labour**
Councillor Geoff Zygadllo	**Labour**
Mr Paul Cooke	**Co-optee**

Please contact Lynn Derbyshire on 0151 471 7389 or e-mail lynn.derbyshire@halton.gov.uk for further information.

The next meeting of the Board is on Tuesday, 13 September 2011

ITEMS TO BE DEALT WITH
IN THE PRESENCE OF THE PRESS AND PUBLIC

Part I

In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.

Agenda Item 3

REPORT TO: Health Policy & Performance Board

DATE: 7 June 2011

REPORTING OFFICER: Strategic Director, Corporate and Resources

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To consider any questions submitted by the Public in accordance with Standing Order 34(9).

1.2 Details of any questions received will be circulated at the meeting.

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

3.1 Standing Order 34(9) states that Public Questions shall be dealt with as follows:-

(i) A total of 30 minutes will be allocated for dealing with questions from members of the public who are residents of the Borough, to ask questions at meetings of the Policy and Performance Boards.

(ii) Members of the public can ask questions on any matter relating to the agenda.

(iii) Members of the public can ask questions. Written notice of questions must be given by 4.00 pm on the working day prior to the date of the meeting to the Committee Services Manager. At any one meeting no person/organisation may submit more than one question.

(iv) One supplementary question (relating to the original question) may be asked by the questioner, which may or may not be answered at the meeting.

(v) The Chair or proper officer may reject a question if it:-

- Is not about a matter for which the local authority has a responsibility or which affects the Borough;
- Is defamatory, frivolous, offensive, abusive or racist;
- Is substantially the same as a question which has been put at a meeting of the Council in the past six months; or
- Requires the disclosure of confidential or exempt information.

(vi) In the interests of natural justice, public questions cannot relate to a planning or licensing application or to any matter which is not dealt with in the public part of a meeting.

(vii) The Chairperson will ask for people to indicate that they wish to ask a question.

(viii) **PLEASE NOTE** that the maximum amount of time each questioner will be allowed is 3 minutes.

(ix) If you do not receive a response at the meeting, a Council Officer will ask for your name and address and make sure that you receive a written response.

Please bear in mind that public question time lasts for a maximum of 30 minutes. To help in making the most of this opportunity to speak:-

- Please keep your questions as concise as possible.
- Please do not repeat or make statements on earlier questions as this reduces the time available for other issues to be raised.
- Please note public question time is not intended for debate – issues raised will be responded to either at the meeting or in writing at a later date.

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton** - none.

6.2 **Employment, Learning and Skills in Halton** - none.

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

6.5 **Halton's Urban Renewal** – none.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background papers under the meaning of the Act.

REPORT TO: Health Policy and Performance Board

DATE: 7 June 2011

REPORTING OFFICER: Chief Executive

SUBJECT: Executive Board Minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Social Care Portfolio which have been considered by the Executive Board and Executive Board Sub are attached at Appendix 1 for information.

1.2 The Minutes are submitted to inform the Policy and Performance Board of decisions taken in their area.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

5.2 **Employment, Learning and Skills in Halton**

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background papers under the meaning of the Act.

APPENDIX 1

Extract of Executive Board and Executive Board Sub Committee Minutes Relevant to the Health Policy and Performance Board

EXECUTIVE BOARD MEETING HELD ON 3 MARCH 2011

EXB98 INVITATION TO BE AN EARLY IMPLEMENTER – HEALTH AND WELLBEING BOARDS

The Board received a report of the Strategic Director, Adults and Community on the Department of Health invitation to Local Authorities to become an Early Implementer for Health and Wellbeing Boards.

The Board was informed that, as part of the proposals for health reforms, the Government had recently announced the establishment of Health and Wellbeing Boards. The Boards would bring together Councils with NHS Commissioners, working to join up services across the NHS, Public Health, Social Care and Children's Services. Elected Members would have a statutory responsibility to be members of the Health and Wellbeing Board along with relevant GP Consortia and membership would also include Directors of Children's Services, Adult Social Services and Public Health as well as local HealthWatch.

Members were advised that Health and Wellbeing Boards would take the lead on developing a shared understanding of local needs (through the Joint Strategic Needs Assessment) and setting the priorities and strategy for health and wellbeing for the local community. The strategies would inform commissioning plans for NHS commissioners and councils, providing a basis for joint working and commissioning. It was noted that, subject to parliamentary approval, Health and Wellbeing Boards would be established from 2013, running in shadow form from 2012 with 2011/12 being a transitional year.

RESOLVED: That

1) the contents of the report be noted ;and

2) the application to become a Department of Health Early Implementer be approved

EXECUTIVE BOARD MEETING HELD ON 31 MARCH 2011

EXB110 NHS SUPPORT FOR SOCIAL CARE

The Board received a report of the Strategic Director, Adults and Community on recent announcements about NHS support for Social Care.

The report advised that, on 5th October 2010, the Department of Health announced that an additional £70m would be allocated to Primary Care Trusts (PCTs) for spending in 2010/2011 on services to promote better re-ablement services for patients upon discharge from hospital. The PCTs were requested to work in partnership with Local Authorities, community services and Acute Trust partners to develop plans on the best way to use this funding, to facilitate seamless care for patients on discharge from hospital and to prevent avoidable hospital readmissions. A proportion of the funding would be used to develop current re-ablement capacity in the community and the PCT was allocated £488,000 for Halton and St. Helens. For Halton, this funding provided additional Intermediate Care Beds and Community Re-ablement.

In addition, on the 4th January 2011, the Department of Health announced a further allocation of £162m to PCTs for immediate spending on social care services that benefit the NHS but which must be committed by 31st March 2011. It was noted that the allocation for Halton Council was £427,000.

Due to the short notice on this allocation, a meeting was arranged by the PCT to agree spending for this financial year, and details of the agreed allocation of funding, were incorporated in the Partnership agreement.

RESOLVED: That

1) the report be noted; and

2) on the basis of the National Guidance, the Adults and Communities Directorate be authorised to enter into a partnership agreement with NHS Halton and St Helens on behalf of Halton Borough Council

EXB115 OUTCOME OF THE CONSULTATION TO MODERNISE AND INTEGRATE DAY SERVICES AND OPPORTUNITIES FOR ALL ADULTS

The Board received a report of the Strategic Director, Adults and Community on the outcome of the consultation to modernise and integrate day services and opportunities for all adults.

The Board had received a report on 13 January 2011, which outlined the key issues and development plan for the modernisation and redesign of Day Opportunities for Older People and Adults, which sought approval to

begin formal consultation with key stakeholders, on the future provision of services. The focus was on:

- Integration of Sure Start To Later Life and Community Bridgebuilders to provide a single access point to all day opportunities and Early Intervention services- providing a service for all adults;

- Decommission Older People's Community Day Services, in it's current format, and further develop alternative day opportunities within the community, ensuring these were utilised more effectively across all client groups;

- De-commission Pingot and the service be delivered in its entirety from within the community as the "Hub and Spoke" model; and

- Oakmeadow Day Centre- to develop as an alternative enablement model, integrated with Adult Day Service as a Community Resource Model.

Details of the consultation were outlined in the report for Members' consideration. It was noted that the Health Policy and Performance Board (PPB) had considered a report at its meeting on 8 March 2011, on the proposals and ongoing discussions had taken place with the Chair and Deputy Chair of the Health PPB as well as the Portfolio holder for Health and Adults.

RESOLVED: That

1) the contents of the report be noted; and

2) approval be given to implement the following proposals:

   i) to integrate the staffing groups for Sure Start To Later Life and Community Bridge Building Service;

   ii) to de-commission Older People's Day Services within the current format and work in partnership with the Third Sector;

   iii) redesign the current provision of Day Care within Oakmeadow, and implement the Business Plan for Oakmeadow Community Resource Centre; and

   iv) to de-commission Pingot Day Centre as a base for the delivery of Day Services.

EXECUTIVE BOARD SUB COMMITTEE MEETING HELD ON 12 FEBRUARY 2011

ES72 INVITATION TO TENDER FOR A COMMUNITY BASED RECOVERY ORIENTED SUBSTANCE MISUSE SERVICE

The Sub-Committee considered a report of the Strategic Director, Adults and Community which sought authority to carry out all the necessary steps in relation to the open tendering and commissioning of a community based recovery oriented substance misuse service.

Currently, there were four organisations co-located at Ashley House providing a range of drug and alcohol services; 5 Boroughs Partnership NHS Foundation Trust, ARCH Initiatives, Addaction and Trust The Process Counselling. Whilst performance from each of the current providers was good and many of the building blocks required to produce a recovery orientated substance misuse service were in place, it was anticipated that the following benefits would accrue from a re-commissioning of services:

- a more streamlined and integrated service;
- an improved response to the changing patterns of substance misuse;
- efficiency savings both in terms of operational delivery and performance management;
- improved support for families and those individuals who achieved abstinence;
- a greater awareness in communities of the issues around recovering from addiction; and
- an improved access to services for those individuals whose alcohol use is problematic.

It was proposed that Halton Borough Council and Halton and St. Helens PCT would jointly commission the new substance misuse service, bringing together the resources that currently separately fund the alcohol and drug services. Children and Young People services and in-patient detoxification would not be included in the tender.

It was anticipated that the new contract would commence on 1st September for a two year period, and whilst current funding allocations for drug services were not currently known, it was anticipated that the yearly contract value for a substance misuse service (drugs and alcohol) would be in the region of £3.4m. In addition it was noted that Ashley House was rented by the 5 Boroughs Partnership Trust from a private landlord. Alternative arrangements would need to be established if they ceased to be the service provider from the 1st September 2011.

RESOLVED: That

(1) the Strategic Director Adults and Community proceeds with the open tendering and Procurement of a community based recovery orientated substance misuse service and proceeds with the award of the necessary contract; and

(2) the Strategic Director, in consultation with the appropriate portfolio holder, be authorised to take such actions as are necessary to give effect to the above decision.

EXECUTIVE BOARD SUB COMMITTEE MEETING HELD ON 3 MARCH 2011

ES78 EXTEND SUPPORTING PEOPLE CONTRACTS

The Board considered a report by the Strategic Director Adults and Community which sought a suspension of relevant standing orders in order to extend existing Supporting People contracts to the dates outlined in the report.

Members noted that due to the late notification of the financial settlement and the subsequent uncertainty about budget setting for individual service areas it was decided to minimise the risk to Halton Borough Council by not entering into tender processes for services which were due to expire on 31st March 2011. It was requested Supporting People contracts be extended until the dates outlined subject to budget provision.

An extension to existing contracts would enable the proposed efficiencies for 2011/2012 to be realised, and give the opportunity for further efficiencies to be identified and achieved in 2012/2013 as follows:

- following the remodelling of floating support services, it was proposed to tender for floating support services and homeless services in September 2011/2012 to be implemented in 2012/2013; and
- a strategic review of sheltered services would be undertaken in 2011/2012 with a view to re-tender those services in 2012/2013 with contracts to be awarded for 2013/14.

RESOLVED: That

1. in the exceptional circumstances set out below (namely to avoid long term funding commitment when external funding uncertain) for the purpose of Procurement Standing Order 1.8.2, procurement standing orders 2.1 to 2.15 be waived on this occasion because compliance with these Standing Orders is not practicable for reasons of urgency which could not reasonably have been anticipated to permit the extension of the existing Supporting People contracts

(listed at Appendix A) to the dates indicated, subject to variations with regard to contract price and contract capacity as agreed by the Operational Director (Prevention and Commissioning) at an estimated price of £3,797,200;

2. subject to the expiry of full Supporting People contracts granted under a waiver due to the exceptional circumstances set out in section 3 and 4.1 of this report, Supporting People services will be procured through a competitive tendering process detailed in section 3.7 and 4.1 of this report; and

3. the Strategic Director, Adults and Community, in conjunction with the Portfolio Holder for Health & Adults, be authorised to take such action as necessary to implement the above recommendation.

EXECUTIVE BOARD SUB COMMITTEE MEETING HELD ON 17 MARCH 2011

ES84 WAIVER OF STANDING ORDERS: EXTENSION OF RESIDENTIAL CARE CONTRACTS FOR PEOPLE WITH LEARNING DISABILITIES AND MENTAL HEALTH

The Sub Committee considered a report which sought approval for a suspension of the relevant procurement standing orders 3.1-3.7 and to authorise the Strategic Director Adults and Community in conjunction with the portfolio holder for Health to enter into a contract with the providers of residential care at Wide Cove, Smithy Forge, Leahurst and Woodcroft on a spot purchase basis from April 2011 to the end of March 2012.

In addition, the report sought approval to waive procurement standing orders 2.1-2.11 and to authorise the Strategic Director Adults and Community in conjunction with the portfolio holder for Health to enter into a contract with the providers of residential care at Holmdale, Glenwood and Bankfield, on a spot purchase basis, with an option to extend for a period of up to a further three years from April 2012 to the end of March 2015.

It was noted that at a previous meeting of the Committee held on 19th November 2009, the Strategic Director, Adults and Community in conjunction with the portfolio holder for Health was authorised to enter into "spot purchase" contracts to 31st March 2011.

Members were advised that the proposed rates set out in the report were competitive when compared with regional and national averages. Ongoing monitoring of services would ensure the standard of quality achieved by these providers was maintained. In addition a full cost analysis would be conducted to ensure any opportunities for efficiency savings were being explored by the provider.

It was also reported that a review of the accommodation and support being offered had been undertaken throughout 2010 with the residents and provider.

RESOLVED: That

1) In the exceptional circumstances set out below, for the purpose of standing order 1.8.2, procurement standing orders 3.1 – 3.7 be waived on this occasion to permit the Strategic Director, Adults and Community to enter into contracts on an individual 'spot purchase' basis with the providers of registered Residential Establishments at:

   Wide cove, Smithy Forge, Leahurst and Woodcroft which meet the Council's quality criteria on the basis that the review of services has concluded that no remodelling is required at this time;

2) in the exceptional circumstances set out below, for the purpose of standing order 1.8.2, procurement standing orders 2.1-2.11 be waived on this occasion to permit the Strategic Director Adults and Community to enter into contracts on an individual 'spot purchase' basis with the providers of registered Residential Establishments at:

   Glenwood, Holmdale and Bankfield on the basis that these non-health services for which commissioning responsibility transferred from NHS Halton and St Helens to the Council in April 2009, meet the Councils' quality requirements; and

3) the strategic director, adults and community be authorised, in consultation with the portfolio holder for health, to enter into 'spot purchase' contract arrangements at the rates set out in section 6.1 of this report, for the contract period in line with other residential contracts in the borough which is one year from April 2011 to the end of march 2012, with an option to extend for a period of up to a further three years from April 2012 to the end of march 2015: and that these purchasing arrangements be reviewed on an annual basis by the strategic director, adult and community, in

consultation with the portfolio holder for health. fee levels initially to be in line with current rates paid and uplifted by 2% as agreed by the council in setting its budget for 2011/12 and to then be reviewed following actions in 4.1 to ensure ongoing value for money is secured.

ES85 INFLATIONARY UPLIFT FOR ADULT SOCIAL CARE CONTRACTS

The Sub-Committee considered a report of the Strategic Director Health and Community which sought approval for the inflationary increases for the Adult Social Care Contract. The Council had approved a 2% Inflationary Uplift on Social Care Budgets for 2011-12, therefore it was proposed that contracts for the provision of domiciliary care, residential and nursing placements were awarded an equivalent inflationary uplift of 2%.

With regard to Out of Borough Placements, it was proposed that the inflationary increase applied to Out of Borough Placements be decided on a case by case basis as follows:

- providers to be informed that inflationary increase would be subject to submission of a written requested to HBC Contracts Department within a specific timeframe; and
- any increase within the agreed HBC rate of 2% to be approved and applied.

Any increase above 2% would be approved by a relevant Operational Director, based on the information submitted by the provider, confirmation of the host authority's approved inflationary rate and the knowledge of the on-going need for the specific service.

RESOLVED: That

1. an inflationary uplift for providers of Domiciliary, Residential & Nursing contracts of up to 2%, which is within the inflationary allowance by the Council to Social Services for 2011/12 be approved; and

2. inflationary uplifts for out of borough Placements are awarded on a case by case basis, limited to the 2% HBC inflationary increase or the prevailing Local Authority rate be approved.

REPORT TO: Health Policy and Performance Board

DATE: 7 June 2011

REPORTING OFFICER: Chief Executive

SUBJECT: Specialist Strategic Partnership minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Social Care Portfolio which have been considered by the Health Specialist Strategic Partnership are attached at Appendix 1 for information.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

5.2 **Employment, Learning and Skills in Halton**

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background papers under the meaning of the Act.

Halton Strategic PARTNERSHIP

HALTON HEALTH PARTNERSHIP BOARD
MINUTES OF THE MEETING held on
10th March 2011

Present: **Debbie Ainsworth (DA)**
Cllr Ellen Cargill (EC)
Glenda Cave (GC)
Dympna Edwards (DE) (**Chair**)
Cllr Ann Gerrard (AG)
Diane Lloyd (DL)
Eileen O'Meara (EO'M)
Sue Parkinson (SP)
Dave Sweeney (DS)
Yeemay Sung (YS)
Karen Tonge (KT)

In attendance: **Clare Myring**
Collette Walsh
Audrey Williamson

In Support: **Margaret Janes**

1.	**Apologies** Jim Wilson, Gerald Meehan, Dwayne Johnson, Emma Bragger
2.	**Minutes of the Meeting 4 November 2010** The minutes were agreed as a correct record.
3.	**Matters Arising** LIT Group – DL had checked previous minutes and advised matters had moved on. Policy Options Paper – Used to inform the Sustainable Community Strategy – goes live 1st April. Halton 2000 Survey Safeguarding – update on progress next agenda. PH White Paper – information being fed into Older People's LIT. Spending Review – Discussed at LSP and how we can work collaboratively. N150 – There will be no new LAA targets for 2011/12. Outcome framework being consulted on at national level. DE understood some targets will need formalising. With regard to targets we need to continue performance managing targets or choose sub set of them.
4.	**Joint Strategic Needs Assessment** DL presented the JSNA on behalf of Emma Bragger who had worked in conjunction with the Council Research team and Sharon McAteer from the PCT. The implementation of the JSNA Communications Plan was planned for June 2011. In terms of going forward the JSNA will be refreshed on an annual basis. It will be a key document for the GP Commissioning Consortia and will form the basis of the development of the Health and Wellbeing Strategy, a responsibility of the Health and Wellbeing Boards. Cllr Gerrard believed this was a useful baseline, there was a lot of information from partners that needed to be picked up by the JSNA in order to provide prevention. It was agreed the JSNA needed to be a rolling document, with information added as necessary. There was a need to use the softer information provided by partners as an early warning system. Liverpool University were currently looking at predicted problems,

	ie housing, as a result of the economic downturn. DE wished to record her thanks to Emma Bragger for her efforts in producing this document.
5.	**Community/LinK Feedback** Sue Parkinson briefed the meeting on activities since the last meeting. Karen Tonge advised Melissa Critchley was supporting the provider forum on Personalisation – a further newsletter will be produced. She advised there had been organisational changes and a report will be available at the next meeting. Cllr Gerrard expressed concern over community groups and projects having a voice in relation to feedback to these groups. Karen Tonge advised there were sub groups that any groups were welcome to join. Cllr Cargill advised there was a community forum and also area forums. D Edwards felt it may be useful to map as much as possible to see if we have routes for the majority through community forums etc; there may be an opportunity through Health and Wellbeing Boards to look at how these engagement links work. Following further discussion it was agreed that any ideas should be forwarded to Audrey Williamson. D Lloyd to forward a copy of Community Engagement Strategy.
6.	**Public Health White Paper** DE referred to the PCT's response to the White Paper and advised that the deadline had been extended. The main responses were around Policy, Wider Determinants of Health and Structure. Following discussion it was agreed that the Health Partnership should produce a response. DE requested people forward additions/changes to her within the next week.
7.	**Health Partnership Development and Feedback** A Williamson had been requested to produce a report for Halton with regard to the Health and Wellbeing Board; the report would be distributed to the Council's Management Team, PCT and PBCs (GPs). This will be a statutory Board that will be Council led and chaired by elected members. The membership would include Director of Children's Services, Director of Adult Services and Director of Public Health. The principles agreed at the Away Day need to be fed in, AW asked for views on what should be incorporated into the report. Cllr Gerrard advised the views of GPs needed to be included; the views of other parties, ie volunteer groups, etc, needed to be fed into the group. She asked whether consideration should be given to a wider membership. DE pointed out that if people were not on the main board they would be on other committees feeding into the H&W Board. A Williamson referred to the Children's Safeguarding Board and its subgroups and suggested that model be used. This proposal was agreed. Any further comments should be emailed to Audrey Williamson.
8.	**Performance Group Feedback and Health Priority Update** Health Priority Update – DL/EO'M were preparing a paper for COG on 15 March, a copy would be forwarded to the group. EO'M gave an update from the last Performance Group: **Mortality** – it was noted there was a lag in the data. The unverified data (from PH Analyst team) showed men were expected to live an additional 2.3 years (75 years) and women an extra 2.2 years (79.2 years). In recent years life expectancy had increased; by 2011/12 we should be able to meet the Local Area Mortality Indicator. **Obesity** – Child Health Profile was not significantly above national average for

Halton Strategic PARTNERSHIP

	Reception age obesity. Government guidance is a reduction of 0.5%, we have reduced by 1% for Reception age group and 0.6% for Year 6. Cllr Gerrard referred to the successes around the community – the bottom up approach from community groups have fed into national award winning pieces of work. The "New Shoots" campaign is growing rapidly and spreading across the Runcorn area. Hospital Admissions for alcohol related harm – it was noted we are now in the mid range as opposed to the top. A copy of the Child Health Profile to be circulated with the minutes.
9.	**SSP Chairs Meeting Feedback/WNF Transition Fund 11/12 Health Priorities** DE confirmed the group had prioritised the Voluntary Sector Counselling Partnership and Accessible Transport for WNF Transition Fund 2011/12. Collette Walsh gave a presentation on Alcohol and providing psycho-social intervention for adults affected by drug or alcohol use by funding the Halton Family Service. They hoped to secure funding of £50k which would give support to 55 families. She advised there were changing patterns for substance misuse in the area having more poly substance users – alcohol, powdered cocaine and ecstasy – these people would not see themselves using a traditional service. They hoped to fund a website so that advice was available and individuals could get self-help through a screening tool and new providers would have a link into the website to enable users to be aware of all services available to them. During discussion KT felt it may be useful to contact Halton Youth Council to support this. Cllr Gerrard advised the Local Authority Marketing group may be able to help. It was agreed to work with Collette Walsh around young people being admitted to hospital and if the LSP agree funding this will be moved forward given time restrictions.
10.	**Drug Strategy – joint working protocol between treatment providers and JobCentre Plus** Debbie Ainsworth gave an update, including new protocol from April and discussion took place around identifying referrals to treatment providers. It was noted that whilst customers are in the "live in" facility they will be able to claim income support straight away. S Parkinson asked how this would affect the homeless. D Ainsworth advised the same process would apply, if they are not looking for work there will be harsher penalties - details awaited. DE requested FAQ information to be included with the meeting notes. Due to the potential increase in patients consideration needs to be given to raising awareness with GPs. DE advised there is a monthly GP Bulletin and requested D Ainsworth to provide highlights of changes so that GPs can be made aware of the situation.
11.	**Any Other Business**
	Transport Board – Diane Lloyd advised the Transport Board sits under the LSP, however there is no health representation on the Board. The next meeting is 23 March at 3pm. There was a need to have representation on a regular basis and D Lloyd requested a nominee from the Health SSP. If no one is nominated D Lloyd agreed to attend if available. If anyone would like to put themselves forward for the group they should contact Diane direct. D Ainsworth advised she was a member but was not always able to attend. **JobCentre Plus** – Debbie Ainsworth advised they would be going to 4 districts (formerly 5) and Halton would be part of Merseyside. Cheshire West, Cheshire East and Warrington would be part of Manchester. **July Meeting** – A venue is needed for the next meeting on 14th July. Debbie Ainsworth

Halton Strategic PARTNERSHIP

	advised there were conference facilities in Runcorn. DL to send details to her to check availability
12.	**Date and time of next Meeting**
	The next meeting will take place on 12th May 9.30-11.30 – Conference Room 2, Municipal Building, Widnes

REPORT TO: Health Policy and Performance Board

DATE: 7th June 2011

REPORTING OFFICER: Strategic Director Policy and Resources

SUBJECT: Performance Management Reports for Quarter 4 of 2010/11

WARDS: Boroughwide

1.0 PURPOSE OF REPORT

To consider and raise any questions or points of clarification in respect of performance management reports for the fourth quarter of 2010/11, to March 2011. The report details progress against service objectives/ milestones and performance targets, and describes factors affecting the service for:

- Prevention and Commissioning
- Complex Needs
- Enablement Services

2.0 RECOMMENDED: That the Policy and Performance Board

1) **Receive the fourth quarter performance management report;**

2) **Consider the progress and performance information and raise any questions or points for clarification; and**

3) **Highlight any areas of interest and/or concern where further information is to be reported at a future meeting of the Policy and Performance Board.**

3.0 SUPPORTING INFORMATION

3.1 Directorate Overview reports and associated individual Departmental Quarterly Monitoring reports have been previously circulated via a link on the Members Information Bulletin to allow Members access to the reports as soon as they become available. These reports will also provide Members with an opportunity to give advanced notice of any questions, points raised or requests for further information, to ensure the appropriate Officers are available at the Board Meeting

3.2 The departmental objectives provide a clear statement on what the services are planning to achieve and to show how they contribute to the Council's strategic priorities. Such information is central to the Council's performance management arrangements and the Policy and Performance Board has a key role in monitoring performance and strengthening accountability.

3.3 For 2010/11 direction of travel indicators have also been added where possible, to reflect progress for performance measures compared to the same period last year.

4.0 POLICY IMPLICATIONS

4.1 There are no policy implications associated with this report.

5.0 OTHER IMPLICATIONS

5.1 There are no other implications associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Departmental service objectives and performance measures, both local and national are linked to the delivery of the Council's priorities. The introduction of a Directorate Overview report and the identification of business critical objectives/ milestones and performance indicators will further support organisational improvement.

6.2 Although some objectives link specifically to one priority area, the nature of the cross - cutting activities being reported, means that to a greater or lesser extent a contribution is made to one or more of the Council priorities.

7.0 RISK ANALYSIS

7.1 Not applicable.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Not applicable.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTIONS 100D OF THE LOCAL GOVERNMENT ACT 1972

Document	Place of Inspection	Contact Officer
Not applicable		

Departmental Quarterly Monitoring Report

Directorate:	Adult and Community Directorate
Department:	Prevention and Commissioning Services
Period:	Quarter 4 - 1st January 2011 – 31st March 2011

1.0 Introduction

This monitoring report covers the Prevention and Commissioning Services fourth quarter period up to 31st March 2011. It describes key developments and progress against all objectives and performance indicators for the service.

The way in which symbols have been used to reflect progress is explained within Appendix 7.

2.0 Key Developments

The Advocacy Hub
A draft strategy for implementation of an Advocacy Hub has been completed and is under local consultation.

Adult Placements
A draft service review for the Adult Placement service is being developed and due for completion in April 2011.

Self Directed Support
The Self Directed Support and Resource Allocation policies and procedures have been completed and agreed by the Policy and Performance Board held on 10th January. The documents have been distributed to the operational teams and are available on the intranet. The care management teams are now independently determining the indicative budget of individuals. The self-directed support process including support planning is now embedded in the care management process.

Brokerage Pilot
Halton in conjunction with the Merseyside improvement and efficiency project, St Helens, Liverpool and Knowsley have developed a model to provide support brokerage to individuals receiving an indicative budget across the four authorities. This is an ongoing piece of work and Halton have specifically commissioned Halton Speakout to deliver this locally. The learning will inform future commissioning decisions.

Direct Payments
A training toolkit for Personal Assistants (PA) is now being implemented and includes e-learning via the direct payments team. The Direct Payment Officers will ensure that the toolkit is completed prior to a PA being employed to ensure that the relevant training is routinely offered and undertaken as early as possible.

Social Care in Practice 'SCIP'
The Social Care in Practice project was commissioned by the Runcorn Practice Based Commissioning Consortium in February 2008 and has run as a pilot to February 2011. The project has established formal links between Primary Care and Social Services within Runcorn, to reduce the barriers for health professionals referring people for social care issues, to provide more holistic assessments and enable more joint working. The Practice Based Commissioning Consortium has agreed to this project being extended for a further two years with an additional third year, subject to review. The Contract arrangements are being formally revised and the Social Care staff that are recruited will be co-located with District nurses and Community Matrons within general practices, and work closely with them to deliver services and support to the older practice population.

Six Lives
Further work is still required to ensure progress is maintained in responding to the Ombudsman's Report Six Lives. Work required primarily relates to healthcare services access/reasonable adjustments and Mental Capacity Act and has begun to be progressed through the multi-agency Healthcare for All sub group of the Partnership Board. The Healthcare for All group has an action plan which is reviewed regularly, their representative Commissioner in Health, has written to the NHS trust re Six Lives progress report, which makes specific reference to the DDA and how the trusts intend to take forward the report. Paper copies of Health Passports have been received and the electronic version has been ordered. Training sessions are being carried out at Whiston Hospital within the mandatory safeguarding training. Further in-depth training for staff is being explored with local community learning disability nurses. Whiston has signed up to the 'Getting it right' charter and progress is monitored via the Whiston Pathway group.

Hearing Impairment Service
Following consultation on the development of hearing impairment services a joint Children's and Adults specification has been agreed. A tendering process was undertaken for the provision of hearing impairment services and the contract was awarded to Deafness Resource Centre who will start working with Children's and Adult services from 1st April 2011. The Joint Commissioning Manager for Disabled Adults has also been invited to sit on the PCT Audiology Procurement Group. The staff have now been recruited and the service is operational. They have been successful in securing carers grant funding to establish self-help groups locally.

Housing Strategy
Following confirmation of planning consent and Homes and Communities Agency (HCA) funding, Halton Housing Trust has now commenced construction of an extra care housing scheme on the site of the former Ditton primary school in Liverpool Road. The scheme will comprise 47 two bedroom apartments, 29 of which will be

for rent and 18 for sale or shared ownership.

Supporting People
Efficiencies have been achieved and implemented to meet the reduction in Supporting People budget for 2011/12.

Work has been undertaken with Support Providers to rationalise floating support services and change service delivery which will be implemented from April 2011.

Supporting People contracts have been extended to enable work to continue to identify further efficiencies for 2011/12 which are expected to be achieved from the tendering of short term accommodation services and floating support services. It is anticipated there will be further rationalisation of floating support services.

Voluntary Sector
Executive Board Sub Committee approved waiver of standing orders for contracts to be awarded from April 2011.

Sensory Services

i) PCT led Audiology Procurement Group
Now meeting regularly to relocate some hospital based services into the community. Halton residential care providers appear to be supportive of their staff being trained in re-tubing hearing aids to avoid the need for them to be sent away.

ii) PCT led Low Vision Project
Pathways are fragmented and need to be redesigned in line with the UK Vision Strategy. Clarification of roles and responsibilities of community based support will fill gaps in services whilst avoiding overlap. This may impact on the Visual Rehab Officers in Physical and Sensory Disabilities who along with Commissioning are part of the group undertaking the review.

3.0 Emerging Issues

Resource Directory
The citizen facing portal is still under development. Content pages are being published on Halton's intranet and the Resource Directory is being mapped on the externally hosted Personalisation portal. Quick search links are being approved by Adults and Community senior management. It is now ready to 'go live' and workshops are being held to inform staff and leaflets have being designed for service users to be distributed.

Integrated Assessment Team
There is a strategic approach and continued modelling to look at the development of a generic duty team to be based with and work alongside, the re-ablement team.

They would provide better sign posting, initial assessment and safeguarding, linked closely to the development of Carefirst 6. This now begins to look holistically at the pathways into complex needs services.

The Integrated Adult Learning Disability Teams, Health Team, are working within the GP's surgeries to ensure that the Learning Disability register held by the surgery are up to date and people on the register are invited to attend for their health check, in line with the Directed Enhanced Service (DES). Health promotion workshops for groups of men and women have been carried out within day services. This is intended to be rolled out further.

Housing Strategy
The HCA has published a prospectus setting out the new funding framework for its affordable housing programme 2011/15. The money available (and the amount of grant per unit) is significantly less than in previous spending rounds. HCA expects Housing Associations to fund future developments by using a combination of:

1. Increased rental stream from letting new and a proportion of relet tenancies on the new 'Affordable Rent' terms i.e. rents set at 80% of local market rents rather than social rents.
2. Cross subsidy (utilising surpluses, funds from asset disposals, market sales)
3. Reduced costs through acquisition of public land at below market value, use of New Homes Bonus, S106, procurement efficiencies)
4. HCA funding (minimum needed to secure viability)

Commentators suggest the ability to generate significant additional income from 'Affordable Rents' will favour areas where there is a large differential between existing social rents and market rents e.g. particularly London and the South East. Housing Associations in the North will be more reliant on 2, 3 and 4 above, which represents a real challenge.

Government Response to Professor Mansell Report "Services for adults with profound intellectual and multiple disabilities" February 2011.
The Department will consider how the Council and PCT are addressing the recommendations to ensure people with complex needs are supported to live as independently as possible as inclusive members of society.

ALD Partnership Board 2010/11 Annual Report
A template has now been received which is simplified from last year. The deadline for submission is late July 2011.

4.0 Service Objectives / milestones

4.1 Progress against 'key' objectives / milestones

Total	**5**	✓	5	?	0	✗	0

All 'Key' objectives / milestones have achieved their annual targets. Details are provided within Appendix 1.

4.2 Progress against 'other' objectives / milestones

Total	**20**	✓	18	?	0	✗	0

The majority of 'other' objective indicators have met their annual targets as planned with two exceptions relating to milestones. Financial uncertainty of future budgets has created delays implementing milestones to enable them to be achieved. The Choice Based Lettings Scheme was approved in March 2011 and will go 'live' towards the end of 2011. The Supporting People Gateway has been postponed to align to the implementation of Choice Based Lettings; however, it is still proposed to be introduced in 2011 -12. The Affordable Housing Policy has been deferred to 2012 awaiting approval of the Core Strategy by Government Inspectors. The PCT have agreed not to progress the 'virtual ward' Project and further work is needed to develop an approach to integrated working. Additional details are provided in Appendix 2.

5.0 Performance indicators

5.1 Progress Against 'key' performance indicators

Total	**3**	✓	0	?	0	✗	3

The three 'Key' Indicators cannot be reported on at this time. The commentary can only reflect estimated data as final year figures will not be known until June 2011. Details can be found in Appendix 3.

5.2 Progress Against 'other' performance indicators

Total	**20**	✓	10	?	0	✗	10

Most of the 'other' performance indicators have achieved their annual targets. Of the remaining indicators which did not reach their annual targets two relate to specific services for client groups which have not attained their client capacity (PCS 2 and NI 142); four indicators are estimated as data will not be known until June 2011 (PCS 4 a & b, PCS 6 and NI 135) and Aug/Sept 2011 for NI40. The indicator for OP/ILS clients supported using domiciliary care (PCS 3) has not reached its 10/11 target only marginally by 2% even though the client capacity has increased. The staffing efficiencies delivered in March 2011 has had an impact on the number of relevant staff in Social Care who have received vulnerable adult training (PCS 8), this target will need to be revised for 2011/12. Additional details are provided in Appendix 4.

6.0 Risk Control Measures

During the development of the 2010 -11 Service activity, the service was required to undertake a risk assessment of all Key Service Objectives.

The 'high' risk, treatment measures have been identified in Appendix 5.

7.0 Progress against high priority equality actions

There are no high priority equality actions to report.

8.0 Data quality statement

The author provides assurance that the information contained within this report is accurate and valid and that every effort has been made to avoid the omission of data. Where data has been estimated, sourced externally, or where there are any concerns regarding the limitations of its use this has been clearly annotated.

9.0 Appendices

Appendix 1 Progress Against ‘key’ objectives / milestones

Appendix 2 Progress against ‘other’ objectives / milestones

Appendix 3 Progress against ‘key’ performance indicators

Appendix 4 Progress against ‘other’ performance indicators

Appendix 5 Progress against risk control measures

Appendix 6 Financial Statement

Appendix 7 Explanation of use of symbols

Appendix 1: Progress Against 'key' objectives / milestones

Ref	Objective
PCS 1	Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for the community of Halton.

Milestones	Progress Q 4	Supporting Commentary
Working in partnership with the PCT, ensure appropriate mechanisms are in place to enable the Local Authority to appropriately commission services for people with learning disabilities (AOF 6 & 7)	✓	Transfer of funding from the PCT to the Local Authority has been agreed and signed off.
Contribute to the safeguarding of vulnerable adults and children in need, by ensuring that staff are familiar with and follow safeguarding processes **Mar 2011.** (AOF6)	✓	The inspection for Adult Safeguarding judged the service to be excellent, whilst the inspection for Children's safeguarding was judged to be good with outstanding features. Training will continue to be delivered in both areas. Building on the positive result of the Adult Safeguarding Inspection, a safeguarding unit is being established with a dedicated staff group.
Continue to establish effective arrangements across the whole of adult social care to deliver self directed support and personal budgets **Mar 2011** (AOF6)	✓	Since October 2010 all new people accessing assessment and care management services have been subject to the self directed support process. This has allowed us to refine the system and make adjustments to the processes, which are monitored on an ongoing basis. The staff involved have now gained expertise in developing support plans with service users. This has improved people's experience of SDS and improved and extended the numbers of support plans.

Appendix 1: Progress Against 'key' objectives / milestones

Ref	Objective
PCS 2	Effectively consult and engage with the community of Halton to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-design of services where required

Milestones	Progress Q 4	Supporting Commentary
Continue to support the development of the LINks to ensure it provides an effective mechanism for community engagement **Mar 2011** (AOF 32)	✓	LINks continues to provide workshops on areas important to the community which informs commissioning strategies.
Continue to negotiate with housing providers & partners in relation to the provision of further extra care housing tenancies, to ensure requirements are met (including the submission of appropriate funding bids) **Mar 2011.** (AOF6 & 7)	✓	In addition to the progress highlighted at section 2.0 of this report, Officers have been in discussion with Housing Associations during February, March and April to ensure proposals for further extra care housing schemes are included in the 'bids' being developed by the Associations to access funds from the 2011-15 HCA programme.

Appendix 2: Progress Against 'other' objectives / milestones

Ref	Objective
PCS 1	Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for the community of Halton.

Milestones	Progress Q 4	Supporting Commentary
Analyse the impact of Valuing People Now on service delivery to ensure that services meet the needs and improve outcomes for people with Learning Disabilities ***Mar 2011*** *(AOF 6 & 7)*	✓	A further annual plan will be developed in partnership with the People's Cabinet in April, ensuring the continuation of the good work undertaken this year. The Adult Learning Disability Board is now a well established Partnership Board and an associate of the Peoples Cabinet. The Partnership Board Annual Plan will be produced by July 2011 and a Business Plan will be developed in line with this.
Revise and strengthen the Transition Strategy and associated working practices/protocols, to ensure they are 'fit for purpose' ***Mar 2011.*** *(AOF 6)*	✓	The completed strategy has been refreshed and is now on the Halton Borough Council website. In line with the Transition Strategy Action Plan, the practices and protocols are in the process of being revised and a working group is underway.
Continue to implement, monitor and review the rollout of the Single Assessment Process. ***Mar 2011*** *(AOF 6 & 7)*	✓	The roll out of the Single Assessment Process will be delivered in cohesion with the Self-Directed Support Process. SAP principals to be adapted.
Introduce Supporting People 'Gateway' or single point of access service ***Mar 2011*** *(AOF 6, 30 and 31)*	Refer to comment	The SP Gateway has been postponed to align to the implementation of Choice Based Lettings. It is still proposed to introduce the SP Gateway in 2011/12 to link into Choice Based Lettings and the Housing Solutions Service.

Appendix 2: Progress Against 'other' objectives / milestones

Ref	Objective		
PCS 1	Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for the community of Halton.		
Revise and update the Supporting People Plan to ensure effective services are in place (AOF 6) ***Sept 2010***		✓	As it was anticipated the Comprehensive Spending Review in October would result in reductions in SP grant allocation it was not appropriate to revise & update the SP plan prior to that date and therefore the target date of September could not be achieved. Proposals for changes to services were presented to SP Commissioning Body in September 2010 and January 2011 which have been implemented from April 2011 and achieved the required efficiencies.
Work with the Council's Planning Department to introduce an affordable housing policy within the Local Development Framework ***Mar 2011*** *(AOF 11)*		✓	The position remains as reported in previous quarters in that an affordable housing policy has now been incorporated in the Halton Core Strategy Proposed Submission Draft approved for consultation by Board on the 18th November 2010. A site viability study has also been completed to provide evidence to justify the policy's requirements. The policy will be implemented after approval of the Core Strategy by Government inspectors, probably in 2012.
Implement and deliver the objectives outlined in the Homelessness and Housing Strategies and Repossessions Action Plan ***Mar 2011*** *(AOF 6 & 30)*		✓	Good progress made against each plan. Significant increase in the prevention of homelessness.
Deliver against the government target to reduce by half (by 2010) the use of temporary accommodation to house homeless households ***Mar 2011*** *(AOF 6, 30 and 31)*		✓	Achieved the target set for the reduction in units of temporary accommodation.
Maintain the number of carers receiving a carer's break, to ensure Carers need are met ***Mar 2011.*** *(AOF7)*		✓	There are Carers assessors based within the care management teams who have a dedicated focus on carers and ensure the teams maintain their targets for the number of carers receiving breaks.
Continue to monitor activity of the joint 'SCIP' service developed with Runcorn PBC, to ensure services are		✓	A report was submitted to the PPB in Jan 11 with an evaluation of SCIP. A contract is now being developed and recruitment of staff with

Appendix 2: Progress Against 'other' objectives / milestones

effectively delivered ***Mar 2011.*** *(AOF2 & 4)*		agreement for funding of the project for a further two years.

Ref	Objective
PCS 1	Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for the community of Halton.

Milestones	Progress Q 4	Supporting Commentary
Continue to monitor activity of the 'Virtual Ward' established with Widnes PBC, to ensure services are effectively delivered ***Mar 2011.*** *(AOF 2 & 4)*	✓	PCT have agreed not to progress with this project. Further work is required to develop an approach to integrated working.
Introduce a Choice Based Lettings scheme to improve choice for those on the Housing Register seeking accommodation ***Dec 2010*** *(AOF11and 30.)*	✓	The draft housing allocations scheme was approved by Executive Board on 3rd March 2011 and has similarly been agreed by the Cabinets of the other participating Councils. It is intended to enter into contract with the ICT supplier during April, with the scheme going live toward the end of 2011.

Appendix 2: Progress Against 'other' objectives / milestones

Ref	Objective
PCS 2	Effectively consult and engage with the community of Halton to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-design of services where required

Milestones	Progress Q 4	Supporting Commentary
Continue to support the development of the People's Cabinet in order for it to effectively contribute to the shaping and influencing of strategy and policy ***Mar 2011*** *(AOF6 & 32)*	✓	Fully established and Exec Board sub committee have approved award of contract to March 2012 with possibility of further extension to 2013 subject to funding. Access to and development of networks for Ministers is being explored so they can canvass and represent views of the wider learning disability community.
Update Joint Strategic Needs Assessment (JSNA) - full data document, following community consultation, to ensure it continues to effectively highlight the health & wellbeing needs of people of Halton ***Mar 2011*** *(AOF 6)*	Refer to comment	JSNA Chapters completed and reviewed by JSNA Working group Feb 2011. JSNA update presented to Adult and Community SMT and Children and Young People's SMT Feb 2011 as scheduled. Minor adjustments being made as a result of feedback. Deadline for publication pushed back from April 2011 to June 2011 due to the report date for presentation to Health PPB and Children's Trust Executive Board.

Appendix 2: Progress Against 'other' objectives / milestones

Ref	Objective
PCS 3	Ensure that there are effective business processes and services in place to enable the Directorate to manage, procure and deliver high quality, value for money services that meet people's needs

Milestones	Progress Q 4	Supporting Commentary
Review existing Direct Payment arrangements to ensure alignment with the personalisation agenda ***May 2010*** *(AOF 34)*	✓	A User Experience Survey is currently being undertaken and the information obtained will be analysed and the results will inform future action planning for the service.
Implement and monitor the preliminary RAS model and explore impact on related systems ***Mar 2011*** *(AOF 34)*	✓	It is intended that during 2011 an electronic version of the Self Assessment Questionnaire (SAQ) will be made available. This is currently being developed by the Social Care IT Development Team. Once this is in place the electronic SAQ will be linked to the indicative budget calculation tool, and therefore the completion of the SAQ will automatically provide an indicative budget calculation. It is also anticipated that Care Financials will be implemented during 2011. When this is fully implemented operational teams will be able to input support plans into Carefirst 6, and the use of virtual budgets can be monitored against the support plans.
Implement the revised Older People's Commissioning Strategy, to ensure services are effectively commissioned for Older People ***Mar 2011.*** *(AOF6 & 7)*	✓	The implementation plan for the Older People's Commissioning Strategy is managed through the Older People's Local Implementation Team. This currently oversees a range of commissioning priorities including the development of Advocacy, carers respite, extra care housing and low-level prevention services. Progress towards the specific targets within the strategy are currently on target and have recently been submitted to the Halton Policy and Performance Board as part of the Older People's Local Implementation Team Annual Review.

Appendix 2: Progress Against 'other' objectives / milestones

Ref	Objective
PCS 3	Ensure that there are effective business processes and services in place to enable the Directorate to manage, procure and deliver high quality, value for money services that meet people's needs

Milestones	Progress Q 4	Supporting Commentary
Review and revise the Joint Carers Commissioning Strategy, to ensure that Carers needs within Halton continue to be met ***Mar 2011.*** *(AOF 7)*	✓	The revised Strategy was approved at SMT on 29.9.10 and approved at the HPPB on 9.11.10. Due to the Carers Grant ending on 31st March a consultation event for Carers was organised 13.12.2010 to inform and influence decisions around the commissioning of services for Carers in 2011 – 2012.
Undertake ongoing review and development of all commissioning strategies and associated partnership structures to enhance service delivery and cost effectiveness ***Mar 2011.*** *(AOF 35)*	✓	A review is underway to consider options for Local Authority Commissioning arrangements, taking into account recent government policy on GP Commissioning and the transfer of responsibilities for Public Health.
Review and deliver SP/Contracts procurement targets for 2010/11, to enhance service delivery and cost effectiveness ***Mar 2011****. (AOF35)*	✓	SP targets have been reviewed in line with Comprehensive Spending review funding cuts to ensure good quality, cost effective services continue to be delivered to meet the needs of the people of Halton. Efficiencies have been identified and implemented from April 2011.

Appendix 3: Progress Against 'key' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
Service Delivery							
PCS15	% of VAA Assessments completed within 28 days	69%	75%	70.75%E			Figure provided is an estimated figure as final year end figure will not be available until June 2011.
NI 136	People Supported to live independently through Social Care Services	3297	3350	3010E			Figure provided is an estimated figure as final year end figure will not be available until June 2011.
NI 130	Social Care Clients receiving self directed support (DP's/Individualised Budgets)	16.8%	30%	27%E			Figure provided is an estimated figure as final year end figure will not be available until June 2011, for all client groups. Increases in the office of National statistics (ONS) estimated population figures for Halton have lead to a reduction in the overall rate reported. Therefore, even if performance remains static, the overall performance indicator outturn will result in a reduction.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
Cost & Efficiency							
PCS 1	% of client group expenditure (ALD) spent on domiciliary care services (Previously AWA LI2)	33%	37%	38%	✓	↑	The percentage of ALD clients supported using domiciliary care has increased compared to last year.
PCS 2	% of client group expenditure (PSD) spent on domiciliary care services (Previously AWA LI3)	28%	28%	23%	✗	↓	The percentage of PSD clients supported using domiciliary care has decreased compared to last year.
PCS 3	% of client group expenditure (OP/ILS) spent on domiciliary care services (Previously OP LI2/ EN 2) **N.B PCS 3 as was has become PCS 13(b) below**	24%	28%	26%	✗	↑	The percentage of OP/ILS clients supported using domiciliary care has increased compared to last year.
PCS 15	% of client group expenditure (MH) spent on domiciliary care services (Previously AWA LI1/ CCS 1)	24%	28%	29%	✓	↑	The percentage of MH clients supported using domiciliary care has increased compared to last year.
Fair Access							
PCS 4(a)	Percentage of adults assessed in year where ethnicity is not stated Key threshold <10% (Previously AWA LI4 & OP LPi5)	0.27	0.5	1.03E	✗	↓	Figure provided is an estimated figure as final year end figure will not be available until June 2011. Direction of travel is based on the estimated figure provided for 2009/10 and not the actual.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
PCS 4(b)	Ethnicity of Older People receiving assessment (Previously OP LI4/ EN 4)	0.36	1.5	0.57E	✗	↓	Figure provided is an estimated figure as final year end figure will not be available until June 2011. Direction of travel is based on the estimated figure provided for 2009/10 and not the actual.
Quality							
PCS 5	Percentage of people receiving a statement of their needs and how they will be met (Previously AWA LI8 & OPLI6)	99.65	99	99.07E	✓	↓	Figure provided is an estimated figure as final year end figure will not be available until June 2011. Direction of travel is based on the estimated figure provided for 2009/10 and not the actual.
PCS 6	Clients receiving a review as a % of adult clients receiving a service (Previously AWA LI9 & OP LI7)	82.40	80	77.11E	✗	↓	Figure provided is an estimated figure as final year end figure will not be available until June 2011. Direction of travel is based on the estimated figure provided for 2009/10 and not the actual.
Service Delivery							
PCS 7	Admissions of Supported Residents aged 18-64 into residential/nursing care (Previously AWA LI10)	0.27	0.4	0.13E	✓	↑	Figure provided is an estimated figure as final year end figure will not be available until June 2011. Direction of travel is based on the estimated figure provided for 2009/10 and not the actual.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
NI 135	Carers receiving Needs Assessment or Review and a specific Carer's Service, or advice and information	26.10	25	23.23E			Figure provided is an estimated figure as final year end figure will not be available until June 2011. Direction of travel is based on the estimated figure provided for 2009/10 and not the actual.
PCS 8	No. of relevant staff in adult SC who have received training (as at 31 March) addressing work with adults whose circumstances make them vulnerable (Previously HP LI2)	475	475	445			A new staff list has been received which has identified a reduction in staff from 497 to 459. Therefore, it is impossible to reach the target of 475. A new target figure will be agreed for 2011/12.
PCS 9	% of relevant adult social care staff in post who have had training (as at 31 March) to identify and assess risks to adults whose circumstances make them vulnerable (Previously HP LI3)	84%	84%	92%			Working closely with operational services staff will be allocated specific training dates to ensure meeting target.
PCS 10	Estimate % of relevant staff employed by independent sector registered care services that have had training on protection of adults whose circumstances make them vulnerable (Previously HP LI 4)	86%	86%	94%			809 Ind. Sector Staff attended training and 138 attended Facilitators/Train the Trainer Training, therefore, assuming that each facilitator trained **3** members of their team that gives a total of 1,223. Assuming a 20% turnover on the staff trained (978) the calculated percentage is 94% from a grand staffing total of 1035.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
PCS 11	Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in the Borough). (Previously HP LI 5)	6.3	4.2	5.5	✓	↑	There is great emphasis placed upon Prevention. The housing solutions team are more community focused and now take a proactive and holistic approach towards tackling homelessness. There has been a vast increase in the prevention outcomes achieved, resulting in more prevention options available to clients and a positive decrease in homelessness.
PCS 12	The proportion of households accepted as statutorily homeless who were accepted as statutorily homeless by the same LA within the last 2 years (Previously HP LI 6)	1.27	1.2	0	✓	↑	The team are community focused and work proactively with external agencies to ensure that the required support plans are in place to assist and empower clients to sustain tenancies, thus reduce repeat homeless presentations.
NI 156	Number of households living in Temporary Accommodation	23	14	4	✓	↑	The changes in service and prevention activity has had a positive impact upon the Temporary accommodation Provision. The service has successfully met and over achieved the initial target of 17 units set by DCLG.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
NI 141	Number of Vulnerable people achieving independent living	82.4%	80%	82.39%			Overall performance has exceeded the target set and has improved again from Quarter 3. The two services failing to meet the target in Quarter 3 have improved their performance; however a further two services have achieved 70.59% and 63.64% respectively. Performance will continue to be monitored and visits undertaken to the services under-performing.
NI 142	Number of vulnerable people who are supported to maintain Independent Living	98.95%	99.04%	98.33%			Overall performance is close to target for 2010/11. The floating support services will continue to be monitored and meetings held on a quarterly basis to ensure performance increases to meet the targets set.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
Area Partner National Indicators: The indicators below form part of the new National Indicator Set introduced on 1st April 2008. Responsibility for setting the target, and reporting performance data, will sit with one or more local partners. As data sharing protocols are developed, baseline information and targets will be added to this section.							
NI 32	Repeat incidents of domestic violence	22%	27%	29%			The number of cases presented to MARAC (the Multi Agency Risk Assessment Conference) during the preceding 12 months has continued to decline from 178 in March 2010 to 138 in March 2011. The majority of cases continue to be referred by the Police (119), the Primary Care Trust (7) and Mental Health Teams (5) with numbers being referred by other agencies being low. Whilst the total number of cases referred during the year has fallen from 239 in 2009 – 10 the number of repeat cases has remained relatively static. Additionally the average number of children per case discusses has also remained relatively static at 1.28 (2010 – 11) as compared to 1.29 in (2009 – 10). This situation is reflective of

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
							the national picture in relation to child representation. Of the 138 cases supported through MARAC during 2010 – 11 there have been 101 children aged 0 – 5; 177 children 0 – 18; 15 pregnant women and I vulnerable adult.
NI 40	Drug users in effective treatment	486	529 The NTA has issued revised targets 10/11 (515).	456 (month 8)			Latest data available is for month 8 (November 2010). In month 8 Halton at 456 is 16 below the expected figure of 472 for the same quarter last year. Final end of year figure is expected in august/ September. NI140 is reported 3 months in arrears to allow for the full counting of numbers of people in treatment for more than 12 weeks. Drug treatment services continue to focus on achieving a high number of planned exits and maintaining prompt access to services. There is also a current focus on improving the numbers of people being vaccinated for hepatitis B or screened for hepatitis C and having a

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
							physical health check. Service users and carer involvement continues to develop, seen particularly in the increased number of posting to the Patient Opinion website, and the development of a volunteers & mentors group that is in the early stages of development.

Appendix 5: Risk Control Measures

Ref	Risk Identified	Treatment Measure	Progress	Supporting Commentary
PCS 1	Adult Safeguarding: the council will be subject to a safeguarding inspection (date to be specified). The outcome of the inspection will impact on council performance 2010/2011	Inspection preparation through: multi- agency inspection group, sub groups, temporary additional capacity to support preparation	✓	Completed. Halton judged to be excellent
	Working with the PCT to ensure there are good mechanisms in place to commission appropriate services for people with learning disabilities, failure to do this will result in severe budget pressure	Close working with Finance Dept and colleagues in the PCT to agree future budget	✓	Transfer of funding from PCT to the council agreed
	Housing repossessions: Halton has been identified as a hot spot for repossessions. Failure to reduce will have a negative impact on Haltons CAA.	Housing Solutions Team to work with key partners including: Lenders, Courts, Welfare Benefits & CAB, RSL's, to develop and action a robust action plan to significantly reduce the number of repossessions across Halton.	✓	A robust action plan was developed and implemented February 2010. The objective aim is to improve partnership working with Lenders, courts, Welfare Benefits, CAB and other relevant agencies, in order to reduce the level of repossessions within the district. HBC appointed a designated officer to work directly with homeowners and tenants, in order to reduce repossessions within the district. To date the mortgage rescue scheme has proven highly successful, resulting in a number of repossession orders reversed and with the help of the prevention fund, the majority of lenders are now working closely with the authority.

Appendix 6 Financial Statement

The Department's Quarter 4 Financial Statement will be prepared once the Council's year-end accounts have been finalised and will then be made available via the intranet by 30th June.

Appendix 7 Explanation of Symbols

Symbols are used in the following manner:

Progress		Objective	*Performance Indicator*
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	*Indicates that the annual target is on course to be achieved.*
Amber		Indicates that it is uncertain or too early to say at this stage, whether the milestone/objective will be achieved within the appropriate timeframe.	*Indicates that it is uncertain or too early to say at this stage whether the annual target is on course to be achieved.*
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	*Indicates that the target will not be achieved unless there is an intervention or remedial action taken.*

Direction of Travel Indicator

Where possible performance measures will also identify a direction of travel using the following convention

Green		*Indicates that* **performance is better** *as compared to the same period last year.*
Amber		*Indicates that* **performance is the same** *as compared to the same period last year.*
Red		*Indicates that* **performance is worse** *as compared to the same period last year.*
N/A		*Indicates that the measure cannot be compared to the same period last year.*

Departmental Quarterly Monitoring Report

Directorate:	Adult and Community Directorate
Department:	Complex Care Services
Period:	Quarter 4 - 1st January 2011 – 31st March 2011

1.0 Introduction

This quarterly monitoring report covers the Complex Care Services fourth quarter period up to 31st March 2011. It describes key developments and progress against all objectives and performance indicators for the service.

The way in which symbols have been used to reflect progress is explained within Appendix 6.

2.0 Key Developments

Review of Community Mental Health Services
The 5BoroughsPartnership have for some time been conducting a review of their community mental health services, prompted in part by a change in commissioning intentions by the PCT, and partly because of a need to rationalise approaches across the Trust footprint. A high-level model has been developed, with input from Local Authority partners, and this model has been agreed by the Trust Board. Some redesign of services has already taken place outside the scope of the review – the Assertive Outreach Team is to be disbanded from June 2011 and the functions of that team will be absorbed by the Community Mental Health Teams. Further detail on the proposals by the 5Boroughs to redesign community teams is to be delivered in April 2011.

Personalisation
The target for achieving 30% of service users and carers who receive self-directed support in mental health services has been achieved. This remains a challenge for future delivery, partly because delivery itself depends on the commitment of partners in the health services, and partly because processes and systems are cumbersome and need to be rationalised.

Mental Capacity Act/Deprivation of Liberty Safeguards
A new IMCA service has been commissioned across the four boroughs of Halton, Warrington, St Helens and Knowsley, and responsibility for managing this contract currently lies within the Halton commissioning services. A formal Section 75 agreement has been put in place between Halton and St Helens Councils and the PCT to cover the work of the Mental Capacity Act Co-ordinator, and a memorandum of understanding is in place to allow Best Interests Assessors to work across the organisations as required. These agreements will need to be re-negotiated in the light of the changes within the PCT. The Training plan for 2011 has been identified and a new programme of e-learning can be accessed through the Council's website. All relevant front line staff in the Directorate are being required to undertake this training, as one of the recommendations from a recent serious case review.

Older People's Mental Health Services
The 5Boroughs have continued to lead a project to deliver the Assessment, Care and Treatment service for people with dementia, which is to be delivered across Halton and St Helens. At this stage, this project appears to be unable to deliver fully against the original specification, with only core elements of assessment and diagnosis to be delivered in the first phase, mainly through redesign of the existing day hospital services. Discussions are continuing about potential amendments to the specification and how to use existing financial commitments. The 5Boroughs is also undertaking a review of the operation of the Older People's Community Mental Health Teams across St Helens and Halton, and the Directorate is now involved in this review.

3.0 Emerging Issues

New referral sources
The delay in the provision by the 5Boroughs of firm proposals for a new structure for community mental health services means that no action has yet been taken to redesign social care services to take account of other referral sources and operational pressures. It is expected that this will now take place in 2011, Quarter 1, once the 5Boroughs plans have become clearer.

National Mental Health Strategy
The new national mental health strategy, "No health without mental health" has now been published by the government, along with specific guidance on the intended outcomes of the strategy. This is to be reported to the management team in Quarter 1 2011.

Deprivation of Liberty Safeguards
Recent case law decisions continue to be considered for their impact on local services. Further work will be done on this in Quarter 1 2011.

Autistic Spectrum Conditions
A multiagency steering group is in place to deliver the aims of the local strategy.

4.0 Service Objectives / milestones

4.1 Progress against 'key' objectives / milestones

Total	**3**	✓	3	?	0	✗	0

All 'Key' Objectives/milestones have achieved their annual targets. Details are provided within Appendix 1.

4.2 Progress against 'other' objectives / milestones

Total	**11**	✓	9	?	0	✗	2

Nine of the 'other' objective indicators have met their annual targets as planned with two exceptions relating to milestones. Implementation of the Local Affordable Warmth Strategy has been delayed due to the departure of the Principal Housing Officer; and the review of policies, procedures/pathways within the HHILLS Service will be reviewed once processes and policies have been completed. Additional details are provided in Appendix 2.

5.0 Performance indicators

5.1 Progress Against 'key' performance indicators

Total	**3**	✓	2	?	0	✗	0

One Key objective has met its target. One indicator is not reportable until 2011/12 (NI 127), as further clarification on the indicator definition is to be provided from NHS Information Centre. One indicator is estimated and the actual outturn figure is expected to be available in June 2011. Details are provided within Appendix 3.

5.2 Progress Against 'other' performance indicators

Total	**19**	✓	8	?	0	✗	8

Eight 'other' Performance Indicators have met their annual targets as planned. Two indicators cannot be reported at this time as they were expected to be reported via the place Survey. One indicator (NI 146) is undetermined as a target was not set, even though direction of travel indicates improvement in performance. Several indicators are reported as estimated. It is expected that the actual outturns for these indicators will become available during Q1, 2011. Additional details are provided in Appendix 4.

6.0 Risk Control Measures

No 'high' priority risk control measures have been identified.

7.0 Progress against high priority equality actions

There are no high priority equality actions to report.

8.0 Data quality statement

The author provides assurance that the information contained within this report is accurate and valid and that every effort has been made to avoid the omission of data. Where data has been estimated, has been sourced directly from partner or other agencies, or where there are any concerns regarding the limitations of its use this has been clearly annotated.

9.0 Appendices

Appendix 1 Progress Against ‘key’ objectives / milestones
Appendix 2 Progress against ‘other’ objectives / milestones
Appendix 3 Progress against ‘key’ performance indicators
Appendix 4 Progress against ‘other’ performance indicators
Appendix 5 Financial Statement
Appendix 6 Explanation of use of symbols

Appendix 1: Progress Against 'key' objectives / milestones

Ref	Objective
CCS 1	Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for people with Complex Care needs

Milestones	Progress Q 4	Supporting Commentary
Implement the Local Dementia Strategy, to ensure effective services are in place **Mar 2011.** (AOF6 & 7)	✓	Dementia project plan for implementation now complete, service pathway mapping is complete and stage two is the redesign of existing services that will take place over the next six months. Redesign will take place within the existing Community Mental Health Team and 5 Boroughs Partnership. It is anticipated that the first elements of redesigned pathway will be implemented by July 2011.

Ref	Objective
CCS 2	Effectively consult and engage with people who have Complex Care needs to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-design of services where required

Milestones	Progress Q 4	Supporting Commentary
Continue to survey and quality test service user and carers experience of services to evaluate service delivery to ensure that they are receiving the appropriate outcomes **Mar 2011** (AOF 32)	✓	Between January and March 2011, the new Adult Social Care Survey was distributed to a sample of 700 Adult Social Care Service users. The survey is to be conducted on an annual basis, from which outcomes based performance indicators will be derived for the new Adult Social Care Outcomes Framework which will be introduced in April 2011. The results of the survey will be reported to Community Directorate Senior Management Team in Q1, 2011.

Appendix 1: Progress Against 'key' objectives / milestones

Ref	Objective
CCS 3	Ensure that there are effective business processes and services in place to enable the Directorate to manage, procure and deliver high quality, value for money services that meet people's needs

Milestones	Progress Q 4	Supporting Commentary
Consider with our PCT partners the recommendations and implications of the review of Halton's section 75 agreement **Mar 2011** (AOF 33,34 and 35)		Programme now aligned to form part of the Local Government NHS White Paper.

Appendix 2: Progress Against 'other' objectives / milestones

Ref	Objective
CCS 1	Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for people with Complex Care needs

Milestones	Progress Q 4	Supporting Commentary
Monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder **Mar 2011.** (AOF 6)	✓	Autism strategy completed.
Consider implications of Autism Act 2009 and review working practices to ensure they are 'fit for purpose' **Mar 2011.** (AOF 7)	✓	New post created to support improved practice.
Contribute to the implementation of the Council wide Volunteering Strategy as a means to improving services to communities **Mar 2011** (AOF 21)	✓	Policy completed and due to be implemented July 2011.
Review policies/procedures/pathways within the HHILLS Service to ensure they are 'fit for purpose' **Mar 2011.** (AOF6 & 7)	✗	Most administrative procedures have been captured but more work is required. We are almost complete on capturing the major adaptation process - once complete we will then review them to ensure they are 'fit for purpose', 2 years on from the amalgamation of the team. The equipment policy is almost complete. The Blue Badge provision is still under review due to Government changes.
Implement the Local Affordable Warmth Strategy, in order to reduce fuel poverty and health inequalities **Mar 2011.** (AOF 7)	✗	Work to implement the Affordable Warmth Strategy has begun. A training programme is in the process of being developed. The programme will help to raise the awareness of front line staff to ensure that they are able to spot the triggers of fuel poverty and refer clients to the relevant agencies who can provide advice and practical help to heat and maximise their incomes. Plans are also in place to

Appendix 2: Progress Against 'other' objectives / milestones

		develop a comprehensive marketing campaign to help maximise uptake of available measures such as Warm Front and its successor Green Deal.
Implement the redesign of the Supported Housing Network to ensure that it is meeting the needs of those with the most complex needs **Mar 2011.** (AOF6 & 7)	✓	Preliminary work completed.

Ref	Objective
CCS 1	Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for people with Complex Care needs

Continue to develop the Single Point of Access to ensure that it delivers an effective mechanism for access into Services **Mar 2011.** (AOF 6 & 7)	✓	The Single Point of Access for mental health services is in place across Halton and St Helens and is fully staffed. The role and function of the social work service – which only covers Halton – will be reviewed in Quarter 1 2011.
Continue to ensure there is a wide choice of pathways into volunteering opportunities to meet the needs of people with a Learning Disability **Mar 2011.** (AOF 6 & 21)	✓	The Bridge Building Team continues to provide access to a wide range of volunteering opportunities for people with a learning disability and has successfully placed over 40 people in 2010-11. The range and scope of future volunteering opportunities will be enhanced in 2011-12 by the merging of the team with the Sure Start service, providing a combined volunteering approach to all service user groups.
Implement the recommendations following the Challenging Behaviour review/project to ensure services meet the needs of service users **Mar 2011** (AOF 6 & 7)	✓	Positive Behaviour Support Service established with funding from Halton and St. Helens PCT, Knowsley B.C. and St. Helens Council.

Appendix 2: Progress Against 'other' objectives / milestones

Ref	Objective
CCS 2	Effectively consult and engage with people who have Complex Care needs to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-design of services where required

Milestones	Progress Q 4	Supporting Commentary
Continue to implement a behaviour solutions approach to develop quality services for adults with challenging behaviour - Models of good practice to continue to be developed **Mar 2011.** (AOF7)	✓	Behaviour analytical work commenced with both adults and children. Clear evidence of improved outcomes.

Ref	Objective
CCS 3	Ensure that there are effective business processes and services in place to enable the Directorate to manage, procure and deliver high quality, value for money services that meet people's needs

Milestones	Progress Q 4	Supporting Commentary
Following the publication of the new national guidance on complaints, review, develop, agree and implement a joint complaints policy and procedure to ensure a consistent and holistic approach **Nov 2010** (AOF 33)	✓	Policy Revised. Joint working continuing with St Helen's Council and local Health providers.

Appendix 3: Progress Against 'key' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
Quality							
NI 127	Self reported experience of Social Care Users	76.75	N/A	Refer to comment	N/A	N/A	The NHS Information Centre is currently developing a new methodology for this indicator, in view of which this PI may not be reportable until 2011/12.
Service Delivery							
NI 145	Adults with Learning Disabilities in Settled accommodation	81.99%	90%	92%	✓	↑	Target achieved. Performance is improving from last year.
CSS 8	Adults with mental health problems helped to live at home (Previously AWA LI13)	3.93	3.5	3.88E	✓	↓	An estimated year end is stated above as final year end figure will not be available until June 2011. Although the estimated figure has exceeded its target it is marginally lower than 2009/10.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
Fair Access							
CCS 2	Number of learning disabled people helped into voluntary work in the year (Previously AWA LI5)	56	43	73E	✓	↑	Figure provided is an estimated figure as final year end figure will not be available until June 2011. Direction of travel is based on the estimated figure provided for 2009/10 and not the actual.
CCS 3	Number of physically disabled people helped into voluntary work in the year (Previously AWA LI6)	11	5	8E	✓	↓	Figure provided is an estimated figure as final year end figure will not be available until June 2011. Direction of travel is based on the estimated figure provided for 2009/10 and not the actual.
CCS 4	Number of adults with mental health problems helped into voluntary work in the year (Previously AWA LI7)	17	17	25E	✓	↑	Figure provided is an estimated figure as final year end figure will not be available until June 2011. Direction of travel is based on the estimated figure provided for 2009/10 and not the actual.
Quality							
CCS 5	% of items of equipment and adaptations delivered within 7 working days (Previously OP LI9)	91.24	93.0	97.96	✓	↑	Performance for equipment and adaptations has exceeded target and has also improved on 2009/10 performance. Performance against minor adaptations has led to improvement against this indicator.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
Service Delivery							
CCS 6	Adults with physical disabilities helped to live at home (Previously AWA LI11) Rate per 1000 population	8.15	8.00	7.95E			Figure provided is an estimated figure as final year end figure will not be available until June 2011. Direction of travel is based on the estimated figure provided for 2009/10 and not the actual.
CCS 7	Adults with learning disabilities helped to live at home (Previously AWA LI12) Rate per 1000 population	4.24	4.30	4.28E			Figure provided is an estimated figure as final year end figure will not be available until June 2011. Direction of travel is based on the estimated figure provided for 2009/10 and not the actual.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
Area Partner National Indicators: The indicators below form part of the new National Indicator Set introduced on 1st April 2008. Responsibility for setting the target, and reporting performance data, will sit with one or more local partners. As data sharing protocols are developed, baseline information and targets will be added to this section.							
NI 146	Adults with learning disabilities in employment	9.14%	N/A	10.68E	N/A		Figure provided is an estimated figure as final year end figure will not be known until June 2011. Direction of travel is based on the actual for 2009/10.
NI 149	Adults in contact with secondary mental health services in settled accommodation	89.3	90	92.8%			At 28th February 2011 Mental Health Services in Halton continue to achieve a high rate of people in settled accommodation. This stands at 92.8%, higher than any of the other areas within the 5Boroughs.
NI 150	Adults in contact with secondary mental health services in employment	N/A	12%	13.3%			At 28th February 2011 This figure stands in January 2011 at 13.4% and is again higher than any of the other areas within the 5Boroughs. This figure had increased from 10.6% in July 2010.
NI 39	Hospital Admissions for Alcohol related harm	2548.6 estimated	2309	2524			Q3 data has been updated. Q4 full data is not yet available and the cumulative figure to the end of February has been used as a proxy.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
NI 119	Self-reported measure of people's overall health and well-being (as being good or very good)	72.8%	N/A	Refer to comment	N/A	N/A	There is no Place Survey in 2010 given a recent Ministerial Announcement. Due to this announcement we will not be reporting these measures for the rest of the year. Consideration will be given to whether there is need for a slimmer local survey in 2011 following clarification of the government's reporting requirements (April 2011) and our own performance management needs.
NI 120	All-age all cause mortality rate per 100,000 population.	Male: 803.8 Estimated Female: 597.3 Estimated	Male: 755 Female: 574	Male 879.3 Female 582.8	 	 	Q3 figures have been updated. February figure used as a proxy for Q4 as March data has not yet been released. Targets for mortality are based on calendar year data and not financial year. Therefore data is unverified mortality rate for calendar year 2010. Based on Q3 data both Male and Female Mortality is above the 2010 targets for all age all cause mortality. Male mortality appears to have increased from verified 2009 data where the rate was 838.09 (an increase in 3 deaths). Female mortality however has continued to

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
							decrease but not enough to hit the 2010 target. Year end 2009 verified data showed a rate of 595.12 by year end 2010 this had reduced to 586.5 (unverified data) To hit year end 2011 rates male mortality would need to reduce to 731 per 100,000 (DSR) and females mortality to 558 per 100,000. There would need to be a substantial improvement in death rates to come near to meeting these targets by the end of 2011.
NI 121	Mortality rate from all circulatory diseases at ages under 75	88.8 Estimated	78.31	96.8			Q3 figure has been updated. February figure has been used as a proxy for Q4 as February data has not yet been released. There has been a marginal decrease in mortality due to circulatory diseases since April. We continue to examine the data to understand the causes of deaths, the age and where these deaths have occurred to enable better targeting of current programmes in place. This means the Circulatory Disease's in Halton are unlikely to hit the PCT calendar year end target of 78.31.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
NI 122	Mortality from all cancers at ages under 75	166.8 Estimated	126.41	149.5			Q3 figure has been updated. February figure has been used as a proxy for Q4 as February data has not yet been released. It is very important to note that these figures are provisional, and that Q4 is based on provisional monthly mortality data to February only. We do not yet hold confirmed figures for 2010 The performance data quoted above are not actually events: they are Directly Standardised Mortality Rates. They represent about 200 cancer deaths per year under age 75. About half of cancer deaths occur under 75.
NI 123	16+ current smoking rate prevalence – rate of quitters per 100,000 population	888 Estimated	1128	879.12			Data is a snapshot as of April 1st 2011 and is not the complete year end data. All previous data has been updated. Data is a snapshot as of 1st April 2011 and will need to be updated when full data is available; October to February data has been updated and are all above target where the preferred outcome is higher. The Stop smoking service is very close to the March target and figures are still being collected from GP Practices for Q4. It is expected we will make the target. This will be a considerable achievement as we have a very high quit rate

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
NI 124	People with a long-term condition supported to be independent and in control of their condition	N/A	18.2% Revised target. English average 78%	80.3%	✓	↑	All data has been updated to reflect updated data as of 26.01.2011. It has been recalculated as per the new definition published by the Information Centre, which is based on a (yes+yes to some extent) / (no+yes+yes to some extent) calculation. PCT data is shown as it is not available at LA level.
NI 126	Early access for women to maternity services	1319 Estimated	3229 85.5%	55.45%	✗	↓	Q4 data is not yet available and Q3 data has been used as a proxy. The drop in performance will be discussed in the Community Health Services Contract Meeting in May. Following further analysis a recovery plan will be developed as appropriate and agreed with the service.
NI 137	Healthy life expectancy at age 65	N/A	N/A	Refer to comment	N/A	N/A	This is sourced through the ONS. To obtain healthy life expectancy, a standard survey question on self-reported health is asked of those over 65. Results of this can then be applied to life expectancy projections at 65 to show how many of the years to be expected will be spent in good health. It was expected that it would become part of the Place Survey however, as this is no longer in existence there is no up to date information.

Appendix 5 Financial Statement

The Department's Quarter 4 Financial Statement will be prepared once the Council's year-end accounts have been finalised and will then be made available via the intranet by 30th June.

Appendix 6 Explanation of Symbols

Symbols are used in the following manner:

Progress		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	*Indicates that the annual target is on course to be achieved.*
Amber		Indicates that it is uncertain or too early to say at this stage, whether the milestone/objective will be achieved within the appropriate timeframe.	*Indicates that it is uncertain or too early to say at this stage whether the annual target is on course to be achieved.*
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	*Indicates that the target will not be achieved unless there is an intervention or remedial action taken.*

Direction of Travel Indicator

Where possible performance measures will also identify a direction of travel using the following convention

Green		*Indicates that* **performance is better** *as compared to the same period last year.*
Amber		*Indicates that* **performance is the same** *as compared to the same period last year.*
Red		*Indicates that* **performance is worse** *as compared to the same period last year.*
N/A		*Indicates that the measure cannot be compared to the same period last year.*

Departmental Quarterly Monitoring Report

Directorate:	Adult & Community
Department:	Enablement Services
Period:	Quarter 4 - 1st January 2011 to 31st March 2011

1.0 Introduction

This monitoring report covers the Enablement Services fourth quarter period up to period end 31st March 2011. It describes key developments and progress against all objectives and performance indicators for the service.

The way in which the Red, Amber and Green, (RAG), symbols and Travel Indicator symbols have been used to reflect progress to date is explained in Appendix 6.

2.0 Key Developments

Prevention Services
An early intervention and prevention strategy is on target for implementation to redesign low-level prevention services to cover four new target areas; Information and Advocacy Hub, Hospital Discharge, Practical Prevention and Engagement. This will lead to a significant improvement in capacity and expected outcomes.

Modernisation of Oakmeadow
The Business Plan for Oakmeadow has been completed and agreed at Executive Board. On target for full implementation within the next 12 months.

Redesign of Older People's Community Day Services
Redesign of Day Services and Sure Start to Later Life/Community Bridge Builders is now complete and agreed at Executive Board and on target for full implementation.

End of life Service
The contract for the End of Life Service, which is commissioned by the PCT, has been agreed for three years with an increase in the number of hours care commissioned.

Funding from the PCT
Reablement and Section 256 funding has been agreed with the PCT and signed off at Executive Board.

3.0 Emerging Issues

Efficiency Programme
Efficiency targets are challenging and work is ongoing to ensure we continue to support effective frontline services.

Integrated Services
Further work in relation to Integrated services will be progressed over the next couple of months.

4.0 Service Objectives / milestones

4.1 Progress against 'key' objectives / milestones

Total	**2**	✓	2	?	0	✗	0

The two 'key' objectives and milestones have both been achieved. That is, the Intergenerational Group is progressing development work to improve outcomes for Older People and the specialist Telecare Team has been established. Further details can be found in Appendix 1.

4.2 Progress against 'other' objectives / milestones

Total	**10**	✓	10	?	0	✗	0

Excellent progress has been made against all 'other' objectives and milestones. Teams continue to provide assessments to all carers; an evaluation of both the Intermediate Care and the Re-ablement Services have taken place as has the development of an Integrated Hospital Discharge Team and the review and redesign of the Halton Integrated Community Equipment Service (HICES). Work has also taken place to reduce bed numbers at Oak Meadow and new services are now being provided. There is also now a more pro-active approach to Health Inequalities in the Borough and a new quality assurance programme. Details of all 'other' objectives and milestones can be found in Appendix 2.

5.0 Performance indicators

5.1 Progress Against 'key' performance indicators

Total	**1**	✓	0	?	0	✗	0

The one key indicator detailed in Appendix 3 is not available this year. The NHS information centre is currently developing a new methodology for this indicator which will most likely be available in 2011/12.

5.2 Progress Against 'other' performance indicators

Total	**5**	✓	5	?	0	✗	0

Details of all the 'other' performance indicators can be found in Appendix 4. These include the numbers of people receiving intermediate care; numbers of days reimbursement as a result of delayed transfer and actual delayed transfer of care targets, which have all been achieved successfully. Similarly, admissions of supported residents has achieved its target.

6.0 Risk Control Measures

There are two risk control measures relating to the overall support to develop an integrated hospital discharge team and the need to develop a proactive response to Health Inequalities within the Borough. Details of these can be found in Appendix 5

7.0 Progress against high priority equality actions

There are no high priority equality actions to report.

8.0 Data quality statement

The author provides assurance that the information contained within this report is accurate and valid and that every effort has been made to avoid the omission of data. Where data has been estimated, sourced externally, or where there are any concerns regarding the limitations of its use this has been clearly annotated.

9.0 Appendices

Appendix 1 Progress Against ‘key’ objectives / milestones
Appendix 2 Progress against ‘other’ objectives / milestones
Appendix 3 Progress against ‘key’ performance indicators
Appendix 4 Progress against ‘other’ performance indicators
Appendix 5 Progress against risk control measures
Appendix 6 Financial Statement
Appendix 7 Explanation of use of symbols

Appendix 1: Progress Against 'key' objectives / milestones

Ref	Objective
EN1	Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for vulnerable people

Milestones	Progress Q 4	Supporting Commentary
Ensure intergenerational issues are taken into account whilst implementing the Early Intervention/Prevention Strategy to improve outcomes for Older People in Halton **Mar 2011.** (AOF6 & 7)	✓	The Intergenerational Group is progressing development work tasked to them by Early Intervention and Prevention group.
Following the evaluation of Telecare Services during 2009/10, develop and implement an action plan, based on the recommendations, to ensure the continued development and use of Telecare **Mar 2011** (AOF 6 & 7)	✓	A Specialist Telecare team was established in April 2011 and a Telecare Steering Group. A Telecare Training plan has also been implemented. A Strategic Action Plan is in place and full implementation of this plan will take place in 2011/2012.

Appendix 2: Progress Against 'other' objectives / milestones

Ref	Objective
EN1	Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for vulnerable people

Milestones	Progress Q 4	Supporting Commentary
Maintain the numbers of carers provided with assessment leading to the provision of services, to ensure Carers needs are met **Mar 2011.** (AOF7)	✓	A carers assessment is identified early on in the Intermediate Care process. Teams continue to provide/offer either joint or individual assessment to all carers involved with Intermediate Care service. This is highlighted on a regular basis at team meetings.
Complete initial evaluation of the redesigned Intermediate Care Services to ensure they are meeting the requirements of the community of Halton. **Mar 2011**	✓	An evaluation and redesign of Intermediate Care services has been completed and an Action plan is in place to implement recommendations.
Complete initial evaluation of the new Re-ablement service to ensure they are meeting the requirements of the community of Halton **Mar 2011.** (AOF6 & 7)	✓	Completed.
Develop an integrated hospital discharge team. **Mar 2011** (AOF 6&7)	✓	Business Plans completed and agreed. Team manager appointed and integrated hospital discharge team developed.
Review/redesign the Halton Integrated Community Equipment Service (HICES) to ensure the service is meeting the requirements of the community of Halton **Mar 2011** (AOF 6&7)	✓	Completed.

Appendix 2: Progress Against 'other' objectives / milestones

Ref	Objective
EN1	Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for vulnerable people

Milestones	Progress Q 4	Supporting Commentary
Review the current service provision within Oak meadow and make recommendations for future provision. **Mar 2011** (AOF 6&7)		Agreed at Full Council that Oak Meadow will reduce the number of its beds to 19, and redesign day care opportunities, to ensure there is a service available across adult services, and for a Business model to be developed in line with this. Due to commence new services April 2011.

Appendix 2: Progress Against 'other' objectives / milestones

Ref	Objective
EN2	Effectively consult and engage with service users to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-design of services where required

Milestones	Progress Q 4	Supporting Commentary
Develop a proactive response to Health Inequalities within the Borough **Mar 2011** (AOF 7)	✓	Completed.
As part of the implementation of the Early Intervention and Prevention Strategy aimed at improving outcomes for Older People, develop a meaningful engagement strategy with Service Users **Mar 2011.** (AOF 7 & 32)	✓	Draft engagement strategy for Older People is under development with Halton Older People's Empowerment Network.
Develop a quality assurance framework for all services to ensure service user views are taken into account when redesigning/evaluating services. **Mar 2011** (AOF 7 & 32)	✓	This has been completed in conjunction with the older people's engagement strategy and will also incorporate the views of Halton Older People's Empowerment Network (OPEN).
Review activity of Halton Older People's Empowerment Network, (OPEN), to ensure that it continues to be effective in its engagement with Older People **Mar 2011.** (AOF7 & 32)	✓	Halton OPEN has continued to develop strongly with the following milestones achieved • Action plan completed and agreed • Recruitment of three new board members • Involvement of mystery shopping of the contact centre • Associated focus groups to feedback results from mystery shopping • Dementia lead presenting plans to Halton OPEN on expected outcomes for the next six months.

Appendix 3: *Progress against 'key' performance indicators*

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
Quality							
NI 128	User reported measure of respect and dignity in their treatment	92.99	95	Refer to comment	N/A	N/A	The NHS Information Centre is currently developing a new methodology for this indicator. This PI therefore is not reportable until 2011/12.

Appendix 4: *Progress against 'other' performance indicators*

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
Cost & Efficiency							
EN 1	Numbers of people receiving Intermediate Care per 1,000 population (65+) (Previously OP LI1)	99.25	90	98.07			Numbers have increased this quarter and the target has been successfully achieved.
EN 3	No. of days reimbursement as a result of delayed discharge of older people (Previously OP LI3)	0	0	0			There are no delays resulting directly from the Social Care element, but the Social Care Services are developing the interface between health and social care to ensure timely and appropriate discharge from hospital by all adults.
Quality							
NI 131	Delayed Transfers of Care	N/A	7.36	4.27			Q4 data is not yet available and the cumulative position at the end of February is being used as a proxy.

Appendix 4: *Progress against 'other' performance indicators*

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
Service Delivery							
EN 5	Admissions of supported residents aged 65+ to permanent residential/nursing care (per 10,000 population) key Threshold < 140 (Previously OP LI9)	45.68	60	55.68E			Figure provided is an estimated figure as final year end figure will not be known until June 2011. Direction of travel is based on the estimated figure provided for 2009/10 and not the actual to give a like for like comparison.
NI 125	Achieving independence for Older People through rehabilitation/ Intermediate Care	85.14	85.0	Refer to comment	N/A	N/A	This target is only collated once a year, in between Oct & Dec 2010, with finalised validated data available in quarter1 of 2011/12.

Appendix 4: *Progress against 'other' performance indicators*

Ref	Description	Actual 2009/10	Target 2010/11	Quarter 4	Current Progress	Direction of Travel	Supporting Commentary
Area Partner National Indicators: The indicators below form part of the new National Indicator Set introduced on 1st April 2008. Responsibility for setting the target, and reporting performance data, will sit with one or more local partners. As data sharing protocols are developed, baseline information and targets will be added to this section.							
NI 129	End of life access to palliative care enabling people to choose to die at home	22.9 estimated	21	23.1%	✓	↑	Q3 figure has been updated. February figure used as a proxy for Q4 as March data has not yet been released. A service specification is currently being developed for Halton Haven hospice and developing a recovery plan to supporting Macmillan nurses into 7 day a week working.
NI 134	The number of emergency bed days per head of weighted population	67317.08 estimated	N/A	58152.1	N/A	↑	Q1-3 have been updated. Q4 is not yet available and an average based on Q1-3 has been used as a proxy. It is anticipated that a Halton target for emergency bed days will be agreed in 2011/12 with the PCT rather than on a PCT footprint.

Appendix 5: ***Progress against risk control measures***

Ref	Risk Identified	Treatment Measure	Progress	Supporting Commentary
EN 1	Overall support to develop an integrated hospital discharge team may not be available from Acute Hospital (Mar 2011)	Operational Director to chair the steering group. Partnership approach to be adopted to support the development	✓	Completed- no outstanding risk
EN 2	Inability to develop a proactive response to Health Inequalities within the Borough (Mar 2011)	Operational Director to lead on a Partnership approach to working with the PCT	✓	Completed- no outstanding risk

Appendix 6 Financial Statement

The Department's quarter 4 financial statement will be prepared once the Council's year-end accounts have been finalised and will then be made available via the intranet by 30th June 2011.

Appendix 7 Explanation of Symbols

Symbols are used in the following manner:

Progress		Objective	*Performance Indicator*
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	*Indicates that the annual target is on course to be achieved.*
Amber		Indicates that it is uncertain or too early to say at this stage, whether the milestone/objective will be achieved within the appropriate timeframe.	*Indicates that it is uncertain or too early to say at this stage whether the annual target is on course to be achieved.*
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	*Indicates that the target will not be achieved unless there is an intervention or remedial action taken.*

Direction of Travel Indicator

Where possible performance measures will also identify a direction of travel using the following convention

Green		*Indicates that* **performance is better** *as compared to the same period last year.*
Amber		*Indicates that* **performance is the same** *as compared to the same period last year.*
Red		*Indicates that* **performance is worse** *as compared to the same period last year.*
N/A		*Indicates that the measure cannot be compared to the same period last year.*

REPORT TO: Health Policy & Performance Board

DATE: 7th June 2011

REPORTING OFFICER: Strategic Director, Communities

SUBJECT: Annual Report for the Health Policy and Performance Board

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Annual Report for the Health Policy and Performance Board for April 2010- March 2011 attached as Appendix 1 to this report**.**

2.0 **RECOMMENDATION: That:**

i) The Board note the contents of the report.

3.0 **SUPPORTING INFORMATION**

3.1 During 2010 -11 the Health Policy and Performance Board has looked in detail at many of Halton's Health and Social care priorities during this period. Further details of these are outlined within the Annual Report (Appendix 1).

4.0 **POLICY IMPLICATIONS**

4.1 None

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**

There are no policy implications as a direct result of this report however the health needs of children and young people are an integral part of the Health priority.

6.2 **Employment, Learning & Skills in Halton**

None identified.

6.3 **A Healthy Halton**

The remit of the Health Policy and Performance Board is directly linked to this priority.

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 None identified

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

None

Cllr Ellen Cargill
Chairman

ANNUAL REPORT
HEALTH POLICY AND PERFORMANCE BOARD
APRIL 2010 – MARCH 2011

As Chair of the Health Policy and Performance Board, I would like to thank all the members of the Board for their contribution to the Board's work during this year. I would particularly like to thank Cllr Lowe for her support as Vice Chair to the Board. I would also like to thank all those who contributed to the work topics for their commitment and time.

2010/11 has been a busy year and the Board received a number of reports linked to the Government's White Paper: *Equity and Excellence: Liberating the NHS*. The implications of the White Paper will mean a significant change to our current ways of working.

During the year, the Board received information on a number of Annual Reviews, including the *Annual report on Customer* Care and *Valuing People Now*, and also had the opportunity to comment on a number of draft strategies including the Telecare Strategy and the Sustainable Community Strategy.

MEMBERSHIP AND RESPONSIBILITIES

During 2010/11 the Board comprised ten Councillors:-

Councillor Ellen Cargill;
Councillor D Austin,;
Councillor R Gilligan;
Councillor M Horabin;
Councillor M Lloyd-Jones;
Councillor J Lowe;
Councillor M Dennett;
Councillor M Fry;
Councillor E Ratcliffe; and
Councillor M Bradshaw.

LINk representation is through a co-optee Paul Cooke.

The primary function of the Board is to focus on the work of the Council (and its Partners) in seeking to improve health in the Borough and to scrutinise progress against the aims and objectives outlined in the Council's Corporate Plan in relation to the Health priority.

REVIEW OF THE YEAR

The Board met seven times this year. One meeting was a special meeting to consider Cheshire and Merseyside Vascular Review. As in previous years there were full agendas for each of the planned meetings, and the Board received reports and presentations on a wide range of Health and Social Care issues. These included:-

Government Policies on both Adult Social Care and NHS

Equity and Excellence: Liberating the NHS (White Paper). Proposals to change commissioning within the NHS have been described as the largest change since 1974 including transfer of commissioning to GP's and the abolition of Primary Care Trusts and the Strategic Health Authority. Councils will be responsible for integration, partnership and leading on the new statutory Health and Wellbeing Board.

The Board also received a report on Adult Social Care, *A Vision for Adult Social Care* and a new performance framework based on outcomes. The Board will be keen to look at future proposals from the government on the cost of Adult Social Care in the forthcoming year.

Strategies:

The Board received a number of draft strategies to comment on including:-

- Telecare Strategy: The Board noted the need to mainstream Telecare Services to promote independence, particularly for older people and to obtain best value for the Council.

- Affordable Warmth: Healthy Halton Policy and Performance Board fully supported this strategy recognising that to maintain people requiring support to continue to live in their own homes then basic requirements such as keeping warm needed to be addressed.

- Sustainable Community Strategy: As in previous years improving health remains a priority in Halton and is contained within this Strategy. It was notable that some health information for example, cancer statistics for residents under 75, gave rise to concern and much work remains to be done to improve the health of residents. The Board will continue to monitor health progress on a regular basis.

- Transition Strategy: 14-25: This was also presented to Children's Young People's Policy and Performance Board as it is important both Children and Adult services work closely together to support young people who require additional services to fulfil their potential. The Transition Strategy has now been extended to young people up to 25 years, recognising that some young people need services for a number of years during this period in their lives. The Board continues to support this work and will monitor progress in the forthcoming years.

Annual Reviews:

- The Health Policy and Performance Board continued to receive reports on a variety of services to ensure that progress had been made.

- The Annual Report on Customer Care was received and it was noted that the numbers of complaints have decreased while the number of compliments had increased. It was recognised that this is an important report as in addition to performance monitoring of national indicators, it offers both qualitative and quantitative information.

- Valuing People Now: Members received the Annual Self Assessment of Halton's Learning Disability Partnership and its work. In addition, members received a presentation from Halton Speak Out noting the importance of Valuing People Now for People with Learning Disabilities. This presentation was well received.

- Health Issues: Throughout the year Healthy Halton Policy and Performance Board have received reports on health both at a national and local level to inform the Board's work. Presentations have been received on service redesign of Dental Services, which in the past has been a Work Topic.

- Members' also received a report on the Emergency Duty Team statutory service that is run in partnership with St Helens Council. The partnership has been very successful and throughout the inspections that have taken place this year, the Emergency Duty Team has been noted to offer an excellent service.

- Options for the use of Cheshire and Merseyside Treatment Centre: Members' are keen to ensure that Halton residents benefit from this building which is of a very high standard.

- Widnes GP Health Centre, Health Care Resource Centre: A redesign of services to ensure that those most vulnerable can access GP services.

WORK TOPICS

The Health Policy and Performance Board received a report on the review of Employment for People with Mental Health, Physical Disabilities or Learning Disabilities. The recommendations were agreed and an action plan has been drawn up. This report was taken to Executive Board. This topic had been chosen as people with mental health issues, physical disabilities or learning disabilities have often found it difficult to access meaningful employment and the Board wished to look at what barriers there were in detail.

Safeguarding Vulnerable Adults: The Health Policy and Performance Board have continued to receive regular reports on this important area of work. Good progress has been made throughout the year on improving and strengthening safeguarding arrangements on a partnership basis, as evidenced in the Annual Report that was presented members. This year also saw an Inspection of Safeguarding Adults by the Care Quality Commission and the Council was judged to be performing excellently in safeguarding adults and supporting increased choice and control for older people, and performing well in supporting improved health and wellbeing of older people. A number of processes have been improved to continue this work including the revision of policies and procedures.

Forthcoming Work Topics 2011/12

The Health Policy and Performance Board have prioritised one Work Topic this year in recognition to scrutinise, in depth, an important subject.

PERFORMANCE ISSUES

The Health Policy and Performance Board continue to receive quarterly monitoring reports on Social Care performance and also receive the report on the Care Quality Commission rating on Halton.

Halton Adult Social Care was judged to be excellent both through Inspection and through its annual performance this year. Performance has continued to remain strong in many areas including the following:

- Joint Intermediate Care Services between Halton and St Helens NHS and Halton Borough Council
- Numbers of Older People and Adults continue to be supported at home
- Good shared service with St Helens for Emergency Duty Team offering emergency services to residents both in Halton and St Helens
- Numbers of carers receiving services to support in their caring responsibilities

WORK PROGRAMME 2010/11

The Health Policy & Performance Board has agreed one Work Topic for this year, which is a new requirement placed on the Local Authority and which recognises the quality of services received by those people needing support.

- Dignity in Care
  This Work Topic carried out this year has just concluded and the Board looks forward to receiving a report in June 2011.

- Services for People with an Autistic Spectrum Disorder
  The Council is required to establish a strategy to ensure that services are available to meet the needs of those people who have a wide spectrum of need with this disorder. Terms of Reference will be agreed at the June 2011 Policy and Performance Board.

Councillor Ellen Cargill
Chairman, Healthy Halton Policy and Performance Board

REPORT TO: Health Policy & Performance Board

DATE: 7 June 2011

REPORTING OFFICER: Strategic Director, Communities

SUBJECT: Windmill Hill Access Centre

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

The purpose of this report is to update to Board on the recent Patient and Public consultation regarding the potential closure of the nurse led Windmill Hill Access Centre.

1.1 A report has previously been submitted to Halton & St Helens PCT Clinical Commissioning Committee in October 2010 and to the Finance Performance Approvals Committee on 27th April 2011.

2.0 **RECOMMENDATION: That the Board note the contents of the report.**

3.0 **SUPPORTING INFORMATION**

3.1 Prior to 1997 the residents of Windmill Hill had access to a singled handed GP practice for their health needs. However, when the GP left, the existing patient list was distributed between Castlefields and Murdishaw practices.

3.2 The Windmill Access Centre was then introduced and provided a limited service to the residents of Windmill Hill. This service, which is delivered by Bridgewater Community Health Services staff, is open from 9am until 5pm Monday to Friday (excluding Bank Holidays). People access the service by telephoning for an appointment time, however, if they arrive without an appointment they can wait to be seen by a nurse.

3.3 Since opening, the access centre has provided health care for people who had coughs, sore throats, rashes, and many other minor illnesses. However, people who have more complex or long term conditions require the continuity provided by their own GP.

3.4 Throughout 2010 attendances to the Nurse led Centre averaged eight patients per day.

3.5 In January 2011 the average number of people attending were seven per day, and in February 2011 the average number was five

per day.

3.6 On 29th January 2010 the new Equitable Access GP practice opened to the residents of Windmill Hill, and now has a list size of 1173 patients.

3.7 The new GP practice provides an enhanced service to that available at Windmill Hill Access Centre. For example: Women's Health Clinic, Well Woman Clinic, Well Man Clinic, Mother & Baby Clinic, Travel Health, Smoking Cessation, Phlebotomy, Respiratory Clinic and many more.

The opening times are 8am – 6.30 Monday to Friday, and 9am – 1pm Saturday and Sunday.

3.8 In January 2011 the PCT completed a three month consultation with the residents of Windmill Hill regarding the access centre.

3.9 The results from the consultation highlight the need for access to health care. Some of the responses include: "Handy location/close to where I live" (59%); "I do not have a car/do not drive and this is convenient for me" (9%). Others (11%) stated they used the access centre if they were unable to get a GP appointment.

4.0 POLICY IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 Children & Young People in Halton

Children and Young people who may need to access health care will be able to register with the GP practice.

5.2 Employment, Learning & Skills in Halton

None identified.

5.3 A Healthy Halton

The health of all residents in Halton continues to be a priority. The residents of Windmill Hill now have an enhanced service on the estate.

5.4 A Safer Halton

None identified.

5.5 **Halton's Urban Renewal**

None identified.

6.0 **RISK ANALYSIS**

6.1 In order to allay fears of 'losing' the nurse-led service, specific targeted and timely communications will be developed for local residents, leading up to the closure. Key messages will include:

- The reasons for the closure, including the need to improve access to Primary Care Services locally
- The availability of nurse and GP appointments at the Windmill Hill Practice (with full explanation of the need for patients to be registered with Windmill Hill GP Practice in order to access these services).
- Advice on how to change GP practice.

7.0 **EQUALITY AND DIVERSITY ISSUES**

The PCT has undertaken an impact assessment. This concluded that individuals with protected characteristics would not be disadvantaged by the proposal. However as part of the assessment the practice will need to report to the PCT how the actions taken have mitigated any risk

REPORT TO: Health Policy & Performance Board

DATE: 7th June 2011

REPORTING OFFICER: Strategic Director, Communities

SUBJECT: Summary of Quality Accounts 2010/11 for Warrington and Halton NHS Foundation Trust

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Health PPB with a summary of the Quality Accounts 2010/11 for Warrington and Halton NHS Foundation Trust.

2.0 **RECOMMENDATION: That:**

i) The Board note and comment on the summary report.

3.0 **SUPPORTING INFORMATION**

3.1 The Quality Accounts summary details a comparison between 2009/10 figures and 2010/11 figures for various subject areas, for example, infection control, pressure ulcers, Thromboprophylaxis, falls, Hospital Standardised Mortality Review (HSMR), along with a narrative for each area.

3.2 *Complaints* – The total number of complaints between 2009/10 and 2010/11 have risen significantly. All complaints are investigated in accordance with Trust policy and wherever appropriate action is taken to achieve service improvements. The top five areas for complaint during 2010/11 were:

- All aspects of clinical treatment
- Appointments, delay/cancellation (outpatient)
- Communication/information to patients
- Patients property and expenses
- Admissions, discharge and transfer arrangements

3.3 *Compliments* – Records of compliments received began in May 2010, so as yet there are no comparisons with previous years. Although the figure for complaints for 2010/11 was 460, the figure for compliments was 2,125.

3.4 *National Impatient Survey 2010* – This survey has demonstrated that the improvement work the Trust has implemented over the past year has had a significant effect on the patients' experience. Patients said:

- They were treated with dignity and respect whilst in hospital (99% rated this as always or sometimes)
- They felt the doctors and nurses worked well – excellent together (97%)
- They would rate the care they received as "good" to "excellent" (97%)

There are issues that the Trust needs to continue to improve upon, and these will be focussed on over the next 12 months. The issues include:

- Responding the patients when they have used their call bell
- Improved ways of communication with patients about their care
- Reducing the delay in the process of discharge from hospital.

4.0 POLICY IMPLICATIONS

4.1 None identified.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None identified.

6.2 Employment, Learning & Skills in Halton

None identified.

6.3 A Healthy Halton

The Quality Accounts summary demonstrates performance in various areas of health at Warrington and Halton NHS Foundation Trust to enable improvement in these areas to be measured, therefore improving outcomes for people using the services.

6.4 A Safer Halton

None identified.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 Annual monitoring of the Quality Accounts ensures that priority areas for improvement are closely observed. Measures are then put in place to improve standards where necessary.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None.

Warrington & Halton NHS Foundation Trust
Summary of Quality Accounts 2010/11 for the Healthy Halton Policy & Performance Board

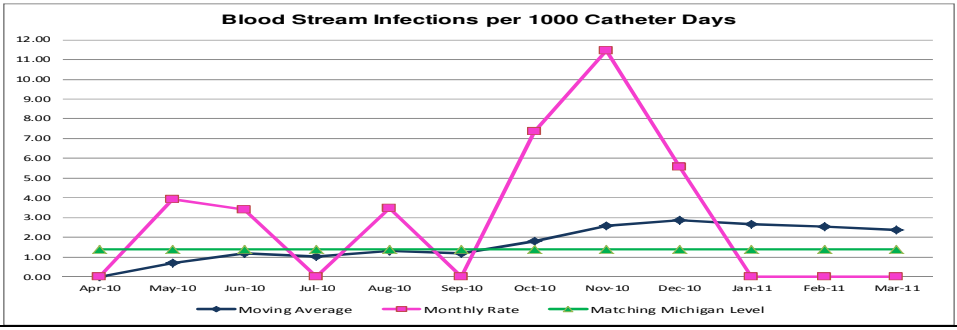
Subject	2009/10	2010/11	Narrative
Infection Control			
MRSA bloodstream infections	**4**	**5**	The targets set for reduction in 2010/11 were for the Trust to have no more that 4 cases of MRSA bloodstream infections and so it was disappointing that there was one more hospital acquired case than had been anticipated.
Clostridium difficile	**114**	**65**	The Trust had 65 cases of Clostridium difficile in 2010/11 against a target of no more than 116. This is a considerable achievement and is testament to the seriousness that the Trust places against infection prevention and control. **Targets 2011 – 2012** • 4 cases of hospital acquired MRSA bacteraemia • 54 cases of hospital acquired Clostridium difficile
Pressure Ulcers (hospital acquired)			
Reducing the incidence of hospital acquired pressure ulcers (grade 3 and 4) was identified as an important challenge for the Trust. During 2010/11, the organisation set itself a target of reduction of 10% of the previous year's total of 39.	**39**	**41**	This will remain a significant priority for the Trust and is the focus of improvement activity. A package of measures to reduce the incidence of hospital acquired pressure ulcers to 29 (or less) has been introduced.
Thromboprophylaxis			
This relates to the assessment, prescribing and administration of treatments to prevent patients from developing deep vein thrombosis. Target set of 90% of patients would be assessed.	**New**	**95.51%**	The plan for the next year is to sustain this excellent achievement.

Falls In the period of 2010/11, the Trust set a trajectory to reduce the number of falls that caused moderate, major or severe harm to patients by 10% from the pervious year's total number of fall of 54 cases	**54**	**55**	The Trust is disappointed that it did not achieve its target and has set about developing a series of measures to improve on this standard.
Hospital Standardised Mortality Review (HSMR) The HSMR scoring system works by taking a hospital's crude rate (actual deaths) and adjusting it for a wide variety of factors such as population size, age profile, level of poverty, range of treatments and operations provided etc.	**92.5**	**90.2**	Nationally the expected HSMR score for a Trust such as Warrington and Halton NHS Foundation Trust is set at a score of 100. This figure does not represent deaths – it is just a baseline number that statisticians use against which to compare observed performances. A number below 100 indicates that a hospital has less than the expected number of deaths.

In last year's Quality Accounts we set out our intention to **reduce harm to critically ill patients** in relation to: reducing ventilator acquired pneumonia (VAP), reducing urinary associated catheter infections and reducing blood stream infections (as part of the 'Matching Michigan' study)

To achieve these goals, we introduced care bundles (which are packages of 'best practice'). Compliance against the implementation of these bundles is audited and we are able to demonstrate a reduction in the associated infections. We set a trajectory of compliance of 90% for compliance against the implementation of care bundles for VAP and the insertion of urinary catheters.

Compliance: VAP - 95%, Catheter Infections – 100%,



This highlights a cluster of 8 infections over a 3 month period in October to December 2010 which significantly reduced our compliance with 'Matching Michigan'.

However, no further infections were reported in January 2011 – March 2011 which is beginning to affect our moving target positively.

Improving the care of the deteriorating patient

This aims to reduce the number of cardiac arrests of hospital patients outside of the Accident and Emergency Department, Theatre Department and the Critical Care areas. In 2010/11, we established our baseline for cardiac arrest and set a 5% reduction trajectory. As a result of the actions the Trust has taken (improving the Modified Early Warning Score system and improved knowledge of our staff) the Trust has reduced the number of cardiac arrests by 23%.

Ensuring Safer Surgery

Last year's Quality Account stated the Trust's intentions to adopt the principals of the 'Safer Surgery Checklist'. A baseline audit of compliance in May 2010 demonstrated a compliance of 43%. This has now increased to 87% at the end of March 2011, which is slightly below our target of 90%.

Complaints	**2009/10**	**2010/11**	All complaints are investigated in accordance with Trust policy and wherever appropriate, action is taken to achieve service improvements Top five subjects **2010/11** All aspects of clinical treatment **267** Appointments, delay / cancellation (outpatient) **59** Communication / information to patients **36** Patients property and expenses **20** Admissions, discharge and transfer arrangements **10**
Total formal complaints received	**379**	**491**	
PALS			Top five subjects **2010/11** Waiting Times For An Appointment **– 70** Support and Advice - **64** Communication Problems With Family - **57** Waiting Times For An Operation - **52** Attitude Nursing – **48**
Total PALS contacts	**920**	**1,253**	
Number of PALS contacts escalated	**15**	**42**	

Complements

Although no figures for complements received has been recorded in previous years it should be noted that from May 2010 (when compliment records began) – April 2011 the Trust received 460 formal complaints, however received 2,125 complements in the same period. These numbers do not reflect the many cards and letters sent direct to the wards and departments which are not forwarded for inclusion in the Divisional reports.

National Inpatient Survey 2010

The National Inpatient Survey 2010 has demonstrated that the improvement work the Trust has implemented over the past year has had a significant effect on the patients' experience.

In the majority of issues that the survey addressed (admission to hospital, the ward patients stayed on, cleanliness, food, care and treatment provided, involvement in decisions, being treated with dignity and respect and discharge from hospital) the Trust has made improvements in its scores. Whilst this is a good result for the Trust, it means that patients feel that they are receiving a much more improved experience at the time they spend under our care.

Overall, patients said that:

- they were treated with dignity and respect whilst in hospital (99% rated this as always or sometimes)
- they felt that the doctors and nurses worked well - excellently together (97%)
- they would rate the care they received as "good" to "excellent" (97%)

There are issues that we need to continue to improve upon, and these will be the focus of our work over the next 12 months. These include:

- Responding to patients when they have used their call bell
- Improved ways of communication with patients about their care
- Reducing the delay in the process of discharge from hospital

Summary paper prepared by: David Melia (Director of Nursing)

REPORT TO: Health Policy & Performance Board

DATE: 7th June 2011

REPORTING OFFICER: Strategic Director, Communities

SUBJECT: Draft Scrutiny Review of Dignity in Care Report

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To introduce the draft report of the Scrutiny Review of Dignity in Care for consideration by the Board.

2.0 **RECOMMENDATION: That**

i) the Board comment on the findings of the Scrutiny Review; and

ii) the Board endorse the Scrutiny Review and its recommendations.

3.0 **SUPPORTING INFORMATION**

3.1 This report (attached as Appendix 1) was commissioned by the Health Policy and Performance Board. A scrutiny review working group was established with five Members from the Board, a Principal Policy Officer from the policy team, the Dignity in Care Co-ordinator and the Divisional Manager from the Independent Living Service.

The report was commissioned as Halton Borough Council is the only local authority in the country with a Dignity in Care Co-ordinator, as well as the only one that covers both the council and the wider remit of Health. The co-ordinator has been in post since July 2009, so this was felt an opportune time as part of an on-going evaluation to focus on Dignity in Care. There is also a national drive for local authorities to carry out scrutiny reviews of Dignity in Care.

The scrutiny review was conducted through a number of means between October 2010 and April 2011, as follows:

- Monthly meetings of the scrutiny review topic group;
- Presentations by various key members of staff from the Council and Health (detail of the presentations can be found in *Annex 2*);

- Provision of information;
- Service-user consultation;
- Field visit to a Productive Ward at Whiston Hospital

4.0 **POLICY IMPLICATIONS**

4.1 Existing policies are endorsed by the report.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The report makes a series of recommendations under each separate area of evidence that was scrutinised and have been collated into an Action Plan at Annex 5 for ease of reference and monitoring.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**

None identified.

6.2 **Employment, Learning & Skills in Halton**

None identified.

6.3 **A Healthy Halton**

The report and recommendations support the Council's strategic priority of Improving Health. Taking on board the recommendations from the report will be positive steps to improving Dignity in Care to the residents of Halton.

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 Identified within the report.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

Document	Place of Inspection	Contact Officer

HALTON
BOROUGH COUNCIL

Draft Scrutiny Review of Dignity in Care

Report

June 2011

CONTENTS

1.0 PURPOSE OF THE REPORT

The purpose of the report, as outlined in the initial topic brief (at *Annex 1*) is to:

- Explore identified areas to ascertain if dignity standards are applied accordingly, for example, within a hospital setting.
- Consider national/north west best practice and research in terms of Dignity in Care and Personalisation.
- An opportunity to raise awareness/promote Dignity in Care and the value for service-users; and
- Make recommendations for improvements to Dignity in Care within Halton.

2.0 STRUCTURE OF THE REPORT

This report is structured with the introduction, a brief summary of the methodology followed by evidence, analysis with findings/conclusions and recommendations. The annexes include the topic brief, methodology detail, documents considered by the group, "My Life Before and After My Operation" presentation by Laura Green and Action Plan.

3.0 INTRODUCTION

3.1 Reason the report was commissioned

Halton Borough Council is the only local authority in the country with a Dignity in Care Co-ordinator, as well as the only one that covers both the Council and the wider remit of Health. The co-ordinator has been in post since July 2009, and it was felt this was an opportune time as part of an on-going evaluation to focus the scrutiny review on Dignity in Care. There is also a national drive for local authorities to carry out scrutiny reviews of Dignity in Care.

3.2 Policy and Performance Boards

This report was commissioned as a scrutiny working group for the Health Policy and Performance Board.

3.3 Membership of the Topic Team

Membership of the Topic Team included:

Members	Officers
Cllr Ellen Cargill Cllr Joan Lowe Cllr Dave Austin Cllr Marjorie Bradshaw Cllr Margaret Horabin Cllr Martha Lloyd-Jones	Helen Moir – Divisional Manager Independent Living Services Tracy Ryan – Dignity in Care Co-ordinator Emma Sutton-Thompson – Principal Policy Officer for Adults and Older People

4.0 Methodology Summary

This scrutiny review was conducted through a number of means:

- Monthly meetings of the scrutiny review topic group;
- Presentations by various key members of staff (detail of the presentations can be found in *Annex 2*);
- Provision of information;
- Service-user consultation;
- Field visit to a Productive Ward at Whiston Hospital

5.0 Evidence (summary of evidence gathered) and Analysis with findings/conclusions

5.1 Dignity in Care Awareness

Tracy Ryan, Dignity in Care Co-ordinator gave a presentation on Awareness of Dignity in Care at the first meeting of the topic group. This covered:

- Background to the Dignity in Care Campaign
- Dignity Challenge and what people can expect from a service that respects dignity
- Briefing of Halton's achievements to date with Dignity in Care
- Halton is the only local authority with a dedicated Dignity in Care Co-ordinator and this covers both the Local Authority and health.

Dignity Awareness Sessions

Since having the Co-ordinator post, the following staff awareness sessions have taken place.

Information Packs are issued to all attendees providing details of:

- What is Dignity
- Information Flyers, Postcards & Posters
- Presentation hand-outs
- Dignity Balance & Challenge Tests
- Best Practice guide & Aide Memoire
- Staff Expectations Card
- Signposting Information e.g. Preventative Services and Multi-agency Contact Sheet for Complaints or Concerns

HBC	**Numbers**		**Numbers**
Dorset Gardens and Extra Care	7	Adult Placement Service	5
SS2LL and volunteers	9	Adult Placement Carers	12
Adults with Learning Disabilities	10	Sheltered Housing Network	4
Day Services	5	Emergency Duty Team	4
Daytime, Community and Residential Support	3	Elected Members scrutiny group	6
		HBC Total	**65**
Provider Services Health and Social Care			
RARS/Intermediate Care Assessment team	2	GP Practice Manager	1
Residential Care & Supporting People Provider Forum	23	HBC officers	12
Croftwood Residential Care Home	10	Safeguarding Adults Board	30
Domiciliary Care Provider Forum	30	Hospital leads	4
Sheltered Housing Provider Forum	14	PCT	12
Social Inclusion Provider forum	20	Age Concern UK	3
Social Care in Partnership Provider Forum	15	Halton Speak Out	1
Domestic Abuse and Sexual Violence Operational Group	20	SCOPE	6
Partnerships in Prevention group	11	ARCH initiatives	8
Leahurst Care Home	12	Widnes Hall Care Homes	1
		Provider Services Total	**235**

Public Awareness-Raising

Public awareness sessions have taken place across the borough. This has included events or meetings where the Dignity Co-ordinator has raised the issue and discussed the role and what dignity involves. There have also been awareness-raising sessions in public areas with display stands, talking to the general public and distributing information. For example:

- Open Door to Dementia Launch
- Disability Awareness Day
- Community Safety RESPECT weeks
- Residents living within Nursing/Residential Care Homes
- Focus Groups with people in receipt of care/treatment
- Dignity Matters Follow-up Event
- CQC Open Public Forum – Adult Social Care Inspection
- Good Place to Grow Old Event
- Dignity and Safeguarding publicity campaign issued borough-wide

Dignity in Care Champions Group

The Dignity in Care Champions group has the following remit:

- Strategic level multi-agency group responsible for overseeing Halton's Dignity in Care campaign for residents to gain/maintain autonomy, dignity and respect whilst in receipt of health and social care services;
- Lead group in rooting out age discrimination or lack of dignity in the treatment of people who use care services and their carers;
- Monitor progress against a Performance Framework of the Halton Dignity in Care Action Plan and Dignity Charter. The Dignity in Care Co-ordinator reports progress to the Older People's Local Implementation Team and Safeguarding Adults Board;
- Disseminate and share good practice working in partnership to improve the service users' care experiences; and
- Halton's Dignity in Care Action Plan and Dignity Charter is implemented multi-agency via Halton's Dignity Champions' Network.

Membership of this group includes:

- Halton Borough Council - All Adults & Older People's services
- Halton Borough Council - Elected Member
- Older People's Local Implementation Team
- Warrington and Halton Hospitals NHS Trust
- NHS Halton and St Helens (PCT)
- 5 Boroughs Partnership Foundation Trust
- St Helens & Knowsley Hospitals NHS Trust
- Halton Voluntary Action
- Age Concern UK
- Halton Older People's Empowerment Network (OPEN)/Local Residents
- Independent Providers: Residential Care, Domiciliary Care & Sheltered Housing

- Older People – Independent Chair
- Carer
- Halton LINk
- Halton Haven

Conclusion

The group concluded that the awareness-raising session clearly demonstrated the standards to which organisations should be working to and the expectations for people using those services. This was an excellent start to the scrutiny review as it set out the baseline from which to work. Having the Dignity Co-ordinator post has helped to ensure the message/information about dignity goes out to the public. This is key to the success in empowering people by giving them the knowledge to work with.

Members also noted that in the recent Care Quality Commission's safeguarding inspection of adult social care Halton was cited as being innovative and challenging in its approach to ensuring local people received high quality, individually tailored support that recognised their uniqueness and promoted their dignity and privacy. The inspection highlighted how the role, leadership and contribution of the Dignity in Care Co-ordinator was highly valued and effective in raising standards and tackling discrimination or poor treatment of people in a variety of settings. There were many examples of the positive impact of this post in promoting and sharing best practice and tackling poor performance.

Recommendations:

(i) ***The group suggested that it would be useful to include the Multi-agency Contact Sheet for Complaints or Concerns in a future edition of Inside Halton.***

(ii) ***Continue with briefing and training staff both within social care and health and continue with the public awareness raising.***

5.2 Dignity in Care and Personalisation

Helen Moir, Divisional Manager for Transformation, gave a presentation on Dignity in Care and Personalisation in the December meeting of the topic group. This presentation included the following main points:

- Currently a pilot offering Self-Directed Support (SDS) to everyone who receives a package of care from adult services using a choice of budget methods: Direct Payment, indirect payment, trust fund, managed account, individual service fund, or virtual budget.
- Robust procedures in place around Personal Assistants – including a series of guideline booklets around the selection, recruitment and training (including information regarding CRBs) for employers and employees.

- As part of the Putting People First milestones, HBC are committed to setting up a User Led Organisation (ULO) to host a forum for voluntary groups locally and to provide peer support and advocacy for the SDS process.

Conclusion

The group noted that in the recent Care Quality Commission's safeguarding inspection of adult social care Halton was cited as having excellent personalisation systems in place.

Recommendations:

(i) Continue to positively promote the work of personalisation within Halton.

5.3 Productive Wards

5.3.1 Presentation

During January, Anne Hyson, Senior Nurse, Professional Development from Whiston Hospital gave a presentation on Productive Wards prior to the site visit. This included:

- Explaining the concept of Productive Wards and the modular programme of implementation including core objectives of safety, quality, efficiency, patient experience and staff satisfaction;
- Showing "before" and "after" photos – these mainly highlighted how untidy areas such as store cupboards, offices and wards were tidied up and the difference this made to staff in accessing areas fully and finding equipment quickly and easily;
- Systems used in the implementation of Productive Wards: "Releasing Time to Care" time and motion study to establish firstly the baseline in terms of the percentage of nurses' time spent on direct patient care and secondly how this percentage changes after the implementation of the Productive Ward.

5.3.2 Site Visit

Following the presentation, the group were taken onto a Productive Ward and given a tour, including the reception area, open wards, private rooms, nurses' station, stock room. The group were shown the notice board with up-to-date information showing recent falls within the ward, MRSA (if any), staff sickness.

NB - A site visit to a ward at Warrington Hospital was proposed as part of the scrutiny review but it was unable to be included. However, a visit has been arranged for mid-June.

Conclusion

Actually visiting the Productive Ward and seeing it in action after hearing the presentation gave the group a really good understanding of how it works in practice. The group felt very strongly that there was a huge difference between a normal hospital ward and a productive ward in terms of:

- the whole atmosphere created by a productive ward being calm and relaxed;
- uncluttered and spacious areas adding to the calmness;
- clearly labelled stock stored in a uniform manner across every stock room so that staff did not have to spend time looking for equipment, meaning they had more time for direct patient care;

Recommendations:

(i) The group would like to suggest the continued roll-out of the Productive Ward concept in both Whiston and Warrington Hospitals.

(ii) The use of Health Passports* throughout the care system and extended beyond Adults with Learning Disabilities.

(iii) In single-sex wards at Whiston Hospital the male/female sign on toilets should be accessible to people with a visual impairment.

** Health Passports – The Health Passport is a document that helps NHS staff to understand the needs of adults with learning disabilities; when attending appointments or visiting hospital. The local version has been adopted from Gloucestershire NHS Foundation Trust.*

5.4 Safeguarding and Dignity in Care

During the February topic group meeting, Diane Gould, Safeguarding Co-ordinator from Whiston Hospital, gave a briefing around safeguarding the links to Dignity in Care.

- Health Passports are currently only used for people with a learning disability and only those people who are known to Social Services. Diane circulated one for the group to look at.
- Whiston Hospital is in the process of changing patient gowns to ones which don't have the gap at the back of them.
- Staff working on the wards are always encouraged to highlight any concerns they may have if they notice something on the ward that isn't best practice.
- With bed availability, patients are placed where they will be best managed in terms of their condition.
- Whiston Hospital uses the "red tray system" that highlights if a patient requires assistance with eating or drinking.

Conclusion

The topic group were impressed with the Health Passport and the concept of its use. Diane had clearly shown that safeguarding was a priority for Whiston Hospital and that measures were being put into place to improve safeguarding wherever possible.

Recommendations:

(i) The use of Health Passports throughout the care system and extended beyond Adults with Learning Disabilities.

(ii) Whiston Hospital to implement training/guidance for staff to feel comfortable raising concerns/making complaints.

5.5 Dignity in Care Forum

On 18th March, the group organised a Dignity in Care Forum for people who currently use services and had had recent experience of either a hospital visit or using care services and wanted to share those experiences.

The forum consisted of members of the topic group and service users from the following service areas:

- Older People Services
- Adults with Learning Disabilities
- Carers
- Mental Health Services
- Halton LINk

The session was facilitated by a Building Common Ground facilitator enabling group discussions which focussed on the following areas:

Key Theme	Discussion Comments
What's already working?	Only LA with Dignity in Care Co-ordinator, Events – listening to people's views, Improvement in care – Halton Hospital, End of Life Strategy and core standards, Health and social services working together, LINk – events, board meetings, Advocacy service, Halton Council leading on improving dignity, Dementia Pathways, Professionals working together, Located in same place, Council looking at Dignity and Raising Awareness, GP Practice, Whiston Hospital, Crossroads and sitting service.
Hopes/ Opportunities	People confident to raise concerns without fear of reprisal – either staff or people using services, Culture change, Training for care givers e.g. dementia, Bed availability, Times adhered to, MRSA, Nurses pay more attention i.e. Health Passports, Nurses attend to one ward only, better communication between staff, Hygiene issues addressed,

Key Theme	Discussion Comments
	Look at volunteer drivers to address transport issues, More staff.
Challenges/ Concerns Faced	No level of consistency in care givers – agencies, Lack of training – agencies, Staff not caring, Young staff and no uniforms, Paperwork looks good – practice very different, Confusion when trying to get help in a crisis, What works at home not transferred to other areas e.g. respite/hospital, Nutrition – not fed in hospital, Not enough staff to address needs, No acknowledgement of role and history and knowledge carers have, Transport – not always available, alternatives to Dial-a-ride expensive, Telephone responses from services – uncivil, Comprehensive care not given in hospital. Continuing Health Care – partnership working, lots of changes in the PCT, People not knowing how to complain or if they do, the fear of reprisal, Dignity is across the board – not just older people, Not having curtain closed properly when in hospital, buzzer being hidden, "Whistle-blowing" – seeing practice that isn't good and feeling able to raise concerns.

Common Issues	Quality of Care, Attitudes, Lack of passion.
Action Needed	Dialogue – continue talking to each other, improve on what we have done so far, Revisit the role of Dignity in Care Champion – publicise this, info and education and job description, Everyone taking responsibility – speaking up, Not trivialising issues – small things make a big difference, Using and acting upon Passports throughout the care system, Never assume, Mandatory training for agencies, Raise standards of care – all settings, Increase numbers of Health Care Assistants in hospitals and raise role profile, Better auditing of agencies/hospitals to raise standards, Increase numbers of volunteers in hospitals and let care assistants care, Encourage carers to stay at hospital to support cared for person, Look at funding opportunities to develop volunteers, User satisfaction forms developed when leaving hospital.
What is the Vision	Build on today's progress, Try to show compassion, Better audits/benchmark – dignity audits, People cared with compassion, People cared with consistency, Every moment is a proud moment, Not having to complain for basic dignity and care to be given, All carers to have an induction and training and have an interest other than profit, Same carer to attend to same person, Use of Hospital Passport, New practices looked at i.e. live in carer.

Personal Experiences

The forum gave opportunity for attendees to relay their personal experiences and these highlighted both positive and negative aspects of dignity in care.

One member of the group requested that her experience was used as evidence with this review and Laura Green's presentation "My Life Before and After My Operation" can be read in full at Annex 3.

It is very moving to hear someone's experience of reality. Laura has been open and frank with her detailed description of events that occurred on her admission to hospital. Unfortunately this seemed to be a situation that other people in the forum had also experienced. One of Laura's quotes "I had a Health Passport that nobody bothered to look at right in the front of my file" demonstrates that although Health Passports are supposedly used, in practice the experience is very different. At the end of Laura's presentation is a section on "How I think it could change" and one of Laura's suggestions is "Nurses to check health passports more often". This has been put into the recommendations.

Conclusion

The topic group concluded that holding this forum was a very valuable exercise for this scrutiny topic. Hearing at first hand the experiences of people using various care services in the area was critical to pin-pointing common areas of concern or areas of good practice with regard to Dignity in Care.

Recommendations:

(i) The consistent use of Health Passports across the North West area and extending this beyond Adults with Learning Disabilities. In particular, hospital and care services should include Health Passports as part of their admission procedures.

(ii) Local Authority to continue to strengthen partnership working with Health.

(iii) Implementing mandatory Dignity in Care training for all agencies, HBC developing Dignity E-Learning.

(iv) Revisit the role of Dignity in Care Champions to raise their profile including publicity, information and education.

(v) Improve customer care so people feel more comfortable and confident about raising concerns or have support in making a complaint.

6.0 Overall Conclusion

This scrutiny review has been both a successful and a worthwhile exercise in terms of covering all the outputs and outcomes from the initial topic brief and gaining a thorough knowledge of Dignity in Care in Halton.

The scrutiny review has highlighted that Dignity in Care is at the forefront in Halton and much progress has already been made across all care services.

There are recommendations for further improvement that have been identified from this scrutiny review and these have been arranged into an Action Plan at Annex 5 for ease of reference and monitoring. The recommendations cover the wider spectrum of both health and social care and the majority of these will be progressed through the work of the Dignity in Care Co-ordinator post.

Annex 1

TOPIC BRIEF

Topic Title: Dignity in Care

Officer Lead: Divisional Manager (Transformation)

Planned start date: August 2010

Target PPB Meeting: June 2011

Topic Description and scope:

A review of Dignity in Care, focussing on exploring specific areas to ensure dignity in care standards are applied accordingly.

Why this topic was chosen:

Halton Borough Council is the only local authority with a Dignity in Care co-ordinator, as well as the only one that covers both the council and the wider remit of Health. The co-ordinator has been in post since July 2009, so this is an opportune time as part of an on-going evaluation to focus on Dignity in Care. There is also a national drive for local authorities to carry out scrutiny reviews of Dignity in Care.

Key outputs and outcomes sought:

- Explore identified areas to ascertain if dignity standards are applied accordingly, for example, within a hospital setting;
- Consider national/north west best practice and research in terms of Dignity in Care with regard to Personalisation;
- An opportunity to raise awareness/promote Dignity in Care and the value for service-users; and
- Make recommendations for improvements to Dignity in Care within Halton.

Which of Halton's 5 strategic priorities this topic addresses and the key objectives and improvement targets it will help to achieve:

<u>Improving Health:</u>

Key Objective A: To understand fully the causes of ill health in Halton and act together to improve the overall health and well-being of local people.

Key Objective B: To lay firm foundations for a healthy start in life and support those most in need in the community by maximising and promoting autonomy.

Key Objective C: To promote a healthy living environment and lifestyles to protect the health of the public, sustain individual good health and well-being and help prevent and efficiently manage illness.

Key Objective D: To reduce the burden of disease in Halton by concentrating on lowering the rates of cancer and heart disease, mental ill health and diabetes and addressing the health needs of older people.

Safeguarding Vulnerable Adults and Children - To improve the outcomes of vulnerable adults and children, so they feel safe and protected and when abuse does occur there are local procedures and processes in place to ensure that the abuse is reported and appropriate action taken against perpetrators and to support victims.

Nature of expected/desired PPB input:

Member led scrutiny review of Dignity in Care.

Preferred mode of operation:

- Review of Dignity in Care within a hospital setting;
- Literature review/best practice in other areas, in particular the impact of Personalisation
- Field visits including:
    - Warrington Hospital;
    - North-west authority/organisation with best practice in Dignity in Care within hospitals, and/or with personalisation; and
    - Focus groups involving partner organisations, for example, Halton LINk, Age Concern, Halton Open, service users and carers.

Agreed and signed by:

PPB chair …… **Officer ……**

Date …….. **Date ……..**

Annex 2

METHODOLOGY DETAIL

a) Presentations

The following officers gave presentations as part of this scrutiny review:

Name of officer	Title of Presentation
Helen Moir, Divisional Manager	Personalisation and Dignity in Care
Tracy Ryan, Dignity in Care Co-ordinator	Dignity Awareness Session
Anne Hyson, Senior Nurse, Professional Development, Whiston Hospital	Productive Wards
Diane Gould, Safeguarding Co-ordinator, Whiston Hospital	Briefing on Safeguarding and the links to Dignity in Care

Annex 3

“My Life Before and After My Operation” by Laura Green

Annex 4

Documents Considered including Best Practice within the review

- Halton Dignity Champions' Network Dignity Action Plan and Charter
- Dignity "Challenge" Tests
- Halton Dignity Matters Follow-up Event Report & Action Plan
- Halton Dignity Best Practice Pack

- Halton's Dignity Audit Tools and Questionnaires will establish baseline of how far dignity embedded with action plans to track progress:
  - Residential Care;
  - Domiciliary (Homecare) Care;
  - Hospitals;
  - Generic services.
- Dignity Questionnaires for people living at home and those accessing services via hospital, residential care and day services will provide a balanced audit of services/teams

Walk a Mile in My Shoes - Scrutiny of dignity and respect for individuals in health and social care services: a guide, The Centre for Public Scrutiny, Improvement and Development Agency, November 2009

DIGNITY IN CARE SCRUTINY REVIEW
ACTION PLAN

ANNEX 5

Action No.	Action	Responsible person	Timescale	Resources Required	Progress
1	Include Multi-agency Contact Sheet for Complaints or Concerns in a future edition of Inside Halton.	Tracy Ryan			
2	Continue briefing and training staff on Dignity in Care from health and social care and continue raising public awareness of Dignity in Care.	Tracy Ryan supported by Halton Dignity Champions' Network and Halton LINk			
3	Continue to positively promote the work of personalisation in Halton.	Helen Moir			
4	Continue the roll-out of the Productive Ward concept in both Whiston and Warrington Hospitals.	Warrington's Productive Ward lead and Anne Hyson at Whiston Hospital.			
5	The use of Health Passports throughout the care system and extended beyond Adults with Learning Disabilities.	???			
6	In single-sex wards at Whiston Hospital the male/female switch outside toilets should be accessible to	???			

	people with a visual impairment.				
7	Visit a ward at Warrington Hospital	Emma Sutton-Thompson			
8	Whiston Hospital to implement training and guidance for staff raising concerns and making complaints.	???			
9	HBC to continue to strengthen partnership working with Health.	Tracy Ryan supported by Halton Dignity Champions' Network			
10	Implementing mandatory Dignity in Care training for all agencies, HBC developing Dignity E-Learning	Tracy Ryan & HBC Learning and Development			
11	Revisit the role of Dignity in Care Champions to raise their profile including publicity, information and education. Halton's Dignity in Care Co-ordinator is a board member of the National; Dignity Partnership Board and Chairs the NW Dignity Leads Network which are currently developing action plans to implement this	Tracy Ryan supported by NW Dignity Leads Network			
12	Improve customer care so people feel more comfortable and confident about raising concerns or have support in making a complaint.	Halton's Customer Care Group and Halton Dignity Champions' Network			

My life Before and after my operation.

Laura Green

I am here today, to speak to you about my experiences in Manchester Royal Hospital.

There where a lot of things I wasn't very happy with when I was in hospital, and I did not have a very nice experience.

- On my first day I was asked to be in for 11am but I had to call the hospital to make sure I had a bed. They did not have a bed available for me until 4pm, this made me very upset as I didn't know if I would be able to have my operation. Eventually they said there was a bed available but we had to wait for 3 hours until my bed was ready. We where stuck in the waiting room.

- That night we found out that there was M.R.S.A on the ward I was staying on. This was very worrying as I was having major surgery the next day.

- The next day I went down for 9 hours open heart surgery, it went well.

- I was in intensive care for 3 days, where I was looked after very well.

- I then went back onto the ward, where things where very different, the next 8 days where very bad, if it wasn't for my mum staying with me through my recovery, I don't think I would have made it through.
- I had a health passport that nobody bothered to look at right in the front of my file.

- Nobody was there to help me pour my drinks or feed me as I had drips and drains. It was hard for me to move.

- My mum was helping other people on the ward because they needed help to.

- I was due on my period, my mum expressed this very clearly, she told them I am very sick when I have a period, and they assured my mum that injections to stop me being sick had been put into place. When I came on my period I started to be violently sick, again it was my mum who had to see to me, she tried five times to get a nurse to give me an injection to stop me being sick because of my wound.

- On my first day getting out of bed it took a nurse and my mum to help me to the toilet, when we got there the toilet seat was full of dried fee-sees, the nurse had to leave me with mum to get something to clean the toilet, my knees buckled and I nearly fell over.

- My mum had gone to get a coffee, the nurse came whilst my mum was away, she got me out of bed to put me on the weighing chair, but forgot to put the break on it and I fell over as I went to sit down.

- The doctors took my drains out too soon, this lead to me getting fluid on my lungs, and having to have an emergeny operation on the ward. Both me and my mum where in a lot of distress, it was very painful and scary.

- A few days later they moved me in to a side room, the room had not been disinfected and another patient had just been moved out of there with M.R.S.A, again there was fee-sees on the toilet. My sister had to make a formal complaint, I was then moved back out of that room so they could disinfect it.

<u>How I think it could change.</u>

- More organisation, making sure all patients due to have an operation have a free bed and a set time to get in to hospital, so nobody is waiting around.

- Patients with M.R.S.A should not be on any ward with vulnerable patients,

- Nurses should pay more attention to patients and their needs.

- Nurses should check health passports more often.

- Nurses should only be on duty to one ward not 2 or 3. That way they can pay attention and be more helpful to patients.

- More organisation should be put in place, for patients who have other medical problems, like my periods. And if plans are made all staff should stick to them.

- More communication between staff, there should be a message book for any urgent needs a patient requires.

- Nurses need to pay more attention to what they are doing, I could have been seriously injured when I fell of that chair.

- More attention needs to be paid to the toilets and side rooms, cleaning should be kept on top of.

- Doctors need to double check before they do anything drastic to patients, like taking their drains out, I was lucky others might not be.

Thank you.

REPORT TO: Health Policy & Performance Board

DATE: 7 June 2011

REPORTING OFFICER: Strategic Director, Communities

SUBJECT: Halton's Health and Wellbeing Joint Strategic Needs Assessment (JSNA)

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the process undertaken for the production of the 2011 JSNA and the key findings of the JSNA.

2.0 **RECOMMENDATION: That the Board note and comment on the report.**

3.0 **SUPPORTING INFORMATION**

3.1 The JSNA pulls together information about the current and future health and well being needs of the local population. It provides an opportunity to look into the future so that we can plan now for likely changes in needs. It is therefore one of the major influences in directing commissioning priorities and planning service development.

4.0 **EVALUATION OF HALTON'S FIRST JSNA**

4.1 In Autumn 2009, it was identified through evaluation of Halton's first JSNA that whilst the report contained lots of relevant data, the JSNA was light on context and Commissioner analysis. This made it a difficult document to decipher and was not user friendly.

4.2 Other feedback and evaluation points included:

- The requirement for a consistent format for each section, given that there are multiple authors involved.
- Greater analysis with clearer outcomes to aid commissioners
- Development of the JSNA to support the various preventative agendas
- Contribution from areas covering the wider determinants of health and wellbeing

4.3 In Autumn 2009 a 'refresh' of data contained in the original JSNA was undertaken and a summary document published with input from Commissioners. This highlighted where there had been any

significant changes in data or key messages from the original JSNA.

5.0 PROCESS FOR UNDERTAKING THE SECOND JSNA

5.1 In June 2010 a JSNA workshop was held with commissioners, analysts and policy representatives from across partner organisations to discuss data requirements for the JSNA. Feedback from the workshop was used to shape the JSNA process and chapter requirements.

5.2 The second JSNA has been developed using the same principles as Nottingham Council, identified as good practice by The NHS Information Centre for Health & Social Care. This was an on line chapter based approach with a focus on input from Commissioners and Lead Officers.

5.3 Following the workshop the Research and Intelligence Unit within the Council and Public Health Evidence and Intelligence Team in the PCT worked through the process of collating the data from the Core Dataset, the identification and analysis of supplementary data/information and transferring this into the various sections of the report. The Public Health Evidence & Intelligence Team pulled together all the policy/background introductions and evidence of what works sections for the PCT-lead chapters. In addition, any relevant research from the key areas was also transferred into the main document ensuring that the JSNA contains the most current available data and information.

5.4 As the various sections were being collated Commissioners were involved via the JSNA Working Group to ensure that the JSNA adequately reflected the local picture.

5.5 Commissioners and Lead Officers then contributed to their relevant chapters such as ensuring the introductions had the most up-to-date information key issues and gaps, recommendations, evidence of what works and further links sections. This provided context to the data to indentify where the gaps in service are and focused thinking for recommendations.

5.6 The main report is to be a web-based document split into chapters, making navigation around the overall report easier.

5.7 The JSNA will be available directly from the Halton Council website and from a link via the PCT website.

5.8 Subsequent JSNA's will continue to use an on line format. In between production of complete refreshes of the documentation, an annual refresh of data will take place coordinated by Halton Council's Research and Intelligence Team with the Public Health Evidence & Intelligence Team.

5.9 Chapters for Housing and Cancer are contained in Appendix 1 to illustrate the content and format of each chapter.

6.0 KEY FINDINGS FROM JSNA

6.1 The draft executive summary is attached in Appendix 2, which includes a summary of key findings and priorities.

6.2 Some of the findings relating to health and wellbeing and cross cutting issues are highlighted below:

6.2.1 **Alcohol** - Halton has been identified as the eighth worst local authority area in England for alcohol related harm and the 50th worst area for binge drinking (2010 LAPE).Alcohol related crime in Halton has reduced by 11% compared to last year and all violent crime has reduced by 12%, although in almost half of the violent crime incidents reported, alcohol was a contributing cause, as it was in 15% of the overall incidents of anti social behaviour.

6.2.2 **Heroine and/or crack cocaine** -Halton was amongst the top performers nationally in 2008/09 for reducing offending related to using heroin and/or crack cocaine. Halton has a high percentage, 85%, of people using heroin and/or crack cocaine seen by its drug services.

6.2.3 **Vulnerable Adults** referral numbers increased from 2004-2007, reduced from 2007-2010, but have significantly increased throughout the period April-December 2010 over the same period in the previous year. 359 abuse allegations were reported in total to Halton Borough Council in the year 2009-10. The reduction in referrals may have resulted from refinement of procedures followed in processing referrals, so whilst we continue to encourage people to refer concerns and allegations, decisions are then taken about the best course of action to deal with them. Managers and practitioners take account of service user views on the way their circumstances are managed, resulting in some referrals not being progressed through the safeguarding adults procedures. Some will result in other activity which will not be counted in the alleged abuse data e.g. care management, complaints procedure, contract monitoring or disciplinary proceedings. It is likely that recent steps taken to raise awareness, including training of staff and volunteers, and publicity, have contributed to the increase in referrals.

6.2.4 **Housing** affordability is a key issue for Halton with the average property price being five times the average income. This, coupled with increased demand for social housing along with falling stock levels, leads to a total net annual need for 891 affordable dwellings per annum (this figure is significantly higher than the 176 found by the Housing Needs Assessment of 2006).

6.2.5 **Deprivation** - The ward with the lowest unemployment rate was Daresbury, with a rate of 2.3%. Windmill Hill ward had the highest unemployment rate in Halton in April 2010 with a rate of 10.7%. The percentage of adults with learning disabilities in employment within Halton is 3.7%. This is lower than the regional average (5.2%) and lower than the average national rate (6.8%).Job Seekers Allowance (JSA) claim rate in Halton was 5.9% in April 2010; this is greater than the North West (4.5%) and Great Britain (4.1%) figures. Halton's median resident weekly pay increased from £345.9 in 2008 to £370.6 in 2009, this was the largest increase in gross weekly pay out of the 6 local authorities in the Liverpool City Region during the period. The most recent figures from 2008 reveal that in total there are 6,550 children living in poverty in Halton. Of these 5,520 children live in out of work families and 1,030 live in households classified as in-work. This underlines that whilst being in work reduces the incidents of child poverty it doesn't guarantee that children will be lifted out of poverty, particularly when there is only one working adult in the household

6.2.6 **Obesity** - According to 2009 & 2010 Health Profiles the percentage of adults classified as obese in Halton has risen slightly between 2003-5 and 2006-8. However rates still remain above the England average.

6.2.7 **Smoking** - The stop smoking rate for pregnant women has improved during 2010 with 25.5% staying quit at time of delivery in the first 2 quarters of 2009/10 compared to 22.5% in 2008/9.

6.2.8 **Teenage Pregnancy -** Since the baseline was established in 1998 we have seen a fluctuating picture in the numbers of conceptions reported. There has been no sustainable reduction over time. The rate increased from 52.3 in 2008 to 58.9 in 2009, placing Halton as having the 13th highest rate in England. However, in quarter 4 2009 Halton saw a reduction in the rate of conception. Halton is seeing a reduction in the percentage of conceptions leading to termination. In England, the percentage in 2009 was 49%. In Halton the percentage was 41%.

6.2.9 **Cancer** deaths make up 28% of total deaths among those over 50 years of age. Overall lung cancer accounts for the largest proportion of cancer deaths (23.2%) followed by colorectal at 9.6% and breast cancer at 7.8%. The rate of all cancer deaths is slightly higher in Halton across all age bands but the difference is only significant in the 85+ age group. Survival from lung cancer in Halton and St Helens is 30% after one year: one of the eight best rates in the North West. Survival from bowel cancer at one year is excellent at 71%. Survival from breast cancer at one year is high at 96%.The "Get Checked" campaign to improve cancer early diagnosis improved early detection of bowel, breast and lung cancer in the

poorest areas in Halton

6.2.10 **Cardio Vascular Disease** (CVD) **and Coronary Heart Disease** (CHD)- 2009 data for Halton indicates deaths from CVD had reduced. Admissions to hospital due to Coronary Heart Disease (CHD) are predominantly seen in the older age bands, admission rates are statistically significantly higher than the Halton borough rates in Grange, Halton Castle, Halton Lea, Ditton, Mersey and Norton South

6.2.11 **Coronary Obstructive Pulmonary Disease** (COPD)- Modelled estimates suggest that unless concerted action is taken, due to changes in population, the prevalence of COPD will increase. Rates are generally slightly higher for men than women, mainly due to differences in smoking prevalence. Death rates vary across the borough, with death rates for those over 40 from COPD during 2005-09 were highest in Halton Castle, Mersey, Halton Lea, Ditton and Appleton wards.

6.2.12 **Dementia** - Estimated numbers of dementia sufferers over 65 years old could increase by 155% by 2025, with over 4,000 patients in Halton and St Helens. Overall for the PCT, numbers of males over 65 years old presenting with dementia is expected to increase by 105% compared to 43% in females.

6.2.13 **Adults with Sensory and Physical Disability** - There are 5,968 people between the ages of 18 and 64 in Halton that have a physical disability. The majority of these (67%) are aged between 45 and 64 with 26% aged between 25 and 44 and 7% between 16 and 24. 3,117 people between the ages of 18 and 64 have a sensory disability. The majority of these (89%) are aged between 45 and 64 with 10% aged between 25 and 44 and only 1% between 16 and 24.

6.3 Additionally the following findings have come from the JSNA:

Priorities identified in the PCT's Commissioning Strategic Plan and by the Health Inequalities National Support Team visit, are still valid- smoking, obesity and alcohol contribute to the majority of deaths and admissions. Early detection is likely to reduce costs and improve outcomes in the major disease areas. Action on these areas should continue as they are likely to make the most difference in the short and longer term.

Some changes in prevalence suggest new priority areas:

- Injury prevention- due to increased hospital admissions and deaths. This could be linked with the alcohol agenda. Also, child accident prevention and older people's falls, whilst not linked to the alcohol agenda, are important causes of ill health for those population groups;

- Mental health, more broadly than early detection of depression, is a priority area due to the rise in suicides and undetermined injury. The economic recession and changes in benefits may also increase demands on services;

- Sexual health due to high prevalence rates;

- Child health- particularly infant mortality linked with maternity services and child and adolescent mental health services. Childhood obesity has levelled but should remain a priority due to the potential high impact.

There are some longer term trends in our population and needs which will impact on priorities:

- The numbers of frail older people will increase with increased need for services including dementia, obesity, falls prevention, chronic disease management hearing, vision and continence services.

- The numbers of people with a severe learning disability will also increase.

6.4 **JSNA 'SIGN OFF' PROCESS**

6.4.1 The JSNA and the Sustainable Community Strategy (SCS) documents were being developed at the same time and are quite clearly linked in terms of identifying key issues for health in Halton. Therefore we have tried to ensure that we work across the two documents to ensure that the SCS is developed around the findings of the emerging JSNA

6.4.2 The JSNA has followed the sign off process below:

Date	**Action**
1st February 2011	Draft JSNA circulated to Commissioners and Lead Officers for comment
16th February 2011	Update report to, and comments from, Adult and Community SMT
22rd February 2011	Update report to, and comments from, Children & Young People's SMT
23th February 2011	Commissioners and Lead Officers meeting to discuss comments received and any amendments required
10th March 2011	Update report to, and comments from the Health Specialist Strategic

	Partnership.
April 2011	Update report to, and comments from PCT Board
11th May 2011	Draft presented to Adult and Community SMT
17th May 2011	Draft presented to Children's Trust Executive Board
June 2011	Draft version presented to the Health Policy and Performance Board
June 2011	Draft JSNA published on Halton Council website and link from PCT website. Requesting comments from public by end of May 2011.
June 2011	Promotion of JSNA availability and how it can be accessed and used.

4.0 POLICY IMPLICATIONS

4.1 The JSNA will be used to inform the Commissioning Plans of the Local Authority and PCT. It will also be available to the third sector where it can be used to inform service development and identify further opportunities.

4.2 Going forward, the White Paper 'Liberating the NHS' undertakes that 'each local authority will lead the statutory joint strategic needs assessment, which will inform the commissioning of health and care services and promote integration and partnership across areas, including through joined up commissioning plans across the NHS, social care and public health.'

4.3 The newly formed GP Consortia will have specific accountabilities, responsibilities and duties that will be set out through primary and secondary legislation. This will include accountability and responsibility for determining healthcare needs, including contributing to the wider joint strategic needs assessment led by local authorities

4.4 Thus, GP consortia and local authorities, including the Director of Public Health, will each have an equal and explicit obligation to prepare the JSNA, and to do so through the arrangements made by the Health and Wellbeing Board. In turn the Health and Wellbeing Board will be expected to produce a overarching framework to commission and deliver plans across for the NHS, social care, public health, and other services. This health and wellbeing strategy should be informed by the needs identified in the JSNA.

4.5 The PCTs Commissioning Strategic Plan is a five-year plan 2008-9 to 2012-13. It covers 7 priority areas:

- Reducing harm from alcohol
- Reducing obesity
- Reducing harm from tobacco
- Early detection of major illness (cardiovascular, diabetes, respiratory, cancer)
- Early detection of depression
- Improving safety, quality and efficiency of service in urgent care
- Improving safety, quality and efficiency of service in planned care

The assessment of needs highlighted in the JSNA continues to reflect these priorities. As well as a strategic assessment of need used to inform the identification of these overarching priorities, a series of specialist health needs assessment and health equity audits conducted by the Public Health Evidence & Intelligence Team, are ongoing to support the delivery of key elements of these programmes.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 There are no financial implications identified in hosting the JSNA on the Halton Borough Council Website; however there may be a financial implication if the Authority receives any requests for hard copies, or copies in an alternative format/language. Printing of hard copies of the executive summary or individual chapters will be undertaken by the Council's Printing Services and done on a request basis. Production of the executive summary or individual chapters in an alternative format may inure an additional cost.

5.2 The Policy Officer (Health), Research Officers from the Council's Research and Intelligence Team and PCT Public Health Evidence & Intelligence Team will undertake any amendments required as a result of comments received on the draft JSNA.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Responsibility for JSNA is shared between the Director of Public Health, the Director of Adult Care and the Director of Children's Services. The JSNA provides a picture of children and young people's health and wellbeing and provides evidence and recommendations for commissioning of services to meet the health and wellbeing needs of Halton's children and young people.

6.2 Employment, Learning & Skills in Halton

Economic factors are a wider determinant of health and wellbeing. Deprivation is correlated with a number of aspects of poor health

and wellbeing in Halton.

6.3 **A Healthy Halton**

The JSNA forms a crucial evidence base and is a key document in the commissioning of health, social care and wellbeing services.

6.4 **A Safer Halton**

The JSNA highlights the impact of community safety issues on health and wellbeing.

6.5 **Halton's Urban Renewal**

The built environment, access to public and leisure services, employment sites and public transport all have an impact on health and wellbeing.

7.0 **RISK ANALYSIS**

7.1 The most recent JSNA data (the Autumn 2009 refresh) is now over 12 months old, therefore to present an up to date local picture of health and wellbeing for use by commissioners and lead officers in service planning and commissioning the JSNA needs to be published in a timely manner.

7.2 The JSNA and Sustainable Community Strategy are closely aligned and therefore the JSNA would have greater impact being published alongside the Sustainable Community Strategy.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 It is stated in the executive summary that if JSNA chapters are required in an alternative format these can be produced on request.

A Community Impact Assessment (CIRA) is not required for this report

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

None.

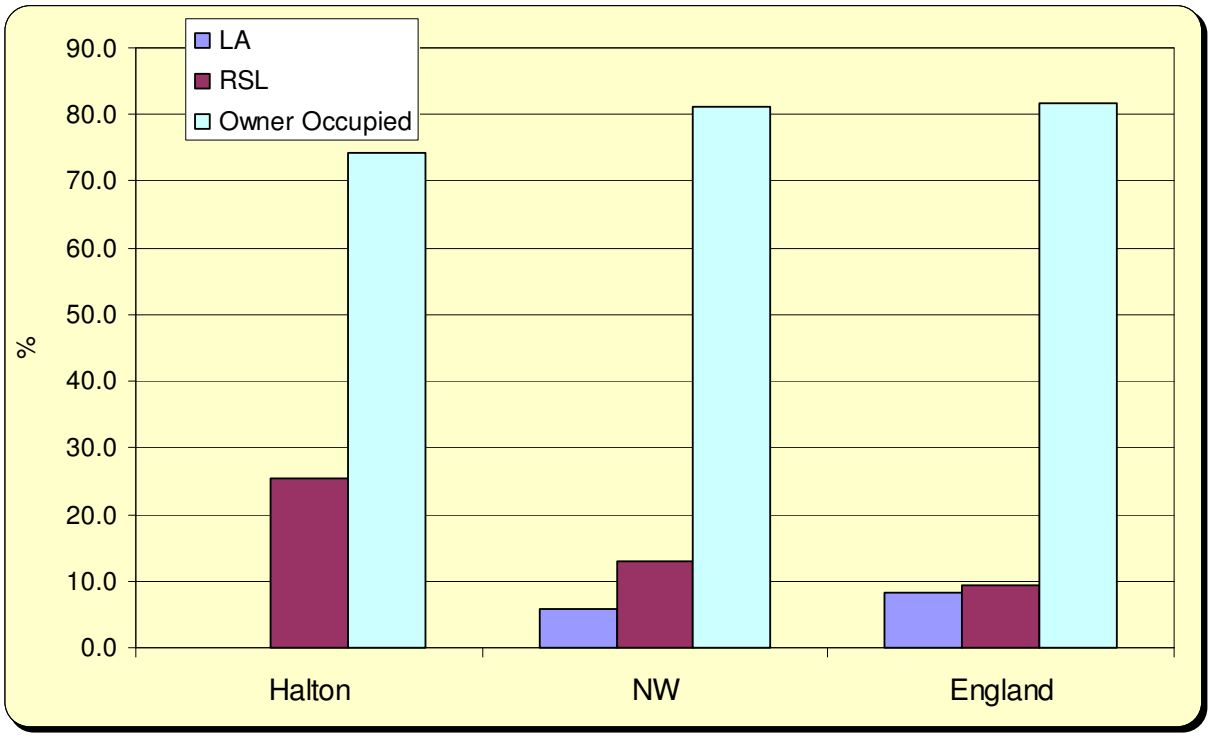
Appendix 1a - Housing

Introduction

The neighbourhood that someone lives in, the type of property that they occupy and the condition of that home, all have a huge impact on their health and well being. Research has clearly demonstrated that poor housing is a key determinant of health outcomes, being intrinsically linked to poor health, a reduced life expectancy, and a reduced overall quality of life / sense of wellbeing.

On the face of it there is also a link between tenure and health. Chart 1 shows Halton has a much higher proportion of social rented accommodation (25%) than both the regional (12.9%) and national (9.5%) averages.

Chart 1: Housing Tenure



Source: ONS Neighbourhood Statistics 2009

Table 1 shows the great variation in housing tenure in Halton. Owner occupancy varies from 99% of households in Birchfield to 6% of households in Windmill Hill, which has the greatest percentage of social rented dwellings. Birchfield on the other hand, contains no social rented dwellings. A significant proportion of social rented housing is located in the New Town estates in Runcorn.

The greatest proportion of privately rented accommodation is in Appleton, where 9% of households are privately rented compared with only 1% in Birchfield and Windmill Hill. Overall in Halton, 66% of households are owner occupied, 28% are socially rented and 4% privately rented, with the remainder being shared ownership dwellings, tied to employment tenancies or households living rent free.

When housing tenure is compared to health deprivation, it becomes clear that there is a strong correlation. The eight most deprived wards in terms of health have the lowest proportion of owner occupation in Halton, whereas the eight wards with the lowest health deprivation have the highest levels of owner occupancy.

However, this is not because social rented housing is in the worst condition, but because it, along with the private rented sector, houses many of the least prosperous members of the community who consequently suffer most deprivation. So the real link is between poverty and health.

Table 1: Housing tenure

Ward	Owner - occupancy %	Social Rented %	Private rented %	Other %	Health Deprivation Ranking
Windmill Hill	6%	92%	1%	1%	1
Castlefields	34%	61%	2%	3%	2
Halton Lea	40%	53%	3%	4%	3
Norton South	49%	47%	3%	2%	5
Riverside	51%	37%	7%	5%	4
Grange	55%	40%	2%	3%	8
Kingsway	60%	33%	3%	4%	7
Halton Brook	62%	32%	5%	1%	6
Broadheath	65%	28%	4%	4%	13
Mersey	65%	24%	8%	3%	11
Hough Green	65%	27%	4%	4%	12
Appleton	68%	18%	9%	4%	9
Ditton	70%	24%	2%	3%	10
Norton North	70%	22%	3%	5%	15
Halton View	77%	16%	4%	2%	14
Heath	86%	6%	6%	2%	16
Farnworth	89%	7%	5%	0%	17
Hale	92%	2%	6%	0%	18
Daresbury	94%	2%	3%	2%	20
Beechwood	95%	2%	3%	0%	19
Birchfield	99%	0%	1%	1%	21
Halton overall	**66%**	**28%**	**4%**	**3%**	

Source: Halton Housing Needs Survey 2006

The Housing Act 2004 gave councils revised powers to tackle the health impact of poor housing under the Housing Health & Safety Rating System (HHSRS), which assesses the risks to health and / or safety posed by housing conditions. There are 29 hazards in the HHSRS, including excess cold, damp, fire, entry by intruder and fall hazards. These hazards are scored and a result of >1,000 equals a Category 1 hazard, where the Council has a duty to act, and a score <1,000 is Category 2 where the Council has the power to take action.

Addressing the health hazards posed by poor physical housing conditions can have a

number of benefits; for example, rectifying an excess cold hazard can reduce the risk of respiratory and cardiovascular disease, lessen the impact on conditions such as arthritis and ease the financial burden and associated stress of trying to heat a home that may be poorly insulated / energy inefficient.

As well as the effect of physical housing conditions on health, there are wider issues to consider in the links between housing and health. Homelessness, or the threat of it, can lead to feelings of stress and depression and other associated health problems. The same can be said of financial worries, which given the current economic climate are a particular issue especially in relation to mortgage repossessions.

Failure to adequately address the investment needs of poor housing conditions also has the potential to lead to –

- Neighbourhoods experiencing low demand as property values reduce.
- The sustainability of social housing estates being jeopardised as tenants seek alternative landlords with better housing in more popular areas.
- Neighbourhood transformation programmes becoming more complex as poor housing conditions impact on a number of baseline indicators such as crime, health and the environment.
- The economic, health and educational well being of residents being adversely affected, resulting in deepening social exclusion.
- Health inequalities being exacerbated.
- Social-inclusion becoming more difficult as poorer families become trapped in low quality housing, limiting their options to move.

Other relevant chapters –

- Economic
- Older People
- Social care
- Child Poverty
- Community Safety
- Coronary Obstructive Pulmonary Disease (COPD)
- Child Accidents

Key issues and gaps

A proportion of the information presented in this chapter is based on historical data as the Housing Needs Assessment was carried out in 2006. At the time of writing this chapter the Council had commissioned a Strategic Housing Market Assessment to update and refresh this data along with its Mid-Mersey Growth Point partners, St. Helen's and Warrington. A first draft of the report on the findings relating to Halton reveals the following headline results –

- Halton's ageing population will lead to increased demand for specialist housing and falling household sizes will mean smaller dwellings are more suitable for some households.

- Unemployment is high and incomes are low with those commuting into the borough for work being higher paid than those residing in the borough.

- There has been an increase in the housing stock over the last decade and increases are likely to be required in the future. There is an imbalance in the housing offer with the proportions of terraced housing and social rented stock being particularly high.

- House prices in Halton are significantly lower than the national average and have been largely unaffected by the economic downturn, however, low incomes and savings mean that many households are unable to access market housing.

- The private rented sector is characterised by a high proportion of benefit claimants, which suggest it is being used as an alternative to social rented housing and has therefore compensated for the reduction in social stock.

- Affordability is a key issue for Halton with the average property price being five times the average income. This, coupled with increased demand for social housing along with falling stock levels, leads to a total net annual need for 891 affordable dwellings per annum (this figure is significantly higher than the 176 found by the Housing Needs Assessment of 2006).

- The greatest demand with regards to market and intermediate (e.g. shared ownership) housing is for three bedroom homes. In the affordable sector, there is a need for smaller and larger units but the groups with greatest priority (i.e. those with children) are more likely to need larger homes.

- There are high levels of housing unsuitability for those with some form of disability or support need and a range of adaptations and support are required to resolve these issues.

- There are a high proportion of households containing pensioners in the borough and this is likely to increase further in the future, leading to an increased need for specialist accommodation and the expansion of support services that are already in place. Older person households are also often under-occupied.

- A significant proportion of housing need / demand in Halton arises from families with dependent children and lone parent groups are particularly disadvantaged and concentrated in social and private rented housing.

Other issues identified have been affected by the current finical climate, and include:

- **Investment** Previous years have seen a significant increase in investment in housing, to meet the national housing shortage identified by the Barker review of housing supply in 2004, and in latter years to provide a stimulus to the construction trade as the economic recession developed. The current financial climate is such that the public sector is experiencing cuts in spending and housing may be one of those areas affected. This will impact on what can be done to meet the needs identified in Halton. Scaling back of the Supporting People programme, which is a Government funding stream that funds housing related support to vulnerable groups living in the community, is also likely to constrain the Council's ability to both maintain existing service levels and support new services.

- **Private Sector building** Private sector house building to meet the needs of the general population has slumped, and mortgage finance is less freely available. This, coupled with the increasing unaffordability of housing for sale, is leading to increased demand for social rented and private sector rented tenancies at a time when potential changes to housing benefit and the wider welfare support system could make private renting more unaffordable, and funding through the Homes and Communities Agency for new social housing could be reduced.

- **Repossessions** In September 2009 Halton was identified as one of 22 repossession hotspots within the UK. Funding was secured from the Working Neighbourhood Fund to provide additional capacity within the team to deal with homeowners at risk of repossession. The Mortgage Rescue Adviser has been in post since February 2010, however the funding was for a fixed period of 12 months. In June 2010 further changes were made to the Support for Mortgage Interest Scheme which saw the interest rate used by the Department of Work and Pensions reduced from 6.08% to 3.63%. This reduction has already had an impact on the workload of the Mortgage Rescue Adviser having seen the number of referrals from September to October increase by 225%.

- **Bank of England Base Rate** The Bank of England base rate has been set at 0.5% since March 2009, any rise would have a significant impact on the number of households at risk of repossession. A 0.4% increase in interest rates would see repossessions increase by 19%, see http://www.communities.gov.uk/documents/housing/pdf/1643688.pdf.

- **Possession Claims** The Ministry of Justice have published figures on possession claims and orders for quarter 2 of 2010/2011. In Halton 55 mortgage possession claims were issued and 45 led to orders being made, these figures are lower then in the same quarter for the previous year, however claims per 1000 households in Halton are amongst the highest in the North West.

This scenario presents a challenging environment in which to just maintain current services, let alone address additional unmet needs and service gaps. It will therefore be

essential to prioritise areas for future development and investment based on whatever reduced level of resources is available.

Recommendations for consideration by commissioners

A number of priorities have been identified in Halton's Housing Strategy 2008-2011, which feed into the Sustainable Community Strategy for Halton –

Priority 1 – A Healthy Halton

- Achieve a year on year reduction in the proportion of non decent private sector homes occupied by vulnerable households
- Improve conditions in the private rented sector
- Increase the number of people on income based benefits who live in energy efficient homes
- Improve the provision of supported housing for an ageing population
- Improve equality of access to housing adaptations

Priority 2 – Halton's Urban Renewal

- Monitor progress towards delivery of decent homes target in the social rented sector.
- Ensure plans are in place to meet Decent Homes Plus (subject to agreed standard being introduced by Government)
- Increase the supply of affordable housing in the Borough in line with the recommendations of the Housing Needs Survey
- Introduce Choice Based lettings by 2010
- Update data on condition of the private sector stock
- Complete the regeneration of the Castlefields estate
- Commission consultants to undertake research to prioritise regeneration of New Town estates
- Work in partnership with local authority partners to improve the housing offer in the Liverpool City Region

Priority 3 – Children and Young People

- Complete Homelessness review and new Strategy
- Reduce the level of overcrowding within social rented housing

Priority 4 – Employment, Learning and Skills in Halton

- Maximise the employment related benefits of physical improvements / refurbishment works
- Expand programme of housing construction/improvement training activity
- Deliver increased employment outreach activity with Registered Social Landlords through Job Centre Plus and Halton People into Jobs

Priority 5 – A Safer Halton

- Work with housing providers to reduce the incidence and perceptions of Anti Social Behaviour
- Conduct research into long term vacant dwellings in Halton with a view to participating in the development of a sub regional Empty Homes Strategy

Many of these actions are ongoing, with the Council's commissioning role limited to 'enabling' through partnership working and direction. Future efforts therefore need to be focussed on –

- A review of the housing strategy following production of the Strategic Housing Market Assessment in 2011.

- The development of an affordable housing policy to secure increased affordable housing provision when market conditions improve.

- The prioritisation of the development of housing to meet the needs of those with disabilities.

- The development and introduction of a new Choice Based Lettings scheme in partnership with local and sub regional partners.

- Securing resources to fund the emerging Affordable Warmth Strategy.

- Managing the anticipated reduction in resources to minimise the impact on front line services.

- Ensure funds are available to assist in the prevention of repossessions. Spend to date from the Communities and Local Government Grant (CLG) grant issued in 2010 is over £40k. This grant is unlikely to be re-issued by CLG given the 20% departmental cuts.

- Continue to provide specialist advice and support to Homeowners by retaining Mortgage Rescue Adviser post. If the post is removed then Halton will be unable to administer the Mortgage Rescue Scheme which has recently received financial backing for a period of 4 years.

- Evaluate effectiveness of publicity campaign for mortgage repossession and determine the best medium to use for a new campaign in 2011.

Level of need in the population

The extent of unmet housing need and poor housing conditions have been established and described in detail through a number of extensive pieces of work, including –

- Housing Needs Assessment 2006
- Gypsy/Traveller Needs Assessment 2007
- Extra Care Housing Commissioning Strategy 2008
- Private Sector Housing Condition Survey 2009
- Annual returns from Housing Associations

This data is refreshed typically every 3 to 5 years and paints the following picture of Halton.

Although Halton enjoys low property prices compared to regional and national averages, housing is becoming unaffordable for an increasing number of people due to house price inflation and the Borough's low wage economy.

Although the population has been stable in recent years, the trend toward smaller households has led to increased housing demand.

Overall need for new dwellings is estimated at 600 per annum.

Demand for social rented housing has increased in recent years but the number of social rented dwellings becoming available for letting has declined, resulting in an estimated need for 176 new 'affordable' dwellings per annum.

The private rented sector has expanded in recent years but cannot fully meet the needs of households who are unable to either buy or access social rented housing.

Halton's status as a Housing Growth Point with St Helens and Warrington offers the opportunity to tackle issues of affordability and access to the housing market, but this has been frustrated in the short term by the economic downturn.

The private sector housing stock is in generally good condition although there are concentrations of older terraced housing with the potential to fall into decline without investment by the owners, and conditions in privately rented property are generally poorer.

Registered Social Landlords are on target to meet the 2010 target of making all homes comply with the decent homes standard.

There is a high demand for aids and adaptations as a consequence of the ageing population profile and poor health in the Borough, and a lack of housing complying with the Lifetime Homes Standard and that are wheelchair accessible.

Provision for Gypsies and Travellers has been improved with the development of a 14 pitch transit site.

There is a need for increased specialist housing provision for a range of vulnerable groups including the elderly, those with physical or learning disabilities, and people with mental health problems.

Homelessness remains an intransigent problem, but the refocusing of services on prevention and the use of new tools has contributed to reducing the number of acceptances and those having to be placed in temporary accommodation.

12.2% of households in Halton are in fuel poverty (spending more than 10% of their net income to maintain satisfactory heating and meet all other fuel needs).

For quarter 2 of 2010/2011 27 owner occupied households received advice with regards to difficulties they were having on maintaining mortgage payments.

Within the same period 17 households were prevented from being repossessed as a result of work carried out by the Mortgage Rescue Adviser.

1 household has been rescued under the Mortgage Rescue Scheme.

67 households received notification of court proceedings in Quarter 2 of 2010/2011, all households received correspondence from the Mortgage Rescue Adviser offering free, impartial and confidential advice.

Current services in relation to need

- **Extra Care Housing** There is currently just one Extra Care housing scheme in Runcorn comprising 40 units.
- **Gypsies & Travellers** Halton has two Council managed caravan sites for Gypsies & Travellers, one a permanent site with 22 pitches and the other a transit site with 14 pitches. There are also two small privately run sites.
- **Affordable Warmth** An Affordable Warmth Strategy is currently being developed and an action plan produced. The Affordable Warmth Steering Group will oversee implementation of the action plan. This will help to address issues surrounding fuel poverty and energy efficiency.
- **Grants** The Council offers a number of means tested grants / loans to assist owners with essential property repairs; for the improvement of energy efficiency; and for adaptations required by the disabled.
- **Landlord Accreditation Scheme** The Council operates a Landlord Accreditation Scheme which seeks to promote high standards in the private rented sector.
- **Rent Bond Scheme** A Rent Bond Guarantee Scheme enables those at risk of homelessness to access accommodation in the private rented sector. This scheme provides the rent deposit, which is unaffordable for many vulnerable households.
- **Housing Solutions** The Council has a dedicated Housing Solutions team who provide advice and assistance to the public on homelessness and housing related issues. The team work to prevent homelessness wherever possible and to assist in finding emergency / temporary accommodation where homelessness

cannot be avoided.

- **Mortgage Rescue Adviser** There is a dedicated Mortgage Rescue (MR) Adviser in the Council's Housing Solutions team who provides advice and assistance to help people to keep their home, including Court representation. The MR Adviser also facilitates the Mortgage Rescue Scheme and repossession fund for Halton Borough Council.
- **Money Advice** Housing Solutions team have provided funding to Halton & District CAB for a fast track money advice service which can be accessed for Mortgage Rescue cases or tenants at risk of repossession.

Evidence of what works

Adaptations – Halton has found that working in partnership with Housing Associations to jointly fund adaptations to the homes of their disabled tenants works successfully, and has significantly reduced backlogs and waiting times for essential works.

Early Intervention – a realignment of the Housing Solutions Service to prioritise prevention work has helped to significantly reduce the number of households becoming homeless. The use of things like rent bond guarantees to help secure private sector tenancies, mediation services, Court representation and supported lodgings schemes for young people, have all proved their worth.

Transit Site – the introduction of a Travellers' transit site in 2009 has greatly reduced the number of unauthorised roadside Traveller encampments, and in the process saved the Council something in the order of £130,000 per year, as well as providing much improved services for this marginalised section of the community.

Extra Care Housing – although there is currently only one extra care housing scheme in the Borough, it has been a great success. The model of providing independent accommodation with on site support for personal care and health needs has been demonstrated both with this scheme and in countless others nationwide to be very popular.

Regeneration – significant investment has been made in transforming the Castlefields estate in Runcorn, one of the most deprived areas of the Borough, demolishing unpopular and obsolete system built deck access housing and replacing it with high quality traditionally constructed housing. This has been accompanied by investment in the local infrastructure. The impact on improved health and sense of well being may become clearer in future years. However the cost of this approach is significant and replication in other parts of the Borough will be a challenge given the economic climate.

Mortgage Rescue – In January 2009 the Government launched a package of measures designed to assist homeowners at risk of repossession as a result of the economic downturn. Under these measures two new schemes were launched; Homeowner Mortgage Support Scheme and the Mortgage Rescue Scheme. In addition

to this the Government relaxed the eligibility criteria for existing support for homeowners under the Support for Mortgage Interest scheme. Local Authorities also received grants from Communities and Local Government to use for the prevention of repossessions. The Secretary of State for Communities and Local Government recently announced a further £200m would be provided over the next 4 years for Mortgage Rescue, however Homeowner Mortgage Support will cease in March 2011.

- Since the Mortgage Rescue Adviser has been in post 94 homeowners have approached the Council for assistance. 36 homes have been saved from repossession representing a substantial cost saving to the Council given that in 2007 CLG estimated the cost of a homelessness case to be over £5k.
- 12 households have completed a full Mortgage Rescue application, 1 household has been rescued, 2 failed to complete the progress and 9 are still ongoing. 1 Homeowner is being assisted in converting his shared ownership property back to a full assured tenancy.
- 17% of the 94 approaches made have been as a result of the PR campaign, 50% of these cases have been assisted in preventing the repossession of their home.

Unmet needs and service gaps

Number of dwellings There is a need to increase the overall number of dwellings being built in the Borough to at least 600 per annum to keep pace with demand.

Affordability The proportion of that housing which is 'affordable' needs to increase, which will require the introduction of an 'affordable housing policy' under the Local Development Framework requiring private developers to contribute.

Extra Care Housing There is a current need for an additional 137 units of extra care housing, and increased provision for those with disabilities (physical / sensory / learning.

Social Rented Housing The process for applicants to apply for social rented housing is made unnecessarily complex due to each Housing Association operating in the Borough maintaining a separate waiting list, and using a different allocations policy. The policies also tend to be outdated models, offering little choice to the applicant. The introduction of more choice and increased transparency would help to make neighbourhoods more sustainable, and a single allocations policy and waiting list would greatly simplify processes and be more customer friendly.

Financial Assistance Take up of financial assistance to repair private sector homes has declined in recent years. Advertising could increase awareness of the help available, which may result in more take-up and an associated improvement in housing conditions. However, resources are constrained and there may be a move to loans in the future, which are not popular with customers.

Health and Safety No action is currently taken against Landlords who refuse to carry

out necessary works on their properties following the identification of Category one hazards under the Housing Health and Safety Rating System. Housing Act 2004 places a duty on Local Authorities to take enforcement action when category 1 hazards are identified.

Eviction Anecdotal evidence indicates that illegal eviction in the private rented sector is a problem within Halton. Perhaps this is due to the fact the no Landlord has been prosecuted by HBC for this behaviour. Harassment and illegal eviction are both criminal offences under the Protection from Eviction Act 1977 and Local Authorities have the power to start legal proceedings and prosecute when the evidence justifies this.

Further needs assessment required

- The 2006 Housing Needs Survey is a key source of data but is now quite out of date. A Strategic Housing Market Area Assessment, jointly procured by Halton, St Helens and Warrington, will provide updated information early in 2011 to inform a review of the Council's Housing Strategy.
- The 2007 Cheshire Partnership Area Gypsy & Traveller Accommodation and Related Services Assessment will need refreshing by 2012.
- Whilst the Housing Needs Assessment provides some information about the specific needs of people with disabilities (physical / sensory / learning), more work is required to more accurately assess needs.
- The information in this chapter has been prepared at a time when a number of reforms were announced by the Coalition Government. Some brief information is presented below; however, continued analysis is required to fully assess the potential impact of the changing policy landscape on housing needs.

Social Housing Reform
Through the Localism Bill, the Government propose a series of reforms to social housing which aim to make the system more flexible by giving social landlords increased freedom around who is offered housing and the type of tenancy they are given in order to restrict access to those in the greatest housing need.

Housing Associations will be able to offer 'flexible tenancies' either at current social rents or a new 'affordable rent' of up to 80% of local market rents. In either case, the tenancies will be for a shorter term (fixed for at least two years with no maximum term) – this is what has been termed the 'end to lifetime tenancies' and the idea behind it is that not all families need lifelong subsidy and should be able to move on when their situation improves (e.g. upon finding employment).

The key concern in relation to the impact of these reforms on housing need is that the introduction of fixed term tenancies could lead to an increase in homelessness applications, depending on the inclination of housing associations to apply policies rigidly and seek possession at the end of the fixed term period. In addition, there are affordability issues to consider in relation to raising social rents to 80% of market rents and there has been controversy over asking families to leave their homes once entering

employment because of the disincentive to work issue.

It is important to remember that housing associations have a choice as to whether they follow these changes or not and it remains to be seen what position those operating in Halton will take. Although, there is an expectation that the additional income generated from charging 80% rents will be used to support borrowing for new housing developments and it is almost a pre-condition for accessing funding.

Welfare Reform
Government have outlined a number of reforms to the welfare system including –

- A cap of £26,000 on the amount of benefits a household can receive in a year.
- Households deemed to be under-occupying their property will face cuts to their housing benefit.
- Increases to the level of deductions from housing benefit for households with non-dependant members.
- Changes to Local Housing Allowance, including removal of the five-bedroom rate and caps on the weekly rates.

It is feared that each of these proposals (especially when considered alongside the social housing reforms) will lead to affordability issues for households, potentially resulting in –

- Families being forced to leave their homes or losing them due to rent arrears.
- Families, including children, being driven deeper into poverty.
- Increased overcrowding levels as families have no choice but to move to smaller, cheaper, accommodation.

Key contacts and further links

Housing Strategy Manager – 0151 471 7450

Halton Housing Strategy 2008 to 2011 – http://hbccms.halton-borough.gov.uk/content/housing/housingstrategy/?a=5441

Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society (2008) – http://www.communities.gov.uk/publications/housing/lifetimehomesneighbourhoods

Commissioning Strategy for Extra Care, May 2008 – http://www2.halton.gov.uk/pdfs/socialcareandhealth/stratextracare08

Housing Needs & Market Assessment Survey, 2006 – electronic copies available from Adults & Communities

Private Sector House Condition Survey, 2009 – electronic copies available from Adults & Communities

Cheshire Partnership Area Gypsy & Traveller Accommodation and Related Services Assessment, 2007 – http://hbccms.halton-borough.gov.uk/content/housing/gypsiestravellers/?a=5441

http://www.communities.gov.uk/documents/localgovernment/pdf/1745945.pdf
see www.justice.gov.uk

Appendix 1b- Cancer

Introduction

In June and July 2010 the Public Health Evidence & Intelligence team undertook an analysis of premature mortality due to cancers in Halton. The team had conducted a health equity audit of cancers in 2008-9. This chapter has taken information from these reports. Additionally an assessment of local cancer screening programmes was included in the 2009-10 Public Health Annual Report.

Cancer is a disease caused by normal cells changing so that they grow in an uncontrolled way. There are over 200 different types of cancer. In Halton the four most common cancers are lung, bowel, breast and prostate. In the UK over half of cancer deaths are due to these four cancers (*Department of Health 2007*).

Whilst the evidence indicates that substantial reduction in deaths from cancers can be achieved by healthy lifestyles (in particular, quitting smoking, eating a healthy diet and not being overweight) interventions to bring about this change are long-term. Local assessment suggests capacity in secondary care is not a significant issue. In the short term the most likely way to improve survival times and reduce deaths from cancer is to get people who have symptoms to come forward for treatment faster. This may have a knock on effect to secondary care services which needs to be factored in. The Primary Care Trust (PCT) has been implementing an Early Presentation and Detection Programme as part of the Healthy Communities Collaborative – the 'Get Checked' project.

Cancers are the second largest single cause of death in Halton (circulatory disease is the largest single cause). Mortality rates have been decreasing over recent years. However, the PCT remains above the rates for the North West and England. The rate of improvement in Halton, especially for women, has been much lower than that of its comparator boroughs (Middlesbrough, Stockton-on-Tees and Hartlepool). The top three site-specific cancers are lung, bowel, breast (women) and prostate (men). There are various approaches to tackling cancers:

- Prevention such as measures to discourage people from starting to smoke cigarettes/tobacco or helping them to quit
- Early detection through encouraging people to identify symptoms and present to their GP as soon as possible
- Systematic screening programmes to target groups at most risk

Other relevant chapters:

- General health and mortality
- Smoking
- Alcohol
- Obesity
- Substance misuse
- Economic

Key issues and gaps

Key findings of the 2010 Halton Premature Mortality from Cancers Report were:

- **Mortality**. Windmill Hill and Halton Castle wards have the highest death rates for all cancers under the age of 75. This is true for both males and females. Broadheath also has a high rate. Beechwood and Hale are statistically lower than the Halton average for female under 75 mortality. Halton's all cancers excess death rate is high compared to all comparators except Hartlepool. The individual cancers with the most number of deaths (and for which comparator data was available) were also investigated. Excess death rates are high for stomach cancer and (especially for females) for oesophageal cancer compared to statistical neighbours.

- **Life expectancy**. The contribution that cancers make to the gap in life expectancy between the PCT and England has fallen (2003-05 to 2006-08). However, it remains a substantial feature, especially for females in Halton where the relative contribution remains above that of the Spearhead PCT group (at 2006-08 27% compared to 22%).

- **New incidents of cancer**. The excess incidence (new cases) of cancers in Halton is high compared to its comparator boroughs. This is especially so for males, where only Middlesbrough experiences a higher excess rate. Halton has one of the highest excess incidence rates for lung cancer (both males and females), is slightly higher for male skin cancer incidence but does not experience excess breast cancer incidence. Perhaps the most stark comparison is with St Helens where incidence is much lower than in Halton for cancers as a whole, lung cancer (both males and females) and males for skin cancer.

- **Risk factors**. The three main risk factors for cancer are smoking, obesity and alcohol. It is possible to estimate the contribution these make to cancer deaths overall (Table 1).

Table 1: Mortality attributable to obesity, alcohol and smoking, 2004-8

	OBESITY		ALCOHOL		SMOKING	
	Male	Female	Male	Female	Male	Female
	Observed	Observed	Observed	Observed	Observed	Observed
Halton	11	23	25	11	200	113
St Helens	16	35	30	14	271	139
PCT	27	59	55	26	472	252

Although the estimated levels of smoking have fallen to be one of the lowest of the comparator group used, it remains above the England average rate. Halton also has one of the highest alcohol-related hospital admissions rates. This is significant as, for certain cancers, the risk of developing cancer rises exponentially for individuals who both smoke and consume high levels of alcohol. This is the case with oesophageal cancer and may go some way to explaining why Halton has one of the highest rates of excess deaths from this cancer of the comparator group for both men and women. Smoking quitters data is only available for comparison at PCT level. At this level, the

PCT has greater success rates than all its comparators. It has a lower level of people setting a quit date per 100,000 population than many of its comparators but conversely, has a higher success rate per 100,000 than all comparators apart from Hartlepool.

- **Environmental factors.** It is estimated that about 2-5% of cancers are due to occupational exposure and 1-5% of cancers are due to environmental factors. This compares to 29% of cancers being due to tobacco with other lifestyle factors also being significant, as is the influence of reproductive hormones (although much less so than lifestyle behaviours).

- **Survival rates.** A new way of monitoring improvements in cancer treatment has been developed by ONS and the National Cancer Intelligence Network (NCIN). For each of the 152 primary care trusts in England and for each of the 11 years 1996–2006, an index has been constructed of one-year relative survival for all cancers combined[1]. For England as a whole there has been an increase in 1-year survival. This is reflected in the local data with annual rate for Halton & St Helens PCT also rising. The PCT 1-year survival rate in 2006 was 65.2% compared to 65% for England as a whole. This was a higher rate than Halton's borough's comparator areas.

Recommendations for consideration by commissioners

Continue to ensure full implementation of the Cancer Reform Strategy:

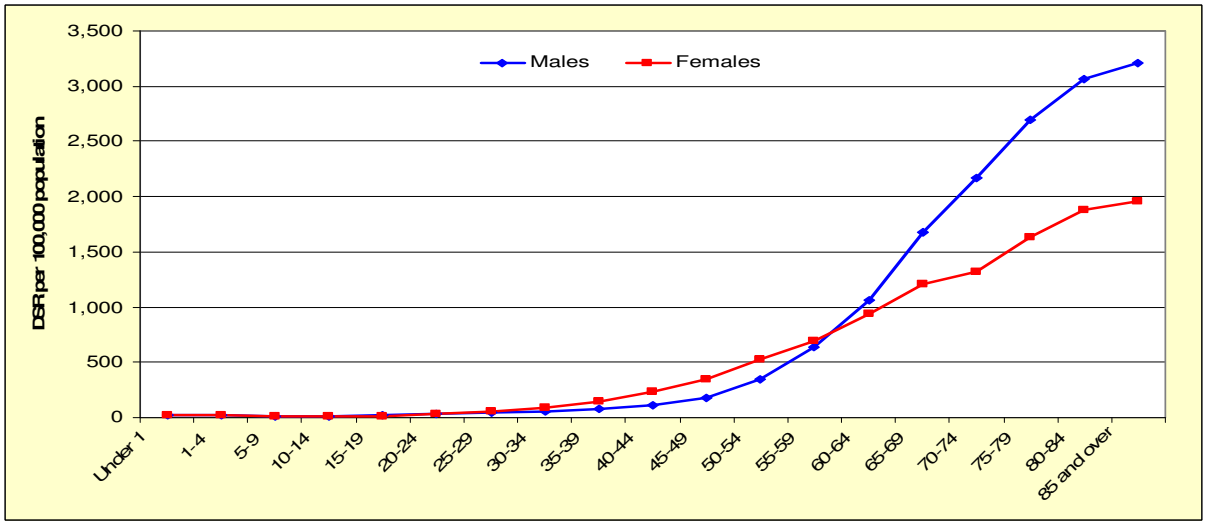
- Continue to support the Early Detection/ Healthy Communities Collaborative for Cancer in Halton to raise awareness of the signs and symptoms of cancer and promote early presentation to health services
- Implement the recommendations made in the 2009-10 Public Health Annual Report for cancer screening
- Ensure cancer prevention is part of all commissioners' approach to tackling premature deaths from cancers.
- Continue to a participate in the peer review process through the cancer network
- Continue to develop and support screening programmes
- Continue to focus on reducing the prevalence of smoking within the population,
- Reducing other risk taking behaviours including alcohol and promoting better diet and more active lifestyles
- Promotion of the human papilloma virus (HPV) vaccination to young girls
- Community focussed social marketing work to understand the barriers to cancer screening through the Get Checked programme
- Improving the expertise of cancer treatment services – balancing concentration of specialist skills with improved access
- Continue to support and develop care pathways for Cancer locality teams to ensure improved access to diagnosis and treatment

Level of need in the population

Incidence

In 2007 nationally there were around 180,000 new cases of cancer registered (malignant and non-malignant) for males and 196,000 for females. Cancer is predominantly a disease of the elderly. The overall crude rates of cancer registrations – 490 per 100,000 population for males and 470 per 100,000 population for females – conceal wide differences between the sexes and across the age groups, as illustrated in Figure 1.

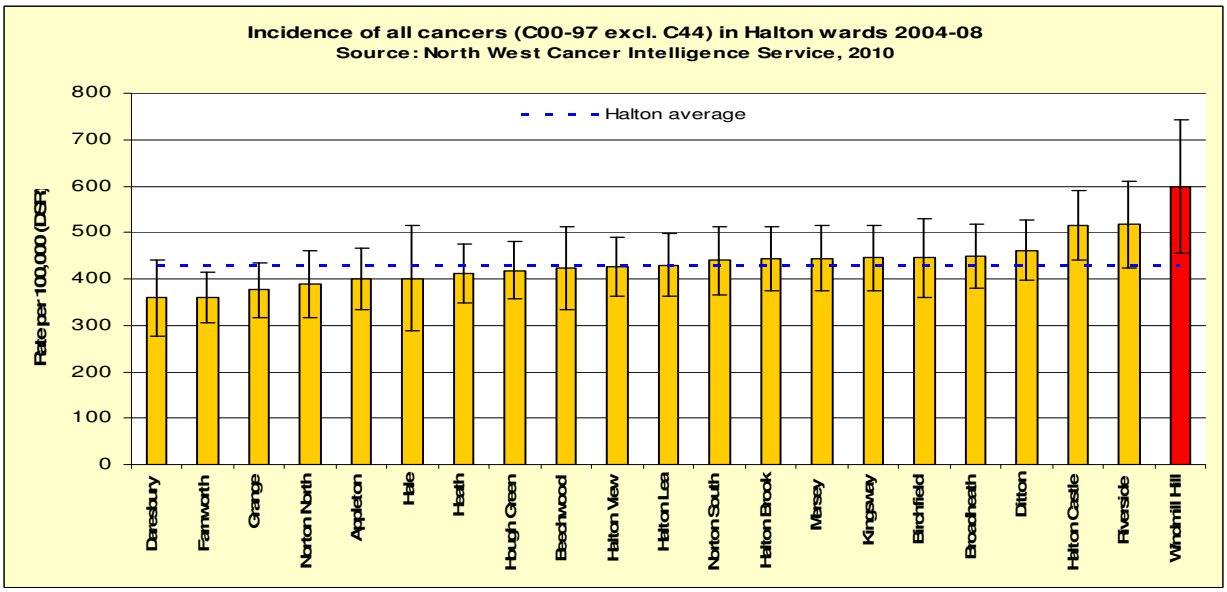
Figure 1: National incidence rates for all malignant neoplasms (excluding non-melanoma skin cancer ICD-10 C44), by age group, 2007



Source: ***Cancer Statistics Registrations 2007***[i]**.**

Local incidence also varies by ward as Figure 2 shows. However, this variation is only statistically significantly different to the Halton average rate for Windmill Hill which has a statistically higher rate.

Figure 2: Cancer Incidence by ward, (all cancers, persons, all ages) 2004-08



Screening

(information taken from 2009-10 Halton & St Helens Public Health Annual Report and PCT cancer screening reports)

The aim of a screening programme is to detect a disease earlier than if the person had waited for symptoms to develop, reducing the harm caused by the disease or its complications and the number of deaths from that disease. The tests used will identify which people have a high risk of disease, and offer those people further testing. The further test will be a diagnostic test. Those diagnosed with the disease can then start appropriate treatment earlier than they otherwise would have done had they waited until they started to have outward symptoms of disease. This increases the likelihood of the disease being cured or successfully managed, the risk of complications may be reduced and the effect the disease has on the persons life minimised. Screening is very different from clinical medicine because the health service is targeting apparently healthy people, and offering them a test to look for a disease.

There are three nationally defined screening programmes for cancer: breast, cervical and bowel.

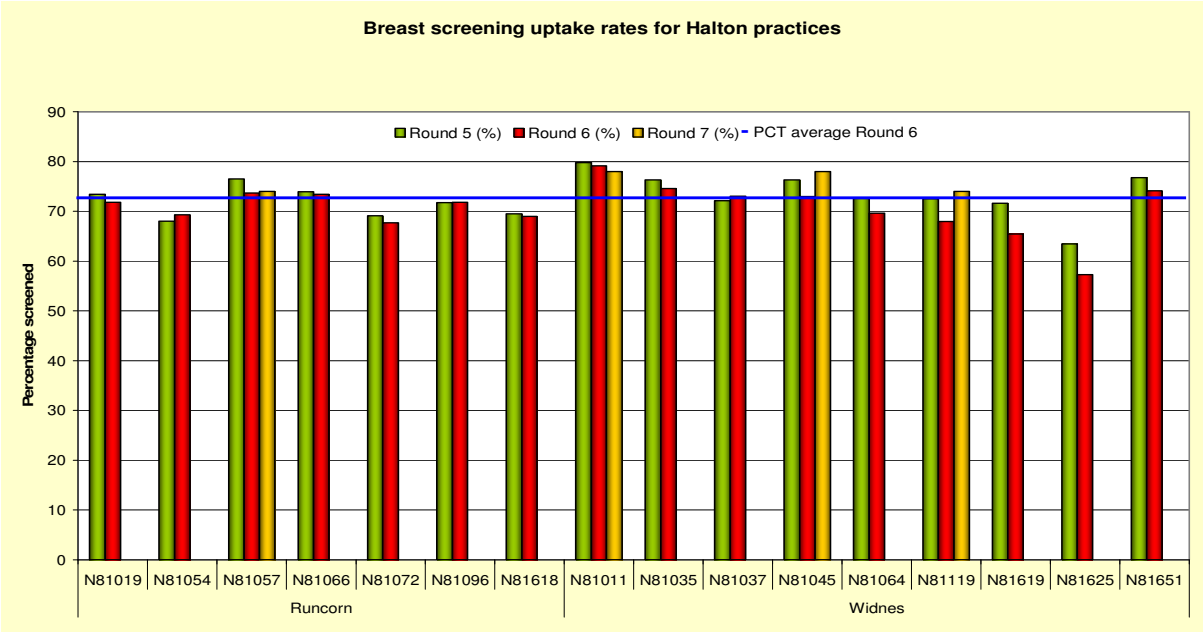
Breast Cancer Screening Programme

- Breast screening detects small, early cancers because they look different from normal breast tissue on a type of x-ray examination, known as a mammogram.
- The breast screening offer is made to women between the ages of 50-70 every three-years. After this age women can self-refer but they are not part of the automatic call-recall system. Figure 3 illustrates breast cancer screening uptake in Halton.
- Out of 1000 women who are screened for breast cancer, about 75 will be called

back for further tests. These tests may include a biopsy.

- Out of 75 women called back, 67 will be told everything is normal, and eight will have an early, treatable cancer diagnosed.

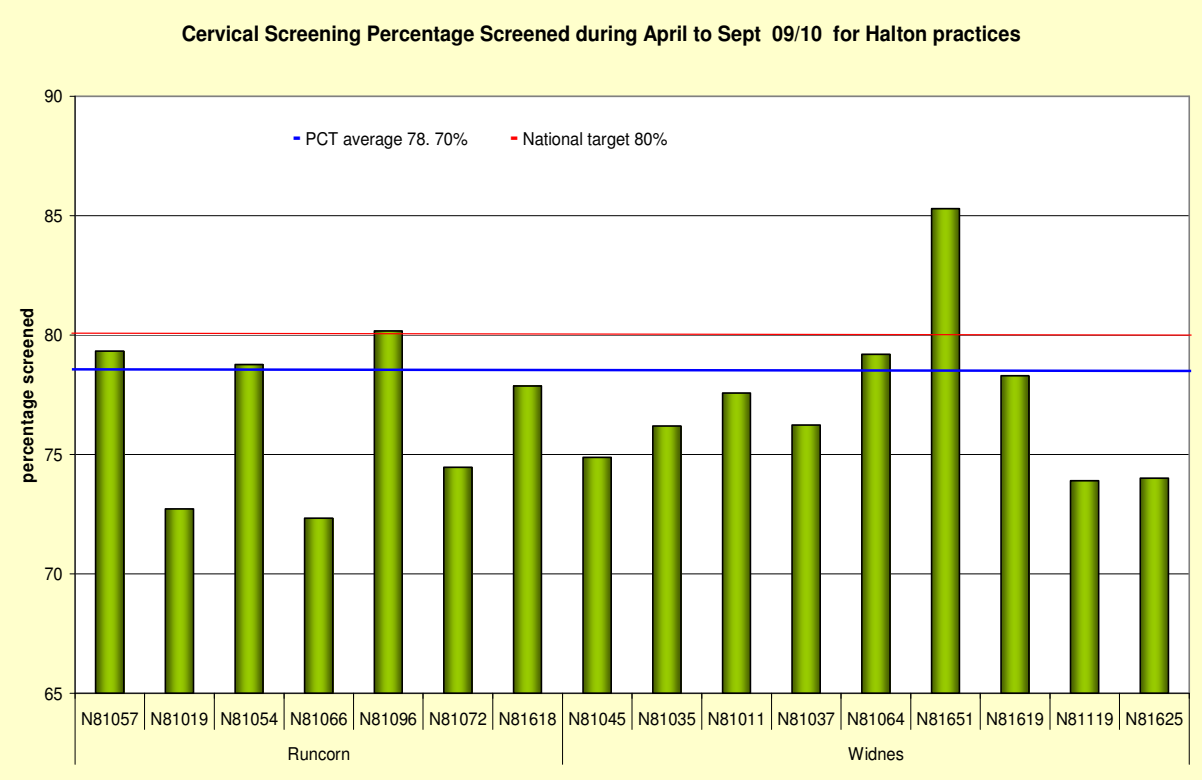
Figure 3: Breast cancer screening uptake, round 5-7, women registered with Halton GP practices



Cervical Cancer Screening Programme

- Cervical screening detects abnormal cells, before any cancer develops. The abnormal cells are found by looking at a small sample of cells with a microscope. The cells are collected using a simple technique by a doctor or nurse. Women with abnormal cells can be seen and treated at colposcopy[2] clinics. The treatment prevents cancer before it develops.
- The cervical cancer screening offer is made to women between the ages of 25 to 49 every three years and to women aged 50 to 64 every five years. Figure 4 illustrates cervical cancer screening uptake.
- 2 out of 100 women whose smear test is difficult to interpret at the laboratory will be asked to have a repeat smear test.
- 1 or 2 out of 100 women will be asked to have their next smear test early
- 5 out of 100 women will be referred to a colposcopy clinic for expert assessment and treatment.

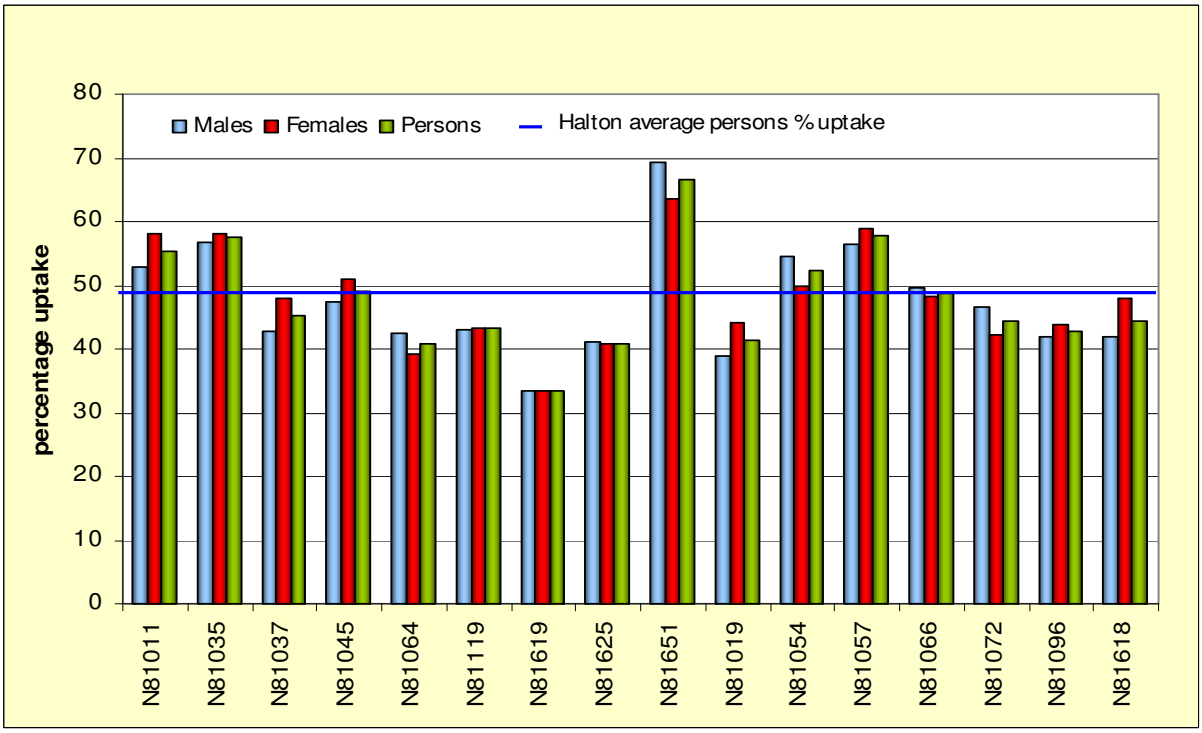
Figure 4: Cervical screening uptake 2009-10, across Halton GP practices



Bowel Cancer Screening Programme

- Bowel screening detects polyps which are cancers, or could develop into cancers**.** Samples of faeces have to be collected at home with a simple kit, and are posted to a laboratory. The laboratory tests for blood in the faeces. People with a positive test are asked to have a specialist examination of their bowel with a colonoscope[3]. The examination is done under anaesthetic. The colonoscope will find polyps, which may be cancers or "pre cancers". Over half of the cancers found are at an early, easily treatable, stage. Polyps can be removed before they develop into cancer.
- The bowel cancer screening offer is made to men and women aged 60 to 69 every two years. Figure 5 illustrates screening uptake.
- Out of 100 people who complete a bowel screening kit in their home, about 2 will have a positive test for blood. These people will be invited to a screening centre to discuss the test with a specially trained nurse.
- Out of 20 people seen at the screening centre, 16 will need a colonoscopy examination.
- Out of 16 people having a colonoscopy, eight will be told everything is normal, 6 will have polyps that can be treated before any cancer develops, and 2 will be told they have a cancer that needs treatment.

Figure 5: Bowel cancer screening uptake 2007-08, across Halton GP practices



Hospital admissions

There is significant variation at ward level for hospital admissions due to cancers as can be seen in Figure 6. This may be due to differences in age and gender structure of each ward. As Figure 7 shows cancer hospital admission rates increase with age, being rare in persons under the age of 50. Also, some but not all cancers are associated with deprivation. Thus the level of both incidence, admissions and mortality will be a reflection of these complex inter-relationships.

Figure 6: Admissions to hospital due to cancers, by ward, 2009-10

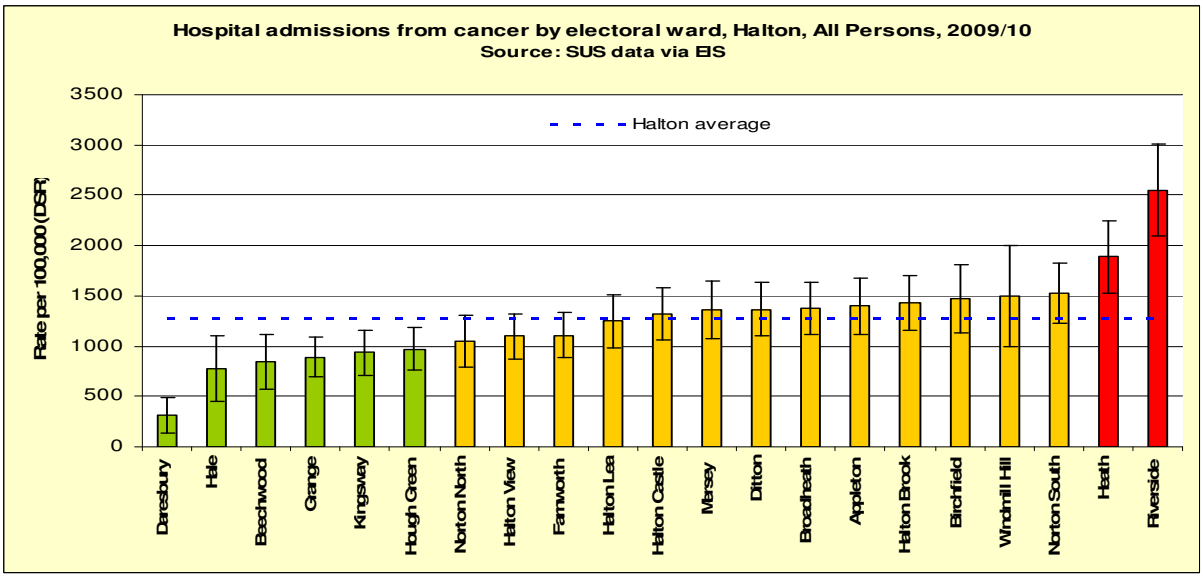
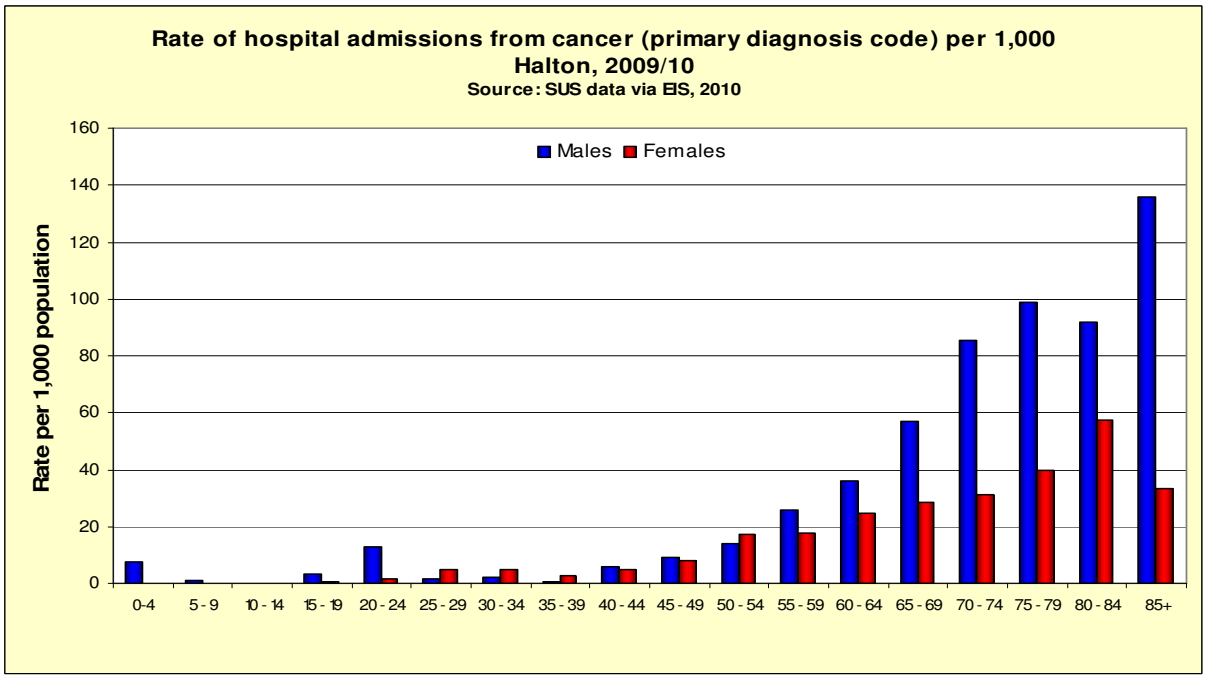


Figure 7: Admissions to hospital by age and gender, 2009-10



Mortality

Overall there has been a reduction in deaths under the age of 75 (often referred to as premature deaths) from cancers. This pattern can be seen in Figures 8 (males) and Figure 9 (females). For the mortality rate in males, the local authority started at a lower rate in 1993 than two of its comparator boroughs, Middlesbrough and Hartlepool, and has maintained this position. For females the local authority was lower than all comparator boroughs in 1993 but improvements have been made to a greater extent in Hartlepool and Stockton-on-Tees. Only the rate in Middlesbrough remains higher than Halton by 2006-08. However, what this also demonstrates is that not only is the reduction less for women than for men, but that compared to England and Halton's statistical neighbours, the reductions for both sexes have been much less marked than for its comparators.

Figure 8: Cancer mortality trends for males, deaths under 75 years, 3-year rolling averages 1993-95 to 2006-08

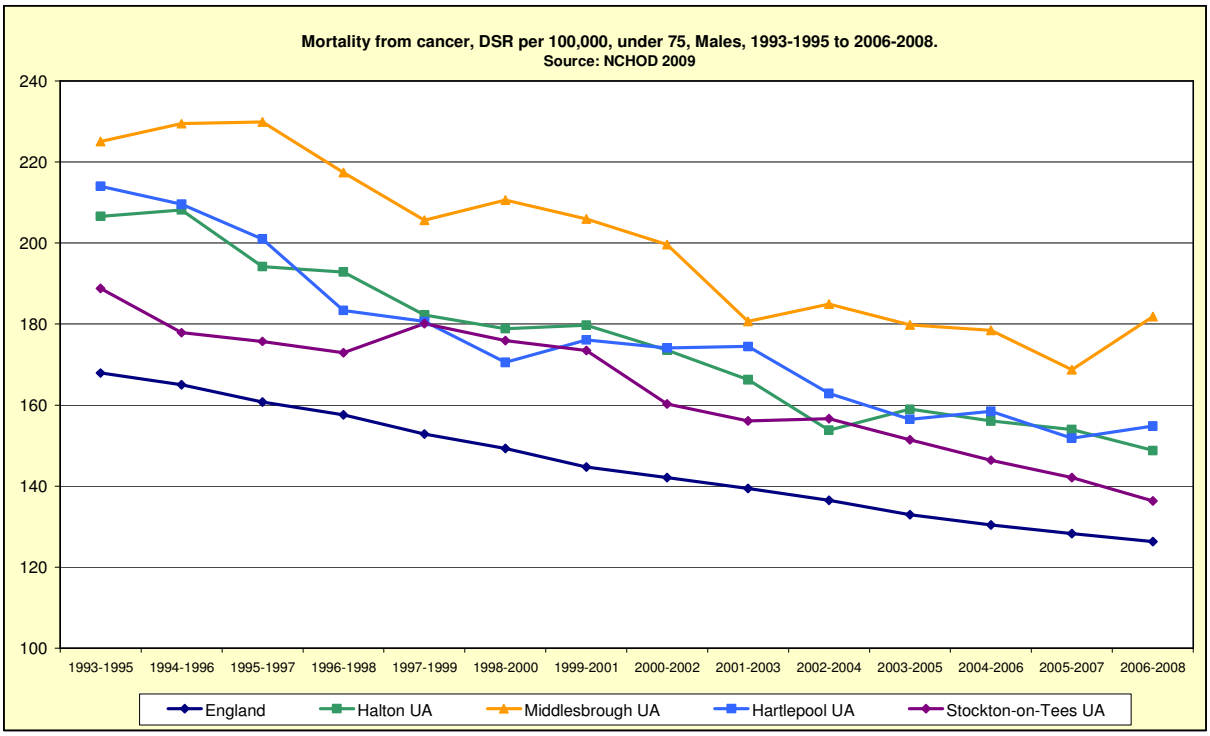
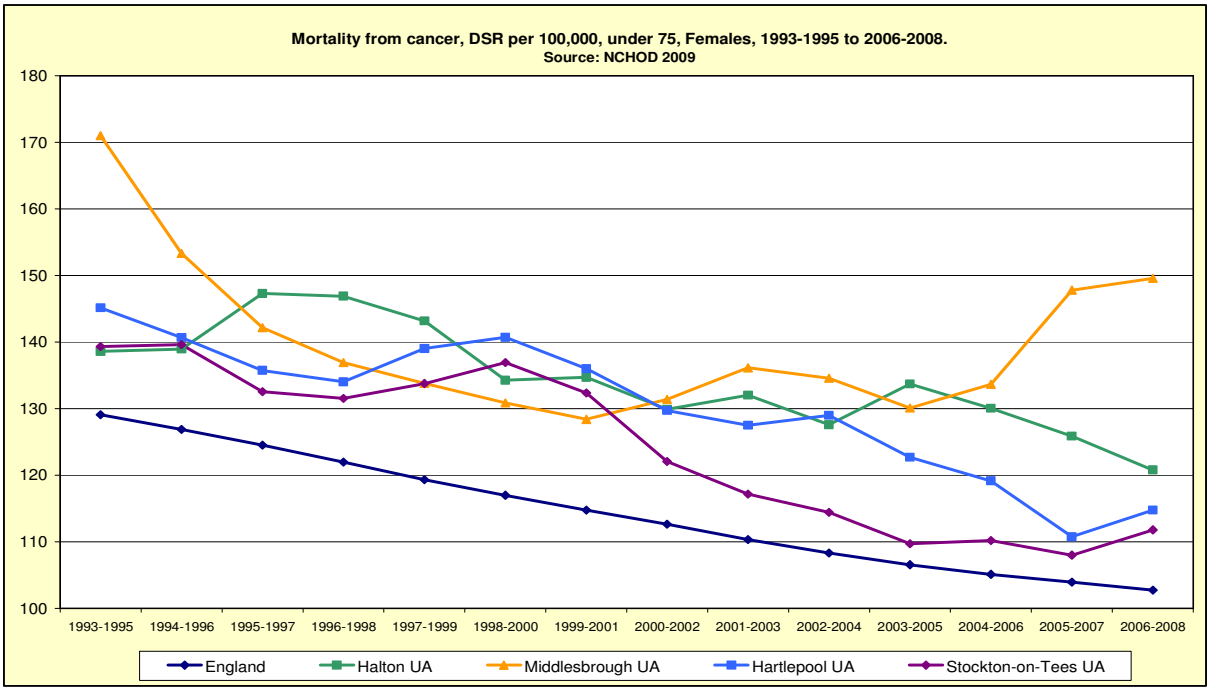


Figure 9: Cancer mortality trends for females, deaths under 75 years, 3-year rolling averages 1993-95 to 2006-08



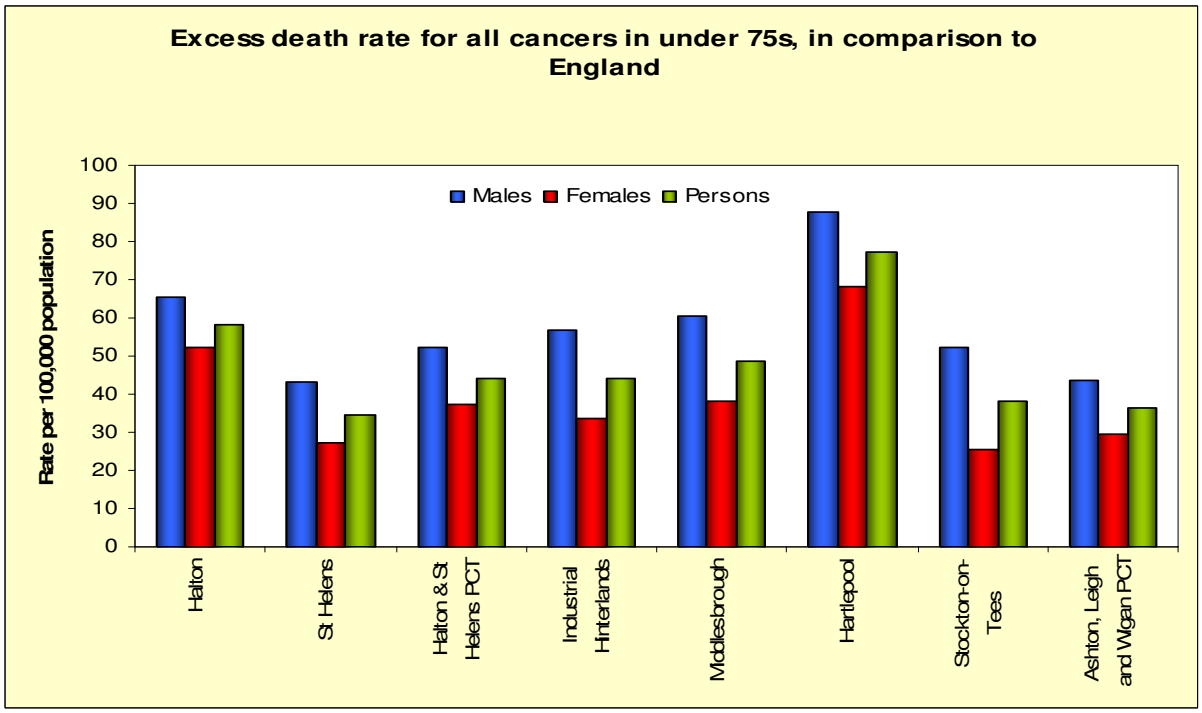
Windmill Hill and Halton Castle have the highest death rates from all cancers under 75 for both males and females. Using the PCT and Office of National Statistics (ONS) group averages this is a statistically significantly higher level for Halton Castle for

females. Windmill Hill also experiences statistically significantly higher rates of cancers in males compared to the PCT and ONS averages.

Excess deaths

Excess deaths refer to the number of deaths above that which would be expected if the area death rate were the same of the England rate. This has therefore been calculated to applying the England age-specific rates to the borough populations for each age group then comparing this figure to the observed number of deaths in the gender/age band. In order to compare the borough against its comparators these numbers were then converted into directly standardised rates.

Figure 10: excess mortality, all cancers, under 75, 2004-08



As with incidence Halton experiences relatively high excess cancer mortality overall. This is particularly marked for stomach and oesophageal cancers, two cancers associated with high levels of alcohol consumption (although other factors also contribute to these cancers). However, the excess death rates are lower than Halton's comparators for lung cancer. It is worth noting that Halton experiences higher rates in all but colorectal cancer compared to St Helens, its nearest neighbour and the other borough covered by the PCT.

An analysis of the impact of three major lifestyle factors on cancer mortality revealed that Halton had a higher burden of deaths caused by smoking, alcohol misuse and obesity than St Helens of England. This was most marked for tobacco. Details of this analysis can be found in the full report.

Current services in relation to need

See also section on levels of need regarding cancer screening programmes and uptake.

Prevention and awareness measures. The PCT "Get Checked" campaign, which includes: community development work with volunteers in defined neighbourhoods, marketing and advertising campaign with evidence based early detection messages across a wider footprint. "Health Checks" - Health checks for all adults in Halton and St Helens via NHS venues, mobile cancer awareness events using the cancer network cancer vehicle "iVan"

Screening. Three cancer screening programmes serve adults in Halton:

- Breast Screening will be extended to all women between 47 and 73 over the next 5 or more years. The current programme, serving women 50-69 years old, was offered to over 8,000 women last year and identified about 60 early breast cancers.
- Bowel Screening is taken up by about half of all men and women between 60 and 69 years old. About 1 in 50 people are called up for follow up, and 10 new cancers were found last year.
- Cervical Screening identifies early, pre cancer when it can be treated easily. All women will get their results within 14 days from December 2010.

Treatment. Survival with cancer is improving each year, and survival rates with cancer are high in Halton and St Helens PCT for many cancers, although for some, there is a social gradient to survival. Local cancer clinicians work with networks across Merseyside and Cheshire to make sure our patients get the most up to date treatment.

Peer review. Halton and St Helens PCT under takes a peer review in relation to specific cancers each year, where actions are needed the PCT will support the locality teams and specialist Multi Disciplinary Team

Cancer support groups. Halton and St Helens PCT commissions numerous voluntary sector groups to support patients with current cancer diagnosis or patients who are in remission

Strategic direction. Halton and St Helens PCT chairs the Eastern Sector locality group whose main function is to drive commissioning decisions and implement peer review recommendations. Members include Warrington and Knowsley PCT, community and Secondary care partners

Cheshire & Merseyside Cancer Network: Cancer dashboard. The cancer dashboard will be outcome driven, with agreed milestones for each PCT. The network will assist them in supporting the gathering of evidence for the individual measures, including measures by practice. It is envisaged that action plans will be developed and

adopted by PCT boards as appropriate and recommendations will be made to commissioners. A key element of the cancer dashboard will be the development of a database that PCTs and practices can access to review performance and to create reports.

The cancer dashboard will:

- Collate primary care equity audits for urgent referrals in the PCT by practice- this will include, review of referring patterns linked to deprivation, number of referrals, cancer yield. This is different than the primary care audits.
- Capture data within templates for survival, mortality, incidence, screening and staging data and will identify key trends and variations.
- Provide PCT reporting in a template that will demonstrate compliance with national and local baseline assessments identified within the Cancer Reform Strategy.
- Provide information about screening performance at GP practice and PCT level, templates for GP practices will be made available.
- Capture action plans to enable Commissioners to make decisions on services.
- Test other performance measures around commissioning such as length of stay analysis and other commissioning priorities.

Evidence of what works

Department of Health (2007) Cancer Reform Strategy

National Institute for Clinical Excellence (NICE)

Diagnosis and Treatment of Lung Cancer (CG24, February 2005)

Referral Guidelines for Suspected Cancer (CG27 June 2005)

Prostate Cancer Diagnosis and Treatment (CG58 February 2008)

Early and locally Advanced Breast Cancer Diagnosis and Treatment (CG80 February 2009)

Guidance on Cancer Services: Improving Outcomes in Colorectal Cancers Manual Update (2004)

National Screening Committee

(See also tobacco, obesity, alcohol for evidence of interventions to support the major lifestyle risk factors associated with cancer)

Unmet needs and service gaps

See Current Services section which outlines improvements to be made.

Further needs assessment required

- Continue to monitor key elements of cancer performance and make this data widely available to stakeholders, including making it publically available via *Instant Atlas* on the PCT website
- Review and update the 2008 Cancer Health Equity Audit during 2011
- Continue to provide practices with regular performance data including screening reports
- Carry out an analysis of local screening performance against that of the North west, England and other standard comparators.

Key contacts and further links

[i] *Cancer Statistics Registrations 2007, Office for National Statistics*

Appendix 2 – Draft JSNA Executive Summary

Health and Wellbeing in Halton

A Joint Strategic Needs Assessment

Executive Summary 2010/2011

1. Introduction

This is a summary of 'Health and Wellbeing in Halton', Halton's Joint Strategic Needs Assessment. The full report can be accessed via the Halton Borough Council website at http://www3.halton.gov.uk/healthandsocialcare/healthandmedicaladvice/healthjointstrategicneedsassessment/

A Joint Strategic Needs Assessment (JSNA) is a means by which Primary Care Trusts and Local Authorities describe the future of health and wellbeing needs of local populations and the strategic direction of service delivery to meet these needs.

Put simply, this is a blueprint for the way Halton Borough Council and the local NHS develop and understand the health, well being and social care needs of people who live in Halton. It does this by:

- Bringing together all the relevant information around health, well being and social care needs;
- Using local knowledge and evidence of effectiveness of current services, it helps identify gaps in service provision, and makes recommendations for consideration by commissioners
- Setting out key priorities for action plans to help us meet those needs in the
- future;
- Providing the basis for all the key strategies and plans produced by the Council and the local NHS to help them get the right services from the right providers.

This then allows us and other relevant service providers to:

- Be better informed and prepared to meet the needs of a changing population now and in the future;
- Work more effectively together to reduce the health inequalities;
- Provide value for money.

A JSNA should not be seen as a product but as a process to inform local planning and commissioning including the Sustainable Community Strategy, and Children and Young People's Plan.

2. The Halton Approach

Halton produced the first JSNA – Health and Wellbeing in Halton, in 2008 which provided a snap shot of the Borough's health and wellbeing at that time. Health and Wellbeing in Halton provided the evidence on which health and social care Commissioners and decision makers identified the key health and wellbeing issues now and in the future.

In autumn 2009 an update was produced based on new data available that illustrated any significant changes in key messages from the original Health and Wellbeing in Halton.

During 2010 a full update of the JSNA was undertaken. A JSNA Working Group with representatives from both Halton Borough Council and the Halton and St Helens NHS Trust was set up. The Working Group's role was to provide data and analysis from their specialist area, providing the context to the 'hard' data. Not only was health, adult social care and children's services represented, but also the wider determinants of health including transport, housing and employment.

An overarching Strategic Board was established to provide strategic direction and guidance for the JSNA process and consisting of:

- Strategic Director, Health & Community Directorate, Halton Borough Council
- Strategic Director, Children & Young People Directorate, Halton Borough Council
- Director of Public Health Strategy, Halton & St Helens NHS
- Divisional Manager for Planning and Commissioning, Halton Borough Council

How to use the JSNA

The JSNA has been set out in chapters; where key issues are highlighted, information about what services are making a difference and the key priorities for the future are identified. The JSNA is intended to be an on line tool, enabling the reader to go straight to the chapters that they require. Each chapter references other relevant chapters that can provide wider context, allowing the reader to access all relevant and interlinking information to the subject area.

The JSNA main report is built on a wealth of information about Halton that is gathered both locally and nationally. There are hyper links to reference materials and relevant supporting information throughout the chapters. Using these hyperlinks will take you to external websites that contain the most current data, analysis, strategies etc.

This assessment has not been done in isolation. Results of local and national consultations, surveys and research with people who use services, carers, residents and service providers have been used to inform the JSNA.

3. Halton's demographic profile – what does Halton look like?

Population

Since 2001, the population of Halton has increased steadily to its current estimate of 118,700 (2009). The table below shows the population breakdown by age.

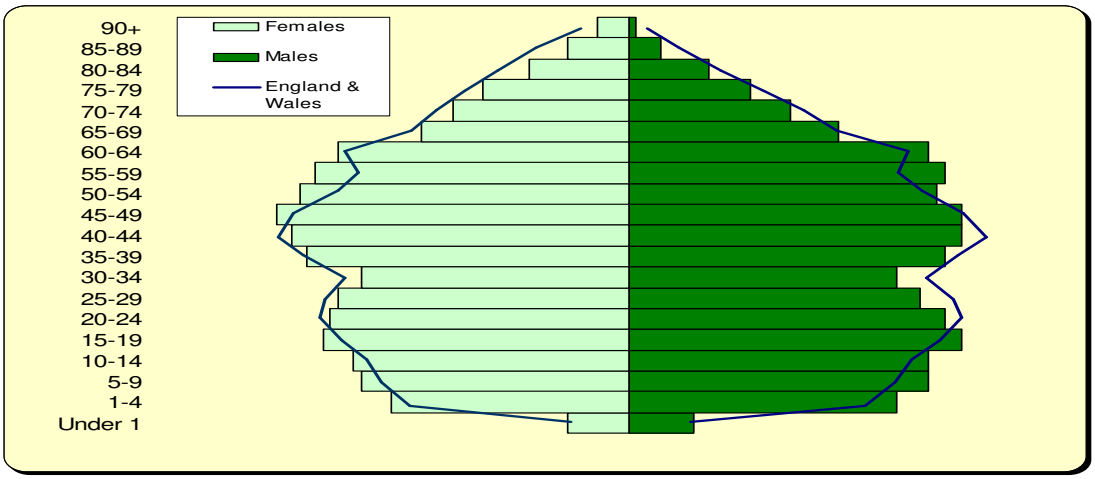
Population of Halton, breakdown by age, 2009

	Total	0-15	16-64	65+
Halton	118,700	24,000	77,600	17,100

The total population rose from an estimate of 118,500 in 2008; this rise was found in the Older People age-range (65+). This group went from 16,800 in 2008 to 17,100 in 2009 whilst the 0-15 population saw a reduction of 100.

The Halton profile matches the general shape of that for England & Wales see figure 1.

Figure1: Population pyramid showing population distribution for Halton and England & Wales, 2009



Source: Office for National Statistics

A few key points, showing comparisons with the England & Wales profile, are highlighted below

Halton has a higher proportion of:

- Children and Young People, aged 1-24
- Older working age, aged 45-59

Halton has a lower proportion of:

- Younger working age, aged 25-44
- Older People, aged over 60

In the long term (2008-2023), Halton's population is projected to grow by 4% from 118,500 to 122,900

The growth in older people will increase the demands for both formal and informal support. While small decreases in the working age population mean there are fewer people to provide and pay for this additional support.

Ethnicity

The ethnic composition of Halton remains predominantly white, with 97.7% of the population falling into this category. This is a significantly higher rate than at either regional (92.1%) or national level (88.2%). This would suggest that there is a lack of ethnic diversity in Halton which is not such an issue within wider boundaries.

Religion

Compared to regional and national figures, Halton has a higher percentage of people of Christian faith and a lower percentage of people of Muslim faith and people with no religion

Housing tenure

In 2008 the proportion of Owner Occupied and Private Rented Dwelling Stock in Halton (75%) was lower than the regional (81.2%) and national averages (81.8%). At 25%, a significantly higher proportion of the population rent housing from a Registered Social Landlord (RSL) than the regional (12.9%) and national (9.5%) averages.

Deprivation

As a result of its industrial legacy, particularly from the chemical industries, Halton has inherited a number of physical, environmental and social problems Halton shares many of the social and economic problems more associated with its urban neighbours on Merseyside. The Index of Multiple Deprivation (IMD) for 2010 is one of the most comprehensive sources of deprivation indicators, as some 37 different indicators are used. It shows for example that overall, Halton is ranked 27th nationally (a ranking of 1 indicates that an area is the most deprived), which is third highest on Merseyside, behind Knowsley and Liverpool, and 9th highest in the North West. Other authorities, St Helens (51st), Wirral (60th) and Sefton (92nd), are all less deprived compared to Halton

The Index of Multiple Deprivation for 2010 suggests that deprivation has worsened in the borough. Since ranking 30th in 2007 there has been an increase in 2010 to the 27th most deprived Authority in England.

The population living in the top 10% most deprived areas nationally has been a useful comparator over time to see whether the number of people severely affected by deprivation is decreasing in Halton. This proportion has remained consistent from 2007 to 2010; with 26% of the total population of Halton residing within the top 10% most deprived LSOA's nationally. This is compared in 2010 to the national figure of 10% and the Liverpool City Region figure of 31%.

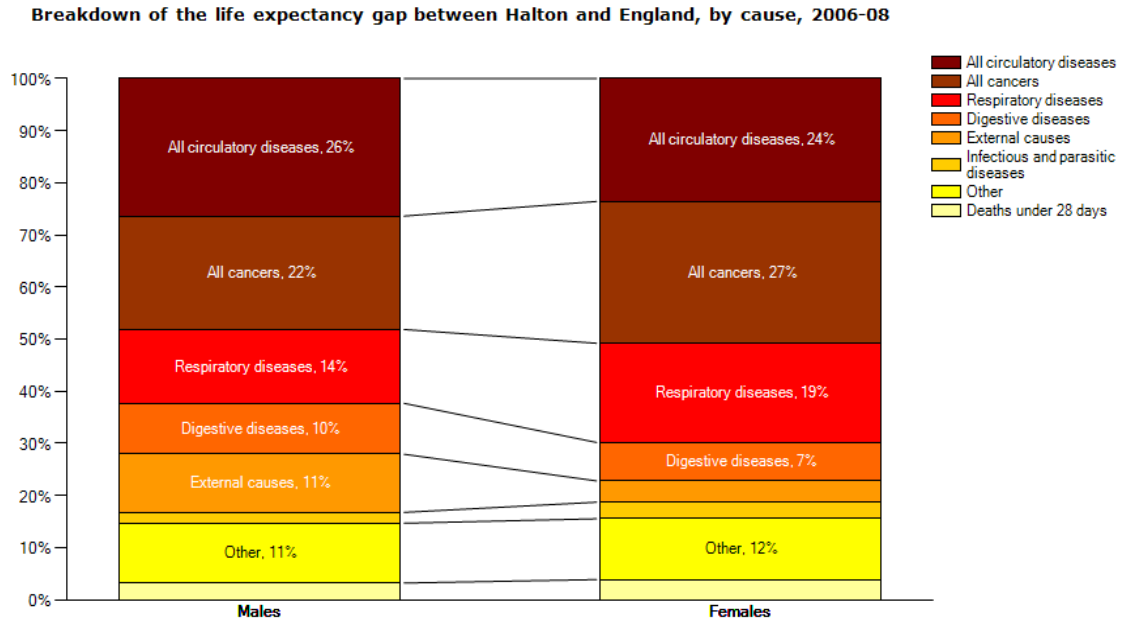
4. Halton's health and wellbeing – where are we now?

Health across Halton has improved over the last 10 years. Life expectancy at birth has increased, deaths from circulatory disease and most cancers have decreased, rates of smoking have decreased. Breastfeeding rates are improving and the number of women who are smoking during pregnancy has reduced recently. However, whilst these improvements are commendable for most of these factors the England rates have improved at a greater pace over the same period widening the gap between the borough and the country as a whole.

Closing the gap in life expectancy remains an enormous challenge. Strong partnerships are required to tackle the lifestyle factors that underlie the mortality rates and the social determinants that in turn influence the lifestyle choices people make

The reasons for the gap in life expectancy are detailed in figure 2, with circulatory disease, cancers and respiratory diseases making up 70% of the gap in females and 62% in males.

Figure 2



One measure of morbidity is limiting long term illness (LLTI) which reflects an individual's perception of how healthy they are. For Halton and St Helens, the boroughs that make up our PCT, the ratio of those with a limiting long term illness is higher across all age groups than the England and North West rates.

Rates overall are marginally higher for Halton than for St Helens. All age groups suffer the burden and possible employment and social consequences of having long-term conditions and disabilities. The older age groups in Halton have a greater burden of chronic conditions and disabilities than the average experienced in England and North West. As the proportion of the population that is aged over 65 is predicted to rise, it is likely the number of people in older age living with limiting long-term illness will also rise. The

number of people aged 65 and over with LLTI will rise by 47.36% overall with the greatest percentage rise being in the 85+ age group 2010 and 2025.

5. Factors affecting health and wellbeing in Halton – what are our priorities?

Whilst acknowledging that there are a plethora of factors affecting Halton resident's health and wellbeing, from factors that have a significant impact on a small proportion of the local population, to factors that have a less significant impact on the wider population, the JSNA focuses on those factors that highlight the greatest health inequalities amongst the local population.

Below are a number of the priority areas affecting Halton resident's health and wellbeing, as identified by the Health Inequalities National Support Team visit to Halton in 2009 and other local indicators from both the local authority and the PCT.

The lists of factors below, and the associated priorities, are *not* exhaustive, but highlight factors that have impact on health inequalities in Halton. Please visit the JSNA page on Halton Borough Council's website to access the full list of chapters which includes further analysis, identification of key issues and further recommendations and priorities.

A list of Chapters contained in the JSNA can be found in Appendix 1 to this executive summary.

A summary of the main local and / or national commissioning plans and strategies can be found in Appendix 2

Environmental Factors

Community Safety

Alcohol related crime in Halton has reduced by 11% compared to last year and all violent crime has reduced by 12%, although in almost half of the violent crime incidents reported, alcohol was a contributing cause, as it was in 15% of the overall incidents of anti social behaviour. During 2009 46 % of total alcohol related crimes committed within Halton occurred within the wards that make up the boroughs town centres (Widnes - Appleton, Kingsway and Riverside, Runcorn - Mersey).

The number of people leaving drug services having completed their treatment has been steadily improving. In 2008/09 Halton's 'planned exit' performance was in line with the regional average. By the end of the first half of 2009/10, they were at 41%; this is in the second highest quarter of national performance. Halton was amongst the top performers nationally in 2008/09 for reducing offending related to using heroin and/or crack cocaine. Halton has a high percentage, 85%, of people using heroin and/or crack cocaine seen by its drug services.

Vulnerable adults are people who, for whatever reason, are at greater than normal risk of abuse. Older people, especially those who are unwell, frail,

confused and unable either to stand up for themselves or keep track of their affairs are vulnerable. Other vulnerable adults include people who are open to abuse because of learning difficulties, physical disabilities or mental illness

Halton has historically experienced high levels of reporting, which is likely to be due to the following:

- Demographic changes – increasing number of frail people
- Large number of people with learning disabilities
- High level of health needs
- High levels of deprivation and unemployment
- Due to publicity, and through the provision of multi-agency training
- Raised awareness of the need to recognise abuse and respond appropriately, within the population

Referral numbers increased from 2004-2007, reduced from 2007-2010, but have significantly increased throughout the period April-December 2010 over the same period in the previous year. 359 abuse allegations were reported in total to Halton Borough Council in the year 2009-10. The reduction in referrals may have resulted from refinement of procedures followed in processing referrals, so whilst we continue to encourage people to refer concerns and allegations, decisions are then taken about the best course of action to deal with them. Managers and practitioners take account of service user views on the way their circumstances are managed, resulting in some referrals not being progressed through the safeguarding adults procedures. Some will result in other activity which will not be counted in the alleged abuse data e.g. care management, complaints procedure, contract monitoring or disciplinary proceedings. It is likely that recent steps taken to raise awareness, including training of staff and volunteers, and publicity, have contributed to the increase in referrals.

During the period July to September 2010 there have been a total of 25 Race Hate, 6 Homophobic and no Disability incidents reported to the Police.
Of the 31 incidents recorded 19 have been found to meet the Hate Crime criteria

In the Halton Places Survey carried out in October 2008, 21% of respondents stated that they agreed that 'The police and other local public services are successfully dealing with anti social behaviour and crime in their local area.' This compares to a UK average of 26%.

Community Safety Priorities

- Focus on borough wide enforcement activity, both proactive and reactive which is intelligence led and demand driven

- Promote awareness of vulnerable adults and their right to be safe in local communities.

- Ensure there is a strong multi-agency response to the safety, wellbeing and dignity of vulnerable adults.

- Equip staff and partner agencies with the necessary tools to both safeguard vulnerable adults and ensure their dignity is respected.

Housing

The neighbourhood that someone lives in, the type of property that they occupy and the condition of that home, all have a huge impact on their health and well being. Research has clearly demonstrated that poor housing is a key determinant of health outcomes, being intrinsically linked to poor health, a reduced life expectancy, and a reduced overall quality of life / sense of wellbeing.

There is great variation in housing tenure in Halton. Owner occupancy varies from 99% of households in Birchfield to 6% of households in Windmill Hill, which has the greatest percentage of social rented dwellings. Birchfield on the other hand, contains no social rented dwellings. A significant proportion of social rented housing is located in the New Town estates in Runcorn.

The greatest proportion of privately rented accommodation is in Appleton, where 9% of households are privately rented compared with only 1% in Birchfield and Windmill Hill. Overall in Halton, 66% of households are owner occupied, 28% are socially rented and 4% privately rented, with the remainder being shared ownership dwellings, tied to employment tenancies or households living rent free.

When housing tenure is compared to health deprivation, it becomes clear that there is a strong correlation. The eight most deprived wards in terms of health have the lowest proportion of owner occupation in Halton, whereas the eight wards with the lowest health deprivation have the highest levels of owner occupancy.

At the time of writing the Housing Chapter for the JSNA the Council had commissioned a Strategic Housing Market Assessment to update and refresh this data along with its Mid-Mersey Growth Point partners, St. Helen's and Warrington. A first draft of the report on the findings relating to Halton reveals the following headline results –

- Halton's ageing population will lead to increased demand for specialist housing and falling household sizes will mean smaller dwellings are more suitable for some households.

- There has been an increase in the housing stock over the last decade and increases are likely to be required in the future. There is an imbalance in the housing offer with the proportions of terraced housing and social rented stock being particularly high

- Affordability is a key issue for Halton with the average property price being five times the average income. This, coupled with increased demand for social housing along with falling stock levels, leads to a total net annual need for 891 affordable dwellings per annum (this figure is significantly higher than the 176 found by the Housing Needs Assessment of 2006).

- There are high levels of housing unsuitability for those with some form of disability or support need and a range of adaptations and support are required to resolve these issues.

- There are a high proportion of households containing pensioners in the borough and this is likely to increase further in the future, leading to an increased need for specialist accommodation and the expansion of support services that are already in place. Older person households are also often under-occupied.

- A significant proportion of housing need / demand in Halton arises from families with dependent children and lone parent groups are particularly disadvantaged and concentrated in social and private rented housing.

Housing priorities

- Improve conditions in the private rented sector

- Improve the provision of supported housing for an ageing population

- The prioritisation of the development of housing to meet the needs of those with disabilities

- Continue to provide specialist advice and support to Homeowners by retaining Mortgage Rescue Adviser post. If the post is removed then Halton will be unable to administer the Mortgage Rescue Scheme which has recently received financial backing for a period of 4 years.

- Increase the supply of affordable housing in the Borough in line with the recommendations of the Housing Needs Survey

- Work with housing providers to reduce the incidence and perceptions of Anti Social Behaviour

Economy and Child Poverty

Halton's economy is relatively small by national standards. Halton has a very low level of economic resilience, ranked 283 out of 324 local authority areas (Experian July 2010). The impact of the significant reductions in levels of public sector spending expected from 2011 onwards will have a major impact on Halton's economy, in addition we have an ageing static population with a shrinking proportion of economically active residents.

In the past the mismatch in the needs of local, new and incoming businesses and the skills of Halton's local people has meant that opportunity and need have been out of balance, contributing to the continuing widespread deprivation in Halton. The skills and knowledge base of Halton's workforce is low, reducing the ability of Halton's residents to compete for existing and new jobs both within and outside the Borough. There is a significant skills deficit both with regard to basic skills, but also in relation higher skills demanded by the sectors that are likely to see the greatest degree of growth over the

coming years (scientific, technology and advanced manufacturing) and also generic management skills

Halton's median resident weekly pay increased from £345.9 in 2008 to £370.6 in 2009, this was the largest increase in gross weekly pay out of the 6 local authorities in the Liverpool City Region during the period

Job Seekers Allowance (JSA) claim rate in Halton was 5.9% in April 2010; this is greater than the North West (4.5%) and Great Britain (4.1%) figures. The ward with the lowest unemployment rate was Daresbury, with a rate of 2.3%. Windmill Hill ward had the highest unemployment rate in Halton in April 2010 with a rate of 10.7%.

Child Poverty is defined as the number of children living in families in receipt of Child Tax Credit whose reported income is less than 60 per cent of the average income or in receipt of Income Support or (Income-Based) Job Seekers Allowance, divided by the total number of children in the area.

The North West of England has above average incidents of children living in poverty. With 23.5% of children under 16 and 22.8% (726,000) of all children living in low income households, of which 167,770 live in the Liverpool City Region. In Halton just under 26.4% of children live in poverty, placing Halton below the Liverpool City Region average. The most recent figures from 2008 reveal that in total there are 6,550 children living in poverty in Halton. Of these 5,520 children live in out of work families and 1,030 live in households classified as in-work.

According to the 2007 figures, Birchfield ward has the lowest percentage of children in poverty, with fewer than 3% of children being in poverty. However, over half of children (54.4%) within Windmill Hill ward are classed as being in poverty. Interestingly, the neighbouring ward of Daresbury has one of lowest percentages.

Key underlying causes of child and family poverty in Halton include low family aspirations and a cycle of benefit dependency, often of an intergenerational nature.

Economic and Child Poverty Priorities

- To foster a culture of enterprise and entrepreneurship and make Halton an ideal place to start and grow a business

- To promote and increase the employability of local people and remove barriers to employment to get more people into work

- To develop a culture where learning is valued and raise skill levels throughout the adult population and across the local workforce

- Cultural challenge and raising aspirations

- Early intervention

- A whole family approach

- Providing a single point of access to support services

Lifestyle Factors

Substance misuse

Problematic drug users are defined as heroin and/or crack cocaine users. In Halton it has been estimated that there are between 569 and 919 Problematic Drug Users (PDUs). The prevalence of PDUs in Halton is 9.2 per 1000 (aged between 15 & 64 years old). This is just below the prevalence in England of 9.76. Locally prevalence estimates range from 7.5 in Cheshire, 8.4 in Warrington and 11.7 in St Helens through to 24.1 in Liverpool

Patterns of drug use are changing, and in common with national trends, Halton is seeing more people under the age of 25 presenting to services with issues around cannabis, alcohol and cocaine use, rather than heroin and crack cocaine. As yet there is insufficient information to estimate the prevalence of this drug use

Substance Misuse Priorities

- Continue to reduce the impact of drug related crime through close working with the police, probation & court services.

- Reduce the harm that is caused to individuals through their drug use by providing easy access to screening, vaccination & health improvement programmes.

- Continue to meaningfully involve service users, carers & families in the development of drug services

Alcohol

Alcohol has a major impact on cirrhosis, hypertension, cancer, and mental illness. In Halton the rate of hospital admissions for alcohol related harm is high and rising in line with national trends. The current rate of hospital admission for alcohol related harm is 2,464 per 100,000. Compared to our statistical neighbours cluster which includes PCTs with similar levels of socio economic status Halton and St Helens PCT admissions are average at 2,200, with Knowsley PCT performing worst at 2,500 and Stoke on Trent PCT performing best at 1,550.

Halton has been identified as the eighth worst local authority area in England for alcohol related harm and the 50th worst area for binge drinking (2010 LAPE). Reducing alcohol related harm is one of our key areas for investment and development in the next five years.

A recent report analysing alcohol consumption with teenage conceptions i.e. conceptions to women under the age of 18, showed that, at both local authority and ward levels, there is a significant positive relationship between

teenage conceptions and alcohol-related hospital admissions in young people. This relationship is independent of deprivation

Alcohol Priorities:

- Develop a robust social marketing and wider communication approach to engage the public in a debate about actions to reduce harmful drinking, tailored to different communities' needs

- There needs to be an assessment of continuity/standards of care across the health and care system for alcohol services. Standardised, evidence-based care pathways and screening assessment tools, need to be localised and developed.

- Health impact assessments should be conducted as part of the planning application process for new and expanding/change of use licensed premises. This should include the wider impacts of the development on other health priorities such as promoting healthy eating, physical activity, teenage pregnancy and promoting and improving mental wellbeing as well as the impact on alcohol consumption

Obesity

Obesity has a major impact on cardiovascular disease, cancer and diabetes. Adult overweight and obesity rates in Halton are high. The 2006 Life Style Survey indicated the percentage of overweight residents has increased from 52% in 2001 to 56.6% in 2006. Obesity within Halton has also increased with 20.2% of residents measuring as obese in 2006 compared to 15.1% in 2001

According to 2009 & 2010 Health Profiles the percentage of adults classified as obese in Halton has risen slightly between 2003-5 and 2006-8. However rates remain above the England average.

Obesity Priorities

- Continue with an emphasis on population level approaches to increase physical activity and improve the diet of the adult population

- There should be interventions to reduce obesity in women of child bearing age in deprived areas as part of a programme to reduce infant mortality

- The needs of frail older people in care homes regarding adequate nutrition should be addressed and the level of malnutrition of this and others groups determined

Tobacco Control and Smoking

Smoking has a major impact on cancer, chronic obstructive pulmonary disease (bronchitis and emphysema) and cardiovascular disease. Halton has improved its smoking quit rate year on year for the past 5 years. Halton and

St Helens now has the 4th highest quit rate in the North West at 1104.74 per 100,000. The stop smoking rate for pregnant women has improved during 2010 with 25.5% staying quit at time of delivery in the first 2 quarters of 2009/10 compared to 22.5% in 2008/9.

Smoking priorities

- There is a need to continue embedding smoking education and support to all schools e.g. through teachers and school nurse training on tobacco control.

- The normalisation of smoke-free lifestyles underpins all actions to support smoking prevention and cessation. Local partners should build on the work undertaken on smoke-free public places to extend the range of smoke-free environments.

- Partners should continue to develop strategies to tackle illegal sales of cigarettes and sales to those under-18.

Sexually Transmitted Disease

Research highlights that sexually transmitted infections (STIs) are not distributed evenly across the population, and inequalities exist across age, area and ethnic groups. STI rates are highest amongst teenage and young adult populations, and there are specific area based inequalities evident in that rates are disproportionately higher in deprived areas.

Locally, excluding syphilis, (as numbers are very small), the biggest increase in numbers has been for uncomplicated gonorrhoea where there has been 920% increase from 10 cases in 1996 to 102 in 2008. This compares with a 16% decrease across the North West where number have been reducing since 2006.

Chlamydial infection which is the most common bacterial sexually transmitted infection has seen increases across the 2 clinics (of the Halton & St Helens NHS Trust) of 827% between 1996 and 2008, this compares with 13% across the North West.

The number of herpes cases diagnosed locally has increased by 183%, this compares with 87% across the North West

The number of cases of anogenital warts has also increased over the time period by 99% , this compares with 20% across the North West

These rises in infections can not definitely be linked to residents of Halton and St Helens but recently published resident based data shows that Halton and St Helens has high levels of infections of diagnosed chlamydia, gonorrhoea and genital warts, therefore showing higher levels of acute STI rates than the North West as a whole.

In the 15-24 year old population Halton and St Helens has the third highest levels of chlamydia diagnosis in the North West. This may be due to a very effective screening programme in this age group actively finding people with chlamydia who are asymptomatic.

Sexually Transmitted Disease Priorities:

- To continue STI surveillance locally so that any clusters can be identified, working closely with service providers who maybe the first to identify clusters

- To continue STI surveillance to identify trends and impacts of interventions

- To continue to develop and strengthen the health promotion and improvement messages locally and working with services health and other services in contact with 'at-risk' populations to deliver key messages

- To develop other health related venues that could opportunistically provide health care interventions for STI's such as Pharmacies providing screening and treatment for Chlamydia

Teenage Pregnancy

Since the baseline was established in 1998 we have seen a fluctuating picture in the numbers of conceptions reported. There has been no sustainable reduction over time. The rate increased from 52.3 in 2008 to 58.9 in 2009, placing Halton as having the 13th highest rate in England. However, in quarter 4 2009 Halton saw a reduction in the rate of conception. Halton is seeing a reduction in the percentage of conceptions leading to termination. In England, the percentage in 2009 was 49%. In Halton the percentage was 41%. This could mean that contraception is being used more effectively and termination is not being used as a form of contraception. Although the numbers are very low for under 16 conceptions, Halton is seeing a small increase in the rate of conceptions to girls aged 13-15.

Teenage Pregnancy Priorities:

- Continuing to extending provision and access to a full range and choice of sexual health information, advice and services available in identified locations and at times appropriate to meet the needs of the local young people.

- There is a need to urgently develop holistic school, college, sixth form and work based holistic health services including sexual health, drugs and alcohol and other risk taking behaviours.

- Work with partners across schools in the borough to support increased training and development opportunities to teachers responsible for delivering Sex and Relationship Education and Personal Health and Social Education.

Conditions

Around half a million people die in England each year, of whom almost two thirds are aged over 75. The large majority of deaths at the start of the 21st century follow a period of chronic illness such as heart disease, cancer, stroke, chronic respiratory disease, neurological disease or dementia. Most deaths (58%) occur in NHS hospitals, with around 18% occurring at home, 17% in care homes, 4% in hospices and 3% elsewhere

Halton's JSNA identifies cardio vascular disease (CVD) and cancers as the predominant influence on reducing mortality rates

Cancer

In Halton the incidence of cancer is rare before the age of 50. Admissions for all types rise from the 50-54 age band, peaking at 65-69 years. Cancer deaths make up 28% of total deaths among those over 50 years of age. Overall lung cancer accounts for the largest proportion of cancer deaths (23.2%) followed by colorectal at 9.6% and breast cancer at 7.8%. The rate of all cancer deaths is slightly higher in Halton across all age bands but the difference is only significant in the 85+ age group. Survival from lung cancer in Halton and St Helens is 30% after one year: one of the eight best rates in the North West. Survival from bowel cancer at one year is excellent at 71%. Survival from breast cancer at one year is high at 96%. The "Get Checked" campaign aims to improve cancer early diagnosis and is focussed in the poorest areas in Halton.

Cancer Priorities

- Continue to support the Early Detection/ Healthy Communities Collaborative for Cancer in Halton to raise awareness of the signs and symptoms of cancer and promote early presentation to health services

- Ensure cancer prevention is part of all commissioners' approach to tackling premature deaths from cancers.

- Reducing other risk taking behaviours including alcohol and promoting better diet and more active lifestyles.

- Improving the expertise of cancer treatment services – balancing concentration of specialist skills with improved access

- Continue to support and develop care pathways for Cancer locality teams to ensure improved access to diagnosis and treatment

Coronary Heart Disease (CHD), Hypertension and Stroke (collectively known as cardio vascular disease)

2009 data for Halton indicates deaths from CHD had reduced. GP registers for patients at high risk of CHD, hypertension and stroke are in place to address the problem of under diagnosis.

Admissions to hospital due to Coronary Heart Disease (CHD) are predominantly seen in the older age bands, admission rates are statistically significantly higher than the Halton borough rates in Grange, Halton Castle, Halton Lea, Ditton, Mersey and Norton South

CHD and Hypertension Priorities

- Further Data collection and analysis - One of the Health Inequalities National Support Team recommendations was a greater use by public health of prescribing and Quality Outcomes Framework data. Also, further investigation/research is needed into how accurate the prevalence estimates for heart failure are likely to be.

- The predicted increases in (CHD) and hypertension need to be factored in to the setting of performance targets and monitor of health outcomes for all Locally Enhanced Services

- Continued roll out of the Health Check Plus programme.

Stroke Priorities

- Consistent and well co-coordinated stroke prevention measures.

- Access to specialist stroke rehabilitation in hospital immediately following acute episode.

- Well co-ordinated community stroke services that offer personalised and flexible life long rehabilitation care and support for all stroke survivors

- Ensure continued collaboration and engagement with multi-disciplinary teams to ensure that we are able to deliver against a better stroke pathway.

Coronary Obstructive Pulmonary Disease (COPD)

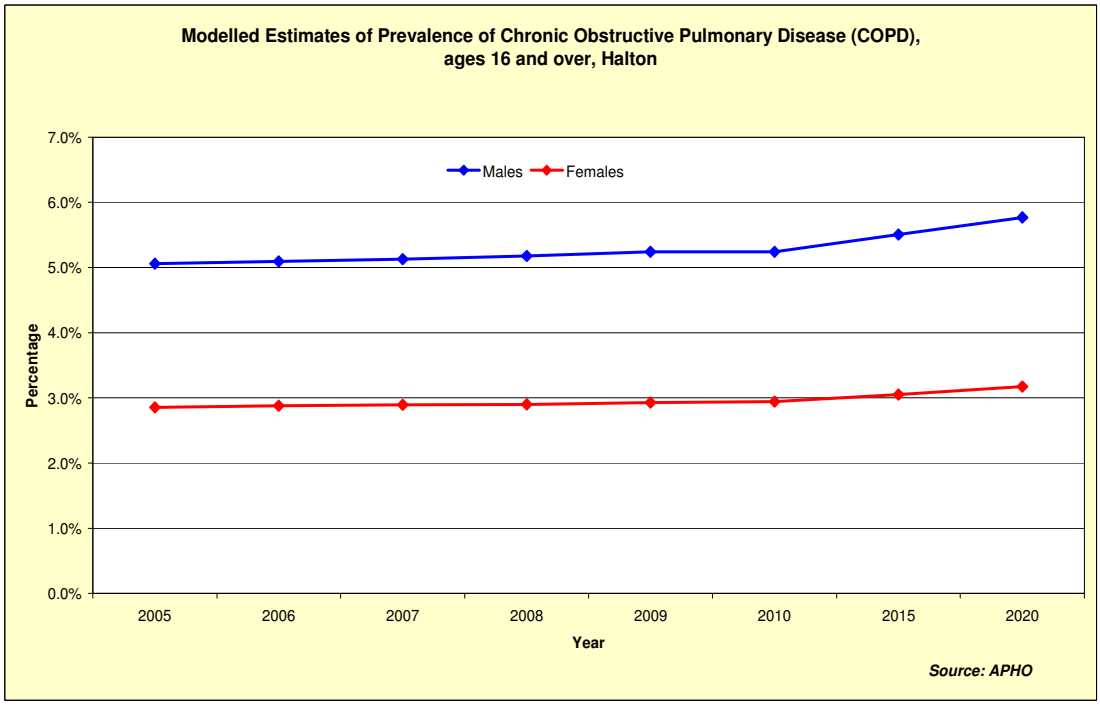
COPD includes two main diseases, bronchitis and emphysema. Asthma may also be included but only where there is some degree of chronic airway obstruction

The major risk factor for developing COPD is smoking. It makes up 80% of the burden of the disease. The disease now effects men and women almost equally due to the increase in the number of women who smoke. Deprivation is associated with smoking prevalence and thus areas of high deprivation are linked to higher COPD prevalence.

Modelled estimates suggest that unless concerted action is taken, due to changes in population, the prevalence of COPD will increase.

Figure 3 shows the estimated prevalence of COPD in Halton up to 2020. Death rates vary across the borough, with death rates for those over 40 from COPD during 2005-09 highest in Halton Castle, Mersey, Halton Lea, Ditton and Appleton wards.

Figure 3: modelled estimated prevalence of COPD in those aged 16+, Halton, 2005-2020.



COPD Priorities

- Commissioning of appropriate community specialist services that are outcome focussed: to include education and self-care, prevention and management of exacerbations, pulmonary rehabilitation, keeping people healthy and at home

- Early detection and diagnosis of COPD

- Development of a consistent, integrated pathway through services

Diabetes

Diabetes has a major impact on heart disease, stroke, lower limb amputation, renal disease, impotence in men and kidney disease. The Diabetes Health Needs Assessment completed in November 2007 clearly indicates that there will be a significant increase in the number of patients with Type 2 Diabetes who will require quality systematic disease management.

The estimated excess deaths among people with diabetes indicator records the number of years of life lost due to mortality from diabetes. The rate for Halton for the period 2006-08 is 3.1 years lost. Halton has a lower rate than its comparators for this period.

Diabetes Priorities

- There are low numbers of diabetic patients accessing patient education programmes. This should be investigated both from a service provider and client perspective before any expansion programme is planned

- One of the Health Inequality Support Team's recommendations was a greater use by public health of prescribing and quality and outcomes framework (QOF) data. Closer links need to be developed between Public Health Evidence & Intelligence Team and Medicines Management and further analysis of relevant prescribing data/information made. A Pharmacy Health Needs Assessment has recently been started which should aid this dialogue.

- Retinopathy screening (eye test for people with diabetes) has improved over the last year and uptake is now at 81% (the minimum national standard is 80%). Maintaining and improving further uptake and ensuring grading quality remain priorities for the PCT.

Mental Health

The North West Public Health Observatory in 2009 undertook the Mental Wellbeing Survey which sampled 500 people across Halton and St Helens and asked individuals a series of questions aimed at measuring wellbeing for the borough. The survey showed 35.4% of adults living within Halton and St Helens had above average mental wellbeing which was significantly higher than the North West average (20.4%). The number of adults who measures themselves as having below average mental wellbeing (4.9%) was significantly lower than the North West average (16.8%).

Changes in the population structure mean that whilst it is predicted that there will be a slight decline in the number of adults aged 18-64 with mental health disorders in Halton, the number of older people suffering with depression and severe depression is predicted to rise.

Mental Health Priorities

- Commission initiatives that promote earlier detection and interventions for people suffering with mental health problems.

- Develop joint strategies with relevant partners to promote recovery, and improve the mental well-being and mental health outcomes of the people of Halton, that also addresses the broader determinants of mental health.
- Ensure that commissioned services are accessible to all and consider those who may be particularly at risk of experiencing health inequalities.

Dementia

Data for 2007/08 indicates that 1269 patients across Halton and St Helens Primary Care Trust (PCT) are registered as having dementia (0.4%). Figures from Projecting Older People Population Information (POPPI) estimate that numbers of dementia sufferers over 65 years old could increase by 155% by

2025, with over 4,000 patients in Halton and St Helens. Overall for the PCT, numbers of males over 65 years old presenting with dementia is expected to increase by 105% compared to 43% in females.

Dementia Priorities

- Development of Dementia Peer Support
- Commissioning of Assessment, Care and Treatment Service
- Commissioning of Dementia Care Advisors
- Training for professionals in basic awareness
- Advanced training for professionals
- Improved quality in existing services i.e. memory clinic, Community Mental Health Team etc.

Vulnerable Groups

Older People

Older people and those with long-term conditions are the most intensive users of the most expensive services. People with long-term conditions are not just high users of primary and specific acute services but also social care and community services, and urgent and emergency care. Numbers are increasing due to factors such as an ageing population, health inequalities and certain lifestyle choices that people make. Because of their vulnerability, simple problems can make their condition deteriorate rapidly, putting them at high risk of unplanned hospital admissions or long-term institutionalisation

By 2026, at a national level, older people will account for almost half (48 per cent) of the number of new households, resulting in 2.4 million more 'older' households than there are today

Older People Priorities

- Ensure that there is enough affordable and quality accommodation
- A wider range of community based services are developed and commissioned to meet the range of health related illnesses that affect older people e.g. Stroke, COPD, Dementia etc.
- Commissioners need to address the continuing issue of falls in older people, both in relation to the prevention of falls and the quality of care if someone does have a fall.
- Continuing to deliver high quality Intermediate Care services to support improved rehabilitation rather than reliance on Residential Care.
- Investigate the full potential of technology, such as Telecare and Telehealth, to support care closer to home for older people.

Vulnerable Children

One way of assessing vulnerability is by the Children in Need. The definition of a child being in need is taken from Section 17(10) Children Act 1989, whereby:

- He/She is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of heath or development without the provision for him/her of services by a local authority.

- His/Her health and development is likely to be significantly impaired or further impaired, without the provision for him/her of such services.

- He/She is disabled

There were 685 Children in Need in Halton in 2009/10. The ward containing the highest number of Children in Need during the period was Kingsway (63 children), the ward with the lowest number in the Children in Need category was Beechwood

There were 137 Children in Care in Halton in 2009/10. The ward containing the highest number of Children in Care during the period was Halton Lea (17 children), four wards in the borough had no Children in Care throughout the period; these were Beechwood, Birchfield, Daresbury and Farnworth

There were 81 Children subject to Child Protection plans in Halton in 2009/10. The ward containing the highest number of these children was Halton Lea (11 children), seven wards in the borough had no Children subject to Child Protection plans throughout the period; these were Beechwood, Birchfield, Farnworth, Broadheath, Ditton, Hale and Heath.

Vulnerable Children Priorities

- Improve parenting support and support for children in need of safeguarding,

- Ensure robust safeguarding processes are in place

- Improve outcomes for children in need of safeguarding.

Adults with a learning disability and adults with a physical/sensory disability

Adults with learning disabilities are one of the most vulnerable groups in society, experiencing health inequalities, social exclusion and stigmatisation. In general, adults with learning disabilities have greater and more complex health needs than the general population, and often these needs are not identified or treated.

Life expectancy of this group is shorter than the general population, though this has increased recently. In addition a number of national reports have highlighted that adults with learning disabilities often experience barriers to accessing healthcare services, and poor levels of care. Indeed, adults with learning disabilities are more likely to die from a preventable cause than the general population

The percentage of adults with learning disabilities in employment within Halton is 3.7%. This is lower than the regional average (5.2%) and considerably lower than the average national rate (6.8%)

Physical impairments may be congenital or acquired at any age, be temporary, long-term, or fluctuating. People with physical impairments may often have unique & multi-dimensional requirements. Sensory impairments may, like physical impairments, be congenital or acquired at any age. They are more prevalent with age as are additional sensory or other impairments. Most sensory impairments develop gradually and are often secondary to other disabilities.

There are 5,968 people between the ages of 18 and 64 in Halton that have a physical disability. The majority of these (67%) are aged between 45 and 64 with 26% aged between 25 and 44 and 7% between 16 and 24. 3,117 people between the ages of 18 and 64 have a sensory disability. The majority of these (89%) are aged between 45 and 64 with 10% aged between 25 and 44 and only 1% between 16 and 24.

Priorities for adults with learning, physical or sensory disability

- To support progress in delivering the National Service Framework for Long Term (Neurological) Conditions in Halton consultation has identified the need for better access to integrated Neurological Rehabilitation and Enablement services and better co-ordination of support for the voluntary sector.

- To support adults and young people in transition to adult services with learning disabilities

6. Conclusion

Early detection is likely to reduce costs and improve outcomes in the major disease areas. Action on these areas should continue as they are likely to make the most difference in the short and longer term.

Some changes in prevalence suggest new priority areas:

- Injury prevention- due to increased hospital admissions and deaths. This could be linked with the alcohol agenda
- Mental health more broadly than early detection of depression is a priority area due to the rise in suicides and undetermined injury. The economic recession and changes in benefits may also increase demands on services.
- Sexual health due to high prevalence rates
- Child health- particularly infant mortality linked with maternity services and child and adolescent mental health services. Childhood obesity has levelled but should remain a priority due to the potential high impact.

There are some longer term trends in our population and needs which will impact on priorities:

- The numbers of frail older people will increase with increased need for services including dementia, obesity, falls prevention, chronic disease management hearing, vision and continence services.
- The numbers of people with a severe learning disability will also increase.

How will the JSNA be used?

The JSNA will be used to inform commissioning decisions and with the forthcoming changes planned under the Health and Social Care Bill , the JSNA will become a main evidence driver for the Health and Wellbeing Board that will operate within Halton. A responsibility of the new Health and Well Being Board will be to develop a high level strategy (joint Health and Wellbeing strategy) to address health inequalities, using the findings of the JSNA to direct strategy.

7. Want to have your say or get involved?

If you would like to comment on how health inequalities in Halton can be reduced or require this document in a different format please use the contact details below:

Policy Officer (Health)
People & Communities Policy Team
2nd Floor Runcorn Town Hall
Heath Road
Runcorn
WA7 5TD

01928 704521

Emma.bragger@halton.gov.uk

If you want to comment on health, well being or social care services in Halton, or get involved with people who can represent your views contact:

Halton Local Involvement Network (the LINK):
www.haltonlink.org.uk.

Halton LINk, Sefton House, Public Hall Street, Runcorn WA7 1NG

01928 592405

Appendix 1: Health and Wellbeing in Halton Contents

Chapters covered by this JSNA

Older People

Older People Falls

Overall health and Wellbeing

Physical, Sensory and Learning Disability

Pregnancy

Sexually Transmitted Infection

Smoking

Substance Misuse (Adults)

Substance Misuse (Children & Young People)

Teenage Pregnancy

Transport

Vulnerable Children

Appendix 2: Summary of Commissioning Plans/Strategies

Chapter	Commissioning Plans/Strategies (Local and/or national)
Adult Immunisations	
Adult Obesity	Department of Health (2008) Healthy Weight, Healthy Lives - A Cross Government Strategy for England
Alcohol (Adults)	Signs for improvement: Commissioning interventions to reduce alcohol-related harm (DH 2009).
Cancer	Department of Health (2007) Cancer Reform Strategy
Child Accidental Injury	Children's Trust Commissioning Framework  Children's Trust Commissioning Frame
Child Immunisations	Reducing differences in the uptake of immunisations
Child Obesity	Department of Health (2008) Healthy Weight, Healthy Lives - A Cross Government Strategy for England.
Child Poverty	Children's Trust Commissioning Framework  Children's Trust Commissioning Frame
Children and Young People Mental Health and Emotional Wellbeing	Children's Trust Commissioning Framework  Children's Trust Commissioning Frame
Community Safety	Halton Anti Social Behaviour Plan
Coronary Obstructive Pulmonary Disease	National Strategy for COPD
Coronary Heart Disease	Department of Health (2000) National Service Framework for Coronary Heart Disease
Dementia	St Helens and Halton Joint Commissioning Strategy for Dementia, available from Sue Wallace-Bonner, Operational Director Older People Halton Borough Council, Runcorn Town Hall 0151 471 7533
Demographics	n/a
Dental	

Diabetes	National Service Framework for Diabetes (2001) Diabetes Commissioning Toolkit (2006)
Economy	Liverpool City Region Employment Strategy http://www.liverpoolcitystrategyces.org.uk/about/
Housing	Commissioning Strategy for Extra Care, May 2008 http://www2.halton.gov.uk/pdfs/socialcareandhealth/stratextracare08 Halton Housing Strategy 2008 to 2011 http://hbccms.halton-borough.gov.uk/content/housing/housingstrategy/?a=5441
Hypertension	Prevention of cardiovascular disease
Mental health	Cross Government Mental Health Outcomes Strategy No Health Without Mental Health
Older People	Older People's Joint Commissioning Strategy 2009-2012, available from Sue Wallace-Bonner, Operational Director- Older People, Runcorn Town Hall 0151 471 7533
Older People Falls	
Overall health and Wellbeing	n/a
Physical, Sensory and Learning Disability	http://www.valuingpeoplenow.dh.gov.uk
Pregnancy	Maternity Matters (DH 2007)
Sexually Transmitted Infection	*Better Prevention, Better Services, Better Sexual Health: The National Strategy for Sexual Health and HIV*. DoH, July 2001- Refreshed 2008 by the Independent Advisory Group for Sexual Health (http://www.dh.gov.uk/assetRoot/04/07/44/86/04074486.pdf)
Smoking	A Smokefree Future: A comprehensive tobacco control strategy for England (Department of Health, 2010)
Substance Misuse (Adults)	2010 National Drug Strategy http://www.homeoffice.gov.uk/publications/drugs/drug-strategy/drug-strategy-2010?view=Binary
Substance Misuse (Children & Young People)	Children's Trust Commissioning Framework  Children's Trust Commissioning Frame
Teenage Pregnancy	Children's Trust Commissioning Framework  Children's Trust Commissioning Frame
Transport	Local Transport Plan http://www3.halton.gov.uk/transportandstreets/transportpolicy/

Vulnerable Children	Children's Trust Commissioning Framework  Children's Trust Commissioning Frame

REPORT TO: Health Policy and Performance Board

DATE: 07th June 2011

REPORTING OFFICER: Strategic Director - Communities

SUBJECT: Sustainable Community Strategy 2010 – 11 Year-end progress report.

WARDS: Borough-wide

1.0 PURPOSE OF REPORT

1.1 To provide information on the progress in achieving targets contained within the Sustainable Community Strategy for Halton.

2.0 RECOMMENDED: That

i. the report is noted; and

ii. the Board considers whether it requires any further information concerning the actions taken to achieve the performance targets contained within Halton's 2006 – 11 Sustainable Community Strategy (SCS).

3.0 SUPPORTING INFORMATION

3.1 The Sustainable Community Strategy, a central document for the Council and its partners, which provides an evidenced-based framework through which actions and shared performance targets can be developed and communicated.

3.2 The current Sustainable Community Strategy included targets which were also part of the Local Area Agreement (LAA). In October 2010 the coalition government announced the ending of government performance management of local authorities through LAAs. Nevertheless, the Council and it's partners need to maintain some form of effective performance management framework to:-

- Measure progress towards our own objectives for the improvement of the quality of life in Halton.
- Meet the government's expectation that we will publish performance information.

3.3 Following extensive research and analysis and consultation with all stakeholder groups including Elected Members, partners and the local community and representative groups, a new SCS (2011 – 26) was approved by Council on 20th April 2011.

3.4 The new SCS will be accompanied by a separate 'living' 5 year delivery plan. This approach will provide sufficient flexibility to evolve as continuing changes within the public sector continue to emerge, for example the restructuring of the NHS and pubic health delivery, implementation of Local Economic Partnerships and the delivery of the 'localism' agenda.

3.5 Work is presently underway to determine a range of performance information that will allow the systematic monitoring of the progress being made in achieving desired community outcomes over time.

3.6 Attached as Appendix 1 is a report on progress of the SCS (2006-11) for the year ending 31st March 2011. This includes a summary of all indicators within the existing Sustainable Community Strategy and additional information for those specific indicators and targets that fall within the remit of this Policy and Performance Board.

3.7 In considering this report Members should be aware that:-

a) The purpose of this report is to consolidate information on all measures and targets relevant to this PPB in order to provide a clear picture of progress.

b) As the requirement to undertake a centrally prescribed Place Survey has now ceased the development of a localised perception based methodology is currently underway with a likely implementation date of autumn 2011.

4.0 CONCLUSION

4.1 The Sustainable Community Strategy for Halton, and the performance measures and targets contained within it will remain central to the delivery of community outcomes. It is therefore important that we monitor progress and that Members are satisfied that adequate plans are in place to ensure that the Council and its partners achieve the improvement targets that have been agreed.

5.0 POLICY IMPLICATIONS

5.1 The Sustainable Community Strategy for Halton is central to our policy framework. It provides the primary vehicle through which the Council and its partners develop and communicate collaborative actions that will positively impact upon the communities of Halton.

6.0 OTHER IMPLICATIONS

6.1 The publication by Local Authorities of performance information is central to the coalition government's transparency agenda. This has been accompanied by a commitment to reduce top down performance management, with the pre-existing National Indicator Data Set (NIS), being replaced from April 2011 with a single comprehensive list of all data that Local Authorities are required to provide to Central Government.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 This report deals directly with the delivery of the relevant strategic priority of the Council.

8.0 RISK ANALYSIS

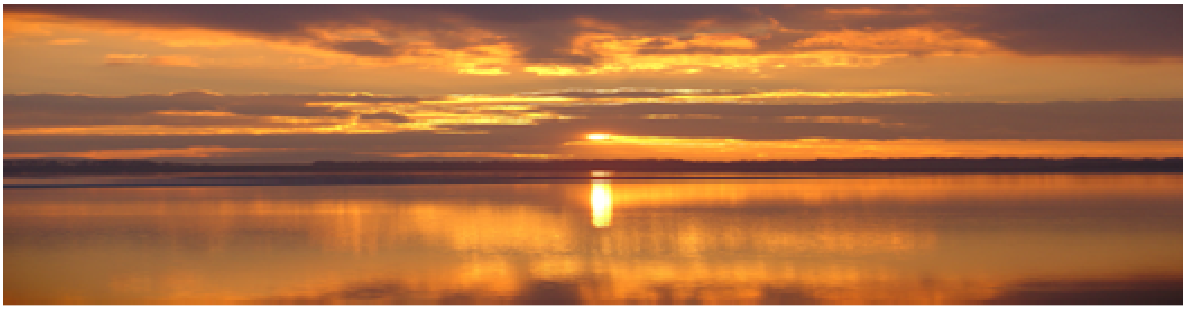
8.1 The key risk is a failure to improve the quality of life for Halton's residents in accordance with the objectives of the Sustainable Community Strategy. This risk can be mitigated thorough the regular reporting and review of progress and the development of appropriate actions where under-performance may occur.

9.0 EQUALITY AND DIVERSITY ISSUES

9.1 One of the guiding principles of the Sustainable Community Strategy is to reduce inequalities in Halton.

10.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Document	Sustainable Community Strategy 2006 – 11
Place of Inspection	2nd Floor, Municipal Building, Kingsway, Widnes
Contact Officer	Hazel Coen



The Sustainable Community Strategy for Halton 2006 - 2011

Year -end Progress Report

01st April 2010 – 31st March 2011

Health Policy & Performance Board

Halton Strategic PARTNERSHIP

Document Contact (Halton Borough Council)	Hazel Coen Divisional Manager, Performance & Improvement Municipal Buildings, Kingsway Widnes, Cheshire WA8 7QF hazel.coen@halton.gov.uk

This report provides a summary of progress in relation to the achievement of targets within Halton's Sustainable Community Strategy 2006 - 2011.

It provides both a snapshot of performance for the period 01st April 2010 to 30th September 2010 and a projection of expected levels of performance to the year-end.

The following symbols have been used to illustrate current performance as against the 2011 target and as against performance for the same period last year.

✓	Target is likely to be achieved or exceeded.	↑	Current performance is better than this time last year
?	The achievement of the target is uncertain at this stage	⟷	Current performance is the same as this time last year
✗	Target is highly unlikely to be / will not be achieved.	↓	Current performance is worse than this time last year

HEALTHY HALTON

Page	NI	Descriptor	2010/11 Target	Direction of travel
	8	Adult participation in sport	✓	↑
	53	Prevalence of breastfeeding at 6 – 8 weeks from birth	✗	↑
	120	All-age all-cause mortality	✗	↓ Male ↑ Female
	123	16+ Smoking rate prevalence	✓	↑
	142	Number of vulnerable people supported to maintain independent living	✗	↓
	150	Adults in contact with secondary mental health services in employment	✓	↑

Non Local Area Agreement Measures / Targets

	121	Mortality rate from all circulatory diseases at ages under 75 (proxy for local indicator H1)	✗	↑
	122	Mortality from all cancers at ages under 75 (proxy for local indicator H2)	✗	↑
	124	Increase the number of people with a long term condition supported to be independent and in control of their condition	✓	↑

NI 8	Increase adult participation in sport

Baseline (2006)	09 – 10 Actual	2011 Target	2010 – 11 Cumulative outturn data				Current Progress	Direction of Travel
			Q1	Q2	Q3	Q4		
20.13%	21.4%	24.13%	24.2%	N/A	26.3%	N/A	✓	↑

Data Commentary

Halton remain in the top 25% of best performing authorities in England. Full data results are next due in June 2011 and it is expected that the 2010-11 target will have been achieved.

General Performance Commentary

Active People Survey 5, Q1 results were published on 17th March 2011 and showed a slight reduction in the participation rate. Removal of free swimming for over 60s could be a contributory factor to this reduction. However, Halton remain in the top 25% of best performing authorities in England.

Summary of key activities undertaken during the year

The Sports Participation Project has increased participation in physical activity by adults. It is supported by the Council, Halton Strategic Partnership, local community organisations, health professionals, Sport England, and private and voluntary sector sports clubs.

It provides increased accessibility to physical activities, especially for adults who have previously done little or no physical activity. For example, the Widnes and Runcorn Cancer group have now been introduced to activities such as archery, golf and badminton. Other new initiatives have included 'Walk to Work Week' and 'Walk for Life Day' and a new 'Walk Map' was created for the Town Park area following work with a Palacefields residents group.

A 'Full of Life' day was also organised to encourage older people to get and stay active in later life. Trewan House tried many of the 20 activities available and have now established their own chair-based exercise and New Age Bowling classes, with support from the Sports Participation Project.

A further range of Project examples include: Zumba, (the latest get fit craze involving dance moves to Latin rhythm inspired by Salsa, Samba and Merengue), Tai Chi and Yoga, and Halton Happy Hearts and Halton Happy Zipper Club, (for people with a heart condition to get light exercise).

NI 53	Prevalence of breastfeeding at 6-8 weeks from birth

Baseline (2008, Q2)	09 – 10 Actual	10-11 Target	2010 – 11 Cumulative outturn data				Current Progress	Direction of Travel
			Q1	Q2	Q3	Q4		
12.1%	19.26%	23%	13.54%	16.48%	18.38%	18.38%		

Data Commentary

Q3 data has been updated and used as a proxy for Q4. Q4 data is not available before this report deadline.

General Performance Commentary

The prevalence of breastfeeding at 6-8 weeks has increased over the previous quarters, but is yet to reach the target.

Summary of key activities undertaken during the year

Progress has been made towards improving breastfeeding rates in Halton

- The breastfeeding policy was agreed by the Clinical Commissioning Committee subject to amendments
- Breastfeeding is a Joint Commissioning Unit priority
- An update and plan was presented to the PCT Clinical Commissioning Committee in March.
- A paper will go to Finance and Approvals Committee highlighting the gap in resources, to be submitted in April.
- Achieving Baby Friendly accreditation is currently at risk due to lack of resources to deliver training and audit.
- CQUIN proposal submitted to Quality Board for inclusion in Acute Trust contract to promote improvement in rates, the outcome is awaited
- The preparation of the Warrington Road Pilot and the Peer support incentive scheme pilot are well underway, and the pilots will begin in June 2011.
- Benefits are already being seen from the pilots through improvements in joint working between Peers Support Workers, Midwives and Health Visitors.
- 10 new voluntary Peer Support workers will be trained in May 2011; this will ensure there is sufficient capacity to run the pilot schemes. Aiming to ensure representation from both Runcorn and Widnes
- The new Child Health System, Paris risks reducing data coverage at 6-8 weeks. Discussions underway to mitigate risk.

NI 120	All-age all cause mortality rate

Baseline (2006)	09- 10 Actual	10-11 Target	2010 – 11 Cumulative outturn data				Current Progress	Direction of Travel
			Q1	Q2	Q3	Q4		
Male 906 per 100,000 pop	803.8 per 100,000 pop	Male 755 per 100,000 pop	849.3	845.0	853.1	879.3		
Female 673 per 100,000 pop	597.3 per 100,000 pop	Female 574 per 100,000 pop	576.4	600	586.5	582.8		

Data Commentary

Q3 figures have been updated. February figure used as a proxy for Q4 as March data has not yet been released. Targets for mortality are based on calendar year data and not financial year. Therefore data is unverified mortality rate for calendar year 2010.

General Performance Commentary

Based on Q3 data both Male and Female Mortality is above the 2010 targets for all age all cause mortality. Male mortality appears to have increased from verified 2009 data where the rate was 838.09 (an increase in 3 deaths). Female mortality however has continued to decrease but not enough to hit the 2010 target. Year end 2009 verified data showed a rate of 595.12 by year end 2010 this had reduced to 586.5 (unverified data)

To hit year end 2011 rates male mortality would need to reduce to 731 per 100,000 (DSR) and females mortality to 558 per 100,000. There would need to be a substantial improvement in death rates to come near to meeting these targets by the end of 2011.

Summary of key activities undertaken during the year

The main focus of activities is specified under the performance for Mortality from Cancer and Circulatory Diseases as these areas have the biggest impact on All Age All Cause.

Additional activities to improve outcomes are:
Chronic Obstructive Pulmonary Disease (COPD): There is a health equity audit being undertaken to review the evidence and services currently delivering and identifying people early with COPD.

Effective management of COPD will help reduce mortality from the condition but more significantly reduce hospital admissions due to COPD exacerbations.
Infant Mortality:

Has a significant impact on early death and will have an impact on life expectancy. Having babies as a teenager, smoking in pregnancy and breastfeeding are two areas that have an impact on infant mortality. Although Halton has not got a high rate of infant mortality compared with England there is potential to improve further. High teenage conceptions, low breastfeeding rates and smoking in pregnancy continue to be challenging areas which are being proactively managed within the Children's Trust.

Suicide and Injury Undetermined:

This is another area that has a significant impact on early death and therefore impacts on life expectancy. Halton and St Helens are participating in an annual suicide audit to understand the background details of suicide victims in order to implement prevention strategies. Year 10/11 trained 89 front line primary care staff in the 'Positive Management of Psychiatric Risk' and 168 Partner Organisations including Fire & Rescue, DWP etc in the early identification of members of the public who posed a risk of self harm.

NI 123	16+ current smoking rate prevalence – rate of quitters per 100,000 population

Baseline (2007/8)	09- 10 Actual	2011 Target	2010 – 11 Cumulative outturn data				Current Progress	Direction of Travel
			Q1	Q2	Q3	Q4		
914 per 100,000 pop	888	1128	257.49	548.55	762.39	879.12	✓	↑

Data Commentary

Data is a snapshot as of April 1st 2011 and is not the complete year end data. All previous data has been updated.

General Performance Commentary

Data is a snapshot as of 1st April 2011 and will need to be updated when full data is available; October to February data has been updated and are all above target where the preferred outcome is higher. The Stop Smoking service is very close to the March target and figures are still being collected from GP Practices for Q4. It is expected we will make the target. This will be a considerable achievement as we have a very high quit rate.

Summary of key activities undertaken during the year

Key tobacco control initiatives to run throughout the year are:

- Delivery of smoking prevention programmes for schools and young people via joint working between the Canal Boat project and the PCT.
- Training for teachers on illicit tobacco and its dangers.
- Tobacco Control training provided for 60 PSHE primary teachers across Halton & St Helens per annum, including support and evaluation of cascade of training to pupils.
- Social marketing driven, comprehensive, and highly visible coverage of targeted interventions delivered across Halton and St Helens.
- Deliver 12 Brief Intervention training sessions-1 each month.
- Implement new intervention to encourage pregnant smokers to stay quit for the term of the pregnancy.
- Raise profile of SUPPORT stop smoking services by targeted brief Intervention training to Halton General and HCRC staff Pre-Op, Cardio respiratory, minor Injury 100% outpatient services in Halton General and 5 Borough Mental Health settings in Halton, trained in referral pathway to stop smoking services.
- Increase the number of Pharmacies offering support to smokers from 15 to 25.
- Increase in cessation data collected from GP practices

- 10% Increase in annual numbers of under 18 attending support to stop smoking

Increase awareness of the Support service to areas of High deprivation and deliver targeted campaigns to pregnant and manual smokers.

- Incentive scheme developed for pregnant smokers.
- Social marketing programme delivered for pregnant smokers.

NI 142 Improve the number of vulnerable people supported to maintain independent living

Baseline (Year)	09-10 Actual	2011 Target	2010 – 11 Cumulative outturn data				Current Progress	Direction of Travel
			Q1	Q2	Q3	Q4		
98.17% (2007/8)	98.95 %	99.04 %	99.39%	98.7%	98.51%	98.33%		

Data Commentary

It should be noted that the reduction in the capacity of floating support services have resulted in services closing cases where service users are no longer engaging with the support service. This was necessary to achieve proposed contractual changes but has caused overall performance to be lower than it would normally be.

General Performance Commentary

Overall performance has failed to achieve the target set for 2010/11. There has been a reduction in services performance during quarter 4 which has lowered the overall out-turn for the year. One service has failed to submit the PI workbook for quarter 4.

Summary of key activities undertaken during the year

The floating support services will continue to be monitored and meetings held on a quarterly basis to ensure performance increases to meet the targets set.

NI 150	Number of adults in contact with secondary mental health services in employment

Baseline (January 2010)	09-10 Actual	2011 Target	2010 – 11 Cumulative outturn data				Current Progress	Direction of Travel
			Q1	Q2	Q3	Q4		
11.1%	11.1%	12.1%	11.7%	12.4%	13.4%	13.3%	✓	↑

Data Commentary

This is the most recent figure as at 28th February 2011. Data is provided by the 5 Boroughs Mental Health Trust.

General Performance Commentary

The figure in January 2011 stood at 13.4%, which is higher than any of the other areas within the 5Boroughs.

Summary of key activities undertaken during the year

A service has been commissioned from Richmond Fellowship (national mental health charity) to support people with severe mental health problems to access work opportunities or return to work after a period of illness, and to support both them and their employers to manage their support needs whilst in work.

NI 121	Mortality rate from all circulatory diseases at ages under 75

Baseline (Year) 1995/97	09-10 Actual	2011 Target	2010 – 11 Cumulative outturn data				Current Progress	Direction of Travel
			Q1	Q2	Q3	Q4		
182.95	88.8	78.31	**97.2**	**103.8**	**101.8**	**96.8**	✗	↑

Data Commentary

Q3 figure has been updated. February figure has been used as a proxy for Q4 as March data has not yet been released.

General Performance Commentary

There has been a marginal decrease in mortality due to circulatory diseases since April. We continue to examine the data to understand the causes of deaths, the age and where these deaths have occurred to enable better targeting of current

programmes in place.
This means the Circulatory Disease's in Halton are unlikely to hit the PCT calendar year end target of 78.31.

Summary of key activities undertaken during the year

Several key initiatives have been put into place or been accelerated within 2010/11:

Identifying people without established Cardiovascular Disease (CVD)
This initiative significantly contributes to detecting CVD and other major illnesses earlier so that we can empower patients to take control and also actively manage the disease onset. We have accelerated the uptake and model of our Health Checks Plus (HC+) Scheme. In 2010/11 over 9000 health checks have been completed, 45% of these in Halton Practices. We have secured new and alternative providers of HC+ assessments. We have also commissioned a community pharmacy pilot in Halton whereby individuals can have a HC+ assessment at the pharmacy.

Optimisation of evidenced based therapy
We know that actively managing blood pressure and cholesterol levels significantly contributes to CVD mortality. The PCT has been actively managing blood pressure and cholesterol levels identified in general practice which significantly contributes to CVD mortality. The PCT have incentivised and supported GP practices to increase the numbers of CVD patients who have a managed BP and cholesterol. We have recently undertaken clinical audits in practices to understand the variation in treatment strategies and address any training needs in the management of Hypertension.

Heart Failure
We have commissioned a new Heart Failure diagnostic service for Halton residents. This new diagnostic test avoids unnecessary visits to the hospital and speeds up the diagnostic pathway in the hope that patients are quickly diagnosed and receive optimal treatment options.

We have recruited two new specialist Heart Failure nurses for the Halton patch. These nurses will work closely with GP practices and run additional community based clinics and attend patients' homes if necessary.

Diabetic Care
In 2010/11 Retinal Screening for Diabetic patients is up by 20% compared to 2009/10. We have commissioned a new Structured Education Service for Type 2 diabetic patients. We are also currently reviewing the Enhanced Diabetes Care scheme within primary care, to ensure that the outcomes of this scheme are directly linked to individual patient outcomes.

Smoking
Smoking has a major impact on levels of heart disease. Smoking cessation rates

are on target and progressing well.
It is expected that we will make the target. Smoking cessation is seasonal with most smokers quitting in the last quarter of January to March. Halton has one of the highest quit rates in the Northwest. Halton is now concentrating on improving smoking in pregnancy figures and will be commencing a new evidence based initiative to encourage quitters to remain quit for the duration of the pregnancy. Patients with COPD are now identified and referred on via the Stop Smoking Service. These patients often have heart as well as respiratory disease. All patients receive information and education. Working with smokers and offering brief advice is now a key part of the critical learning pathway for all clinical staff.

Obesity
Obesity is another major contributor to high levels of heart disease. The weight management services commissioned support the high numbers of patients identified as obese through the Health Checks Plus Programme. A recent audit of outcomes and outputs indicates that overall services are meeting their targets and levels of customer satisfaction are high. Adult weight management services are now embedded. There has been a considerable reduction in the waiting time for level 3 & 4 specialist services. Training for staff in behaviour change has started and will be rolled out in 2011/12. Numbers for exercise on prescription have increased and will continue to expand. Men's Health will be further expanded.

Evidence
In order that we understand the real needs of the Halton population we have completed a CVD Health Equity Audit. This report highlights several areas of recommendation. The lead commissioner has established a task and finish group to collectively address the issues raised within the report. A copy is available upon request.

NI 122	**Mortality from all cancers at ages under 75**

Baseline (Year) 1995/97	09-10 Actual	2011 Target	**2010 – 11 Cumulative outturn data**				Current Progress	Direction of Travel
			Q1	**Q2**	**Q3**	**Q4**		
185.98	166.8	126.41	151.5	158	150.9	149.5		

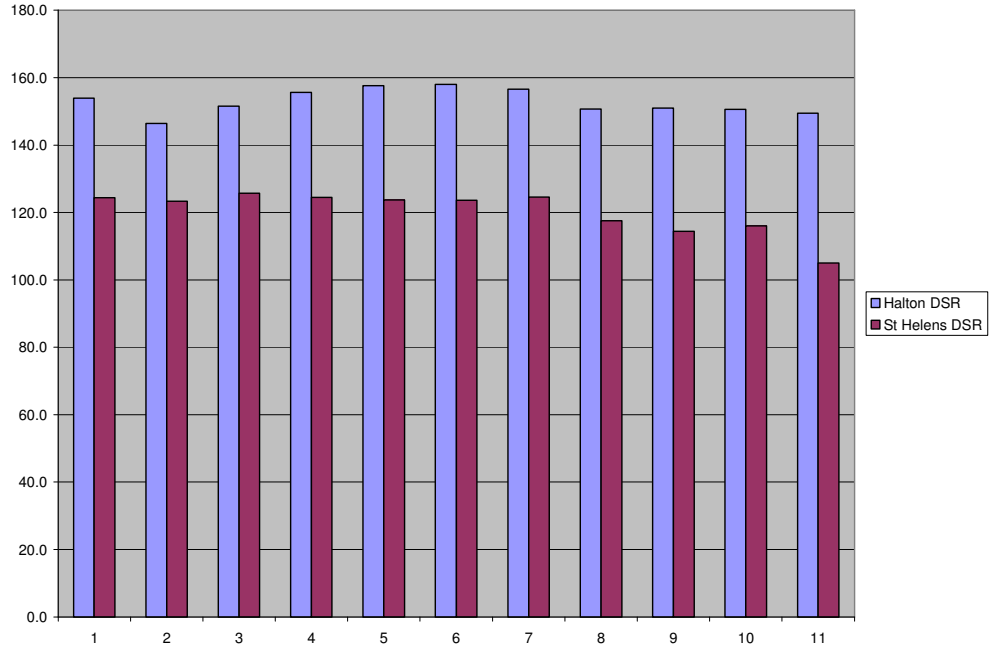
Data Commentary

Q3 figure has been updated. February figure has been used as a proxy for Q4 as March data has not yet been released. It is very important to note that these figures are provisional, and that Q4 is based on provisional monthly mortality data to February only. We do not yet hold confirmed figures for 2010. The performance data quoted above are not actually events: they are Directly Standardised Mortality Rates. They represent about 200 cancer deaths per year under age 75. About half of cancer deaths occur under 75.

General Performance Commentary

Cancer mortality in Halton is high, and not improving as much as the national average or as our neighbours in St Helens

Chart: Month by month rolling annual mortality rates in Halton and St Helens during 2010/11 (month 1 = April 2010)



Summary of key activities undertaken during the year

The Local Authority and NHS partners held a Cancer Summit in February to consider the cancer mortality challenge in Halton and St Helens. The new Cancer Action Plan is being prepared following the summit.

We estimate that new screening programmes for bowel cancer are saving about five lives per year. Other improvements in early detection, such as through the get checked campaign, result in earlier diagnosis of cancer. However, rates remain high. The single biggest factor remains smoking. Lung cancer is the biggest single contributor, including in women.

Investment in cancer prevention and earlier detection has been less than planned during 2010/11, because of the overall PCT financial environment.

NI 124	% people with a long term condition supported to be independent and in control of their condition

Baseline	10-11 Target	2010 – 11 Cumulative outturn data				Current Progress	Direction of Travel
		Q1	Q2	Q3	Q4		
-	18.2%	80.3%	80.3%	80.3%	80.3%	✓	↑

Data Commentary

PCT data is shown as it is not available at LA level. All data has been updated to reflect updated data as of 26.01.2011. It has been recalculated as per the new definition published by the Information Centre, which is why there is such a huge difference against the target. An appropriate new target will be set for 2011-12.

General Performance Commentary

The English average is now 78%. As the method of calculating the results has changed recently it is currently impossible to identify any longer term trends. However, the current performance is encouraging and reflects the continued focus on improvement in the priority disease areas such as Diabetes, COPD, CVD and Cancer across all sectors (Primary Care, Community Services, Secondary Care and third sector). An excellent example of this is the Respiratory Care Group which is driving quality and service improvements for patients with respiratory disease and has active membership from all sectors.

Summary of key activities undertaken during the year

Local Commissioners, including GP Consortia and Local Authority partners have identified LTC as a top priority for 2011/12. It is therefore included in the commissioning intentions for the 2011/12 contract with our community service providers. The review and redesign of services will be led at a local level from within the GP Commissioning Consortia, with strategic oversight provided by the Local Community Services Commissioning Board (which includes senior representatives of GP Consortia and Local Authority partners). Implementation plans will be developed at a local level to reflect the differences between approach and priorities of the 4 GP consortia. A key outcome of the redesign will be to reduce preventable and emergency admissions for people with Long Term Conditions.

In addition the PCT is leading on a QIPP level 3 programme to improve care for Frail Elderly people across the whole spectrum of sectors and providers. This will include many people with multiple Long Term Conditions; and a QIPP level 3 programme to improve the COPD pathway in community and primary care.

REPORT TO: Health Policy & Performance Board

DATE: 7th June 2011

REPORTING OFFICER: Strategic Director, Communities

SUBJECT: The Cheshire and Merseyside Treatment Centre

1.0 **PURPOSE OF REPORT**

1.1 NHS Halton and St Helens is undertaking a formal consultation on future plans for the building known as The Cheshire and Merseyside Treatment Centre. This report is being presented to gain views from the Health Policy & Performance Board as part of this consultation.

2.0 **RECOMMENDATIONS: That the Board note and comment on the contents of the report.**

3.0 **SUPPORTING INFORMATION**

3.1 The Cheshire and Merseyside NHS Treatment Centre (CMTC) is located adjacent to Halton Hospital in Runcorn. The CMTC has been operational since 2006 providing a range of Orthopaedic services, to residents of Halton in addition to residents from Cheshire and Merseyside.

The CMTC is due to cease the provision of the current Orthopaedic services on the 31st May 2011.

3.2 NHS Halton and St Helens have developed a business case which identifies a range of options to be considered for the future provision of services on this site.

4 broad options have been identified by the PCT and Runcorn GP Commissioning Consortium as from 1st June 2011:

- Do nothing- included only to provide a benchmark for cost comparison
- Divest- sell the building on the open market guided by an assessment by the District Valuer
- Lease- seek through a procurement process an organisation that is willing to take on a lease for the building
- Utilisation- use the asset for local health care provision, if costs including capital charges, depreciation and running costs can be recouped.

5.0 **CONSULTATION**

5.1 NHS Halton and St Helens will be consulting with all key local

stakeholders in relation to these proposed plans.

The consultation period runs from 6th May 2011 to 29th July 2011.

6.0 POLICY IMPLICATIONS

Identified within the attached Business Case

7.0 FINANCIAL/RESOURCE IMPLICATIONS

7.1 Identified within the attached Business Case – should Option D4 be supported the proposal could include the location of some Council staff on the Second floor. Some resources may be required to facilitate this move.

8.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

8.1 Children & Young People in Halton

None identified.

8.2 Employment, Learning & Skills in Halton

None identified.

8.3 A Healthy Halton

The proposed developments could provide Halton residents with a good balance of urgent care centre, primary care, intermediate care services and surgery, with a "community hospital" feel.

8.4 A Safer Halton

None identified.

8.5 Halton's Urban Renewal

None identified.

9.0 RISK ANALYSIS

9.1 Identified within the attached Business Case

10.0 EQUALITY AND DIVERSITY ISSUES

10.1 Identified within the attached Business Case

11.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

DOCUMENT	PLACE OF INSPECTION	CONTACT

"Business Case for a Halton Health Care Resource Centre	NHS Halton and St Helens	Simon Banks Operational Director of Planned Care and Market Development

NHS
Halton and St Helens

Business case for a Halton Health Care Resource Centre

April 2011

finnamore

Contents

1 Executive Summary

1.1 Introduction

This document sets out the options and presents a business case to assist the PCT Board in considering the proposed future use of the Cheshire and Merseyside NHS Treatment Centre (CMTC) as a multi-purpose health care resource centre.

The CMTC is located on a site adjacent to Halton Hospital in Runcorn - the site is owned by Warrington and Halton Hospital NHS Foundation Trust (WHHFT) - and is subject to a 60 year lease arrangement, with 55 years remaining.

The CMTC has been operating under the GC5W Project Agreement since 1st June 2006 providing a range of orthopaedic services. This commercially binding contract is between the Department of Health (as the Authority), the primary care trusts in Cheshire and Merseyside and the provider, InterHealth Care Services (UK) Ltd. The five year fixed term will end on 31 May 2011. The leasehold interest in the building and equipment is expected to transfer from the Secretary of State for Health to NHS Halton and St Helens from 1 June 2011 and, under the current lease terms, the premises must be retained as a health care facility. The asset will be included on the Primary Care Trust's (PCT's) balance sheet at Depreciated Replacement Cost.

The PCT and Runcorn GP Commissioning Consortium identified four broad options for the CMTC as of 1 June 2011:

- A: Do nothing – included only to provide a benchmark for cost comparison purposes.
- B: Divest - sell the building on the open market guided by an assessment by the District Valuer.
- C: Lease - seek through a procurement process an organisation that is willing to take on a lease for the building.
- D: Utilisation - use the asset for local health care provision, if costs including capital charges, depreciation and running costs can be recouped.

1.2 Existing lease

The existing lease between the Department of Health (DH) and WHHFT contains a restrictive covenant which prevents any leasee from sub-letting the land AND buildings thereon at more than the agreed ground rent (which is £50,000 p.a. plus 5 years indexation to be applied at 1 June 2011). This would prevent the PCT from recovering the full costs of capital charges and other buildings related costs that it will incur. This would fetter progress in regard to options B, C and D.

1.3 Option appraisal

The initial option list was expanded with the inclusion of four utilisation options which were identified following discussions with a range of stakeholders, with differing combinations of surgery and/or primary care and community services.

A benefits appraisal was undertaken and, assuming that the covenant does not apply, it was concluded that the greater benefits can be achieved with the utilisation options that have the greatest proportion of primary care, intermediate care and community based services.

It was also considered that the options which resulted in a single organisation taking over the whole facility (options B, C and D1) carried the greatest risks in terms of deliverability.

The affordability implications are as follows:

	Option A £'000	Option B £'000	Option C £'000	Option D1 £'000	Option D2 £'000	Option D3 £'000	Option D4 £'000
With restrictive covenant in force							
2011/12 part year effect							
Net additional costs	873	580	940	940	942	954	955
Projected 3rd party income	-	-	317	317	226	195	114
Potential savings	-	-	-	-	55	96	96
Net cost pressure/(surplus)	**873**	**580**	**623**	**623**	**660**	**663**	**746**
2012/13 full year effect							
Net additional costs	905	-	1,434	1,434	1,442	1,490	1,497
Projected 3rd party income	-	-	419	419	299	258	150
Potential savings	-	-	-	-	219	477	477
Net cost pressure/(surplus)	**905**	**-**	**1,015**	**1,015**	**924**	**755**	**870**
With no restrictive covenant							
2011/12 part year effect							
Net additional costs	873	581	940	940	942	954	955
Projected 3rd party income	-	-	1,542	1,542	1,028	848	385
Potential savings	-	-	-	-	55	96	96
Net cost pressure/(surplus)	**873**	**581**	**(602)**	**(602)**	**(141)**	**10**	**475**
2012/13 full year effect							
Net additional costs	905	-	1,434	1,434	1,442	1,490	1,497
Projected 3rd party income	-	-	1,884	1,884	1,256	1,036	471
Potential savings	-	-	-	-	219	477	477
Net cost pressure/(surplus)	**905**	**-**	**(450)**	**(450)**	**(33)**	**(23)**	**549**

1.4 Conclusions

The key factor in identifying the best way forward is resolution of the restrictive covenant in the existing lease. If that covenant remains and is applied, none of the options represent an affordable solution to the PCT as it will not be possible to recover costs incurred.

If the covenant is removed then a number of options are feasible. Option A "do nothing" identifies a baseline cost of over £0.9m simply to mothball the facility. Option B for the sale of the facility scored badly in the benefits appraisal and carries a risk of impairment if the achieved market value is below the DV valuation. Option C for the lease of the facility scored better in benefits terms as it would retain the facility for healthcare purposes but, along with option D1, carries a higher risk of failing to attract market interest to take on the whole facility. These two options would have the best affordability if a provider can be found.

The options with an element of primary and community services scored highest in benefit terms, are seen to reduce the risk by having a mix of providers and services, and D2 and D3 could be broadly revenue neutral. D4 scored well in benefits terms but makes the most changes to the current building and requires the most capital investment and, subject to a more detailed study of which community based services could be relocated, has an ongoing revenue cost of around £0.6m.

Taking into account the overall mix of benefits, costs and risks and assuming that the covenant does not apply, it is recommended that further work should be undertaken to develop the implementation detail for options D2 and D3 as they will:

- Provide a good balance of urgent care centre, primary care, intermediate care services and surgery, with a "community hospital" feel.
- Reduce the risk of reliance on finding a single provider for the whole facility.
- Subject to a more detailed review of the capital requirements and implementation costs, deliver an affordable long-term solution.

2 Overview

2.1 Purpose

NHS Halton and St Helens, together with Runcorn Shadow GP Commissioning Consortium, has been considering options for the future utilisation of the Cheshire and Merseyside NHS Treatment Centre (CMTC) as a multi-purpose health care resource centre.

This document sets out those options and presents a business case to assist the PCT Board in considering the proposed future use of the facilities to provide local health care.

2.2 Introduction

The CMTC has been operating for five years to provide a range of orthopaedic services from forty-four inpatient beds, twelve day case beds, four theatres, a diagnostics suite and outpatient facilities. It is located on a site adjacent to Halton Hospital in Runcorn - the site is owned by Warrington and Halton Hospital NHS Foundation Trust (WHHFT) and is subject to a lease arrangement with 55 years remaining of the original 60 year lease.

The buildings on the site have been constructed and operated since 2006 by InterHealth Care Services, who have had a Department of Health procured ISTC Wave One contract to provide a range of elective orthopaedic services to patients from a wide area covering Chester, Crewe, Ellesmere Port, Knowsley, Macclesfield, Liverpool, Runcorn, Sefton, Southport, St. Helens, Warrington and Wirral.

The five-year, fixed term contract concludes on 31 May 2011. A final payment of around £33m will be made by the DH (under the legally binding terms of the contract) to recognise the residual value of the building. The leasehold interest in the building and equipment is likely to transfer from the Secretary of State for Health to NHS Halton and St Helens from 1 June 2011 and, under the current lease terms, the premises must be retained as a health care facility. The asset will be included on the PCT's balance sheet at Depreciated Replacement Cost.

NHS Halton and St Helens identified three broad options for the CMTC as of 1 June 2011:

- Divest - sell the building on the open market guided by an assessment by the District Valuer.
- Lease - seek through a procurement process an organisation that is willing to take on a lease for the building.
- Utilisation - use the asset for local health care provision, if costs including capital charges, depreciation and running costs can be recouped.

This business case was commissioned in order to:

- Evaluate the potential mix of service activities to test the viability of initial utilisation proposals.
- Test the financial viability of the service proposals, to determine what mix and level of activity is required to ensure that the costs of operating the facility are recovered.
- Set out the risks and benefits of the utilisation options.
- Compare the utilisation option with the two alternative options.

2.3 Document structure

This document has been prepared using the agreed standards and format for business cases, as set out in the Office of Government Commerce (OGC) Five Case Model and as per the HM Treasury Green Book guidance. The next sections of the document are:

- Section 3 Strategic Case: Provides an overview of the business need for change and its alignment with national and local strategies.
- Section 4 Economic Case: Develops a long list of service scoping options. A set of agreed criteria is used to appraise these options to determine the preferred option.
- Section 5 Commercial Case: Outlines the potential commercial arrangements for the preferred option.
- Section 6 Financial Case: Presents the financial viability and affordability implications for the preferred option.
- Section 7 Management Case: Demonstrates the achievability of the preferred option and the management approach.
- Section 8 Appendices: Supporting documentation.

2.4 Approach

The business case has been built up by:

- Engaging with a wide range of stakeholders during the preparation of this document to understand the key issues and opportunities from a range of perspectives – stakeholder details are included in Appendix 1.
- Applying the outcomes from that engagement to establish a schedule of potential services that could be based in the CMTC in terms of:
  - Current service provision including activity levels, costs, accommodation and funding.

  - Drivers for future provision including demographics, commissioning intentions and priorities, emerging best practice service models and care pathways.
  - Projected activity, costing, accommodation requirements and funding for services that could be located in the CMTC.
  - Accessibility implications.
  - Impact assessment on the wider health care system.
  - Benefits and risks of service provision at the CMTC.
- A high level review - by an architect experienced in healthcare facilities and design - of the suitability of the building for the emerging service options.
- Undertaking an option appraisal process with a group of stakeholders (membership details in Appendix 6).
- Completing a high level financial and commercial appraisal of the various options including a baseline “do nothing” option.

3 Strategic Case

Business cases are typically driven by the need to identify a solution to address specific business and service needs faced by an organisation or health economy. This business case is different: the availability of the CMTC facility, which is still relatively new and has been purpose built for the delivery of health care services, presents an opportunity to explore service options that would optimise use of the CMTC and of other local health accommodation in a way that would not otherwise be possible. Therefore, although the initial review is estates driven, it opens up the potential to reconsider the reconfiguration of local service and facilities in order to improve integration, streamline and redesign care pathways and increase productivity.

PART A: STRATEGIC CONTEXT

3.1 Organisational overview

3.1.1 NHS Halton and St Helens

NHS Halton and St Helens was established as a Primary Care Trust on 1 October 2006, replacing the former Halton PCT and St Helens PCT. The PCT has a total annual budget of £605million. The boundaries match those of Halton Borough Council and St Helens Metropolitan Borough Council, incorporating three main towns (St Helens, Runcorn and Widnes) and a total resident population of around 300,000.

3.1.2 Demographics

The area is significantly challenged in terms of employment opportunities, due to the decline of traditional coal mining and chemical manufacturing industries. Halton and St Helens has a high number of people on state benefits (around 38,000) and over half are on incapacity benefit (around 21,000), largely for preventable or manageable conditions. High unemployment has resulted in the area becoming one of the country's most deprived (worst 10% in the country), and this has a significant impact on the health of local populations.

3.1.3 Health profile

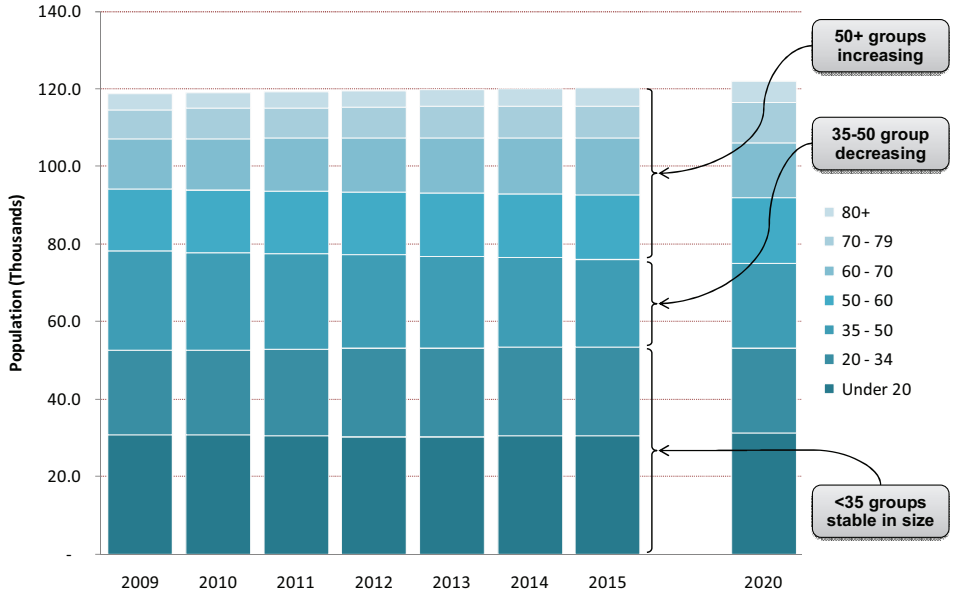
Significant health issues are experienced within the PCT boundary, including high incidences of cancer, heart disease and vascular disease; and high rates of smoking, obesity and alcohol and drug misuse:

- The mortality rate for Halton and St Helens is 19% worse than the national average, equivalent to 560 extra deaths per year. Much of this is lifestyle dependent, arising from heavy drinking, smoking and a poor diet.

- The emergency (non-elective) admission rate is 37% higher than the national average with significant resources focused reactively on treating sickness.
- Smoking prevalence is 12% higher than national average, and mortality rate attributable to smoking is 28% higher, accounting for over 129 deaths per year. There are over 1,176 annual admissions to hospital attributable to smoking, accounting for 8,500 bed days being consumed (equal to 1 full ward a year).
- Alcohol binge drinking is 27% higher than national average, with over 6,000 annual admissions to hospital relating to alcohol, and a 33% higher than national average alcohol-related mortality rate accounting for 42 more deaths per year.
- Obesity amongst adults is 10% higher, and for children is 25% higher than national average.
- There are over 3,400 annual admissions to hospital for cancer, accounting for 18,000 bed days being consumed (equal to 2 full wards a year), and the local mortality rate attributable to cancer is 20% higher than national average.

Life expectancy within Halton and St Helens is around 2 years below the national average, with local populations living in high deprivation wards living up to 6 years less than the national average. Although local life expectancy has been increasing over the last decade, this is at a slower rate than the national average, so the gap in health inequalities in the local areas compared to the national average has widened.

It is predicted that the total population will increase by 1.6% over the next 5 years. However, the 50+ age groups are becoming a larger percentage of the local population, with forecast increases in the over 65s population of 13%. Since the elderly population places the largest demand on health services, this will significantly impact on local service demand. Population forecasts for Halton UA are as follows:



3.1.4 Organisational transformation

By April 2013 all PCTs will be abolished and their commissioning role taken over by the new GP consortia. At present, there are four shadow GP Commissioning Consortia within the Halton and St Helens boundary: United League, Runcorn, STHealth and Widnes. These will form the basis of permanent GP commissioning consortia, with the new PCT Clusters leading the transition process. Details of the clusters in Merseyside and Cheshire have recently been agreed and Halton & St Helens will be part of the Merseyside cluster.

3.1.5 Runcorn Shadow GP Commissioning Consortium

Runcorn Shadow GP Commissioning Consortium consists of seven practices, covering:

- Brookvale Practice
- Weaver Vale Medical Centre
- Castlefields Health Centre
- Grove House Practice
- Heath Road Medical Centre
- Murdishaw Health Centre
- Tower House Practice

In the first three quarters of 2010/11 the Runcorn practices spent £23.4m on hospital activity against a planned budget of £25.9m.

3.1.6 Future Arrangements for Asset Ownership and Management

In light of forthcoming PCT disbandment, processes will need to be in place for acquisition/ disposal of PCT property. David Flory's letter of 16 February 2011, to all SHA and PCT Chief Executives, set clear directions concerning all transactions involving PCT property post 2011. Under this guidance, the PCT requires explicit agreement from the SHA to any property transaction (acquisition or disposal) with a value of up to £35m. For transactions over £35m DH approval is also required.

There is no guidance as yet on the process that would need to be followed for the PCT to dispose of an interest in a PFI (or LIFT) building. Recent guidance has focussed on the transfer of owned or conventionally leased buildings to Aspirant Community Foundation Trusts.

3.2 Business strategies

3.2.1 Overall planning context

The context for this development is contained within the following documents, which provide key policy drivers for determining local commissioning priorities:

- **Equity and Excellence: Liberating the NHS:** relevant policy developments within the July 2010 White Paper include the shift of commissioning from PCTs to GP Consortia; and an emphasis on patient choice of provider.
- **Spending Review 2010:** although 'protected' in the Spending Review, the NHS faces its tightest financial settlement in recent years, meaning that economic constraints will necessarily influence planning and asset management decisions.
- **Quality, Innovation, Productivity and Prevention:** the NHS needs to achieve up to £20 billion of efficiency savings by 2015, via QIPP, reinvesting any savings in patient care.
- **Transforming Community Services:** TCS supports the care closer to home agenda, aiming to improve and diversify community services so that care can be moved out of the acute setting.
- **NHS Operating Framework 2010/11:** in preparing for transition to GP commissioning, key points within the framework include: formation of PCT clusters to manage the transition; alterations in tariff and non-tariff prices for providers; publication of an outcomes framework.
- **Commissioner Investment & Asset Management Strategy (CIAMS):** a structured estate management approach, and rationalisation programme will help NHS organisations to achieve cost efficiencies, generate capital receipts, and maximise income through commercially-minded use of hospital sites.
- **Procurement guide for commissioners of NHS-funded services:** all services will need to be subject to procurement which complies with this guidance and an appropriate contract award made. Dependent on the expected delivery this will be through either an Any Willing (Qualified) Provider accreditation process of a Single tender action process.

3.2.2 Local commissioning context

The primary strategic document setting the context for this work is NHS Halton and St Helens' Commissioning Strategic Plan 2009, which outlines the PCT's strategic approach to improving the health of local populations, through a commitment to:

- Helping people to stay healthy and take greater responsibility for their own health and care.
- Increasing the range and scale of local programmes to detect illness earlier.
- Improving the quality and safety of local health care services.

The CSP has committed the PCT to improve the quality, safety and efficiency of services it commissions. This commitment is being realised through the delivery of the CSP Planned Care Workstream that has the following outcomes:

- Reduction of 10% in overall first outpatient attendances across all specialties.
- Reduction in outpatient follow up appointments (65,000 by 2013).
- Reduced wait time to 12 weeks.

These will be achieved through the following schemes:

- Planned Care Standards.
- Direct access to diagnostics.
- Integrated models of care across all commissioned services.
- Increasing day case surgery rates.
- Reducing length of stay.
- Reducing healthcare-associated infections.

These strategic objectives are supported via the detailed Commissioning Intentions (November 2010), wherein NHS Halton and St Helens and local Practice Based Commissioning Consortia formally set out their commissioning priorities. Initiatives that are relevant to this business case include:

- A shift of a significant proportion of outpatient attendances from secondary care to non-acute (community based) settings. There is also an expectation that this will achieve significant cost reductions with costs at around 70% of tariff.
- In support of this, there is an intention to develop Community Assessment and Treatment Services (CATS) for a range of outpatient specialties.
- For orthopaedics: revised thresholds for hip and knee surgical interventions, and a need to review protocols for joint replacement follow ups and discharge.
- For Urgent Care: provision of an Urgent Care Centre at the Halton Hospital site, plus a Single Point of Access solution for Urgent Care (applying learning from the SPA pilot).
- For Substance Misuse: development of a new, integrated (both alcohol and drugs) substance misuse treatment system in Halton, to commence on 1 September 2011.

3.2.3 Local Provider Landscape

The provider landscape is made up of acute, community, mental health, independent, social care, and primary care providers, offering a range of NHS clinical services to the local population of Halton and St Helens.

Approximately 70% of the PCT's commissioning budget is spent on hospital-based services, whilst the greatest number of contacts by patients with health professionals takes place in primary and community settings (over 80%). The majority of diagnostic tests and most access to urgent care services are currently undertaken in secondary care, although the initiative set out in the CSP, and changes in commissioning practices are expected to lead to a significant shift of services from acute to primary care settings.

As outlined in the 2009 CSP, the provider landscape can be summarised as follows:

- **Primary Care:** 2 walk-in centres (Widnes, St Helens); 1 community hospital (Widnes); 51 GP practices (184 GPs); 43 dentists; 29 opticians; 69 pharmacies.

- **Secondary Care:** 2 main district general hospitals, with A&E (Warrington & Halton Hospitals, and St Helens & Knowsley Hospitals NHS Trust); numerous tertiary providers.
- **Mental Health:** 1 main provider (5 Boroughs Partnership).
- **Child and Family:** wide range of providers – acute, hospitals, community services and voluntary sector.
- **Independent:** Cheshire & Merseyside NHS Treatment Centre located on Halton Hospital Site, Spire Healthcare, Fairfield Independent Hospital.
- **Voluntary Sector:** wide range of provision – adult, children's and accommodation services.
- **Community Health Services:** Halton and St Helens community services will be delivered from 1 April 2011 by a new NHS Trust organisation which will provide services across Halton and St Helens, Warrington, Trafford, Ashton, Leigh and Wigan. Work will progress over the next two years on the development of service specifications that will transform community services.

The PCT's overall commissioning portfolio for 2010/11 is as follows:

Item	Budget £'000
Services commissioned from NHS Bodies	332,115
ISTC	4,106
Services commissioned from non-NHS bodies	49,601
Primary Care Services	138,108
Provider Services	41,248
Corporate & Support Services	28,392
Reserves	8,424
CSP Investment	2,972
PBC	2,684
Unidentified CRES	(2,768)
Total NHS H &StH:	604,882

3.2.4 NHS Halton and St Helens Estates Overview

The NHS Halton and St Helens Estates Strategy 2009-14 shows that the PCT has a freehold or leasehold interest in 45 properties and an additional 50 properties owned by GPs from which it commissions services.

Total areas for PCT properties across Halton and St Helens are as follows:

- 27,154m² freehold and leasehold properties
- 68,751m² GP practices

It is intended that ownership of PCT facilities used for the provision of services will be transferred to the new community services trust.

B: CASE FOR CHANGE

3.3 Investment objectives

The availability of the CMTC building provides an opportunity for the PCT and Runcorn PBC to address commissioning priorities in terms of:

- **Quality:** improving patient care, patient safety, and patient / staff experience, by improving access to primary, community and acute services, and ensuring delivery from fit-for-purpose premises.
- **Productivity:** rationalising use of existing accommodation to improve productivity from available assets.
- **Efficiency:** reviewing clinical fit of services to existing buildings, to remove waste or dissipation of resources from the system and improve efficiency.
- **Deliverability:** achieving an expedient solution to cover ISTC building capital charges and building-related costs, that can be executed quickly, with minimal investment in infrastructure.

3.4 Current arrangements for the CMTC

3.4.1 Facilities

The CMTC building was designed to then Health Building Note (HBN) and Health Technical Memoranda (HTM) standards, and covers an area equating to approximately 5,890m² gross internal area over three main floors plus plant and services on the roof area. It has been operating for five years to provide a range of orthopaedic services from accommodation including:

- 44 inpatient beds (including 4 single rooms of which 2 are isolation rooms) and 12 day case beds.
- 4 theatres (2 ultra-clean).
- 12 outpatient consulting rooms.
- Diagnostics suite with 2 plain film X-ray rooms, 1 CT suite (16 slice), 1 MRI suite (1.0 TESLA), 1 ultrasound room.

The facility has been regarded as performing well, with achievements including the facility being free of MRSA and C Diff. National NHS Patient Experience Survey results indicate that 100% of patients would “recommend the facility to a friend”.

However, there are some reported issues with the existing building:

- The configuration of day case beds within the CMTC means they can only be used for same sex operating lists. This has restricted the flexibility of list scheduling.
- Two of the four theatres are not laminar flow and, depending on the planned future use, could require upgrading.
- Existing sinks and taps do not comply with current regulations and would need replacing if/when alterations are made to the building.
- There is no dedicated anaesthetic preparation area (the current provider's care pathways did not require such an area).

The current provider contracted out the Facilities and support staff to OCS.

3.4.2 Service contract arrangements

The buildings on the site have been constructed and operated since 2006 by InterHealth Care Services, who have had a 5 year, fixed term contract to provide elective orthopaedic services to patients from a wide area covering Chester, Crewe, Ellesmere Port, Knowsley, Macclesfield, Liverpool, Runcorn, Sefton, Southport, St. Helens, Warrington and Wirral.

3.4.3 Lease arrangements

The CMTC is located on a site adjacent to Halton Hospital in Runcorn - the site is owned by Warrington and Halton Hospital NHS Foundation Trust (WHHFT) - and is subject to a 60 year lease arrangement, with 55 years remaining. The ground rent started at £50,000 per annum and is index-linked.

InterHealth's five-year contract ends on 31 May 2011. The GC5W project agreement states that the leasehold interest in the building and equipment will transfer from the Secretary of State for Health to an NHS body – assumed at this stage to be NHS Halton and St Helens - from 1 June 2011 and the premises must be retained as a health care facility.

The existing lease between the DH and WHHFT contains a restrictive covenant which prevents any leasee from sub-letting the land AND buildings thereon at more than the agreed ground rent (which is £50,000 p.a. plus 5 years indexation to be applied at 1 June 2011). This would prevent the PCT from recovering the full costs of capital charges and other buildings related costs that it will incur.

3.5 Arrangements from 1 June 2011

At this stage it is assumed that the leasehold interest in the CMTC asset, valued by the District Valuation Service (DVS) on a Depreciated Replacement Cost (DRC) basis at £18.1m, will transfer to NHS Halton and St Helens with effect from 1 June 2011.

Assuming this transfer proceeds as anticipated, ongoing maintenance costs will be incurred by the PCT immediately from that date. It is anticipated that there will be a gap of several months between the end of service provision and commencement of services under any new arrangements due to the procurement and registration by the Care Quality Commission timetables. This will mean that it is likely that no new services will be provided from the CMTC until autumn 2011 at the earliest.

3.6 Business needs

The business needs that this business case responds to include:

- **Financial:** to cover the ongoing costs of the CMTC that will be incurred by the PCT with effect from 1 June 2011.
- **Care pathways and service redesign:** to assess opportunities to redesign and rationalise care pathways across a range of services.
- **Capacity:** to provide additional capacity within the local healthcare system, particularly for the resident population of Runcorn and immediate surrounding areas.
- **Facilities:** to reduce the overall costs of the estate within the local health and social care economy through shared use of facilities.
- **Service development opportunities:** to consider opportunities for the development of new local services through relocation or expansion to serve the local community.
- **Deliverability:** to identify a solution that can be implemented quickly, and with minimal additional investment in infrastructure.

This rationalisation prospect offers the potential to deliver against key service requirements, including:

- The opportunity to optimise the use of an existing building, and ensure strong fit between services and their accommodation.
- The opportunity to increase capacity within the local health economy, to help manage demand for clinically appropriate interventions.
- The opportunity to reduce transaction costs of care.

3.7 Main benefits criteria

Based on the investment objectives and business needs set out above, the benefits required from the future use of the CMTC have been defined as a set of criteria:

- Optimise the use of existing CMTC facilities.
- Rationalise use of other existing accommodation.
- Provide opportunities for integration of services (primary, community, acute, mental health, social care).
- Improve overall quality of service provision.

- Help to meet demand for clinically appropriate interventions.
- Maintain / improve access to services: primary / community / acute / mental health / social care.
- Maintain / improve productivity of service provision.
- Maintain / improve efficiency of service provision.
- Is deliverable within: an acceptable timescale, competition rules, available procurement routes.

3.8 Main risks

The main risks to this endeavour are outlined as follows:

- **Competition and procurement issues.** Depending on the option, the PCT may enter into either a business transaction or a service procurement. As a business transaction, the PCT could acquire the assets and then sell or lease on the assets to another owner / tenant. If the PCT retains the assets and procures services to be provided through the use of those assets, the PCT will have to comply with UK and EU procurement law and go through market testing.
- **TUPE.** If services are provided from the CMTC within a period of 3 months a new provider would have to take account of any commitments resulting from TUPE regulations.
- **Below tariff payments.** Verification is sought around the assumption that non-hospital outpatients can be charged at a lower cost than in a hospital setting (i.e. below tariff). The 2011/2012 PbR guidance will preclude pricing below tariff unless it can be demonstrated that there is a clear difference in the service specification.
- **Planning approval.** It is understood that the definition under "Permitted Use" within the lease is as a healthcare facility, but the planning approval is for an orthopaedic hospital. Clearly there is a risk that a new planning application will be needed for a change of use, potentially representing an associated delay and additional cost.
- **Lease.** As set out in section 3.4.4 above, legal interpretation of the lease is required, to clarify Schedule 5, clauses 6.2 (a) and 6.3 (c), which state that the tenant (NHS Halton and St Helens) cannot charge any sub-tenants in excess of the lease cost of £50,000 per annum (plus indexation). If these clauses stand, they represent a significant issue for the PCT, as it will not be able to pass on the cost of capital charges and other running costs through sub-lets.
- **PCT Cluster:** it is understood that the CMTC will be covered by the Merseyside PCT Cluster, whose newly appointed Chief Executive is Derek Campbell. If the cluster view is different to NHS Halton St Helen's view regarding use of the CMTC, this could represent a significant barrier to progress.

3.9 Constraints / dependencies

This asset transfer takes place within a context of constraints, including:

- **Time:** there is a need to cover costs quickly, meaning that 'do nothing' becomes a costly and impracticable option.
- **Political expediency:** given current pressures on the NHS to rationalise estates, 'mothballing' the CMTC building is not a politically acceptable solution.
- **Lease:** as above, the lease contains a restrictive covenant for the PCT, regarding charges to sub-tenants. This requires resolution through discussions between the DH, SHA and the landlord (WHHFT).
- **Transfer:** the building must be handed over to the NHS on 1st June 2011 as a fully working hospital, not as a decommissioned facility.

4 Economic Case

This section of the business case considers a range of options that have been developed in response to the project objectives and service scope identified in the strategic case.

4.1 Critical success factors

The following critical success factors have been identified:

- The preferred solution must cover the additional capital charges and other building related costs associated with the CMTC that would otherwise represent an increase in PCT expenditure.
- The preferred solution must be deliverable within an acceptable timeframe.
- The preferred solution must be compliant with the appropriate rules and guidance on procurement and competition.

4.2 Key assumptions

The appraisal process, identification of options and scoring has been undertaken on the basis of a number of key assumptions:

- That the leasehold interest in the CMTC is transferred by the Secretary of State to the PCT on 1st June 2011 and will be on the PCT's books with effect from that date.
- That the restrictive covenant in the existing lease with WHHFT is negotiated out (by DH and SHA). If this covenant remains then none of the options considered constitute value for money for the PCT and would create an unacceptably high recurrent cost pressure.
- That there is sufficient space in option D3 for the whole of the existing services based at Hallwood Health Centre (including primary care, community services and pharmacy) to relocate to the CMTC.
- That the CMTC could be available for non-health care use under option B (divest) but not under option C (lease) as the PCT would only sub-lease for health care provision.
- Service provision does not commence until at least autumn 2011, due to the requirement to undertake a formal procurement process for the services to be delivered within the CMTC.

The first two issues underpin the process – it is important to stress that if either assumption proves to be invalid, this business case is also invalid.

4.3 Service options long list

As outlined in section 2.2, NHS Halton and St Helens initially identified three broad option categories for the CMTC as of 1 June 2011:

- Divest: sell the building on the open market guided by an assessment by the District Valuer.
- Lease: seek through a procurement process an organisation that is willing to take on a lease for the building.
- Utilisation: use the asset for local health care provision, if costs including capital charges, depreciation and running costs can be recouped.

In addition, there is the need to consider a 'Do Nothing' option, to provide a baseline for development opportunities. Following further consideration the utilisation option has been developed into four service configurations giving a long list of options as follows:

- **Option A:** Do nothing.
- **Option B:** Divest.
- **Option C:** Lease.
- **Option D:** Utilisation.
  - Option D1: Orthopaedic centre.
  - Option D2: Surgical centre.
  - Option D3: Dedicated day surgery centre, plus Health Care Resource Centre (primary care / community services).
  - Option D4: Health Care Resource Centre only (primary care / community services) with no / very little surgery.

The options are described in detail in the next sections.

4.4 Option A: Do Nothing

This option is not considered to be a practical way forward – it is included only to provide a baseline.

Key features

- No services provided from CMTC – the building would be mothballed.
- The PCT would continue to pay ground rent to WHHFT, plus capital charges and relevant maintenance costs. There would be non recurrent costs to decommission equipment; there could be a capital receipt for MRI, CT and other equipment.

4.5 Option B: Divest

The leasehold interest would be sold on the open market.

Key features

- Services would be as delivered by the chosen provider.
- PCT would sell the lease via market testing and appropriate open procurement.
- PCT picks up ground rent, capital charges and relevant maintenance costs in short term until sale is completed. No ongoing costs to the PCT (if covenant does not apply).

4.6 Option C: Lease

The lease would be transferred to another organisation following market testing and open procurement.

Key features

- No service contract would be attached to the lease.
- Services would be as delivered by the chosen provider.
- The PCT would assign the lease to the chosen organisation for the remaining period (60 years).
- PCT picks up ground rent, capital charges and relevant maintenance costs in short term until sub-lease is completed. Assume that the ongoing costs should be covered by the income received through the sub-lease i.e. no net cost to the PCT (if covenant does not apply).

4.7 Option D: Utilisation options

4.7.1 Option D1: Orthopaedic Centre

Potential floor layouts are illustrated in Appendix 2. The exact layout would be as required / defined by the user – the illustrated floor layouts show that the number of single rooms could be increased but would reduce the overall bed capacity.

This option would provide:

Services

- Elective orthopaedic services: inpatient (i/p), day case (d/c), outpatient (o/p), physiotherapy, possibly Musculoskeletal (MSK).

Layout

- Ground floor - Imaging, outpatients, physiotherapy.
- First floor - 40 inpatient beds.
- Second floor - 12 day beds, 4 theatres.

This option would retain the current use of most of the building with some minor modifications.

Table 1 : Option D1 services

Floor	Services
Ground	Imaging department, outpatients, physiotherapy area, potential MSK area. Options to add an extension at the back of the building adjacent to current physiotherapy gym but this is not essential.
First	Ward area plus admin/office and support areas. Two existing 4-bed rooms could be converted in single rooms with ensuite giving a total of 40 beds (8 x 4-bed rooms, 8 single rooms). The single rooms (existing and proposed) exceed current HBN standard but the current 4-bed rooms (56m² and 60m²) are below the current standard of 72.5m².
Second	Four theatres and day surgery suite (12 beds) as current. The only modification proposed is the conversion into an anaesthetics preparation room. Two of the theatres may need to be converted to laminar flow in order to maximise orthopaedic throughput.

The market share of the range of elective orthopaedic activity provided from the CMTC in 2009/10 for the area covered by NHS Halton and St Helens and the neighbouring PCTs for Warrington, Western Cheshire and Central & Eastern Cheshire was:

- Warrington & Halton Hospitals 17.6%
- CMTC 16.2%
- Mid Cheshire Hospitals 14.3%
- St Helens and Knowsley 9.0%
- Countess of Chester 9%
- Spire Cheshire 5%

The indicative activity "gap" for NHS Halton & St Helens for activity that has been undertaken at the CMTC is:

CMTC provider	Indicative activity	Indicative value (£m)
Inpatients	251	1.168
Day Cases	653	1.078
First & Follow Ups	1,369 and 2,315	0.395
Total:	**4,588**	**2.641**

The PCT has agreed indicative contracts with a number of providers to cover this capacity gap through awards of standard acute contracts to accredited "Any Willing Providers". Patient choice of secondary care provider will demonstrate the revised provider landscape.

Clearly this is only a small proportion of the current CMTC activity provided through the GC5W Project Agreement and other commissioners are making their own arrangements. For this option to be financially viable to a provider, it is likely that the provider would need to relocate existing activity and services from another site into the CMTC in order to optimise use of the facilities and to cover the buildings-associated costs that it would be charged by the PCT.

The benefits to a provider could be all or some of:

- Reducing the current costs of service provision elsewhere by transferring elective orthopaedics to the CMTC facility.
- Adding overall orthopaedic capacity to increase market share and income, and therefore improve overall contribution.
- Freeing up space / accommodation elsewhere to facilitate other service developments or to rationalise estate.

The financial implications to the PCT are that the buildings-associated costs would be charged to the provider who would recover those costs through normal tariff charging.

4.7.2 Option D2: Surgery centre plus Health Care Resource Centre on ground floor

Potential floor layouts are illustrated in Appendix 3. As for D1, the exact layout would be as required / defined by the user – the illustrated floor layouts show that the number of single rooms could be increased but would reduce the overall bed capacity.

This option would provide:

Services

- Elective surgery services (i/p, d/c, o/p, physiotherapy); Urgent Care Centre (UCC) / diagnostic treatment centre.

Layout

- Ground floor - Imaging, UCC / diagnostic treatment centre.
- First floor - 40 inpatient beds, outpatients.
- Second floor - 12 day beds, 4 theatres.

Table 2 : Option D2 services

Floor	Services
Ground	Imaging department, UCC / diagnostic treatment centre. Options to add an extension (glass conservatory style) into the courtyard to add waiting space; also at the back of the building adjacent to current physiotherapy gym.
First	As Option D1. Ward area plus admin/office and support areas. Two existing 4-bed rooms converted in single rooms with ensuite giving a total of 40 beds (8 x 4-bed rooms, 8 single rooms). The single rooms (existing and proposed) exceed current HBN standard but the current 4-bed rooms (56m² and 60m²) are below the current standard of 72.5m². Could provide outpatient rooms in the existing admin area.
Second	As Option D1. Four theatres and day surgery suite (12 beds) as current. The only modification proposed is the conversion of clean utility into an anaesthetics preparation room.

This option is similar to option 1 in that the first and second floor would be used to provide a range of surgical inpatient, day case and outpatient services, with access to the imaging department on the ground floor.

The ground floor, however, would be used as a “Health Care Resource Centre”. Two service opportunities were considered initially: providing either primary care or urgent care services.

Primary care

Hallwood Health Centre is a GP owned facility housing two GP practices located adjacent to the Halton Hospital site. The PCT currently lease part of the building on a peppercorn rent until 2021 for a range of community services (including dentistry, SALT, a base for midwives). The site has benefited from some refurbishment works however the overall condition of accommodation at the site is ‘C’. Utilisation of clinical space is substantial at 53% although there is capacity for additional clinics if required.

No other practices in the locality have indicated an interest in relocating to the CMTC at this stage, mainly because it would mean moving further away from geographical area they serve.

On consideration of the currently available space and range of services provided at Hallwood Health Centre, it is clear that the space available on the ground floor would be insufficient even with the extension options. This option, therefore, would have the Urgent Care Centre plus outpatient facilities on the ground floor, not GPs.

Urgent Care Centre

Emergency admissions have continued to increase across Halton and St Helens PCT, with 1,471 Non Elective Emergency Admissions for Runcorn Shadow GPCC during 2009/10 (April/December). This affects the Acute Trust's ability to meet four-hour wait targets within local A&E departments and, on occasion, the percentage of cancelled elective admissions and ambulance response times.

Bed occupancy at both local acute trusts is over the nationally recommended level of 85%, with levels of 86% at St Helens and Knowsley Teaching Hospitals NHS Trust (StH&K) and over 90% at WHHFT. These high occupancy levels have an adverse effect on acute trusts being able to respond flexibly and responsively to peaks in unplanned care activity, and can potentially impact on elective admissions.

If the status quo is allowed to continue the residents of Halton will continue to access A&E in Warrington for the diagnosis and treatment of minor illness/minor injuries.

In response, there is a proposal to develop a new Urgent Care Centre on the Halton Hospital site, which is supported by the Runcorn Shadow GPCC. This new UCC would be a development of the current service delivered from the site's nurse-led Minor Injuries Unit, and would provide a jointly-led medical and nursing service, from 07:00 to 22:00, seven days a week. The service would be supported by diagnostic provision and access to pharmaceutical services. A business case and outline workforce plan have been developed, although further work is required to identify specific costs and ensure appropriate resource allocation. The CMTC building offers an alternative building to locate the UCC.

The Single Point of Access (SPA) pilot for Urgent Care will cease of 31 March 2011, but it is a PCT commissioning intention to build learning into a permanent SPA solution for UC. This would provide a 15 hour a day, 7 day a week service for professionals to ensure the quick and smooth referral of patients to the most appropriate service.

4.7.3 Option D3: Dedicated Day Surgery Centre plus Health Care Resource Centre

Potential floor layouts are illustrated in Appendix 4. The exact layout for the first floor ward would need further development, but at this stage a 28-bed wards has been modelled. Similarly, the second floor has been modelled to increase the potential number of day case beds to 22 in order to accommodate both male and female patients on the same day.

This option would provide:

Services

- Elective day surgery services; two GP practices; UCC; intermediate care ward; outpatients.

Layout

- Ground floor - Imaging, Urgent Care Centre, 1 GP practice.
- First floor - 28 inpatient intermediate care beds, 2nd GP practice, outpatients.
- Second floor - 22 day beds (2 wards), 4 theatres, outpatients.

Table 3 : Option D3 services

Floor	Services
Ground	Imaging department, Urgent Care Centre, 1 GP practice (6 GPs). Options to add an extension (glass conservatory style) into the courtyard to add waiting space; also at the back of the building adjacent to current physiotherapy gym.
First	Ward area with two existing 4-bed rooms converted in single rooms with ensuite and three existing 4-bed rooms converted into GP rooms giving a total of 28 beds (5 x 4-bed rooms, 8 single rooms). The single rooms (existing and proposed) exceed current HBN standard but the current 4-bed rooms (56m² and 60m²) are below the current standard of 72.5m². Admin area converted into GP / outpatient rooms.
Second	Current four theatres and day surgery suite (12 beds) plus second day surgery suite (10 beds) to provide separate male and female wards. Conversion of two areas into anaesthetics preparation rooms. Convert admin to outpatient rooms.

Day surgery

This option would provide a dedicated day surgery unit on the top floor with four theatres and the potential to have two ward areas (male and female) with around 22 beds. It could also be possible to include an endoscopy facility either by converting two theatres or through the conversion of other rooms on the top floor. The facility could also be used to provide dermatology procedures. Rooms currently used for administrative and office space could be easily converted into outpatient consulting rooms.

The ground and first floor would provide a range of primary care and community facilities including community hospital inpatient provision.

Intermediate Care

The PCT commissioned a review of intermediate care capacity planning and pathway which was completed at the end of 2010. The definition of intermediate care applied is as set out in the DH publication “Halfway Home” (2009): “a range of integrated services to promote recovery from illness, prevent unnecessary hospital admission and premature admission to long term residential care, support timely discharge from hospital and maximise independent living”.

Halton currently operates a pooled budget arrangement under a S75 partnership agreement between NHS Halton & St Helens and Halton Borough Council (BC), covering the period 2009 to 2012. Under this agreement, Halton BC is the host partner and manages the intermediate care budget (£4.716m for 2010/11). The PCT and Borough Council contribute funding to the Pooled Fund in proportions set out in a schedule to the partnership agreement, the proportions varying between services. Providers then invoice the Pooled Fund.

Access to all Intermediate Care service in Halton (bed and community) is via the Halton Intermediate Care Assessment Team (HICAT) which is operationally part of Halton Borough's Reablement & Rapid Response Service (RARS) service. This referral route is used by staff at WHH, GPs and community services and is open to self referral via an Intermediate Care Single Point of Access phone line.

Bed based provision for Halton service users requiring IC is provided at two sites:

- **Halton Intermediate Care Unit (HICU):** a jointly-commissioned sub-acute, 22 bedded facility located within a dedicated unit at Halton General Hospital. Pathways for admission to HICU include rehabilitative care post acute hospital admission; management of sub-acute exacerbation of chronic conditions from the community; diagnostics, treatment and sub-acute care from the community; treatment and care for single diagnosis conditions requiring higher level sub-acute management. Medical cover is provided under contract by GPs (Halton Health) supported by access to and planned input from consultant medical cover (one session per week provided by WHHFT).
- **Oakmeadows Residential Home:** 13 IC beds, with 5 additional beds block purchased during 2009/10 for additional capacity. RARS provides therapy and nursing support to Oakmeadows patients, with 24/7 medical cover from Appleton General Practice.

In addition, due to capacity issues and mainly in reaction to winter pressures, a number of beds are 'spot-purchased' (9 for 2009/10).

Halton provides a Homecare Reablement service, offering a 6-8 week home reablement programme, provided by a multi-disciplinary team which includes nurses, occupational therapists, physiotherapist, community psychiatric nurse, technical instructors, social workers, a pharmacist and support workers.

The Department of Health's guidance on Intermediate Care (2001 and 2009) has led to significant improvements in IC provision across Halton. All services work towards the locally agreed Gold Standard Framework for Intermediate Care Services, which operates within a specific QIPP framework.

Analysis of Halton Intermediate Care activity data for 2009/10 shows:

- 62% of referrals are from the acute sector and 38% from the community.
- 87% of referrals to RARs are appropriate.
- 86% conversion rate from assessment to commence IC services.

- Split between community service and bed provision is 73% community and 27% beds (however, if Halton's homecare Reablement service is excluded, the split is 41% beds and 59% community).
- 1,659 total assessments undertaken for 2009/10.

Analysis of Halton IC capacity and unit costs data for 2009/10 shows:

Table 4 : Intermediate care 2009/10

Bed capacity	HICU	Oakmeadow	Halton Total
2009/10 activity			
Number of beds	22	18	40
Number of admissions	208	178	386
Admissions/ bed	9.5	9.9	9.7
Average length of stay (days)	32*	39	
Average occupancy	83%	92%	
Total cost of unit (£)	£1,631,626	£666,497	
Cost per bed (£)	£74,165	£37,028	
Cost per bed per week (£)	£1,426	£712	

* The figure for HICU includes one service user whose length of stay was 235 days. This was a special case which was specifically approved by the Halton ECB. Excluding this case, the length of stay would have been 31 days.

The average length of stay for the NHS Benchmarking Network survey respondents was 27, with Halton reporting above this with average length of stay at 35 days. This has a significant impact on available capacity and unit costs.

Occupancy is already high at both Halton units, and there are waits for bed based provision resulting in the continued use of B3 at Halton Hospital for patients waiting for HICU. In addition, both Whiston and Warrington Hospitals are unable to consistently provide proactive coverage of A&E and other front end departments, suggesting unmet demand for local intermediate care services.

Potential demand for intermediate care services in Halton was modelled in the 2010 review, taking into account the increasingly elderly population profile (60+ age band increasing by 61% by 2031, a high proportion of long-term limiting illnesses (25% of Halton population compared with 19% nationally, and a high incidence of long term conditions.

Possible scenarios for developing capacity to meet demand were developed, starting with an assumption that 20% of hospital admissions of over 65s could be suitable for intermediate care. The impact of three different assumptions on the split of activity between bed and community provision has been modelled: 30%/70%; 35%/65%; and 40%/60%.

For Halton, results show that in all scenarios more beds are required to meet potential 2010/11 demand, and further capacity would be required within community services in all scenarios. Even with 30% productivity gain the 30%/70% split identifies a need for 11 additional beds.

Under this option, the beds currently in Halton Hospital would be relocated into the CMTC building, to improve the standard of accommodation and to provide additional capacity and to be co-located with an Urgent Care Centre and GP practices.

Urgent Care Centre

As for option D2 above.

Primary care

As for option D2 above except that accommodation would be split over the ground and first floors, with dedicated areas for each practice as well as shared space. A further detailed study would be needed to ensure that all facilities from Hallwood Health Centre could be accommodated but the initial assessment suggests that it should be possible over the two floors.

4.7.4 Option D4: Health Care Resource Centre only (no surgery)

Potential floor layouts are illustrated in Appendix 5. The ground and first floors are as for option D3 but here the top floor would have theatres removed and would be converted to provide a range of community based services.

This option would provide:

Services

Two GP practices; UCC; intermediate care ward; outpatients, base for range of community services.

Layout

- Ground floor - Imaging, Urgent Care Centre, 1 GP practice.
- First floor - 28 inpatient intermediate care beds, 2nd GP practice, outpatients.
- Second floor - Community services centre.

Table 5 : Option D4 services

Floor	Services
Ground	As Option D3. Imaging department, Urgent Care Centre, 1 GP practice (6 GPs). Options to add an extension (glass conservatory style) into the courtyard to add waiting space; also at the back of the building adjacent to current physiotherapy gym.
First	As Option D3. Ward area with two existing 4-bed rooms converted in single rooms with ensuite and three existing 4-bed rooms converted into GP rooms giving a total of 28 beds (5 x 4-bed rooms, 8 single rooms). The single rooms (existing and proposed) exceed current HBN standard but the current 4-bed rooms (56m² and 60m²) are below the current standard of 72.5m². Admin area converted into GP / outpatient rooms.
Second	Remove theatres and convert into community service facilities eg therapy centre, podiatry, phlebotomy etc.

Intermediate care, primary care, urgent care centre

As for option 3.

Other community services

This option provides the opportunity to relocate / develop a range of community based services on the second floor. The following section summarises some of those opportunities identified at this stage.

Community based outpatient clinics across a range of specialties

The PCT has committed to improving quality and efficiency of commissioned services, through delivery of the CSP Planned Care Workstream. This outlines two relevant objectives:

- 10% reduction in overall first outpatient attendances across all specialties.
- Reduction in outpatient follow up appointments (65,000 by 2013).

It is proposed that this will be supported via Planned Care Standards, direct access to diagnostics, and integrated models of care across all commissioned services.

The opportunity to provide outpatient services from the CMTC site provides a pertinent development option which aligns well with strategic direction. Specific outpatient service lines have been reviewed, and are outlined in more detail below.

ENT:

For 2009/10 total activity for NHS Halton & St Helens was 23,834 appointments, at a total cost of £5.461m.

The PCT has identified a potential to divert at least 70% of ENT diagnostics and treatment away from secondary care clinics to community settings at no more than 70% of current tariffs. There is a commissioning intention to develop Community Assessment and Treatment Services (CATS) in ENT.

Gastroenterology:

2009/2010 total activity for gastroenterology was 16,201 appointments at a total cost of £4.784m.

There is a commissioning intention to develop a CATS for gastroenterology, and it is anticipated that a minimum of 20% of gastroenterology referrals for assessment could be seen within this primary care service (diverted from secondary care).

Gynaecology

2009/2010) total activity for gynaecology was 29,977 appointments at a total cost of £8.501m.

Gynaecology complaints and symptoms represent a large proportion of GP consultations, and there is currently no formal community provision in place to support the delivery of standard or enhanced gynaecology services for Halton and St Helens. The PCT commission a consultant-led, community based level 2 sexual health service (CASH) which includes the provider arm and Brook. The PCT has also commissioned a locally enhanced service (LES) from GP's in relation to the delivery of enhanced Sexual Health services, although uptake has been low.

SUS data highlights a year-on-year increase in the numbers of gynaecological referrals to secondary care. There has also been a significant increase in the number of outpatient procedures undertaken within the time period. Opportunity locator suggests that approximately 2,900 first OP appointments per annum for gynaecology could be shifted to the community if the PCT were performing at the 25th percentile, and approx 3,900 first OP appointments could be shifted compared to the 10th percentile. This equates to a financial value of care that can be shifted of £420k at the 25th percentile, and £563k at the 10th percentile.

For follow up appointments, opportunity locator suggests that at the 25th percentile 7,730 could be moved to the community each year, releasing £770k. At the 10th percentile 9,340 follow up appointments could be moved to the community, releasing £930k. Therefore, if the PCT progressed plans to significantly shift secondary activity into the community and perform at the 25th percentile, it would collectively shift 10,630 appointments per annum which in turn would release £1.190m.

There is a commissioning intention to develop CATS for gynaecology via a range of potential service options: GP-led Community Gynaecology Clinics; Consultant-led Community Gynaecology Clinics, including diagnostic/ therapeutic interventions; Locally Enhanced Scheme/ AWP for GP's.

Dermatology

2009/2010) total activity for dermatology was 21,775 appointments at a cost of £2.914m.

There is a need to develop primary care capability to enable the implementation of shared care arrangements in dermatology, particularly where the presenting conditions require frequent attendance in secondary care clinics and/ or long term management and monitoring.

There is the opportunity for a shift of approximately 60% of current activity from secondary care clinics to community based provision at no more than 80% of current tariffs. A specification for community based provision was incorporated into the St Helens and Knowsley Teaching Hospitals NHS Trust in the 2010/11 contract. Progress to the achievement of this specification and the development of an integrated service needs to be reviewed and options to secure this offering agreed.

Musculoskeletal (MSK)

National trends and local demographic factors point to continued rising demand for MSK services, and latest estimates suggest that 30% of GP consultations are for MSK conditions.

In response to increases in PCT spend and secondary care activity across trauma and orthopaedics and rheumatology, NHS Halton and St Helens and the Practice Based Commissioning Consortia have undertaken a procurement process to provide an interface Clinical Assessment and Treatment Service, Direct Access Physiotherapy, and a Chronic Pain service.

The new service will enhance the management of patients within primary care, providing an alternative to hospital based treatment for the majority of patients being referred by General Practitioners for physiotherapy and MSK assessments and for the management of chronic pain. Patients would be referred to hospital only when there is a need for hospital based specialist services. The consortium provider is currently looking for a base for the new service.

Community midwifery

NHS Halton and St Helen's is the only PCT-run midwifery service in the North West (most midwifery services are run by the acute sector). The service looks after approximately 1,800 women, with around 1,600 births a year, divided 50:50 between Widnes and Runcorn. Births take place at WHH, Whiston, Chester, and Liverpool Women's.

At present, there is no permanent administrative base for Runcorn's community midwifery team. Instead, the team is required to work out of GP premises on an ad hoc basis, and out of cars. This impacts on efficiency and safety of working practices, and is not equitable with the Widnes team, which has access to permanent facilities and IT at their headquarters building.

There is an opportunity to develop a permanent Runcorn base for 16 midwives and 2 support workers (working out of 2 clinic rooms plus waiting and reception space). Parenting classes could also be provided from the site during evenings and Saturdays. This would align with the PCT's commissioning intentions to increase availability of community based antenatal and postnatal care in areas with poor access rates, and to increase the availability of midwifery led care.

4.8 Shortlisted options

It was agreed that all the options in the long list should be appraised.

4.9 Evaluation of shortlisted options – benefits appraisal

The benefits criteria set out in section 3.7 were given a weighting out of 100 by a project group of representatives from the PCT, the GP consortium, the current CMTC NHS contract manager and the Halton Local Involvement Network (LINk) lead officer (a list is included in Appendix 6), initially on an individual basis by participants then confirmed following discussion at the March appraisal meeting. The weightings used were as follows:

Table 6 : Benefits criteria weightings

Criteria		Ranking	Weighting
1	Optimises use of existing CMTC facilities	**1**	**15.8**
2	Rationalises use of other existing accommodation	**9**	**6.5**
3	Provides opportunities for integration of services: primary/community/acute/mh/social care	**3**	**13.4**
4	Improve overall quality of available services	**2**	**14.2**
5	Helps to meet demand for clinically appropriate interventions	**5**	**11.1**
6	Maintain/improve access to services: primary/community/acute/mh/social care	**4**	**12.4**
7	Maintain/improve productivity of existing services	**8**	**7.5**
8	Maintain/improve efficiency of service provision	**7**	**8.3**
9	Option is deliverable within: an acceptable timescale, competition rules, available procurement routes	**6**	**10.8**
		Total	**100**

Each option was then scored in turn out of 10 against each of the benefits criteria, using the following guide:

0 Does not meet criterion at all.

1 - 2 Barely meets criterion.

3 - 4 Meets criterion but not adequately.

5 - 6 Meets criterion quite well.

7 - 8 Meets criterion very well.

9 - 10 Meets criterion perfectly.

Finally, scores were multiplied by the weightings to generate a weighted score.

The results of the appraisal are:

Table 7 : Raw and weighted scores

Raw scores

		A Do nothing	B Divest Sell to another org	C Lease Assign lease to another org	D1 Utilise Ortho-paedic centre	D2 Utilise Surgical centre PLUS	D3 Utilise Day surg + Health Care Resource Centre	D4 Utilise Health Care Resource Centre
1	Optimises use of existing CMTC facilities	0	4	6	6	7	4	3
2	Rationalises use of other existing accommodation	0	0	0	0	2	2	4
3	Provides opportunities for integration of services	0	0	1	3	3	7	8
4	Improve overall quality of available services	0	0	1	4	7	7	6
5	Helps to meet demand for clinically appropriate interventions	0	0	1	4	7	7	6.5
6	Maintain/improve access to services	0	0	6	6	7	8	8
7	Maintain/improve productivity of existing services	0	0	0	3	5	5	5
8	Maintain/improve efficiency of service provision	0	0	0	3	5	5	6
9	Option is deliverable within: an acceptable timescale, competition rules, available procurement routes	10	7	2	4	4	4	4
Total		**10**	**11**	**17**	**33**	**47**	**49**	**50.5**
Rank		**7**	**6**	**5**	**4**	**3**	**2**	**1**
% of highest score		**19.8%**	**21.8%**	**33.7%**	**65.3%**	**93.1%**	**97.0%**	**100.0%**

Weighted scores

									Weight
1	Optimises use of existing CMTC facilities	0.0	63.1	94.7	94.7	110.5	63.1	47.4	15.8
2	Rationalises use of other existing accommodation	0.0	0.0	0.0	0.0	13.1	13.1	26.2	6.5
3	Provides opportunities for integration of services	0.0	0.0	13.4	40.1	40.1	93.5	106.9	13.4
4	Improve overall quality of available services	0.0	0.0	14.2	56.9	99.5	99.5	85.3	14.2
5	Helps to meet demand for clinically appropriate interventions	0.0	0.0	11.1	44.3	77.5	77.5	72.0	11.1
6	Maintain/improve access to services	0.0	0.0	74.1	74.1	86.5	98.9	98.9	12.4
7	Maintain/improve productivity of existing services	0.0	0.0	0.0	22.5	37.4	37.4	37.4	7.5
8	Maintain/improve efficiency of service provision	0.0	0.0	0.0	25.0	41.7	41.7	50.1	8.3
9	Option is deliverable within: an acceptable timescale, competition rules, available procurement routes	108.4	75.9	21.7	43.4	43.4	43.4	43.4	10.8
Total		**108.4**	**139.0**	**229.2**	**400.9**	**549.7**	**568.1**	**567.4**	100.0
Rank		**7**	**6**	**5**	**4**	**3**	**1**	**2**	
% of highest score		**19.1%**	**24.5%**	**40.3%**	**70.6%**	**96.8%**	**100.0%**	**99.9%**	

The two highest ranked options were D3 (day surgery plus HCRC on 2 floors) and D4 (HRHC on 3 floors) with scores so close together that is would not be appropriate to differentiate between them, followed closely by D2 (surgical centre plus HRHC on 1 floor).

Option D1 (orthopaedic centre) was scored significantly lower than those three options but well ahead of options A, B and C.

The scoring rationale was:

Optimise CMTC facility. The do nothing option does not use the facilities at all. Other options make varying use, with the options that focussed mainly on surgery scoring highest. As the proportion of "HCRC" increased and "surgery" decreased, the more work would have to be done to the existing facility to accommodate different services. The day surgery option was also marked down because of the risk that there would not be sufficient activity to attract full use of the facility.

Rationalise other accommodation. Options A, B, C and D1 would have no impact on PCT / primary care accommodation (although there could be benefit to the wider health economy, depending on how the CMTC was used). The other options would facilitate some relocation of services to free up existing accommodation, but not to a significant level.

Opportunities for integration. Options A and B would not provide such opportunities, with option C only marginally better. The surgical options D1 and D2 should provide some degree of integration (dependent on the service provider – there has been little integration to date). The HCRC options would provide much more significant integration opportunities across primary, community and acute services and between ambulatory and non-acute inpatient services.

Improving quality. For options A, B and C the same logic applied as for integration therefore they were scored very low. For D1 the current service offers good quality therefore the improvement would be limited. For D2 and D3 there would be opportunities to improve quality through integration and redesign of care pathways. Option D4 was scored slightly lower as surgery is not included.

Meeting demand. This was scored the same as above for quality except that D4 was scored marginally higher as this option increases capacity for a wide range of community services.

Maintain/improve access. All the options which provide health care were given a score of 6 or more, with the increasing HRHC element giving a slight increase to D3 and D4.

Maintain/improve productivity. Options A, B and C would have no impact on productivity. The main benefits of improved productivity in D1 would be with the provider, but the commissioners would benefit more as more elements of the HRHC are introduced.

Maintain/improve efficiency. Scored as for productivity except that D4 was given one additional point for the benefits in running a full "community hospital" configuration.

Deliverability. Option A was given the maximum score as, by definition, it is entirely deliverable. Option B was also scored highly as it could be delivered in a relatively short timescale. The other options all require market testing, selection of one or more provider organisations, CQC accreditation etc and would therefore take longer. Option C was scored lowest as it was considered to be the most difficult to deliver in a short timescale.

Conclusion

The conclusion of the benefits appraisal was that options D2, D3 and D4 were joint preferred options as the difference in weighted scores was not significant.

4.10 Economic appraisal

An economic appraisal has been undertaken for all of the shortlisted options against both of the potential scenarios for the covenant that restricts the rent that the PCT can charge another user for the building i.e. firstly with the restrictive covenant still in force, secondly with no restriction on sub-leasing.

4.10.1 Financial assumptions

The economic (and affordability) appraisal has been made with the following approach and assumptions:

- Two variants of the appraisal have been completed. One considers the effect of the restrictive covenant in the lease for the land being retained, preventing the PCT from charging more than the ground rent for any user of the building. The other assumes that a solution is found that enables the PCT to charge the full market rent.
- The Open Market Value (OMV) for the building - defined as "the estimated amount for which a property should exchange between a willing buyer and a willing seller in an arms-length transaction after proper marketing wherein the parties had each acted knowledgably, prudently and without compulsion - has been estimated by the District Valuer at £22.5m. This valuation does not reflect the impact of the restrictive covenant which, if still in force, could significantly reduce the actual value received by the PCT. In that circumstance, the PCT could be faced with a significant impairment charge to Income & Expenditure Account (I&E) in the year of sale. This appraisal has **not** attempted to quantify the value of any impairment but it is an important additional factor to be aware of.
- Capital investment costs have been estimated - at a ***very high level*** without the benefit of a full survey – using a benchmark cost per m² for the conversion of accommodation, uplifted to reflect fees (16%), equipment (15%) and VAT (20%). Only capital costs that would be incurred by the PCT have been included in the analysis – those that would be made by a third party provider are outside the scope of this work (although these may affect the negotiated rent payable or the value of any subsequent service contract).
- The PCT capital costs associated with each option are summarised in the table below.

Table 8 : High level capital costs to be met by the PCT

Estimated capital costs includng fees, equipment and VAT	Option A £'000	Option B £'000	Option C £'000	Option D1 £'000	Option D2 £'000	Option D3 £'000	Option D4 £'000
Urgent care centre and outpatients					100		
Convert theatre space for community services							500
Convert ground floor - Imaging, UCC, GP practice						600	200
Second GP practice						150	150
Total	**-**	**-**	**-**	**-**	**100**	**750**	**850**

- Capital charges (including depreciation) on the existing building have been derived from the DV's Depreciated Replacement Cost valuation of the asset at £18.1million and its estimated useful life. During periods when the building is not in use it is treated as an asset under construction, which is not depreciated but upon which the capital absorption duty is payable.
- Ground rent payable to WHH as landlord is included at the level to which it is predicted to rise in 2011/12. Although it is possible that the freehold may be transferred to the DH before 1st June 2011, this remains uncertain and therefore, at this stage, the ground rent is still included in the appraisal. If this transfer were to take place it would have an impact on the overall valuation of the land and building, which is not yet known. A key assumption is that the PCT would not incur the capital costs of acquiring freehold as these would be borne by the Secretary of State and therefore no additional acquisition costs are included. This requires formal confirmation.
- Capital charges on any refurbishment or adaptation work have been assessed on an assumption of a 25 year useful economic life for these works.
- The latest estimates for cleaning, hard facilities management (FM) and security costs have been obtained from OCS. It has been assumed that:
  - Cleaning costs will not be incurred while capital work is in progress or if the building is not in active use.
  - Hard FM costs will be incurred for all options for which the site is retained, but at a lower level when the site is mothballed.
  - Security costs will be incurred at their stated level for all options.
- For the variant where it is assumed that the covenant does not apply, the value of rent recoverable for the building has been based on the DV's assessment of the market rent. Where only part of the building is to be let the rental income receivable has been scaled back accordingly.
- Decommissioning costs have been assumed for Option A, but will not be incurred for any of the other options.
- In all options a delay is anticipated between acquisition of the asset and its bringing back into operation. This is a reflection of the requirement for a procurement process – whether for an operator of clinical services or a construction supply chain. In each case this pushes the date that the option will be operational to 1 January 2012.

- An estimate of lifecycle costs has been included for options where the building is retained.
- Where current PCT commitments to premises costs are known (e.g. Hallwood Health Centre) any savings have been offset against the revenue costs for the option.
- For the Urgent Care Centre, net savings are assumed at 20% of the value of current activity diverted from A&E, based on work on that project completed earlier in the year. (No savings from the current MIU premises costs have been included.)
- For the intermediate care service, the net saving from diverting acute admissions has been offset against the costs of provision.
- For the variant with the covenant still applying it has assumed that FM costs could be recovered from providers - this would be subject to legal confirmation.

4.10.2 Net present costs

The net present costs of the options have been calculated using discounted cash flows over a 55 year period with a 3.5% discount rate. The results of the two appraisals are show in the tables below.

Table 9 : Economic appraisal

Discounted cash flow Summary - with covenant	Option A £'000	Option B £'000	Option C £'000	Option D1 £'000	Option D2 £'000	Option D3 £'000	Option D4 £'000
Net present cost							
- Capital / lifecycle costs	21,882	761	38,716	38,716	38,800	39,326	39,425
- Revenue costs	6,811	31	10,395	10,395	10,395	10,395	10,395
- Income /savings	0	0	-10,395	-10,395	-12,738	-17,955	-15,283
- Total	28,693	792	38,716	38,716	36,457	31,767	34,537
Appraisal period (years)	55	2	55	55	55	55	55
Equivalent annual cost	4,886	1,170	6,593	6,593	6,209	5,410	5,882
Note:							
Benefits appraisal scores	*108.4*	*139.0*	*229.2*	*400.9*	*549.7*	*568.1*	*567.4*
Benefits per £m EAC	*22.2*	*118.8*	*34.8*	*60.8*	*88.5*	*105.0*	*96.5*
Rank	*7*	*1*	*6*	*5*	*4*	*2*	*3*

Discounted cash flow Summary - no covenant	Option A £'000	Option B £'000	Option C £'000	Option D1 £'000	Option D2 £'000	Option D3 £'000	Option D4 £'000
Net present cost							
- Capital / lifecycle costs	21,882	761	38,716	38,716	38,800	39,326	39,425
- Revenue costs	6,811	0	10,395	10,395	10,395	10,395	10,395
- Income /savings	0	0	-46,851	-46,851	-36,546	-37,336	-23,280
- Total	28,693	761	2,261	2,261	12,649	12,386	26,540
Appraisal period (years)	55	2	55	55	55	55	55
Equivalent annual cost	4,886	1,124	385	385	2,154	2,109	4,520
Note:							
Benefits appraisal scores	*108.4*	*139.0*	*229.2*	*400.9*	*549.7*	*568.1*	*567.4*
Benefits per £m EAC	*22.2*	*123.6*	*595.3*	*1,041.3*	*255.2*	*269.3*	*125.5*
Rank	*7*	*6*	*2*	*1*	*4*	*3*	*5*

Given the broad assumptions behind these figures they should only be considered as indicative, at this stage. In particular, they are based on the assumption that:

- Full market rental is achieved as follows: in options C and D1 for 100% of available space, in D2 for 67% of available space, in option D3 for 55% of available space and in D4 for 25% of available space. Thus options D1 and D2 carry the greatest risk of not achieving the assumed income streams.

The results for the two variants clearly demonstrate the impact of the covenant issue on the overall financial position. If the covenant remains, the best value for money is delivered by Option D3, with D4 close behind. If the restriction described in the covenant can be removed, Options C and D1 are economically the best options, although with the greatest risk.

The affordability implication for each option under the two variants – which is the key test for the PCT in determining the right course of action - is set out in section 6.

4.11 Risks

The most significant risk to the project is associated with the resolution of the covenant issue described in the lease of land. This single issue has a huge impact on the potential income for the PCT – restricting the annual rent from a market rent of £1.5 million to c. £60,000.

The service planning associated with some of the clinical activities that may move into the facility is still at a relatively high level, and the interrelationships between these and other community and acute services within the health and social care community need to be examined in greater detail to establish with certainty the net effect on the commissioner.

There is also the scope for the capital costs of any adaptation work to be different from the estimates reflected in this report. The current costs have been derived at a very high level, without the benefit of a full survey, and further financial implications could be identified when this work is undertaken with greater accurately.

5 Commercial Case

This section of the business case outlines the NHS Halton and St Helens commercial and procurement strategy for the Cheshire and Merseyside Treatment Centre building it is due to acquire on 1 June 2011. The areas covered include:

- Competition and procurement
- TUPE
- Planning approval
- Underlying lease
- Capital funding
- PCT cluster

5.1 Competition and procurement

Depending on the preferred option, the PCT may enter into either a business transaction or as a service procurement. As a business transaction, the PCT could acquire the assets and then sell or lease on the assets to another owner / tenant. If the PCT retains the assets and procures services to be provided through the use of those assets, the PCT will have to comply with United Kingdom (UK) and European Union (EU) procurement law and go through market testing. Under the latter scenario, the procurement route would need to be a full market test, depending on the nature of the services to be included.

Under either eventuality, the PCT will have sufficient time - for the reasons stated in section 5.2 below - to prepare a robust set of service specification documents and to alert the market to maximise the number of potential bidders.

5.2 TUPE

If services are provided from the CMTC within a period estimated to be three months from the end date of the InterHealth contract, a new provider would have to take account of any commitments resulting from TUPE regulations.

Whilst the PCT will take on the obligations of the CMTC asset with effect from 1 June 2011, together with the associated financial commitments, it is highly unlikely it will be able to procure services within three months. There is a programme of works which will need to be undertaken to ensure the building is compliant with current building regulations before it can be let to potential tenants. Any potential tenant would also have to comply with current registration requirements from the Care Quality Commission. This means that the risk of TUPE requirements applying is minimal.

5.3 Planning approval

The definition under "Permitted Use" within the lease (and the land use permission) is as a healthcare facility, but it is understood that the original planning approval for the building referred specifically to an “orthopaedic hospital”. Clearly there is a risk that a new planning application could be needed for a change of use, representing an associated delay and additional cost. This risk potentially would only affect the PCT under Option D. It is unlikely to apply to Option D1 but may arise under all other Option D variants. The PCT is engaging with the planning authorities on a regular basis and does not anticipate this becoming a material issue.

5.4 Underlying lease

There is a significant issue contained within the drafting of the lease in favour of the landlord, Warrington and Halton Hospitals NHS Foundation Trust. Schedule 5, clauses 6.2 (a) and 6.3 (c) state that the tenant (which, in this case, would be the PCT) cannot charge any sub-tenants in excess of the ground rent of £50k per annum (plus indexation). Any potential bidder’s due diligence would reveal these clauses. This creates a significant impediment to the PCT mitigating its financial risks in accepting ownership of the asset. The consequence of this clause means that the PCT would be unable to recover the capital charges or any other costs associated with running the CMTC building.

This issue can only be resolved by the DH, SHA and WHHFT. Pending any further progress, it is recommended that PCT takes separate legal advice in respect of this point. It is assumed that any remedial costs would be borne by the Secretary of State.

5.5 Capital costs and funding

Table 8 in section 4.10 shows the capital investment requirements for each of the shortlisted options, with indicative capital costs to be funded by the PCT of up to £850k. This level of funding requirement may warrant exploring the options for accessing funding.

The PCT’s assumption is that the initial investment requirement would be funded by the SHA, with the PCT bearing the ongoing capital charge liability. Should this not prove to be the case the PCT could consider, in addition to use of its own Capital Resource Limit (CRL) / External Financing Limit (EFL):

- Establishing a property joint venture, such as a Local Asset Backed Vehicle (LABV), which could also embrace other projects. The benefit of this approach would be to provide access to third party finance whereby investors would match the value of the asset put in by the PCT through a cash injection. Investors would be attracted by the security of a fully indexed revenue stream which is government backed. The LABV would also be sufficiently flexible to operate beyond April 2013 by enabling participation by other public sector bodies. Potentially, this could also be structured to be “off balance sheet”, thus minimising the capital charge liability.

- Alternatively, the PCT could explore options for putting the CMTC into the local NHS LIFT. However, there is considerable uncertainty about the future of NHS LIFT projects, given the impending abolition of PCTs.

5.6 PCT Cluster

It is understood that the CMTC will be covered by the Merseyside PCT Cluster. Derek Campbell has recently been appointed as Chief Executive of the Merseyside Cluster. If the cluster view is materially different to that of NHS Halton and St Helens regarding use of the CMTC, this could represent a significant barrier to progress, complicating both logistics and the strategy going forward. This risk will be mitigated by NHS Halton and St Helen's engaging with the cluster at the earliest opportunity to maximise the likelihood of a strong alignment of objectives.

6 Financial Case

The affordability consequences to the PCT of each of the shortlisted options have been appraised. This comprised consideration of the elements of income and expenditure (as set out in section in 4.10 above) that will apply in 2011/12 (part year effect) and 2012/13 (which is essentially full year i.e. steady state).

The analysis has focussed on the premises elements of cost, since these allow the greatest comparability between options. The total financial flows for the PCT will also reflect the other direct and indirect costs of the services provided.

The results of this analysis are summarised in the table below.

Table 10 : Affordability Summary

	Option A £'000	Option B £'000	Option C £'000	Option D1 £'000	Option D2 £'000	Option D3 £'000	Option D4 £'000
With restrictive covenant in force							
2011/12 part year effect							
Net additional costs	873	580	940	940	942	954	955
Projected 3rd party income	-	-	317	317	226	195	114
Potential savings	-	-	-	-	55	96	96
Net cost pressure/(surplus)	**873**	**580**	**623**	**623**	**660**	**663**	**746**
2012/13 full year effect							
Net additional costs	905	-	1,434	1,434	1,442	1,490	1,497
Projected 3rd party income	-	-	419	419	299	258	150
Potential savings	-	-	-	-	219	477	477
Net cost pressure/(surplus)	**905**	**-**	**1,015**	**1,015**	**924**	**755**	**870**
With no restrictive covenant							
2011/12 part year effect							
Net additional costs	873	581	940	940	942	954	955
Projected 3rd party income	-	-	1,542	1,542	1,028	848	385
Potential savings	-	-	-	-	55	96	96
Net cost pressure/(surplus)	**873**	**581**	**(602)**	**(602)**	**(141)**	**10**	**475**
2012/13 full year effect							
Net additional costs	905	-	1,434	1,434	1,442	1,490	1,497
Projected 3rd party income	-	-	1,884	1,884	1,256	1,036	471
Potential savings	-	-	-	-	219	477	477
Net cost pressure/(surplus)	**905**	**-**	**(450)**	**(450)**	**(33)**	**(23)**	**549**

Note: These figures EXCLUDE any impairment cost in option B if there is a loss on sale. They also exclude any impairment that may result from a revised valuation as a result of change of use of the building.

As this table demonstrates, options C and D1 appear to present the PCT with the most affordable solution if the covenant is removed. If this is not the case, all of the options except B carry a significant recurrent unrecoverable cost, and B may carry a significant one-off impairment cost.

Without this restriction, the rent recoverable for the CMTC (at DV valuation) exceeds the costs incurred in retaining it. However, these options are also the ones that carry the greatest risk in terms of the ability of the PCT to find a partner that is willing to match the DV's assessment of the market rent for the whole building.

This risk diminishes gradually with each variant of Option D, and is lowest in Option D4. The affordability for options D2 and D3 show potentially a broadly break even position. Further work would need to done on the D2, D3 and D4 options to carry out a more detailed assessment of service relocation opportunities.

Option D4 has a net cost of around £550k. However, this is in part because the option envisages the accommodation on site of a series of services that have not yet developed sufficiently for the costs to have been identified or where a net investment is required to remedy a current service deficiency (e.g. the absence of a Runcorn base for midwives).

Least affordable is Option A, which has only been retained as a comparator. The costs of retaining the building, even when kept as low as is feasible, are significant and bring with them no corresponding benefit.

7 Management Case

Assuming that the leasehold interest in the CMTC is transferred to the PCT and that the restrictive covenant is removed, the PCT will need to identify a resource to manage a number of workstreams:

- The ongoing maintenance of the building and equipment. For all options there will be an ongoing maintenance requirement for several months in 2011/12, either in readiness for sale or lease or during the period of procuring future service providers. The PCT will need to secure the services of an FM provider at least to cover the short term requirement.
- Procurement of a third party to take over the building or of one or more organisation to secure service provision from the CMTC.
- Depending on the preferred option, estates advice may be required to undertake a more detailed study of the building alterations required.

It is recommended that a Project Team is established to oversee the next steps, with representation from Commissioning, IM&T, Procurement, Communications, Estates, Facilities Management and external advisors (for example architects) and user groups.

The scheme should be established as a PRINCE2 project with clear governance and reporting arrangements including both the PCT and the GP Commissioning Consortium.

8 Conclusions

This business case has evaluated the benefits, risks and costs of a number of options for the future use of the CMTC facility.

The key factor in identifying the best way forward is resolution of the restrictive covenant in the existing lease. If that covenant remains and is applied, none of the options represent an affordable solution to the PCT as it will not be possible to recover costs incurred.

If the covenant is removed then a number of options are feasible. Option A "do nothing" identifies a baseline cost of over £0.9m simply to mothball the facility. Option B for the sale of the facility scored badly in the benefits appraisal and carries a risk of impairment if the achieved market value is below the DV valuation. Option C for the lease of the facility scored better in benefits terms as it would retain the facility for healthcare purposes but, along with option D1, carries a higher risk of failing to attract market interest to take on the whole facility. These two options would have the best affordability if a provider can be found.

The options with an element of primary and community services scored highest in benefit terms, are seen to reduce the risk by having a mix of providers and services, and D2 and D3 could be broadly revenue neutral. D4 scored well in benefits terms but makes the most changes to the current building and requires the most capital investment and, subject to a more detailed study of which community based services could be relocated, has an ongoing revenue cost of around £0.6m.

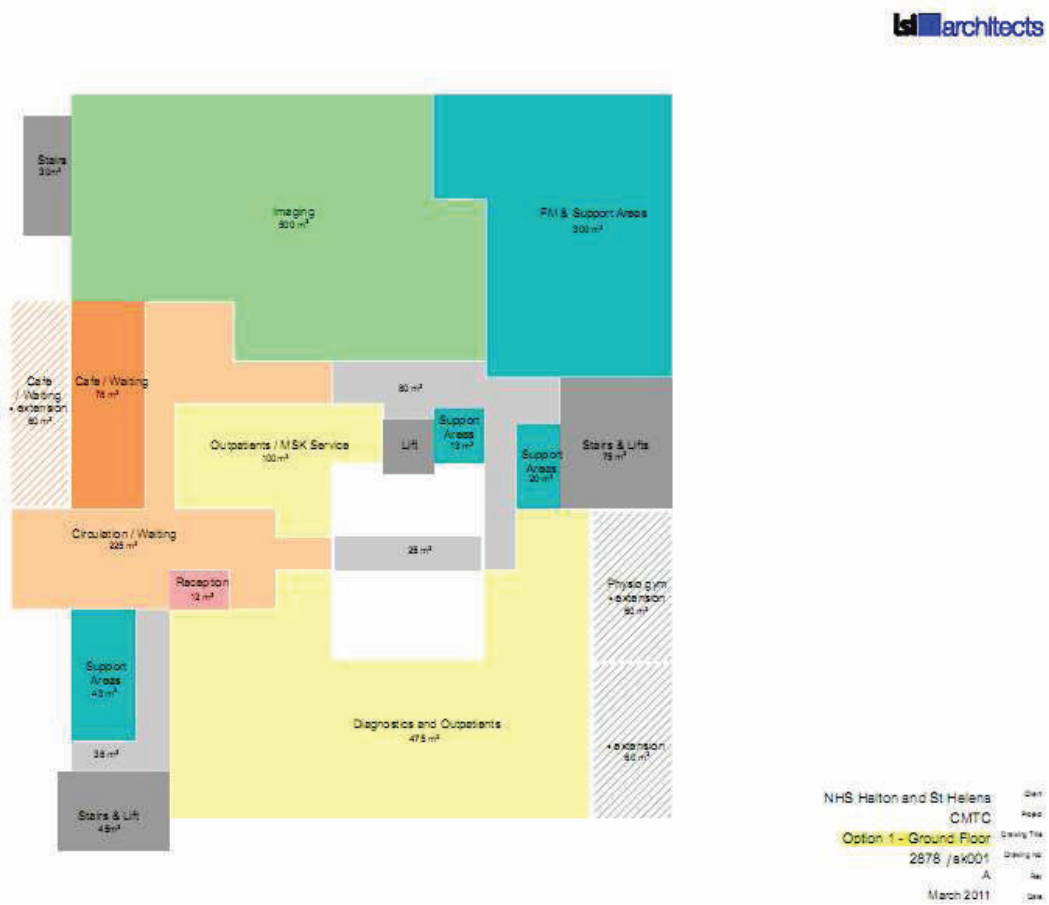
Taking into account the overall mix of benefits, costs and risks and assuming that the covenant does not apply, it is recommended that further work should be undertaken to develop the implementation detail for options D2 and D3 as they will:

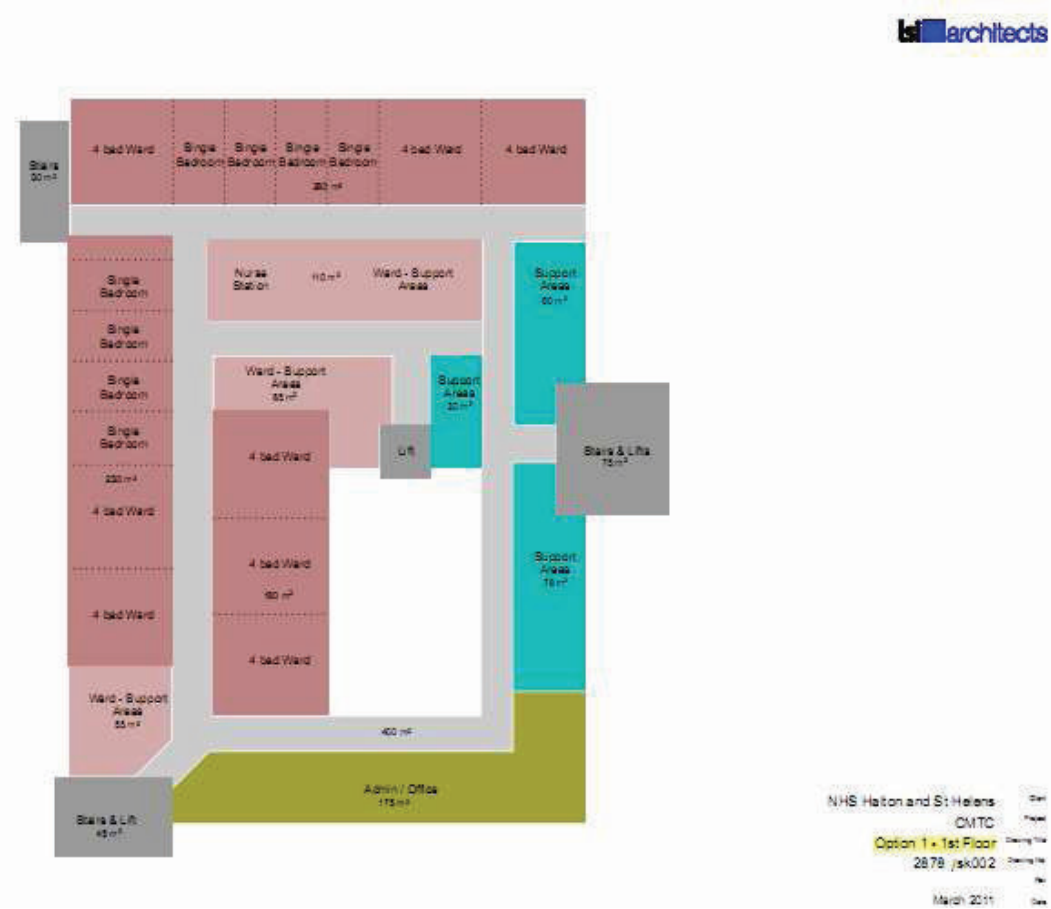
- Provide a good balance of urgent care centre, primary care, intermediate care services and surgery, with a "community hospital" feel.
- Reduce the risk of reliance on finding a single provider for the whole facility.
- Subject to a more detailed review of the capital requirements and implementation costs, deliver an affordable long-term solution.

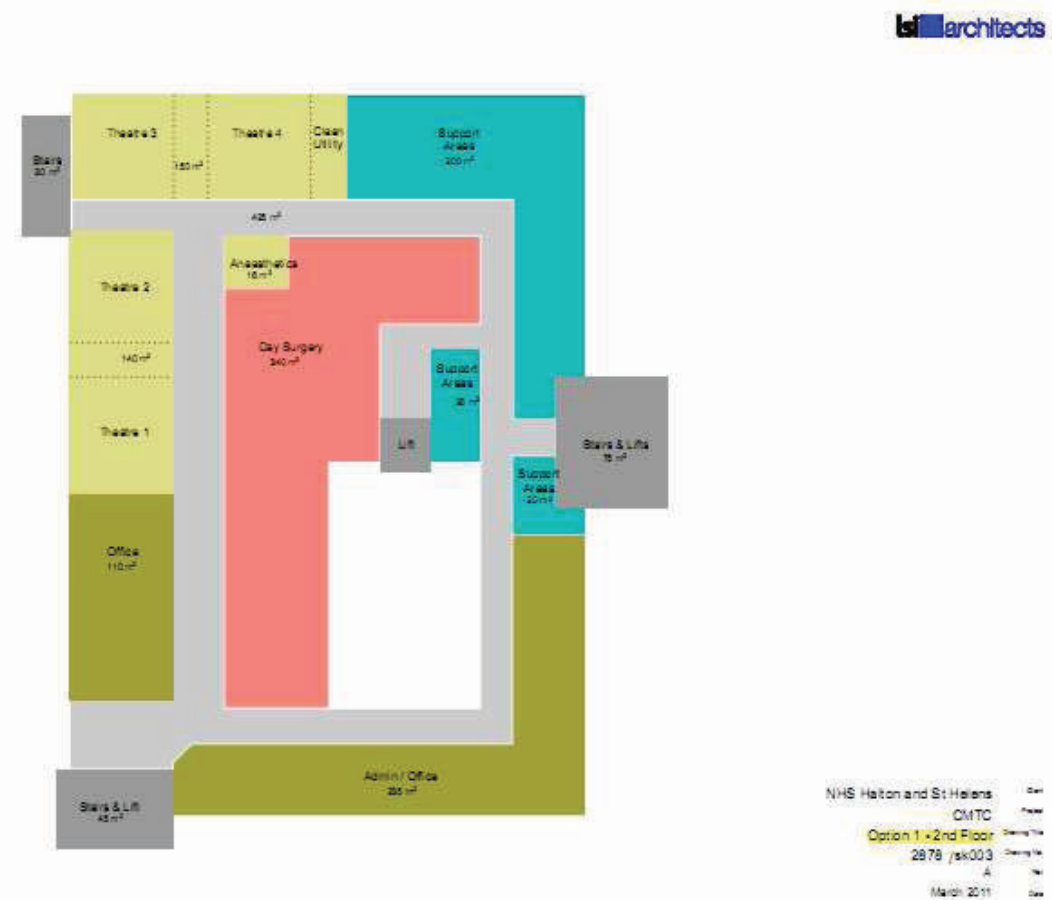
Appendix 1 Stakeholders

Name	Title and organisation
Simon Banks	Operational Director of Planned Care and Market Development, NHS Halton & St Helens
Dr Cliff Richards	Chair, Runcorn Shadow GP Commissioning Consortium
Dr Claire Forde	Vice Chair, Runcorn Shadow GP Commissioning Consortium
Chris Webb	Business Manager, Runcorn Shadow GP Commissioning Consortium
Lyn Williams	LINk Lead Officer
Pam Broadhead	Head of Independent Sector Contracts, NHS Western Cheshire
Sue Wallace-Bonner	Operational Director, Adults & Community, Halton Borough Council
Mark Holt	Halton & St Helens Community Services
Ian Ball	Assistant Director of Estates & Facilities, NHS Halton & St Helens
Ken Jones	Senior Financial Accountant, NHS Halton & St Helens
Simon Griffiths	Head of Primary Care, NHS Halton & St Helens
Mervyn Kennedy	Head of Practice Based Commissioning, NHS Halton & St Helens
Rob Foster	Director of Performance, NHS Halton & St Helens
Dave Tanner	Head of Community Commissioning, NHS Halton & St Helens
Dwayne Johnson	Head of Adults & Community, Halton Borough Council
Anne Garrett	Councillor, Halton Borough Council
Chris Turner	Urgent Care, NHS Halton & St Helens
Carina Casey-Hardman	Head of Midwifery, NHS Halton & St Helens
Jane Lunt	Operational Director, Child & Family Health, NHS Halton & St Helens
Dave Sweeney	Operational Director of Partnerships, NHS Halton & St Helens
Martin McDowell	Deputy Director of Finance, NHS Halton & St Helens
Paul Butler	Operational Director Funded Care, NHS Halton & St Helens
Barry Fereday	Head of Contracting, NHS Halton & St Helens
Jonathan Stephens	Director of Finance, Warrington & Halton Hospitals
Simon Wright	Chief Operating Officer, Warrington & Halton Hospitals
Janet Dunn	Intermediate Care, NHS Halton & St Helens
Graham Rose	Head of Commercial and Contracts, NHS North West

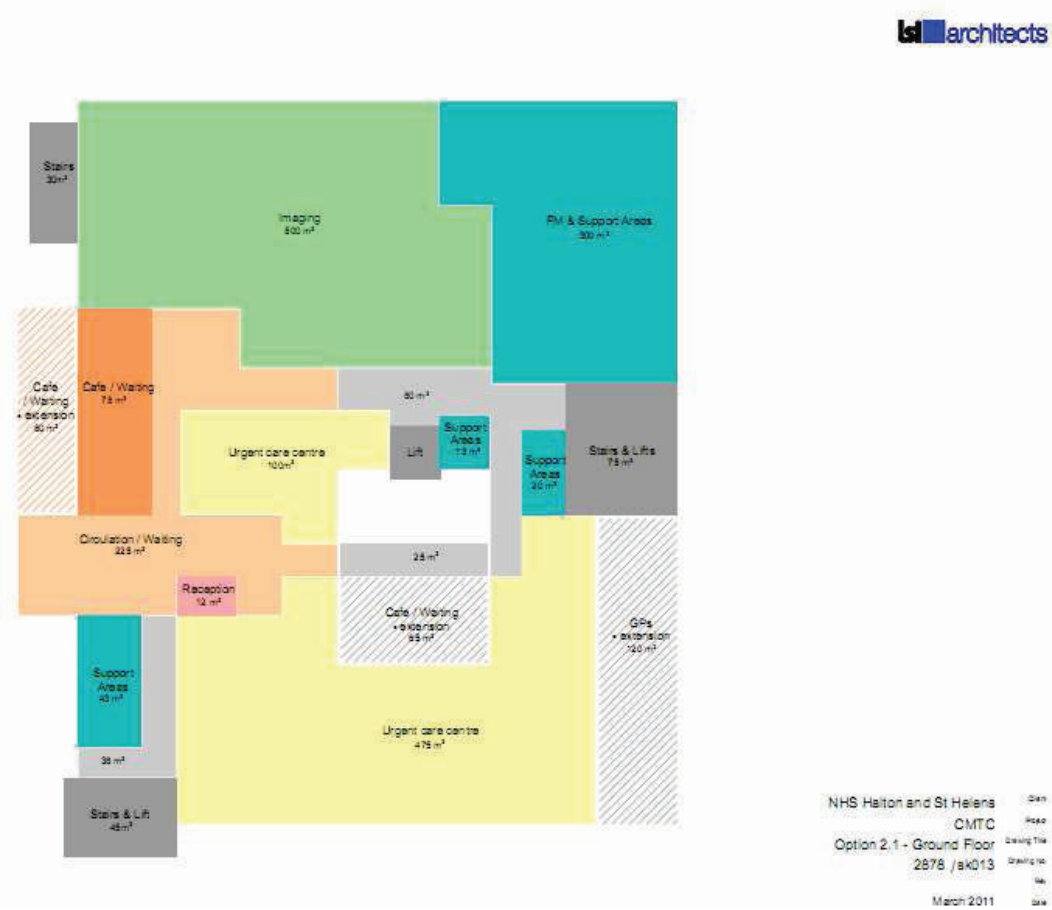
Appendix 2 Potential floor layouts – Option D1 Orthopaedic Centre

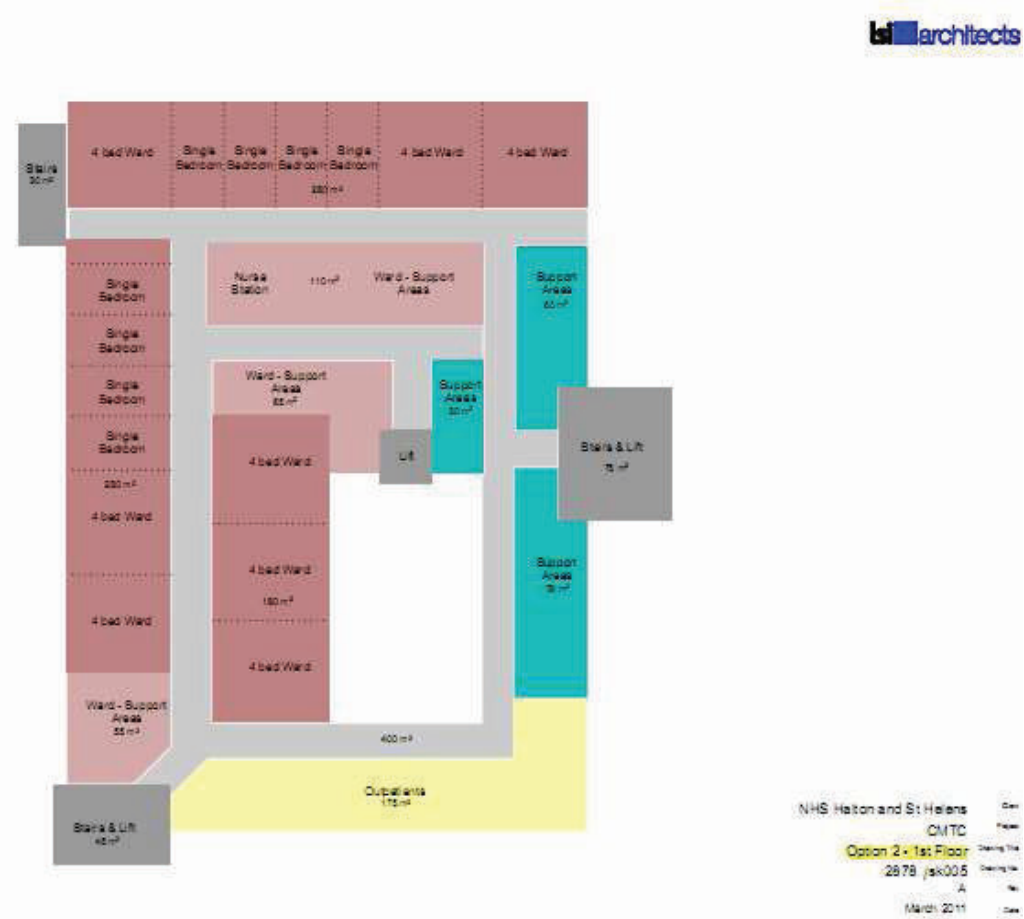



architects
4 bed Ward
Single Bedroom
Nurse Station
Ward - Support Areas
Support Areas
Lift
Stairs & Lifts
Admin / Office
NHS Halton and St Helens
OMTC
Option 1 - 1st Floor
2878 /sk002
March 2011


architects
Theatre 3
Theatre 4
Clean Utility
Support Areas
Stairs
Anaesthetics
Theatre 2
Day Surgery
Support Areas
Lift
Stairs & Lifts
Theatre 1
Support Areas
Office
Admin / Office
Stairs & Lift
NHS Halton and St Helens
CMTC
Option 1 - 2nd Floor
2878 /sk003
A
March 2011

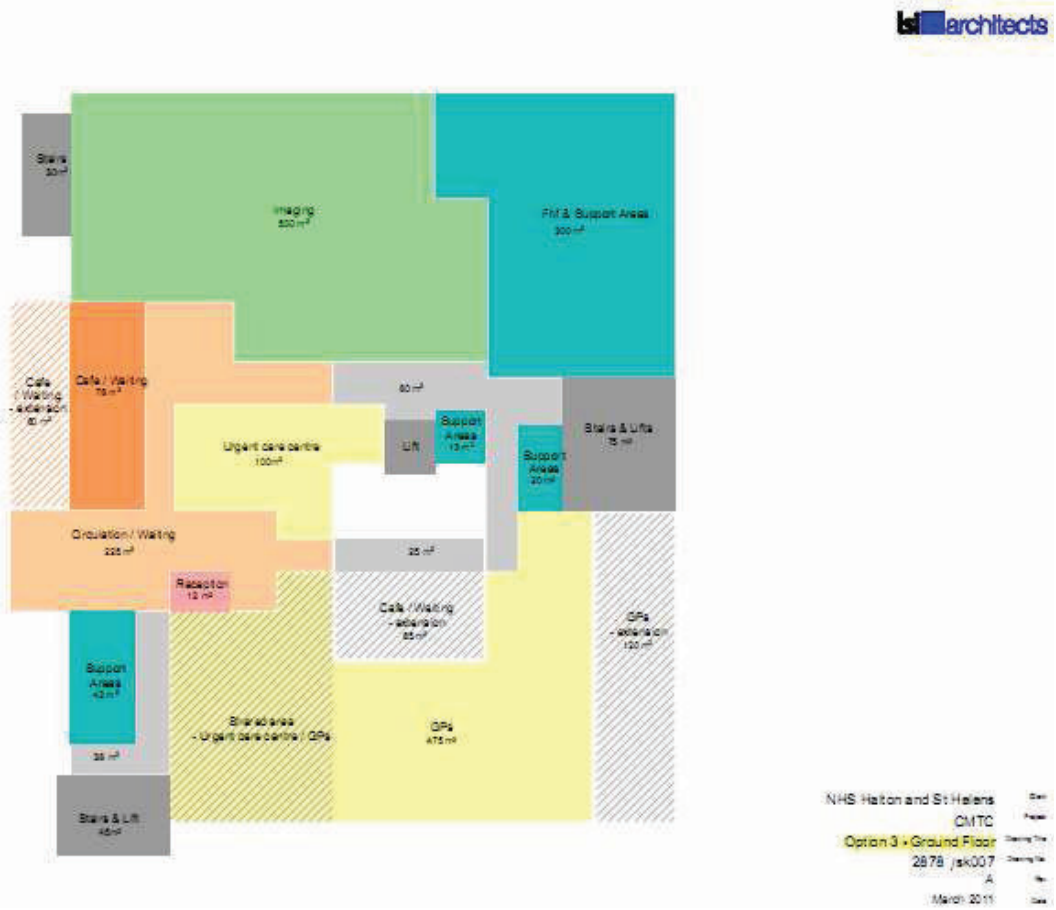
Appendix 3 Potential floor layouts – Option D2 Surgery Centre plus HCRC on one floor

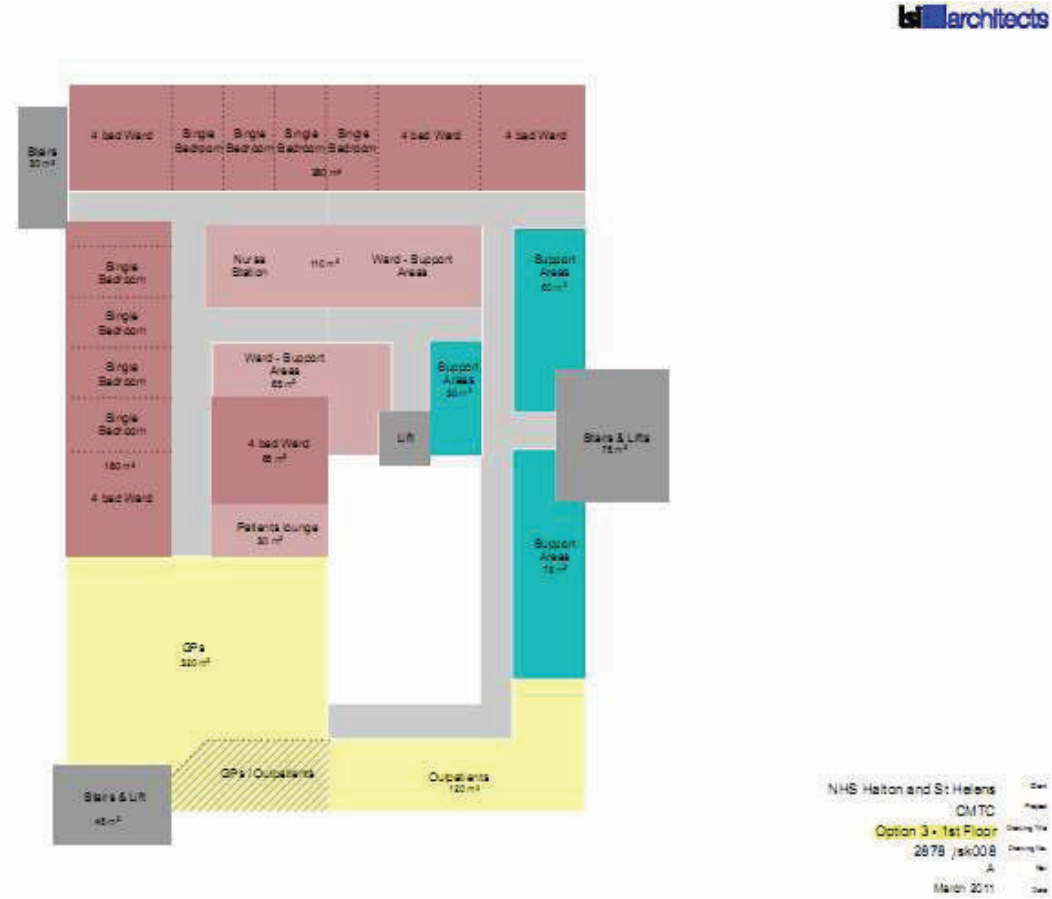


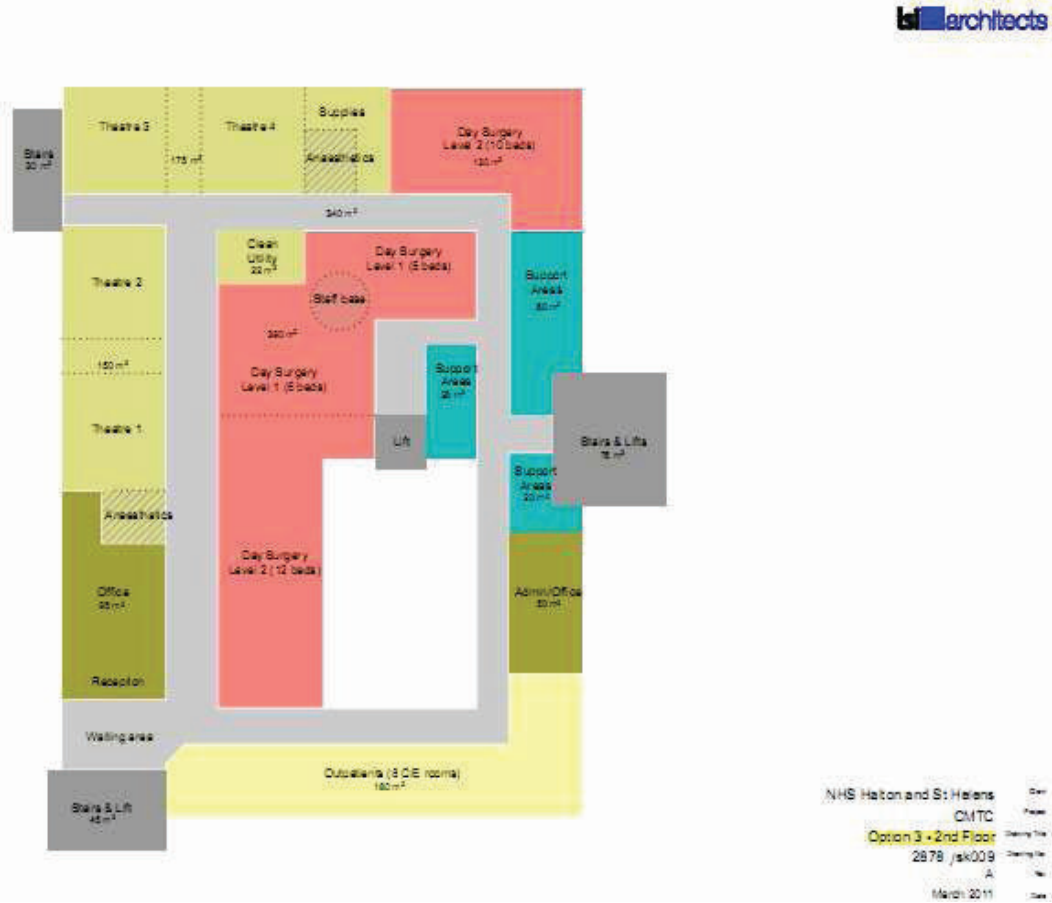

architects
4 bed Ward
Single Bedroom
Nurse Station
Ward - Support Areas
Support Areas
Lift
Stairs & Lift
Outpatients
NHS Halton and St Helens
CMTC
Option 2 - 1st Floor
2879 /sk005
A
March 2011


architects
Theatre 3
Theatre 4
Clean Utility
Support Areas
Stairs
Theatre 2
Anaesthetics
Day Surgery
Support Areas
Stairs & Lift
Lift
Theatre 1
Office
Support Areas
Admin / Office
Stairs & Lift
NHS Halton and St Helens
CMTC
Option 2 +2nd Floor
2875 /sk008
A
March 2011

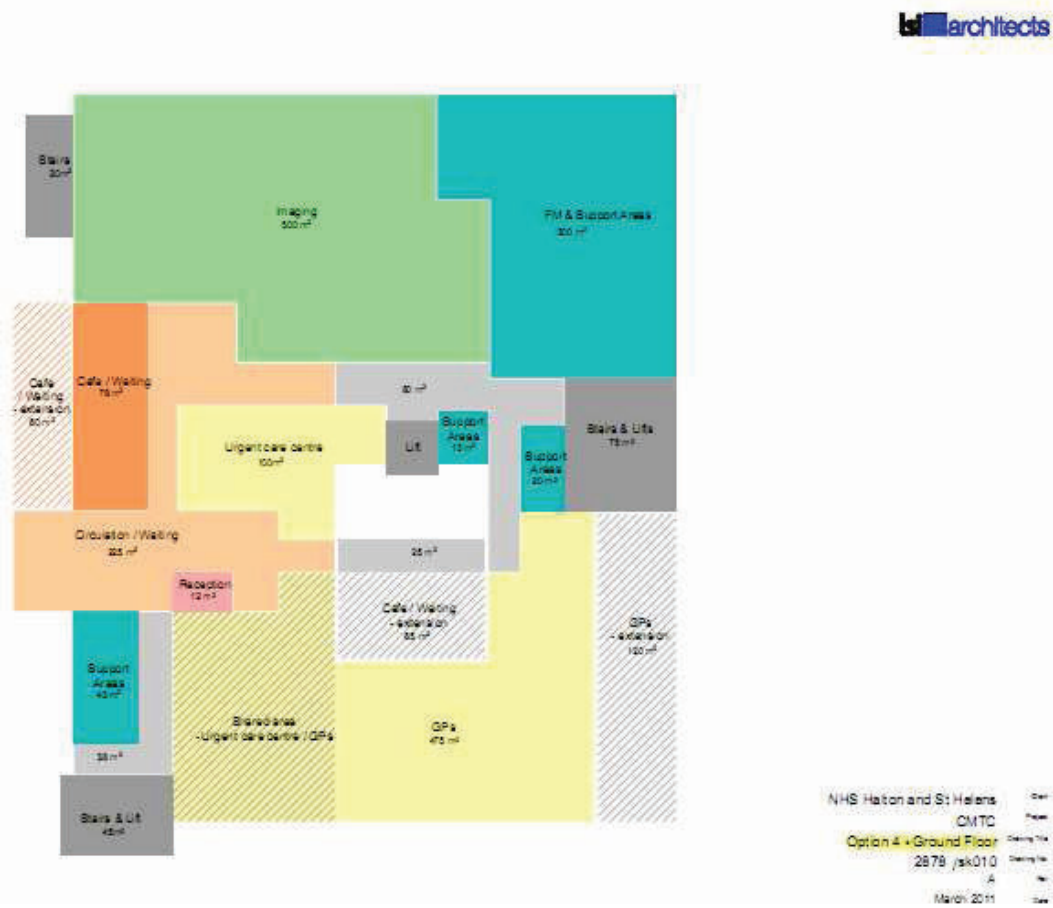
Appendix 4 Potential floor layouts – Option D3 Day Surgery Centre plus HCRC on two floors

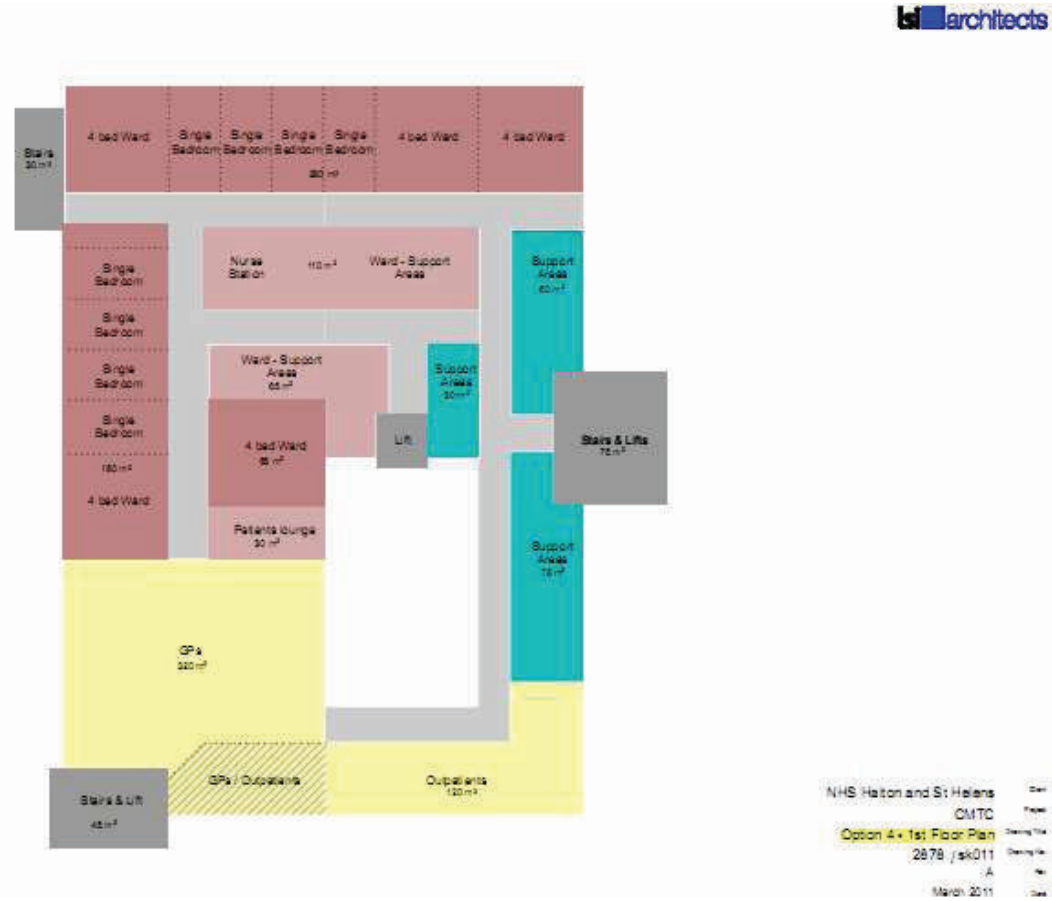


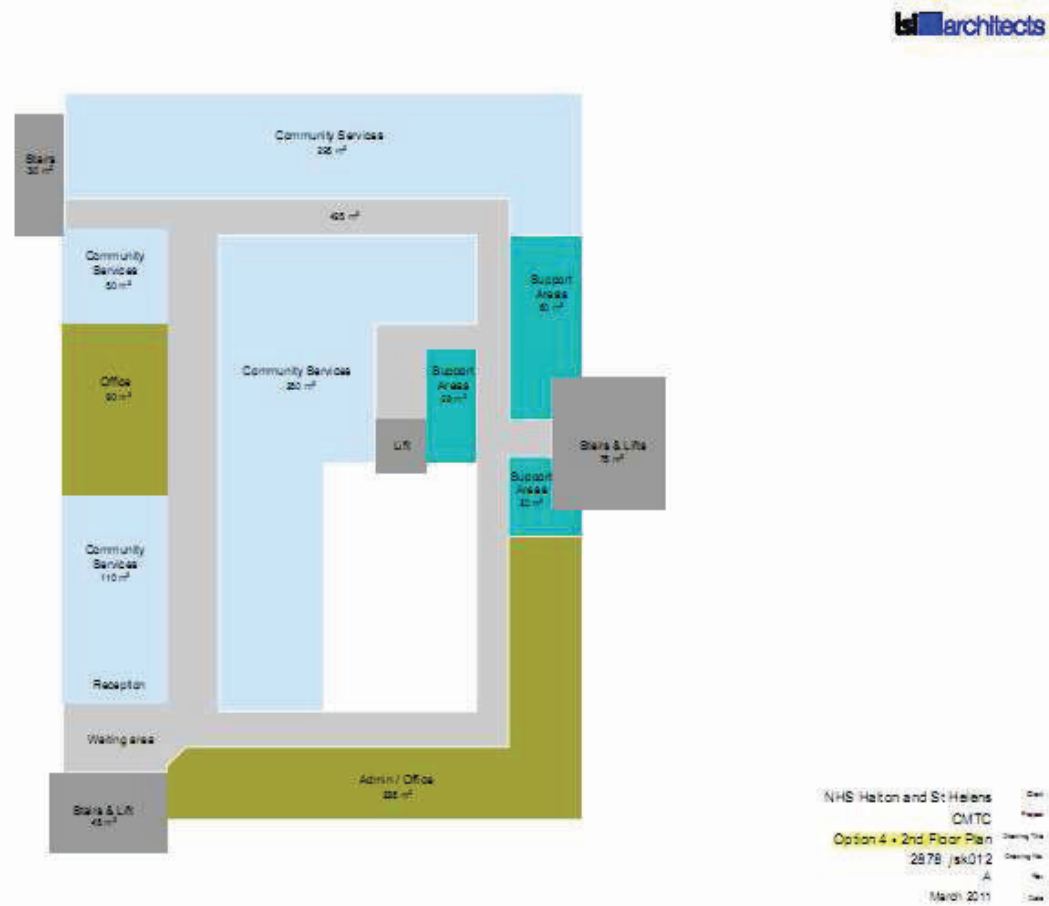

architects
4 bed Ward
Single Bedroom
Single Bedroom
Single Bedroom
Single Bedroom
4 bed Ward
4 bed Ward
Stairs
Single Bedroom
Single Bedroom
Single Bedroom
Single Bedroom
4 bed Ward
Nurse Station
Ward - Support Areas
Support Areas
Ward - Support Areas
Support Areas
4 bed Ward
Lift
Stairs & Lifts
Patients lounge
Support Areas
GPs
GPs / Outpatients
Outpatients
Stairs & Lift
NHS Halton and St Helens
CMTC
Option 3 - 1st Floor
2879 /sk008
A
March 2011


bdl architects
Theatre 3
Theatre 4
Supplies
Anaesthetics
Day Surgery
Level 2 (10 beds)
Stairs
175 m²
340 m²
Clean
Utility
Day Surgery
Level 1 (6 beds)
Theatre 2
Staff base
Support
Areas
150 m²
Day Surgery
Level 1 (6 beds)
Support
Areas
Theatre 1
Lift
Stairs & Lifts
Support
Areas
Anaesthetics
Day Surgery
Level 2 (12 beds)
Office
Admin/Office
Reception
Waiting area
Outpatients (8 OE rooms)
Stairs & Lift
NHS Halton and St Helens
CMTC
Option 3 + 2nd Floor
2878 /sk009
A
March 2011

Appendix 5 Potential floor layouts – Option D4 HCRC on three floors




architects
4 bed Ward
Single Bedroom
Single Bedroom
Single Bedroom
Single Bedroom
4 bed Ward
4 bed Ward
Stairs
Single Bedroom
Single Bedroom
Single Bedroom
Single Bedroom
4 bed Ward
Nurse Station
Ward - Support Areas
Support Areas
Ward - Support Areas
Support Areas
4 bed Ward
Lift
Stairs & Lifts
Patients lounge
Support Areas
GPs
GPs / Outpatients
Outpatients
Stairs & Lift
NHS Halton and St Helens
OMTC
Option 4 - 1st Floor Plan
2878 / sk011
A
March 2011


architects
Community Services
Stairs
Community Services
Office
Community Services
Reception
Waiting area
Stairs & Lift
Community Services
Support Areas
Community Services
Support Areas
Lift
Stairs & Lifts
Support Areas
Admin / Office
NHS Halton and St Helens
CMTC
Option 4 - 2nd Floor Plan
2878 /sk012
A
March 2011

Appendix 6 Option appraisal group

Name	Title and organisation
Simon Banks	Operational Director of Planned Care and Market Development, NHS Halton & St Helens
Dr Cliff Richards	Chair, Runcorn Shadow GP Commissioning Consortium
Dr David Lyon	GP, Runcorn Shadow GP Commissioning Consortium
Chris Webb	Business Manager, Runcorn Shadow GP Commissioning Consortium
Lyn Williams	LINk Lead Officer
Pam Broadhead	Head of Independent Sector Contracts, NHS Western Cheshire
Sue Wallace-Bonner	Adults & Community, Halton Borough Council
Ian Ball	Assistant Director of Estates & Facilities, NHS Halton & St Helens
Ken Jones	Senior Financial Accountant, NHS Halton & St Helens

Appendix 7 Affordability tables

WITH COVENANT STILL IN PLACE	Option A		Option B		Option C		Option D1		Option D2		Option D3	
	2011/12 £'000	2012/13 £'000	2011/12 £'000	2012/13 £'000	2011/12 £'000	2012/13 £'000	2011/12 £'000	2012/13 £'000	2011/12 £'000	2012/13 £'000	2011/12 £'000	2012/13 £'000
Additional costs incurred												
Headlease	46	60	31	-	46	60	46	60	46	60	46	60
Capital charges on land and buildings	526	631	368	-	623	1,015	623	1,015	623	1,015	623	1,015
Capital charges on refurbishment	-	-	-	-	-	-	-	-	2	7	14	56
Facilities management payments	178	214	181	-	271	359	271	359	271	359	271	359
Decommissioning costs	123	-	-	-	-	-	-	-	-	-	-	-
Sub-total	**873**	**905**	**580**	**-**	**940**	**1,434**	**940**	**1,434**	**942**	**1,442**	**954**	**1,490**
Less: Income recovered												
For lease of premises	-	-	-	-	46	60	46	60	46	60	46	60
Contribution towards FM costs	-	-	-	-	271	359	271	359	181	239	149	198
Sub-total	**-**	**-**	**-**	**-**	**317**	**419**	**317**	**419**	**226**	**299**	**195**	**258**
Less: Potential savings/available funding												
Urgent care centre premises budget	-	-	-	-	-	-	-	-	55	219	55	219
Hallwood premises reimbursement	-	-	-	-	-	-	-	-	-	-	-	95
Intermediate care: saving vs acute admission	-	-	-	-	-	-	-	-	-	-	41	163
Community outpatients	-	-	-	-	-	-	-	-	-	-	-	-
MSK CATS premises budget	-	-	-	-	-	-	-	-	-	-	-	-
Community midwifery base	-	-	-	-	-	-	-	-	-	-	-	-
Sub-total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**55**	**219**	**96**	**477**
Net cost/(saving)	**873**	**905**	**580**	**-**	**623**	**1,015**	**623**	**1,015**	**660**	**924**	**663**	**755**
Acute/intermediate care provider share of total floorspace					100%	100%	100%	100%	67%	67%	55%	55%
Capital costs												
Urgent care centre and outpatients									100			
Convert theatre space for community services												
Convert ground floor - Imaging, UCC, GP practice											600	
Second GP practice											150	
Total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**100**	**-**	**750**	**-**
Expected useful life	25	25	25	25	25	25	25	25	25	25	25	25
Depreciation	-	-	-	-	-	-	-	-	4	-	30	-
CAD	-	-	-	-	-	-	-	-	3	-	26	-
Capital charge - part/full year	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**2**	**7**	**14**	**56**
Note: Net capital cost for economic appraisal	-	-	-	-	-	-	-	-	83	-	625	-

ASSUMING COVENANT NOT APPLIED	Option A		Option B		Option C		Option D1		Option D2		Option D3	
	2011/12	2012/13	2011/12	2012/13	2011/12	2012/13	2011/12	2012/13	2011/12	2012/13	2011/12	2012/13
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Additional costs incurred												
Headlease	46	60	32	-	46	60	46	60	46	60	46	60
Capital charges on land and buildings	526	631	368	-	623	1,015	623	1,015	623	1,015	623	1,015
Capital charges on refurbishment	-	-	-	-	-	-	-	-	2	7	14	56
Facilities management payments	178	214	181	-	271	359	271	359	271	359	271	359
Decommissioning costs	123	-	-	-	-	-	-	-	-	-	-	-
Sub-total	**873**	**905**	**581**	**-**	**940**	**1,434**	**940**	**1,434**	**942**	**1,442**	**954**	**1,490**
Less: Income recovered												
For lease of premises	-	-	-	-	1,271	1,525	1,271	1,525	847	1,017	699	839
Contribution towards FM costs	-	-	-	-	271	359	271	359	181	239	149	198
Sub-total	**-**	**-**	**-**	**-**	**1,542**	**1,884**	**1,542**	**1,884**	**1,028**	**1,256**	**848**	**1,036**
Less: Potential savings/available funding												
Urgent care centre premises budget	-	-	-	-	-	-	-	-	55	219	55	219
Hallwood premises reimbursement	-	-	-	-	-	-	-	-	-	-	-	95
Intermediate care: saving vs acute admission	-	-	-	-	-	-	-	-	-	-	41	163
Community outpatients	-	-	-	-	-	-	-	-	-	-	-	-
MSK CATS premises budget	-	-	-	-	-	-	-	-	-	-	-	-
Community midwifery base	-	-	-	-	-	-	-	-	-	-	-	-
Sub-total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**55**	**219**	**96**	**477**
Net cost/(saving)	**873**	**905**	**581**	**-**	**(602)**	**(450)**	**(602)**	**(450)**	**(141)**	**(33)**	**10**	**(23)**
Acute/intermediate care provider share of total floorspace					100%	100%	100%	100%	67%	67%	55%	55%
Capital costs												
Urgent care centre and outpatients									100			
Convert theatre space for community services												
Convert ground floor - Imaging, UCC, GP practice											600	
Second GP practice											150	
Total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**100**	**-**	**750**	**-**
Expected useful life	25	25	25	25	25	25	25	25	25	25	25	25
Depreciation	-	-	-	-	-	-	-	-	4	-	30	-
CAD	-	-	-	-	-	-	-	-	3	-	26	-
Capital charge - part/full year	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**2**	**7**	**14**	**56**
Note: Net capital cost for economic appraisal	-	-	-	-	-	-	-	-	83	-	625	-

REPORT TO: Health Policy and Performance Board

DATE: 7th June 2011

REPORTING OFFICER: Strategic Director, Communities

SUBJECT: Proposal for the development of a Health and Well-being Board

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide:

- An update on the development of a Shadow Health and Well-being Board for Halton;
- An update on Halton's application to become an Early Implementer of Health and Well-being Boards;
- Draft Terms of Reference for comment and discussion.

2.0 RECOMMENDATION: That

(1) the Board note the contents of the report;

(2) comment on the draft Terms Of Reference (Appendix 1) and suggest amendments/ changes as appropriate;

(3) note the recommendations for the links to the Health and Well-being Boards for Children's Services as set out in point 3.19; and

(4) agree the next steps as set out in 3.30

3.0 SUPPORTING INFORMATION

NHS White Paper Equity and Excellence: Liberating the NHS

3.1 The NHS White Paper published on 12th July 2010 developed a number of proposals for the transformation of Health Services in the country. Key features include: -

- Abolition of PCT's and Strategic Health Authorities.
- A focus on a consortium of GP's acting as commissioners of the majority of Health Services.

- The creation of a National Commissioning Board to commission primary care services, oversee consortia activity and deal with specialist commissioning issues.

- The establishment of a national Public Health Service and transfer of responsibility for commissioning of Health improvement to Local Authorities who would employ a Director of Public Health.

- Improved patient and public involvement through Health Watch (presently LINks).

- An enhanced role for local Councillors and Local Authorities.

- Improvement in integrated working.

- The creation of Health and Well-being Boards in all local authorities.

In its response to the consultation the Government has reaffirmed its intention to progress these initiatives and create statutory Health and Well-being Boards (Liberating the NHS: Legislative Frameworks and next steps. December 2010)

Proposals for a Statutory Health and Well-being Board

3.2 The Government indicates that when statutory Health and Well-being Boards are created statutory requirements will be minimal with Local Authorities enjoying freedom and flexibility as to how the Board would work in practice.

3.3 The Government proposes that Statutory Health and Well-being Boards will have the following main functions: -

- To assess the needs of the local population and lead statutory Joint Strategic Needs Assessments.

- Promote integration and partnership across areas including through promoting joined up commissioning plans across the NHS, Social Care and Public Health and to publish a Joint Health and Well-being Strategy.

- To support joint commissioning and pooled budget arrangements where all parties agree this makes sense.

3.4 The guidance further states that whilst responsibility and accountability for NHS Commissioning would rest with the NHS Commissioning Board and GP consortia, the Health and Well-being Boards would give Local Authorities influence over NHS Commissioning and corresponding influence for NHS Commissioners in relation to Health Improvement, reducing Health Inequalities and Social Care.

3.5 The guidance for the function of GP commissioning consortia also states under Duties that the GPs should "co-operate with local authorities and participate in their Health and Well-being Boards".
In addition they will "contribute to the Joint Strategic Needs Assessment and the joint Health and Well-being Board(s) and the have regard to the JSNA and the joint strategy in exercising any relevant functions."

3.6 The Health and Well-being Board will also have an important role in relation to other partnerships including those relating to Adult and Children's Safeguarding although these initiatives are yet to be developed/tested.

3.7 The proposals indicate that the Board will bring together local elected representatives, Social Care, NHS Commissioners, Local Government and patient representatives around one table. The guidance as presently stated would be for the elected members of the Local Authority to decide who would chair the Board.

3.8 For the Board to function well it is anticipated that Local Authorities, elected members, Directors of Adult Social Care, Public Health and Children's Services, and a representative of Local Health Watch (presently LINks) will have a seat on the Board. Representatives of relevant GP consortia and PCT staff will also play a key role.

3.9 The Board will have a key role in promoting joint working with the aim of making commissioning plans across the NHS, Public Health and Social Care, coherent, responsive and integrated.

The Present Situation in Halton

3.10 The Halton Health Partnership (HHP) currently acts as the thematic partnership for the Healthy Halton priority. The Partnership reports into the Halton Strategic Partnership Board as one of the five Specialist Strategic Partnerships (SSPs).

3.11 The HHP has strategic responsibility for the Healthy Halton priority and for those elements of work that contribute to the objectives of the Sustainable Community Strategy (SCS) and Local Area Agreement (LAA).

3.12 The Halton Health Partnership is presently chaired by the Acting Director of Public Health.

3.13 Health priorities are also addressed by the Healthy Halton Policy and Performance Board and Children's health issues are included in the work of the Children's Trust and the Children and Young People's PPB.

3.14 Safeguarding is addressed by the Safeguarding Adults Board (SAB) which reports directly into the Safer Halton Partnership and is a non statutory board. Children's Safeguarding issues are addressed by the Safeguarding Children's Board (LSCB) which is a statutory board which reports and challenges into the Children's Trust and provides an annual report to the Council's Executive Board.

Proposal for a Shadow Health and Well-being Board in Halton

3.15 Given the evolving nature of proposals outlined in the Health White Paper and in the Legislative Framework, which detail significant levels of change within local authorities, it would seem appropriate to set up a Shadow Health and Well-being Board in Halton.

3.16 The Shadow Health and Well-being Board will be responsible for guiding and overseeing the implementation of the ambitions outlined in the Health White Paper as well as providing the strategic direction for the Health priority in Halton. Principally this will include:

- guiding and overseeing the Joint Strategic Needs Assessment,
- developing a high-level joint health and Well-being strategy based upon the findings of the JSNA and the priorities identified by the Sustainable Community Strategy (SCS);
- guiding and overseeing the transfer of Public Health responsibilities and arrangements to the Local Authority;
- the establishment of sound joint commissioning arrangements,

3.17 Formal decision- making responsibility will continue to rest with the Council's Executive and the relevant governance bodies of the local health services until new legislation is enacted. Transitional governance arrangements are key in establishing the Shadow HWBB, given that Health and Well-being Boards will assume their statutory responsibilities from April 2013.

3.18 Overview and Scrutiny issues will need to be confirmed by the Government.

3.19 In terms of the relationship between the HWBB and Children's Services it would seem short sighted to disassemble existing structures when they are working well. The Children's Trust, LSCB and SAB should therefore have representation on the Health and Well-being Board. It is proposed that the Chair of these boards would fulfil this role.

3.20 Improving health and Well-being in Halton cannot be achieved in isolation and it is clear that it crosses all aspects of the LSPs work. Therefore an early decision will be required around the relationship with the LSP and other Specialist Strategic Partnerships.

3.21 Guidance indicates that the Board may have a role in relation to "place based budgets". This will be clarified when further guidance on this is available.

Early Implementer

3.22 On 27 January 2011 the Department of Health issued a letter asking Local Authorities to consider whether they would wish to become an

Early Implementer for Health and Well-being Boards. As a result Halton decided to submit a letter of application.

3.23 A response to Halton's application was received on 10th March 2011 inviting Halton to join the early implementer network. (Please see Appendix 2).

3.24 The early implementer network will offer three levels of support:

- **Sharing learning and information** - via the web and an interactive web forum hosted by LGID;
- **Building connections** – signposting you to other early implementers areas with similar interests; and
- **Practical support** - through workshops, facilitated discussions, peer support and challenge and disseminating learning products.

3.25 As the letter states the following key themes will provide the initial focus for activity:

- **Setting a new direction while continuing to deliver services through the transition –** ensuring the reforms achieve improved outcomes and integrated working, while managing the risk of losing relationships, talent and capacity during transition.
- **Relationships and knowledge –** focusing on building new relationships, particularly between GP consortia and councils. This includes building understanding of how partner organisations function and transfer of knowledge.
- **Accountability and transparency –** making a success of governance arrangements and complex accountabilities, while improving transparency and accountability to local people.
- **Boundaries and levels –** managing the complexities of operating where GP consortia and councils are not co-terminus, and where county and district councils need to work together.

Consultation with partners/ stakeholders

3.26 During March discussions have been held with key partners and stakeholders across Halton as follows:

- Interim Director of Public Health, NHS Halton and St. Helens
- Medical Director, NHS Halton and St. Helens
- Chief Executive, Halton VCA
- Representatives from both GP consortia
- LinKs
- Strategic Director of Children's Services
- Strategic Director, Adults and Community

3.27 The purpose of these discussions was to gauge opinion on the draft Terms of Reference, discuss membership (where appropriate), share experience on HWB implementation from St. Helens, discuss the role of the JSNA and to offer support and guidance where required.

3.28 A Commissioning day was organised with the GP Consortia, PCT and Council with over 60 people in attendance. The main outcome was that a significant amount of work needed to be undertaken on understanding the current commissioning structures, examining their effectiveness and reviewing potential new approaches. It was agreed that a small task and finish sub group should be formulated to take this forward. This will be a critical group to the establishment of the Health and Well Being Board.

3.29 Some of the key issues raised at the meetings were are as follows:

- **Learning and Development-** Understanding one another's role and the wider role and remit of partner organisations is particularly important when establishing a new Board. This is particularly important to GP colleagues who are approaching new ways of working. GP colleagues felt that there was no need to rush into setting up the board, final arrangements for GP Consortia (e.g. election of Board/ Chair) are still being finalised and they felt it was more important to establish relationships and share knowledge /understanding before having formal meetings. They also emphasised the need to ensure that where there is evidence of things working well, that we build this into the new system rather than start from scratch.

- **Structures/ Support**- It was felt that the commissioning structures to support the HWB were essential to ensure that high level decisions made at the Board could be delivered at an operational level. Therefore these structures would need to be developed alongside proposals for the Health and Well-being Board and would ideally be in place before the first normal business meeting is held.

- **Voluntary Sector/ Links (HealthWatch)**- Further to discussions with the Chief Executive of Halton VCA it was agreed (subject to formal endorsement of TOR) that there would be one Voluntary Sector representative (i.e. Chief Executive Halton VCA) and one LinKs/ HealthWatch representative.

- **PCT-** After April 2013 the PCT will be disband. However, up until this time the membership of the Health and Well-being Board will need to include the Chair of the Clinical Commissioning Committee**.**

Next Steps

3.30 It is proposed that a Shadow Health and Well-being Board will be established by summer 2011. Recent consultation with GP colleagues highlights a desire not to rush into any formal arrangements, but to take a more measured approach in order to allow the new Board to evolve as all parties become clearer about their respective roles and the emerging role for the new partnership Board. In order to progress development of a Shadow Board the following points are suggested for action:

- Distribute draft Terms of Reference more widely following comments from PPB members;
- If it is agreed that the new Shadow Health and Well-being Board could also incorporate the role of the Health Partnership Board arrangements will need to be made to dissolve the HHP board.
- Arrange first meeting/ development session for the new Shadow Health and Well-being Board to take place in Summer 2011.
- Make use of the Early Implementer Network to share experiences with other areas and benefit from the expertise offered from the DH.

4.0 POLICY IMPLICATIONS

4.1 The policy implications stemming from the *NHS White Paper, Equity and Excellence: Liberating the NHS* are far reaching. Although the creation of a Health and Well-being Board in Halton could incorporate the role of the Health Partnership. It will promote integration across health and adult social care, children's services, including safeguarding and the wider local authority agenda.

5.0 SAFEGUARDING IMPLICATIONS

5.1 The Health and Well-being Board will have a role in terms of safeguarding. The role and remit of the Board in terms of safeguarding is yet to be clarified, but will form part of the discussion resulting from the draft Terms of Reference.

6.0 FINANCIAL/RESOURCE IMPLICATIONS

6.1 The cost of establishing a Shadow Health and Well-being Board in Halton will amount to officer time and resource to support the development of the board and member, stakeholder and senior officer time to contribute to meetings and any other relevant working groups. By streamlining existing arrangements it should be possible to achieve similar outcomes with the same or reduced cost.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 Children & Young People in Halton

The Health and Wellbeing Board will have a role in addressing the health and wellbeing needs of children and young people and this important area of work will form an integral part of the Joint Strategic Needs Assessment and the resultant Health and Wellbeing Strategy. Children's health issues are also covered by the Children's Trust Board.

Children's Safeguarding issues are addressed by the Safeguarding Children's Board (LSCB) which is a statutory board which reports and challenges into the Children's Trust and provides an annual report to the Council's Executive Board.

Through the proposals outlined in this report it is recommended that the Chairs of both the Children's Safeguarding Board (LSCB) and the Chair of the Children's Trust are members of the Health and Wellbeing Board.

7.2 Employment, Learning & Skills in Halton

Addressing the wider determinants of health including Employment, learning and Skills will be a key consideration of the Health and Wellbeing Board and will form part of the Health and Wellbeing Strategy.

7.3 A Healthy Halton

The Shadow Health and Well-being Board will be responsible for guiding and overseeing the implementation of the ambitions outlined in the Health White Paper as well as providing the strategic direction for the Health priority in Halton.

7.4 A Safer Halton

Creating safer and stronger communities has a direct impact on improving the health and wellbeing of local people.

7.5 Halton's Urban Renewal

The built environment, access to public and leisure services, employment sites and public transport all have an impact on health and wellbeing.

8.0 RISK ANALYSIS

8.1 The implementation of proposals in the NHS White Paper are potentially far reaching as they will change the way Health services are commissioned and delivered. The Shadow Health and Well-being Board will, in part, be responsible for overseeing the implementation of these proposals and will attempt to minimise the risk of their implementation at a local level by bringing together key organisations and representatives.

9.0 EQUALITY AND DIVERSITY ISSUES

9.1 In developing the Health and Well-being Board due regard will be given to the Equality Act 2010, including new legislation around the Public Sector duty.

9.2 It has not been appropriate, at this stage, to complete a Community Impact Review & Assessment (CIRA)

Appendix 1

DRAFT TERMS OF REFERENCE FOR HALTON SHADOW HEALTH AND WELL-BEING BOARD

Aims of the Shadow Health and Well-Being Board

1. The Shadow Health & Well-Being Board (HWBB) is responsible for guiding and overseeing the implementation of the ambitions outlined in the Health White Paper "Equity and Excellence - Liberating the NHS" as well as providing the strategic direction for the Health priority in Halton. Principally this will include:

    - guiding and overseeing the Joint Strategic Needs Assessment,
    - developing a high-level joint health and Well-being strategy based upon the findings of the JSNA (including priorities identified by the Sustainable Community Strategy (SCS));
    - guiding and overseeing the transfer of Public Health responsibilities and arrangements to the Local Authority;
    - the establishment of sound joint commissioning arrangements,

2. The Shadow HWBB aims to develop a model for an established HWBB, in preparation for expected new legislation that will enact proposals set out in the government's Health White Paper. The Shadow HWBB will also take account of the response to the results of the consultation on the White Paper, "Liberating the NHS: Legislative Framework and next steps" and of the public health strategy for England, "Healthy Lives, Healthy People". It will provide a key forum for public accountability of NHS, Social Care for Adults and Children and other commissioned services that the Shadow HWBB agrees are directly related to health and Well-being in Halton.

3. Formal decision- making responsibility will continue to rest with the Council's Executive and the relevant governance bodies of the local health services until new legislation is enacted. Transitional governance arrangements are key in establishing the Shadow HWBB, given that Health and Well-being Boards will assume their statutory responsibilities from April 2013.

Suggested Terms of Reference based on the above:

Principle Responsibilities

- To be responsible for guiding and overseeing the implementation of the ambitions outlined in the Health White Paper "Equity and Excellence-Liberating the NHS."

- To establish sound joint commissioning arrangements

- To assess the needs of the local population and lead the Statutory Joint Strategic Needs Assessment.

- To promote integration and partnership across areas including through promoting joined up commissioning plans across the NHS, Social Care and Public Health.

- To work with the Children's Trust to ensure that the Children's Services commissioning is embedded into the role of the Health and Well-being Board and effective relationships established between the two Boards.

- To support strategic planning and joint commissioning and publish a Joint Health and Well-being Strategy

- To contribute to the developments of Health and Well-being Services in Halton which may arise as a result of changes in Government Policy and relevant legislation.

Other Responsibilities

- To give strategic direction to relevant Commissioning Activity

- To oversee the work of Joint Commissioning Groups.

- To develop and monitor relevant activity and performance.

- To ensure that Halton's health priorities (as defined by the JSNA, SCS and relevant health targets) are addressed by Joint Commissioning Groups.

- To ensure that Joint Commissioning Groups work effectively with other Strategic Partnerships to address cross-cutting areas of work e.g. alcohol to ensure an holistic approach.

- To improve access for service users and patients through closer working arrangements and in particular to address issues in relation to disadvantaged groups.

- To effectively monitor and review the progress of programmes designed to impact on key targets.

- To ensure dissemination of learning as a result of good practice.

- To disseminate and share strategies and action plans in order to facilitate partnership working

- To maintain appropriate linkages with other partnership boards including those relating to Adults and Children's Safeguarding.

Membership

Elected Member (Chair)

Executive Board Portfolio Holder for Health & Adults

Executive Board Portfolio Holder for Children and Young Peoples Services (Chair of Children's Trust)

Chief Executive, Halton Borough Council

CVS/Forum Representative

LINks/Health Watch Representative

Representatives from each of the practice based consortia in Halton

Director of Partnership Commissioning PCT

Operational Director Commissioning & Complex Needs HBC

Strategic Director, Adults & Community (Chair of SAB)

Strategic Director, Children & Young People

Director of Public Health

Chair of LSCB

Chair of PCT

Chair of PCT Clinical Commissioning Committee

Meetings

Meetings of the Health and Well-being Board will take place quarterly. The chair may call an extraordinary meeting at any time. The agenda and associated papers will be sent out a minimum of one week (five clear working days) in advance of the meeting. Minutes of the board will be formally minuted.

Chair

The Chair will be an elected member of Halton Borough Council

Quorum

The meeting will be quorate provided that at least fifty per cent of all members are present. This should include the Chair or Vice Chair and at least one officer of the PCT and one officer of the Local Authority. Where a Board is not quorate, business may proceed but decisions will need to be ratified.

Decisions

Where a decision is required, that decision will be made by agreement among a majority of members present. Where a decision needs to be ratified by one of the statutory agencies, the ratification process will be in accordance with the agreed process within that particular agency.

Minutes

Minutes of the proceedings of each meeting of the Board will be drawn up, circulated and agreed as a correct record at the subsequent meeting, once any required amendments have been incorporated.

Review

The membership and terms of reference of this partnership will be reviewed regularly (normally annually) to ensure that they remain relevant and up to date.

Appendix 2

Sent via email

Mr David Parr
Chief Executive
Halton Borough Council
Halton Borough Council Municipal Building
Kingsway
Widnes
Cheshire WA8 7QF

10 March 2011

Dear Mr Parr

Further to my letter of 27 January, I am writing to thank you for responding to our invitation and to confirm that you are now part of the early implementers' network. This letter sets out what being part of the early implementer network means and how we can support you.

How will the network work?

The early implementers' network will be a learning network. Subject to parliamentary approval, each council will be responsible for establishing a health and Well-being board from April 2013. There is an expectation that each council will establish a health and Well-being board in shadow form by April 2012. The purpose of the network is to support councils to prepare for this new role, working with Local Government Group, Solace, ADASS, ADCS and the public health community, along with SHAs. We have agreed that the best way to do this is through the development of networks bringing together key partners at a local level to learn together how best to establish health and Well-being boards. This approach is designed to offer three levels of support;

- **Sharing learning and information** - via the web and an interactive web forum hosted by LGID;
- **Building connections** – signposting you to other early implementers areas with similar interests; and
- **Practical support** - through workshops, facilitated discussions, peer support and challenge and disseminating learning products.

This activity will take place at a national, regional and local level, according to the needs of all partners and in order to achieve maximum impact. This role will of course need to evolve in response to our understanding of key challenges through 2011/12 and as we move to shadow running in 2012/13.

Focus of the network

Developing health and Well-being boards, the public health system, GP consortia, local HealthWatch and wider partnership arrangements provide a real opportunity to ensure that agencies act together to meet the needs of local people in a coordinated and coherent way. In our early discussions to date, early implementers have identified the following key themes as an initial focus for activity;

- **Setting a new direction while continuing to deliver services through the transition –** ensuring the reforms achieve improved outcomes and integrated working, while managing the risk of losing relationships, talent and capacity during transition.
- **Relationships and knowledge –** focusing on building new relationships, particularly between GP consortia and councils. This includes building understanding of how partner organisations function and transfer of knowledge.
- **Accountability and transparency –** making a success of governance arrangements and complex accountabilities, while improving transparency and accountability to local people.
- **Boundaries and levels –** managing the complexities of operating where GP consortia and councils are not co-terminus, and where county and district councils need to work together.

In designing the learning network the key is to capture the learning which emerges and to share it across the network. There are a number of approaches that early implementers may want to take;

- National & regional conferences
- Action Learning Sets
- Issue focussed workshops
- Regional and Sub-regional networks
- Virtual networks & Web-based discussions

Nationally the DH will work to establish the learning network with early implementers, other Government Departments and LGID. We will also set up some focussed national work on core overarching issues such as the development of JSNAs and joint health and Well-being strategies, implementation of local HealthWatch and the role of elected Members.

As a next step we want to know what all members of the early implementers learning network would want to support their work locally in addition to the work which will be required at a national level. Therefore DH staff will make contact with each council over the next two weeks to discuss how to build the learning network.

As part of this, we will be particularly interested to know whether you think we have identified the right areas of focus, and whether the offer to empower the learning network I have described is the right one. We will then write to you again about the next steps.

The leadership team for this work is lead by Andrew Larter, working alongside DH teams in the regions and SHAs, supporting discussions and sharing learning between local areas. The lead contact for this in your region is David Jones, Deputy Regional Director for Social care and Partnerships, working closely with the Regional Director of Public Health, Ruth Hussey, and the Director of Commissioning Development, Joe Rafferty. I know that David Jones has already been in touch regarding the setting up of North West "Transition Alliance" to support the ongoing process of exchange and early implementation work.

Accessing learning

We've created an online channel to support you at www.dh.gov.uk/healthandcare. Through this you'll be able to access a directory and map of early implementers, identifying who else is working on similar issues. You can see some vox pops of places talking about what they hope to achieve through health and Well-being boards at http://healthandcare.dh.gov.uk/category/local-government/ . We are also working with LGID to set up a community of practice for you to discuss issues and work collaboratively.

Links to GP pathfinders

We will bring together the learning and communications for early implementers with GP pathfinders through www.dh.gov.uk/healthandcare and other joint communications. A map of GP pathfinders to date is available at http://healthandcare.dh.gov.uk/721/ .

Links to HealthWatch

I wrote to all Local Authorities with Joan Saddler, National Director for Public and Patient Affairs, earlier this week, describing our approach to supporting learning on HealthWatch and inviting Pathfinder proposals. We will also link this work closely to the early implementers for health and Well-being boards.

Promoting the network

We are delighted by the level of response to our invitation to join the early implementer's network, and it's likely that Ministers will be talking about this in the press over the coming week. If you have plans to talk about your local work in the press, our communications lead Amy Key would love to hear from you, and to offer any support you might need.

Action

In order to arrange the early discussion about how this might work, please contact Andrew Larter on andrew.larter@dh.gsi.gov.uk.

The team here in DH look forward very much to working with you to take this forward.

Yours sincerely

David Behan CBE
Director General
Social Care, Local Government and Care Partnerships
Department of Health

Useful contacts

National

Andrew Larter
Deputy Director
020 7972 4401
Andrew.larter@dh.gsi.gov.uk

Kathy Wilson
Local Government Policy Lead
020 7972 4200
Kathy.wilson@dh.gsi.gov.uk

Amy Key
Communications lead
Amy.key@dh.gsi.gov.uk

Regional

Deputy Regional Director for Social Care and Partnerships;
David Jones
David.g.jones@dh.gsi.gov.uk
0161 952 4193

Regional Director of Public Health;
Ruth Hussey
Ruth.hussey@northwest.nhs.uk

SHA Director of Commissioning Development;
Joe Rafferty
Joe.rafferty@northwest.nhs.uk

REPORT TO: Health Policy & Performance Board

DATE: 7 June 2011

REPORTING OFFICER: Strategic Director, Communities

SUBJECT: Safeguarding Adults

WARDS: All

1.0 **PURPOSE OF REPORT**

1.1 To update the Board on key issues and progression of the agenda for Safeguarding Vulnerable Adults.

2.0 **RECOMMENDATION:**

i) That the Board notes the contents of the report.

3.0 **SUPPORTING INFORMATION**

3.1 Halton **LINk** held an **informal 'drop-in' event**/coffee morning in February 2011 to mark **Dignity Action Day**. The aims were to offer LINk's support to the local and national Dignity in Care campaign, raise awareness of the importance of Dignity in Care and what's taking place locally, remind society that the dignity of those in their community is not the sole responsibility of health or social care staff- everyone has a role to play, remind the public that staff have a right to be treated with dignity and respect too, and hear about people's experiences of local health and social care services over the past 12 months.

3.2 On the 15th February 2011, a shocking report from the **Health Service Ombudsman**, Ann Abraham, was published called ***"Care and Compassion"*** www.ombudsman.org.uk

The report stated that the NHS is failing to treat older people with care, compassion, dignity and respect and highlighted ten investigations from complaints made about the standards of care provided to older people by NHS Hospital Trusts and GP practices. These cases involved people aged 65 and over all of whom suffered indignity, unnecessary pain, distress, poor care, medication management and discharge planning arrangements. The investigations revealed personal and institutional attitudes which failed to recognise people's humanity and individuality alongside care/treatment which lacked sensitivity, compassion and professionalism.

The report was brought recently to Halton's Safeguarding Adults Board, where a decision was taken to develop and monitor a local action plan

that will pick up learning from this report and from the **'Six Lives'** report which was published in March 2009 and investigated the deaths of six people with learning disabilities, highlighted in the report by MENCAP in 2007 called 'Death by Indifference', which in turn raised concerns about the care given six individuals with learning disabilities.

3.3 A report of a Serious Untoward Incident that occurred in 2010 was brought to the Board recently. The SUI review undertaken by NHS Halton and St Helens looked at contributory factors (including underlying medical conditions) and found unsatisfactory practices in a number of areas. The Board's Chair has written to St Helens and Knowsley Teaching Hospitals NHS Trust, requesting the matter also be investigated by the Trust.

3.3 All NHS Trusts that interface with Halton have agreed to **report Serious Untoward Incidents** involving a Safeguarding element to the SAB

One SUI has been reported to the Board, which will **monitor progress** on actions to prevent recurrence of the issues it raised

Work is being undertaken to improve arrangements for patients pathway through health provision locally.

3.4 **Recent reports on service deficiencies** occurring in other localities, along with the Munro Report identifying problems within child protection have been considered for any **learning** that could benefit Halton's Safeguarding Adults services:

3.5 Halton's draft **Hate Crime Strategy and Action Plan** has been reviewed to ensure vulnerable adults content.

3.6 **Brief training** has been provided for providers of **Homelessness services** and a **Basic Awareness Briefing** provided for **Custody Visitors** (who conduct visits in either Halton, Warrington, Cheshire East or West Cheshire**),** and marketing materials and practice guidance distributed.

3.7 The **2011-12 training programme** has been agreed

The E-Learning course will constitute our Basic Awareness training course, but the recent decision not to directly provide Basic Awareness course will be reviewed later in the year [2011-12] against take up of the E-Learning course.

3.8 A pilot is about to begin, with the aim of gathering **learning from people (service users and carers)** who have experienced the local multi-agency safeguarding adults service.

3.9 **Adult Social Care Reform – Law Commission Review**

The government has signalled the biggest reform of adult care law in 60 years after a three-year review proposed sweeping changes to adult safeguarding and carers' rights, and the extension of direct payments to residential care.

Among the commission's recommendations are:

• A set of statutory principles setting out the purpose of adult social care.

• The introduction of direct payments for residential care.

• A statutory basis for adult safeguarding boards

• A duty on councils to investigate adult safeguarding cases.

• A duty on councils to assess carers without them having to request an assessment.

• A duty on councils to produce a care and support plan for all eligible users and carers, including self-funders.

• Separate care laws for England and Wales.

This signals a significant step in moving us closer to a clearer and more coherent framework for adult social care.

3.10 The Government has published a **'Statement of Government Policy on Adult Safeguarding'**, which outlined:

- Government Policy
- Principles
- Suggested outcomes
- Links to other statements on adult social care, and Key Milestones, including:
  - response to the review of 'No Secrets'
  - research commissioned by the Department of Health
  - Law Commission report on the law on Adult Social Care (11 May 2011)
  - **'**A vision for adult social care: Capable communities and active citizens' (November 2010)
  - the Police Reform and Social Responsibility Bill
  - Report of the Independent Commission on the Funding of Care and Support July 2011
  - White Paper on social care reform December 2011

3.11 The government halted the registration of workers and volunteers with children and vulnerable adults to the **vetting and barring scheme** due

to commence on 26 July 2010, saying that the programme can be 'remodelled to proportionate and common sense levels'. Existing requirements for Criminal Record Bureau checks remained in place and the Independent Safeguarding Authority continued to operate lists of barring decisions, pending a full review of the vetting & barring arrangements.

4.0 POLICY, LEGAL AND FINANCIAL IMPLICATIONS

4.1 There are no policy, legal or financial implications in noting and commenting on this report.

4.2 All agencies retain their separate statutory responsibilities in respect of safeguarding adults, whilst Halton Borough Council's Adult and Community Directorate has responsibility for coordination of the arrangements, in accordance with 'No Secrets' (DH 2000) national policy guidance and Local Authority Circular (2000) 7/Health Service Circular 2000/007.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 Children & Young People in Halton

Safeguarding Adults Board membership includes:

- The Chair of the Local Safeguarding Children Board and
- Divisional Manager for the Children's Safeguarding Unit in the Children and Young People's Directorate.

Halton Safeguarding Children Board membership includes adult social care representatives.

Joint protocols exist between Council services for adults and children.

The HSAB chair, sub-group chairs and lead officers for related services meet regularly and will ensure a strong interface between, for example, Safeguarding Adults, Safeguarding Children, Domestic Abuse, Hate Crime, Community Safety, Personalisation, Mental Capacity & Deprivation of Liberty Safeguards.

5.2 Employment, Learning & Skills in Halton

None identified.

5.3 A Healthy Halton

The safeguarding of adults whose circumstances make them vulnerable to abuse is fundamental to their health and well-being. People are likely to be more vulnerable when they experience ill-health.

5.4 **A Safer Halton**

The effectiveness of Safeguarding Adults arrangements is fundamental to making Halton a safe place of residence for vulnerable adults.

5.5 **Halton's Urban Renewal**

None identified.

6.0 **RISK ANALYSIS**

6.1 Failure to address a range of Safeguarding Adults issues could expose individuals to abuse and leave the Council vulnerable to complaint, criticism and potential litigation.

7.0 **EQUALITY AND DIVERSITY ISSUES**

7.1 It is essential that the Council addresses equality issues, in particular those regarding age, disability, gender, sexuality, race, culture and religious belief, when considering its safeguarding policies and plans.