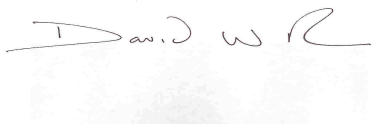
Public Document Pack

Health Policy and Performance Board

Tuesday, 10 January 2012 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
Co-optee	Vacancy

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, 6 March 2012

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: 10 January 2012

REPORTING OFFICER: Strategic Director, Corporate & 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: 10 January 2012

REPORTING OFFICER: Chief Executive

SUBJECT: Specialist Strategic Partnership Minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The final Minutes relating to the Health and Adults 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
THURSDAY, 13th OCTOBER 2011

Present: Emma Bragger (EB)
Cllr Ellen Cargill (EC)
Glenda Cave (GC)
Lorraine Crane (LC)
Dympna Edwards (DE) Chair
Dwayne Johnson (DJ)
Amanda Lewis (AL)
Diane Lloyd (DL)
Eileen O'Meara (EO'M)
Sue Parkinson (SP)
Yeemay Sung (YS)
Karen Tonge (KT)
Jim Wilson (JW)

In Attendance: Hazel Coen (HC)

In Support: Margaret Janes

		ACTION
1.	**Apologies** Sue Wallace-Bonner, Gerald Meehan, Ian Stewardson, Councillor Marie Wright.	
2.	**Minutes of the Meeting** The minutes were agreed as a correct record.	
3.	**Matters Arising** **Item 4** – DL had forwarded information to Lorraine Crane. H&WBB to give consideration to communications with the voluntary sector going forward. **Item 6** – Obesity – figures had been amended. Teenage Pregnancy Target – target set and included in paper. **Item 8** – Social Enterprise – DS to provide.	
4.	**Community/LinK Feedback** SP provided an update to the Board. She advised LinK were currently looking at their effectiveness and planning for the transition to HealthWatch. A report from the Future NW Forum on Ageing had been circulated to the Board from Halton's representative Doreen Shotton. It was noted that the DWP will continue to provide funding for 2011/2012. KT had circulated a copy of E-Times. Any items for the November publication to be forwarded by the end of October. DE to forward the Public Health Annual Report summary.	**DE/MJ**
5.	**Public Health Annual Report 2010/11**	

	DE gave a presentation on the PHAR. The JSNA is a comprehensive assessment of the range of issues in the Borough; each year a key theme is picked up by the Director of Public Health to focus on certain areas within the PHAR. It was noted that • Health is improving but inequalities persist • As Health improves in some areas other priorities come to the fore - eg cancers, suicides. • Thorough changes need to ensure continuity of focus on community development, prevention and early detection • Delivering these programmes makes a tangible difference to local communities. • There is room for improvement - specific recommendations in the report for particular agencies DE confirmed health was improving year on year and efforts are making a difference. A four page summary document was available if this would help to publicise the key messages.	
6.	**Feedback from HSPB Meeting on 21st September** The Halton Strategic Partnership Board had presentations on the Public Health Annual Report and a voluntary sector update. It considered the Child and Family Poverty Strategy, health reforms, the Localism white paper and had updates on the Residents Survey and the proposed planning guidance on hot food take-aways.	
7.	**NHS Transition Update** DE advised there was a single management team across the Merseyside PCTs. A Voluntary redundancy scheme has been available to staff and this could reduce management costs by 15-20%. Over the coming months the cluster will work with the Clinical Commissioning Groups (CCG)to identify the staff they need and to integrate GP consortia are working through the authorisation process in order to apply and become Clinical Commissioning Groups. Widnes and Runcorn consortia have agreed to work together to form Halton CCG. There will be formal sub committees of the PCT Board to enable Clinical Commissioning Groups to start operating in shadow form. Over the coming months, Cluster Directors will work on the staff needed for their directorate; some staff will be aligned directly to Clinical commissioning Groups, some to the Commissioning Support Unit and some to the National Commissioning Board. These new arrangements should be operational by January 2012. Local arrangements will continue for Public Health with some collaborative work across Merseyside. There are plans to recruit a Director of Public Health for Halton. DJ referred to VR and whether this would affect the determining of shadow budgets for Public Health. DE advised the budget return had been based on the spend for 2010/11 which will help to form the baseline; she confirmed the money would still be included in the baseline spend. SP advised that LINks had conducted a 360 degree appraisal to enable them to look at the transition to HealthWatch; they were currently consulting with members. EB advised she attend a LINk transition group, they will be looking to work up a HealthWatch specification early in the New Year. DE advised it was vital for people to continue to communicate in order to work	

	through the new situations and challenges we are facing.	
8.	**Performance Group Update** HC referred to Performance Framework – Sustainable Community Strategy (2011 – 2016) and the Appendix and advised these were key measures that needed to be tracked over the next 5 years; she asked that this proposal be adopted. DL advised whilst the framework may be adopted by this committee it will need to go to the H&WB Board for adoption. DE confirmed as a strategic group these were key outcomes which need to be considered and managed, however it was for the H&WB Board to approve and they may wish to add to the framework; she requested the information be made available to the H&WB Board. DL asked whether there would be quarterly monitoring. HC advised that was up to the H&WB Board, they were happy to provide information on a quarterly basis depending on the level of detail required. DJ advised they work on the next 12-18 months and not a 5 year target as the Board may decide there is a different set of priorities. DE thanked the group for the work the performance group had carried out over the years.	**HC**
9.	**Halton Health and Wellbeing Board Development** DJ advised the group that key stakeholders had been consulted on the draft Terms of Reference for the Health and Wellbeing Board and all partners were signed up. The first meeting was scheduled for 5 December. A draft agenda was being prepared and biographies had been requested from participants. Some members would be attending an event in Bolton on 17 October to understand from other organisations how they have managed the transition to H&WB Boards.	
10.	**Halton Senior Managers Meeting Next Steps** DJ referred to the report and advised the aim is to link with existing structures and strategic approaches with a more co-ordinated approach to health on a locality level. Children's services have delivered some very positive outcomes; in addition they now have seven area forums which overlay other children's locality groups. It was proposed to follow some recommendations by Marmot and look at health and social re-engineering and the wider determinants of health, this will give a model to move towards health promotion/prevention. The JSNA already provides a comprehensive analysis of need across the borough; however, it is also proposed that locality profiles are produced to give a better understanding of need at ward/ Area Forum level. It was proposed that the locality model of health be taken to the first meeting of the new Health and Wellbeing Board. EO'M advised following that opportunity needs to be given to people in the community to become health champions. There was a need to look at multidisciplinary teams to make best use of resources available. After further discussion it was agreed to support the above proposal.	
11.	**Halton Health Partnership Achievements/Legacy** DE wished to acknowledge the scale of work and achievements made by HHP since it was established in 2001. All agreed that partnership working had been excellent and the investment had been very worthwhile. The Board acknowledged the achievements made and anything that could be taken forward to assist in the challenges ahead.	

Halton Strategic PARTNERSHIP

12.	**Any Other Business** **Smoke Free Parks** EO'M advised Halton were the first Borough Council to do this. Wardens will be trained so they are able to deal with questions from the public. **Caring For Our Future** DJ referred to the briefing note and advised adult social care will change fundamentally in 2012. The government had put forward a number of options, Louise Wilson was the lead for HBC and people should contact her direct with responses to the consultation questions. DJ was leading nationally on behalf of ADASS. Currently pulling together a policy response which will be circulated in the next 3 weeks. Responses to Louise Wilson by 21 October. In closing DE thanked everyone for their contributions over the years and in particular thanks to Diane Lloyd. JW added his thanks to the Chair and DL for their efforts over the years.	**All**

REPORT TO: Health Policy and Performance Board

DATE: 10 January 2012

REPORTING OFFICER: Chief Executive

SUBJECT: Shadow Health & Wellbeing Board Minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Adults Portfolio which have been considered by the Shadow Health & Wellbeing Board 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.

SHADOW HEALTH AND WELLBEING BOARD

At a meeting of the Shadow Health and Wellbeing Board on Monday, 5 December 2011 in The Board Room - Municipal Building, Widnes

Present: Councillors Polhill (Chairman), Hignett, Wright, and P.Cooke, D. Johnson, D. Parr, W Rourke, D Edwards, Dr K.Fallon, Dr M. Forrest, Dr D.Lyon, A. McIntyre, M. Pickup, C. Richards, N.Rowe, N. Sharpe, R. Strachan, D. Sweeney and S. Yeoman

Apologies for Absence: Councillor Swain and J. Lunt, G. Meehan, A. Marr, I.Stewardson, L.Williams and A. Williamson

Absence declared on Council business: None

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB1 BOARD INTRODUCTIONS

The Chairman welcomed everyone to the first meeting of the Shadow Board. Each member introduced themselves and a pack of pen portraits were circulated for information.

HWB2 BACKGROUND AND CONTEXT

The Chief Executive, David Parr, provided an overview of the aims of the Shadow Board for the next 12 months as developing a model for an established Health and Wellbeing Board by April 2013.

The Board was advised that it was intended that the Shadow Board would be responsible for guiding and overseeing the implementation of the ambitions outlined in the Health White Papers, “Healthy Lives, Healthy People”, and “Equity and Excellence – Liberating the NHS”, as well as providing the strategic direction for the Health priority in Halton.

It was agreed that membership of the Shadow Board would be regularly reviewed and updated depending on how

the health agenda developed during this shadow period.

HWB3 TERMS OF REFERENCE

The Board considered a report on the proposed Draft Terms of Reference.

The Board would be responsible for overseeing and implementing the ambitions set out in the Health White Papers, "Equity and Excellence – Liberating the NHS", and "Healthy Lives – Healthy People", the health strategy for England, as well as providing the strategic direction for the Health priority in Halton.

The Board discussed the importance of producing the strategy to underpin the Joint Strategic Needs Assessment.

The suggested terms of reference detailed in the report included:

- Principle responsibilities
- Other responsibilities
- Membership
- Frequency of Meetings
- Chairmanship
- Arrangements for a quorum at meetings
- Decision making powers
- Distribution of Minutes
- Arrangements for Review

RESOLVED: That, subject to meetings being held monthly, the Draft Terms of Reference be adopted. D Johnson

HWB4 ACCOUNTABILITY

The Board considered the document 'Operating Principles for Health and Wellbeing Boards'.

The document contained a set of operating principles intended to help the Board consider how to create effective partnerships across local government, local communities and the NHS. These principles were listed as :

1) to provide collective leadership to improve health and wellbeing across the local authority area, enable shared decision-making and ownership of decisions in an open and transparent way;

2) To achieve democratic legitimacy and accountability, and empower local people to take part in decision-making;

3) To address health inequalities by ensuring quality, consistency and comprehensive health and local government services are commissioned and delivered in the area; and

4) To identify key priorities for health and local government commissioning and develop clear plans for how commissioners can make best use of their combined resources to improve local health and wellbeing outcomes in the short, medium and long term.

RESOLVED: That the Operating Principles be adopted. D Johnson

HWB5 STRUCTURES

The Board considered a document which outlined the current organisation structure of the Halton Strategic Partnership and the proposed structure of the Health and Wellbeing Board (HWB).

The current structure of the Strategic Partnership Board showed linkages to Halton's existing Locality Area Forums. The Board discussed how their involvement in the health agenda could be enhanced.

The proposed structure of the HWB included three sub groups which were intended to be the vehicle for development of the work to be presented to the main Shadow Board. The three sub groups would be :-

- Health Strategy Group
- Commissioning Sub Group
- Public Health Commissioning Sub Group
- Executive Officer Group

D Johnson

RESOLVED That the proposed structure for the Shadow Health and Wellbeing Board be agreed.

HWB6 REFRESH OF JOINT STRATEGIC NEEDS ASSESSMENT

Dympna Edwards provided an update on the Joint

Strategic Needs Assessment (JSNA) Executive Summary 2010/11.

The JSNA was a means by which the Primary Care Trusts and Local Authorities described the future of health and wellbeing needs of the local populations and the strategic direction of service delivery to meet those needs.

It was noted that the JSNA would be used to inform commissioning decisions and be the main evidence driver for the Health and Wellbeing Board (HWB) which would operate in Halton. Using the findings of the JSNA, a high level strategy would be developed as part of the new responsibility of the HWB.

RESOLVED: That the report be noted.

HWB7 KEY REPORTS

The Board received a verbal report from the Strategic Director, Communities, which explained the linkages between a number of statutory reports and the work of the Shadow Health and Wellbeing Board.

RESOLVED: That the Shadow Board receive a brief overview presentation of the following plans at the next meeting:

- Adults
- Children and Young People
- Clinical Commissioning Group
- Hospital and Community Trusts
- 5 Borough Service Providers
- LiNKS

HWB8 HEALTH AND WELLBEING STRATEGY

The Board considered a report of the Strategic Director, Communities, on the requirement of the Health and Wellbeing Board (HWB) to produce a local HWB Strategy.

The report outlined the functions of HWB's, the requirements to produce a strategy as part of its statutory responsibilities, the relationship between the Strategy and Section 75 arrangements, the co-production of the strategy and the gathering of views from the partner agencies, and the scoping exercise for the HWB strategy.It was agreed that a weighting system was required to determine the

priorities.

RESOLVED: That the report be noted and a further detailed report be presented to the next meeting. | D Edwards

HWB9 HEALTH ACTION ZONES

The Board considered a report of the Strategic Director, Communities which advised on the outcomes of the Health Summit in June 2011.

The Board noted that implementing changes outlined in the NHS proposals would mean greater integration with the Council, taking greater responsibility for health improvement, well-being and associated public health services in Halton.

One of the key ideas arising from the health summit was the proposal to establish 7 health zones in Halton, to mirror the existing Area Forum boundaries. Each zone would adopt a healthy lifestyle approach and encourage local businesses, schools, colleges, GP Practices, restaurants and takeaways to apply the relevant standards to become part of the zone.

In addition, the Board considered the possibility of developing a fully integrated, scaled up and systematic wellness model, in line with the Marmott Review and the NST for Health Inequalities. A diagram of this was attached at Appendix 3.

RESOLVED: That the areas detailed in Appendix 2 be agreed and re-named Healthy Lifestyle Zones. | D Johnson

HWB10 COMMUNICATION AND MARKETING

The Board considered the need for a communications strategy, which embraced a number of methods of communication both for GP's and external users. Members viewed an e-portal system demonstrated by Simon Riley and Emma Danton form Halton's ICT Service.

Board members were encouraged to submit comments or suggestions on how they would like the website to be developed, to the project co-ordinator, Emma Danton by email : emma.danton@halton.gov.uk.

RESOLVED: That the presentation be noted and work on a communications strategy be commenced. D Johnson

HWB11 NEXT STEPS

David Parr outlined the next steps for the Shadow Board from the actions arising at the meeting. These were agreed as:-

- Agree to review membership of the Board at regular intervals
- Identify Lead Officers, membership and workloads for the Health Strategy Group, the Commissioning Sub Group and the Public Health Commissioning Sub Group
- Review the JSNA strategy and decide on priorities
- Develop a communications strategy and develop an e-portal facility
- Presentations on partnership plans to be prepared for the next meeting (maximum of 5 minutes)
- A note of this meeting to be made available on the e-portal and shared by email to all members
- The Healthy Lifestyle Zones be developed and shared with GP's and the Local Authority

HWB12 DATE AND TIME OF NEXT MEETING

Board Members agreed that it would be appropriate to convene monthly meetings of the Shadow Board rather than quarterly meetings, the first meeting to commence on 22 February 2012.

RESOLVED: that the following meeting dates for 2012 be confirmed at 2.00pm in the Karalius Suite, Halton Stadium, Widnes:

22 February
21 March
25 April
23 May
20June
18 July
12 September
10 October
14 November
12 December

Meeting ended at 11.00 a.m.

REPORT TO: Health Policy & Performance Board (HPPB)

DATE: 10 January 2012

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults

SUBJECT: Warrington & Halton Hospitals NHS Foundation Trust

WARD(S): Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To receive a presentation from Mel Pickup, Chief Executive of Warrington & Halton Hospitals NHS Foundation Trust.

2.0 **RECOMMENDATION: That the Board note content of the presentation**

3.0 **SUPPORTING INFORMATION**

3.1 Warrington and Halton Hospitals NHS Foundation Trust manages Warrington Hospital and Halton General Hospital. There vision is ***'High Quality, Safe Healthcare'*** and their staff work together to provide high quality, safe health care services across the towns of Warrington, Runcorn, Widnes and the surrounding areas.

They are responsible for a budget of around £200 million each year, manage over 4,100 staff and provide access to care for over 500,000 patients.

3.2 A number of developments have been made recently within the Hospitals which will be on particular interest to Members of the Board.

4.0 **POLICY IMPLICATIONS**

4.1 None identified at this stage.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None identified at this stage.

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**

All issues outlined in the presentation will focus directly on 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 at this stage

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 Any services provided which seek to address the health needs of the residents of Halton needs to be fully accessible.

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

None under the meaning of the Act.

REPORT TO: Health Policy & Performance Board

DATE: 10 January 2012

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults

SUBJECT: Adult Social Care Annual Report

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Board with the first Adult Social Care Annual Report (Local Account). The report is included as Appendix 1 to this report, with a proposed communication schedule shown in Appendix 2.

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

3.0 **BACKGROUND**

3.1 In past years all Local Authorities had a duty to report Adult Social Care performance to the Care Quality Commission (CQC) on an annual basis. The annual performance assessment consisted of both performance data and a contextual document which centred on seven outcome areas – detailing achievements in the current year and priorities for the forthcoming year.

3.2 CQC's focus has recently shifted to an increasingly regulatory role. In light of this, the role of the Department of Health (DoH) has strengthened in relation to the performance management of Councils.

3.3 To replace the CQC annual performance assessment, the DoH now requires Councils to produce a 'Local Account' which reflects annual performance in Adult Social Care, where local residents are the audience, as opposed to a regulatory body. This represents a shift in terms of accountability whereby Councils will become increasingly accountable to their local population, rather than to Central Government.

3.4 The 'Local Account'(Appendix 1) includes the following sections:

- Introduction
- What is Adult Social Care?
- Equality & Diversity

- Fair Access to Care Services (FACS)
- Adult Social Care and Personalisation
- Safeguarding Adults
- Examples of the type of Adult Social Services that Halton Borough Council Provide
- Paying towards the cost of your care services
- Adult Social Care Expenditure
- Priorities for Adult Social Care over the next twelve months
- How does your local Councillor contribute to the Adult Social Care Agenda?
- Your Views are Important
- Compliments & Complaints
- Contact Us
- Feedback

3.5 **Publishing and Communications**

Marketing and Communications Team have worked along side Policy and Performance Officers to make the report more accessible to the general public, as a statement of where the Council sees its services, welcoming the general publics' perspective.

It is proposed that the Local Account be published as a Web-accessible document on the Halton Borough Council website. A proposed communications schedule has been developed to publicise the Local Account. This is provided at Appendix 2.

3.6 **The Name for the Local Account**

In order to reduce the possibility for confusion, it was agreed that the 'Local Account' be named as the 'Adult Social Care Annual Report'. This follows discussions with other Local Authorities who have steered away from naming the document as a 'Local Account', in case the intended audience may not know what a 'Local Account' is. It is perceived that 'Adult Social Care Annual Report' may be more self-explanatory.

4.0 **POLICY IMPLICATIONS**

4.1 Local accounts were mentioned in the Department of Health's 'Transparency in Outcomes: a framework for adult social care' consultation paper (November 2010, section 4) in the context of localism and transparency and in the subsequent 2011/12 outcomes framework published in March 2011.

4.2 Responses from the Adult Social Care Sector to the Local Government Group consultation on 'Taking the Lead: Self Regulation and Improvement in Local Government' also included many positive responses to the wider use of self assessment as a tool for improvement and local accountability.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 It is proposed that costs will be minimised by publishing the Local account on the Council's website. Other North West Councils surveyed have adopted a similar approach.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The Adult Social Care Annual report can be read alongside the Children's and Young Peoples Plan, demonstrating and describing performance in social care to local people.

6.2 Employment, Learning & Skills in Halton

Employment support activities to help people prepare for and find the right kind of employment are included on page 11 of Appendix 1.

6.3 A Healthy Halton

The Local Account is intended to generate awareness of Adult Social Care in the Borough. It is intended that promoting the work of Adult Social Care to the general population may offer residents an opportunity to access the necessary support available to improve their health and wellbeing.

6.4 A Safer Halton

The report also raises awareness that Safeguarding is everybody's business with communities playing a part in preventing, detecting and reporting neglect and abuse (pages 5 & 6 of Appendix 1).

6.5 Environment & Regeneration in Halton

Services provided by the Council in respect of Housing and Homelessness are included on page 7 of the Appendix 1.

7.0 RISK ANALYSIS

7.1 Failure to produce a Local Account for Halton may be perceived negatively by the Department of Health in terms of sharing learning and best practice. However, Councils are no longer mandated by Government and are able to exercise local discretion regarding how and when the Local Account is published.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The Local Account will meet Council requirements in association

with the local equality and diversity policy.

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

None identified under the meaning of the Act.

HALTON
BOROUGH COUNCIL

Annual Report 2011
Adult Social Care in Halton

www.halton.gov.uk

Annual Report 2011
Adult Social Care in Halton

Contents

Introduction

Welcome to the first Annual Report on Adult Social Care for Halton residents.

At Halton Borough Council, we have a responsibility to support, care for and protect the most vulnerable people in the community, as well as providing information and support to the residents of Halton.

Halton's vision for Adult Social Care is:

"To promote effective, affordable, quality services that are accessible, equitable, timely and responsive and to enable individuals and groups in Halton to make informed choices."

Delivering this vision will mean people in Halton;

- live independently and safely.
- have as much choice and control over their lives as possible.
- live in their own home if they wish, or other accommodation of their choice.
- find out about information, services and support available and how to access them.
- get the support they need in local and community settings.
- remain safe from abuse.

We continue to be really proud of the progress and achievements made by Halton Adult Social Care Services over the last few years, with the robust support of elected councillors, staff, the wider Council and our partner organisations, such as the National Health Service.

Dwayne Johnson
Strategic Director
Communities

Annual Report 2011
Adult Social Care in Halton

What is Adult Social Care?

Adult Social Care offers support to people in a wide range of circumstances. Everyone can get information and advice from us, and many people receive further help. Most of the support we give is aimed at enabling people to maintain their independence, in their own home in their local community for example via Home Care, Meals on Wheels, Day Care Services, Residential and Nursing Care etc.

Adult social care is committed to helping all vulnerable adults. These would include:

- people with long term conditions e.g. People with Dementia, mobility issues etc
- people with learning disabilities
- carers
- people with alcohol and drug problems
- people with mental health problems

Facts & Figures

As at March 2011 there were almost 5000 people receiving Domiciliary Care Services, Residential Care Services and Nursing Services.

Debbie O'Connor, Adult Placement Carer with Marjorie.

My Life

'My Life' is a website where you can easily find lots of information about Adult Social Care Support and Services to help you get on with your life and keep your independence. My Life is a useful information source and is aimed at those who know nothing about Adult Social Care, to those who may use our services and want to find out more.

Equality and Diversity in Halton

In Halton we ensure that in providing services to the community no individual, or group of individuals, will be treated any less favourably as a result of their personal circumstances and status. Elected Councillors and Council Officers work together with our partners to ensure that equality, diversity, and the cohesion of our community remain at the heart of everything that we do.

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Fair Access to Care Services (FACS)

The principle behind FACS is that there should be one single process to determine eligibility for social care support, based on risks to an individual's independence over time. Halton's Eligibility criteria is built on the principles of being non-discriminatory and being applied equally across all adult service user groups including adult carers.

Facts & Figures

In Halton, the older people age group (65+) is projected to grow by 43% from 16,900 in 2008 to 24,200 in 2023.

The ethnic composition of Halton remains predominantly white (97.5%).

Adult Social Care and Personalisation

Personalisation (sometimes referred to as Self Directed Support) describes a way of doing things whereby a person in need of social care services gets to decide themselves what support they need, who from, where and when. In Halton, all of our Adult Social Care Services are 'personalised'.

In the longer term people will be happier, healthier and have better prospects for the future if they are put in control of their own social care support.

A Supported Assessment Questionnaire (SAQ) is completed by the individual and a Care Manager, in order to identify what the individual's needs are. This is done by asking the individual about different aspects of their lives including their social activities, physical and mental wellbeing and practical aspects of daily living.

The results of the SAQ are then used to calculate a budget, which is usually the maximum amount of funding that can be made available to meet the needs of the individual.

The Care Manager and individual will then work together to write a Support Plan to show how this budget will be spent, to meet the individual's identified needs.

Safeguarding Adults

We believe that safeguarding is everybody's business with communities playing a part in preventing, detecting and reporting neglect and abuse. Measures are in place locally to protect those least able to protect themselves. Safeguards against poor practice, harm and abuse are an integral part of care and support.

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During September 2010, the Care Quality Commission carried out a Safeguarding Inspection and concluded that Halton is performing excellently in safeguarding adults and in supporting increased choice and control for older people, and performing well in supporting the improved health and wellbeing of older people.

Adult Abuse

If you, or someone you know, is being hurt, not looked after or taken advantage of, tell someone. **If abuse happens we can help you.**

It is a fact that adults do get abused and sometimes people's circumstances make them more vulnerable to abuse, e.g. frailty, illness, mental health issues or disabilities of any kind.

Vulnerable adults deserve dignity and protection from abuse.

Abuse can happen anywhere at any time and can be deliberate or unintentional, and might be as a result of negligence, ignorance or carer stress.

We have run marketing campaigns to raise awareness of adult abuse, the different types of abuse and how to report it. The campaign included press advertising, billboards, leaflet & poster distribution and taxi adverts.

Facts & Figures

In 2010/11, Halton Borough Council dealt with over 800 referrals to Adult Social Care in relation to concerns about potential Adult abuse in Halton. All cases were investigated and appropriate action taken.

Halton Domestic Abuse Forum

Domestic Violence and Abuse

Domestic violence and abuse can be experienced regardless of race, gender, age, disability, sexuality and lifestyle. Domestic abuse is often thought to be a purely physical form of abuse, partly due to it traditionally being referred to and seen as Domestic Violence however it can take different forms such as bullying, verbal abuse, fraud etc.

Facts & Figures

There were 479 repeat incidents of Domestic Abuse reported in Halton in 2010/2011. There are a number of support services available in Halton to report Domestic Abuse and support people who have experienced Domestic Abuse.

Dignity in Care

Dignity in care is about creating a care system where there is zero tolerance of abuse and disrespect of people in care – this includes, hospitals, care homes etc. Being treated with dignity and respect is not an optional extra, but a basic human right.

If you suspect that someone you know is not being treated with dignity and respect, please contact our Customer Services by calling call us on: 0303 333 4300.

Facts & Figures

Halton has been identified (in 2011) by the Equality and Human Rights Commission as an example of best practice regarding work done around embedding a human rights based approach in all these areas dignity in care.

Examples of the type of Adult Social Services that Halton Borough Council provide

Housing / Homelessness

Halton Borough Council is no longer a property landlord of council housing following the transfer of our housing stock to Halton Housing Trust in 2005; however the Council still maintains a housing register. This is managed by Halton Housing Trust and you can contact them to add your name to the register. Other housing associations also operate in Halton. You can approach these housing associations directly to discuss adding your name to their own register.

The Council operates a Landlord Accreditation Scheme which seeks to promote high standards in the private rented sector.

The Council's Environment Team can take enforcement action against private landlords whose properties do not meet minimum standards or who attempt to harass or illegally evict their tenants.

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. 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. This service has helped to significantly reduce the number of households becoming homeless.

Facts & Figures

Halton has two Council managed caravan sites for Gypsies and Travellers, one a permanent site with 22 pitches and the other a transit site with 13 pitches. There are also two small privately run sites.

Preventing homelessness, services in action…

Client A approached the Council for assistance with their homeless situation. The quickest and most effective homeless prevention tool for this family was the Bond Guarantee Scheme. The Bond Guarantee Scheme provided the landlord with a bond and also set up direct payment of Local Housing Allowance, which helped in persuading the landlord to accept Client A despite their adverse credit history.

Client A and their family were in settled accommodation for nearly 18 months, with no issues, however a change in his circumstances affected their benefits and resulted in a shortfall in the rental payments. As the client had come through the Bond Guarantee Scheme, the landlord knew they could make contact with a designated officer within the Council at an early stage to highlight the issues.

The Council made a referral to the Council's Welfare Rights Team. They were able to work with Client A and ensure they were receiving all of the benefits they were entitled to, which in turn allowed them to get their rental payments back on track. The client and their family were therefore able to remain in the property and the tenancy is still continuing successfully to date.

Residential / Nursing Care

A care home is a place to live, where people can be cared for by trained staff day and night. It is an option that people consider because of things like: being frail or infirm; because of age; having a disability; and they find it difficult to live independently in their own home.

There are two types of care home: Residential Homes and Nursing Homes. Care Homes can be run by: voluntary organisations; private individuals; private companies and the council. All care homes are registered with, and inspected by, the Care Quality Commission to make sure minimum standards are met.

Facts & Figures

178 Halton residents aged 65 and over were living in residential or nursing care at 31st March 2011 as their normal place of residence.

Halton has the lowest number of people living in residential and nursing accommodation in the North West and is one of the lowest throughout the whole of England.

The number of individuals moving into residential or nursing care accommodation in recent years has declined due to the fact that we promote people living independently within their own homes for as long as possible. Services that we deliver to support this include Home Care; Meals on Wheels; Community Alarm; Sheltered housing; Direct Payments.

Other than residential and nursing care there are other types of supported housing as follows:

Extra Care Housing

Extra care housing is a type of sheltered housing that can offer care to support independent living whilst providing round-the-clock support and packages of care designed to meet individual needs. Extra Care Housing can also be known as very sheltered housing, assisted living, or simply as 'housing with care'. It can be ideal for people who are less able to manage on their own. Extra care housing offers people the opportunity to live in a home of their own, even when they have high level care and support needs.

Older people are increasing as a percentage of the local population and the Council has prioritised the development of Extra Care schemes to provide a greater choice of housing for people in their retirement.

Supported Housing can be available with or with out care included. Halton Supported Housing Network is run by Halton Borough Council, for adults with a learning disability to help people live in their own homes. The people who use our services are helped to access different activities, such as, theatre trips and holidays including trips abroad. We help people across Widnes and Runcorn to live in their own homes. This means that these people are able to see friends, have choices and go to the shops or bank or access leisure centres.

Support services working together…

Client B went into supported living accommodation after the culmination of a comprehensive planning process to see Client B move in to appropriate accommodation for their needs. This was an important first stepping stone from home into wider society and to secure their long term future.

The process was made smooth by the Adults with Learning Disabilities Team and the Housing Support Team.

A number of other teams and services had supported Client B over many years to get them to the point of feeling confident about moving out of home and developing their independence. These teams included Day services, Respite care services, Transport services, Community Bridge Building Team who helped Client B gain confidence and independence in using public transport, and Adult Placement services who helped Client B prepare for their move.

Home Care, Intermediate Care and Reablement

In Halton we are committed in helping people stay living safely and independently in their homes for longer, with a better quality of life. We offer a wide range of Home Care, Intermediate Care and Reablement services seven days a week, that may include support from nurses, care assistants and occupational therapists, that can offer you help and support to help you do this if this is your choice. Help is also available to people recovering from a hospital stay and needing temporary help to maintain their independence and quality of life at home.

Short term support, longer term benefit…

Client C is a 92 year old man who was independent prior to admission to hospital. Whilst in hospital Client C had exploratory surgery.

On discharge from hospital Client C was referred to the Reablement service for support in a morning with personal care, until he recovered from his operation. After 4 weeks of Reablement support, Client C no longer needed support with personal care after regaining his independence.

Regaining confidence and independence after a hospital stay, services in action…

Client D was referred to Rapid Access Rehabilitation Service (RARS) by their GP following a fall at home. An initial assessment was completed the same day by Halton Intermediate Care Assessment Team at which it was determined that Client D required further physiotherapy and Occupational Therapy input.

A set of jointly agreed and consented goals including being able to move around the home independently, getting in and out of bed and using the bathroom independently.

Close liaison and planning with Client D's family was undertaken at each stage and after a visit to Client D's home the home environment was adapted for downstairs living. Further support included a referral to community physiotherapy for ongoing therapy. Advice was also provided to the family regarding acquisition of ramp for the front door to allow access to their home.

Integrated Hospital Discharge

Most people spend a very short period of their lives in hospital; their discharge follows a fairly predictable pattern and they usually return home. However for those people already in the care system, or for those who will need ongoing support when they leave hospital, discharge processes should ensure continuity of the right care in the right place first time.

The Warrington and Halton Integrated Discharge (ID) and the Whiston ID teams operate as a single point of referral for all patients within the Hospitals, irrespective of which Borough they are resident in. The person's discharge is planned irrespective of whether it is a health or social care discharge.

Benefits of this approach to discharge include earlier engagement with patients and families to better mange need and expectations, therefore reducing delays and reduction in admissions to long term care.

Positive Behaviour Support Service (PBSS)

This is a new service which works with children and adults with learning disabilities, Autism and who display difficult or challenging behaviour. The aim of the service is to reduce such behaviours and hence improve the quality of life for individuals and their families. The PBSS play a significant role in supporting the work outlined in our own local Autism Strategy for Halton which is leading to improved services for both Adults and Children with Autism and their families.

Autism is described as a lifelong developmental disability. The Department of Health has published the first National Autism Strategy. The Strategy follows the implementation of the Autism Act 2009 which sets out a legal framework for Local Councils to drive forward the change needed to improve the lives of people with Autism.

Day Services and Employment Services

Day care is a popular service offered to people who need some help with personal or practical care and are unable to get out and about by themselves.

Day care is usually available in a resource centre, community building or a residential home and offers more support than an ordinary day centre can provide. Professional caring staff can support the person with personal care. The person will also have a hot meal and drinks during the day and a chance to socialise and to take part in a number of leisure and craft activities.

Day Care Services for Adults with Learning Disabilities

Halton Community Services (formerly known as Halton Day Services) has many projects that offer our service users with learning and physical disabilities excellent ways to develop their employment and social skills whilst having fun in the process!

The service is held over 17 venues within the borough like: Castlefields Community Centre, Grangeway Community Centre, Murdishaw Community Centre and Upton Community Centre. The service also provides a base at Bredon for people with higher support needs.

Some of the Projects you may have heard about or visited include:-

- Country Garden Catering
- Country Garden Cupcakes
- Altered Image Hair & Beauty Salon
- Coach House Crafts
- Bikes in the Park
- Norton Brewing & The Cottage Tea Room
- Refectory Café at Norton Priory
- Shopmobility

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Facts & Figures

Our Day Services have won many awards in innovation in the services we offer to Halton residents. Day services are no longer a group of people playing bingo or painting. We offer a wide range of stimulating activities which includes:

Massage, Music Therapy, Work Opportunities such as catering, craft making and our new venture hairdressing, gardening, keeping fit, football, bowling, line dancing, computing skills, shopping, to name only a few.

Other employment services

Halton Borough Council also offers a number of other employment support activities to help people prepare for and find the right kind of employment. Activities available include:

Next Step – information and advice to help individuals make the right choices about learning or work

Carers – pre employment programme to support carers with accessing employment or training.

Enterprise – Business Start up support for customers considering self employment.

In addition to the above, there are also services designed around the needs of people with disabilities or additional needs to help them prepare and find employment. These include confidence building, skills training and voluntary work.

Independent Living

People over the age of 18, who live in Halton and need practical help due to sight or hearing loss, physical or learning disabilities, frailty or illness, can have an assessment of needs through Social Services. Individuals can also access their own assessment for equipment e.g. raised toilet seats, bath boards, tap turners etc. to help out with day to day tasks via 'SmartAssist'. This is an online assessment system free to anyone living in Halton.

Individuals, their family or carers can find out about any equipment that could support living independently at home.

Halton Home Improvement and Independent Living Services are a team of Occupational Therapists and Community Care workers. Their aim is help individuals improve or maintain independence at home. They help to identify different options to help people adjust to disability or ill health. This may include adaptations to their home or the loan of specialised equipment.

Halton's Independent Living Centre is a resource centre for anyone who wants to know more about equipment for independent living. It is for people with disabilities and their carers, professionals and other organisations. The centre houses permanent displays of basic and specialist equipment that assist with independence and caring. The centre also holds regular Open Days throughout the year for equipment demonstrations. These informal open days will give the opportunity to try out equipment and discuss equipment needs with companies and manufacturers of equipment for independence.

Halton Accessible Homes Service matches the needs of disabled applicants to accessible and adapted homes available within Halton. Registered Housing Providers tell us when they have an accessible and adapted home available to rent.

Facts & Figures

Over 1,000 Minor Adaptations were provided by Halton Borough Council in 2010/11 to enable individuals to manage with every day tasks. For example by using Grab rails and hand rails to help support them around the home.

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Bridge Building

The Halton Bridge Building team work with people who have a disability and are socially isolated within their own home, also children in transition to adulthood and Carers. People are supported to have an active role in their community which improves their health and well being. Support might involve helping the person to access meaningful volunteering, education, travel training, social activities, faith and beliefs, and building up relationships with family and friends.

Bridge Building in action…

Client E was referred to the Bridge Building (BB) Team by the Adults with Learning Disabilities Team when they moved to Runcorn. Client E did not know anyone in the area and wanted to do voluntary work in a children's nursery and also some courses in the Learning Centre. Following investigations BB found a placement (initially for one day a week) for Client E and supported them initially at the beginning of their placement. Client E was also enrolled on a Literacy course in the Learning Centre.

The placement has been a success and they are now a valuable member of staff. Client E has also made new friends and attends a number of social groups in the local area.

Sure Start to Later Life

Sure Start to Later Life is an information service for the over 55s, providing a free personal, confidential information service to help people to live a happy independent life and can offer information on activities available in the local community that enable older people take an active part in their community.

Sure Start to Later Life, service in action…

Client F was referred to the Sure Start to Later Life service by AGE UK as they were becoming increasingly isolated as they were unable to get out and about easily on their own and as a result they started to feel lonely.

Through Sure Start to Later Life it was arranged for a volunteer to make regular home visits for a chat and a cup of tea and to help Client F identify what other support they might like.

The volunteer and client had common interests and Client F was pleased to have weekly visits. The volunteer helped Client F to attend a regular luncheon club and arranged transport so that they could get there, helped Client F receive a home podiatry service, referred them for a Welfare Rights benefit check to make sure that Client F was receiving everything that they were entitled to and made a referral to the Independent Living Team for help with bathing.

Client F is really happy that they get to see people and is getting out and about more.

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Carers

A Carer is someone who cares, unpaid, for a relative or friend who is unable to manage on his or her own because of illness, disability or frailty. The majority are unpaid family carers and as a result sometimes you may not see yourself as a carer. Carers can be any age and come from all walks of life and backgrounds. More women are carers than men and they are more likely than male carers to care for someone with very demanding care needs and to care for a wider range of relatives.

For 2011 Carers Week, we asked some of our carers to help raise the profile of carers by becoming Halton's 'True Face of Carers'. The campaign included featuring our carers in press advertising, videos, animated adverts across Halton.

If you would like help and support in terms of your caring situation, contact the Council on Tel: 0303 333 4300 or contact the Halton Carers Centre on Tel: 01928 580 182.

Facts & Figures

At 31st March 2011, over 1,100 Carers received a service from Halton Borough Council following a Carers Assessment undertaken by dedicated Carers Assessors.

A Carers Voice...

Client G is a carer for someone with a mental illness and as a result of their caring responsibilities developed their own health problems over a number of years due to coping without any support. Client G was put in touch with the mental health support group and met people who had similar experiences to what they had gone through. Initially Client G found it hard to communicate with people and they felt unable to express themselves.

However via the support group they found out about an art group that was being run. As a result Client G joined the art group and has now found a new lease of life. Client G felt that the friendliness and support that the group offered enabled them to rebuild their confidence and to lead conversations and not feel isolated. As a result Client G now feels more confident to offer her help and support to other carers who may be in the same situation that they were once in.

Mental Health Services

Mental health problems can be wide ranging and can include mild cases of anxiety and depression to more severe problems which can be life debilitating such as severe depression, Bi-polar Disorder, Schizophrenia and Dementia.

At Halton Borough Council, we provide Adult Social Care Services for:

- People who are experiencing moderate or severe mental health problems, who need extra help or support because of their mental health.
- Families, relatives and carers of those experiencing mental distress.
- People who need to move back into the community after a long stay in hospital.
- People who may seriously harm themselves or others as a result of their mental health problems.

If you want to speak to us or require help to apply for the services that we can offer please contact our Customer Services Team on Tel: 0151 907 8306.

Transition Services

What is Transition?

Transition refers to the process of change between being a young person to being an adult. This is a time of great change and opportunity for all young people, but it can also present challenges, particularly for young people who have social and health care needs arising from sensory and physical disabilities, long-term conditions, learning disabilities or mental health problems.

Young people with social and health care needs are likely to require support from a variety of professional organisations during the transition process and we work together in the interests of the young people and young adults and their families who need their support.

In Halton we recognise that planning for this transition needs to start early, and the planning processes will be geared to this from Year 9 at school (when the young person is about 14). Although young people officially reach adulthood at 18, we recognise that young adulthood continues to be a time of considerable change, and so transition arrangements continue until the age of 25.

Drug and Alcohol Services and Support

Individuals, families and carers who seek help from substance misuse services in Halton are often experiencing a variety of complicated and difficult challenges which are having a damaging effect on their everyday lives. To provide the range of help that people need we have a 'one stop shop' at Ashley House, Widnes. As well as drug and alcohol treatment, there is help with improving overall health, finding a job or a training course and managing debts.

Ashley House also runs a number of support groups, both for those in recovery from their addiction and Carers. Meeting other people who are experiencing situations similar to your own can often be a tremendous help.

There is no waiting list at Ashley House, so help, advice and support is provided as soon as you contact the service. The feedback on the services provided at Ashley House is also extremely positive. (www.patientopinion.org.uk)

Facts & Figures

In a typical year around 800 individuals will receive treatment for their drug or alcohol addiction. Support is also provided to over 100 Carers.

Halton Community Alarm Service (Telecare)

The service gives families and friends the peace of mind that their loved one is safe and maintains their independence by allowing them to live a full life in their own home.

The Community Alarm Service can provide equipment, which enables people to summon help in an emergency. Environmental sensors can monitor for potential floods and fire situations. Lifestyle monitoring sensors such as fall sensors and bed sensors can monitor someone in case they have a fall or do not go to bed.

When the alarms activates they send information down the telephone line. This information is then received at a control centre where the appropriate action is taken.

People choose to have Halton Community Alarm Service for different reasons. Some people live on their own and want some reassurance that if they have some difficulty, they can contact someone easily. Other people have difficulty getting around the house or have health problems. They may need to contact someone quickly if they are unwell or have an accident. Halton Community Alarm Service gives reassurance and can get practical help when it is needed.

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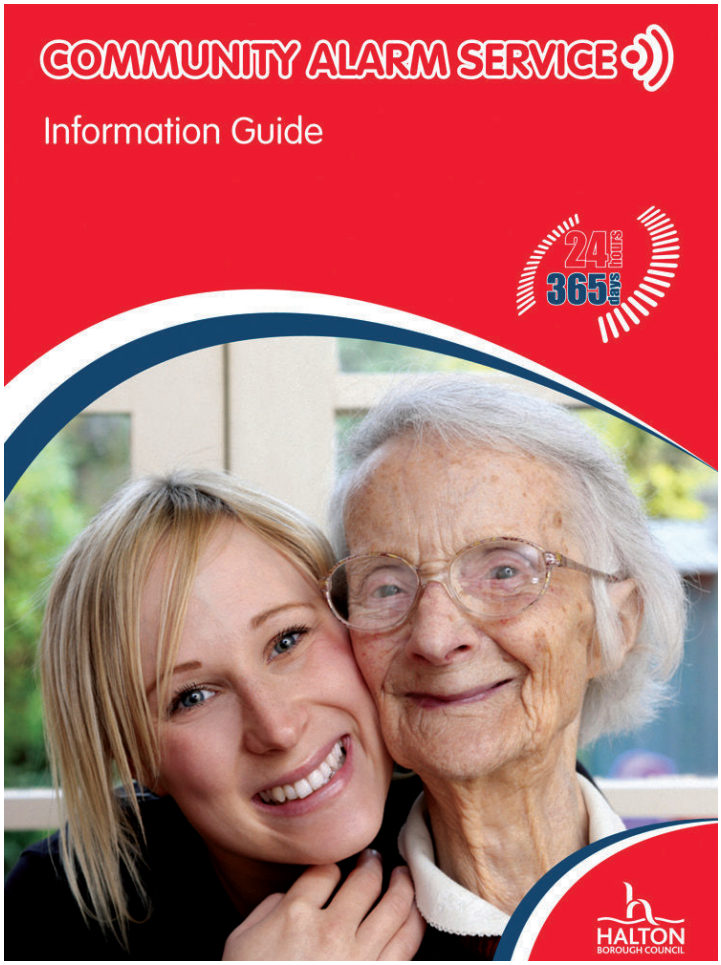
Facts & Figures

Over 1,500 individuals living in Halton have their home fitted with a Community Alarm.

The Halton Community Alarm Service (formerly Lifeline) has been granted Platinum (European Standard) status with in the Telecare Services Association. Halton Community Alarm Service is one of only seven community alarm services in the United Kingdom to be accredited to Platinum status and is testament to the excellent service provided by Halton Borough Council.



Halton Community Alarm system in action…

Client H is in their 80's and has some mobility problems which puts them at risk of falls. Client H's family do not live locally but visit often and they have lots of support from friends. Client H wants to live as independently as they can in the comfort of their own home for as long as possible. Halton Community Alarm Service allows them, and their family, that choice.

Client I is nearly 70 and has a long term condition and some mobility problems. Client I's family want them to live as independently as they can in the comfort of their own home for as long as possible. Halton Community Alarm Service allows them to offer Client I that choice.

Paying towards the cost of your care services

The Government expects people who can afford to pay towards the cost of their care package to do so. This helps to continue to provide Adult Social Care Services to the growing number of people who need them. The amount of the contribution individuals may have to pay depends on the outcome of a financial assessment, which is carried out when care services are to being put in place.

The assessment looks at the level of income, savings and expenditure that the individual has available to them. The amount they pay can be as little as no contribution - right up to the full cost for services.

As part of the financial assessment process, Halton offers all individuals the opportunity to have a Welfare Rights check carried out. This is a free and confidential service that is undertaken by qualified and experienced Welfare Rights Officers. The Officers visit individuals in their home and identify any additional benefits, allowances or payments that the individual may be entitled to receive.

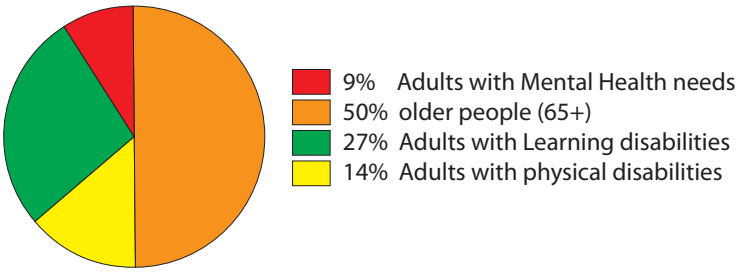
If you feel that you may be missing out on benefits and would like a Welfare Rights check then please ring the Income and Assessment Team on 01928 704592.

Facts & Figures

During 2010/11 our Welfare Rights Officers helped 143 individuals to successfully claim a total of £400,000 in previously unclaimed, additional benefits. This equates to an average of £2,700 per year in additional income for each individual identified as having missing benefits.

Adult Social Care Expenditure

In the financial year 2010/2011 we spent approximately £43 million on Adult Social Care in Halton. The breakdown of expenditure is shown in the chart below.



Priorities for Adult Social Care over the next twelve months

There are many changes and challenges facing Adult Social Care over the next 12 months and beyond.

The Council and its NHS partners will be working closely to ensure there is a smooth transition of Public Health services to the Council in 2013. The Adult Social Care department will therefore be considering opportunities to improve adult social care and health outcomes

Other developments will include:-

- Creation of a Health and Wellbeing Board - The Board will be responsible for identifying and assessing the needs of the local population.
- Development of a Halton wide Health and Wellbeing Strategy – The joint Health and Wellbeing Strategy will outline how the Council and Partners can address the key Health & Wellbeing issues in Halton.
- Joint Strategic Needs Assessment (JSNA) – To continue to update the assessment which brings together all the relevant information around health, well being and social care needs
- In 2012 plans to develop new accommodation and services will commence with a focus on adults with a disability and identifying individuals who may be able to return to Halton from currently placed outside of the Borough.
- Local Health Watch - From October 2012 HealthWatch will be the independent consumer champion for the public - locally and nationally - to promote better outcomes in health for all and in social care for adults. Locally, it will also provide information and advice to help people access and make choices about services as well as helping people to access independent complaints advocacy to support people if they need help to complain about NHS services.

Review of homelessness services

It is good practice to periodically assess the effectiveness of services provided for those who are homeless and this review is part of that process. The results will also feed into the wider strategic review of homelessness and development of the borough's next Homelessness Strategy in 2012.

Care Closer to Home

Building on the work that we undertake with regards to prevention and early intervention involving supporting people to live as independently as possible for as long as possible, the Council is committed to further develop it's services to achieve positive outcomes for the people who live in Halton and need Adult Social Care support.

Safeguarding & Dignity

Keeping people safe and ensuring that they are treated with respect and dignity are high priorities for Halton Borough Council. We will continue to build on the excellent results achieved in the Safeguarding Inspection to ensure Safeguarding and Dignity are central to the work that we do in Adult Social Care.

How does your local Councillor contribute to the Adult Social Care Agenda?

Councillors have an important role in contributing to Adult Social Care Services by representing local people's views and making decisions about what services the Council provides. For Adult Social Care, we have a lead Councillor – Marie Wright, whose role it is to ensure that services reflect the needs of local people. Details of which Councillor represents your area and how to contact them can be found on the Halton Borough Council Web site.

Your views are important

We need to hear your views to make sure that we deliver the right services needed for you, or the person you care for. Only when we hear your views can we make changes to improve your care services.

One of the ways we ask you about your experience of adult social care, is through questionnaires. You may have been asked to get involved in letting us know what you think.

Here are some examples of the questionnaires we send out to Halton residents.

- **Adult Social Care Survey**
  The aim of the survey is find out about your experience of Adult Social Care. We do this every year between January and March. From the survey undertaken during 2010/11, 46% of individuals responded. 93% of people were satisfied with the care and support services they receive. 92% of people reported feeling safe.

- **Safeguarding Survey**
  The aim of the survey is to examine the way in which a number of cases of alleged abuse are dealt with using our procedures to learn if we can do anything better.

- **Home Care Survey**
  This survey seeks to find out how well our home care services meet your needs and where we can improve the services we provide including the quality of care you receive from carers who come to your home to care for you.

- **Minor / Major Adaptations**
  This consultation is for individuals living at home who have had minor or major adaptations to their property. The consultation is taking place between 1st January 2011 and 31st March 2012.

Consultation Database
Details of all consultations that Halton Borough Council undertakes are recorded on a consultation database which can be accessed on the Council web site. So, if you have received a questionnaire and want to find out more, you can find out online.

User Involvement Groups and Forums
Halton Borough Council sees that it is very important that individuals who use our services are able to join groups and forums that are designed to enable you to get more involved in the way we deliver services locally. We have many involvement groups including the Carers Reference Group, OPEN (Older People's Empowerment Network), the Learning Disability Partnership, Drug and Alcohol Service User Group and the Mental Health Local Implementation Team. If you would like to get involved, then get in touch.

Halton Local Involvement Network (LINk)
Did you know that if you have an opinion on how things could be improved in local social care and health services you can also contact your local LINk? The Halton Local Involvement Network (LINk) is open to everyone living or working in Halton or anyone who makes use of local

health or social care services. The Halton LINk provides everyone in the community – from individuals to voluntary groups – with the chance to say what they think about local health and social care services – what is working and what is not. Halton LINk gives people the chance to influence how services are planned and run, through providing feedback about what people have said so that things can be improved. The Halton LINk independently operates from the Council and has a role in challenging the Council and NHS services to improve services provided in the local area.

Compliments and Complaints

In Halton, where people receive social care support to help them, we always try to make sure that it is what suits them best, to help them to live their lives. Sometimes things can go wrong and that's where Halton's new 'Help Us Help You' service comes in.

Where people do have concerns, it's often best to raise them as early as possible, usually with whoever is providing the support, so things can be put right. However, we do understand that sometimes people may find that hard, particularly where they are vulnerable and rely on the support they receive.

'Help Us Help You' enables you to speak to us about any concerns that you have about services provided or arranged by the Council, for you or someone you know. We will help you to get your concerns sorted out as informally or formally as you want, ranging from a 'quiet word' to a formal complaint.

'Help Us Help You' is also about us learning; and finding out what works well is just as important, so please do tell us what works well for you. That way we can help develop services to reflect what people want and need.

If you prefer, for matters concerning Adult Social Care, you can contact the Social Care Customer Care Team direct on: Tel: 01928 704411 Text 07775 765489 e-mail: ssdcomplaints@halton.gov.uk.

Help Us Help You

0303 333 4300

HDL, Municipal Building, Kingsway, Widnes WA8 7QF

hdl@halton.gov.uk

www.halton.gov.uk/contact

FEEDBACK

What do you think of this report?

As this is the first report for Adult Social Care we have produced for Halton, we want to know what you think of it. We would appreciate it if you could complete and return the slip below.

Was the amount of information right?

Too much ☐ Not enough ☐ Just Right ☐

How easy was it to understand?

Very easy ☐ Fairly easy ☐ Too Difficult ☐

Is there anything extra we should include? Please give details below

.....
.....
.....
.....

Other Comments…

Return to:

Lead Policy Officer, Policy & Resources Directorate,
Runcorn Town Hall, Heath Road, Runcorn, Cheshire, WA7 5TD

Contact Us

Throughout this report, we have given you direct contact details which may help you to speak the right person you may need to speak to. Also in this section are some useful contact details. You may choose to use our website, ring our dedicated Social Care telephone line, or call into one of our Halton Direct Link 'one-stop shops' and speak directly to one of our staff.

Website: www.halton.gov.uk

Telephone: 0151 907 8306

(Halton Adult Social Care 24 hours)

One-Stop Shops:
Runcorn Direct Link
Church Street
Runcorn
Cheshire
WA7 1LX
0151 907 8300

Halton Lea Direct Link
Concourse Level
Rutland House
Halton Lea
Runcorn
WA7 2ES
0151 907 8300

Widnes Direct Link
7 Brook Street
Widnes
Cheshire
WA8 6NB
0151 907 8300

Ditton Direct Link
Queens Avenue
Ditton
Widnes
Cheshire
WA8 8HR
0151 907 8300

PROPOSED COMMUNICATIONS SCHEDULE **APPENDIX 2**

Publicity Activity					
Area of Activity: (press; internal communications; digital; design; print; advertising etc)	**Description of activity**	**Progress**	**Outline of responsibilities**	**Key milestones and deadlines**	**Completed (date)**
Website	Create short url for report		J MacQuire / Paul Martin	December 2012	
PR	Press release to publicise report & promote website address		J MacQuire / Press Team	January 2012	
PR	Circulate Press release to all partners, Police, NHS, Housing etc. for inclusion on intranets, newsletters, notice boards etc.		J MacQuire / Press Team	January 2012	
Website	Press release news story on Internet homepage		J MacQuire / Paul Martin	January 2012	
Advertising	Display screen advert on Halton Direct Link screens		J MacQuire	January 2012	
Advertising	Display screen advert on Halton Library screens		J MacQuire	January 2012	
Internal Communication	Press release news story on Intranet homepage		J MacQuire	January 2012	
Internal Communication	Article in Team Brief, Leaders Newsletter, Information Bulletin		J MacQuire	January 2012	
Internal Communication	Article in InTouch staff magazine		J MacQuire	February 2012 edition	
Advertising	Article and in Inside Halton Magazine		J MacQuire	March 2012 edition	

REPORT TO: Health Policy & Performance Board

DATE: 10 January 2012

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults

SUBJECT: Re-design of the Adult Acute Care Pathway and the Later Life and Memory Services.

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform members of the Health Policy and Performance Board of the 5 Boroughs Partnership NHS Foundation Trust proposals to re-design the Adult Acute Care Pathway and the Later Life and Memory services for older people.

2.0 **RECOMMENDATION: That the Board note the content of the reports.**

3.0 **BACKGROUND**

3.1 During 2010/2011, 5 Boroughs Partnership NHS Foundation Trust, with the support of Commissioners, has examined the Acute Care Pathway. This process has been led in its initial stages by an expert group of 5 Boroughs clinicians and senior managers, mental health commissioners, social care leads and the GP Clinical Lead for Mental Health. This group reviewed current service configuration, utilisation, care pathways, service pressures and other demands to inform potential adjustments to care pathways across adult and older people services. The intention is to enable improvements in access, quality of care, recovery rates and increased avoidance of acute care bed use and out of area treatments.

3.2 The Acute Care Pathway re-design relates to adult mental health services only. It will include services for older people with functional illness who access adult services, but does not include services for older people with organic and frail elderly people with mental illness.

3.3 The consultation document 'Proposal for a New Model of Care – Adult Acute Care Pathway' sets out the drivers for change. Key amongst these are:

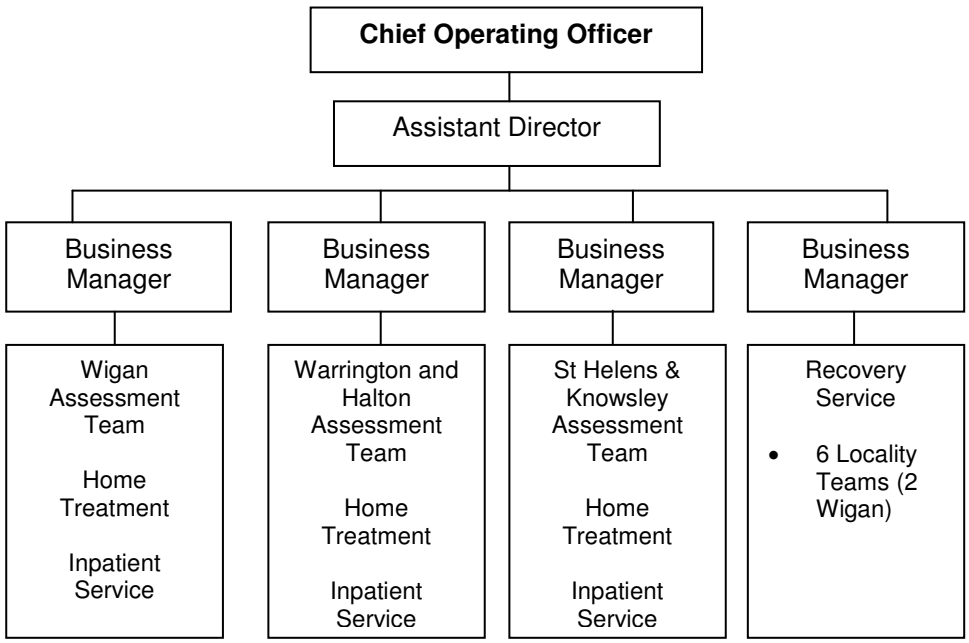
- Service user concerns and complaints regarding their transfer between the often confusing range of existing community

services
- Concerns regarding consistency and effectiveness of carer support
- GP concerns regarding the Trust's effective management of GP referrals
- Differing configuration and scale of Local Authority and Primary Care Services

3.4 Re-design of services is expected to address these issues and in so doing should maximise the impact of evidence based clinical practice, improve access and assessment, increase the number of people receiving treatment at home, decrease the number of inpatient admissions and reduce length of stay, reduce the number of teams, minimise waits and reduce the transactional burden of moving from team to team.

3.5 By re-designing acute care for adults and older people, there is potential for a reduction in the need for beds across the 5 Boroughs Partnership localities. This may result in a need for estate rationalisation – that is, current in patient beds and office locations.

3.6 The proposals, if agreed will lead to a joint Warrington and Halton Assessment Team and Home Treatment, alongside six Recovery Services, as shown below:



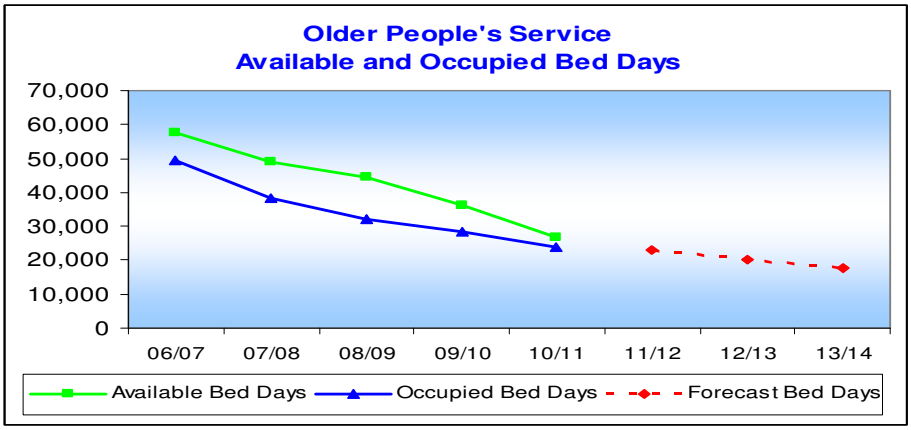
3.7 The ambition of the model is to further promote community interventions and reduce reliance on inpatient services.

3.8 The Later Life and Memory Service re-design relates to older adults mental health services. The model includes a proposal to develop a single point of access, which will provide cognitive and functional screening for patients. It is envisaged that this function will

considerably reduce the waiting time from referral to service delivery and greatly improve patient experience.

3.8.1 The model aims to give increased integration between inpatients and community services through Crisis Intervention, specialist Old Age mental health services and a dedicated Community Mental Health Service to deliver person-centred interventions and care on the basis of need.

3.8.2 The model describes the current service provision in terms of available and occupied days across the four boroughs. Occupied bed days for older people's services have fallen from 49,505 in 2006/07 to 23,952 (year end forecast) in 2010/11, which represents a 51.6% reduction. During the same period commissioned beds fell by 39.8%.



3.8.3 The model makes further assumptions that the occupied bed days rate will continue to fall over the next five years and that would mean a furter reduction in the amount of beds and an increasing reliance on quality community services, this is at the centre of the model and how it will shift service provision in the future.

3.8.4 The proposals were discussed by 5 Boroughs Partnership NHS Foundation Trust, with the support of Commissioners. This process has been led in its initial stages by an expert group of 5 Boroughs clinicians and senior managers, mental health commissioners, social care leads and the GP Clinical Lead for Mental Health.

It was agreed that there was still some additional evidence required to support the model's assertion that Community services will be of sufficient quality to deliver the required levels at the same time as reducing the bed levels. Therefore 5Boroughs Partnership will be carrying out a pilot of the changes in Wigan starting in January 2012.

3.9 **Implications for Halton**

3.9.1 The Brooker Centre currently provides inpatient services for the people of Halton, as such this has proven a valuable resource and

also has 10 beds for Older People, it is not clear what the future of the Brooker Centre is and this will need clarification.

3.9.2 The proposal to create a combined Warrington and Halton Assessment and Home Treatment Teams also requires further examination. This is because it is not clear from the proposals what will be the impact upon the existing community mental health teams in Runcorn and Widnes. It should also be noted that there is a separate piece of work being undertaken on the Care Pathway for people with dementia and frail elderley with mental health problems, The document 'Building on Strengths' (August 2011) sets out proposals. The potential overlays between this set of proposals and those related to the **Acute Care Pathway** will need clarification.

3.9.3 The pilot of the **Later Life and Memory Services** project will mean that no re-design in Halton will be implemented until the evaluation of the pilot (expected by October 2012). The pilot will ensure that the model can be fully and robustly be tested, however the delay in delivery locally is not helpful for current service provision.

3.10 **Next Steps**

3.10.1 Local discussions will now take place between the 5 Boroughs Partnership and HBC lead officers. This will provide the opportunity for detailed discussion on the proposals for the **Acute Care Pathway** and the **Later Life and Memory services**. This will provide the basis for further scrutiny by the Health PPB in March 2012.

4.0 POLICY IMPLICATIONS

4.1 A range of policies and procedures associated with the **Acute Care Pathway** and the **Later Life and Memory Services** may need to be reviewed in conjunction with the 5 Boroughs Partnership. Further advice (e.g. form legal services) on this will be sought as the programme progresses.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The financial implications of the proposals are, as yet, unknown.

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 effective **Acute Care Pathway** and **Later Life and Memory services** will lead to adults and older people receiving the most appropriate and effective services.

6.4 **A Safer Halton**

Creating safer and strong communities has a direct impact on improving the health and wellbeing of local people.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

As part of the re-design of the **Acute Care Pathway** and **Later Life and Memory Services** an appropriate risk register will be completed along with associated risk control measures to ensure that any identified risks as part of the project are mitigated.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 It is essential that the Council addresses issues of equality, in particular those regarding age, disability, gender, sexuality, race, culture and religious belief, when considering its polices and plans.

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

Document	**Place of Inspection**	**Contact Officer**
Proposal for a New Model of Care (26 Sept 2011) – 5 Boroughs Partnership	2nd Floor, Runcorn Town Hall	Paul McWade

5 Boroughs Partnership NHS
NHS Foundation Trust

Proposal for a New Model of Care

Adult Acute Care Pathway

4th November 2011

A Better View

Contents

Executive Summary

This model outlines proposals to qualitatively change the nature and balance of service provision by 5 Boroughs Partnership NHS Foundation Trust (hereafter called 'The Trust') and its partners for people having their mental health needs met within the Adults Business Stream.

A new and robust model of care is proposed, that will enable the modernisation of services, focussing upon improving access to assessment, diagnosis and evidenced based treatment whilst streamlining the patient journey through services, offering more effective early intervention and home/community based support and treatment. Working closely with local authority partners mental health services are envisaged to continue to be provided on a partnership basis.

Trust strategic objectives emphasise that recovery focused mental health services require statutory and voluntary agencies to work together and closely with service users, carers and families to ensure that services are needs-led, local, accessible and well resourced.

In accordance with National drivers, the model aims to concentrate on improving productivity and eliminating duplication whilst focusing on clinical quality (DoH 2010a). This proposal offers the development of services within existing financial frameworks and expectations. We aim to deliver in partnership a comprehensive, evidence based Adults Mental Health specialist model (DoH 2008). This will encompass core functions to deliver a high quality rapid response, evidence based, collaborative needs led care service for adults.

The model includes a proposal to provide an enhanced assessment service that will provide three teams that will directly support GP practices and the 3 local acute Trusts within the footprint of the Trust up to 24 hrs per day.

1 The increased capacity and skill-set of the service will ensure that adults requiring assessment will be subject to only one comprehensive assessment, wherever or whenever that assessment is required. The new service offers greater efficiencies' of working compared to the existing differing teams, duplicated interventions and assessments. This will support increased contract activity at key parts of the care pathway, enabling effective navigation.

2 The new enhanced assessment service would also be able to offer a model of consultation and liaison at the interface between primary and specialist mental health care

3 The model proposes a dedicated and focussed home treatment service that will work closely with existing adult inpatient services to increase the effective capacity of the treatment team to

avoid hospital admission and facilitate early discharge wherever possible. This will provide greater integration between inpatients and community services

4 It is proposed to consolidate the functions of the range of separate community teams into an integrated local service that can offer a focus of support and recovery to the local community. The Trust currently has over 70 teams across various localities and opportunity exists to offer increased co-ordination of the various functions to increase clinical activity and efficiencies.

5 The model encompasses a dedicated community Mental health service to deliver person-centred interventions and care on the basis of need not age, in accordance with the Department of Health's four priority areas (DOH 2010b). These are an integral part of improving the care and experience of service users and carers.

Building on current partnership working with statutory and voluntary sector organisations will enable the provision of additional support on a range of areas including accommodation, welfare benefits, advocacy, carer assessment. Thus supporting and promoting the personalisation agenda.

The model is designed to improve productivity by simplifying the assessment and treatment pathway, whist offering a focus for recovery thereby creating the capacity to meet increased demand for the services.

This model of care will, if successful reduce in patient activity, however there will be no agreed plans to reconfigure the inpatient estate until the model has been fully implemented and evaluated, then any emerging plans would be subject to a separate consultation exercise.

In summary the model will deliver the following benefits:

- Increased capacity, improved skill set and increased activity
- Increased levels of consultation and liaison to support primary care
- Focussed home treatment service
- Consolidation of existing community teams
- Person centred interventions promoting personalisation

It is intended to review the improvements in community services as part of the project implementation. Local Implementation Teams are proposed for each locality that will have the responsibility to monitor and report project objectives and the baseline performance measures. Membership of the teams will include representation from all operational stakeholders. It is proposed to report progress formally to evidence progress at 6 and 12 months to facilitate stakeholder evaluation and inform next steps.

1. Introduction

Using the principles and objectives contained in recent Department of Health publications, we aim to deliver a community based service supporting to people to remain at home, whilst improving and maintaining the quality of life of service users and their carers.

The care pathway will clarify and standardise the care delivered to adults with complex functional and psychological conditions whose needs are best met by specialist health services.

The Assessment Service will deliver improved waiting times and offer more efficient diagnosis of patient needs in a wide range of accessible localities.

The dedicated Home Treatment Service will be supported by access to specialist in-patient beds in instances when the service user cannot be safely or appropriately managed safely within their local community.

Facilitated by the new Recovery Service, the model proposes a comprehensive and integrated secondary care pathway for adult mental health services that will enable the Trust and its partner agencies to deliver a comprehensive range of integrated, evidence based services in accordance with stakeholders' wishes and appropriate to meet the challenge of rapidly increasing levels of need.

If progressed, the planning assumption of the model is that it is expected to reduce the need for adult in-patient beds in the future.

The clinical model's activity testing indicates that the benefits of getting the assessment right first time and by increasing the capacity and focus of home treatment services. The benefits are projected to offer a reduced need in overall inpatient bed capacity.

The longer term aim is therefore to allow the release of resources to support the development of the quality of inpatient services with an excellent physical environment with care delivered by a specialist multi-professional team of staff.

2. Scope

The model includes the delivery of service within the geographical footprint of the five boroughs of Halton, St Helens, Knowsley, Warrington and Wigan, including services commissioned by NHS commissioning bodies within this area.

The primary focus of the model includes all services delivered to adults with complex mental health and psychological conditions whose needs are best met by specialist mental health services. The model includes older people with a functional illness whose particular needs are better met by adult mental health services. Early Intervention in Psychosis" services are considered to be examples of "best practice", with a strong evidence base and will be retained as a separate service.

3. Background

To build a healthier, more productive and fairer society in which we recognise difference, we have to build resilience, promote mental health and wellbeing, and challenge health inequalities. We need to prevent mental ill health, intervene early when it occurs, and improve the quality of life of people with mental health problems and their families. Improving assessment, treatment and recovery services will be a key part of the Trust's objectives to support the agenda of the wider health community.

The quality of mental health care has improved significantly in recent years. Skilled and committed front-line staff have developed services that are internationally recognised. Two examples are the development of Early Intervention in Psychosis teams and the Improved Access to Psychological Therapies. The development of community-based services and the widespread integration of health and social care have meant that fewer people need inpatient care and the number of inpatients taking their own life has reduced.

The Trust wish to continue and add to the improvements by developing the Acute Care Pathway and monitor the outcomes of its introduction and work alongside partner agencies to promote mental health and wellbeing. The improved assessment services will aim to prioritise early intervention for all complex mental health difficulties and incorporate mental health promotion and wellbeing.

The Acute Care Pathway aims:

- to identify mental health problems and intervene early across all age groups;
- to ensure equity of access for all groups over 18 years of age, including the most disadvantaged and excluded to

high-quality, appropriate, comprehensive services;

- to build care and support for outcomes that matter to individuals to enable them to live the lives they want to live, including good relationships, education, housing and employment;

- to offer people age and developmentally appropriate information, and a choice of high quality evidence and/or good practice based interventions, including psychological therapies for all service users.

- to ensure that all people with severe mental health problems receive high quality care and treatment in the least restrictive environment, in all settings; supporting the achievement of NICE guidance for mental health conditions.

- to work with the whole family, using whole-family assessment and support plans where appropriate

In devising the Acute Care Pathway all workers in the assessment services have been involved in setting the good practice agenda of the assessment services based on experiences and suggestion to improve existing services

The Acute Care Pathway has been developed following a series of three briefing meetings and five expert workshops with clinicians and commissioners from across the 5 Boroughs Partnership NHS Foundation Trust foot-print. The workshops used system dynamics modelling approaches to ensure any activity assumptions are resiliently tested and determined.

Furthermore through a series of briefing meetings front-line practitioners have contributed to the design, planning of the proposals of the Acute Care Pathway service proposals as they are often well placed to help GPs and local partners in commissioning high-quality services.

3.1 Current service configuration and environment

Evaluation of the Trust's current services for adults considers the impact of the previous strategic change initiative "Change for the Better" aimed to capture the expectations and configuration of the NHS plan services that were accompanied with population based activity and staffing targets. This change event excluded Ashton Wigan and Leigh PCT due to commissioning intentions at the time and did progress the Trust to add to successful achievement of DoH targets, however effective access to services remained an issue for the local health communities, particularly General Practitioners.

The challenge for the project group was of reviewing how to best manage the resources allocated to over 70 differing functions of clinical teams to ensure the attributes any new blueprint of service focussed upon the delivery of care. A number of the existing functions were nationally prescribed functions that were linked with specific investment

streams as part of the DoH Mental Health National Service Framework and associated Policy Implementation Guides. Unintended consequences created a degree of service fragmentation and overlapping of resources with resulting inefficiencies, service user and GP concerns.

Additional investments and initiatives have sought to address the issue of access with limited success. One of the key themes of the expert group involved in the development of this proposed Acute Care Pathway (ACP) recognised the importance and long term benefits of investing in the skills and capacity of any assessment service to a greater degree than previously implemented.

3.2 Current staffing skill mix

The current staffing mix has been informed by the previous change event and considerations have been given during workforce planning. Workforce considerations were to ensure that the proposed services that populate the Acute Care Pathway take full opportunities of creating teams that offer the right skills to support the patients' journey through the pathway. Views of all professional groups were solicited during the development of the teams and consensus has been reached to ensure that an appropriate balance of professionals is achieved to support the expectations of NICE guidance and whilst offering the expectation of competitiveness and efficiency that the public expect of statutory services.

Investment in Local Authority services within the localities of the Trust understandably varies in relation to local needs and priorities. The agenda of integrated working and a joint approach to patient care will be fully supported by the new teams.

Please note that the workforce details below are numbers of staff employed not whole time equivalent

Table 1 Breakdown of Adult Services Community staff

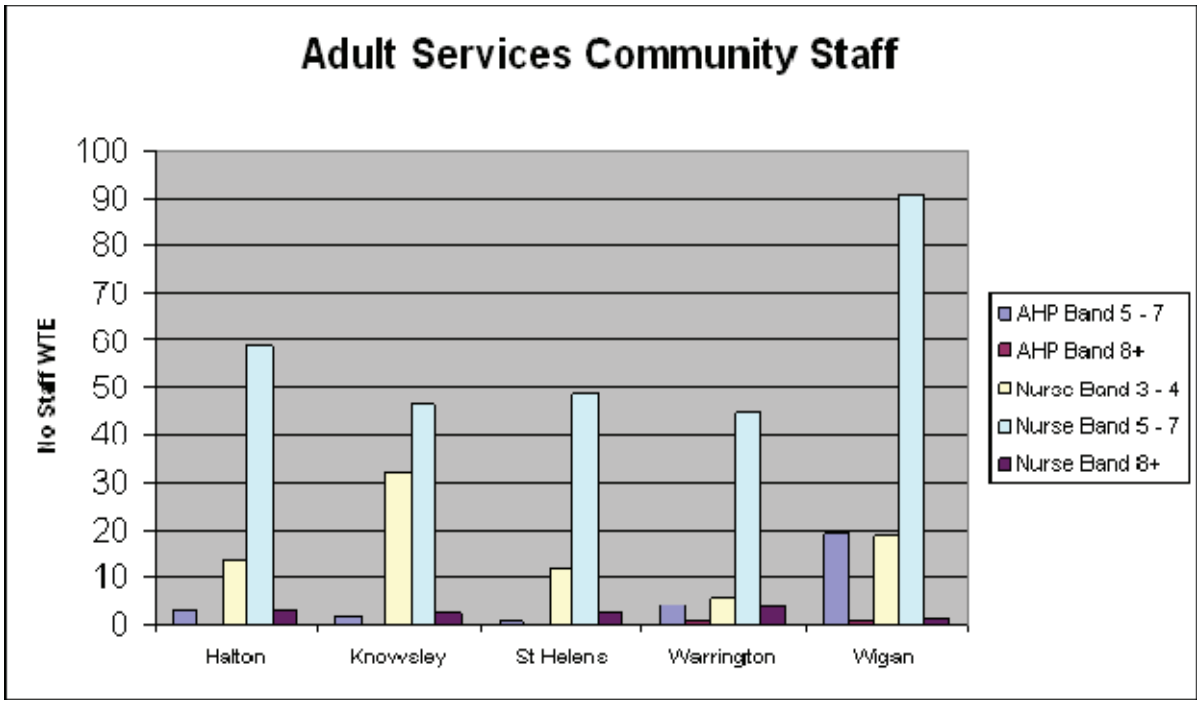


Table 1 illustrates that the majority of staff (Band 7 and below) working across community services are qualified nurses. This is followed by Nursing Assistants and Allied Health Professionals (Including Occupational Therapists and Psychologist).

Table 2 (below) illustrates that the majority of in-patient staff (Band 7 and below) working across inpatient services are qualified nurses. This is followed by Nursing Assistants. There are no practitioners working at Band 8 and above within in-patient services.

Table 2 Breakdown of Adult Services In-patient Staff

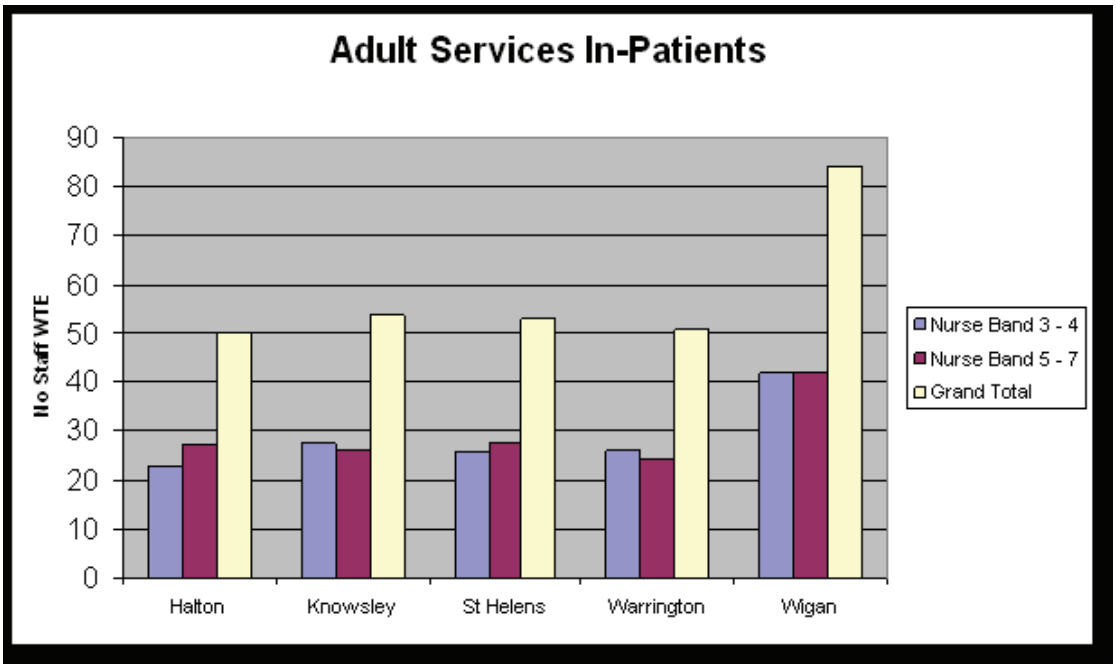
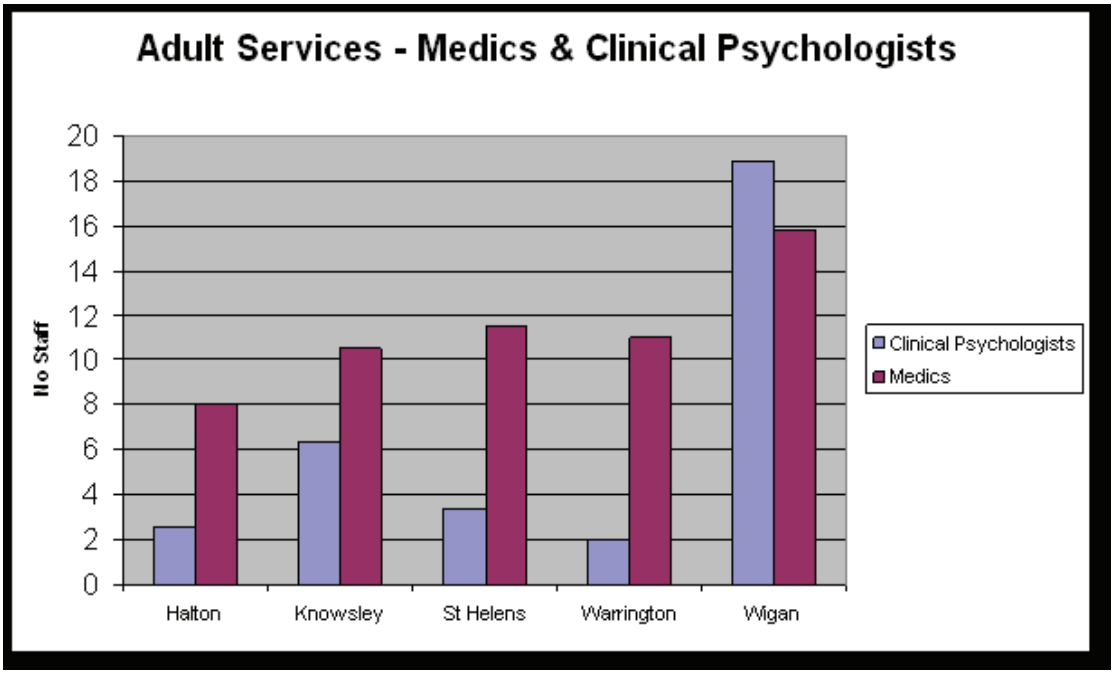


Table 3: Breakdown of Medical Staff and Clinical Psychologists working across both community and inpatient settings



There is a total of 56 Medical staff working across inpatient and community services. (Please note Warrington currently is not commissioned to provide secondary care based

psychological therapy services; St Helens and Knowsley have a psychologist based Eating Disorder Service).

Local Authority Staff

The majority of community teams are jointly delivered with local authority staff, underwritten with formal Partnership agreements with all local authorities. Discussions regarding how best to allocate local authority resources within and around the ACP will focus upon meeting the particular local community needs. We will continue to deliver services in an integrated approach with local authority colleagues and managers to ensure the model meets the needs of our service users and carers now, and in the future.

3.3 Challenges: the need for change

The drivers for change are summarised as:

1. Service User concerns and complaints regarding their transfer between the often confusing range of existing community services

2. Service User concerns regarding the timeliness, capacity, location and diagnostic accuracy of the current assessment functions of the Trust.

3. This is particularly relevant in the existing Access and Advice Service and can lead to pathway distortions and increased referral for unscheduled assessments by the existing Crisis Resolution and Home Treatment Teams

4. Concerns regarding consistency and effectiveness of carer support. Themes have presented via the Trust's complaints processes around how the Trust shares information to enable carers to support and inform care planning;

5. GP concerns regarding the Trust's effective management of GP referrals to its secondary / complex care services;

6. GP concerns regarding the Trust's capacity to deliver collaborative working practices to fully support all GP Practice patients registered on practice Severe Mental Illness (SMI) registers.

7. Differing configuration and scale of Local Authority and Primary Care Services: This can create demand issues from differing referral locations and impacts upon signposting opportunities to support people closer to their communities;

8. Concerns from front line clinicians who have expressed (St Helens Lean Business Process Review) that the effect of multiple teams, assessment, and governance processes negatively impacted upon available clinical time with patients.

9. The current absence of a "Clozapine at Home" service requires inpatient admission solely for Clozapine initiation.

10. The quality, innovation, productivity and prevention (QIPP) challenge is an opportunity to prepare the NHS to defend and promote high quality care in a tighter economic climate. We know we have one more year of guaranteed growth in 2010/11, but the NHS needs to be making efficiency savings of £15-£20 billion per year by 2013/14. Frontline NHS staff will play a crucial role in this work because they have first-hand experience and knowledge of the areas where QIPP will start to make a difference.

11. Opportunities created by the 2007 amendment of the Mental Health Act 1983 which abolished the professional role of the approved social worker and created that of the Approved Mental Health Professional.

12. This role is broadly similar to the role of the approved social worker but is distinguished in no longer being the exclusive preserve of social workers. It can be undertaken by other professionals including community psychiatric nurses, occupational therapists and psychologists.

13. In addition the Trust would like to fully explore the role of other lead professionals undertaking the role of Responsible Clinician.

14. The development of Payment by Results for mental health, work continues on developing currencies for use in the commissioning of mental health services for adults of working age and older people. The ultimate goal is the creation of a national tariff for these currencies. Any new care pathway will need to clearly articulate the interventions that are required to solicit a cluster payment.

4. National and Local Strategies and Drivers

4.1 National Policy and Guidance

There has been a growing body of policy and guidance in recent years including:

- the white paper '*Equity and Excellence: liberating the NHS*' (DOH 2010)
- the '*Revision to the Operating Framework for the NHS*' (DOH 2010)
- *Equality Act* (DOH 2010)
- *Equity and excellence: Liberating the NHS* (DoH 2010)
- '*No health without mental health: a cross-Government mental health outcomes strategy for people of all ages* (DOH 2011)
- *"The economic case for improving efficiency and quality in mental health"* (DoH 2011)
- *Talking therapies: a four year plan of action* (DoH 2011)
- *Delivering better mental health outcomes for people of all ages* (DoH 2011)
- Personalisation of Adult Social Care services
- The National Dementia Strategy (DOH 2009)
- *Early Intervention in Psychosis: Achieving Ordinary Lives* (2010)

These publications have been consistent in promoting services based on need, holistic person-centred responsive and consumer centred services. The need for a whole-systems response that integrates mental health services and actively involves service users and carers by supporting carers and supporting people in the community as far as possible.

Liberating the NHS stated that Department will "implement a set of currencies for adult mental health services for use from 2012/13" It also committed to "develop payment systems to support the commissioning of talking therapies."

The themes and recommendations implicit in these documents underpin the review of the Trust's adult service provision, and continue to shape our service redesign.

4.2 Quality Initiatives

Innovation is one of the central focuses for the Department of Health and the NHS, as demonstrated by the Quality Innovation Productivity Prevention (QIPP) programme. Organisational innovation and service redesign also have a major role in improving patient care, and lean methodologies are increasingly being adopted into the NHS, boosting efficiency and productivity.

Within the Adult Business Stream there are a number of Quality

Initiatives across the boroughs:

- Essence of Care (EOC) – Rating assessment and peer review has been undertaken across all teams / services / wards to identify areas of good practice. The new model supports the sharing of good practice across the Business Stream.

- Accreditation of Inpatient Mental Health Services (AIMs) – whilst a number of our existing wards have been successful in gaining accreditation through the Royal College of Psychiatrists' accreditation programme, a number of recommendations for further improvement remain unresolved e.g. access to therapies in the in-patient setting.

- Improving Access to Psychological Therapies in Wigan and Knowsley boroughs in Primary Care Services. In addition to successful waiting list initiatives in St Helens and Halton for Secondary Care services.

- Development of a new Personality Disorder Hub Service that works in partnership with service users. It provides expert assessments for people who may have a Personality Disorder in order to develop an appropriate care plan as soon as the person is referred to the Trust. The service also provides nationally recognised training in Personality Disorder for Trust staff, colleagues from partner organisations (such as Primary Care), service users and carers. The training is jointly provided by staff and service users who have been diagnosed with a Personality Disorder.

- Mental Health Passport, an innovative approach to the Care Programme Approach values and principles, a paper based folder that is completed in partnership with the patient during their stay as an inpatient and kept by the patient following their journey through mental health services. It has the advantages of driving up patients' engagement, but also limits duplication and provides a live experience from a patient perspective, which directly informs care planning.

- "Single Point of Access Pilot", an 18 months pilot exercise of a newly developed clinical model for Access & Advice service at Warrington, promoting prompt access to treatment ,reducing waiting times, reinforcing communication with GPs and improving patient's journey . Outcomes of this clinical initiative have offered evidence based justification for the Acute Care Pathway

- CQUINN contract activities that deliver physical health screen for some of our most vulnerable and at risk patients prescribed anti psychotic medication

4.3 Health of the Nation Outcome Scale (HoNOS) and Payment by Results (PbR)

The business stream has implemented HoNOS across community as well as inpatient services. HoNOS plus is being used as the basis for 'clustering' for Payment by Results.

The proposed new model directly relates the assessment and intervention processes to the clinical presentation of patients and their resultant PbR cluster PBR will be delivered via 21 clusters, this model of care will inform a framework of delivery in the non organic clusters (see table 5 below).

Table 5 Map of PBR Clusters

Cluster	1	Common Mental Health Problems (Low Severity)
Cluster	2	Common Mental Health Problems (Low Severity with greater need)
Cluster	3	Non-Psychotic (Moderate Severity)
Cluster	4	Non-Psychotic (Severe)
Cluster	5	Non-Psychotic Disorders (Very Severe)
Cluster	6	Non-Psychotic Disorder of Over-valued Ideas
Cluster	7	Enduring Non-Psychotic Disorders (High Disability)
Cluster	8	Non-Psychotic Chaotic and Challenging Disorders
Cluster	9	Blank cluster
Cluster	10	First Episode Psychosis
Cluster	11	Ongoing or recurrent Psychosis (Low symptoms)
Cluster	12	Ongoing or recurrent Psychosis (High Disability)
Cluster	13	Ongoing or recurrent Psychosis (High Symptoms and Disability)
Cluster	14	Psychotic Crisis
Cluster	15	Severe Psychotic Depression
Cluster	16	Dual Diagnosis
Cluster	17	Psychosis and Affective Disorder - Difficult to Engage
Cluster	18	Cognitive Impairment (low need)
Cluster	19	Cognitive Impairment or Dementia Complicated (Moderate Need)
Cluster	20	Cognitive Impairment or Dementia Complicated (High Need)
Cluster	21	Cognitive Impairment or Dementia (High Physical or Engagement)

Needs Led Care Framework

Co-ordination of care/Collaborative Care arrangements must be negotiated based upon individual service user needs. Presentation and need is likely to change, therefore ongoing review is required, this framework will offer a context to practitioners when considering clustering patients within the Assessment Service

Need 5	(Severe – High Needs) **Risk & Complex case Management Interventions** – Intensive Risk and Crisis Management/Inpatient treatment (PBR Clusters Organic 21, Functional 5,6,7,8,13,15,17)
Need 4	**(**Moderate – Severe Need**) Crisis Prevention Intervention –** Intensive home treatment, Specialised treatment, Acute hospital liaison (PBR Clusters organic 20,21 Functional 4,5,6,7,8,12,13,15,17)
Need 3	**(**Moderate Needs**) Personalised Symptoms Management Intervention –** To work with families to reduce stress, Respite care, Specialist care home clinics, Medication reviews, Family, carer and staff training (PBR Clusters organic 19 Functional 3,4,11)
Need 2	(Mild - Moderate Needs) **Early intervention & Rehabilitation Intervention –** To aid with adjustment, Diagnose, Specialist groups, Cognitive Behavioural and psychodynamic therapies, Cognitive stimulation, Anti dementia drugs, Family and carer support (PBR Clustering 18,19 Functional 2,3,4,11)
Need 1	(Mild Needs) **Self (Family) Management & Health Promotion Intervention –** To maintain health and well being, Primary healthcare In home practical social care packages, Day care, Voluntary networks (PBR Clustering organic 18 Functional 1,2)

4.4 Demographic Factors

An overview of the prevalence of mental health issues can be found below. Trends indicate to 2030 a reduction in the overall population and presentation of mental health disorders by approximately 4 percent in line with the associated population reduction. Appendix iix describes the prevalence of psychological needs that would be expected to be supported by the IAPT services within the Trust footprint. The Trust delivers IAPT services within the Wigan and Knowsley localities and it is planned that this service will offer a high degree of operationally seamless integration with the proposed secondary care pathway avoiding referral back to GPs.

The overall reductions in population demand support the consolidation of pathways and teams proposed allowing services to focus upon achieving quality outcomes.

Table 4: An Overview: Profile of population that is likely to have a mental health need.

	% males	% females
Common mental disorder	12.5	19.7
Borderline personality disorder	0.3	0.6
Antisocial personality disorder	0.6	0.1
Psychotic disorder	0.3	0.5
Two or more psychiatric disorders	6.9	7.5

Data taken from PANSI

Table 5: Breakdown of the local population and projections for 2030

	Total Population 18-64		Number with Mental Health Disorder		Number with 2 or more psychiatric disorders	
Borough	**2010**	**2030**	**2010**	**2030**	**2010**	**2030**
Halton	74,400	68,700	12,045	11,086	5,357	4,949
Knowsley	92,600	87,000	15,067	14,101	6,680	6,272
St Helens	108,600	102,500	17,555	16,494	7,831	7,373
Warrington	123,800	124,600	19,858	19,933	8,890	8,955
Wigan	190,500	184,500	30,694	29,602	13,724	13,270
Total	**589,900**	**567,300**	**95,219**	**91,216**	**42,482**	**40,819**

(Data source: POPPI 5.1; Department of Health, 2010)

Looking at this data by percentage change highlights the variances across the 5 Boroughs (see Table 6).

Table 6: Projected percentage range from 2010 to 2030

	Total Population 18-64		Number with Mental Health Disorder		Number with 2 or more psychiatric disorders	
Borough	**Change (2010-30)**	**Change in 2030**	**Change (2010-30)**	**Change in 2030**	**Change (2010-30)**	**Change in 2030**
Halton	-5,700	-7.7%	-959	-8.0%	-408	-7.6%
Knowsley	-5,600	-6.0%	-966	-6.4%	-408	-6.1%
St Helens	-6,100	-5.6%	-1,061	-6.0%	-458	-5.8%
Warrington	800	0.6%	75	0.4%	65	0.7%
Wigan	-6,000	-3.1%	-1,092	-3.6%	-454	-3.3%
Total	**-22,600**	**-3.8%**	**-4,003**	**-4.2%**	**-1,663**	**-3.9%**

(Data source: POPPI 5.1; Department of Health, 2010)

5. Performance Trends

Analysis of performance trends over recent years, along with projections for future performance supports the development of the new strategic model.

The breakdown below details the available bed days against the occupied bed days across the Trust for the past 5 years

	2006/07	2007/08	2008/09	2009/10	2010/11
Available Beds	82,075	77,976	68,888	67,924	67,100
Occupied Beds	82,857	68,349	62,611	65,233	61,736
% Occupancy	101.0%	87.7%	90.9%	96.0%	92.0%

The breakdown below details the total community plan against the actual plan for the last 3 years.

	2006/07	2007/08	2008/09	2009/10	2010/11
Number of Total Contacts	158,461	192,783	203,517	217,055	260,042
Plan Contacts			168,611	223,009	247,882
Actual V's Plan			120.7%	97.3%	104.9%

Overview of Total ACP Planned Activity compared to 11/12 Contract Activity

Trust Total Planned Activity on the ACP Model V's 11/12 contract activity

5 Boroughs Partnership NHS
NHS Foundation Trust

Indicative	Planned Activity	11/12 Contract*	% Variance	11/12 YTD Actual	11/12 Forecast**	% Variance against Planned
Assessment Service	32,860	28,895	12.07%	16,641	33283	-1.29%
Recovery Service	158,720	130,929	17.51%	75,830	151660	4.45%
Home Treatment Service	42,660	20,420	52.13%	11346	22691	46.81%

*This is based on basic realignment of the teams, please note the Crisis function which has been split based on the teams functions.
* 4897 planned contacts for Other Adult have been aligned to the Recovery Team

** Based on ytd activity April - September 2011

This overview of activity endeavours to illustrate the activity of health care funded practitioners. This table did not presume to include the activities of any of local authority professionals who currently practice with community teams as part of the Trusts current partnership agreements.

6. Proposed New Model of Service

The proposed new model reflects the Trust's Strategic Development Objectives to have; Effective and Efficient Organisations, Service Innovations and Business Development, Financial Viability, Governance and Organisational Development.

The configuration of adult services within the 5 Boroughs Partnership NHS Foundation Trust has traditionally been on a locality basis and the economies of scale that a large mental health trust may offer have not been fully explored by the provision of pan borough clinical services.

The model that the clinical stakeholders developed offers the opportunity for more consistency and robustness of service delivery than a locality based approach that is exposed to a risk of fragmentation.

Local commissioning communities have invested funding into community services however the challenge moving forward is assuring all stakeholders that available resources are delivered to ensure front line clinical services are best designed to meet the national agenda.

The clinical model offers three main community services that support people with complex mental health needs to avoid and reduce the necessity for hospital based inpatient care.

As part of the delivery of the Assessment Service, Home Treatment Service and the Recovery Service it is proposed that all 3 services will be within all 5 localities of the Trust. It is important

to emphasise that whilst St Helens / Knowsley and Warrington / Halton will share Assessment and Home Treatment teams all localities will have community clinics to ensure local delivery of services working closely with local authority resources. These joint management arrangements offer increased efficiency and the Trust currently applied this management model within its Early Intervention Teams.

Initial Service Specifications of the 3 new services have been developed and copies of the draft documents for discussion can be found in appendix xii-xiv. It is envisaged that their ongoing development will continue with partners after the TAG remit is complete.

Consideration has been given to recent guidance regarding Early Intervention Services and it is felt the provision of one Trust wide service to meet this agenda would be most appropriate and this service will remain as commissioned

The redesign of inpatient services is not proposed at this juncture until the benefits of the new Acute Care Pathway can be demonstrated following their implementation.

6.2 Assessment Service

It is proposed to replace the existing assessment arrangements with one service that offers assessments based upon the three health economy areas of Cheshire, Manchester and Merseyside. The guiding principle emphasised by the clinical staff was that all types of assessment should be managed wherever possible by the same team. The issues of differing teams conducting differing and sometimes multiple assessments was considered clinically questionable and an inappropriate use of resources by the clinical team. It is proposed to consolidate the assessment functions within Access and Advice" "Hospital Liaison" and the current Crisis Resolution teams into one coordinated assessment service that is proposed to have 24hour seven day per week accessibility. This new service would interface with all localities within the community and acute hospital environments'.

For example when a person presents themselves at the Accident and Emergency department of a local hospital this demand for service will be managed or signposted onwards to another part of the care pathway by the new Assessment Service. This will result in less duplication, delay and improved risk management.

The services increased capacity will enable not just assessment but also advice to referring agencies. Working closely with our local authority partners the ability to jointly assess offers more effective use of resources together with a more effective user experience and subsequent navigation through the services provided and available within the wider community. It is intended that the point of contact of the assessment teams is to be consistent and widely circulated. Issues in respect of the format of referral forms have been raised and it is proposed to establish a task and finish group working with

GPs' and other stakeholders to develop the format to meet service users' needs. Following assessment service users care pathway will be internal to the provider wherever possible. The benefits of one comprehensive initial assessment will negate any reason to refer back to the GP to re-refer to another part of this Trust care system.

Discussions regarding the Warrington Prison In-reach Assessment Service being within scope of the Warrington and Halton Assessment Service may offer increased efficiencies. Discussions are planned with the local PCT Commissioner to consider any benefits of this transfer of resources.

6.3 Home Treatment Service

The DoH in England has recommended Crisis Resolution and Home Treatment (CRHT) in its best practice and policy implementation guidance since 2000. In 2007 it described CRHT as a key step in implementing the mental health National Service Framework, partly to ensure inpatient care is only used where necessary. So far several studies have found a reduction on admission rates, and reduced length of inpatient stay following introduction of CRHT. However a common problem in assessing the impact of CRHT is that service development generally anticipates the introduction of CRHT teams by reducing inpatient bed numbers. The reduction in beds may have increased pressure on inpatient wards to discharge patients earlier than would previously have been the norm, resulting in a reduction in length of stay.

Differing patterns of staffing and operational policy also led to different outcomes in service. Evidence from the National Audit Office demonstrates that CRHT teams are sufficiently staffed and resourced they reduce inpatient admissions. The success of CRHT services appears to be dependent to some extent on there being medical support and full gate keeping responsibility intrinsic to the team. It has been found that if there are limited resources or if essential functions such as gate keeping are absent, the services tend to deviate from the core aims of CRHT service provision and spend more time performing assessments and providing longer-term care.

This tendency has been evidenced by Judy Harrison, when from 2008 Central Manchester home treatment service, to meet local activity targets, referral routes into CRHT were extended to include primary care, as a result the throughput more than doubling and 20% of referrals coming directly from primary care. The average duration of contact with the service fell significantly; the main interventions for those with less severe illness are assessment, support and signposting to other services.

A similar trend has been identified on 5 Boroughs Partnership NHS Foundation Trust CRHT teams with a increased focus on assessments and a diminished capacity to provide treatment for acute and severe mental illness at

home as an alternative to admission or early discharge.

The development of a revised Acute Care Pathway, aims to create a parallel to inpatient team aiming to provide to all service users a full psychiatric history, regular medical reviews, physical examination and investigations and medicines management. Interventions will offer short term supervision and support of up to 6 weeks to patients who can be safely managed outside hospital.

The new Home Treatment teams will have allocated sessions of supervision and assessment as needed from psychologist.

Psychosocial intervention will be offered as a matter of routine to reinforce the outcomes for improving mental health as a whole for our service users. The service is intended to be offered 7 days per week from 8am to 8pm.

Furthermore the care team will be on-call 24/7 out of hours to ensure consistency of care.

6.4 Recovery Service

It is proposed to consolidate the various prescribed community teams into one borough based Recovery Service which will be accessed via the Assessment Service. The Recovery Service will have a clear aim to improve the quality of life and social functioning of people with severe and enduring mental health needs. It will provide multi-disciplinary care management, support and biological, psychological and social interventions to enable people receiving our services to manage or reduce symptoms, gain insight, learn skills and participate in psychological therapy
This team will promote independence and the personalisation and personal health budgets agenda will be a key enablers in developing service user centric care packages.

Furthermore, working with commissioners and others in the development of the service specifications the Trust will agree to adopt clear outcomes measures that measure the recovery of the people we care for.

The functions of the Recovery Service will retain the skills knowledge and abilities of the Assertive Outreach, Personality Disorder, and Dual Diagnosis practitioners. The sharing of practitioner skills and knowledge of specialist practitioners will be supported by a service wide training plan as it is felt that all community team members would benefit from this knowledge sharing.

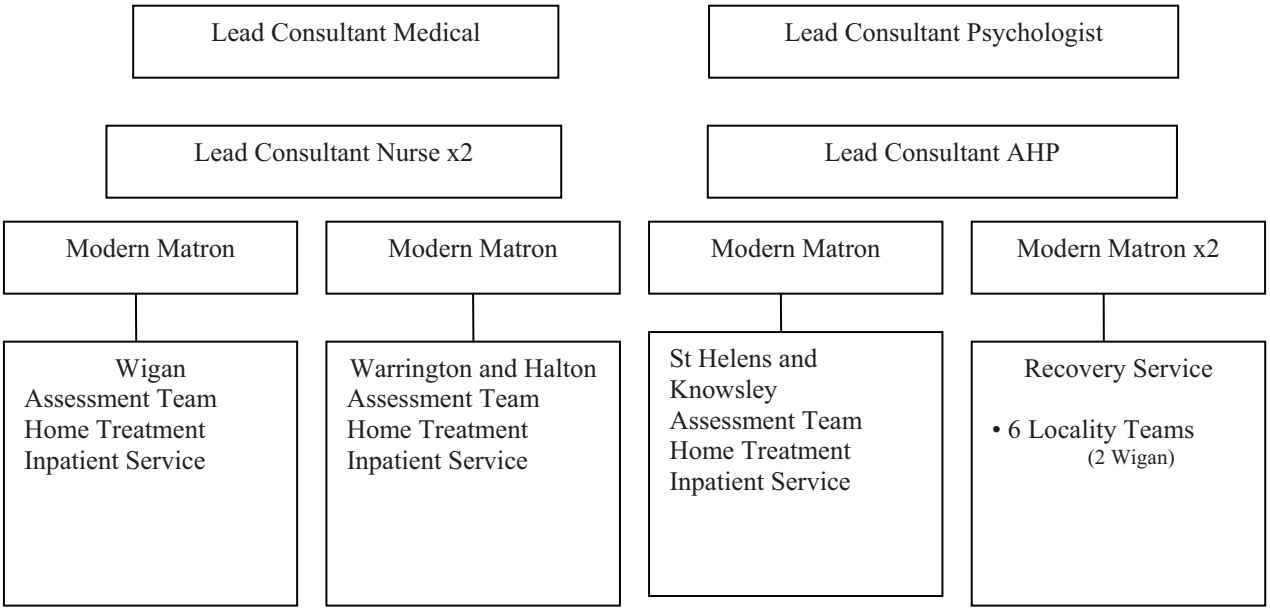
This service will also manage the initiation of medication regimes that help avoid the use of in-patient beds for example Clozapine.

Service Users will be supported from 8am up to 8pm 5 days per week. It is recognised that the user profile of the recovery service will be predominantly of treatment periods of up to 2 years, however the service will support people with long term complex mental health needs and any associated risk issues.

6.5 Leadership

To ensure effective leadership and management the new model proposes that each borough has a dedicated integrated clinical leadership team that is fit for purpose to provide key functions. The Leadership Team will comprise senior operational managers and senior clinical staff from a range of professions.

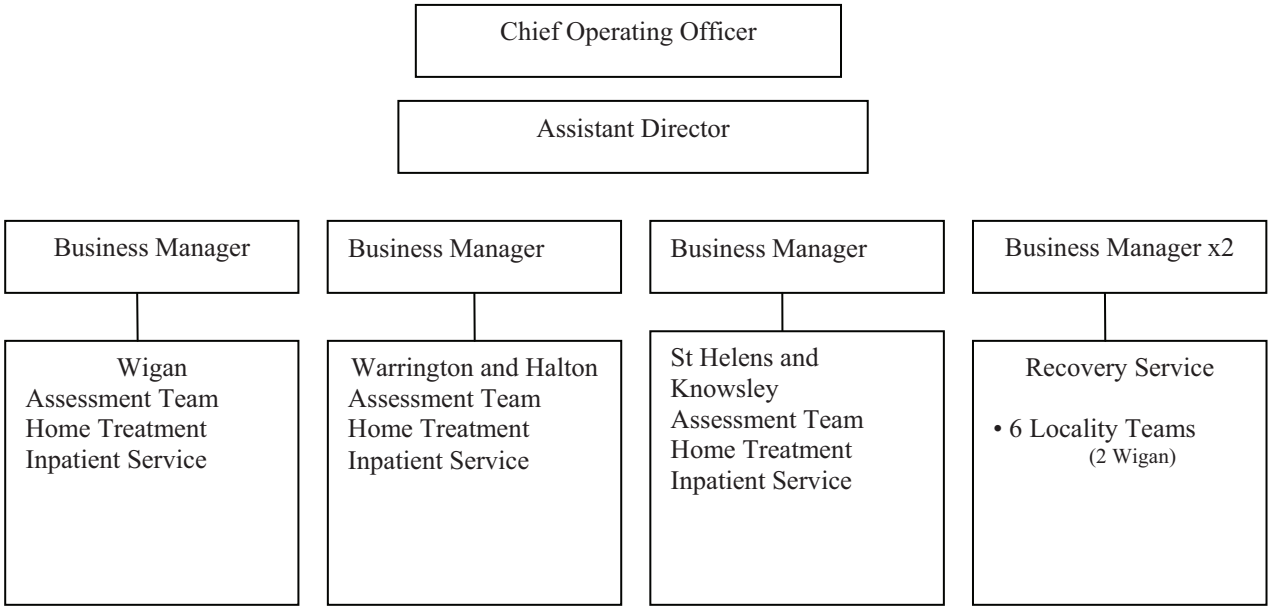
Figure 2 Proposed Leadership Model



In summary the proposed new model offers the following clinical benefits to patients:

- Operates extended hours in line with GP opening times (8am to 8pm, Monday to Friday) for scheduled referrals and 24 hour access to emergency referrals.
- Single point of access
- Same day screening
- All referrals accepted seen within 10 days (inclusive of weekends and bank holidays)
- Clear intervention pathway through services
- Good quality early diagnosis and intervention
- Specialist detailed single comprehensive assessment
- Improved crisis prevention
- Dedicated and focused Home Treatment opportunities
- Fully Integrated Access, Crisis, Inpatient, Liaison Service Delivery.
- Acute liaison support to Acute General Hospital A&E departments.
- All team members will work flexibly across areas and interface to cover annual leave and staff absence improving service resilience

Figure 3 Proposed Management Model



Consideration has been given wherever possible to preserve the value of the existing locality based visibility of operational managers and clinical leadership. The proposed arrangements seek to maintain this whilst offering the opportunity of more consistent service developments across the Trust.

7. Evidence-Based Clinical Care

Within the new model, greater emphasis is placed on the provision of *evidence-based* clinical care, in accordance with National Institute of Clinical Excellence (NICE) guidance.

Common conditions that will be supported by the ACP include:

- Mental and behavioural disorders due to psychoactive substance use.
- Mood disorders,
- Neurotic, stress related disorders and somatoform disorders
- Eating disorders (St Helens and Knowsley only),
- Schizophrenic, schizotypal and delusional disorders,
- Behavioural syndrome associated with physiological disturbances and physical factors,
- Disorder, of adult personality and behaviour

The evidence suggests that people can benefit from a wide range of psychological therapy to reduce mental health problems, increase quality of life, increase the effective management of long term conditions (including diabetes and heart disease), decrease the rates of suicide and increase independence in the community (Positive Practice Guide, 2009). Psychological therapy can also help to address wider health and social care costs by reducing GP appointments and having less reliance on the prescription of anti-depressants, reducing contact with A&E departments, and reducing admission to mental health in-patient services.

The Spending Review states that by 2015, every patient in the country should be able to get timely access to evidence-based psychological therapies and that money needs to be invested to up-skill staff in therapeutic interventions to enable the provision of evidence based psychological interventions as defined in NICE Guidance. The new model will be fully integrated with Trust IAPT services to add value to the care pathways and offer clinical support to the practitioners working within these services.

The development of IAPT Services will benefit people whose needs fall into clusters 1, 2, 3 and 4 and evidence suggests that psychological therapy is beneficial for the remaining clusters as well.

8. Enablers

8.1 Estates and Facilities

The Trust currently provides services, both in patient and community, across 31 sites within the 5 Boroughs Partnership NHS Foundation Trust foot-print.

The model of care is committed to providing community services locally. The Care Pathway helps to determine where service users should receive their assessment and treatment.

There are many instances where this will typically be in the service users home, others will require access to a local "out-patient clinic" environment.

As part of the process to recommend the estate for the future delivery of the model of care a full options appraisal has taken place.

8.1.2 Community estates

Through the use of enabling technologies it is anticipated that service users will receive increasingly more assessment care and treatment in their own homes whenever appropriate. When access to clinics is required or access to group interventions for service users or carers is appropriate, then these will be provided locally using existing facilities.

All local community clinics will be welcoming and will be fully equipped to carry out assessment, diagnostics and interventions.

8.1.3 In-Patient Estate

The Trust currently operates in-patient services from five main sites:

- Hollins Park - Warrington
- Leigh Infirmary – Ashton, Wigan & Leigh
- Knowsley Resource & Recovery Centre
- Peasley Cross – St. Helens
- Brooker Centre – Halton

And also two satellite units:

- Fairhaven Unit – Warrington
- Willis House – Knowsley

Adult inpatient wards are currently located on each of the five main sites.

The acute care pathway building requirements have informed the Trusts Realignment Business Case.

The ambition of the model is to further promote community interventions and reduce reliance on in patient services. Should this aim be realised the Trust will bring forward further ideas for discussion and agreement in regard future in patient estate.

8.1.4 Assessment Service

This service is proposed to be offered by 3 separate teams supporting the needs of the 3 health communities. The assessment teams will offer assessment and liaison to the

presentation of adults with mental health needs to GPs and A&E departments by the establishing a local focus and visibility to other health care providers.

To facilitate this, local assessment teams are proposed to be administratively based at:

- Whiston Hospital, Prescot
- Boston House, Wigan
- Wakefield House, Warrington

To support all localities however there it is proposed to be local buildings facilitates to support clinical assessments within all localities. This will also support the reduction in travelling time for clinicians and was a key concern from our statutory partners.

8.1.5 Home Treatment Service

Similarly this service is proposed to be offered by 3 separate teams supporting the needs of the 3 health communities. The home treatment teams will offer support to the Trust inpatient wards and therefore will be based at the areas of greatest provision.

To facilitate this local Home Treatment teams are proposed to be based at:

- Peasley Cross Court Hospital , St Helens
- Leigh Infirmary, Leigh
- Hollins Park Hospital , Warrington

8.1.6 Recovery Service

This service is proposed to be offered by six separate teams supporting the local needs of the five localities. The recovery teams will offer support and integrated care pathways with the resources of the local authorities. As such they will be based within the five existing community localities

- St Helens Recovery Team, Peasley Cross Court
- Warrington Recovery Team, Wakefield House
- Halton Recovery Team St Johns
- Knowsley Recovery Team Dudley Wallis Centre
- Wigan Recovery Team, Boston House / Wigan Investment Centre
- Leigh Recovery Team Leigh Infirmary

8.2 Workforce Planning and Development

Detailed workforce development plans are in place to support operational staff throughout the change process. Staffside engagement is currently ongoing to facilitate the development of the proposals and this will be continued.

In preparation for implementation a range of activities are being planned to ensure that the new care pathway is delivered to the highest standard. Examples being

- Interview Skills Workshops
- Managing Personal Change & Stress Workshops
- Counselling Services via OH
- Coaching Sessions for Team Managers
- Managing Change – e-book for Managers
- Team Development Planning for Team Managers

Additionally workforce skills development exercises have considered the following as priority areas:

- Risk Assessment and Management
- Best Practice in Managing Risk
- Physical health assessment
- Drug & Alcohol assessment
- Personality Disorder assessment

8.3 Information and Communication Technologies

The Trust in currently piloting a range of enablers to facilitate working efficiencies, .this supports increased patient contacts from practitioners.

Current pilots are considering the use of digital pen and dictation facilities to support increased accuracy, completeness and timeliness of recording clinical interventions

Mobile working infrastructure is also being explored to fully support all community staff recording directly and securely into Trust clinical databases.

Furthermore the Trust is currently implementing a complementary change programme “Making Time for Clinicians” with the objective to review clinical processes

The trust will adopt the appropriate IT infrastructure to support the full implementation of PBR and this model of care.

8.4 Shared Care within Primary Care

Shared care agreements have now been clinically agreed for all localities and the implementation of same will support the success of the ACP. The Trust in collaboration with PCT partners is developing a financial model for the transfer of resources to support the effective prescribing of mental health medication at the GP interface. Before entering into the shared care of a patient, the GP must be fully aware of his/her responsibilities for monitoring, when to refer back to the consultant etc. The shared care agreements clearly identify the roles and responsibilities of G.Ps and Consultants. The GP should be aware that by prescribing for the patient under a shared care agreement they are

accepting full legal and clinical responsibility. The Trust has recently reviewed its policy in respect of shared care and this is available on request.

8.4 Improving Access to Psychological Therapies (IAPT) Step 2 and 3 Primary Care Services

Significant progress and local investment has been achieved to support IAPT primary care services to reduce waiting times for psychological therapies. This service supports the successful discharge of patients back to the community and the consistent provision of IAPT steps 2 and 3 will be a key enabler to the ACP. The Trust currently provides primary care psychological services with Wigan and Knowsley and will manage referrals directly between these services thus avoiding the necessity of a referral back to the local GP.

8.5 Personalisation and Personal Health Budgets.

Personalisation can be described as placing the person at the centre of everything you do and understanding that they are “best placed to know what they need and how those needs be best met”. The expectations of this agenda are currently being advanced by local authorities and considerations of how this proposed community redesign can compliment this vision.

As set out in the “High Quality Care for All” paper launched in June 2008, the NHS is moving towards an NHS which empowers staff and gives patients choice. It is a vision which aims to help people stay healthy by focusing on improving health and tackling sickness. As one of the steps towards reducing ill health, the government has set out a vision that Health Authorities will provide Personal Health Budgets. The development of the Recovery Service is expected to provide a coordinating focus for this approach with the local authority. As service specifications and operational policies are developed it is expected they will provide the operational framework for these empowering activities.

9. Service Users and Carers

The pressure for a new clinical model was initially supported by service user and carer concerns and complaints regarding delays and inconsistencies within the assessment process for eligibility for Trust services. Navigation of service users through a care pathway that included numerous teams and assessment processes inadvertently created delays and confusion to the people we care for at times that they were most vulnerable. This is further supported by messages from staff within the existing limited assessment access and advice services. Currently there is a programme of service user and carers’ engagement being undertaken. The key messages from this listening exercise will continue to inform the proposed improvements to community services.

10. Summary of Benefits

The increasing expectations of timely and effective clinical services supporting adults represents a serious future challenge and we can only meet this by working in partnership with a broad range of local partners and stakeholders. Most importantly we must regard the service users we care for and their families as active partners and their active engagement is essential if we are to ensure that their lives are healthy and meaningful.

We are committed to working in partnership with key stakeholders and commissioning colleagues, to ensure that service gaps are appropriately addressed. This will enable the delivery of our vision to provide high quality, accessible, community services to support service users in their own homes and communities for as long as possible to promote quality of life. In addition, when in-patient treatment is required it will be available; the new model will be supported by considerable capital investment to ensure when required, it is delivered in fit for purpose local accommodation that offers a full range of specialist assessment and treatment opportunities'

In summary, this new model aims to deliver:

- Extended Opening Hours
- Timely response to assessment
- Rapid Response to urgent referrals, same day face to face
- Single care assessment process
- Improved clinical outcomes
- Improved quality of care
- Reduced psychological distress
- Improved Access to Psychological therapies
- Shorter length of stay in in-patient settings
- Reduced readmission rates
- Coordinated service delivery individual to need and performance
- Needs led services
- Increased interface between services
- Strong leadership presence
- Cost effectiveness
- Improved carer/service user experience
- Improved quality of assessment and care in general hospital A&E Deportments
- Reduced and more effective patient journey
- Increased consistency and quality of service provision across localities

11. Mapping the Change

The trust has mapped out the current position to future state which is up to 2014. The following have been developed to support the development of the model -

- A workforce plan to establish what impact the change will have on the existing workforce
- A financial model which includes the impact of estate development within the proposed model
- A service delivery plan to demonstrate all the stages from development, to engagement, consultation and implementation of the model. It describes the milestones, timescales and identified leads
- A training needs analysis to ensure that all staff have the skills and knowledge required to enable them to deliver quality clinical care within the new model
- A consultation and communication plan has been developed.

There is a nominated Business Transformational lead working with the senior managers and a Business Transformation Steering Group established to oversee the projects progress. The Steering Group is overseen by the Trust Operational Management Board.

12. Cost Improvement and Efficiency

Monitor and the Department of Health have published their planning guidance for Foundation Trusts for the foreseeable future. The guidance identifies that each Trust is required to make a 4% cost improvement each year for the next few years.

In 2011/12 and in future the PCTs through the national tariff will reduce contracts with Trusts by 4% to reflect this, this money will therefore sit in PCT (or successor bodies) budgets. Trusts's will be given uplifts to reflect inflation but this is to offset automatic price increases like pay awards and inflation.

This means that in real terms, year on year the Trust will be 4% worse off and if it doesn't make savings it will fall into deficit.

So in order to stand still financially the Trust has to put in plans to improve efficiency and reduce costs by 4% each year (20% over five years). Putting this into context; the Trust has an had, 2010/11, an income of approx £100m (excluding secure services) and an annual turnover of £148m, so a 4% efficiency gain is the equivalent of £6m a year, or £30m over 5 years.

The Trust's plans and strategic intent is to make this happen whilst maintaining the level and quality of the services provided to patients and

contracted for by commissioners, without any need for new investment by commissioners.

Appendix (i) Adult Business Stream – Community and Out-patients data

						Forecast Information using Average Increase year on year			
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Number of Referrals Received	27,220	29,226	34,658	37,579	39,081	42,418	46,040	49,971	54,237
Number of Total Contacts	**158,461**	**192,783**	**203,517**	**217,055**	**260,042**	**289,846**	**323,067**	**360,095**	**401,367**
Total DNA's	2,948	16,658	21,478	22,610	26,330				
% DNA's	1.8%	8.0%	9.5%	9.4%	9.2%				
Number of Discharges	19,335	24,630	27,675	32,710	36,095				
% Increase Year on Year Referrals Received		6.9%	15.7%	7.8%	3.8%				
Average Increase Year on Year					**8.5%**				
% Increase Year on Year Total Contacts		17.8%	5.3%	6.2%	16.5%				
Average Increase Year on Year					**11.5%**				

Appendix (ii) Adult Business Stream – In-patient Profile

						Forecast based on 85% Occupancy Levels			
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Average LOS	45.8	38.4	29.4	25.4	26.9	24.0	24.0	24.0	24.0
Available Beds	82,075	77,976	68,888	67,924	67,100	67,160	55,480	52,560	43,800
Occupied Beds	82,857	68,349	62,611	65,233	61,736	57,086	47,158	44,676	37,230
% Occupancy	101.0%	87.7%	90.9%	96.0%	92.0%	85.0%	85.0%	85.0%	85.0%
Total Commissioned Beds			192	184	184	184			
Actual Number of Beds at Year End	**218**	**204**	**190**	**184**	**184**	**184**	**152**	**144**	**120**
Number of Beds by Borough									
Halton	29	28	28	28	28				
Knowsley	31	23	33	33	33				
St Helens	34	32	32	32	32				
Warrington	66	64	39	33	33				
Wigan	58	57	58	58	58				

Notes :
All data includes PICU Beds

Appendix (iii) Number of Admissions by Admission Source

Borough of Ward	Admission Source	2006/07	2007/08	2008/09	2009/10	2010/11
Adult Mental Health Admissions	Local Authority Pt 3 Residential Accommodation	1				
	Missing data					1
	NHS prov - High Security	1	1		1	
	NHS provider - WD for general pts or YPD or A&E	121	114	163	245	287
	NHS provider - WD for Mat or Neonates	3	3	1	2	
	NHS provider - WD for MI or LD	56	45	71	28	30
	NHS run care home	6	1	5		1
	Non-NHS Hospice (not LA)			1		
	Non-NHS Hospital	14	26	3	1	5
	Non-NHS Residential Care Home (not LA)	5	1	2		
	Penal, Court or Police Stn	60	54	64	48	58
	Temporary Residence	21	12	23	48	34
	Usual place of Residence	1,583	1,510	1,763	1,779	1,853
	(blank)					
	Total	**1,871**	**1,767**	**2,096**	**2,152**	**2,269**

Appendix (iv) Occupancy April 2010 to 14/15 projections

Adult Mental Health (including PICU) - Total Number of Beds as at Year End

						Forecast Information			
	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	13/14
Total Number of Beds	218	204	190	184	184	184	152	144	120
% Reduction Year on Year		-6.4%	-6.9%	-3.2%	0.0%	0.0%	-17.4%	-5.3%	-16.7%
Average Reduction					-4.1%	Forecast Average - Year on Year		-9.8%	

Available Beds

						Forecast Information			
	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Available Beds	82,075	77,976	68,888	67,924	67,100	67,160	55,480	52,560	43,800
% Reduction Year on Year		-5.0%	-11.7%	-1.4%	-1.2%	0.1%	-17.4%	-5.3%	-16.7%
Average Reduction					-4.8%	Forecast Average - Year on Year		-9.8%	

Occupied Beds

						Forecast Information to remian at 85% occupancy			
	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Occupied Beds	82,857	68,349	62,611	65,233	61,736	57,086	47,158	44,676	37,230
% Reduction Year on Year		-17.5%	-8.4%	4.2%	-5.4%	-7.5%	-17.4%	-5.3%	-16.7%
Average Reduction					-6.8%	Forecast Average - Year on Year		-11.7%	

% Occupancy

						Forecast Information			
	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Occupied Beds	101.0%	87.7%	90.9%	96.0%	92.0%	85.0%	85.0%	85.0%	85.0%

Appendix (v) Mental Health Act (Sections) Report

TOTAL Occupied Beds

Adult Wards	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	2010/11 Total
Austen Ward	515	535	548	515	414	420	505	499	531	532	516	506	**6,036**
Bridge Ward	336	387	399	397	414	395	380	421	421	441	379	395	**4,765**
Cavendish Unit	812	762	720	748	714	700	744	755	739	753	565	687	**8,699**
Coniston Unit	470	539	448	425	293	423	506	484	538	554	497	498	**5,675**
Grasmere Unit	464	416	433	492	345	400	375	398	329	380	316	412	**4,760**
Iris Ward	421	420	436	453	301	392	421	416	350	300	337	370	**4,617**
Lakeside Unit	775	786	658	595	671	727	759	748	771	809	696	761	**8,756**
Rivington Unit	214	214	230	213	179	214	232	203	208	191	211	244	**2,553**
Sheridan Ward	465	461	456	474	477	441	467	461	483	471	381	448	**5,485**
Taylor Ward	424	525	480	492	507	340	457	472	516	522	469	517	**5,721**
Weaver Ward	423	392	395	408	339	373	395	414	421	407	341	361	**4,669**
Total	**5,319**	**5,437**	**5,203**	**5,212**	**4,654**	**4,825**	**5,241**	**5,271**	**5,307**	**5,360**	**4,708**	**5,199**	**61,736**

Total Occupied Beds of SECTIONED patients

Adult Wards	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	2010/11 Total
Austen Ward	240	266	248	183	169	179	147	152	180	295	208	166	**2,433**
Bridge Ward	116	143	132	131	126	144	143	180	147	100	79	154	**1,595**
Cavendish Unit	248	280	216	216	192	213	192	219	231	293	234	235	**2,769**
Coniston Unit	198	178	136	168	94	131	117	94	123	240	258	259	**1,996**
Grasmere Unit	208	145	137	218	157	174	133	64	79	109	104	189	**1,717**
Iris Ward	136	147	163	141	154	201	142	147	114	146	79	53	**1,623**
Lakeside Unit	106	210	171	239	289	381	488	362	369	377	391	504	**3,887**
Rivington Unit (PICU)	214	212	229	213	179	214	232	203	207	190	206	244	**2,543**
Sheridan Ward	188	202	201	172	306	314	157	109	107	55	77	156	**2,044**
Taylor Ward	214	292	285	197	233	177	234	281	263	296	261	315	**3,048**
Weaver Ward	76	34	74	118	66	100	84	127	139	60	40	49	**967**
Total	**1,944**	**2,109**	**1,992**	**1,996**	**1,965**	**2,228**	**2,069**	**1,938**	**1,959**	**2,161**	**1,937**	**2,324**	**24,622**

% of Sectioned Patients on Wards

Adult Wards	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	2010/11 Total
Austen Ward	46.6%	49.7%	45.3%	35.5%	40.8%	42.6%	29.1%	30.5%	33.9%	55.5%	40.3%	32.8%	**40.3%**
Bridge Ward	34.5%	37.0%	33.1%	33.0%	30.4%	36.5%	37.6%	42.8%	34.9%	22.7%	20.8%	39.0%	**33.5%**
Cavendish Unit	30.5%	36.7%	30.0%	28.9%	26.9%	30.4%	25.8%	29.0%	31.3%	38.9%	41.4%	34.2%	**31.8%**
Coniston Unit	42.1%	33.0%	30.4%	39.5%	32.1%	31.0%	23.1%	19.4%	22.9%	43.3%	51.9%	52.0%	**35.2%**
Grasmere Unit	44.8%	34.9%	31.6%	44.3%	45.5%	43.5%	35.5%	16.1%	24.0%	28.7%	32.9%	45.9%	**36.1%**
Iris Ward	32.3%	35.0%	37.4%	31.1%	51.2%	51.3%	33.7%	35.3%	32.6%	48.7%	23.4%	14.3%	**35.2%**
Lakeside Unit	13.7%	26.7%	26.0%	40.2%	43.1%	52.4%	64.3%	48.4%	47.9%	46.6%	56.2%	66.2%	**44.4%**
Rivington Unit (PICU)	100.0%	99.1%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%	99.5%	97.6%	100.0%	**99.6%**
Sheridan Ward	40.4%	43.8%	44.1%	36.3%	64.2%	71.2%	33.6%	23.6%	22.2%	11.7%	20.2%	34.8%	**37.3%**
Taylor Ward	50.5%	55.6%	59.4%	40.0%	46.0%	52.1%	51.2%	59.5%	51.0%	56.7%	55.7%	60.9%	**53.3%**
Weaver Ward	18.0%	8.7%	18.7%	28.9%	19.5%	26.8%	21.3%	30.7%	33.0%	14.7%	11.7%	13.6%	**20.7%**
Total	**36.5%**	**38.8%**	**38.3%**	**38.3%**	**42.2%**	**46.2%**	**39.5%**	**36.8%**	**36.9%**	**40.3%**	**41.1%**	**44.7%**	**39.9%**

Appendix (vi) Diagnosis Data

All Patients admitted to Adult Wards in year with Primary Diagnosis as below

Primary Diagnosis	2006/07	2007/08	2008/09	2009/10	2010/11
Behavioural and emotional discorders with onset usually occurring in childhood and adolescence	1	4		2	8
Behavioural syndromes associated with physiological disturbances and physical factors	10	4	8	9	20
Disorders of adult personality and behaviour	71	94	135	220	228
Disorders of psychological development	10	10	14	14	7
Mental and behavioural disorders due to psychoative substance use	236	186	329	415	266
Mental Retardation			1		5
Mood [Affective] disorders	599	626	825	871	789
Neurotic, stress-related and somatoform discorders	162	172	258	259	252
Organic, including symptomatic, mental discorders	8	10	27	27	31
Other	128	102	137	96	212
Schizophrenia, schizotypal and delusional disorders	488	493	652	596	593
Unknown	243	188	1		2
Unspecified Mental Discorder	3		1		
Total	**1,959**	**1,889**	**2,388**	**2,509**	**2,413**

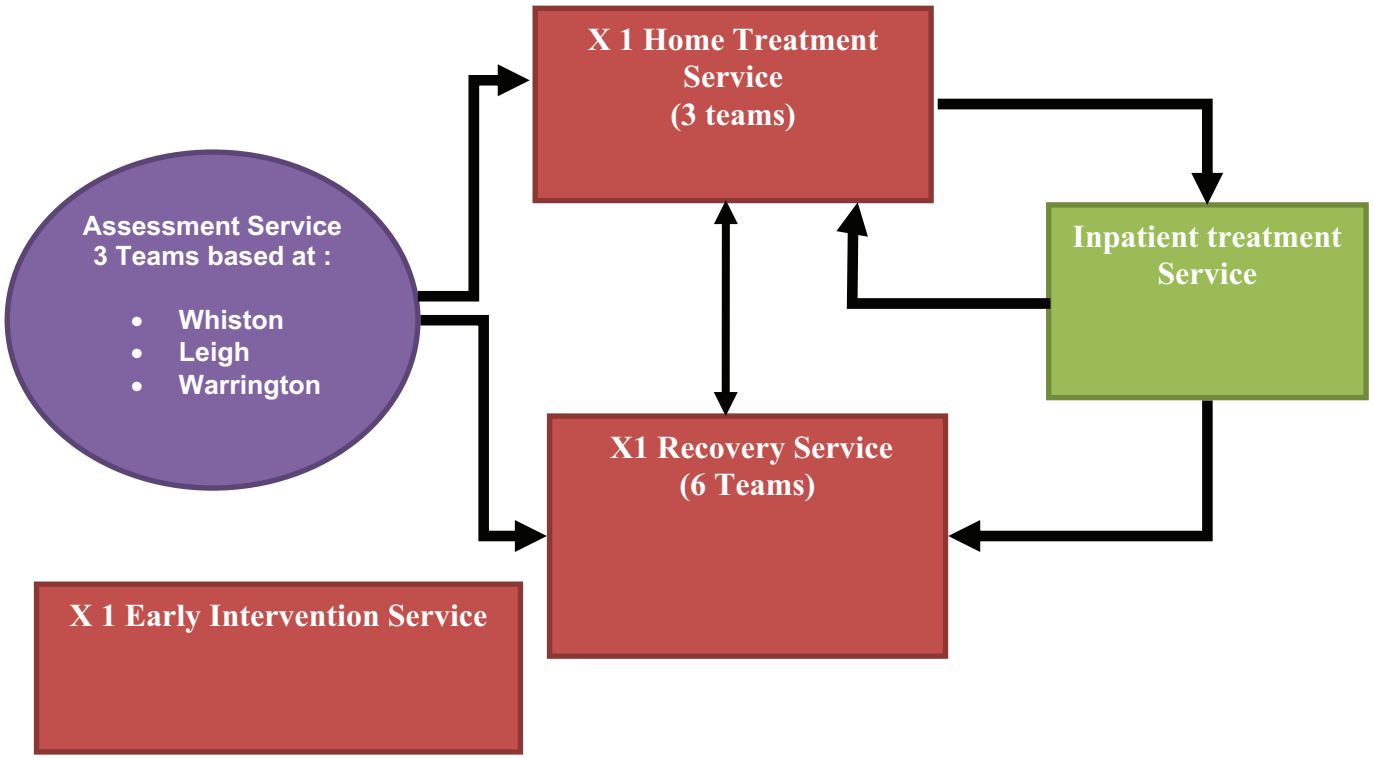
Appendix (vii) Delayed Discharges – Total days lost by Ward

		Number of Days Lost		
Ward	**Responsibility**	**2008/09**	**2009/10**	**2010/11**
Austen Ward	Attribute to Both	70		
	Attribute to Social Care (Note that these days will qualify for reimbursement)	152		
	Responsibility of NHS (i.e. includes patients making own arrangements)	161	670	337
Austen Ward Total		**383**	**670**	**337**
Bridge Ward	Attribute to Both			110
	Attribute to Social Care (Note that these days will qualify for reimbursement)	48		
	Responsibility of NHS (i.e. includes patients making own arrangements)	350	38	
Bridge Ward Total		**398**	**38**	**110**
Cavendish Unit	Attribute to Both	35		
	Attribute to Social Care (Note that these days will qualify for reimbursement)	52	147	
	Responsibility of NHS (i.e. includes patients making own arrangements)	13	56	
Cavendish Unit Total		**100**	**203**	
Coniston Unit	Attribute to Both	69		
	Attribute to Social Care (Note that these days will qualify for reimbursement)		31	
	Responsibility of NHS (i.e. includes patients making own arrangements)	21	236	318
Coniston Unit Total		**90**	**267**	**318**
Grasmere Unit	Attribute to Social Care (Note that these days will qualify for reimbursement)	16	9	23
	Responsibility of NHS (i.e. includes patients making own arrangements)	84	35	4
Grasmere Unit Total		**100**	**44**	**27**
Iris Ward	Attribute to Both			1
	Attribute to Social Care (Note that these days will qualify for reimbursement)	21	38	
	Responsibility of NHS (i.e. includes patients making own arrangements)	300	492	109
Iris Ward Total		**321**	**530**	**110**
Lakeside Unit	Attribute to Both	28		
	Responsibility of NHS (i.e. includes patients making own arrangements)	713	822	1,142
Lakeside Unit Total		**741**	**822**	**1,142**
Rivington Unit (PICU)	Responsibility of NHS (i.e. includes patients making own arrangements)		921	698
Rivington Unit (PICU) Total			**921**	**698**
Sheridan Ward	Attribute to Both	43	35	
	Attribute to Social Care (Note that these days will qualify for reimbursement)	168		132
	Responsibility of NHS (i.e. includes patients making own arrangements)		30	
Sheridan Ward Total		**211**	**65**	**132**
Taylor Ward	Attribute to Social Care (Note that these days will qualify for reimbursement)	21		
	Responsibility of NHS (i.e. includes patients making own arrangements)	201	239	463
Taylor Ward Total		**222**	**239**	**463**
Weaver ward	Attribute to Social Care (Note that these days will qualify for reimbursement)	2		
	Responsibility of NHS (i.e. includes patients making own arrangements)	87		51
Weaver ward Total		**89**		**51**
Total Days lost in Adult Services		**2,655**	**3,799**	**3,388**

Appendix (vii) Delayed Discharges – Number of Patients by Ward

		Number of Patients		
Ward	Responsible	2008/09	2009/10	2010/11
Austen Ward	Attribute to Both	1		
	Attribute to Social Care (Note that these days will qualify for reimbursement)	5		
	Responsibility of NHS (i.e. includes patients making own arrangements)	5	6	4
Austen Ward Total		**11**	**6**	**4**
Bridge Ward	Attribute to Both			2
	Attribute to Social Care (Note that these days will qualify for reimbursement)	1		
	Responsibility of NHS (i.e. includes patients making own arrangements)	5	3	
Bridge Ward Total		**6**	**3**	**2**
Cavendish Unit	Attribute to Both	1		
	Attribute to Social Care (Note that these days will qualify for reimbursement)	3	3	
	Responsibility of NHS (i.e. includes patients making own arrangements)	1		
Cavendish Unit Total		**5**	**3**	
Coniston Unit	Attribute to Both	1		
	Responsibility of NHS (i.e. includes patients making own arrangements)	1	3	11
Coniston Unit Total		**2**	**3**	**11**
Grasmere Unit	Attribute to Social Care (Note that these days will qualify for reimbursement)	1	1	2
	Responsibility of NHS (i.e. includes patients making own arrangements)	2	1	1
Grasmere Unit Total		**3**	**2**	**3**
Iris Ward	Attribute to Social Care (Note that these days will qualify for reimbursement)		1	
	Responsibility of NHS (i.e. includes patients making own arrangements)	10	3	4
Iris Ward Total		**10**	**4**	**4**
Lakeside Unit	Attribute to Both	1		
	Responsibility of NHS (i.e. includes patients making own arrangements)	10	8	16
Lakeside Unit Total		**11**	**8**	**16**
Rivington Unit (PICU)	Responsibility of NHS (i.e. includes patients making own arrangements)		9	8
Rivington Unit (PICU) Total			**9**	**8**
Sheridan Ward	Attribute to Both	1	1	
	Attribute to Social Care (Note that these days will qualify for reimbursement)	2		2
	Responsibility of NHS (i.e. includes patients making own arrangements)		2	
Sheridan Ward Total		**3**	**3**	**2**
Taylor Ward	Attribute to Social Care (Note that these days will qualify for reimbursement)	1		
	Responsibility of NHS (i.e. includes patients making own arrangements)	4	8	8
Taylor Ward Total		**5**	**8**	**8**
Weaver ward	Attribute to Social Care (Note that these days will qualify for reimbursement)	1		
	Responsibility of NHS (i.e. includes patients making own arrangements)	3		1
Weaver ward Total		**4**		**1**
Total Number of Patients Delayed in Adult Services		**60**	**49**	**59**

Appendix (iix) New Secondary Care Pathway



Appendix (ix) IAPT Population Need (Projected)

North East Public Health Observatory
Mental Health Brief no 4: May 2008 (Extract)

Estimating the prevalence of common mental health problems in local and nearby PCTs in the northwest

A first approximation of the expected caseload for new psychological therapy services

		Rates per 1000 population							Estimated cases							
PCT Name	PCT 2006	Any neurotic disorder	All phobias	Depressive episode	Generalised anxiety disorder	Mixed anxiety depression	Obsessive compulsive disorder	Panic disorder	Any neurotic disorder	All phobias	Depressive episode	Generalised anxiety disorder	Mixed anxiety depression	Obsessive compulsive disorder	Panic disorder	Population 16-74
Ashton, Leigh and Wigan	5HG	201.0	26.5	27.6	63.8	108.2	17.2	2.9	45389.1	5974.4	6225.3	14399.3	24435.8	3892.2	650.5	225815
Warrington	5J2	185.1	24.5	25.3	59.0	99.6	15.8	2.6	26239.3	3478.1	3593.0	8368.1	14116.1	2235.7	374.0	141745
Knowsley	5J4	247.0	32.4	34.2	76.9	133.2	21.0	3.6	27050.4	3544.9	3743.2	8426.6	14587.9	2299.6	393.1	109509
Halton and St Helens	5NM	209.2	27.4	28.9	66.0	112.5	17.8	3.1	45559.5	5959.1	6291.3	14376.8	24487.7	3875.2	664.9	217757
Sefton	5NJ	216.1	28.0	29.7	68.8	115.9	18.2	3.2	43377.2	5616.4	5972.1	13804.2	23270.0	3649.6	638.2	200743
Wirral	5NK	220.5	28.6	30.5	69.9	118.3	18.7	3.3	49165.4	6379.5	6810.7	15580.0	26365.3	4161.6	727.1	222939
Liverpool	5NL	262.2	34.4	35.9	77.9	143.0	23.2	3.6	86025.0	11280.8	11780.9	25572.2	46923.2	7605.0	1196.3	328149
Western Cheshire	5NN	164.6	21.4	22.6	51.9	88.7	14.0	2.4	28284.1	3676.0	3889.0	8917.0	15239.5	2398.8	407.7	171812
Central and Eastern Cheshire	5NP	148.2	19.5	20.4	47.7	79.4	12.5	2.1	48484.3	6366.7	6677.0	15594.6	25989.6	4095.0	701.9	327245
Trafford	5NR	206.5	27.3	28.1	65.8	111.3	17.4	3.0	31485.4	4167.1	4288.5	10032.6	16964.7	2655.0	454.9	152474
Manchester	5NT	263.2	35.2	35.2	74.7	146.0	24.1	3.5	88398.2	11821.1	11830.7	25079.0	49011.7	8107.2	1164.4	335806

This supplementary spreadsheet accompanies Mental Health Brief no 4. It provides data on estimated rates and case numbers in the population for 2006-reorganisation PCTs. Data on rates are presented as total cases per 1000 population aged 16-74. Detail of case numbers are presented for males and females, for quinary age-groups. These are not intended to be used at this level, rather to provide flexible data for grouping up.

Appendix (x) Nice Guidance

CG 100: Alcohol dependence and harmful alcohol use: provides recommendations in the diagnosis and management of alcohol related physical complications The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below..

http://www.nice.org.uk/nicemedia/live/12995/49004/49004.pdf

CG115: Alcohol use Disorders: provides recommendations in the diagnosis, assessment and management of harmful drinking and alcohol dependence. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below.

http://www.nice.org.uk/nicemedia/live/13337/53194/53194.pdf

CG 45: Antenatal and Post Natal Mental Health makes recommendations in antenatal and postnatal mental health in terms of clinical management and service guidance. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/11004/30432/30432.pdf

CG 72: Attention Deficit Hyperactivity Disorder makes recommendations in the diagnosis and management of Attention Deficit Hyperactivity Disorder in children, young adults and adults. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/12061/42107/42107.pdf

CG 38: Bipolar Disorder makes recommendations for the management of bipolar disorder in adults, children and adolescents, in primary and secondary care. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/10990/30191/30191.pdf

CG123: Common Mental Health problems makes recommendations for the identification and pathways to care for common mental health disorders including depression, generalized anxiety disorder, panic disorder, obsessive compulsive disorder, post traumatic stress disorder and social anxiety

disorder. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/13476/54523/54523.pdf

CG 52: Drug Misuse: Opioid Detoxification and Psychosocial interventions (CG51) make recommendations about the psychosocial interventions to be used in substance misuse services and good practice for opioid detoxification. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE in the substance misuse services in the Trust. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/11813/35996/35996.pdf

CG 76: Medicines adherence makes recommendations for involving patients in decisions about prescribed medicines and supporting adherence. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/11766/42891/42891.PDF

CG 31: Obsessive Compulsive Disorder makes recommendations for the core interventions to be used in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/10976/29945/29945.pdf

CG120: Psychosis with coexisting substance misuse offers best practice advice on the assessment and management of people with psychosis and coexisting substance misuse. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE and is supported by the Nurse Consultant Dual Diagnosis lead in the Trust. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/13414/53731/53731.pdf

CG 82: Schizophrenia guidance makes recommendations relating to the treatment and management of schizophrenia for adults in primary and secondary care. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/11786/43610/43610.pdf

CG 25: Violence makes recommendations relating to the short-term management of disturbed / violent behaviour in in-patient psychiatric settings

and emergency departments. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE within in-patient areas. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/10964/29716/29716.pdf

CG 89: When to suspect child maltreatment offers guidance on alerting features of child maltreatment with recommendations to either ‘consider’ or ‘suspect’ child maltreatment. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/12183/44872/44872.pdf

Appendix (11) ACP Existing Activity and Resources compared to Proposed

Halton Borough Total Planned Activity on the ACP Model V's 11/12 contract activity

	Proposed ACP Team Activity++	11/12 Contract*	% Variance against Planned	11/12 YTD Actual***	11/12 Forecast**	% Variance 11/12 Forecast against Proposed ACP
Assessment Service**	**4,093**	**5,145**	**-25.71%**	**708**	**1416**	**65.40%**
Recovery Service	**23,760**	**17,229**	**27.49%**	**10672**	**21344**	**10.17%**
Home Treatment Service	**5,379**	**2,819**	**47.58%**	**1453**	**2906**	**45.97%**

*This is based on basic realignment of the teams, please note the Crisis function which has been split based on the teams functions.
* Other Adult have been aligned to the Recovery Team
** Assessment service contract, has been based on historic data, informed by Open Minds being physically based in the Halton Borough.
Overall the capacity and contract activity for Halton & St Helens is exceeded by 8.31%

Knowsley Borough Total Planned Activity on the ACP Model V's 11/12 contract activity

	Proposed ACP Team Activity++	11/12 Contract*	% Variance against Planned	11/12 YTD Actual***	11/12 Forecast**	% Variance 11/12 Forecast against Proposed ACP
Assessment Service	4,871	3,628	25.52%	1028	2057	57.78%
Recovery Service	27,920	23,934	14.28%	13768	27536	1.38%
Home Treatment Service	6,402	3,935	38.54%	2243	4485	29.93%

*This is based on basic realignment of the teams, please note the Crisis function which has been split based on the teams functions.
* Other Adult have been aligned to the Recovery Team

St Helens Borough Total Planned Activity on the ACP Model V's 11/12 contract activity

	Proposed ACP Team Activity++	11/12 Contract*	% Variance against Planned	11/12 YTD Actual***	11/12 Forecast**	% Variance 11/12 Forecast against Proposed ACP
Assessment Service**	5,949	4,062	31.72%	504	1008	83.06%
Recovery Service	27,920	23,929	14.29%	15622	31244	-11.91%
Home Treatment Service	7,818	4,307	44.91%	2296	4592	41.27%

*This is based on basic realignment of the teams, please note the Crisis function which has been split based on the teams functions.
* Other Adult have been aligned to the Recovery Team
** Assessment service contract, has been based on historic data, informed by Open Minds being physically based in the Halton Borough. Overall the capacity and contract activity for Halton & St Helens is exceeded by 8.31%

Warrington Borough Total Planned Activity on the ACP Model V's 11/12 contract activity

	Proposed ACP Team Activity++	11/12 Contract*	% Variance against Planned	11/12 YTD Actual***	11/12 Forecast**	% Variance 11/12 Forecast against Proposed ACP
Assessment Service	6,727	5,431	19.27%	2033	4066	39.56%
Recovery Service	23,600	25,053	-6.16%	13116	26232	-11.15%
Home Treatment Service	8,841	2,828	68.01%	2405	4810	45.60%

*This is based on basic realignment of the teams, please note the Crisis function which has been split based on the teams functions.
* Other Adult have been aligned to the Recovery Team

Wigan Borough Total Planned Activity on the ACP Model V's 11/12 contract activity

	Proposed ACP Team Activity++	11/12 Contract*	% Variance against Planned	11/12 YTD Actual***	11/12 Forecast**	% Variance 11/12 Forecast against Proposed ACP
Assessment Service	11,220	10,509	6.33%	2754	5509	50.90%
Recovery Service	55,520	40,629	26.82%	21331	42662	23.16%
Home Treatment Service	14,220	6,650	53.23%	3072	6143	56.80%

Please Note:
*This is based on basic realignment of the teams, please note the Crisis function which has been split based on the teams functions.
* Other Adult have been aligned to the Recovery Team
*Primary Care Wigan, IAPT and Eating Disorders have been excluded from this process

*** Based on ytd activity April - September 2011

Please note as this is borough based activity the lead boroughs have the overall alignment of the team.
"++ Individual Borough proposed ACP Team Activity has been been calculated using the 2001 Census adult (20-64) population by Borough

5BP Commissioning Alliance Draft Specification

Home Treatment Service

Service Title: Home Treatment

1. **Service Description:**

The Team's role is to provide intensive Home Treatment for people who have mental health needs that can only be addressed by a secondary mental health service provider. The Home Treatment Team will respond rapidly to referrals intervening with Service Users at an early stage, actively involving families and carer's and offering a flexible approach to Service Users in the least restrictive and most appropriate community environments.

The Team will work with a range of other professionals and voluntary organisations to ensure smooth pathways are in place between services and back into Primary Care when appropriate.

The Home Treatment Team will provide a service for adults supported by national guidance in relation to Payment by Results Care clustering. The Home Treatment Team will act as a gatekeeper to all hospital Inpatient beds within the 5 Boroughs, rapidly supporting the assessment and appropriate placements of Service Users across the organisation. Gatekeeping is described as the clinical decision making regarding the need to admit someone to inpatient care. The process of locating a bed will be a separate function. The Team will be central to the decision making process in conjunction with the Multi-disciplinary Team and ensuring all referrals are assessed before admission to an Inpatient bed. The team will also support early discharge from inpatient care for those service users whose treatment can be proactively managed in the community with intensive home treatment support. The team will provide 72 hour follow-up for those discharged who have been previously unknown to secondary services and for those receiving home treatment. All other service users will be supported post discharge by the respective recovery teams, including early intervention services.

The Team will work with people over the age of 16 years old. The Team will provide mental health assessment and intensive home treatment for all Service Users referred to the Home Treatment Service. They will have efficient processes that provide fair and equitable response times across the whole community of the 5 Boroughs Partnership Mental Health Foundation Trust as defined in the operational policy.

The Team will work in an integrated way with Inpatient Services and will be inextricably linked to ensure the service users journey is co-ordinated and supportive. It will also link with community organisations across Health and Social Care to avoid unnecessary delays in discharge and to improve

the follow up of Service Users. The Team will operate within the direction of Trust local Policy and Procedures including the CPA process and following relevant National Guidance.

2. **Provider Name:**

   5 Boroughs Partnership NHS Foundation Trust.

3. **Address of Organisation:**

   Trust Headquarters, Hollins Park, Hollins Lane, Winwick, Warrington, WA2 8WA.

4. **Base / Location of Service:**

   The Home Treatment Teams will be located at the following bases:
   - Warrington
   - St Helens
   - Wigan

5. **Lead Contact at the Trust:**

   Chief Operating Officer

   The Chief Operating Officer is responsible for:

   - Ensuring that the strategic direction is consistently communicated to all staff regarding the delivery of the Home Treatment Service.
   - The further development of this Guidance in conjunction with the Accountable Director and other stakeholders.
   - Ensuring that delivery of the Home Treatment Service is subject to monitoring, development and review.
   - Ensuring that resources are available for the commissioned provision of the Home Treatment Service.

6. **Telephone:**

   01925 664000

7. **Service Availability:**

   The Home Treatment Services will be available between the hours of 8.00am until 8.00pm, 7 days a week including Bank Holidays over 365 days per annum. Outside of these hours the team will operate a non-waking night on-call service for those service users who are open to the Team.

8. **Out of Hours Cover:**

Out of hours cover will be provided for service users who have an open episode of care with the Team via a non waking night on-call service.

9. Scope:

- The Home Treatment Service will be available for the catchment population which will be defined by the population of each GP Practice whose surgery address's falls within the defined area of the 5 Boroughs Partnership NHS Foundation Trust and the locality Primary Care Trust. The Service is appropriate for adults over the age of 16 years old who present with a moderate to severe functional mental health problem who will require intensive home treatment. The service will work people with mental health issues not included in Payment by Results clusters 1-4.

Intensive Home Treatment will take place in a variety of settings including:

- Health resources
- Community resources
- Service Users normal place of residence

Referrals to the service will be accepted from in-patient, recovery teams including Early Intervention Teams, Assessment & Liaison teams following the requirements of the electronic care record system.

The Team will adhere to the principles of Access, Booking and Choice and Copying Correspondence to Service Users.

10. Geographical Area Served:

The service will operate within the usual boundaries of the Trust's specific GP Consortia.

11. Key Relationships with other Agencies:

- Work formally in an integrated manner with Local Authority (LA) Social Services staff and other teams including those in the statutory, public and third sector
- To enhance treatment for Service Users with drug or alcohol addiction through close and effective working with Substance/Alcohol Misuse Teams and other teams including those in the third sector

12. Links to other NHS Teams/Services:

The service will work closely with inpatient services, assessment & recovery teams and other Mental Health professionals working within the

locality including other NHS, Social Care and Criminal Justices Services as appropriate.

The service will establish clear and accessible communication links with Primary Care Mental Health Services in order to prevent referrals falling between services.

13. Age Range:

16 years and above with no upper age limit for people with a functional illness. Older adults with a suspected functional mental illness will not be excluded from the Home Treatment Team purely on the grounds of age.

14. Source of Referrals:

Referrals to the Home Treatment Team will come directly from the Trust Assessment Services, mental health acute inpatient services and Recovery Teams including Early Intervention Teams.

15. Response Times:

The Home Treatment team will contact service users within 4 hours of the referral to agree an initial treatment plan. Individual contact times will vary according to need and risk.

16. Risk Assessment and Management including CPA requirements:

This must comply with the guidance in "*Refocusing the Care Programme Approach"* (DH 2008).

17. Age, Culture and Gender Specifics

There are no exclusions on gender and culture.

18. Interventions / Treatments to be offered:

The Home Treatment will use a variety of assessment tools to aid the care planning process of Service Users open to the team. This will include a range of interventions which will take into account the service users assessed clinical and social care needs.

The team will support early discharge from the acute mental health in-patient wards to ensure treatment can be provided in the least restrictive environment that is conducive to the service users recovery.

Treatments will be effective and evidence based interventions. The team will also provide advice and support to Service Users, families and carer's through the carer assessment, planning & evaluation processes offered to them. Upon discharge from the services the teams will liaise closely with

Service Users, families and carer's in conjunction with Primary Care and the relevant community team.

The pharmacological management of Service User symptoms will be considered carefully. The prescriptions of any medication will adhere to the National Institute of Clinical Excellence (NICE Guidelines).

19. Choice:

The NHS encourages choice and people from other geographical areas out with the usual catchment zone can choose to have their Inpatient care provided at the Trust. The follow up care may therefore require liaison with a team from another area. This process will be managed via the PbR system in respect of payment for care.

20. Workforce Issues:

The team consists of:

- Team Manager
- Deputy Team Manager
- Senior Nurse Practitioner
- Occupational Therapist
- Consultant Psychiatrist
- Staff Grade / Speciality Doctor
- Office Manager
- Administrative staff

The team will have active support and input from a Psychologist, Pharmacist and Junior Doctors. The team will work in an integrated way with Local Authority colleagues in accordance with local service provision.

The Trust will provide annual mandatory training for all staff members with updates on safeguarding children and vulnerable adults and management of violence (not an exhaustive list).

Before new staff has contact with Service Users or family/carer they must attend the Trust Induction Programme and an Enhanced Criminal Records Bureau (CRB) check completed.

21. Activity Recording

All staff within the Home Treatment Service will be required to adhere to the Trust Protocol for record keeping. In addition staff will consider other Policies and Procedures for which their work will be defined within such as Care Programme Approach and the Trust Safeguarding Children's Policies and Vulnerable Adult Policy and Procedures. This list is not exhaustive.

22. Key Targets to be achieved:

All Service Users must be seen within locally agreed response times. The Home Treatment Team will be required to meet or exceed the local delivery plan targets for the number of episodes for Home Treatment as outlined in schedule 5 of the contract. The Team Manager will work closely with the Performance and Information Department to collect the mandatory monthly returns and any adhoc data reporting as agreed.

23. Financial

TBC

24. Performance Monitoring Arrangements:

At a minimum there will be quarterly contract meetings with the commissioning alliance to discuss performance, finance, quality and activity aspects of the contract. There will also be monthly meetings with local commissioners from Primary Care Trust's (PCT's) to discuss service developments, operational and quality issues pertinent only to that local area.

The performance data must be submitted in a monthly basis by the 15th working day following month end.

In addition the provider will produce a report detailing its performance against the clinical quality indicators set out in schedule 3 part 4A. From 2010 this will be published on a public basis as per the national requirement.

As per clause 31.1 of the contact the provider shall meet the service targets (where stated) in this service specification in addition to any applicable national targets and outcomes measures from time to time set out in guidance or otherwise specified by the Secretary of the State. The procedure for any underperformance due to an unforeseen increase in demand, or as a result of action taken or omitted by a commissioner is described in clause 31.2.

Schedule 15 describes the process that will be followed to correct any serious problems.

25. Audit Requirements:

Regular audits of the service should be undertaken to ensure that gaps in service provision are filled and quality of care meets the required standards. Audit should always include feedback from Service Users and their family/carers via the Patient Opinion website and Patient Experience Questionnaires.

26. National Strategy or Policy Context;

In developing this service specification particular emphasis has been placed on:

- The Mental Health Act 2007
- Implementation of 'Refocusing the Care Programme Approach' (DH 2008)
- Ten High Impact Changes for Mental Health – National Institute for Mental Health in England (NIMHE) 2006
- Related guidance and clinical guidelines such as achieving the National Suicide Prevention Strategy and (NICE) Guidelines for Schizophrenia
- The Journey to Recovery (DH Publications November 2001)
- No Health without Mental Health (2011)
- Health and Social Care Bill (2011)
- PIG for CRHT
- Personalisation

27. Local Strategy or Policy Context:

TBC

28. Quality Measures / Standards:

The quality measures outlined in Appendix 2 including:

- Personalisation Agenda – Scope for Direct Payments Unable to collect
- Employment Assistance Unable to collect although we do produce the LA 149 and 150 which is employment and settled accommodation data.
- Help with Accommodation as above
- CQUINN and 'Advancing Quality'
- Multiple Anti-psychotic prescribing where applicable – not able to extract
- Compliance with NICE guidance – not able to produce
- Care Quality Commission Standards Compliance (From 1st April 2009) do you mean the monitor compliance? As I don't think we can do this to team level
- Health Promotion activities unable to produce
- Research Requirements – unable to produce
- Liaison Activity - what do you mean by liaison activity, would this not be face to face seen.

Quality monitoring should be facilitated by selection from an appropriate number of indicators, such as:

- HoNOS Score - ? would this not be pbr – as currently we don't produce community HONOS
- % of patients with a carer who is in receipt of carer's assessment
- Admissions per 100,00 population
- Patient Survey Scores – performance are unable to produce
- SDQ – Strengths and Difficulties Questionnaire – unable to produce
- Experience of Service User Questionnaire (ESQ) unable to produce
- Waiting/Response Times
- Complaints – numbers received and response times
- Litigation Claims
- Number of Serious Unexpected Incidents (SUI's)
- Threshold Assessment Grid (TAG) unable to produce
- Treatment Outcome Profiles (TOPS) in Substance Misuse unable to produce
- Essence of Care Benchmarks unable to produce
- Others (to be determined and/or negotiated)

29. What is the Service Intended to Achieve:

Ensure an effective assessment and appropriate care plan for those Service Users referred to the Home Treatment Team. The assessment will include a comprehensive timely and multi-disciplinary review looking at all aspects of an individual's health and social needs incorporated in a qualitative risk assessment and management plan. The team will provide intensive home treatment as an alternative to hospital admission and will support early discharges from the adult acute inpatient wards. Upon completion of the care plan the Service User may be referred onto Recovery Services or back to Primary Care.

30. Transfer and Discharge Process:

The team will remain involved with the Service User until the episode of Intensive Home Treatment is completed. Following the completion of Home Treatment appropriate sign posting, transfer or discharge will occur. Whatever process is followed it should include the following:

- A formal plan detailing the Service Users needs and any contingency plans should a re-referral be required in the future
- A summary of the Intensive Home Treatment that has been provided alongside the outcomes that the Service User has obtained
- Details of any follow up arrangements

31. Community Partners Involved in Service:

- Social Services
- Local Crisis facilities where present
- Local Authority Leisure, Libraries and other community support

- Primary Care Mental Health Team
- General Practitioner
- Drug and Alcohol Action Teams (DAAT's)
- Housing
- Local Voluntary Sector
- Social Enterprise Organisations
- Adult Education
- Job Centres
- Community Pharmacists

32. Local Variations:

33. Approval Date:

34. Approved by:

35. Review Period:

5BP Commissioning Alliance Draft Specification

ASSESSMENT SERVICE

Service Title: ASSESSMENT SERVICE

1. Service Description:

The Team's role is to provide assessment, for people who may need contact with secondary mental health services. Assessment service practitioners will support access to services in a timely manner, as well as ensure arrangements are in place to enhance smooth pathways between primary care and secondary services.

The Assessment Team will provide a mental health service for adults with moderate to severe symptoms. In addition to mental health and risk assessments, the team provides support for the delivery of educational and self-help material in a variety of locations, including the client's home, where appropriate. Good partnerships are maintained with services in the non-statutory sector, to ensure effective care for people with more severe conditions.

The Team will work in partnership with primary care and acute Trusts to provide a service for patients who require specialist psychiatric assessment using Payment by Results clustering and / or management of people who have severe mental illness who cannot be supported in primary care alone. NM - Not quite sure what it means?

The service will provide a triage function and act as a 'gatekeeper' to mental health services including inpatient care, as appropriate. Rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service. NM - the gatekeeping role for inpatient care is on the Home treatment team? The issue of gatekeeping remains with Home Treatment during 8-8 but the above sentence states that the service will provide this role when appropriate but will need clarification in operational guidance

The service will provide access to specialist mental health services through a single point of access. This service will ensure that anyone requiring specialist mental health assessment or advice has ease of access to a timely response. This forms part of a wider acute care system provided by the Trust and this service performs a crucial coordinating function to ensure that service users experience a smooth journey through the most appropriate care pathways.

This Service will operate in the context of Effective Care Co-ordination Policies and Procedure, and all other Policies of the Trust and Local Authorities.

2. Provider Name:

5 Boroughs Partnership NHS Foundation Trust

3. Address of Organisation:

Hollins Park, Hollins Lane, Winwick, Warrington WA2 8WA

4. Base/location of Service:

The Assessment Teams will be located at the following bases:

Warrington
Delete St. Helens Knowsley
Wigan

5. Lead Contact at Trust: Chief Operating Officer

The **Chief Operating Officer** is responsible for:

- Ensuring that the strategic direction is consistently communicated to all staff regarding the delivery of Assessment service.
- The further development of this Guidance in conjunction with the Accountable Director and other stakeholders.
- Ensuring that delivery of Assessment service is subject to monitoring, development and review.
- Ensuring that resources are available for the commissioned provision of Assessment service

6. Telephone:

01925 664007

7. Service Availability:

The services will available 24 hrs a day 365 days a year with its core business hours operating between the hours of 8am to 8pm, 7days a week including Bank holidays.

8. Out of Hours Cover:

Not applicable.

9. Scope:

The Assessment service has a number of key components. Each must be in place if the service is to operate effectively

The service is appropriate for adults NM - (>18) who present with a moderate to severe functional mental health problem. There needs to be a statement agreed with Linda Kellie relating to scope of service in terms of age range email forwarded today (20/10/11) at 12:45.

The service will work people with mental health issues not included in Payment by Results clusters 1-4 (May need clarification of this sentence)

The following paragraph and bullet points relating to service exclusions were deleted

Assessments/interventions will take place in a variety of settings including police custody suites, places of safety, acute hospitals assessment centres and service users home.

- The service will provide a single point of access into secondary services. All referrals will be screened for eligibility criteria as above.
- If referral does not meet eligibility criteria the referral will be signposted to the most appropriate service and referrer informed in writing within 2 working days
- Everyone who is referred, who meets the eligibility criteria, will be offered assessment with 7 working days The referrer will receive a written response detailing the outcome of the assessment within 10 working days after the assessment
- GP's who require telephone advice in respect of a patient who is known to secondary mental health services will have a response within 1 working day. The outcome of this advice will be confirmed in writing within 2 working days. If the person is open / known by Recovery the response must come from them.
- *All assessments will be prompt and risk factors taken into account when prioritizing referrals. Referrals considered high risk will be undertaken within 24 hours, these may be completed or coordinated by the assessment team*
- *Where appropriate a multidisciplinary assessment of service users needs and level of risk will involve a process of consultation with other mental health professionals.*
- *Mental Health Act assessments will be conducted by appropriate practitioners. and will be coordinated by the assessment team*
- *The assessment team will follow the agreed trust procedure for Service users who Do Not Attend.*
- Assessment will actively involve the service user, carers/family and all relevant others, for example, GP.
- Service user involved in decision making and monitoring effects of medication.
- *The Principles of "access booking and choice" and "copying correspondence" will be adhered to.*

10. Geographical Area Served:

The service will operate within the usual boundaries of the Trust's specific GP Consortia, but this needs to be agreed contractually

11. Key Relationships with other Agencies:

- Work formally in an integrated manner with Local Authority (LA) Social Services staff. An issue relating to referrals for safeguarding children or adults by central duty teams / clearing house in social services may need addressing with LA colleagues
- To enhance treatment for a service user with drug or alcohol addiction through close and effective working with Substance/Alcohol Misuse Teams and other teams including those in ***the third sector***.

12. Links to other NHS Teams/Services:

The service will work closely with other Mental Health teams working within the locality and other NHS, social care and criminal justices services as appropriate.

The service will establish good links with primary care mental health services so as to prevent referrals falling between services.

The service will establish close working relationships with general practitioners.

13. Age Range:

18 years and above with no upper age limit for people with a functional illness. Older adults with a suspected functional mental illness will not be excluded purely on age grounds. Email sent to Linda Kellie (20/10/11) to confirm statement to be used

14. Source of Referrals:

The Team will operate an "open access" referral system, accepting referrals from e.g. Primary Care, deleted self-referral family/carer (where the individual is aware of and agreeable to the referral), statutory and voluntary agencies on completion of the teams' referral form or local Choose and Book systems. Referral to the service should be easy and referral pathways clear to all involved.

It is expected that routine referrals from other professionals will be via the referral form. This must be completed in full, be legible and with accurate information. The team will not accept responsibility if the demographic information is incorrect

Urgent referrals will be accepted via the telephone a referral form will be completed by an assessment team practitioner during the call to ensure all essential information is collected. Deleted Note about self presentation

15. Response Times:

The assessment team will provide a response according to need and risk. This is not an emergency service.

GP's who require telephone advice in respect of a patient who is known to secondary mental health services will have a response within 1 working day from assessment or recovery service as appropriate. The outcome of this advice will be confirmed in writing within 2 working days.

Everyone who is referred, who meets the eligibility criteria, will be offered assessment within 7 working days. The referrer will receive a written response detailing the outcome of the assessment within 10 working days after the assessment

All assessments will be prompt and risk factors taken into account when prioritizing referrals. Referrals considered high risk will be completed within 24 hours. The team will make all reasonable efforts to contact service user within 2 hrs of receiving referral.

16. Risk Assessment and Management including CPA requirements:

This must comply with the guidance in "Refocusing the Care Programme Approach" (DH 2008).

17. Age Culture and Gender Specifics:

There are no exclusions on the grounds of age, gender and culture.
Deleted The service will also …

18. Interventions/Treatments to be offered:

- Prompt, expert and holistic assessment of mental health problems and risk assessments will be provided
- Signpost, transfer or discharge to appropriate service.
- Provision of information for service users and carers about how their treatment and care should progress and the options available to them.
- Effective, evidence based brief interventions will be provided where appropriate (by the medical consultant only) to reduce and shorten distress and suffering
- Provide advice and support to service users, families and carers
- Telephone advice to GPs on management of potential referrals and known service users to the recovery team

- The pharmacological management of service user's symptoms will be considered carefully. The prescriptions of any medication will adhere to the National Institute for Clinical Excellence (NICE) guidelines.

20. Choice:

The NHS encourages choice and people from other geographical areas out-with the usual catchment zone can choose to have their inpatient care provided at the trust. The follow up care may therefore require liaison with a team from another area

21. Workforce Issues:

The Team consists of:

Team manager
Deputy team manger
Senior nurse practitioner
Occupational therapist – MW (from Cath Burrows) -The only comment that I have is that I feel that the team does not need an Occupational Therapist as these posts would be better situated within a home treatment or recovery team, it does however need more band 6 practitioners to provide the service within the spec, 24 hour/7day service both to the community and A&E, which is also to provide brief interventions as the staff will have to care co-ordinate these clients and provide intensive input. I also feel that the admin compliment within the team is very inadequate and that there should only be Band 3 and above admin, given the constraints of the Band 2 job spec. I am also a bit unclear as to why the team needs input from a clinical psychologist? Stays in until after consultation
Social worker (AMHP)
Consultant Psychiatrist
Staff grade/specialty doctor
Office manager
Administrative staff
Consultant Psychologist

The team will have active support and input from:

Pharmacist and junior Doctors,

The Trust will provide annual mandatory training for all staff members with updates on safeguarding children and vulnerable adults and management of violence. Deleted along with

Before new staff has contact with service users or their family/carer they must attend the trust induction programme and an enhanced Criminal Records Bureau (CRB) check completed.

22. Activity Recording:

- *All services users will have relevant Effective Care Co-ordination documentation completed following assessment.*
- *Records will be kept in keeping with the trusts records lifestyle management policy and information governance policy.*
- *Written and electronic records will conform to the Mental Health Minimum Data Set.*
- *The team will ensure that all clinical activity and Effective Care Coordination documentation is inputted onto the Trusts information systems.*

- Staff will at all times practice in accordance with the Trust's Safe guarding Children's Policy and Procedures. Staff should ensure that they document and communicate NM - through the Trust electronic communication form directly with the Trusts Safeguarding Children and Adults Team, Named Nurse Child Protection lead should they identify concerns or require advice.

In addition to the data items in the mental health minimum data (MHMDS) set a number of quality and outcome measures are to be recorded. The full list is shown in Schedule 5 of the contract.

23. Key Targets to be achieved:

All patients must be seen after triage or referral within the response times agreed and the caseload must meet or exceed the Local delivery Plan (LDP) targets as outlined in Schedule 5 of the contract.

Data will be supplied by the Team Manager on a monthly basis to monitor referrals to the Service. Other data to be collected on a monthly basis to include –

- Referral source
- Referral type
- Seen within target time
- Date of assessment
- Response letter to GP
- Activity
- Outcome of contacts
- Age band
- Gender
- Ethnicity
- Letters to referrer

24. Financial: ?????

25. Performance Monitoring Arrangements:

At a minimum there will be quarterly contract meetings with the commissioning alliance to discuss performance, finance, quality and activity

aspects of the contract. There will also be monthly meetings with local commissioners from Primary Care Trusts (PCTs) to discuss service developments, operational and quality issues pertinent only to that local area.

The performance data must be submitted on a monthly basis by the 10th working day following the month end.

In addition the provider will produce a report detailing its performance against the clinical quality indicators set out in schedule 3 part 4A. From 2010 this will be published on a public basis as per the national requirement.

As per clause 31.1 of the contract the provider shall meet the service targets (where stated) in this service specification in addition to any applicable national targets and outcomes measures from time to time set out in guidance or otherwise specified by the Secretary of State. The procedure for any underperformance due to an unforeseen increase in demand, or as a result of action taken or omitted by a commissioner is described in clause 31.2. Schedule 15 describes the process that will be followed to correct any serious problems.

26. Audit Requirements:

Regular audit of the service should be undertaken to ensure that gaps in service provision are filled and quality of care meets the required standards. Audit should always include feedback from service users and their family/carers.

27. National Strategy or Policy Context:

In developing this service specification particular emphasis has been placed on:

- The Mental Health Act 2007.
- Implementation of 'Refocusing the Care Programme Approach' (DH 2008).
- Ten High Impact Changes for Mental Health - National Institute for Mental Health in England (NIMHE) 2006,
- Related guidance and clinical guidelines such as achieving the National Suicide Prevention Strategy and (NICE) Guidelines for Schizophrenia.
- The Journey to Recovery (DH Publications November 2001)
- No Health without mental health (2011)
- Health and Social care bill (2011)
- Talking Therapies a four year action plan (DH, 2011)

28. Local Strategy or Policy Context:

This Next section needs to be agreed with performance department consistently for each service specification., Do assessment team need carers assessment as an outcome / quality measure

29. Quality Measures/Standards:

The quality measures outlined in Appendix 2 including:

- Personalisation Agenda - Scope for Direct Payments
- Employment Assistance
- Help with Accommodation
- CQuin and "Advancing Quality"
- Multiple Anti-psychotic prescribing where applicable
- Compliance with NICE guidance
- Care Quality Commission Standards Compliance (From 1st April 2009)
- Health Promotion activities
- Research Requirements
- Liaison Activity

Quality monitoring should be facilitated by selection from an appropriate number of indicators, such as:

- HoNOS Score
- % of patients with a carer who is in receipt of a carer's assessment.
- Admissions per 100,000 population
- Patient Survey Scores
- SDQ –Strengths and Difficulties Questionnaire
- Experience of Service User Questionnaire (ESQ)
- Waiting/Response Times
- Complaints – numbers received and response times
- Litigation Claims
- Number of Serious Unexpected Incidents (SUIs)
- Threshold Assessment Grid (TAG)
- Treatment Outcome Profiles (TOPS) in Substance Misuse
- Essence of Care Benchmarks
- Others (To be determined and/or negotiated)

30. What is the service intended to achieve:

- . Ensure effective risk assessment and safe management of risk within the new guidance on CPA.
- A comprehensive, timely and multi disciplinary mental health assessment that includes all aspects of an individual's health and social needs incorporating a qualitatitive risk assessment and management plan.
- Following assessment appropriate signposting, transfer or discharge

31. Transfer and Discharge Process:

The team will remain involved with the client until the assessment is completed. Following assessment appropriate signposting, transfer or discharge will occur.

Handover should include:

- An agreement on the appropriateness of referral
- A formal plan detailing the service users needs and contingency plans including risk factors and relapse signatures.

.

- If a service user moves out of area arrangements will be made with an appropriate team receiving the referral
- Deleted bullet-point On discharge from the assessment team …
- A letter will be sent to the person's referrer and GP within the agreed timescale following discharge or transfer.

32. Community Partners involved in Service:

- Social Services
- Local Crisis facilities where present
- Local Authority Leisure, Libraries and other community support
- Primary care Mental Health Team
- General Practitioner
- Drug and Alcohol Action Teams (DAATs)
- Housing
- Local Voluntary Sector
- Social Enterprise Organisations
- Adult Education
- Job Centres
- Community Pharmacists

33. Local Variations:

34. Approval date:

35. Approved by:

36. Review Period:

5BP Commissioning Alliance Draft Specification

Recovery Service

Service Title: Recovery Team

1. Service Description:

The recovery team will work predominately with service users with functional severe and enduring mental health needs over the age of ?18(*awaiting clarity from CAMHS*) who cannot be managed appropriately or solely within primary care mental health services, or who require shared care with such teams when appropriate, due to the level of risk. It includes any person with moderate to severe functional mental health problems and has been assessed as requiring secondary mental health services.

The majority of service users seen by the recovery team will have been included in Payment by Results (PBR) clusters 11-17 and may require monitoring and treatment as part of their ongoing recovery process which could take several years.

The recovery team will work with service users included in PBR clusters 5-8 who will be referred back to the Primary Care Mental Health Team (PCMHT) and/or their General Practitioner (GP) after a period of treatment when their condition has improved.

Recovery Teams are a specialist secondary mental health service and will work with partner agencies and services to:-

- Ensure that the service is targeted to assist people appropriately within a recovery model and make effective use of resources.
- Provide a suitable response within the agreed timescales. (See Response Times Section)
- In conjunction with service users and carers, continually assess individual needs, develop care plans and review the appropriateness of these plans. These actions will be in line with the agreed Effective Care Co-ordination (ECC) process.
- Ensure that the personalisation agenda/direct payments is addressed
- Offer a carer's assessment and where required refer to a provider service.
- Identify young carers and liaise with Children's Services to ensure an appropriate assessment is undertaken.

- Assess and identify risk, developing risk management strategies as part of individual care plans. This will be in accordance with the guidance provided by the ECC process.

- Share expertise to assist colleagues to support service user's both within the organisation and externally.

- Strive to provide services that are sensitive to issues of ability, ethnicity, gender and sexual orientation and involve service users and carers in all aspects of service planning and delivery.

- Work with the service users and other agencies to promote good physical health and wellbeing.

2. Provider Name: 5 Boroughs Partnership NHS Trust

3. Address of Organisation:

Hollins Park, Hollins Lane, Winwick, Warrington, WA2 8WA

4. Base/location of Service:

The recovery teams will be based at the following locations
Halton
Knowsley
St Helens
Warrington
Wigan

5. Lead Contact at Trust:

Lead Contact at Trust: Chief Operating Officer

The Chief Operating Officer is responsible for:

- Ensuring that the strategic direction is consistently communicated to all staff regarding the delivery of Assessment service.
- The further development of this Guidance in conjunction with the Accountable Director and other stakeholders.
- Ensuring that delivery of Assessment service is subject to monitoring, development and review.
- Ensuring that resources are available for the commissioned provision of Assessment service.

6. Telephone: 01925 664007

7. Service Availability:

Core hours will be Monday to Friday 9am to 6pm – excluding bank holidays (there will be flexibility to work between the hours of 8am to 8pm to meet the needs of service users)

8. Out of Hours Cover:

Service users would need to be transferred to the home treatment team should for a short period of time an out of hours service be deemed necessary

9. Scope of the Service:

To include the following conditions:
Those individuals with a severe and enduring mental health problem included in PBR clusters 5-8 and 11-17 with evidence of severe social disability which may include risks to the individual or others and would include those with severe and enduring mental health problems and severe and enduring mental health problems and substance misuse problems. They are likely to have complex problems and may present difficulties with engagement. Typically such patients may require interventions under the Mental Health Act. They will present predominantly but not exclusively with a psychosis such as schizophrenia or bipolar disorder. This will also include severe disorders of personality where these can be shown to benefit by continued contact and support with secondary core mental health services.

Those disorders requiring specialist and/or intensive treatment such as psychological therapies and/or medication maintenance for treatments such as Clozapine or the initiation of medications such as lithium requiring blood tests where the level of risk is greater than can be dealt with safely by the primary care team. They may need assistance with activities of daily living either themselves or with the support of a carer. The Recovery Team will help with a range of activities, for example in education, employment and social activity, which will help promote recovery. Where it is commissioned this may involve working with those who are homeless.

10. Geographical Area Served:

The service will operate within the usual boundaries of the Trust specific GP Consortia but these will need to be agreed contractually.

11. Key Relationships with other Agencies:

Recovery Teams will work closely with other services such as Local Authority Departments and staff, Criminal Justice, Substance Misuse, Advocacy; Health promotion

- To support them in managing Service Users receiving care from the Recovery Team within agreed protocols.

- To pilot and evaluate new ways of working with other services.

- To access services and departments such as housing, education, leisure and other teams based on local Partnership agreements.

- The Recovery Teams will work jointly with other specialist services including those in the third sector.

12. Links to other NHS Teams/Services:

The links with Primary Care Teams are paramount and joint protocols must be established to ensure continuity of care and expedite the transfer of cases from the Recovery Team back to primary care. Links with the PCMHT also need to be clear to ensure that physical health needs are met as soon as indicated by the presenting clinical status.

The Recovery Team will work closely with the Home Treatment Team who will normally work with a similar client group but who take the lead when the service user is in an acute phase and where there is a risk of admission to hospital. The Recovery Team will take over when the acute phase has subsided. The Recovery Team will also work closely with in patient services and may take discharges from in patient services where the service user has been known previously to the Recovery Team or where they are not previously known they will have had a plan of care that will be met most appropriately by the Recovery Team.

Links to the Assessment team must be clear so that service user's assessed as requiring on going treatment for a severe and enduring mental health problem can move swiftly through to the Recovery Team.

13. Age Range:

?18 years upwards with no upper age limit. Older adults with severe and enduring functional mental needs should not be excluded purely on age grounds. Their needs should be assessed and treatment provided by the most appropriate team based on needs. Clients who have problems related to ageing or dementia should be transferred to the Later Life and Memory Services regardless of age.

14. Source of Referrals:

Referrals will routinely come from the Assessment Team but referral's will also be accepted from Early Intervention services (EI), in-patient services and home treatment.

15. Response Times: to referrals received

Clients must not wait longer than 10 working days for initial contact with the Recovery Team and the type and timing of the initial contact will be determined by the route of referral and assessment of need and risk assessment carried out by the referring team.

16. Risk Assessment and Management including CPA requirements:

This must comply with the guidance in 'Refocusing the Care Programme Approach' (DoH 2008) and will be initiated by the referring team and will be reviewed by the Recovery Team on an on-going basis

17. Anti-discriminatory Practice:

There will be no exclusions or discrimination on the grounds of age, gender, race, sex, disability, sexual orientation and religion or belief.

18. Interventions/Treatments to be offered:

- Use of agreed care pathways and interventions compliant with NICE guidance and Per pathways
- Active involvement and liaison with the ward staff where a service user is admitted to hospital.
- Risk Assessment, care planning, monitoring and review in line with ECC policy.
- Assessment and support with their physical health needs and onward referral to services such as smoking cessation or weight management services if appropriate.
- Shared care with primary care for the prescribing of atypical anti-psychotic medications.
- Maintenance for service users with relatively stable severe and enduring mental health needs when appropriate until transfer back to Primary Care Services can be organised in line with Pbr pathways.

Following assessment and care planning the recovery teams will provide services that will meet the needs of the service user which promote recovery and independence away from specialist mental health services.

- This may involve a process of on-going assessment of needs following the initial assessment.
- Continued care planning that focuses on recovery and independence.
- To provide individual care co-ordination when in an acute phase of ill health and a point of contact while planning recovery, prior to discharge from services.
- To provide information or assessments that support commissioning of services by local authority or specialist health services.
- To support the client in the maintenance of their physical health, by assessing needs and linking in to appropriate resources to help improve health.
- To provide evidence based therapies and medical, nursing, psychological and occupational interventions.
- To work closely with other services to avoid duplication of information and a smooth transition between services
- Evidence based psychological therapies? not commissioned in Warrington
- Evidence based treatments such as Occupational Therapy, relapse prevention strategies and psycho-education.
- Treatments will be based on need whilst also promoting choice and recovery

Physical Health Care

- Physical health needs need to be given a priority and be regularly assessed and action and/or advice given if indicated. Assessing and addressing the physical health needs of the service user should be given a high priority particularly those people on anti-psychotic medication.

Health promotion

- The Recovery Team must ensure that service user's should have assess to activities which look at diet, nutrition; substance misuse, sexual health, smoking cessation, and exercise. The Recovery Team should also encourage access to dental and optical examinations and flu vaccinations where appropriate.

- Assessments should address the adequacy of housing, educational and leisure needs and where appropriate assessments, including risk, should be referred onto local authority departments or other agencies to tackling and resolving issues. Each service users accommodation status should be assessed and actions taken to ensure security of tenancy where applicable.

- N.B. The socially excluded adults Public Service Agreement (PSA) 31 has signalled the Government's priority in achieving improved

settled accommodation outcomes for adults receiving secondary mental health services.

- The service user's employment status and needs should be assessed and referral made to employment support where applicable.

19. Choice

The NHS encourages choice and service user's from other geographical areas outside of the usual catchment area and can choose to have their care provided at the Trust. This may therefore involve liaison with teams from another area.

20. Workforce issues:

The recovery team is multidisciplinary and includes Doctors, Nurses, Occupational Therapists, Psychologists, Psychological Therapists and Social Workers as well as other qualified or experienced health and social care professionals. All staff will be supervised and supported in providing recovery services. Supervision will consist of mandatory management and clinical or professional supervision.

The team will have active support from a Pharmacist.

The Trust will provide mandatory training for all staff members with updates on safeguarding children and vulnerable adults and the management of violence.
Before new staff members have contact with service users and/or their family/carer they must attend the Trust induction programme and have an enhanced Criminal Records Bureau (CRB) check.

21. Activity Recording:

All service users will have relevant ECC documentation completed Records will be stored in keeping with the Trusts records lifestyle management policy and information governance policy
Written and electronic records will conform to the Mental Health Minimum Data set.

The team will ensure that all clinical activity and ECC documentation is inputted onto the Trusts information systems.

Staff will at all times practice in accordance with the Trusts Safeguarding Children and adult Policy and Procedures.

In addition to the data items in the mental health minimum data set (MHMDS) a number of quality and outcome measures are to be recorded. The full list is shown in Schedule 5 of the contract.

22. Key Targets to be achieved:

All patients must be seen after referral within the response times agreed and the caseload must meet the Local Delivery Plan (LDP) targets as outlined in schedule 5 of the contract.

23. Financial:

???????

24. Performance Monitoring Arrangements:

At a minimum there will be quarterly contract meetings with the commissioning alliance to discuss performance, finance, quality and activity aspects of the contract. There will also be monthly meetings with local commissioners from Primary Care Trusts (PCTs) to discuss service developments, operational and quality issues pertinent only to that local area.

The performance data must be submitted on a monthly basis by the 10th working day following the month end.

In addition the provider will produce a report detailing its performance against the clinical quality indicators set out in schedule 3 part 4A. From 2010 this will be published on a public basis as per the national requirement.

As per clause 31.1 of the contract the provider shall meet the service targets (where stated) in this service specification in addition to any applicable national targets and outcomes measures from time to time set out in guidance or otherwise specified by the Secretary of State. The procedure for any underperformance due to an unforeseen increase in demand, or as a result of action taken or omitted by a commissioner is described in clause 31.2. Schedule 15 describes the process that will be followed to correct any serious problems.

25. Audit Requirements:

Regular audit of the service will be undertaken to ensure that gaps in service provision are filled and quality of care meets the required standards. Audit should always include feedback from service users and their family/carers.

26. Strategy or Policy Context:

In developing this service specification particular emphasis has been placed on

- Implementation of 'Refocusing the Care Programme Approach' (DH 2008).
- The Mental Health Act 2007 as amended
- Ten high impact changes for Mental Health – National Institute for Mental Health in England (NIMHE) 2006
- Clinical guidelines such as NICE Guidelines for schizophrenia, bi-polar disorder and borderline personality disorder
- The Road to Recovery (DH publications Nov 2001)
- No Health without Mental Health (DoH 2011)
- The Health and Social Care bill (2011)
- Talking Therapies a four year action plan (DoH 2011)

27. Local Strategy or Policy Context:

This needs to be agreed with the Performance Dept for each service specification.

28. Quality Measures/Standards:

The quality measures outlined in ? Appendix 2 including

- Physical Screening and Wellbeing Advice
- Smoking Cessation
- Referral for Personalisation Agenda - Scope for Direct Payments
- Referral for Employment Assistance
- Help with Accommodation
- CQuin and "Advancing Quality"
- Multiple Anti-psychotic prescribing where applicable
- Compliance with NICE guidance
- Care Quality Commission Standards Compliance (From 1st April 2009).
- Health Promotion activities
- Research Requirements
- Liaison Activity

Quality monitoring should be facilitated by selection from an appropriate number of indicators such as:

- HoNOS Score
- % 7 day follow up
- % of Emergency Re-admissions within 28 days
- DNA rate first attendance
- DNA rate subsequent attendance
- % patients with a comprehensive care plan
- % of patients with a carer who is in receipt of a carer's assessment.
- Admissions per 100,000 population
- Patient Survey Scores

- SDQ –Strengths and Difficulties Questionnaire
- Experience of Service User Questionnaire (ESQ)
- Waiting Times
- Complaints – numbers received and response times
- Litigation Claims
- Number of Serious Unexpected Incidents (SUI)
- Patient Health Questionnaire (PHQ) PHQ9 and GAD7
- Clinical Outcomes Routine Evaluation (CORE)
- Quinmac: Quality Improvement Network for multi agency child and adolescent mental health services (CAMHS)
- Threshold Assessment Grid (TAG)
- Treatment Outcome Profiles (TOPS) in Substance Misuse
- 12 Week retention in treatment for Substance Misuse
- Essence of Care Benchmarks
- Duration of Untreated Psychosis (DUP)
- Others (To be determined)

29. What is the service intended to achieve:

The overall aim of the Recovery Team is to promote recovery, prevent relapse and encourage as well as facilitate social inclusion. The team will strive to reduce the stigma attached to mental illness and the distress that this can cause to service users and their carers/families

The Recovery Team should:

- Maximise the potential of service users to recover from their mental illness to a level that they aspire to.
- Improve engagement with service users, provide evidence-based interventions and promote recovery.
- Reduce hospital admissions and length of stay.
- Increase stability in the lives of service users and their carers/family
- Improve social functioning and inclusion, facilitate personal growth and provide opportunities for personal fulfilment.
- Provide a service that is sensitive and responsive to service users' cultural, religious and gender needs.
- Support the service user and his/her family/carers for sustained periods.
- Promote effective interagency working.
- Ensure effective risk assessment and safe management of risk.
- Promote good physical health and wellbeing.

30. Transfer and Discharge Process

When the care pathway has been provided and or a good level of recovery is has been sustained for six months, transfer back to the PCMHT should be considered. A care plan will be provided with a relapse plan for the primary care team and service user to use, if necessary in the

future. The care co-ordinator will be responsible for supporting the discharge and this will involve meetings with primary care and universal services as indicated in the care plan

If re-referral to the Recovery Team is required there should be arrangements in place to ensure this will receive priority within the assessment team.

If a service user moves out of area the transfer arrangements should be made with appropriate teams in the receiving patch.

A discharge letter will be sent to the service users GP within the agreed timescale following discharge or transfer.

31. Community Partners involved in Service:

- Social Services
- Local Authority Leisure, Libraries and other community support
- Primary care Mental Health Team
- General Practitioner
- Housing
- Local Voluntary Sector
- Social Enterprise Organisations
- Adult Education
- Job Centres
- Community Pharmacists

32. Local Variations:

33. Approval date:

34. Approved by:

35. Review Period:

Open Letter from Director of Finance to TAG

5 Boroughs Partnership NHS
NHS Foundation Trust

Our Ref: Tender
Your Ref:

Date: 28/10/11

Hollins Park House
Hollins Lane
Winwick
Warrington
WA2 8WA

Tel: 01925 664025
Fax: 01925 664052
Email: dean.marsh@5bp.nhs.uk

Open letter to members of TAG

Dear colleague

Ref: Financial aspects of Acute Care Pathway and Later Life model of care at 5 Boroughs

At the last TAG meeting the Trust was challenged over the depth of its financial information in support of the proposed models of care for adult and later life services at 5 Boroughs.

Whilst I maintain that the emphasis of the advisory group is to review the clinical and operational aspects of the models of delivery proposed, I recognised at that meeting that there were some assurances that TAG members would need to be able to support the model:

i) Value for money

ii) Extent to which the service models support the QIPP agenda

iii) Ensuring that costs are not inadvertently passed onto other organisations.

I write this open letter to TAG members to respond specifically to these three areas of assurance.

Value for Money

The national indicator used to monitor value for money is the reference cost indices. This is an annual exercise carried out by the Department of Health and compares the average cost of services of every provider organisation in the NHS. It compares 'like with like' by comparing mental health service providers with mental health service providers for example. The average cost of all providers across the country is calculated and this is given a standard reference cost of 100. Providers with reference cost of less than 100 therefore have a lower than average unit cost. The latest set of published data (available on the DoH website) relate to 2009/10, and the results for 2009/10, for the mental health trusts across the North West are shown in the table below.

Chief Executive: Mr. Simon J. Barber
Chairman: Mr. Bernard Pilkington
Trust Headquarters, Hollins Park House, Hollins Lane, Winwick, Warrington, WA2 8WA
Mini Com Number 01925 664094

Mental Health Provider	2009/10 Reference cost index
5 Boroughs Partnership	**95**
Cheshire and Wirral Partnership	105
Greater Manchester West	92
Merseycare	106
Manchester Mental Health and Social Care Trust	96
Pennine Care	90
Cumbria Partnership	108
Lancashire Care	119
National average for MH Trusts	**100**

From the table we can see that 5 Boroughs costs are 5% lower than the national average for mental health trusts and that only two trusts across the North West had a lower reference cost in 2009/10, and neither of these provide services across the footprint commissioned by those commissioners represented at the TAG.

The unpublished data for 2010/11 has suggested that for that reference period 5 Boroughs reference cost index has fallen even further.

QIPP

Whilst the TAG concerns itself with the clinical model, pathways and operational aspects of the Trust's proposals, a question has been raised about the extent to which the new models support the QIPP agenda. I maintain that it is not the Trust's 5-year financial strategy that should be under review, as there are many other groups and forum that deal specifically with this matter (primarily the commissioning and contract meetings held with our commissioners). In order to support the TAG though, I have produced information below which shows the specific financial impact of the changes currently under consideration by the TAG.

	Baseline £'000	2012/13 £'000	2013/14 £'000	2014/15 £'000	2015/16 £'000	2016/17 £'000
Acute Care Pathway	18,290	16,786	16,423	16,423	16,423	16,423
Later Life	4,820	4,209	3,419	3,544	3,544	3,544
Total for proposed models	**23,110**	**20,995**	**19,842**	**19,969**	**19,969**	**19,969**

As colleagues will know from our original presentation the Trust will already lose upwards of 4% per annum from its contract as part of the QIPP agenda and it is the effective redesign of services that reduces cost but maintains or improves quality and outcomes that will make the QIPP process a successful one. The Trust's proposals seek to do just that. The table above should show that the two proposals would contribute on an ongoing basis £3.1m towards the Trust's QIPP target.

TAG colleagues should note that these figures do not include any contribution to QIPP from the realignment of any estate across the Trust as a consequence of impact of the new model of care.

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'Cost shunting'

The passing of costs from one organisation to another is rarely, if ever, as a consequence of a financial strategy or financial decision. It usually arises where an organisation removes part or all of a service or function that it has historically undertaken or carried out (I accept that this may be as a consequence of a savings plan). It is therefore not possible to express this in financial terms, other than to state that it remains the stance of 5 Boroughs not to pass responsibility or costs for functions currently carried out by the Trust, by stealth, to its partners.

The real test for this assurance has to come through the TAG testing out the operational delivery of the proposed model of care and all stakeholders having mature conversations about the role and responsibilities of the Trust under the model of care. It is of course always possible that commissioners will decommission services and transfer responsibility to another provider (shared care is a good example) and the responsibilities and costs that would then transfer from one organisation to another contractual conversations that take place in the appropriate forum for those negotiations.

I hope that this responds to the points raised by TAG members.

Yours faithfully

Dean Marsh
Director of Finance

A Better View... *of mind & body*

Chief Executive: Mr. Simon J. Barber
Chairman: Mr. Bernard Pilkington
Trust Headquarters, Hollins Park House, Hollins Lane, Winwick, Warrington, WA2 8WA
Mini Com Number 01925 664094

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5 Boroughs Partnership
NHS Foundation Trust

Building on Strengths

Proposal for a New Model of Care

Later Life and Memory Services

October 2011

A Better View

Contents

Executive Summary

This model outlines proposals to qualitatively change the nature and balance of service provision by 5 Boroughs Partnership NHS Foundation Trust (hereafter called 'The Trust') and its partners for people having their mental health needs met within the Later Life and Memory Service Business Stream.

A new and robust model of care is proposed, that will enable the modernisation of services which reflects the Commissioning intentions set out in the 4 Borough Alliance strategy 'Securing Better Mental Health for Older Adults (2009). This focuses on early intervention and home/community based support and treatment promoting independence and personalised care. Effective Mental Health Services will be provided on a partnership basis. The Trust strategic objectives emphasise that recovery focused Mental Health services require statutory and voluntary agencies to work together closely with service users, carers and families to ensure that services are needs-led, local, accessible and well resourced.

In accordance with National drivers, this model aims to concentrate on improving productivity and eliminating duplication whilst focusing on clinical quality (DoH 2010a). We aim to deliver, in partnership with Primary Care, Social Care, Local Authority, Statutory, Independent and Not for Profit sectors, a comprehensive, evidence based Older Adults Mental Health specialist model (DoH 2008). This will encompass core functions to deliver a high quality needs led service for people with organic and/or specific Older Adult functional needs.

The model includes a proposal to utilise a single point of access / gateway function to provide cognitive and functional screening with direct access to advanced assessment and consultation. The model also outlines a Crisis Intervention function for Older Adults requiring specialist Old Age mental health services, and will provide greater integration between inpatients and community services allowing for extending hours to services.

The model encompasses a dedicated Community Mental Health Service to deliver person-centred interventions and care on the basis of need not age, in accordance with the Department of Health four priority areas (DOH 2010b). These are an integral part of improving the care and experience of service users and carers.

Also, in line with the National Dementia Strategy objectives (DOH 2009) our multidisciplinary memory services will provide high quality services including:

- Health promotion and education within Primary Care settings
- Early detection and diagnosis of cognitive impairment
- Specialist treatment and intervention for service users and carers in partnership with local authorities and third sector organisations.
- Specialist input to minority groups e.g. Black Asian and Minority Communities, Younger people with Dementia, Learning Disabilities and Dementia.

Building on current partnership working with statutory and voluntary sector organisations will enable the provision of additional support on a range of areas including accommodation, welfare benefits, advocacy, carer assessment and support.

The model is designed to improve productivity by simplifying the assessment and treatment pathway, thereby creating the capacity to meet increased demand for the services.

1. Introduction

Using the principals and objectives contained in recent Department of Health publications, we aim to deliver a community based service supporting people to remain at home, whilst improving and maintaining the quality of life of service users and their carers.

The care pathway will clarify and standardise the care delivered to people with organic conditions and older adults with complex functional conditions whose needs are best met by specialist older people's services.

Community provision will be supported by access to specialist in-patient beds in instances when the service user cannot be safely or appropriately managed within their local communities.

The in-patient beds will form a Centre of Excellence delivering short term assessment and treatment within an excellent physical environment with care delivered by a specialist multi-professional team of staff.

This model proposes a pathway for older people's mental health services that will enable the Trust and its partner agencies to deliver a comprehensive range of integrated, evidence based services in accordance with stakeholders' wishes and appropriate to meet the challenge of rapidly increasing levels of need. Being fully committed to integrated, local community services, the model enables the delivery of enhanced community provision.

2. Scope

The model includes the delivery of service to the geographic areas of the five boroughs of Halton, St Helens, Knowsley, Wigan and Warrington and to services commissioned for the population of the area by NHS commissioning bodies.

Its primary focus is services for people with organic mental health conditions, i.e. Alzheimer's disease, Vascular dementia, Dementia with Lewy Bodies, Fronto-temporal dementia (including Pick's disease) and others, some of whom may also have a functional illness, such as depression *and* those people with a functional illness whose needs are better met by the later life and memory services.

3. Background

Under the Equality Act (DOH 2010h), age discrimination in the provision of facilities, goods, services and public function is prohibited; therefore, services must be provided on the basis of needs not age. Older people who have mental health problems have a different medical presentation compared to younger adults and services have to respond to this.

The model outlined in this strategy details specialist provision for adults with older people's needs, and is not an age specific service. The services will work collaboratively with Adults Services to ensure that provision is equable as set out in the Equality Act (2010).

In the UK, it is estimated that 700,000 people have dementia and have an estimated cost of £17 billion pounds per year. By 2037, this is set to double to 1.4 million people with an increased cost of £50 billion per year. Dementia costs approximately £8.2 billion per year in direct health and social care costs; however, much of this spend is in response to crisis in later stages of the disease. The Department of Health (DoH) launched the National Dementia Strategy in February 2009, which is a comprehensive yet ambitious 5 year plan aimed at helping people live well with dementia. The DoH estimated that the strategy would cost £1.9 billion to implement over 10 years and this would be funded largely through efficiency savings. These savings could be achieved by reducing the amount of time that people with dementia spend in hospital when they no longer have a medical need to be there, or by reducing premature entry to care homes by providing better support in the community (estimated that £1.93 billion direct cost of dementia in care homes in 2009: House of Commons, 2010). These savings could then be re-directed to other areas such as early diagnosis and interventions in people's own homes. Also, national and regional leadership would be put in place and initial seed funding of £150 million would be allocated to Primary Care Trusts (PCTs) to assist the implementation over the first two years.

However, in practice, the Department has failed to match its commitments to raise the quality and priority of dementia care with a robust approach to implementation. It has failed to align leadership, funding, incentives and information to help deliver the strategy (House of Commons, 2010). Consequently, services are reviewing their working arrangements with partner agencies and key stakeholders to strive to meet the aims of the Department's strategy despite the current fiscal pressures.

3.1 Current service configuration and environment

Evaluation of the Trust's current services for older people reveals that modernisation has been limited and varies greatly from one borough to the next. Services lack flexibility and do not fully meet the needs of service users and carers, e.g. lack of access to out of hours services. Currently, community services operate Monday – Friday, 9am – 5pm excluding Bank Holidays, and

In-patient wards are available 24/7. Whilst there has been some development in the form of designated memory services, they are, in the main, provided through a traditional model of service that is in need of modernisation to enable services to deal with the forecast substantial growth in demand.

At present, each borough has its own Organic in-patient ward: Stewart Assessment ward based at Peasley Cross St. Helens, Sephton Unit based at Leigh Infirmary, Kingsley ward based at Hollins Park Warrington, Grange ward based at the Brooker Centre in Halton, and Rydal ward based at Whiston Hospital in Knowsley; older people with functional health needs are admitted to the Adult Acute in-patient wards. However, there are occasions where it is not considered appropriate for older, frail service users to be admitted to adult wards, and they are admitted to the organic wards.

Map of location of current inpatient wards. ↗ = Site.

The map is a separate attachment to this document.

Only one of the organic wards is currently fit for purpose, having undergone major refurbishment in 2010 which has brought about ensuite single bedrooms, a sensory garden area, conservatory and quiet lounge area, along with consulting rooms.

The photographs of the refurbished unit are on a separate attachment.

The décor and signage within the ward has been chosen specifically to suit service users with dementia. Whilst the other organic wards have had some minor updating, they do not fully meet our aspirations to provide an excellent environment for patients being admitted with Dementia. A key issue for the Trust is that whilst we meet the DoH guidance on provision of single sex accommodation, we do not currently have single sex organic wards, and this adds to the difficulty in nursing people with increasingly challenging clinical presentations. However, despite these challenges the in-patient wards all meet Essence of Care (EOC) and Accreditation of Inpatient Mental Health Services (AIMS) standards and have successfully implemented the Advancing Quality Initiatives (AQIs) improving the quality of inpatient care.

In the community service provision varies: gateway and/or access services are provided in various ways:

- Assessment and Treatment Centres in two boroughs,
- Memory clinics in four boroughs,
- Day services in two boroughs,
- Older people's Community Mental Health teams (CMHTs) in four boroughs,
- 'Ageless' CMHTs in the Wigan borough,
- Hospital liaison services provided for all five boroughs.

Dedicated crisis services do not exist. Currently a crisis is managed through existing community services, during normal opening hours, but there is very little available outside routine opening times.

In addition all boroughs undertake psychiatric out-patient clinics. Services are provided from a range of sites – some of which are Trust owned, but not all, and again they are not all 'fit for purpose' i.e. lack sufficient consulting rooms, have poor décor, lack appropriate waiting areas, and are not all easily accessible.

3.2 Current staffing skill mix

On review of the current staffing skill mix it becomes clear that there is a heavy emphasis on nursing staff, whilst therapy staff and psychologists are poorly represented within the directorate.

Table 1 Breakdown of Older People's Services Community staff

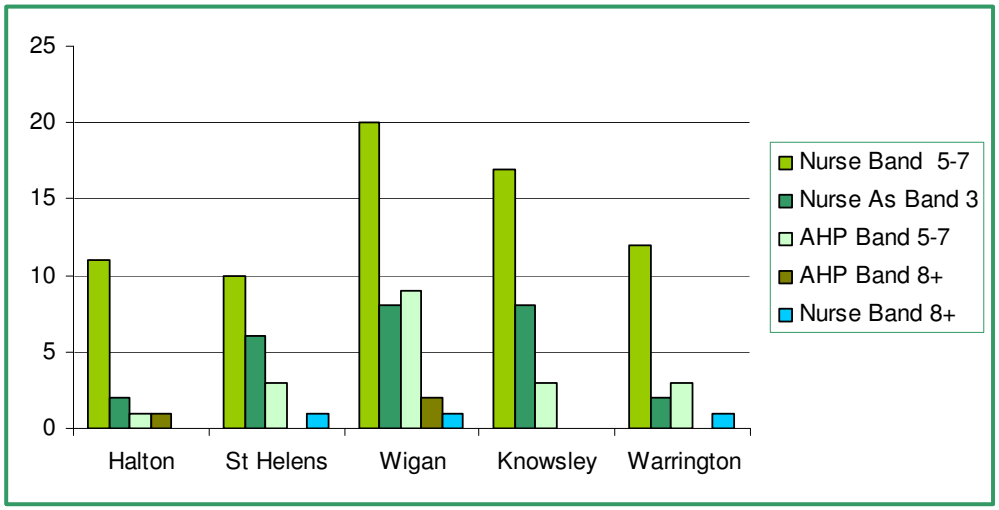


Table 1 shows that the majority of staff (Band 7 and below) working across community services are qualified nurses (N=73). This is followed by Nursing Assistants (N=26) and AHP's (N=19). There is a total of 6 practitioners (3 Nurses and 3 AHP's) working at Band 8 and above.

Table 2 (below) shows that the majority of staff (Band 7 and below) working across inpatient services are qualified nurses (N=73). This is followed by Nursing Assistants (N=82) and AHP's (N=0). There are no practitioners working at Band 8 and above.

In addition to these, there are 3 staff working in in-patients at a Band 2 level, fulfilling a housekeeper role.

Table 2 Breakdown of Older People's Services In-patient Staff

Table 3: breakdown of Medics and Clinical Psychologists working across both Community and Inpatient settings

There are a total of 18 Medics working across inpatient and community services. There are 2 Clinical Psychologists (8b) working in the Wigan Borough only (community).

Local Authority Staff

Our community teams are also supported by local authority staff through a variety of routes. St. Helens council second their social work staff into the CMHT whilst Warrington operates on a more "virtual team" basis. We will continue to work with our local authority colleagues and managers to ensure the best service model is delivered to meet the needs of our service users and carers now, and in the future.

3.3 Challenges: the need for change

Concerns have been raised by service users, carers, clinicians and stakeholders about the increasing demand being placed on existing resources to meet the needs of an ageing population. In recent years there has been a significant increase in older adult referrals, resulting in the present services

not being able to meet the demand in a timely way. Stakeholders have also expressed concern over the waiting times for assessment from specialist mental health services and gaining access to evidence based interventions.

Concerns have also been raised regarding the inequity between adults and older people's mental health services in being able to respond to crisis intervention and providing rapid response services.

The Healthcare Commission (in its national study of older people's mental health services) found that a contentious issue was the perception by some Trusts that services 'based on need, not age' meant that specialist services for older people were no longer required. This led to the Department of Health and the Care Service Improvement Partnership issuing clarification on 'age equality' (Minshull, 2007).

As there is a move away from purely operating from a medical model to a more person centred bio-psychosocial model of care, more attention needs to be paid towards the staffing structure across in-patient and community services. This is to ensure that high quality, evidence based assessment and care can be provided. We believe our current skill and staffing mix limits the availability we have to provide evidence based interventions.

Our proposal attempts to address these concerns, and ensure that the plans for a new service can equitably meet the needs of older people with mental health problems, through the provision of specialist services. The outline of the proposed model has been presented and discussed at a variety of venues within the LLAMS Service User and Carer Forums. (See Appendix

The National Audit Commission's report entitled 'Improving Dementia Services in England' (2007) stated that dementia is a significant and urgent challenge for health and social care. They found significant shortfalls in the NHS in the way care was provided:

- There was a lack of joint working across health and social care services,
- Spending was too late in the illness pathway,
- Too few people were diagnosed with dementia,
- People were not diagnosed with dementia early enough,
- Early interventions that were known to be cost-effective were not widely available.

These themes have been reflected in our redesign proposal. The challenge is for service providers to work collaboratively to facilitate person centred care, where the patient and their carers are able to prioritise their needs and make informed choices about their care which improves quality of life, choice and control, and freedom from discrimination.

During these times of financial constraint, there is even more reason to ensure that our services are provided in the most efficient and clinically effective way, as set out by 'The NHS Quality/Innovation, productivity and prevention challenge: an introduction for clinicians' 2010a (QUIPP).

4. National and Local Strategies and Drivers

4.1 National Policy and Guidance

There has been a growing body of policy and guidance in recent years including:

- The National Dementia Strategy (DOH 2009),
- the white paper '*Equity and Excellence: liberating the NHS*' (DOH 2010)
- the '*Revision to the Operating Framework for the NHS*' (DOH 2010)
- the Department of Health '*Quality Outcomes for people with Dementia*' (DOH 2010)
- the Equality Act (DOH 2010)
- the paper '*No health without mental health: a cross-Government mental health outcomes strategy for people of all ages* (DOH 2011)
- '*Nothing ventured, Nothing Gained: Risk Guidance for people with dementia*' (DOH 2010),
- '*The use of antipsychotic medication for people with dementia: Time for action*' (S. Banerjee 2009)
- Care Services Improvement Partnership paper '*Age Equality: what does it mean for older people's mental health services*' (CSIP 2007)

These publications have been consistent in promoting services based on need and not age, holistic person-centred services, the need for a whole-systems response, integrated mental health services involving service users and carers, supporting carers and supporting people with dementia in the community as far as possible.

The themes and recommendations implicit in these documents underpin the review of the Trust's older people's service provision, and continue to shape our service redesign.

4.2 Quality Initiatives

Innovation is a central focus for the Department of Health and the NHS, as demonstrated by the Quality Innovation Productivity Prevention (QIPP) programme. Organisational innovation and service redesign also have a major role in improving patient care, and lean methodologies are increasingly being adopted into the NHS, boosting efficiency and productivity.

Within the Older People's Business Stream there are a number of Quality Initiatives across the boroughs:

- Essence of Care (EOC) – Rating assessment and peer review has been undertaken across all teams / services / wards to identify areas of good practice. The new model supports the sharing of good practice across the Business Stream.

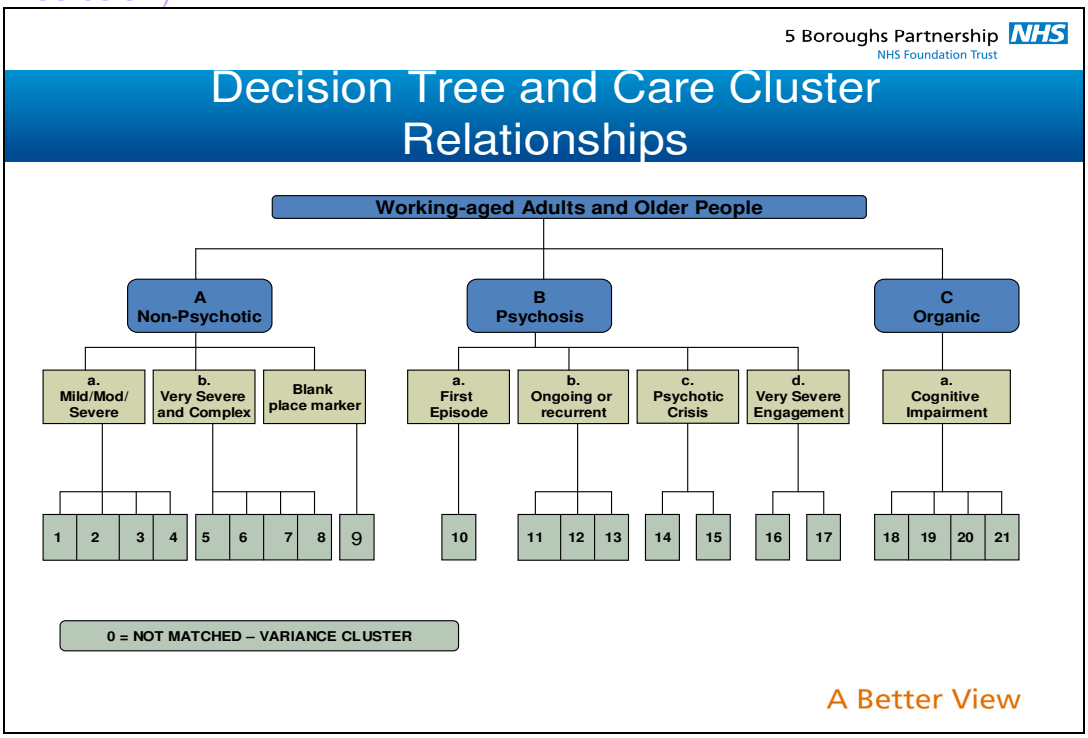
- Accreditation of Inpatient Mental health Services (AIMs) – whilst a number of our existing wards have been successful in gaining accreditation through the Royal College of Psychiatrists' accreditation programme, a number of recommendations for further improvement remain unresolved e.g. access to therapies in the in-patient setting, and single sex accommodation.
- Memory Service National Accreditation Program (MSNAP) – Three of the Trust's memory services have gained accreditation with 'Excellence'. The new model will ensure that 'gaps' identified in this process can be addressed e.g. access to neuropsychological assessment.
- Advancing Quality Initiatives (AQIs) – The Older People's business stream is implementing AQIs relating to in-patient services to improve the quality of inpatient care. Data collection regarding this commenced in December 2010.

4.3 Health of the Nation Outcome Scale (HoNOS) and Payment by Results (PbR)

Part of the Government plan is to 'modernise' the NHS by calculating the price for each transaction and then create a market (revised NHS Operating framework). This moves the contracting of services from a historical block contract basis into a more transparent process which:

- rewards efficiency
- is a fair and consistent basis for funding
- links payments to activity.

The Later Life and Memory Services Business stream has implemented HoNOS across community as well as inpatient services. HoNOS plus is being used as the basis for 'clustering' for Payment by Results (see PbR Decision Tree below).



The proposed new Model directly relates the assessment and intervention processes to the clinical presentation of patients and their resultant PbR cluster (see Figure 1 below).

Figure 1 Needs Led Care Framework

Need 5	(Severe – High Needs) **Risk & Complex case Management** **Interventions** – Intensive Risk and Crisis Management/Inpatient treatment (PBR Clusters Organic 21, Functional 5,6,7,8,13,15,17)
Need 4	**(**Moderate – Severe Need**) Crisis Prevention** **Intervention –** Intensive home treatment, Specialised treatment, Acute hospital liaison (PBR Clusters organic 20,21 Functional 4,5,6,7,8,12,13,15,17)
Need 3	**(**Moderate Needs**) Personalised Symptoms Management** **Intervention –** To work with families to reduce stress, Respite care, Specialist care home clinics, Medication reviews, Family, carer and staff training (PBR Clusters organic 19 Functional 3,4,11)
Need 2	(Mild - Moderate Needs) **Early intervention & Rehabilitation** **Intervention –** To aid with adjustment, Diagnose, Specialist groups, CBT, Cognitive stimulation, Anti dementia drugs, Family and carer support (PBR Clustering 18,19 Functional 2,3,4,11)
Need 1	(Mild Needs) **Self (Family) Management & Health Promotion** **Intervention –** To maintain health and well being, Primary healthcare In home practical social care packages, Day care, Voluntary networks (PBR Clustering organic 18 Functional 1,2)

Analysis of existing open episodes of care has indicated that at present the percentage split across the 5 levels of need are as follows:

Need 5	Need 4	Need 3	Need 2	Need 1
1%	28%	22%	39%	10%

Needs 1& 2 will be provided within the assessment and memory services. Capacity for future increase in demand will be created through implementation of Shared Care arrangements, as a significant proportion of those patients with level 3 needs will be transferred to Primary Care for monitoring. In addition, in-reach into care home settings providing education and advice regarding symptom management will enable those services to meet the service user's needs.

At present, Level 4 specialised treatment is provided by CMHTs and liaison. In the proposed model, the pooled community resource will additionally be able to provide intensive home treatment and crisis prevention. The expectation is that this will reduce the demand for Level 5 in-patient facilities.

4.4 Demographic Factors

The prevalence of organic and functional problems (including depression and dementia) is set to increase significantly as the population ages.

The 'Projecting Older People Population Information System' (POPPI) database identifies key characteristics within that population, projects numbers into the future, and compares future populations against

performance data. The tables below highlight the older adult population across the 5 Boroughs and the estimated prevalence of dementia and depression.

Projected population of over 65s across the 5 Boroughs:

Borough	2008	2010	2015	2020	2025	% Increase
Halton	16,800	17,400	20,300	22,700	24,700	**47%**
St Helens	29,800	30,600	34,600	36,800	39,300	**32%**
Warrington	30,400	31,800	36,400	39,700	43,200	**42%**
Knowsley	17,325	17,400	18,375	19,800	21,750	**26%**
Wigan	48,300	50,900	59,000	63,100	67,400	**39%**
Total	**142,625**	**148,100**	**168,675**	**182,100**	**196,350**	
Increase over 2008	**-**	**4%**	**18%**	**28%**	**38%**	

Projected population of over 65's with dementia across the 5 Boroughs:

Borough	2008	2010	2015	2020	2025	% Increase
Halton	1,123	1,162	1,291	1,472	1,705	**52%**
St Helens	2,007	2,080	2,309	2,613	2,936	**46%**
Warrington	2,101	2,175	2,487	2,832	3,317	**58%**
Knowsley	1,130	1,182	1,309	1,397	1,514	**34%**
Wigan	2,985	3,059	3,449	4,022	4,696	**57%**
Total	**9,346**	**9,658**	**10,845**	**12,336**	**14,168**	
Increase over 2008	**-**	**3%**	**16%**	**32%**	**52%**	

Dementia: The number of people with Dementia relates directly to the over 65 population. The incidence of Dementia increases the older people become. For the combined populations of the five boroughs the increase is forecast to be 82.6% between 2010 and 2030.

Breakdown of the local population and Depression projections for 2030:

Borough	OA Population		Depression	
	2010	2030	2010	2030
Wigan	50,500	75,800	4,364	6,471
Halton	17,300	27,600	1,485	2,374
St. Helens	30,600	43,300	2,653	3,737
Knowsley	23,100	33,300	2,011	2,874
Warrington	31,800	50,900	2,756	4,378
TOTAL	**153,300**	**230,900**	**13,269**	**19,834**

(Data source: POPPI 5.1; Department of Health, 2010)

Looking at this data by percentage change highlights the variances across the 5 Boroughs.

Projected % change from 2010 to 2030:

Borough	OA Population		Depression	
	Increase (2010-30)	Change in 2030	Increase (2010-30)	Change in 2030
Wigan	25,300	50.1%	2,107	48.3%
Halton	10,300	59.5%	889	59.9%
St. Helens	12,700	41.5%	1,084	40.8%
Knowsley	10,200	44.2%	863	42.9%
Warrington	19,100	60.1%	1,622	58.8%
TOTAL	**77,600**	**50.6 %**	**6,565**	**49.5%**

(Data source: POPPI 5.1; Department of Health, 2010

Depression: The percentage increase in depression is forecast to match the projected percentage increase in population resulting in a 49.5% increase between 2010 and 2030.

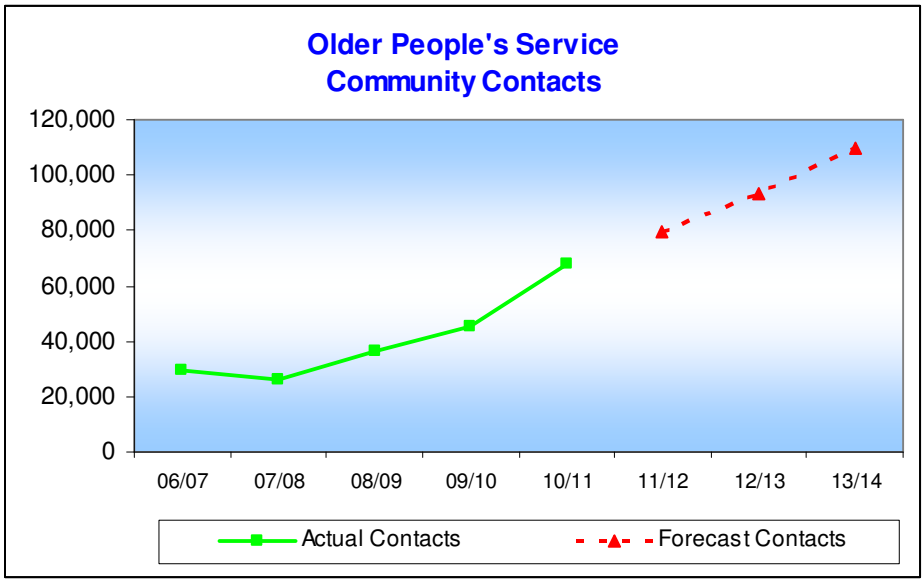
Whilst the percentage increase in Anxiety and Depression is 50% the increase in dementia outstrips this at 83%, indicating that the demographic trend predicts that as the population lives longer the predicted number of people developing dementia will increase disproportionally. Additionally, the clinical presentation will be more complex and severe as the severity of dementia increases with age: 13% of people aged over 65 have severe dementia but this increases to 23% for people over the age of 95.

4.5 Activity Trends

Analysis of activity trends over recent years, along with projections for future performance supports the development of the new strategic business model.

The number of community referrals has been steadily increasing with an average year on year increase of 17.1%. Table 1 demonstrates that between 2006/07 and 2010/11 the total community contacts rose from 29,217 to 66,556, an increase of 127.8%. Community activity is projected to rise further in coming years in line with the demographic changes highlighted previously; between 2010/11 and 2013/14 the community contacts are expected to increase by a further 60.6% to 106,913 per year. In order to meet this level of demand it is necessary to increase the community resource.

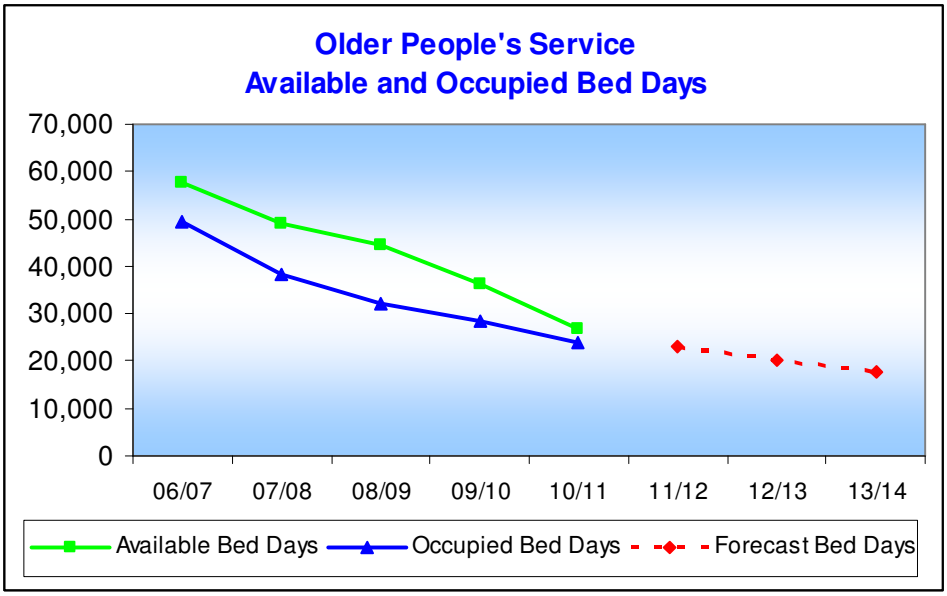
Older People's Services – community contacts



As community resources have increased to meet the 128% increase in community activity, the number of commissioned bed days has reduced as a consequence of the reduced demand of inpatient stay. Our data shows a further increase in community resources is required to meet what we believe will be the increase demand in community activity.

At the same time, evaluation of in-patient use reveals that occupied bed days for older people's services have fallen from 49,505 in 2006/7 to 23,952 (year end forecast) bed days in 2010/11, a reduction of 51.6%. During this period the number of commissioned beds has fallen by 39.8%. Between 2006/7 and 2010/11 average inpatient provision fell from 82.7 days to 51.8 days, primarily as a result of people being better supported in the community, and improved discharge arrangements. Table 2 demonstrates these findings:

Older People's Services – available and occupied bed days



The increase in community resources has been in the following areas;

- Older People Liaison Service provided in the Acute Hospitals
- Assessment, Treatment and Care Services
- Intermediate Care Service- Halton

Interventions by these teams have helped to prevent unnecessary transfers to mental health wards. The majority of service users are now admitted to the wards from their own homes.

With further enhancements to community provision by including Assessment, Care and Treatment Services with Liaison and improving skill mix by introducing Advanced Practitioners, Neuro Psychologists and Dementia Care Advisors, occupancy projections to 2013 demonstrate that further reductions in demands on beds should be achieved.

Scrutiny of admissions in the last year shows an increase in the number of detained patients – from 21% in April 2010 to 48% in February 2011 (Appendix iv). With good, effective community services in place, only those people who cannot be assessed in the community setting need to be admitted to the Trust's wards. Enhancing community services would also therefore enable some of those patients not detained, to have their assessment needs met in their usual place of residence rather than the hospital.

The redesign includes in-patient beds for older people with non-organic presentations. Review of the primary diagnosis of patients admitted (Appendix v) highlights that in 2010/11, 74.7% of admissions were for people with a diagnosis of Alzheimers (N=150), Organic/Dementia (N=140) and 'other' (N=41) presentations which were not functional. 25.3% of admissions were for *non*-organic presentations. This distribution is consistent with the proposed redesign of two single sex wards for organic presentations, and a single ward for older adults with functional conditions, whose needs cannot be met within the Adult Acute setting.

5. Performance Trends

Analysis of performance trends over recent years, along with projections for future performance supports the development of the new strategic model.

The number of community referrals has been steadily increasing with an average year on year increase of 17.1% (Appendix i). Between 2006/07 and 2010/11 the total community contacts rose from 29,217 to 66,556, an increase of 127.8%. Community activity is projected to rise further in coming years in line with the demographic changes highlighted previously; between 2010/11 and 2013/14 the community contacts are expected to increase by a further 60.6% to 106,913 per year. Clearly this level of increase can not be

accommodated within existing services configured as they are, hence the need to realign resource into community settings, thereby strengthening them and equipping them to meet the challenge of increased demand.

At the same time, evaluation of in-patient use (Appendix ii) reveals that occupied bed days for older people's services have fallen from 49,505 in 2006/7 to 23,952 (year end forecast) bed days in 2010/11, a reduction of 51.6%. During this period the number of commissioned beds has fallen by 29.7%, but clearly there is scope to reduce the number of in-patient beds provided by the Trust, and reinvest the savings into community services. Additionally, the Average length of stay has reduced from 82.7 days in 2006/7 to 51.8 in 2010/11 as people are being supported to remain in the community more, and discharge arrangements from in-patients are being facilitated more quickly. Both of these trends put increasing pressure on community services.

Reviewing the source of admissions (Appendix iii) highlights that the number of admissions from General Acute hospital has reduced over the past 5 years, from 210 to 74. This reflects the introduction of Mental Health Liaison services provided in all acute hospitals within the 5 Boroughs footprint. This helps to prevent unnecessary transfers to Mental Health in-patient units. The majority of patients are admitted to mental health wards from home.

Another trend which supports the redesign proposal is the fall in number of delayed discharges. In 2008/9 the number of bed days lost due to delayed discharge was 3515, attributable to 543 patients. In 2010/11 this has fallen to a total of just 774 lost bed days, attributable to just 133 patients. Enhanced community services and integrated working with local authority services will help reduce the delays further.

6. Proposed New Model

The proposed new model reflects the Trust's Strategic Development Objectives, these being to have; Effective and Efficient Organisations, Service Innovations and Business Development, Financial Viability, Governance and Organisational Development.

In line with national drivers to meet increasing demands, absorb increasing costs, concentrate on improving productivity and eliminate waste whilst at the same time focusing on clinical quality (QIPP 2010), there is a need to review pathways into and within the Trust's Older People's services.

This model sets out a new pathway of specialist mental health care that is built on the commissioning intentions of the Alliance strategy 'Securing Better Mental Health for Older Adults' (2009). It is designed to facilitate the development of a comprehensive dedicated Later Life and Memory Service. It will provide a high quality service, focusing on three key dimensions of quality; clinical effectiveness, safety and service users/carers experience (Dazi 2008) by implementing a new streamlined pathway (Appendix vi).

The model establishes a fully integrated Later Life and Memory service which provides three key functions of referral / access, assessment and intervention. This will be achieved by 'pooling' existing older people's community resources within each Borough. This will ensure that the main service provision remains local to its community, providing services that are accessible and meet the needs of its population.

To ensure the successful implementation of the model, the following components are essential:

Integration of Services: the needs of the service user can be met via the new care pathway by linking primary care, hospital care and community care, based on local agreements with a range of providers. Following the core assessment, needs are identified and the appropriate provider will deliver the interventions.

Shared Care arrangements: An agreement is required between the Consultant and the GP regarding transfer of patient under the shared care protocol from secondary to primary care.

Patients will be considered suitable for transfer for GP prescribing when:

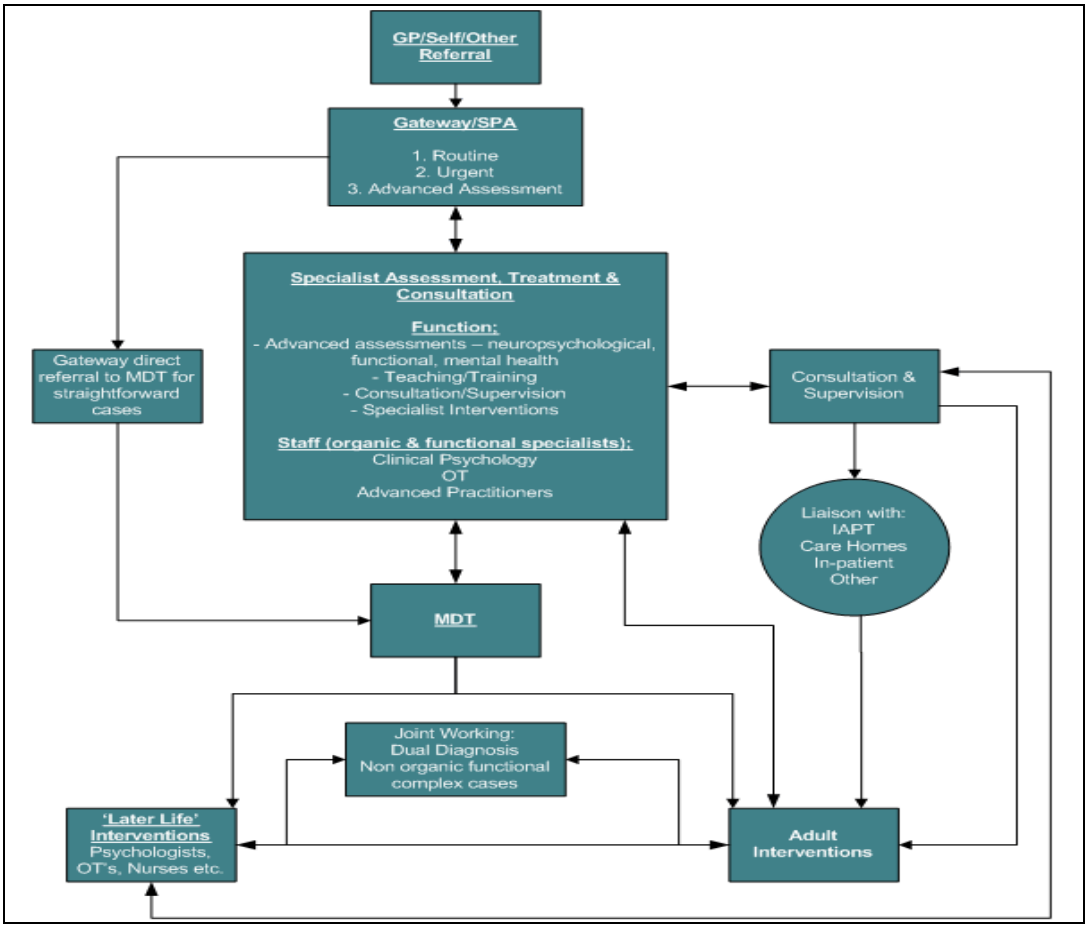
- The patient's condition is stable
- The side effects from medication are manageable
- Drug concordance is established

Training for Partner providers: For the community pathway to be successful, partner providers e.g. care homes need to have staff trained and skilled in the management of people with Dementia. This can be facilitated through attendance at Trust training events, as well as through in-reach from specialist secondary care teams.

Dementia Advisors: Need to be available in each borough, and work in collaboration with later life and memory services.

Acute Physical Care: Access to physical health care providers via robust SLA agreements. This may include links with acute Trust medics as well as other integrated primary care health professionals e.g. Speech and language Therapist, Physiotherapist, Dietician.

Later Life & Memory Services Care Pathway:



6.1 Community Provision

Existing community mental health teams, memory services, assessment and treatment services, and Liaison services in each borough will integrate and by efficient implementation of the new care pathway an 'enhanced community team' will be formed. These teams will be multidisciplinary in nature, and will be able to provide an advanced assessment along with appropriate evidence based interventions and specialist consultation. Essentially, the service user will have their needs assessed and care/intervention provided within one 'umbrella' team, thus reducing the need for multiple assessments, whilst streamlining the pathway to treatment.

6.2 Access and Crisis Management

It is proposed that through integrated working with existing Gateway or Access and Crisis Resolution services, access and crisis intervention functions for older people with a functional illness will be introduced, these services operating extended hours, in line with GP practices. The management of crisis situations for people with Organic presentations out of

hours will be enhanced by the staff from the organic in-patient units providing advice and support directly to service users, or via local authority, or third sector, out of hours, and 5 Boroughs Crisis teams where staff will have the flexibility to work across into the community. Implementation of this model thereby meets the request from stakeholders to provide older people out of hour's services.

Referrals will be screened the same day (Monday – Friday, excluding bank holidays); service users with an organic presentation will enter the older people's service pathway. The use of the Camberwell Assessment of Need for the Elderly (CANE) for screening purposes, will help to identify those service users presenting with a functional illness whose needs would best be met by older people's services rather than adult mental health services. 'Urgent' referrals will receive a face to face assessment on the same day. Routine referrals accepted to the service will be seen within 10 working days.

We recognise that pressure may be placed on community services in delivering the services outlined above within the suggested timeframes, but the introduction of new technology to aid community working will also bring efficiencies in service delivery. The Trust will invest in technology following robust trials to ensure that service improvement and efficiency is assured. Future activity rates are projected and shown in Appendix (i).

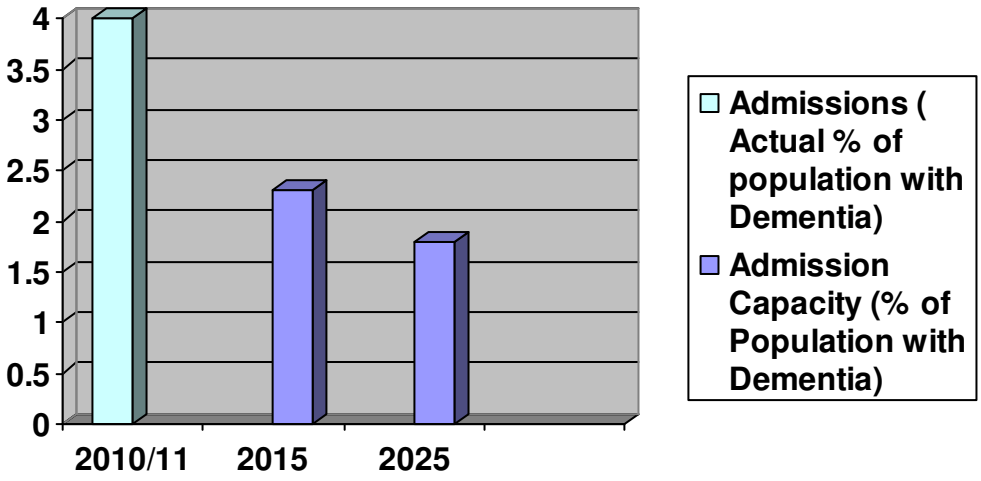
6.3 In-patient Wards

It is evident from the performance data that there is an inverse correlation between the demand for community services and the demand for in-patient beds. Evidence from 'Dementia: The NICE-SCIE Guideline on supporting people with dementia and their carer's mental health and social care' (National Collaborating Centre for Mental Health, 2007) states that people should be assessed and treated in their own home/environment as much as possible. If there are skilled community teams (including outreach services, crisis resolution and home treatment teams), less than 1% of people with dementia should require treatment in an inpatient unit. Applying this percentage to the POPPI data (Department of Health, 2010), and using an average length of stay of 52 days (in 2010-11 it was 51.8 days within the Trust) the demand for in-patient beds can be calculated.

Projected population of over 65's with dementia across the 5 Boroughs:

Borough	2015	1% X 52 bed days	No. Beds Req.	2020	1% X 52 bed days	No. Beds Req.	2025	1% X 52 bed days	No. Beds Req.
Halton	1,291	676	2	1,472	780	3	1,705	884	3
St Helens	2,309	1196	4	2,613	1352	4	2,936	1560	5
Warrington	2,487	1300	4	2,832	1456	4	3,317	1716	5
Knowsley	1,309	676	2	1,397	728	2	1,514	780	3
Wigan	3,449	1820	5	4,022	2080	6	4,696	2444	7
Total	**10,845**	**5668**	**17**	**12,336**	**6396**	**19**	**14,168**	**7384**	**23**

In 2010/11 the Organic bed usage in the Trust was 20,434 bed days, from a population with dementia of 9658, equating to 4%. Implementation of the new pathway enhances the community interventions, and therefore the % population with dementia requiring admission is expected to decrease. Whilst it is acknowledged that achieving a 1% target for admissions may take some time to achieve, the new model has the capacity to accommodate gradual progress towards this.



The projections suggest a reducing demand for beds which mean it will potentially not be cost effective to continue to provide inpatient facilities in each Borough.

The new model offers the opportunity to consolidate older people's in-patient provision onto one site, providing a male organic ward (18 beds), a female organic ward (18 beds) and a mixed sex functional ward for people whose needs cannot be met within the Adult acute setting (12 beds). Whilst it is recognised that Women have a longer life expectancy, and therefore could have a higher demand for in-patient beds, recent trends in bed occupancy has shown that current usage is 44% male to 56% female in terms of number of admissions over a 6 month period. However, the rate of turnover is higher for females, which accounts for the higher percentage. Male patients tend to have more challenging clinical presentations which result in a longer length of stay.

The design of the centre of excellence will allow for flexibility in the use of the beds so that fluctuations in occupancy rates by gender and diagnosis can be accommodated.

Other options considered are outlined below.

1. Maintain current provision of service: Due to greater use of community resources and support, the demand for in-patient care has reduced. Therefore it would be inefficient to continue with the existing service configuration.

2. Two site Option for inpatient care: This would still create inefficiencies in service delivery, because the proposed model involves the implementation of Single Sex accommodation for people with challenging organic presentations. Additionally, it is the intention to provide a functional ward for older people with complex conditions, but there is not the demand to warrant provision on two sites.

6.4 A Single Site

Having the in-patient facilities on one site will allow for current 'gaps' in service provision such as Occupational Therapy, Dietetics, Speech and Language Therapy, Physiotherapy to be addressed, along with access to psychological assessment and intervention whilst service users are in this setting. This approach enables older people's in-patient services to be delivered within a 'Centre of Excellence' for acute mental health care.

The model of care aims to deliver separate male and female dementia wards and a smaller functional old age ward that will manage men and women within the same ward but with completely separate facilities. The ambition is to deliver care from purpose re-designed wards all with single room en-suite shower and toilet facilities. The wards will also provide assisted bathrooms, family visiting facilities, and access to a sensory garden as well as therapeutic activity areas. The overall aim will be to provide a 'homely' environment, with décor and signage specifically chosen to meet the needs of people with organic conditions.

The skill mix will be more integrated and accessible with greater integration of specialists' services.

Experience in the NHS of having specialist services has demonstrated consolidation can be effective in centres such as The Walton Centre NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust, and The Christie NHS Foundation Trust.

Evidence tells us that wards for our targeted group should be closely aligned with a "hot" acute site to enable timely access to a full range of diagnostic tests and to allow for improved provision and access to specialist physical health care, which is so often an associated factor in older people's clinical presentations (NICE-SCIE, 2007). The Royal College of Psychiatrists' report 'In-patient care for older people within mental health services' (April 2011) reaffirms that mental health beds for older people, ideally should be based on the same site as a general hospital.

Our Resource and Recovery Centre situated on the Whiston Hospital site is the only site where the Trust has direct access to an A&E department and on site emergency support. Frequently older people are admitted to acute wards for medical or physical related conditions. This change of environment adds to their distress and disorientation. We believe that developing positive working

relations with the key staff in the acute hospital will avoid unnecessary admissions to their wards and minimise distress to a service user.

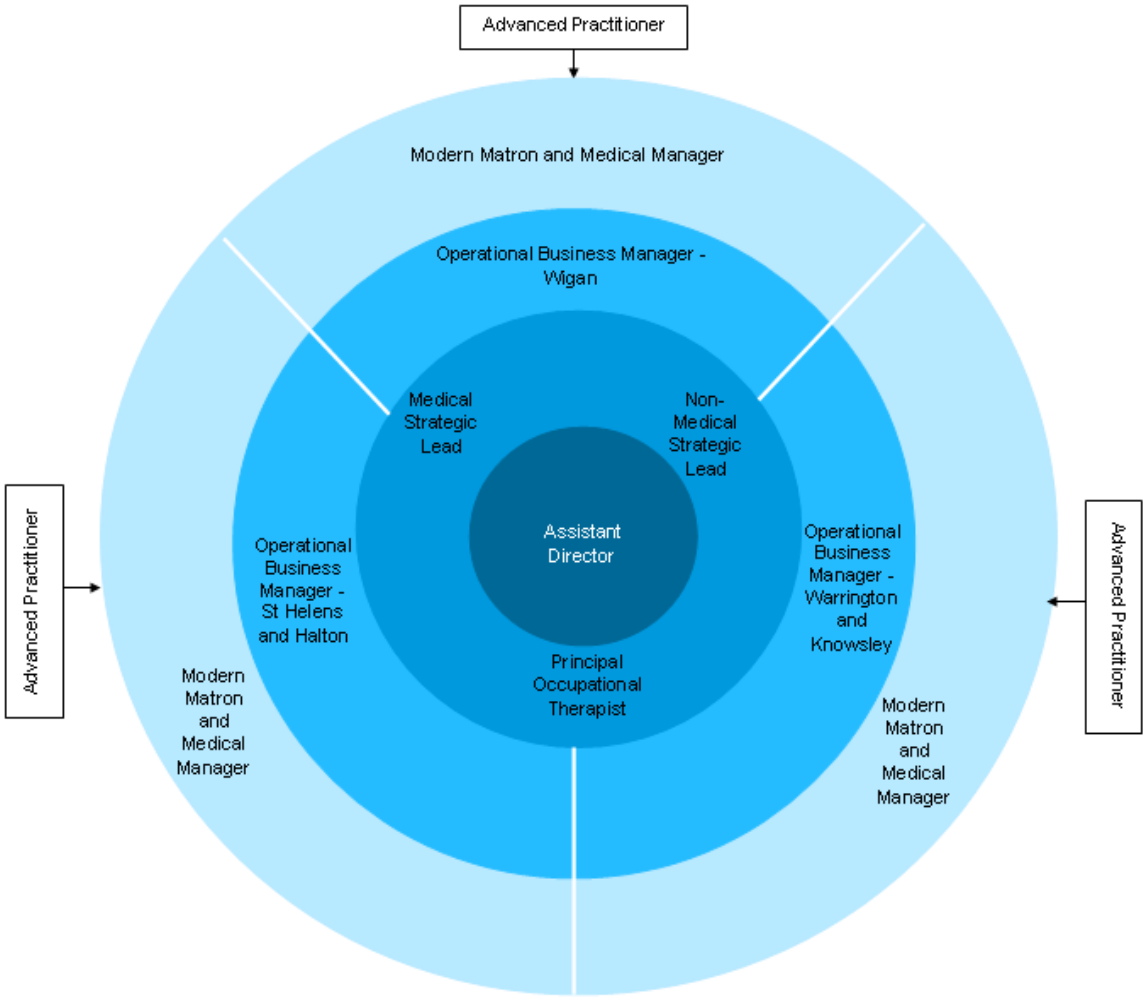
Alternative solutions for the provision of suitable accommodation for a Centre of Excellence for the Trust would involve the construction of a new building on sites that are not adjacent to an acute hospital, and which have therefore been discounted.

The Trust acknowledges that some carers / relatives may find it difficult to travel to the proposed Whiston site, should the service user need an in-patient admission. The Trust is committed to provide travel from current existing in-patient sites to the new Centre of Excellence, should this be required.

6.5 Leadership

To ensure effective leadership and management the new model proposes that each borough has a dedicated integrated clinical leadership team that is fit for purpose to provide key functions. In July 2010 a new leadership structure (Figure. 2) was introduced into older people's services.

Figure 2 Leadership Model (as of July 2010)



The redesign of service provision sets out to deliver the essence of Government strategy, improving awareness of dementia, facilitating early diagnosis and high quality treatment at what ever stage of the illness and in what ever setting (DOH 2009).

7. Evidence-Based Clinical Care

Within the new model, greater emphasis is placed on the provision of *evidence-based* clinical care, in accordance with National Institute of Clinical Excellence (NICE) guidance for both organic and functional presentations.

This includes the reduction in the use of Anti-psychotic medication for older people (DoH 2009) as well as access to the provision of anti-dementia medications at earlier stages of the illness development. Alongside pharmaceutical treatments, evidence based psychosocial interventions will be available for older people with organic and/or functional difficulties.

7.1 Functional Mental Health

Functional problems include: depression, anxiety, schizophrenia, alcohol and drug abuse, suicide, self-harm and neglect. The evidence suggests that older people can benefit from a wide range of psychological therapy to reduce mental health problems, increase quality of life, increase the effective management of long term conditions (including diabetes and heart disease), decrease the rates of suicide and increase independence in the community (Positive Practice Guide, 2009). Psychological therapy can also help to address wider health and social care costs by reducing GP appointments and having less reliance on the prescription of anti-depressants, reducing contact with A&E departments, and reducing admission to mental health in-patient services.

The Spending Review states that by 2015, every patient in the country should be able to get timely access to evidence-based psychological therapies and that money needs to be invested to up-skill staff in therapeutic interventions including: Counselling, Interpersonal Therapy (IPT), Brief Dynamic Therapy and Couple Therapy (Ministers Speech, 2010). At present, the over 65 population accessing IAPT (Improving Access to Psychological Therapies) is approximately 4%, and is significantly less than this in some Boroughs within the Trust footprint. This figure should be around 12%, in line with the demographic and clinical prevalence data. The new model will support service users to access IAPT services and provide training/support to the practitioners working within these services to ensure they are equipped to meet the needs of an older adult population.

The research evidence for the provision of psychological therapies for older people with a functional mental health problem highlights that:

- Psychotherapy for emotional disorders in later life seems comparable in efficacy to medication. (Pinquart et al., 2006)
- Structured multi-component interventions may reduce and delay institutionalisation (Laidlaw, 2008)
- Recent developments in later life anxiety shows evidence for highly specialised CBT for people with cognitive impairment (Mohlman et al., 2008)
- Interpersonal Therapy (IPT) has been modified for older adults with cognitive impairment (IPT-ci). These modifications are expanding its clinical usefulness for increasing sub-group of depressed older adults with cognitive impairment (Mild Cognitive Impairment - 'MCI'; early dementia) who are not usually suitable candidates for psychological therapy (Miller et al., 2005).

7.2 Dementia

Mild Cognitive Impairment (MCI) is a relatively recent concept and is characterised by memory impairment that cannot be explained by normal ageing or by dementia. Research suggests that approximately 40% of people over the age of 65 have age-associated memory loss, with 10% of this population group presenting with an MCI. It is estimated that within one year, 10-15% of people with an MCI will develop dementia, with this rising to 50 % within 5 years.

Memory services should assess this patient group and those identified with an MCI should be followed up by this specialist service in order to monitor cognitive decline (NICE-SCIE, 2007).

The research evidence for interventions for people with MCI indicates that:

- A diagnosis of MCI is an opportunity to identify the patient at increased risk of developing dementia and to initiate treatment that can delay further decline (Pace & Graham, 2008)

- Neuropsychological assessment is helpful in diagnosing MCI and allows for distinctions between the different types of MCI including: anmestic; non-amnestic; single and multiple domain (Rosenburg et al. 2006).

- Individuals with MCI can benefit from a multi-component cognitive rehabilitation programme with regards to Activities of Daily Living, mood and performance (Kurz et al, 2009).

Cognitive rehabilitation is a relatively new approach for improving the well-being and quality of life for people with dementia. Psychosocial interventions can also be provided along with medications and it is possible that these approaches will complement one another in order to maximize the benefits for the person with dementia.

Cognitive rehabilitation enables people with cognitive impairments or deficits to achieve an optimum level of functioning by reducing the disability caused by damage to the brain. Cognitive rehabilitation is used in conditions that result in cognitive deficits such as Alzheimer's disease. Cognitive rehabilitation was initially developed for individuals for non-progressive brain injury; however, it is increasingly being used for progressive conditions as well. Cognitive rehabilitation approaches include restoration of function, compensatory techniques, and environmental modification. These techniques are incorporated with approaches that are directed towards the person's emotional response to their limitations. It is important to target those areas where cognitive deficits affect everyday life. Specific techniques are used to address those areas while the person's emotional responses are addressed (Clare, 2008).

The research evidence for interventions that support people with cognitive impairment suggests:

- Early intervention for memory difficulties in mild cognitive impairment, using cognitive rehabilitation in compensatory strategies, can assist in minimizing everyday memory failures as evaluated by performance on prospective memory tasks and knowledge of memory strategies. (Kinsella et al, 2009)

- Facilitating remaining episodic memory functioning. Where the aim is to build on the remaining episodic memory ability to encourage learning of important new information, or re-learning of previously-known information, a number of guiding principles can be followed. These include providing support at both encoding and retrieval (Bäckman 1992), ensuring effortful processing (Bird and Luszcz 1993), reducing errors during the learning process (Clare, Wilson, Breen, and Hodges 1999; Clare et al. 2000), and encouraging encoding through multiple sensory modalities (Karlsson et al., 1989). Specific methods include spaced retrieval (Camp 1989), cueing (Clare and Wilson 2004; Clare, Wilson, Carter, Roth, and Hodges 2002), simple mnemonics (Clare, Wilson, Breen & Hodges (1999), encouraging semantic processing of material (Bird and Luszcz 1991, 1993) and the use of subject-performed tasks as an aid to encoding (Bird and Kinsella 1996).

- Supporting procedural memory. Where the aim is to improve or restore the ability to carry out selected activities of daily living, action-based learning can be used (Hutton, Sheppard, Rusted, and Ratner 1996). Prompting methods can be used to encourage and support performance of an activity. A schedule of prompts can be devised on the basis of a detailed task analysis; prompts may be verbal or physical. Once performance is well-established, prompts can be faded out. Approaches of this kind can be useful when introducing new external memory aids.

- Supporting semantic knowledge. Approaches used with people who have semantic dementia include repeated rehearsal combined with contextual information (Reilly, Martin, and Grossman 2005; Snowden and Neary

2002), and demonstration of object use (Bozeat, Patterson, and Hodges 2004).

Despite existing knowledge around mental health problems in older people, one of the main obstacles continues to be the lack of appropriate assessment, diagnosis and management of care. Implementation of the new model will seek to address this through the establishment of strong clinical leadership and the training of staff to deliver evidence-based therapies.

Different therapies are useful during different stages of Dementia, as summarised below:

All types and severities of dementia which have co-morbid agitation:

- Aromatherapy
- Multi-sensory stimulation
- Music/Dance therapy
- Animal-assisted therapy
- Massage

People with dementia who have depression and/or anxiety:

- Cognitive Behaviour Therapy (CBT)
- Reminiscence therapy
- Multi-sensory stimulation
- Animal assisted therapy
- Exercise
- Evidence is emerging for other psychotherapeutic interventions including interpersonal therapy and psychodynamic psychotherapy

Psychological interventions in the early stages of dementia: (therapy aimed at enhancing adjustment and mood)

- CBT (modified)
- Life review
- Cognitive rehabilitation approaches

Psychological interventions in the moderate/later stages of dementia: (therapy aimed at increasing well-being and quality of life – usually provided for in residential/nursing homes)

- Cognitive Stimulation Therapy
- Reminiscence Therapy
- Music, dance, arts and craft therapies
- Behavioural management approaches to be pursued before prescribing psychotropic medications

Psychological interventions for late stages of dementia: (therapy aimed at increasing well-being and quality of life – usually provided for in residential/nursing homes)

- Multi-sensory stimulation
- Music therapy
- Animal-assisted therapy
- Hand massage
- Aromatherapy

(NICE-SCIE Guideline, 2007)

7.3 Support for Carers

Evidence suggests that a well supported and resourced carer is a major factor in the long term well being of the person they are caring for. Through close working with other partner agencies (e.g. Alzheimers Society, Carer Support Services) the new model supports Professionals to carry out a carer's assessment and seek to identify psychological distress and the psychosocial impact of the dementia on the carer. This will be an ongoing process and may include a period after the person with dementia has entered residential care.

Carers will have access to a variety of psychosocial interventions including:

- education on dementia (individual or group based)
- access to peer support groups
- support via the telephone or the internet
- supportive counselling
- psychotherapy
- rapid support in crisis
- faith based spiritual assistance

(NICE-SCIE Guideline, 2007)

7.4 Quality of Life in Dementia

Health related quality of life questionnaires that examine the patient's perceptions of their global quality of life (not the number of symptoms they have), has been shown to be extremely important for older people. This is due to the fact that the complex nature of their health status can result in symptom alleviation in one domain but deterioration in another. For example, with regards to cognition, an increase in cognitive impairment does not necessarily result in a decrease in quality of life. (Selai & Trimble, 1999).

There are two popular and evidence based quality of life measures that are used with dementia; Quality of Life-Alzheimer's Disease (QOL-AD; Logsdon et al 2002) and the Dementia Quality of Life (DEMQOL; Smith et al, 2005). The QOL-AD is a brief 13 item measure designed to obtain a rating of an individual's quality of life from both the patient and caregivers perspective. The measure has been developed for use with people with dementia and covers a range of areas including cognition, finances, physical health and

mood. The DEMQOL is a 28 item and 31 item measure and is used to gain a subjective account of quality of life from both the patient (DEMQOL 28 item) and from the caregiver's (DEMQOL-PROXY 31 item) perspective.
The DEMQOL and the DEMQOL-PROXY both provide a reliable way of measuring health related quality of life in dementia. The DEMQOL can be used with mild to moderate dementia whilst the DEMQOL-PROXY is showing promise with severe dementia.

7.5 Integrated teams - skill mix and knowledge

The demand for patient-led services has led to careful thought on the skill mix of teams. The NHS workforce should involve: 1) team working across professional organisations and boundaries, 2) flexible working to make the best of the range of staff knowledge and skills, 3) streamlining the workforce planning and development (based on patient not professional need), 4) maximising the contribution of all staff and implementing New Ways of Working for Consultant Psychiatrists, 5) modernising education and training to ensure staff are equipped with the right skills and 6) expanding the workforce to meet demands (Practice Management Network, 2011).
The LLAMS business stream has developed a training programme in conjunction with the Trust Education Centre. Modules are now available covering core key skills / knowledge including: safeguarding, mental capacity act, Deprivation of Liberty, management of challenging behaviour, and physical health care.

Non-medical staff

There needs to be a clear distinction between clinical leadership and organisational management. Organisational management ensures there are sound policies, procedures and systems for managing staffing matters, finances and information systems. Clinical leadership is focused on strategic vision and driving service improvement and effective team working to provide excellence in patient/client care (Department of Health, 2007). In order for this to happen, senior clinical roles for non-medical staff need to be established. These roles can provide clinical leadership within teams, advanced skills in working with service-users, formal and informal education and supervision of others. They are also essential for meeting legal requirements, for example, under the Mental Health Act and can assist in the recruitment and retention of clinical expertise in the workforce.

Medical staff

The document "New Ways of Working for Psychiatrists" (Department of Health, 2005) values and encourages the use of the advanced skills and competencies of other members of the mental health multidisciplinary team, which in turn, would "free up" the time of the Consultant Psychiatrist so that they can focus on the more complex cases. The document encourages distributed responsibility, effective input and focused leadership from Consultant Psychiatrists. This new Model of Care for our LLAMS is consistent with New Ways of Working. It has an emphasis on a person-centred bio-

psycho-social approach in which the broad training and experience of the Consultant Psychiatrist is fully utilised to enhance the experience of service users and carers.

7.6 Key enablers

Creating time for clinicians is a piece of work currently being developed through discussions with staff, service users and carers. The aim being to obtain representative views on how this could be achieved. The evaluation of the focus groups will determine a way forward. Mobile technology is currently being piloted in some of our clinical areas. We are piloting the use of digital pens, computer tablets and assistive dictation. The evaluation of the pilot will determine what has been successful to enable us to roll out these tools to other areas in the Trust.

7.7 Research

The 5 Boroughs Partnership Foundation Trust has a dedicated research facility with a satellite site based in the Memory Assessment service in Knowsley. Recent research projects have focused on depression, schizophrenia, dementia and Mild Cognitive Impairment (MCI). The MCI trial explores the use of a vaccine to delay the onset of Alzheimers disease. It uses detailed psychometric assessment and neuroimaging to facilitate early diagnosis and treatment. Other projects are exploring the use of psychosocial treatments including music therapy, cognitive stimulation and simulated presence therapy. Future work will explore the use of vitamins as preventative therapies for dementia.

The research team is embedded within the Later Life business stream giving service users the opportunity to participate in cutting edge treatments. It also allows best clinical research practice to be cascaded straight into the heart of our services at the earliest instance.
The Trust is a regional lead in mental health research and has published widely on improving mental health outcomes in later life. This includes showing the effectiveness of Community Memory services in delaying nursing home placement and the reduction of carer distress.
The Trust is also about to publish NICE promoted research on the effectiveness of dementia drugs in severe Alzheimers disease and has recently published guidance on the management of schizophrenia in later life.

8. Estates and Facilities

8.1 Estates

The Trust currently provides services, both in patient and community, across 31 sites within its footprint. Our model of care is committed to providing community services locally. The Care Pathway helps to determine where

service users should receive their assessment and treatment. There are many instances where this will typically be in the service users home, others will require access to a local “out-patient clinic” environment.

8.2 Community estates

As mentioned earlier it is anticipated that service users will receive assessment care and treatment in their own homes if appropriate. If access to out-patient clinics is required or access to group interventions for service users or carers is appropriate then these will be provided locally.

Out-patient facilities will be warm and welcoming and will be fully equipped to carry out assessment, diagnostics and interventions.

8.3 In-Patient Estate

The model of care aims to deliver separate male and female dementia wards and a smaller functional old age ward that will manage men and women within the same ward but with completely separate facilities. The ambition is to deliver care from purpose re-designed wards all with single room en-suite facilities.

Evidence tells us that wards for our targeted group should be closely aligned with a “hot” acute site to enable timely access to the range of diagnostic tests and physical interventions required.

9. Summary of Benefits

There is no doubt that the growth in our older people’s population presents one of the biggest challenges of the coming decades and we can only meet it by working in partnership with a wide range of local and national organisations. Most importantly we must see those who are ageing and their families as partners. Their active engagement is essential if we are to ensure that longer lives are happy, healthy and meaningful lives.

We are committed to working in partnership with key stakeholders and commissioning colleagues, to ensure that service gaps are appropriately addressed. This will enable the delivery of our vision to provide high quality, accessible, community services to support service users in their own homes and communities for as long as possible to promote quality of life. In addition, when in-patient assessment is required, the new model will ensure it is provided in fit for purpose accommodation, delivering the full range of specialist assessment and treatments.

In summary, this new model ‘Building on Strengths’ aims to deliver:

- Extended Opening Hours
- Timely response to assessment

- Rapid Response to urgent referrals, same day face to face
- Single care assessment process
- Improved clinical outcomes
- Improved quality of care
- Reduced psychological distress
- Improved Access to Psychological therapies
- Shorter length of stay in in-patient settings
- Reduced readmission rates
- Coordinated service delivery individual to need and performance
- Needs led services
- Increased interface between services
- Strong leadership presence
- Cost effectiveness
- Improved carer/service user experience
- Improved quality of care in general hospitals
- Reduced use of anti psychotic medication
- Increase in independent living
- Improved outcomes for service users in care homes

10. Mapping the Change

The trust has mapped out the current position to future state which is up to 2014. The following have been developed to support the development of the model -

- A workforce plan to establish what impact the change will have on the existing workforce
- A financial model which includes the impact of estate development within the proposed model
- A service delivery plan to demonstrate all the stages from development, to engagement, consultation and implementation of the model. It describes the milestones, timescales and identified leads
- A training needs analysis to ensure that all staff have the skills and knowledge required to enable them to deliver quality clinical care within the new model
- A consultation and communication plan has been developed.

There is a nominated Business Transformational lead working with the senior managers and a Business Transformation Steering Group established to oversee the projects progress. The Steering Group is overseen by the Trust Operational Management Board.

11. Cost Improvement and Efficiency

Monitor and the Department of Health have published their planning guidance for Foundation Trusts for the foreseeable future. The guidance identifies that each Trust is required to make a 4% cost improvement each year for the next few years.

In 2011/12 and in future it is the PCTs through the national tariff will reduce contracts with Trusts by 4% to reflect this, this money will therefore sit in PCT (or successor bodies') budgets. Trusts will be given uplifts to reflect inflation but this is to offset automatic price increases like pay awards and inflation.

This means that in real terms, year on year the Trust will be 4% worse off and if it doesn't make savings will fall into deficit.

So in order to stand still financially the Trust has to put in plans to improve efficiency and reduce costs by this 4% each year (20% over five years)

The Trust's plans and strategic intent is to make this happen whilst maintaining the level and quality of the services provided to patients and contracted for by commissioners.

Appendices
Appendix (i) Older Peoples Business Stream – Community and Out-patients data

					Forecast Information			
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Number of Referrals Received	6,154	5,902	8,841	8,870	11,401			
Number of Total Contacts	**29,217**	**26,389**	**36,187**	**45,486**	**66,556**	**77,948**	**91,289**	**106,913**
Total DNA's	313	1,130	1,201	1,821	2,121			
% DNA's	1.1%	4.1%	3.2%	3.8%	3.1%			
Number of Discharges	3,220	4,918	6,220	7,564	8,132			
% Increase Year on Year Total Contacts		-10.7%	27.1%	20.4%	31.7%			
Average Increase Year on Year					17.1%			

Appendix (ii) Older Peoples Business Stream - In-patients

						Forecast Information			
	2006/07	2007/08	2008/09	2009/10	April 10 to Feb 11	2010/11	2011/12	2012/13	2013/14
Average LOS	82.7	75.7	72.6	71.5	51.8	51.8			
Available Beds	57,763	48,922	44,511	36,075	24,604	26,841			
Occupied Beds	49,505	38,173	31,961	28,283	21,956	23,952			
% Occupancy	85.7%	78.0%	71.8%	78.4%	89.2%	89.2%			
Total Commissioned Beds			118	131	83	83			

Whilst the Trust remains commissioned for 83 beds, it is currently utilising only 69 beds:
Stewart = 12
Grange = 12
Rydal = 6
Kingsley = 16
Sephton = 23
TOTAL = 69

Appendix (iii) Number of Admissions by Admission Source

Borough of Ward	Admission Source	2006/07	2007/08	2008/09	2009/10	April 10 to Feb 11	2010/11
5 Boroughs Partnership NHS Foundation Trust Summary	Local Authority Pt 3 Residential Accommodation	6	12	16	6	3	
	NHS prov - High Security	8					
	NHS provider - WD for general pts or YPD or A&E	210	194	166	103	74	
	NHS provider - WD for Mat or Neonates	2					
	NHS provider - WD for MI or LD	10	1	9	13	13	
	NHS run care home	17	7	4	6	3	
	Non-NHS Hospice (not LA)	1	1				
	Non-NHS Hospital				1		
	Non-NHS Residential Care Home (not LA)	25	15	14	16	19	
	Not Specified				1		
	Penal, Court or Police Stn	2	4	1	1	1	
	Temporary Residence	5	7	9	11	3	
	Usual place of Residence	404	344	354	348	290	
	Total	690	585	573	506	406	

Appendix (iv) Mental Health Act (Sections) Report

Financial Year 2010/11
APRIL 2010 - FEBRUARY 2011

TOTAL Occupied Beds

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Older People Wards													
Kingsley Ward	566	563	547	560	462	446	563	514	370	389	428	0	**5,408**
Grange Ward	353	367	359	371	332	331	371	349	319	343	334	0	**3,829**
Stewart Assessment Centre	494	537	561	565	560	558	500	477	466	472	414	0	**5,604**
Sephton Unit	637	669	601	581	575	581	549	633	670	676	640	0	**6,812**
Rydal Unit	0	0	0	0	0	0	0	0	0	140	163	0	**303**
Total on a Section	**2,050**	**2,136**	**2,068**	**2,077**	**1,929**	**1,916**	**1,983**	**1,973**	**1,825**	**2,020**	**1,979**	**0**	**21,956**

Occupied Beds of SECTIONED patients

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Older People Wards													
Kingsley Ward	97	74	87	10	45	40	42	78	127	133	145	0	**878**
Grange Ward	173	175	171	151	111	116	88	125	151	190	181	0	**1,632**
Stewart Assessment Centre	66	113	118	122	30	48	85	178	212	120	214	0	**1,306**
Sephton Unit	101	111	155	151	161	162	105	153	176	297	401	0	**1,973**
Rydal Unit	0	0	0	0	0	0	0	0	0	25	7	0	**32**
Total on a Section	437	**473**	**531**	**434**	**347**	**366**	**320**	**534**	**666**	**765**	**948**	**0**	**5,821**

Percentage Occupancy of SECTIONED patients

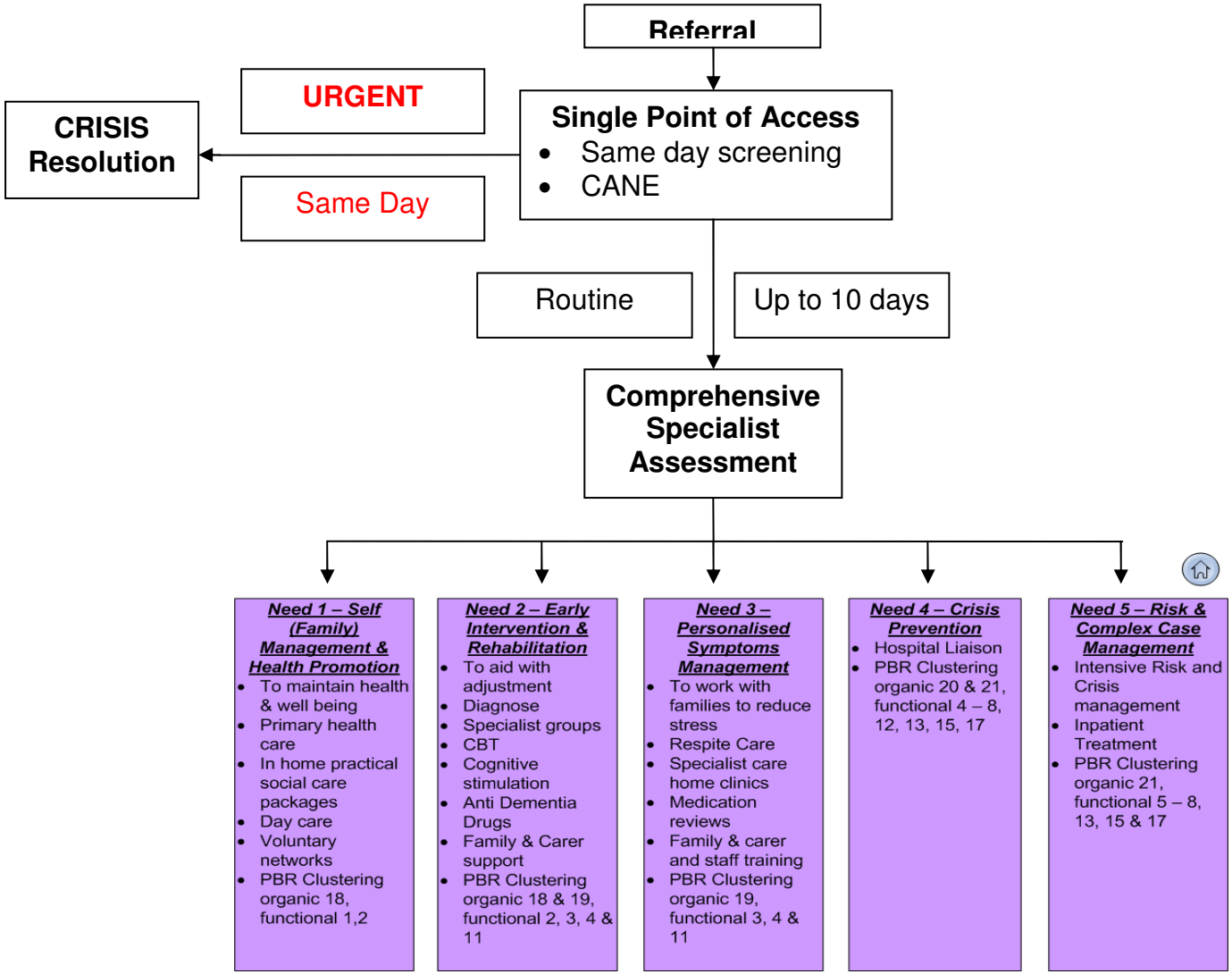
PCT	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Older People Wards													
Kingsley Ward	17%	13%	16%	2%	10%	9%	7%	15%	34%	34%	34%		**16%**
Grange Ward	49%	48%	48%	41%	33%	35%	24%	36%	47%	55%	54%		**43%**
Stewart Assessment Centre	13%	21%	21%	22%	5%	9%	17%	37%	45%	25%	52%		**23%**
Sephton Unit	16%	17%	26%	26%	28%	28%	19%	24%	26%	44%	63%		**29%**
Rydal Unit	-	-	-	-	-	-	-	-	-	18%	4%		**11%**
% on a Section	21%	22%	26%	21%	18%	19%	16%	27%	36%	38%	48%		**27%**

Appendix (v) Diagnosis Data

All Patients admitted in year with Primary Diagnosis as below

Primary Diagnosis	2006/07	2007/08	2008/09	2009/10	2010/11
Alzheimers	120	95	111	167	150
Anorexia nervosa				1	
Antiparkinsonism drugs					1
Disorders of adult personality and behaviour	2		1	1	1
Huntington's disease					1
Mental and Behavioural Disorders	8	12	10	12	4
Mood Disorders	155	105	92	95	58
Need for continuous supervision	1				
Neurotic, stress related	41	28	39	25	6
Organic/Dementia	206	154	227	184	140
Other	65	70	51	40	41
Parkinson's disease	6	5	14	9	5
Schizophrenia	42	50	35	27	24
Unknown	80	81			
(blank)					
Observation	2	8	3		12
Grand Total	**728**	**608**	**583**	**561**	**443**

Appendix (vi) New Streamlined Pathway



(Appendix vii) New Community Pathway – Pilot Project

Rationale

In order to demonstrate the effectiveness and efficiencies that can be achieved by implementing the new community pathway for LLAMS, we intend to Pilot the new way of working in one Borough.

Methodology

The project will run from January 2012 for an initial period of 6 months. At this stage a review will take place which examines the changing patterns of service usage i.e. Response rate to referrals, bed occupancy, Length of Stay, Demand for 'Extended Hours services', impact of shared care arrangements and benefits of integrated working with local authority and non-statutory agencies.

After this review, consideration will be given to expanding the Pilot across another Borough for a further 6 months. At 12 months, a full review will take place to examine the evidence and inform full implementation of the new Model.

Option Appraisal to determine site for Pilot

In order to determine the best site to run the pilot, the following criteria matrix was used, highlighting key components of the LLAMS proposed new pathway:

	HALTON	St.HELENS	WARRINGTON	KNOWSLEY	WIGAN & LEIGH
Single point of Access			✔	✔	✔
Memory Service Including:	✔	✔	✔	✔	✔
Specialist nurse	✔	✔	✔	✔	✔
Psychology					✔
Social worker		✔			✔
OT	✔		✔	✔	✔
Counsellor					✔
Dementia Advisors			✔	✔	✔
Admiral Nurse service				✔	
OPCMHT	✔	✔	✔	✔	✔
Liaison service	✔	✔	✔	✔	✔
Care Home inreach (advanced practitioner)	✔		✔		✔
Shared Care		✓			✔
Extended Hours					
Crisis / Home Treatment					

Based on the above criteria, Wigan & Leigh meet the majority of the requirements of the new model.

Gap Analysis

None of the existing services currently provide extended hours or Crisis and Home Treatment services. We do not want to introduce another pathway into services which could become confused with the adult crisis and home treatment service and therefore a clear criteria and system will be developed to avoid this from occurring.

Recommendation

It is recommended that the Pilot is run in the Wigan & Leigh Borough, and that to facilitate implementing the extended hours and Crisis service functions additional funding is made available for additional staffing:

Band 6 Specialist Nurse Practioner	1 wte
Band 5 Nurse Practitioner	1 wte
Band 3 Health Care Support Worker	1 wte

This will allow the service to operate between the hours of 9am – 9pm Monday to Friday, and 9am – 1pm Saturdays.
Some preparation work will be required to take place between the Trust and the Emergency Duty Team to avoid duplication and ensure effective communication takes place during the pilot.

Outside these hours, crisis response will be provided by existing services within the Local Authority Emergency Duty Team and Acute Trust A&E.

(Appendix viii)

LLAMS Service User and Carer Forum

Dates 2011	Venue
Tuesday 8th February	United Reform Church St Helens, Ormskirk Street, St Helens, WA10 1BQ
Tuesday19th April	Legends Bar Leigh Sports Village Leigh Stadium Sale Way Leigh WN7 4JY
Monday 13th June	Huyton Suite Knowsley Civic Way, Liverpool, Merseyside L36 9GD
Tuesday 9th August	The Foundry Halton 65 Lugsdale Rd Widnes, Cheshire WA8 6DA
Tuesday 18th October	Winwick Leisure Centre, Myddleton Lane, Winwick, Warrington, WA2 8LQ
Tuesday 13th December	St Helens, World of Glass

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REPORT TO: Health Policy and Performance Board

DATE: 10th January 2012

REPORTING OFFICER: Strategic Director Resources

PORTFOLIO: Resources

SUBJECT: Performance Management Reports for Quarter 2 of 2011/12

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 second quarter of 2011/12 to September 2011. The report details progress against service objectives/ milestones and performance targets, and describes factors affecting the service for:

- Prevention and Assessment
- Commissioning & Complex Care

2.0 RECOMMENDED: That the Policy and Performance Board

1) **Receive the second 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 Since 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

9.1 None under the meaning of the Act.

Departmental Quarterly Monitoring Report

Directorate: Community Directorate

Department: Prevention and Assessment Services

Period: Quarter 2 - 1st July 2011 – 30th September 2011

1.0 Introduction

This monitoring report covers the Prevention and Assessment Services second quarter period up to 30th September 2011. It describes key developments and progress against 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

Environmental
Following confirmation at the Health PPB, Smoke Free Playgrounds will be launched in Halton during the October half term. This voluntary code will ask that persons refrain from smoking in the vicinity of a children's playground.

Self Directed Support
Direct payments continue to be an important strand within self directed support. The Directorate teams continue to promote the use of direct payments to enable individuals and their carers to exercise choice and control.

Brokerage Pilot
The pilot has been completed and the learning has been evaluated. The learning will now inform future work in order to develop the role of the independent broker locally. The learning is to be shared with Merseyside Improvement and Efficiency Programme (MIEP) to inform future commissioning arrangements across the Mersey footprint.

Modernisation of Oakmeadow
The Business Plan for Oakmeadow has been completed and agreed at Executive Board. Working groups have been established to implement the business plan. There have been changes to the bed base at Oakmeadow to support the development of intermediate short term care. The refurbishment plan will support the development of Oakmeadow as a hub for a range of community based services and a venue for local groups to use.

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 ran 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 in place. The Social Care staff are now recruited. They are 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.

Integrated Adult Learning Disability Team
The Integrated Adult Learning Disability Teams 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. Health promotion workshops for groups of men and women have been carried out within day services and will be ongoing. Further events have been carried out with Halton Adult Learning Disability Support, (HALDS), a local family and carers support group. The Anticipatory Care Calendar via Merseyside and Cheshire Cancer network is being progressed through the supported housing network in Halton, and with targeted provider organisations. This development will be rolled out further once the initial training has been delivered in early November.

Learning Disability Partnership Board Annual Self Assessment
The 2010/11 assessment of Halton's progress in implementing the Government Valuing People Now strategy has been completed and was presented to the Partnership Board prior to sign off by people with learning disabilities and family carers. Progress in increasing numbers in paid employment was noted.

Integrated Hospital Discharge Teams Warrington and Whiston Hospitals
The Integrated Discharge Teams at Warrington Hospital and Whiston Hospital are operating. The Whiston team is progressing into the next phase to include complex discharge work and pathways into Intermediate Care. Review of the Warrington Team and resulting action plans will continue to progress the management and operation of this team.

3.0 Emerging Issues

Integration of Health and Social Care Services
This work is ongoing with health commissioners and Providers to transform community services. A provisional model for community multi-disciplinary teams that will draw on a range of services and professional staff to meet the needs of individuals has been developed. An operational group is working on the detail of the model with a plan to have teams operating by April 2012.

Development of a Sensory Hub
Work has commenced with commissioners and the Third sector to establish a sensory hub locally. The aim of this work will be to establish a local centre of excellence to inform best practice, accessibility, service provision and support multi disciplinary working.

Blue Badge Reform Programme
The Government has announced wide ranging reforms to the Blue Badge scheme. There has been a group established to oversee the implementation. Some of the reforms include :- eligibility to be extended to children under the age of 3 with specific medical conditions, provide a new way to provide and distribute badges, and change legislation to enable Local Authorities to decide on the charges for badges locally.

4.0 Service Objectives / milestones

4.1 Progress against 'key' objectives / milestones

Total	**6**	✓	6	?	0	✗	0

All 'key' objectives / milestones are presently on track to achieve annual targets; additional information can be found within Appendix 1.

4.2 Progress against 'other' objectives / milestones

Total	**7**	✓	7	?	0	✗	0

All 'other' objectives / milestones are presently on track to achieve annual targets; additional information can be found within Appendix 2.

5.0 Performance indicators

5.1 Progress Against 'key' performance indicators

Total	**4**	✓	3	?	1	✗	0

There are two new indicators for this financial year that cannot be reported at this time because there is no comparable data. Data for Air Pollution Controls will be

available at the end of the financial year. However, of the remaining indicators the majority remain on track to achieve annual targets. Additional details are provided in Appendix 3.

5.2 Progress Against 'other' performance indicators

Total	**22**	✓	6	?	4	✗	0

There are twelve indicators for this financial year that cannot be reported at this time; due to there being no comparable data, data reporting issues or because the indicators relate to data that will not be available until the end of the financial year.

Of the remaining indicators six remain on track to achieve annual targets, although at this stage there is some uncertainty regarding Client group expenditure on domiciliary care services, delayed transfers of care, ethnicity of older people, and mortality rate from all circulatory diseases at ages under 75 and from all cancers at ages under 75. Further information can be found in Appendix 4.

6.0 Risk Control Measures

No 'high' risk, treatment measures were identified during the development of the 2011 -12 Service activity.

However, in light of an increase in financial costs borne by the Directorate, partly due to increases in service demand, measures continue to be applied in order to manage and control operational service expenditure levels. The measures put in place are intended to minimise the financial risk to the organisation as well as identifying areas for cost efficiency.

7.0 Progress against high priority equality actions

As a result of undertaking a departmental Equality Impact Assessment no high priority actions were identified for the service for the period 2011 – 2012.

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 Financial Statement

Appendix 6 Explanation of use of symbols

Appendix 1: Progress Against 'key' objectives / milestones

Ref	Objective
Service Objective: PA 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 vulnerable people

Milestones	Progress Q 2	Supporting Commentary
Commence implementation of the Early Intervention/Prevention Strategy to improve outcomes for Older People in Halton. **Mar 2012.** (AOF6 & 7)	✓	Project plan has been developed and implementation of the 19 areas is currently on target. This is being managed through the Prevention and Early Intervention Steering group. Performance will also be submitted through the Health Policy and Performance Board.
Commence implementation of Telecare strategy and action plan. **Mar 2012.** (AOF 6 & 7)	✓	The Telecare Implementation Group has been established and recruitment to the Telecare team is ongoing. The implementation of the strategy is on target.
Continue to establish effective arrangements across the whole of adult social care to deliver self directed support and personal budgets. **Mar 2012** (AOF6)	✓	Effective arrangements have been established and incorporated in care management arrangements. Further development is underway within Intermediate Care services and an audit of Self Directed Support is being undertaken to ensure learning is incorporated into practice.
Review and evaluate new arrangements for integrated hospital discharge. **Mar 2012.** (AOF 6&7)	✓	Reviews of both services completed. Whiston Team will now include complex discharge and pathways into Intermediate Care. Warrington Team is strengthening its management and performance reporting frameworks.

Appendix 1: Progress Against 'key' objectives / milestones

Ref	Objective
Service Objective: PA 1 (Continued)	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 2	Supporting Commentary
Commence implementation of Business Plan for Oak meadow. **Mar 2012.** (AOF 6&7)	✓	The Business Plan for Oak Meadow has been completed and agreed at Executive Board. Working groups have been established to implement the business plan. There have been changes to the bed base to support the development of intermediate care and there is a refurbishment plan, which will support the development of Oak Meadow as a hub for a range of community based services and a venue for local groups to use.

Ref	Objective
Service Objective: PA 2	To address air quality in areas in Halton where ongoing assessments have exceeded national air quality standards set out under the Environment Act 1995, in consultation with all relevant stakeholders

Milestones	Progress Q 2	Supporting Commentary
Develop Air Quality Action Plan. **April 2011-December 2012**	✓	Preparation of the plan is underway and progress is according to the schedule set.

Appendix 2: Progress Against 'other' objectives / milestones

Ref	Objective
Service Objective: PA 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 vulnerable people

Milestones	Progress Q 2	Supporting Commentary
Implement recommendations of the QIPP Review to ensure the Intermediate Care Service is meeting the requirements of the community of Halton. ***Sept 2011.*** *(AOF7)*	✓	This work continues with St Helens Council, Halton and St Helens PCT, Bridgewater Community Healthcare Trust and Warrington and Whiston Halton Hospitals.
Develop a Business Plan to ensure that the Re-ablement service is meeting the requirements of the community of Halton. ***Mar 2012.*** *(AOF6 & 7)*	✓	Business Plan in Development.
Review Halton Home Improvement & Independent Living Service (HHIILS) to ensure 'fit for purpose'. ***Mar 2012.*** *(AOF6 & 7)*	✓	Review commenced April 2011 with an initial scoping exercise.
Continue to monitor activity of the joint Social Care in Practice (SCIP) service developed with Runcorn Practice Based Commissioning (PBC), to ensure services are effectively delivered. ***Mar 2012*** *(AOF2 & 4)*	✓	The Practice Based Commissioning Consortium agreed this project being funded for a further two years. There are renewed contract arrangements in place. Staff have now been recruited to the service The service is monitored with agreed outcomes set out in the contractual arrangements.

Appendix 2: Progress Against 'other' objectives / milestones

Ref	Objective
Service Objective: PA 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 vulnerable people

Milestones	Progress Q 2	Supporting Commentary
Implement the Local Affordable Warmth Strategy, in order to reduce fuel poverty and health inequalities. ***Mar 2012.*** *(AOF 7)*	✓	A number of front line staff from the Council and a range of partner agencies has received training in the issues surrounding fuel poverty and where to signpost for possible solutions. In addition, the trainer has attended team meetings at Halton People into Jobs and Affinity Sutton Housing Association. Plans are in place to attend future team meetings in the Older People's Team Widnes, Mental Health Outreach Team and the Think Family Team. An e-learning package is being developed by the Corporate Training Team in consultation with Energy Projects Plus and a Marketing Strategy is in the process of being developed. An article has been placed in the Private Landlords e-newsletter advising of the help and support available to heat and insulate their tenanted properties.

Appendix 2: Progress Against 'other' objectives / milestones

Ref	Objective
Service Objective: PA 2	To address air quality in areas in Halton where ongoing assessments have exceeded national air quality standards set out under the Environment Act 1995, in consultation with all relevant stakeholders

Milestones	Progress Q 2	Supporting Commentary
Formal consultation and consequent development of Air Quality Action Plan. ***Jan 2012***	✓	Action plan is being drafted and will be ready for consultation in January 2012.
Publication of the Air Quality Action Plan ***March 2017***	✓	Publication on schedule.

Appendix 3: Progress Against 'key' performance indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
Cost & Efficiency							
PA 1	Numbers of people receiving Intermediate Care per 1,000 population (65+) (Previously EN 1)	98.07	99	47.8%	✓	↑	This is a cumulative figure and equates to 403 people in receipt of intermediate care in the 65+ age bracket for this quarter.
PA 5	Percentage of people fully independent on discharge from intermediate care/reablement services	N/A	40% (New Indicator).	42%	Refer to comment	Refer to comment	Quarter 2 figure may need to be revised due to data issues. This is a new indicator for this financial year; therefore no comparison can be made from previous years.
Service Delivery							
PA 6	Number of people receiving Telecare Levels 2 and 3	166	164	44	✓	↑	A continued increase in referrals and subsequent connection onto service indicates that target for the year will be achieved

Appendix 3: Progress Against 'key' performance indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
Quality							
PA 14	% of items of equipment and adaptations delivered within 7 working days (Previously CCS 5)	96.65	96	97.72			The quarter 2 figure does not include Deafness Resource Centre (DRC) equipment due to data issues.
PA18	a) % of scheduled Local Air Pollution Control audits carried out b) % of Local Air Pollution Control Audits being broadly compliant.	- -	New Indicator	Refer to comment		Refer to comment	This is a new indicator for this financial year; therefore no comparison can be made from previous years. This is an annual target and will be reported at the end of the year.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
Cost & Efficiency							
PA 2	Percentage of client group expenditure (OP/ILS) spent on domiciliary care services (Previously PCS3)	33%	28%	33%	?	⇔	Whilst the percentage has remained the same from 10/11, the target is may not be achieved due to increases in service demand.
PA 3	Percentage of people referred to intermediate care/reablement who progressed to receive a service	-	60% (New Indicator)	65%	Refer to comment	Refer to comment	Services remain on track and have achieved target this quarter. This is a new indicator for this financial year; therefore no comparison can be made from previous years.
PA 4	Average length of stay for those accessing intermediate care/reablement services	-	34 days (New Indicator)	28 Days	Refer to comment	Refer to comment	This is a new indicator for this financial year; therefore no comparison can be made from previous years.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
Service Delivery							
PA 7	Admissions of Supported Residents aged 18-64 into residential/nursing care (Previously PCS 7)	0.13	0.4	0.0	✓	⇔	There have been no admissions in Q2. A low figure indicators good performance.
PA10	Percentage of adults with Learning Disabilities in Settled accommodation (Previously NI 145 – Complex Care)	92%	90%	N/A	N/A	N/A	Data for this indicator is not available for Q2. It is expected that the data will be available for Q3.
Quality							
PA 15	Percentage of people receiving a statement of their needs and how they will be met (Previously PCS 5)	99.15	99	N/A	N/A	N/A	Figure for quarter 2 cannot be provided at this moment in time. This is due to the changes of recording carer services within the Carefirst database system currently taking place.
PA 16	Clients receiving a review as a percentage of adult clients receiving a service (Previously PCS 6)	79.15	80	N/A	N/A	N/A	Figure for quarter 2 cannot be provided at this moment in time. This is due to the changes of recording carer services within the Carefirst database system currently taking place.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
Fair Access							
PA 21	Ethnicity of Older People receiving assessment (Previously PCS 4b)	0.59	1.5	0.46	?	↑	In Quarter 2 there was 1 client whose ethnicity was other than white. This indicator is subject to great fluctuation given the small ethnic population in Halton.
PA 22	Percentage of adults assessed in year where ethnicity is not stated Key threshold <10% (Previously PCS 4a	0.9	0.5	4.27	✓	↓	The number of clients assessed where ethnicity is not stated relates to 26 clients, 7 more than the same period last year. Exception reports are produced of these clients for teams to action to ensure target will be met at year end.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	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.							
PA 23	All-age all cause mortality rate (Previously NI 120)	Male 853.1 Female 586.5	Male 858.8 Female 627.1	Male 825.7 Female 562.1	✓	↑	Q1 data was updated on 09.09.2011 by Public Health Intelligence Team (PHIT). Q2 data currently unavailable so situation at the end of August 2011 used as a proxy. Male and Female mortality continue to reduce throughout 2011, although this data is unverified and more deaths may yet be registered. In Halton cancer and circulatory diseases make up the biggest causes of deaths so initiatives for these areas are those that will have the largest impact on all age all cause mortality deaths. In relation to prevention tobacco control, alcohol, and weight management programmes will have the biggest impact on future prevalence of chronic diseases which impact on all age all cause mortality.
PA24	Mortality rate from all circulatory diseases at ages under 75 (Previously NI 121)	96.8	91.8	88.5	?	↑	Q1 data was updated on 09.09.2011, by Public Health Intelligence Team (PHIT). Quarter 2 data not yet available so situation at the end of August 2011 used as a proxy. Performance continues to improve in respect to this target, with a marginal decrease in mortality due to circulatory diseases since Q1. 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

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
							current programmes in place.
PA25	Mortality from all cancers at ages under 75 (Previously NI 122)	149.5	145.0	145.2	?	↑	Q1 data was updated on 09.09.2011 by Public Health Intelligence Team (PHIT). Quarter 2 data not yet available so situation at the end of August 2011 used as a proxy. Halton's under 75 (un-validated) cancer mortality figures have now shown a fall in four successive quarters, but rates remain higher than we want. The fall over the past two years is about 5/100,000 each year. This represents more than 5 lives saved each year. The introduction of Bowel Cancer Screening and the local early detection efforts that are under way, with improvements in treatment and falls in smoking amongst men, are amongst the most significant reasons for the improvement. We should welcome these encouraging provisional figures, without becoming complacent: We must not stop activities that have an evidence base, and we cannot be sure that all of our preventive and early detection activities are of sufficient scale or breadth to make enough of a difference.
PA26	16+ current smoking rate prevalence – rate of quitters per 100,000 population (Previously NI 123).	1223.00	1223.55	357.20	✓	↓	The Stop Smoking Service is meeting set targets and we expect it to continue to do so. In 2010/11 Halton had one of the highest quit rates in the NW. 2010/11 data has been updated with the verified annual data, by Public Health Intelligence Team (PHIT) on 05.09.2011. Q1 & Q2 data is a snapshot as of

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
							06.10.2011 and will be updated in the Q3 report. Both the rate per 100,000 population, as per the NI123 definition, and the actual number of quitters have been included as per the request made at the Halton Health Partnership Performance group meeting on 30.06.2011. Halton Stop Smoking service is one of top performing services in the country. It is expected we will meet the Q4 target.
PA 29	Proportion of People using Social Care who receive self-directed support and those receiving Direct Payments (1C) Previously NI 130	26.98%	35%	N/A	N/A	N/A	Figure for quarter 2 cannot be provided at this moment in time. This is due to the changes of recording carer services within the Carefirst database system currently taking place.
PA 30	Proportion of Adults with Learning Disabilities in paid employment (1E) Previously NI146	7%	7%	7.46%	✓	↑	Target exceeded. The number of adults this quarter in paid employment is 30.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
PA 31	Permanent Admissions to residential and nursing care homes (18+) per 100,000 population (2A)	105.05	108.74	147.89	Refer to comment	Refer to comment	This is a new indicator in that it includes admissions in the 18+ age range rather than just the 65+ age range. This figure equates to 68 people having permanently been admitted to residential or nursing home in the last quarter.
PA 32	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services (2B) Previously NI 125	68.83% (Up to 31st Dec 2010)	70%	Refer to comment	Refer to comment	Refer to comment	The data is not reportable until the end of the financial year – following the collection, submission and assessment of the Adult Social Care Combined Activity Return (ASC-CAR) in May 2012.
PA 33	Delayed transfers of care from hospital, and those which are attributable to adult social care (2C) Previously NI 131 (Weekly rate per 100,000 population aged 18+)	4.27	To be confirmed by PCT	1.86	✓	↑	Q1 data has been updated, Q2 data is not available. The situation at the end of August has been used as a proxy. The rate for Q2 is lower than the 2010/11 rate which demonstrates an improvement in performance.

Appendix 4: Progress Against 'other' performance indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
PA 34	The Proportion of people who use services and carers who find it easy to find information about support (Adult Social Care Survey and Carers Survey)	65.6%	65%	Refer to comment	Refer to comment	Refer to comment	This is an annual survey which will be undertaken again in January 2012, with the results becoming available at the end of quarter 4.
PA 35	The Proportion of People who use services who feel safe (Adult Social Care Survey) 4a	53.1%	53%	Refer to comment	Refer to comment	Refer to comment	This is an annual survey which will be undertaken again in January 2012, with the results becoming available at the end of quarter 4.
PA 36	The Proportion of People who use services who say that those services have made them feel safe and secure (Adult Social Care Survey) 4b	N/A	N/A	Refer to comment	Refer to comment	Refer to comment	This question was not asked in the 2010/11 Survey but will be included in the Survey in January 2012 so it will be reported in quarter 4.
PA 37	Proportion of adults with learning disabilities who live in their own home or with their family. 1G	N/A	N/A	Refer to comment	Refer to comment	Refer to comment	This information is obtained from the Adult Social Care Combined Activity Return (ASC-CAR) at the end of the financial year.

Appendix 5: Financial Statement

COMMUNITIES – PREVENTION & ASSESSMENT DEPARTMENT

Revenue Budget as at 30th September 2011

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	7,682	3,582	3,511	71
Other Premises	67	24	18	6
Supplies & Services	696	486	512	(26)
Consumer Protection	443	222	218	4
Transport	144	71	62	9
Food Provision	19	10	2	8
Aids & Adaptations	113	37	46	(9)
Contribution to JES	231	0	0	0
Community Care:				
Residential & Nursing Care	9,448	3,970	4,465	(495)
Domiciliary & Supported Living	6,848	2,813	3,251	(438)
Direct Payments	2,463	1,264	1,229	35
Day Care	231	142	162	(20)
Other Agency	178	107	98	9
Contribution to Intermediate Care Pool	2,516	1,285	1,244	41
Total Expenditure	**31,079**	**14,013**	**14,818**	**(805)**
Income				
Other Fees and Charges	-119	-46	-38	(8)
Sales Income	-76	-76	-75	(1)
Reimbursements and Other Grant Income	-448	-68	-92	24
Residential & Nursing Income	-3,521	-1,600	-1,648	48
Community Care Income	-709	-404	-432	28
Direct Payments Income	-82	-61	-69	8
Transfer from Reserves	-343	0	0	0
LD & Health Reform Allocation	-4,272	-4,653	-4,653	0
PCT Contribution to Care	-621	-182	-104	(78)
PCT Contribution to Service	-1,691	-1,023	-1,023	0
Total Income	**-11,882**	**-8,113**	**-8,134**	**21**
Net Controllable Expenditure	**19,197**	**5,900**	**6,684**	**(784)**
Recharges				
Premises Support	336	106	106	0
Asset Charges	160	0	0	0
Central Support Services	2,727	877	877	0
Internal Recharge Income	-420	0	0	0
Total Recharges	**2,803**	**983**	**983**	**0**
Net Departmental Total	**22,000**	**6,883**	**7,667**	**(784)**

Appendix 5: Financial Statement

Comments on the above figures:
In overall terms the Net Controllable Expenditure for Quarter 2 is £825,000 over budget profile excluding the Intermediate Care Pool.

Staff costs are less than expected at the mid point of the financial year. To date staff costs are £71,000 under budget profile due to vacancies in front line staff and also slippage on grants due to delays in appointing to new posts. The Staff saving target of £191,874 within the Department is likely to be met by year end.

The main pressure area is the Community Care budget which is currently £912,000 over budget profile net of income. This is an increase of £651,000 from Quarter 1. Community care includes expenditure on clients with Learning Disabilities, Physical & Sensory Disabilities and Older People. The large increase in spend is partially due to Continuing Health Care disputes being resolved resulting in additional spend so far this financial year of £260,000. This has also been accompanied with a continued increase in the number of service users accessing the service. In Older People the increase this financial year is 8%. The increase in service users accessing the service in Learning Disabilities and Physical & Sensory Disabilities has slowed down in Quarter 2 and reduced in September.

A recovery plan is now in place for the whole Community Care budget within the Communities Directorate in order to bring spend back in line with budget however this will be on going for the next 18 months.

Appendix 5: Financial Statement

Contribution to Intermediate Care Pooled Budget

Revenue Budget as at 30th September 2011

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	1,390	873	875	(2)
Supplies & Services	446	207	165	42
Transport	10	8	7	1
Other Agency Costs	258	84	84	0
Total Expenditure	**2,104**	**1,172**	**1,131**	**41**
Income				
Total Income	-113	0	0	0
Net Controllable Expenditure	**1,913**	**1,172**	**1,131**	**41**
Recharges				
Central Support Charges	448	87	87	0
Premises Support	77	26	26	0
Total Recharges	**525**	**113**	**113**	**0**
Net Departmental Total	**2,516**	**1,285**	**1,244**	**41**

The above figures relate to the HBC contribution to the pool only.

Comments on the above figures:

In overall terms revenue spending at the end of quarter 2 is £41,000 below budget profile, which in the main relates to expenditure on supplies & services that is £42,000 under budget. This is due to costs incurred on the Halton Intermediate Care Unit being less than anticipated at this stage of the year.

Capital Projects as at 30th September 2011

	2011/12 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
Social Care & Health				
Oakmeadow Phase 2	28	14	10	18
Total Spending	**28**	**14**	**10**	**18**

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: Communities Directorate

Department: Commissioning & Complex Care

Period: Quarter 2 - 1st July 2011 – 30th September 2011

1.0 Introduction

This quarterly monitoring report covers Commissioning and Complex Care Services for the second quarter period up to 30th September 2011. It describes key developments and progress against 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

The reorganisation of the Communities Directorate has lead to the Drug Action Team (DAT) contracts and monitoring functions being transferred to the Quality Assurance Team to ensure a consistent approach to performance management of these contracts.

Work on 'winter pressures' is beginning, with all Providers supplying updated plans and contingency measures.

Tenders are being prepared for homeless, floating support and domestic abuse services. The tenders are due to be advertised on 17th October 2011 to enable contracts to be issued from April 2012.

Mental Health Services
The 5Boroughs NHS Foundation Trust has produced proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems. Implementation groups are being established to ensure a coordinated approach is developed.

3.0 Emerging Issues

Model of Care to develop a Comprehensive Community services infrastructure for Adults with Learning Disabilities
Commissioners across Health and Social Care in Halton, St Helens, Knowsley and Warrington are evaluating the levels of community focussed support for adults with learning disabilities. This support will be aimed at reducing reliance on specialist learning disability in-patient services or out of area placements. It is then proposed to consult on the de-commissioning of the in-patient beds provided by the 5 Boroughs Foundation Trust.

4.0 Service Objectives/Milestones

4.1 Progress Against 'Key' Objectives/Milestones

Total	**7**	✓	7	?	0	✗	0

All 'key' objectives / milestones are presently on track to achieve annual targets; additional information can be found within Appendix 1.

4.2 Progress Against 'Other' Objectives/Milestones

Total	**16**	✓	15	?	1	✗	0

All 'other' objectives/milestones are progressing as planned although at this stage it is uncertain whether the Housing related support 'Gateway' will be implemented within the financial year. Further information can be found within Appendix 2

5.0 Performance Indicators

5.1 Progress Against 'Key' Performance Indicators

Total	**4**	✓	1	?	2	✗	0

One of the four 'key' Performances Indicators is on track to achieve annual targets. It is uncertain at this time whether two of the 'key' performance indicators relating to Dementia assessments and Dementia services will achieve annual targets.

Due to data issues one indicator cannot be reported at this time – Adults with mental health problems helped to live at home. Further information is provided within Appendix 3.

5.2 Progress Against 'Other' Performance Indicators

Total	**6**	✓	5	?	1	✗	0

Five 'other' Performance Indicators are on track to achieve annual targets.
However, it is uncertain at this time whether the reduction in hospital admissions for alcohol related harm will achieve its annual target as quarter 2 has been produced based on proxy data for September 2011.

There are two indicators which cannot be reported at this time due to changes in recording data on the Carefirst system and a further four indicators cannot be reported at this point in the year.
Further information is provided within Appendix 4.

6.0 Risk Control Measures

No 'high' risk, treatment measures were identified during the development of the 2011 -12 Service activity.

However, in light of an increase in financial costs borne by the Directorate, partly due to increases in service demand, measures continue to be applied in order to manage and control operational service expenditure levels. The measures put in place are intended to minimise the financial risk to the organisation as well as identifying areas for cost efficiency.

7.0 Progress Against High Priority Equality Actions

As a result of undertaking a departmental Equality Impact Assessment no high priority actions were identified for the service for the period 2011 – 2012.

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
CCC 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 Q2	Supporting Commentary
Implement the Local Dementia Strategy, to ensure effective services are in place. **Mar 2012.** (AOF6 & 7)	✓	Service specification for the Dementia Care Advisors has been completed and will now go out to formal tender. Assessment, Care and Treatment service has now started and evaluation of the initial findings of the project will be submitted by March 2012. An update on project progress will be available from November 2011.
Work with Halton Carers Centre to develop appropriate funding arrangements past September 2011, to ensure that Carers needs within Halton continue to be met. **Jun 2011** (AOF 7)	✓	Work is currently taking place within a sustainability group for Carers Providers of which Halton Carers Centre is acting as a lead.

Appendix 1: Progress Against 'Key' Objectives/Milestones

Ref	Objective
CCC 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 Q2	Supporting Commentary
Introduce specialist support provision for victims of a serious sexual offence **Mar 2012** *(AOF6 & 7)*		The Safe Place Project has set up a Sexual Assault Referral Centre (SARC) for Cheshire, Halton and Warrington. SARCs are a national initiative and care for people who have suffered rape or serious sexual assault. It provides forensic medical examination, care and aftercare and has close links with domestic violence. Halton, as part of this project, pays to utilise St Mary's Hospital in Manchester for all forensic medical examinations needs and access to a child Independent Sexual Violence Adviser (ISVA). The crisis service went 'live' on 1 April 2011 and is located at St Mary's Hospital in Manchester and provided by Central Manchester University Hospitals NHS Foundation Trust. There is also an aftercare service funded 50% by the Local Authorities which went 'live' on 1 October 2010 covering Cheshire, Halton and Warrington. The aftercare service is provided by the Rape and Sexual Abuse Support Centre (RASASC). This provides an individual ISVA in our area to provide a service to those aged 13+, with provision increased due to greater capacity of a larger team. This service will now be able to offer family continuity and a more comprehensive service. This post also offers ongoing support to victims in their local area, which can include support with the court process, emotional support and in gaining access to other required services such as counselling and further medical advice. In order to access the service, victims can self-refer, RASASC can offer support. Cheshire Police will transport victims to the facility for cases that have been reported.

Appendix 1: Progress Against 'Key' Objectives/Milestones

Ref	Objective
CCC 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 Q2	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 2012.** (AOF 32)		Two consultations commenced during Quarter 2. The first is a survey consultation to evaluate customer satisfaction with their experience of Housing Solutions in order to continually monitor and improve service delivery. The second is a survey consultation to find out the experience of service users who had had a minor or major adaptation, to gauge the level of satisfaction and to improve the experience for future service users.

Appendix 1: Progress Against 'Key' Objectives/Milestones

Ref	Objective
CCC 2 (continued)	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 Q2	Supporting Commentary
Ensure HealthWatch is established and consider working in partnership with other Councils to deliver this. **Mar 2012** (AOF 32)	✓	The implementation date for Local HealthWatch has now been put back by Government to October 2012. During this extended transition period the LA has a statutory responsibility to maintain LINk activity. The current LINk Host contract will be extended to October 2012, with an option of 6 x 1 month extension options (should the implementation date slip again) subject to Exec Board Sub approval in early November 2011. There is a LINK Transition Group (Sub Group of the LINk Board) established to undertake planning for Local HealthWatch; on which the Divisional Manager for Commissioning, a Commissioning Manager and Policy Officer sit. Within HBC there is a HealthWatch Project Group identified to undertake the technical aspect of the procurement of a HealthWatch Service. Partnership working with other councils may come in the form of joint commissioning of a HealthWatch organisation across a wider geographical footprint; but with HealthWatch boards present within each LA area, or the joint commissioning of the NHS Complaints Advocacy Service (from April 2013) across a wider geographical footprint; these options will be considered if/when appropriate.
Update the Joint Strategic Needs Assessment (JSNA) summary of findings, following community	✓	The draft JSNA has been available from both HBC and PCT website since July 2011 and requests comments by March

Appendix 1: Progress Against 'Key' Objectives/Milestones

consultation, to ensure it continues to effectively highlight the health and wellbeing needs of people of Halton. **Mar 2012** (AOF 6)		2012. Feedback/comments will be collated by the Policy Officer (Health) and a refreshed protocol is being developed between Policy/Public Health and HBC Research & Intelligence to ensure that the JSNA remains as current and useful as possible.

Ref	**Objective**
CCC 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 Q2**	**Supporting Commentary**
Consider with our PCT partners the recommendations and implications of the review of Halton's section 75 agreement in light of the publication of the Government White Paper 'Equity and Excellence: Liberating the NHS'. **Mar 2012.** (AOF 33,34 and 35)	✓	Detailed arrangements for the Health and Wellbeing Board have now been finalised and there are advanced discussions regarding the transfer of Public Health to the Council.

Appendix 2: Progress Against 'Other' Objectives/Milestones

Ref	Objective		
CCC 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 Q2**	**Supporting Commentary**
Monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder. ***Mar 2012.*** *(AOF 6)*		✓	The Autism Strategy for Halton is still in draft form, however work is progressing to finalise the strategy and achieve final sign off from all partners as soon as possible. Progress updates of the strategy are provided to the Autism Spectrum Condition (ASC) Strategic Group on a quarterly basis. The Autism Strategy includes an action plan to be monitored on a regular basis in order to track progress on implementing statutory and best practice guidance regarding services available for children and adults with Autism Spectrum Conditions living in Halton.
Consider implications of Autism Act 2009 and review working practices to ensure they are 'fit for purpose'. ***Mar 2012.*** *(AOF 7)*		✓	The Autism Act 2009 and subsequent strategies such as 'Fulfilling and Rewarding Lives' have been considered and all action points for local authorities to deliver have been included in the 'Halton Autism' Strategy to ensure implementation and that the services provided locally are fit for purpose. The action plan included in this strategy identifies responsible officers and clear timeframes for delivery. The action plan will be monitored on a regular basis and updates presented to the ASC Strategic Group. A Scrutiny Review of Autism Spectrum Conditions commenced in June 2011 and the review will run until September 2011. The Scrutiny Review Topic Group includes the Operational Director for Commissioning and Complex Needs, Principal Policy Officer and the Principal and Practice

Appendix 2: Progress Against 'Other' Objectives/Milestones

		Managers for the Positive Behaviour Support Service. The final report of findings from the review will be presented at the Health PPB in March 2012.
Contribute to the implementation of the Council wide Volunteering Strategy as a means to improving services to communities. ***Mar 2012.*** *(AOF 21)*	✓	It has now been agreed that the strategy will be progressed by Policy and Strategy in conjunction with Directorate staff.
Implement the redesign of the Supported Housing Network to ensure that it is meeting the needs of those with the most complex needs. ***Mar 2012.*** *(AOF6 & 7)*	✓	With the continued implementation of 'active support' a system devised by Dr Sandy Toogood, a Behavioural Analyst, the service continues to improve Tenants' lives, developing a wider range of activities and an increase in social inclusion. Staff continue to complete weekly records of participation for indoor/outdoor activities and community presence. Each Tenant has his or her own activity support plan. Tenants are able to participate with activities in their own home i.e. laundry, preparing meals, weekly tasks etc. We continue to use the person centred approach offering choice and empowering Tenants. The interactive training being completed with Esther Gibbons the Network and Day Services has given the staff more insight to what those with complex needs are trying to communicate. When this work is complete, all Tenants will have a Care Plan to show how people communicate at the very least their likes and dislikes. Progress remains robust and the service went from a 'C' rating to 'B' after the last Supporting People inspection.
Implement and review the Single Point of Access to ensure that it delivers an effective mechanism for access into Services. ***Mar 2012.*** *(AOF 6 & 7)*	✓	This work has now been subsumed into the joint work with the 5Boroughs NHS Foundation Trust on the redesign of Mental Health Services.

Appendix 2: Progress Against 'Other' Objectives/Milestones

Ref	Objective
CCC 1 (cont'd)	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 Q2	Supporting Commentary
Continue to ensure there is a wide choice of pathways into volunteering opportunities to meet the needs of people with a Learning Disability. ***Mar 2012.*** *(AOF 6 & 21)*	✓	Sure Start to Later Life advertises for volunteers through Halton Voluntary Action (HVA). HVA identify and train suitable applicants from a job description for specific volunteer roles. The Sure Start Senior Information Officer then coordinates the volunteers. The volunteers are matched with appropriate older persons. The volunteers fulfill a variety of roles with older people including befriending, dog walking and ICT training. The Bridge Builder (BB) works with people to find out the type of voluntary work that they would like to do and then goes out and markets them in the local community. Part of the role is to have a presence in the community mapping and capacity building and the team have built up positive relationships with employers. The BB will offer on going support to the employer and the client to ensure that the placement is as successful as possible and last year we enabled 94 people with disabilities to access voluntary opportunities of their choice. We also have a pathway for people who have proven to themselves that they are valued in their community and wish to pursue paid work via Halton People into Jobs (HPiJ) and we will continue to support the individual through this process.
Implement the recommendations following the Challenging Behaviour review/project to ensure	✓	Positive Behaviour Service is now established and delivering cost savings and quality outcomes.

Appendix 2: Progress Against 'Other' Objectives/Milestones

services meet the needs of service users. ***Mar 2012.*** *(AOF 6 & 7)*		
Introduce Housing related support 'Gateway' or single point of access service. ***Mar 2012*** *(AOF 6, 30 and 31)*	?	Gateway to be developed and implemented in line with Choice Based Lettings and the introduction of a new homelessness system. The use of a single system, Abritas, will provide a common database for everyone requiring housing and/or support services. A report is being prepared detailing the proposed structure and costing's of the Gateway service.

Ref	Objective
CCC 1 (cont'd)	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 Q2	Supporting Commentary
Maintain the number of carers receiving a carers' break, to ensure Carers needs are met. ***Mar 2012*** *(AOF7)*	✓	The Targets for Carers short respite breaks have been set for April 2011.
Maintain the numbers of carers provided with assessment leading to the provision of services, to ensure Carers needs are met. ***Mar 2012.*** *(AOF7)*	✓	Carers Assessments meetings are planned to bring together operational teams to discuss service provision and increase the numbers of hidden carers receiving an assessment in accordance with their caring needs.

Appendix 2: Progress Against 'Other' Objectives/Milestones

Ref	Objective		
CCC 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 Q2**	**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 2012.*** *(AOF7)*		✓	Team now fully staffed and evidence of improved outcomes.
Implement the new Statutory Adult Social Care Survey across all Client Groups. ***May 2011.*** (AOF 32)		✓	The Adult Social Care Survey was undertaken for the first time in January 2011. The return demonstrated positive results for Halton. All Local Authorities have a statutory duty to undertake the survey on an annual basis. The next Adult Social Care Survey is in January 2012.
Update the Joint Strategic Needs Assessment (JSNA) ***-*** *full data document, following community consultation, to ensure it continues to effectively highlight the health and wellbeing needs of people of Halton.* ***Mar 2012*** *(AOF 6)*		✓	The draft JSNA has been available from both HBC and PCT website since July 2011 and requests comments by March 2012. Feedback/comments will be collated by the Policy Officer (Health) and a refreshed protocol is being developed between Policy/Public Health and HBC Research & Intelligence to ensure that the JSNA remains as current and useful as possible.
In conjunction with Halton OPEN, implement mechanisms to ensure that Older People are able to effectively contribute to service monitoring and reviews, including the development of mystery shopping. ***Mar 2012.*** *(AOF 7 & 32)*		✓	Halton OPEN completed their first mystery shopping project in Q1 as part of the review of the contact centre. The next review will be undertaken in the new year and Halton OPEN in conjunction with Halton Borough Council is currently developing a framework for this.

Appendix 2: Progress Against 'Other' Objectives/Milestones

Ref	Objective
CCC 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 Q2	Supporting Commentary
Undertake ongoing review and development of all commissioning strategies and associated partnership structures to enhance service delivery and cost effectiveness. ***Mar 2012.*** *(AOF 35)*	✓	Work is ongoing to review existing Partnership Commissioning Structures in line with Government proposals for the development of Health and Well Being Boards and an increased focus on joint Commissioning between Social Care and Health.
Review and deliver SP/Contracts procurement targets for 2012/13, to enhance service delivery and cost effectiveness. ***Mar 2012****. (AOF35)*	✓	The Tender process will enable the further rationalisation of floating support services and give support providers the option to offer further efficiencies by tendering for a number of services within each tender. In addition, partnership working with Registered Social Landlords (RSL's) as part of the development and implementation of a Sanctuary policy has resulted in a reduction in the number of Sanctuary measures completed to date in 2011/12 and it is anticipated the proposed efficiencies will be achieved.

Appendix 3: Progress Against 'Key' Performance Indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
Service Delivery							
CCC 6	Adults with mental health problems helped to live at home (Previously AWA LI13/CCS 8)	3.97	3.97	N/A	N/A	N/A	Figure for quarter 2 cannot be provided at this moment in time. This is due to the changes of recording carer services within the Carefirst database system currently taking place. We are working with the Carefirst team and are hopeful to begin reporting this indicator again in the near future.
CCC 7	Total number of new clients with dementia assessed during the year as a percentage of the total number of new clients assessed during the year, (18+)	4.6%	5%	2.4%	?	N/A	The proportion of clients assessed with Dementia (23) is small in comparison to the total number of clients assessed at the end of Quarter 2. It is expected that the number of clients assessed with Dementia will increase in Quarters 3 and 4 as the figure is calculated cumulatively.

Appendix 3: Progress Against 'Key' Performance Indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
CCC 8	Total number of clients with dementia receiving services during the period provided or commissioned by the CSSR as a percentage of the total number of clients receiving services during the year, (18+).	3.3%	5%	3.7% (E)	?	N/A	The proportion of clients with Dementia receiving services is estimated as higher than the 2010/11 outturn figure. However the figure is estimated as a result of changes to the way services are recorded for carers. It is hoped that the reporting issues will be addressed by quarter 3.
CCC 9	The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years (Previously PCS 12).	0	1.2	0	✓		The Authority had sustained a zero repeat homelessness status.

Appendix 3: Progress Against 'Key' Performance Indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
CCC 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 PCS 11).	5.78 (940 cases)	4.4	5.02			The service is more community focused. Due to increased early intervention measures and partnership working this has resulted in an increase in the prevention activity and successful outcomes.
CCC 14	Carers receiving Needs Assessment or Review and a specific Carer's Service, or advice and information (Previously NI 135).	24.13	24.5	N/A	N/A	N/A	Figure for quarter 2 cannot be provided at this moment in time. This is due to the changes of recording carer services within the Carefirst database system currently taking place. We are working with the Carefirst team and are hopeful to begin reporting this indicator again in the near future.

Appendix 4: Progress Against 'Other' Performance Indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
Service Delivery							
CCC 4	Adults with physical disabilities (aged 18-64) helped to live at home per 1,000 population (Previously CCS 6)	7.89	8.0	N/A	N/A	N/A	Figure for quarter 2 cannot be provided at this moment in time. This is due to the changes of recording carer services within the Carefirst database system currently taking place. We are working with the Carefirst team and are hopeful to begin reporting this indicator again in the near future.
CCC 5	Adults with learning disabilities (aged 18-64) helped to live at home per 1,000 population (Previously CCS 7)	4.37	4.3	N/A	N/A	N/A	Figure for quarter 2 cannot be provided at this moment in time. This is due to the changes of recording carer services within the Carefirst database system currently taking place. We are working with the Carefirst team and are hopeful to begin reporting this indicator again in the near future.

Appendix 4: Progress Against 'Other' Performance Indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
Service Delivery (cont'd)							
CCC 15	Average Percentage of Communities Directorate working days/shifts lost to sickness absence during the financial year. (Previously PCS 14).	N/A	8	4.49%	N/A	N/A	Data was unavailable for 10/11 so there is no comparable data; this is the first reporting period for 11/12. The quarter 2 absence figure is an average for the whole Communities Directorate for the period April to August 2011. However, the average % absence less long term sick for the same period is 2.16%.
Fair Access							
CCC 19	Total number of learning disabled people helped and supported into voluntary work on a yearly basis, rather than just new clients getting work in the year. (Previously CCS 2).	85	45	89			Target already achieved. There has been an increase of 68 clients compared to the same quarter in 2010/11.

Appendix 4: Progress Against 'Other' Performance Indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
CCC 20	Total number of physically disabled people helped and supported into voluntary work on a yearly basis, rather than just new clients getting work in the year. (Previously CCS 2).	8	8	6			Indicator in line to achieve target. There has been an increase of 1 client compared to the same quarter in 2010/11
CCC 21	Total number of adults with mental health helped and supported into voluntary work on a yearly basis, rather than just new clients getting work in the year. (Previously CCS 2).	25	21	14			Indicator in line to achieve target. There has been an increase of 3 clients compared to the same quarter in 2010/11.

Appendix 4: Progress Against 'Other' Performance Indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
Area Partner Indicators: The indicators below form part of the old National Indicator Set introduced on 1st April 2008. Responsibility for setting the target, and reporting performance data, will now sit with one or more local partners. As data sharing protocols are developed, baseline information and targets will be added to this section.							
CCC 22	Reduce Hospital Admissions for Alcohol related harm (Previously NI 39) Rate per 100,000	2809 Predicted value, synthetic estimate by Public Health	2916	1419.1	?		Quarter 1 has been updated with actual data, quarter 2 has been produced based on proxy data for September 2011 (1) All Tier 2 and Tier 3 Alcohol Treatment Services have been decommissioned as of 01.01.12. A competitive tender nears conclusion for future Tier 2 and 3 drug and alcohol services (as part of an integrated Recovery Service). Work to support the tender continues. (2) An Alcohol Liaison Nurse Project is being developed in Whiston and Warrington Hospitals. The Clinical service specification received clinical approval at Halton & St Helens Clinical Executive Committee on 15 September 2011 and a Business Case has been approval. The implementation stage of the project has now commenced.

Appendix 4: Progress Against 'Other' Performance Indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
CCC 23	Drug users in effective treatment (Previously NI 40).	456 Nov 2010	N/A	Refer to comment	Refer to comment	N/A	Data for this is no longer provided by the National Treatment Agency (NTA). As per Q1 an alternative local measure is being investigated in line with the new 'Drugs & Alcohol' Strategy. Therefore this indicator will be removed from future reports.

Appendix 4: Progress Against 'Other' Performance Indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 2	Current Progress	Direction of Travel	Supporting Commentary
CCC 38	Social Care-related Quality of life (Adult Social Care Survey) 1A.	18.9%	N/A	N/A	N/A	N/A	The Adult Social Care Survey was undertaken for the first time in January 2011. The fieldwork for the 2011/12 survey will take place between January and March 2012.
CCC 39	The Proportion of people who use services who have control over their daily life (Adult Social Care Survey) 1B.	79.2%	N/A	N/A	N/A	N/A	The Adult Social Care Survey was undertaken for the first time in January 2011. The fieldwork for the 2011/12 survey will take place between January and March 2012
CCC 40	Proportion of Adults in contact with secondary mental health services in paid employment (NI 149) 1F.	13.3%	12%	13.2%	✓	↑	Mental Health Services in Halton continue to achieve a high rate of people in paid employment. The figure for Q2 is higher than in Q2 2010/11 (12.4%)
CCC 41	Proportion of Adults in contact with secondary mental health services living independently, with or without support (NI 150) 1H.	92.8%	93%	92.7%	✓	↓	Mental Health Services in Halton continue to achieve a high rate of people in settled accommodation. However, the figure for Q2 is slightly lower than in Q2, 2010/11 (93.1%)
CCC 42	Overall satisfaction of people who use services with their care and support (Adult Social Care Survey) 3A.	61.7%	To confirm	N/A	N/A	N/A	The Adult Social Care Survey was undertaken for the first time in January 2011. The fieldwork for the 2011/12 survey will take place between January and March 2012.

Appendix 5: Financial Statement

COMMISSIONING & COMPLEX NEEDS DEPARTMENT

Revenue Budget as at 30TH September 2011

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	6,681	3,602	3,608	(6)
Other Premises	320	199	207	(8)
Supplies & Services	4,547	702	695	7
Contracts & SLA's	548	43	41	2
Transport	295	133	111	22
Emergency Duty Team	103	26	18	8
Community Care:				
Residential & Nursing Care	806	362	304	58
Community – Home Care	359	145	114	31
Direct Payments	144	87	96	(9)
Block Contracts	174	93	87	6
In-House Day Care	23	8	5	3
Food Provision	35	18	8	10
Other Agency Costs	564	255	265	(10)
Payments To Providers	4,216	2,096	2,089	7
Grants To Voluntary Organisations	270	133	135	(2)
Total Expenditure	**19,085**	**7,902**	**7,783**	**119**
Income				
Residential & Nursing Fees	-68	-31	-32	1
Direct Payment Charges	-3	-2	-3	1
Community Care Income	-4	-1	-5	4
Sales & Rents Income	-182	-132	-127	(5)
Fees & Charges	-387	-150	-146	(4)
PCT Reimbursements : Care	-202	-51	-51	0
PCT Reimbursements :Service	-1,918	-993	-1,000	7
Transfer From Reserve	-1,151	0	0	0
Reimbursements	-288	-168	-145	(23)
Government Grant Income	-292	-165	-169	4
Total Income	**-4,495**	**-1,693**	**-1,678**	**(15)**
Net Controllable Expenditure	**14,590**	**6,209**	**6,105**	**104**
Recharges				
Premises Support	506	179	179	0
Asset Charges	406	0	0	0
Central Support Services	2,242	682	682	0
Transport	449	132	132	0
Internal Recharge Income	-88	0	0	0
Net Total Recharges	**3,515**	**993**	**993**	**0**
Net Departmental Total	**18,105**	**7,202**	**7,098**	**104**

Appendix 5: Financial Statement

Comments on the above figures:

Net Controllable Expenditure is £104,000 below budget profile at the end of the second quarter of the financial year.

The above figures include income and expenditure in respect of the Community Care element of Mental Health Services. The current expectation is a year end position of £187,000 under spend on the Community Care Budget which is based on data held for all know care packages at the present time. This figure is subject to fluctuation, dependent on the number and value of new packages approved, and the termination or variation of existing packages. The position to date shows the community care budget is currently £93,000 under budget profile, representing the variance for the first six months of the financial year.

Other expenditure is generally in line with budget at this point in the year, and it is not anticipated that there will be any significant budget variances in these areas at the end of the financial year. Expenditure on transport is currently below budget profile by £22,000 and this relates to transport costs incurred in Adult Day Services. This is due to the replacement of taxi contracts with transport provided by fleet vehicles.

Similarly, income received to date is currently broadly on target. There is evidence that income generated by Community Centres may be reduced from previous years as a result of economic pressures, although the position is being monitored closely, and remedial action will be taken if necessary to achieve a balanced budget.

At this stage, net expenditure for the Complex & Commissioning Care Department is anticipated to be in line with budget by the end of the financial year.

Capital Projects as at 30th September 2011

	2010/11 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Allocation Remaining £'000
Renovation Grant	166	83	61	105
Disabled Facilities Grant	660	330	330	330
Energy Promotion	6	0	0	6
Stairlifts	200	100	122	78
RSL Adaptations	560	230	204	356
Modular Buildings	27	13	0	27
User Lead Adaptations	55	0	0	0
Choice Based Lettings	40	0	0	40
Extra Care	463	0	0	463
Borough Placements	464	0	0	464
Total Spending	**2,641**	**756**	**717**	**1,869**

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.*

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REPORT TO: Health Policy & Performance Board

DATE: 10 January 2012

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults

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: That the Board notes the contents of the report.**

3.0 **SUPPORTING INFORMATION**

3.1 Discussions have begun, aimed at developing a pilot project in Halton based on the 'Safe Around Town' scheme which is currently running in St Helens. The scheme's purpose is to provide a safe sanctuary for people with learning disabilities in St Helens town centre. The working group will think about widening the proposed scope of the scheme in Halton to include vulnerable people of all ages and needs in the wider community rather than limiting it to shopping areas. Halton Speak Out has a lead role in the project and it is hoped that collaboration can also be achieved with other voluntary groups, community centres and employers.

3.2 Feedback received during the Care Quality Commission of Adult Social Care in Halton (in 2010) and from other research highlighted that:

- People wanted a less formal way of raising concerns; and
- Many people were nervous about raising concerns when they, or their family member, were in a vulnerable situation (such as in hospital, care home, in a dependant position etc)

In response, a working group was formed, which included Social Care Customer Care, Corporate Complaints, Customer Services and Communications & Marketing, to look at developing methods of encouraging the public to provide both positive and negative feedback on services. One of the outcomes is that a logo is being added to all Council literature, which focuses on how we can help the public improve our services to them. The strap-line 'Help us Help You' is used, moving away from focusing on telling people how to complain and emphasising that the

Council welcomes feedback.

Health and private sector partners are being encouraged to adopt the Logo and approach, with their own contact details. Halton Direct Link and the Customer Care Team will monitor the number of Referrals, on a monthly basis, and Communications & Marketing will monitor all artwork produced on an ongoing basis to ensure the logo is used correctly.

3.3 Halton Speak Out (a voluntary sector organisation that supports people with learning disabilities) held an event for self-advocates in September 2011, following the screening of the story about Winterbourne View Hospital on the Panorama TV programme and the news. Halton Speak Out were upset by what they saw and wanted to give members a chance to talk about what had happened, say what they thought about it and to make sure that members knew enough about abuse to recognize it if it happened to themselves or a friend and feel confident enough and know how to speak up about it. Comments about the event included the following:

- 'It would be great if more people came or this could be done again.'
- 'I found it emotional. It helped me to talk about my lifestyle to the staff.'
- 'Enjoyed today. Just sad about people getting hurt but I know something is being done.'
- 'An excellent event talking about a difficult topic.'
- 'I enjoyed today. It was very interesting and I learned a lot.'
- 'It is great people are being made more aware of abuse.'
- 'I can help my friends in supported housing understand more about it.'
- 'I found it good.'
- 'Liked it a lot.'
- 'I felt happy that something is being done but shocked that things are happening. I know the people to talk to if I saw it happening.'

3.4 A presentation was delivered at the Domestic Abuse Survivors Conference in November 2011, providing a 'snapshot 'of the Safeguarding Adults service and its links with Domestic Abuse support services, and highlighted the importance of partnership working, including information sharing and referral pathways. The event, attended by approximately 125 delegates including survivors and specialist service providers, explored effective approaches to preventing violence against men, women and children whilst supporting survivors of Domestic Abuse and Sexual Violence.

3.5 A newly developed Safeguarding Adults Induction Workbook, intended for all staff and volunteers, has now been finalised. Plans are being made to disseminate it widely to local agencies, groups and individuals including to Elected Members. An advance copy is available below to PPB members.

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Training & Developme

3.6 The first two of four multi-agency Joint (Safeguarding Adults and Children) Alerter Training Events planned for 2011-12 took place in November 2011. The events, which received very positive feedback from delegates attending, were delivered by a drama group and facilitated by Halton Borough Council officers who were present to deal with any queries arising that relating to local issues

3.7 The safeguarding (adults and children) customized training provided for transport staff, contracted transport service providers and volunteers, is being reviewed and updated and messages about Hate Crime and Hate Incidents incorporated.

3.8 A range of issues surrounding dignity have been developed and attached at Appendix 1 is a report that will be presented to the Safer PPB (17/01/12).

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 whose circumstances make them vulnerable to abuse, whilst Halton Borough Council, through its Communities Directorate, fulfils its responsibility for coordination of the arrangements. These arrangements are 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 (SAB) membership includes a Manager from the Children and Enterprise Directorate, as a link to the Local Safeguarding Children Board.

Halton Safeguarding Children Board membership includes adult social care representation.

Joint protocols exist between Council services for adults and children.

The SAB chair and sub-group chairs 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 adults whose circumstances make them vulnerable to abuse.

5.5 **Halton's Urban Renewal**

None identified.

6.0 **RISK ANALYSIS**

6.1 Failure to address a range of Safeguarding 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 issues of equality, in particular those regarding age, disability, gender, sexuality, race, culture and religious belief, when considering its safeguarding policies and plans. Policies and procedures relating to Safeguarding Adults are impact assessed with regard to equality.

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

None under the meaning of the Act.

REPORT TO: Safer Halton Policy & Performance Board

DATE: 17 January 2012

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO Health & Adults

SUBJECT: Dignity and Human Rights

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide an update on Halton's involvement in the Equality and Human Rights Commission formal inquiry into older people and human rights in home care.

2.0 **RECOMMENDATION: That: the report be noted.**

3.0 **SUPPORTING INFORMATION**

3.1 The Commission launched the inquiry to investigate the extent to which the current legislative, regulatory and quality control systems provided sufficient human rights protection for older people requiring or receiving home care.

3.2 Stage 1 - in March '11 the Equality and Human Rights Commission wrote to request Halton's participation in this inquiry citing their legal powers for our involvement under section 16 of the Equality Act 2006 and included their Terms of Reference (Appendix A). This initial stage involved completion of an online survey which included human rights considerations for the following areas:

- Commissioning and procurement processes;
- Needs assessments;
- Complaints handling;
- Views on regulation;
- Staff training;
- Information, advice and advocacy;
- Funding of and eligibility for services;
- Examples of good practice within the local authority and in partnership with other organisations.

The response offered an ideal opportunity to highlight Halton's approach to dignity and human rights. In particular, that Halton was the only local authority in the country to have appointed a dedicated Dignity Co-ordinator with responsibility across both health and social care services working in partnership via a multi-agency Network. Also, to note the benefits this role offered:

- Increased the profile, level of understanding and awareness of dignity/respect and human rights amongst public, staff and agencies/organisations;
- Implementation of a Network Dignity Action Plan, Charter and whole system Best Practice case studies;

- Dignity Audit Frameworks and Questionnaires;
- The positive outcomes evidenced in Halton's CQC Adult Social Care Inspection being awarded Excellent;
- People and staff taking ownership to help embed dignity by signing up as Dignity Champions.

3.3 Stage 2 - in April '11 the Commission sought further documentary evidence towards the inquiry to support Halton's response and conducted an extensive interview with Halton's Dignity Co-ordinator and the Divisional Manager for Independent Living Services.

3.4 Stage 3 - in May '11 the Commission wrote to the Chief Executive stating how impressed they were with Halton's integration of the dignity and human rights based approach and sought permission to conduct interviews to gather further evidence towards the inquiry. In preparation for the interviews the Commission provided an Interview Framework detailing the thematic areas of evidence they wished to explore, with a particular emphasis on the integration of human rights (Appendix B). The Commission conducted the interviews during June/July '11 which included the following different roles:

- Elected member with responsibility for adult social care;
- Chair of Health PPB;
- Strategic Director, Communities;
- Operational Director Commissioning and Complex Needs;
- Operational Director Prevention and Assessment;
- Officers with responsibility for equality/human rights;
- Dignity Co-ordinator;
- Safeguarding Co-ordinator;
- Commissioning Manager;
- Home Care Manager;
- Contract Monitoring Manager;
- Sure Start 2 Later Life Manager;
- Adult Placement Service Manager;
- Principal Manager Assessment
- Social Worker;
- Chair of Halton Dignity Champions' Network.

Interview based evidence was also sought from relevant bodies in the area for example, independent home care providers, third sector organisations including advocacy and advice giving bodies, older people and their families.

On completion of the interviews, the Commission informed the Dignity Co-ordinator that Halton had been selected as an exemplar of best practice and sought permission for the Council to be named within their published report due to be issued in November '11.

3.4 In November '11, prior to the report being published, the Commission contacted the Dignity Co-ordinator to advise that Halton was in fact the only local authority to be 'officially' named within their published report in terms of best practice. Although evidence had been sought from many other local authorities no others had 'ticked all the boxes'. This being due to Halton's whole-system dignity and human rights based approach, the Commissions 'Close to Home' report was published on 23 November '11. Halton is referenced on page 43, Part 3c: 'How well

do local authorities promote and protect older people's human rights?' and page 55 involving commissioning, procurement and contract management practices.

Reference 1 (page 43):
Halton Borough Council employs a Dignity in Care Co-ordinator, whose role is to integrate a 'whole system' human rights based approach across all health and social care services including home care. All partner organisations and care providers work to embed dignity via a Dignity Champions' Network; having signed up to Halton's Dignity Charter and appointed Dignity Champions. Providers report back regularly on the practical steps they are taking to promote the human rights of people using their services. ***A senior local authority manager highlighted the benefit of having a dedicated co-ordinator****: 'It (dignity) becomes the norm really for [us] ... It becomes the norm to recognise that within contracts and ... in the provision of services as well.'*

Reference 2 (page 55):
Halton Borough Council uses the 'Dignity Challenge' approach pioneered by the Department of Health. ***Halton Borough Council written evidence:*** *"In our commissioning and contracting, we include the 10-point Dignity Challenge in our service specifications for block contracts, within principles and standards, and within the outcomes required for spot contracts. Dignity and human rights are underlying themes – 'golden threads' in our Quality Assurance Framework [QAF]. This means that providers will be assessed according to the degree to which they meet these standards, being mainstreamed into the QAF rather than as a tick list. In the procurement of services prospective providers have to evidence how they meet these underlying themes prior to the award of a contract and this becomes part of the contract monitoring process. We also publicise the annual Dignity Day to providers to highlight its importance and to give providers the opportunity to showcase good practice."*

4.0 POLICY IMPLICATIONS

4.1 The development and modernisation of older peoples' and all adults' services involving the dignity and human rights based approach supports the council's commitment to provide appropriate, flexible care and support for older people. This improves their choices, health and avoids admission to long-term care.

4.2 Halton Dignity Champions' Network is the multi-agency strategic-level group responsible for driving forward the Dignity campaign ensuring that policies include dignity become embedded in practice.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The Co-ordinators' post is jointly funded through NHS and Council resources.

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**

We continue to have a positive approach to dignity and human rights by working across the health and social care system in Halton. This enables people to be treated as individuals by offering a personalised service thus maintaining a maximum level of independence, choice and control over their lives.

6.4 **A Safer Halton**

By ensuring we continue to invest in the Dignity Campaign we will continue to have a positive impact on the key challenges in this area for example, acting to alleviate people's feelings of isolation and loneliness, having a zero tolerance against all forms of abuse and ensuring people feel able to complain without fear of retribution.

6.5 **Environment and Regeneration in Halton**

None identified.

7.0 **RISK ANALYSIS**

7.1 Failure to continue improving service provision may affect our CQC performance rating as measurement of users' experience of being treated with respect and dignity in their Health and Social Care which has become increasingly seen as central to the maintenance of high-quality care.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 The work in progress demonstrates that services to adults and older people across the borough are intolerant of indignity, age discrimination, promoting equality, diversity and human rights in services delivered.

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

None under the meaning of the Act

Appendix A

Terms of Reference: Equality and Human Rights section 16 Inquiry

To inquire into the extent to which the human rights of older people[i] who require or receive home-based care and support, however funded, are promoted and protected by public authorities, working singly or with others, and the adequacy of the legal and regulatory framework within which they are required and empowered to do so.

In particular to identify:

1. The extent to which public authorities are effective in protecting and promoting the human rights of older people , including those paying for their own services, in the initial and ongoing assessment of their needs, commissioning home based care and support and subsequent contract management;

2. Good practice in the promotion and protection of human rights of older people in home based care, including by reference to examples of how public authorities have addressed human rights matters in discharging their existing duties to promote race, gender and disability equality or through the development of single equality schemes;

3. Public authorities' understanding of their duties under the Human Rights Act in relation to promoting and protecting the human rights of older people requiring or receiving home based care and support;

4. The extent to which the legal framework for human rights and community care adequately protects and promotes the human rights of older people requiring or receiving home based care and support services;

5. The extent to which appropriate information, advice and advocacy is provided to older people directly purchasing home based care and support in order to protect and promote their human rights;

6. The extent to which inspectorate and regulatory bodies, including professional regulatory bodies, protect and promote the human rights of older people requiring or receiving home based care and support services and the extent to which it is appropriate for them to do so.

7. The scope for enhancing the role of inspectorate and regulatory bodies, including professional regulatory bodies, individually and collectively, in promoting and protecting the human rights of older people receiving home based care and support;

8. The extent to which people, including the families of older people requiring or receiving care and support, based on their experience, have confidence that the system will promote and protect their human rights.

In carrying out the inquiry the Commission will have regard to the extent to which the diverse experiences and needs of older people related to their disability, age, gender, gender identity, race or ethnicity, religion or belief and sexual orientation are effectively incorporated.

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[i] By older people we mean people who are ages 65 and over.

Appendix B

Interview framework

All interviews will start with an exploration of the individual's role and the relevance of human rights to their specific context.
Interviews will end with interviewees being invited to share their thoughts on any barriers to the promotion and protection of human rights of older people receiving homecare and methods of overcoming these.
Interviews will include questions around:

- any challenges that may arise when operating in a rural context;
- the extent to which human rights that may be at risk when older people receive home care;
- training and support to support incorporation of human rights.

The following areas will be covered, with particular emphasis dependant on the role of the interviewee:

Commissioning
The incorporation of older people's human rights in:

- commissioning strategy for home care;
- service specifications;
- contracts;
- contract monitoring systems;
- scrutiny and reporting;
- information/advice given to providers.

Personalisation
The impact of personalisation on promotion and protection of human rights of older people.

Assessments
The incorporation of older people's human rights in the needs assessment framework and how this works in practice.

Information, advice and support for people seeking home care

- Availability of support e.g. advocacy or communication support.
- Information and advice offered to people seeking home care (including self funders).
- Complaints systems and how they operate, covering complaints against the authority as well as homecare providers.

Regulation
The effectiveness/extent of current approaches and how these may be improved.

REPORT TO: Health Policy & Performance Board

DATE: 10 January 2012

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults

SUBJECT: Positive Behaviour Support Service (PBSS)

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To inform Members of the work of the Positive Behaviour Support Service (PBSS).

2.0 RECOMMENDATION: That: the Board note the content of the report.

3.0 INTRODUCTION

3.1 This report sets out the development, current activities and future direction for the Positive Behaviour Support Service (PBSS). This is a new service with the primary purpose of supporting and improving the lives of children and adults with learning disabilities and/or autism, and who exhibit 'challenging behaviour'. Such behaviour can include: stereotypical behaviour, self-injury, disengagement or aggression.

3.2 The consequence of such behaviour can place carers and parents under considerable stress and tend to limited opportunities for an ordinary life for the individuals concerned. It is precisely to counter such consequences that the PBSS has been established. The service is staffed by Board Certified Behaviour Analysts, who hold an internationally recognised qualification requiring intensive training and continuous supervision.

4.0 BACKGROUND

4.1 Behaviour analytic approaches were introduced into Halton Borough Council Adult Social Care Services in 2008. The approach, which depends upon the careful collection and analysis of data and the formulation of intervention plans, is designed to answer some deceptively simple questions:–

- what maintains challenging behaviour?
- how can the environment be changed to reduce those

behaviours?
- how can alternative repertoires of behaviour be encouraged and maintained?

Sustained work was undertaken with individuals who challenged services and the results were significant improvements in quality of life and concomitant reductions in challenging behaviour.

4.2 These outcomes were then disseminated to potential funding partners, including NHS St Helens and Halton Primary Care Trust and neighbouring Councils, in the form of a business case. A key element of the business case was that the PBSS is an 'invest to save' service. This is because traditional ways of supporting people who challenge services can be very high cost either through residential placements or repeated admissions to NHS assessment centres.

4.3 Through reducing levels of challenging behaviour, such costs can be reduced, and the business case estimated that cumulative savings of £300,000 could be achieved over a three year period.

4.4 **Current Position**

4.4.1 Recruitment for the team commenced in late 2010, and the full staff team of 13 was established in November 2011. The service is funded by St Helens Council (Adults), Knowsley Metropolitan Borough Council, NHS St Helens and Halton Primary Care Trust and Halton Borough Council. The service works with children and adults across four related areas:

l) Early Intervention

The PBSS provides a service to high risk groups, e.g. children with Autistic Spectrum Conditions. Early intervention work consists of:
- Parent/carer training workshops
- Work with individuals
- Close working with schools

i) Crisis Prevention and Management

The PBSS has a prominent focus on crisis prevention and management. Such work includes:
- Developing mainstream service staff competencies and mentoring
- Mechanisms for surveillance, i.e. behaviour monitoring, early identification of potential behaviours that may present challenges to services
- Prevention of placement breakdown and out of borough placement
- The PBSS also aims to have presence at key risk times

ii) Technical Support

The PBSS provides specialist individualised treatment for the most complex cases. This includes:

- Referral, review, and allocation for full functional Assessment
- Person centred intervention plan
- Clear service exit preparation
- Follow-up and maintenance (linking back into crisis prevention and management)

iii) Placement Development

A core aim of the PBSS is to return people who are currently out of borough to their local area.

4.5 **Examples of Work** (prepared by team members)

4.5.1 *Case Study 1*

PBSS service is working with a fantastic young gentleman aged 27. He has a diagnosis of Learning Disability, Cerebral Palsy, Epilepsy and PICA. This young man originally resided within his own, single occupancy, supported tenancy. Previously he had been to an NHS assessment and treatment unit, due to behaviour that was challenging the service. When he returned home the behaviours intensified in frequency and severity. Therefore he was transitioned back to the assessment and treatment unit, for a longer term assessment.

This was the point the PBSS became involved. At the time of the referral, there were several behaviours of concern including, eye poking, smearing faeces, tearing clothing, hitting, biting, tearing and eating furniture, self-induced vomiting, loud vocalisations/screaming, banging walls and furniture and eating his incontinence pads.

A functional assessment and ratings scales were completed with the manager of the supported tenancy and the young man's named nurse. The assessment and treatment unit took data on the occurrence of the behaviour. Members of the PBSS, including Behaviour Analysts, Assistant Behaviour Analysts and support workers went and completed nine direct observations.

At the assessment and treatment unit this man was under stimulated. There was nothing for him to do, staff sat in the doorway and only interacted with him to tell him to sit down or respond to behaviour that challenges. There was no or very little behaviour that challenges out in the community but it would consistently happen as soon as he returned.

Interim recommendations were made to the assessment and treatment unit. These included non-contingent reinforcement in the

form of attention and increased engagement in social activities. This small measure has already reduced the occurrence of many of the behaviours that challenge the service.

In the near future we wish to teach him to ask for food, drinks, activities and attention. We hope to implement a wait and a toilet program. We also anticipate increasing in his independent skills within the home, which will incidentally keep him actively engaged in activities. Longer term, we hope to get him involved in sports club, particularly wheel chair races and take up some part time employment.

4.5.2 *Case Study 2*

The PBSS is working with a man, who was seventeen years old at the time of referral to the PBSS and has recently had his eigteenth birthday. He has a rare chromosome disorder, autism and a learning disability. He lives with his mother and father in the family home. He does not currently attend a school, college or work placement, so spends the vast majority of his time at home with his mother. He accesses some short breaks during the week and at weekends.

The young man was referred to the PBSS due to the following behaviours of concern: prolonged episodes of aggression towards others (hitting, pulling hair, kicking, biting, pinching, throwing objects, breaking objects, head butting) which were reported to sometimes last for hours at a time; swearing which again could last for hours at a time with between one and three episodes per day and directional spitting, which occurred less frequently than the other behaviours of concern.

A full functional assessment interview and behaviour rating scales were completed with the young man's mother, to help identify possible functions of the three target behaviours. At this point, the young man's mother also began to collect daily data on the frequency of the three behaviours. Subsequently, a series of direct observations were conducted by the Behaviour Analyst and Assistant Behaviour Analysts, when the behaviours could be observed in the context in which they typically occur. This allowed some early verification of the behaviour functions hypothesised during the assessment interview.

The functional assessment and observations indicated that the young man engaged in all three behaviours in order to gain access to tangible things that he wanted, to gain social attention from others or to avoid or escape situations that he didn't wish to be in (particularly community settings eg shops, doctors). The assessment highlighted that historically, the strategies used by those around him had reinforced the behaviours. For example, contingent on such behaviours people would: approach and engage with him (providing

social attention), may offer him an activity to do (tangible item) or withdraw him from the situation in which he felt uncomfortable. Through this process, the young man had learnt that this was an effective way to get his social and tangible needs met.

The intervention plan is delivered by an Assistant Behaviour Analyst during two 1.5 hour sessions per week conducted in the young man's home. The young man's mother follows the lead of the assistant behaviour analyst and continues the approach across the remainder of the week. The young man's parents and his regular outreach worker have received ongoing training from the PBSS team, as the new stages of the intervention plan are introduced.

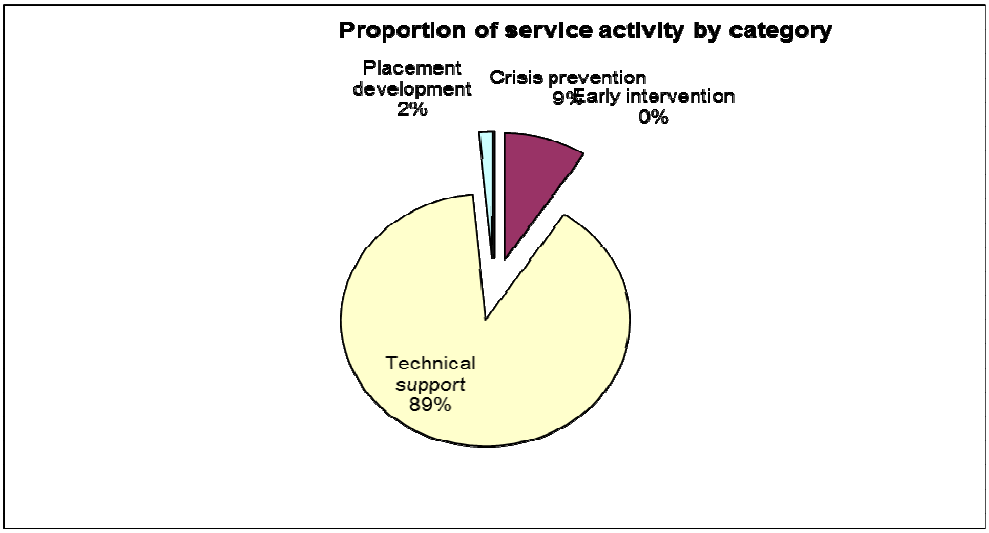
The interventions are proving successful and this is evidenced through a reduction in frequency and duration and intensity of behaviours in graphic form. Parental and professional anecdotal reports also support this. Examples of these reports are:

- Intensity and duration of behaviour episodes have reduced significantly
- Where the young man previously used non-verbal gestures or single word requests to ask for things, he is now using full and clear sentences
- Where much of his communication was initiated by others and required him only to give a yes or no answer (usually in the form of a nod or shake of the head), he is actively seeking people out and expressing his needs eg *will you clean my glasses?, can I have a drink?, I can't find it, my head hurts, I think it's bruised*
- He has now been to a number of prolonged medical appointments without engaging in any of the inappropriate behaviours.

4.6 **Cost Effectiveness**

4.6.1 *Time Analysis*

All members of the team systematically log their time across the domain categories set out in para. 4.4 (above). Further detail on client and other activity is also recorded, and an example is provided below:



This enables funding partners to receive reports that will confirm levels of activity against their prioties (e.g. crisis prevention).

4.6.2 *Cost Saving*

Saving acrued for Halton Borough Council to date means that the service is already self-funding and additional savings will increasingly acrue. Similar results are being acheived for the PCT and also will be achieved for St Helens and Knowsley Metropolitan Borough Council over the next six to nine months.

4.7 **Future Developments**

4.7.1 In the wake of the Panorama programme and subsequent closure of Winterborne Assessment and Treatment Centre, the team will be working alongside staff from the NHS to ensure that those peole who challenge services are receiveing high quality care.

4.7.2 The team will now rapidly move to full caseload, invovling around 40 individuals who require intensive intervention. The current waiting list is 30.

4.7.3 Training has been undertaken with around 150 staff across children and adult services. This programme with expand further and similarly with parents and carers.

4.7.4 The model of service could move to a social enterprise wherby there is greater control amongst service users, carers and staff in its service delivery.

5.0 **POLICY IMPLICATIONS**

5.1 No identified implications.

6.0 OTHER/FINANCIAL IMPLICATIONS

6.1 Funding for the team is initially on a short term basis, i.e. until March 2013, although Knowsley have committed funding until 2014.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 Children & Young People in Halton

The aims of the PBBS are consistent with delivering high quality outcomes for some of the most vulnerable children and their parents.

7.2 Employment, Learning & Skills in Halton

The PBSS is increasingly working with providers to secure local education and work opportunities for people who challenge services.

7.3 A Healthy Halton

Achieving high quality outcomes impacts on the health and well being both of service users and their families.

7.4 A Safer Halton

Enabling people who challenge to increasingly access ordinary community life and activities builds stronger, more inclusive communities.

7.5 Halton's Urban Renewal

None identified.

8.0 RISK ANALYSIS

The major risk is that long term funding for the service cannot be secured.

9.0 EQUALITY AND DIVERSITY ISSUES

9.1 The PBSS ensures equality of access and outcome to all service users and their families.

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

None under the meaning of the Act

REPORT TO: Health Policy & Performance Board (HPPB)

DATE: 10 January 2012

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults

SUBJECT: Health and Wellbeing Strategy

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of this report is to provide a briefing to the Board on the requirement to produce a local Joint Health and Wellbeing Strategy and the process involved.

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

3.0 **SUPPORTING INFORMATION**

Background

3.1 The NHS White Paper *Equity and Excellence: Liberating the NHS* set out three main functions for the new Health and Wellbeing (HWB) Boards as detailed below:

- 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 Wellbeing Strategy**
- To support joint commissioning and pooled budget arrangements where all parties agree this makes sense.

3.2 The second of these functions is to produce a Joint Health and Wellbeing Strategy. The strategy should provide the overarching framework within which commissioning plans for the NHS, Social Care, Public Health and other services which the Health and Wellbeing Board agrees are relevant, are developed.

3.3 **Requirements**

The HWB Board will be required to produce the strategy as part of its statutory responsibilities.

'The responsible local authority and each of its partner commissioning consortia must prepare a strategy for meeting the needs included in the assessment by the exercise of functions of the authority, the national Health Service Commissioning Board or the consortia' (A Joint Health and Wellbeing Strategy - Health & Social Care Bill).

3.4 In addition, HWB Boards will be able to consider whether the commissioning arrangements for social care, public health and the NHS, developed by the local authority and Clinical Commissioning Group respectively, are in line with the JHWB Strategy; and if not, the HWB Board will be able to write formally to the NHS Commissioning Board & the Clinical Commissioning Group or Local Authority leadership.

3.5 When the Clinical Commissioning Group send their commissioning plans to the NHS Commissioning Board, they will be under an obligation to state whether the HWB agrees that their plans have held due regard to the JHWS & send a copy of their plans to the HWB at the same time.

3.6 It will therefore be very important to ensure `ownership' of the Strategy by all parties from the outset and have good joint working arrangements in place to agree priorities at an early stage.

3.7 **Production of the Strategy**

In developing the strategy a range of views will need to be gathered from a wide range of partner organisations especially given the scope and remit of the strategy. It will also be essential to develop ways of involving members of the public in the preparation of the strategy.

3.8 Linked to the above, Members will also have a vital role to play in helping to develop the strategy in conjunction with identifying the priorities for action

The Centre for Public Scrutiny (CfPS) report ' Peeling the Onion - learning, tips and tools from the Health Inequalities Scrutiny Programme' highlights the role that local overview and scrutiny committees have in addressing health inequalities and provides a number of tools and tips. The report recognises and sets out to demonstrate the active and vital role that 'scrutiny' can have in helping its partners understand issues so that gaps in inequalities can be narrowed.

Below is a link to this documents :-

http://politiquessociales.net/IMG/pdf/CfPSPeelingonionfin_1_1_.pdf

3.9 A major challenge for scrutiny is ensuring that review topics have greatest influence and prioritising issues is key. The Joint Health and Wellbeing Strategy (in conjunction with the Joint Strategic Needs Assessment) will be able to be used to help members in the future to understand issues in more depth and can also support in exercising their role as locally elected councillors in helping public services to understand the issues that their communities face.

3.10 **Halton's Health and Wellbeing Strategy**

At a local level Halton has recently updated its Joint Strategic Needs Assessment for Health and Wellbeing and is currently in the process of developing locality needs analyses. Both of these will be used to underpin the Joint Health and Wellbeing Strategy.

Some initial scoping work has begun in terms of gathering the evidence base, determining the outline of the strategy and collating best practice (where available) from other areas

4.0 POLICY IMPLICATIONS

4.1 The Health and Wellbeing strategy should provide the overarching framework, within which commissioning plans for the NHS, Social Care, Public Health and other services which the Health and Wellbeing Board agrees are relevant, are developed.

4.2 The implementation of the strategy at a local level will have direct policy implications for the future delivery of services however until the detail of the strategy is worked through and developed it will be impossible to say exactly what these are at this time.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Improving the Health of Children and Young People is a key priority in Halton and will continue to be addressed through the Health and Wellbeing Strategy whilst taking into account existing strategies and action plans so as to ensure a joined-up approach and avoid duplication.

6.2 Employment, Learning & Skills in Halton

The above priority is a key determinant of health. Therefore

improving outcomes in this area will have an impact on improving the health of Halton residents.

6.3 **A Healthy Halton**

All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**

Reducing the incidence of crime, improving Community Safety and reducing the fear of crime have an impact on health outcomes particularly on mental health. There are also close links between partnerships on areas such as alcohol and domestic violence.

6.5 **Environment & Regeneration in Halton**

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing and will therefore need to be addressed through the Health and Wellbeing Strategy.

7.0 RISK ANALYSIS

7.1 Developing a Health and Wellbeing Strategy in itself does not present any obvious risk however, there may be risks associated with the resultant action plans and how these are to be implemented. These will be assessed as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The Joint Health and Wellbeing Strategy will seek to reduce health inequalities across Halton and will be inclusive in it's approach. Whilst services will continue to be offered across the whole borough, it is anticipated that a focussed approach may be needed where areas of high need are identified.

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

Document	Place of Inspection	Contact Officer
Health and Social Care Bill	Department of Health website	Louise Wilson

For further information please contact :-

Louise Wilson or Diane Lloyd
People and Communities Policy Team, Halton Borough Council
Contact: 0151 471 7368
E-Mail : louise.wilson@halton.gov.uk or Diane.Lloyd@halton.gov.uk

REPORT TO:	Health Policy & Performance Board (HPPB)
DATE:	10 January 2012
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health and Adults
SUBJECT:	Health Policy and Performance Board Work Programme 2012/13
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 This report is the first step in developing a work programme of Topics for the Board to examine during 2012/13.

2.0 RECOMMENDATION

That Members of the Health Policy & Performance Board:

i) Put forward and debate its initial suggestions for Topics to be included in the Board's 2012/13 work programme.

ii) Develop and informally consult on a shortlist of it's own 2012/13 Topic suggestions ahead of the Board's meeting on 6th March 2012, taking into account the Council's Topic selection criteria (Appendix 1).

iii) Decide at it's meeting on 6th March 2012, a work programme of Topics to be examined in 2012/13.

3.0 SUPPORTING INFORMATION

3.1 Whilst the Board ultimately determines its own Topics, suggestions for Topics to be considered may also come from a variety of other sources in addition to Members of the Board themselves. This may include members of the Council's Executive, other non-Executive Members, officers, the public, partner and other organisations, performance data and inspections.

3.2 Prior to determining the Board's preferred Topics, the PPB may wish to take soundings from relevant Executive Board portfolio holders, the Health & Well Being Board and other key partners.

3.3 In previous year's scrutiny topics have included :-

2011/12 - Autism
- Homelessness
2010/11 - Dignity
2009/10 - Review of Adaptations for Disabled People

4.0 POLICY IMPLICATIONS

4.1 The outcomes from scrutiny topics may result in the need to review associated policies.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The outcomes from the scrutiny topics may result in recommendations which have financial or other implications and these will be considered as necessary.

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

Any topics identified will support the Council's strategic priority of Improving Health.

6.4 A Safer Halton

None identified

6.5 Environment and Regeneration in Halton

None identified

7.0 RISK ANALYSIS

7.1 No risks associated with this report have been indentified

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 An Equality Impact Assessment is not required for this report

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

None under the meaning of the Act.

APPENDIX 1

OVERVIEW AND SCRUTINY WORK PROGRAMME

Topic Selection Checklist

This checklist leads the user through a reasoning process to identify a) why a topic should be explored and b) whether it makes sense to examine it through the overview and scrutiny process. More "yeses" indicate a stronger case for selecting the Topic.

#	CRITERION	Yes/No
Why? Evidence for why a topic should be explored and included in the work programme		
1	Is the Topic **directly aligned with and have significant implications for at least 1 of Halton's 5 strategic priorities & related objectives/PIs, and/or a key central government priority?**	
2	Does the Topic **address an identified need** or issue?	
3	Is there a **high level of public interest or concern about the Topic** e.g. apparent from consultation, complaints or the local press	
4	Has the Topic been **identified through performance monitoring** e.g. PIs indicating an area of poor performance with scope for improvement?	
5	Has the Topic been **raised as an issue requiring further examination through a review, inspection or assessment, or by the auditor?**	
6	Is the Topic area likely to have a **major impact on resources or be significantly affected by financial or other resource problems** e.g. a pattern of major overspending or persisting staffing difficulties that could undermine performance?	
7	Has some **recent development or change** created a need to look at the Topic e.g. new government guidance/legislation, or new research findings?	
8	Would there be **significant risks** to the organisation and the community **as a result of not examining this topic**?	
Whether? Reasons affecting whether it makes sense to examine an identified topic		
9	**Scope for impact** - Is the Topic something the Council can actually influence, directly or via its partners? Can we make a difference?	
10	**Outcomes –** Are there clear improvement outcomes (not specific answers) in mind from examining the Topic and are they likely to be achievable?	
11	**Cost: benefit** - are the benefits of working on the Topic likely to outweigh the costs, making investment of time & effort worthwhile?	
12	**Are PPBs the best way to add value** in this Topic area? Can they make a distinctive contribution?	
13	Does the organisation have the **capacity** to progress this Topic? (e.g. is it related to other review or work peaks that would place an unacceptable load on a particular officer or team?)	
14	Can PPBs contribute meaningfully given the **time** available?	