Public Document Pack

Health Policy and Performance Board

Tuesday, 6 March 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 To be Confirmed

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

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1. MINUTES	
2. DECLARATIONS OF INTERESTS (INCLUDING PARTY WHIP DECLARATIONS) Members are reminded of their responsibility to declare any personal or personal and prejudicial interest which they have in any item of business on the agenda, no later than when that item is reached and, with personal and prejudicial interests (subject to certain exceptions in the Code of Conduct for Members), to leave the meeting prior to discussion and voting on the item.	
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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:

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.

Agenda Item 4

REPORT TO: Health Policy and Performance Board

DATE: 6 March 2012

REPORTING OFFICER: Chief Executive

SUBJECT: Health & Well Being Board minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 There are no minutes available relating to the Health and Social Care Portfolio which have been considered by the Health & Well Being Board since the last meeting of the Board.

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.

Agenda Item 5a

REPORT TO:	Health Policy & Performance Board (HPPB)
DATE:	6 March 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 To provide members of the Board with an update on the Joint Health and Wellbeing Strategy.

2.0 **RECOMMENDATION: That the report be noted**

3.0 **SUPPORTING INFORMATION**

3.1 At the first meeting of the Health and Wellbeing Board in December the board received a report about the requirement to produce a Joint Health and Wellbeing Strategy (JHWBS). 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.

3.2 **Development of the JHWBS**
Halton HWBB has set up a JHWBS group led by the Director of Public Health. This group held its first meeting in January 2012. It has agreed Terms of Reference, membership, a timeline and project plan. It has developed a draft outline framework and began to populate it with information. This has been presented to the Health Strategy sub group.

3.3 Recent JHWBS guidance
A member of the JHWBS group is part of the National Learning Network for health and wellbeing boards which is supporting health and wellbeing boards as they develop and enabling them to write JHWBSs.

A narrative document, *Joint Strategic Needs Assessments and joint health and wellbeing strategies explained* was published in December 2011 to set out the context of JSNAs and joint health and wellbeing strategies for health and wellbeing board members.

3.4 Since the last meeting, the Department of Health has produced draft guidance on Health and Wellbeing Strategies which is currently open for consultation. The guidance will then be refined before publishing the final statutory guidance after Royal Assent, before Summer Recess 2012.

3.5 Key points outlined in the guidance are as follows:

- JSNAs look at a range of evidence on the local area to identify what is needed to improve the health and wellbeing of the local population now and in the future, and possibly what assets can be used to meet these needs
- *narrative on the data and should provide the trail from impartial evidence to decisions made, providing a clear rationale*
- Joint health and wellbeing strategies are where health and wellbeing board members agree their top priorities to focus on together as a basis for (but not the totality of) their commissioning plans and decisions
- *prioritise the greatest needs and not try to take action on everything all at once*
- Commissioning plans to be informed by the priorities identified in the joint health and wellbeing strategy, involving the health and wellbeing board in their development
- *flexibilities in commissioning – find best way to meet the needs, including joint action*
- Cover the whole population and life course – including children & young people, older people, hard to reach / chronically excluded groups; looking at a range of types of need – including health, wellbeing, care and wider influences
- Cover the upper-tier local authority area, consulting districts / borough councils, and involving the NHS Commissioning Board - unique to the area
- Undertaken by the whole health and wellbeing board – equal responsibility
- *Are links with other responsibilities health and wellbeing board members have (e.g. addressing health inequalities)*
- Involve other local partners and the community, considering accessibility and Public Sector Equality Duty, with Local Healthwatch as a facilitator or conduit
- *Use expertise of other partners to understand and address the needs of different groups, especially the excluded and vulnerable*
- Are continuous and iterative processes, building on and informing other assessments and strategies
- *They are not ends in themselves*
- *Can use agreed priorities to influence wider commissioning and action at a local level – encourage partners to adopt the outcomes and all contribute*
- Strategic tools to understand and taking action on local

inequalities
- Are integral part of commissioning cycles so should be timed to align
- JSNAs can drive improved evidence in areas where it has been poor in the past (e.g. homelessness)

3.6 **Halton's JSNA**
At a local level work is currently underway to ensure that Halton's existing JSNA is fit for purpose (according to existing guidance).
A key needs document has been developed which will be reviewed by commissioners. This document will assist the Health and Wellbeing Board in being able to identify the priorities that will underpin the Health and Wellbeing Strategy within the required life course approach. (Appendix 1)

3.7 **Consultation on Priorities**

It is essential that all members of the HWBB, council members, CCGs, Policy and Performance Boards and members of the public are engaged in setting health priorities. Priorities should be based on information from the JSNA with a clear audit trail.

Agreement on the Health and Well Being Strategy priorities and alignment of a number of CCG priorities against these must be reached by early June 2012 to enable Clinical Commissioning Groups (CCG) to sign off commissioning intentions by the end of June.

Consultation has started on determining the local priorities. An event with Halton CCG has been planned for 28th February which will seek to gain the views of local stakeholders on the key priorities for the CCG and Health and Wellbeing Strategy.

A Public Health transition event took place on 7th February attended by Elected Members and staff from both the Local Authority and Public Health. This event also provided the opportunity to discuss key Health priorities. In addition to this press releases have been prepared for a number of local publications, newsletters and bulletins and there will also be the opportunity to leave comments online.

3.8 **Scoping**

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.
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 has 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 **Halton's Urban Renewal**

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. These will be assessed as appropriate.

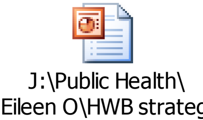
8.0 **EQUALITY AND DIVERSITY ISSUES**

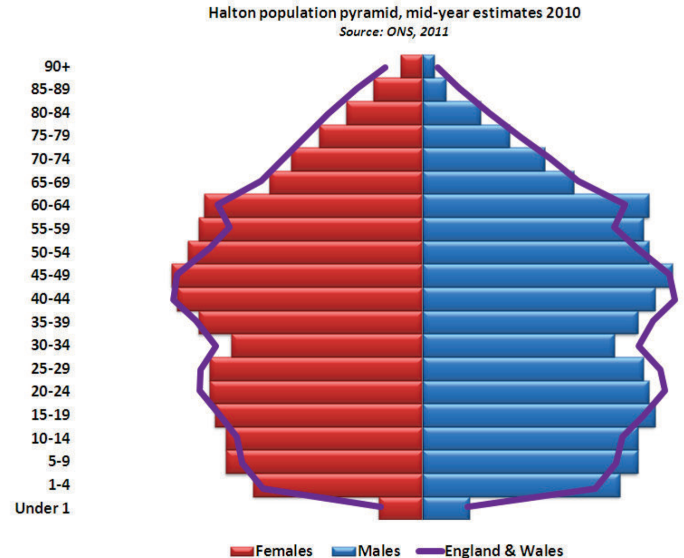
8.1 The Joint Health and Wellbeing Strategy will seek to reduce health inequalities across Halton and will be inclusive in it's approach. Whilst services will continue to be offered across the whole borough, it is anticipated that a focussed approach may be needed where areas of high need are identified.

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

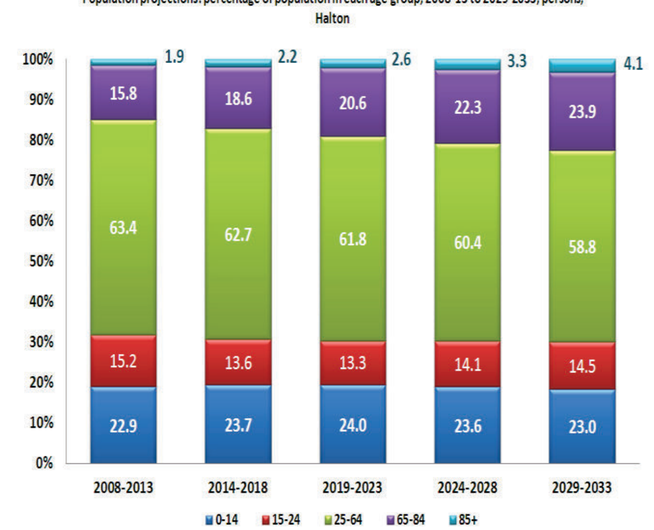
The Health and Social Care Bill

Appendix 1



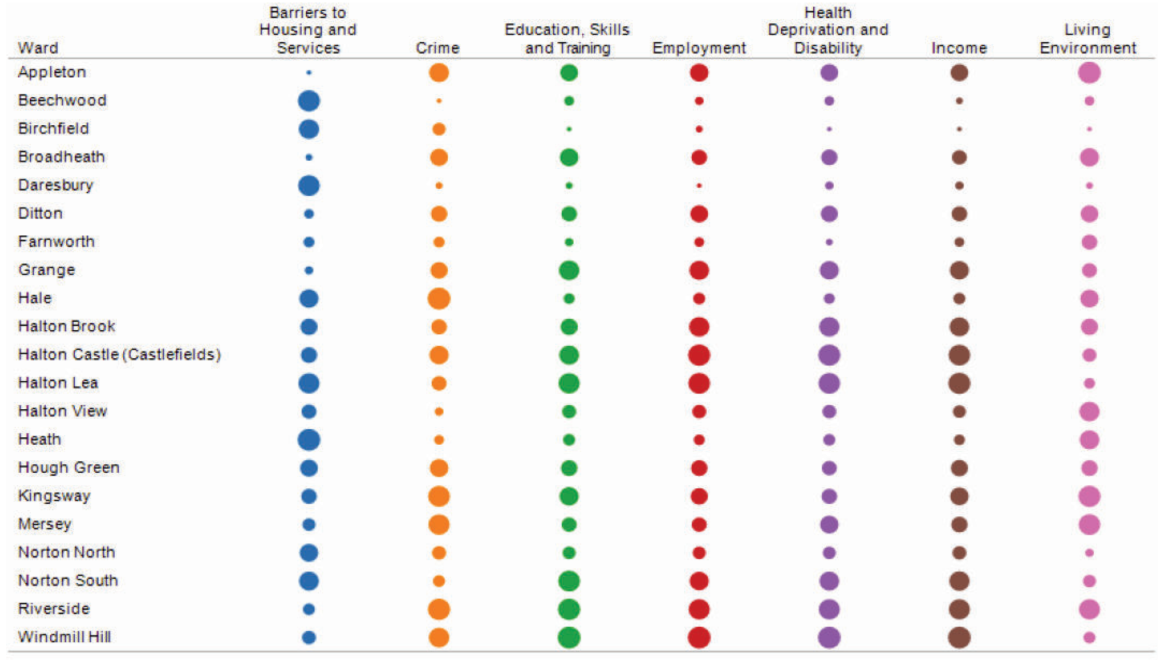


- Mid year population estimate is 119,300
- 48.4% male to 51.5% female
- Younger age bands to remain static, working age population to shrink and older age bands to increase as a proportion of total population
- Population registered with Halton GPs is 128,107 (24/7/11)



Index of Multiple Deprivation (IMD) 2010

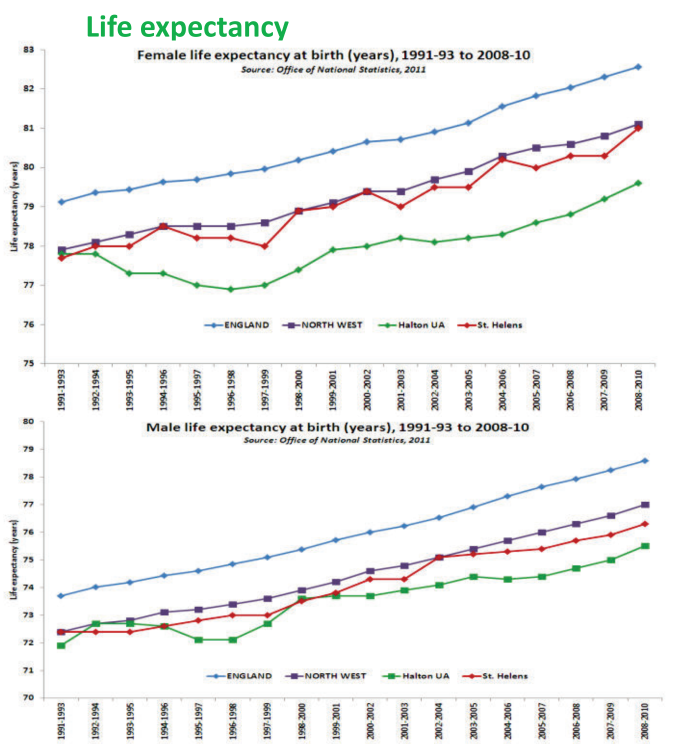
- Halton is ranked as the 27th most deprived local authority in England (out of 326 local authorities). This is the 3rd worst out of the six local authorities which make up the Liverpool City Region, behind Liverpool and Knowsley.
- The ward with the highest average IMD score in 2010 and therefore the most deprived ward in Halton is Windmill Hill. The least deprived ward in Halton is Birchfield.
- The overall IMD is made up of seven domain measures. Daresbury ward does well across all of these whilst Windmill Hill has some of the highest scores.
- Deprivation scores at small area geography (known as Lower Super Output Areas) shows that the area with the highest deprivation is located in Kingsway ward.
- There are 21 LSOAs in Halton that fall in the top 10% most deprived nationally. Of these 10 fall in the top 3% most deprived nationally and 2 fall in the top 1%.



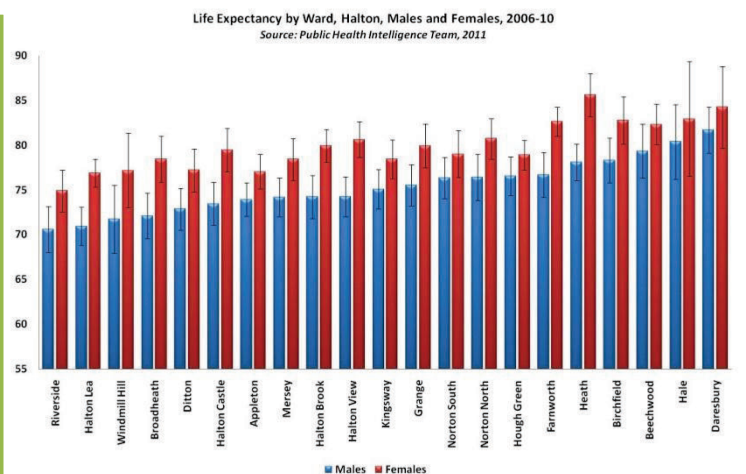
Size of bubble is determined by the rank of average ward scores. Therefore the more deprived the ward the larger the bubble.

HALTON JSNA: OVERALL HEALTH STATUS

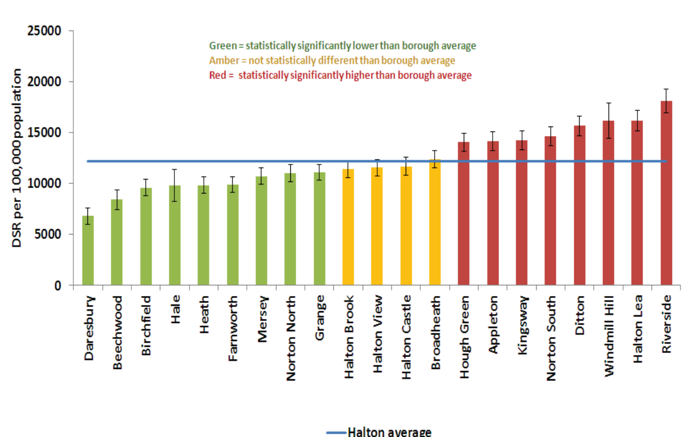
Life expectancy



- Life expectancy has risen steadily over time. In 2008-10 average life expectancy in the borough was 75.5 for men and 79.6 for women. However, this is lower than its comparators (about 3 years lower than the England figures).
- Internal difference in life expectancy are marked, ranging from 70.6 years males and 74.9 years females in Riverside to 81.7 years males and 84.3 years females in Daresbury: a difference of 11.1 years for males and 9.4 years for females
- When life expectancy is correlated with local IMD deprivation deciles there is a very strong association (r= 0.91 females and r =0.96 males).



Hospital admissions



- There were 15,779 emergency admissions, with injuries accounting for 14.6%, respiratory for 12.8%, digestive and circulatory 9.6% each. Riverside ward had the highest admissions rate and Daresbury the lowest.
- There have been year on year improvements in the number of people identified with long term conditions. There does remain a gap between the numbers identified and the estimated levels but this closing.

Disease prevalence: expected against observed rates

Modelled Estimates of long-term conditions against QOF observed prevalence
Source: APHO 2010 and Information Centre, 2011

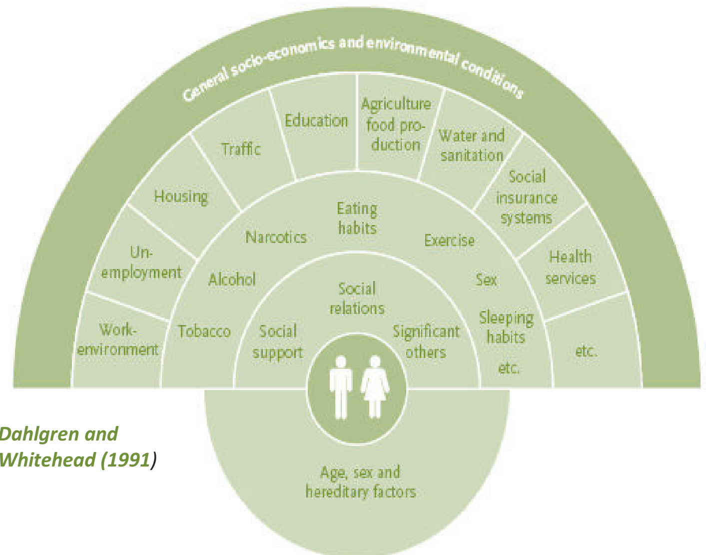
LONG TERM CONDITION	MODELLED		OBSERVED	
	Number	Prevalence	Number	Prevalence
CHD	6928	5.40	5,665	4.4
HYPERTENSION	32141	25.10	18,411	14.4
STROKE	2866	2.20	2,362	1.8
DIABETES	8321	8.70	6,901	6.8
CKD	7,474	8.2	4,421	4.4
COPD	3633	2.80	3,048	2.4

HALTON JSNA: SOCIAL DETERMINANTS AND MARMOT REVIEW ON INEQUALITIES

Social determinants of health

Health outcomes are rooted in the social, economic and environmental circumstances of people's lives. In tackling health it thus becomes important to consider:

- Health needs including mental health, health protection, and prevention of poor health
- Care needs including universal advice and the needs of carers
- Wider social, environmental and economic factors that impact on health and wellbeing, such as opportunities for physical activity, housing type, and working conditions
- How needs can interact or overlap for certain groups both within and across service areas. For instance older people with long-term conditions may need support such as reablement or a carer to remain in their own home, but may also experience fuel poverty.



Dahlgren and Whitehead (1991)

Marmot Review Fair Society, Healthy Lives

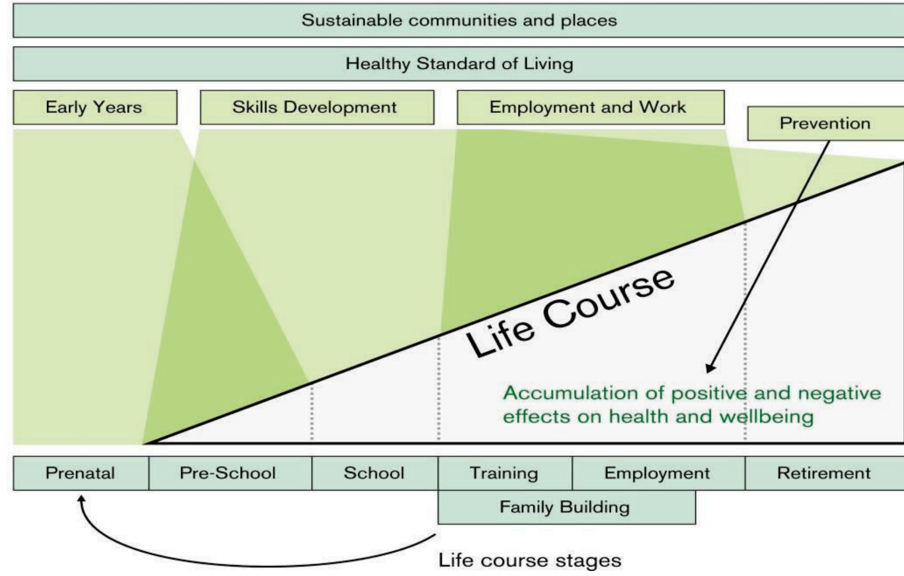
The Marmot review published in 2010 brought the debate about how to tackle inequalities in health up to date. Three central features:

- Fairness at the heart of all policies.
- Health inequalities result from social inequalities – requires action on all the social determinants; the causes of the causes
- Focusing solely on the most disadvantaged will not reduce inequalities sufficiently – action is needed across the social distribution

Six Policy Objectives

1.Give every child the best start in life
2.Enable all children, young people and adults to maximise their capabilities and have control over their lives
3.Create fair employment and good work for all
4.Ensure healthy standard of living for all
5.Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention

This gives rise to what is referred to as the ***'life course approach'*** to action to tackle the social determinants to reduce inequalities.



HALTON JSNA: DATA ON HEALTH & WELLBEING ACROSS THE LIFECOURSE

Pregnancy & 1st year of life

X live births in

- Smoking at time of delivery ***21.7%***, higher than comparators
- Low birth weight ***1.8%***
- Breastfeeding initiation ***48.6%***, lower than comparators
- Access to antenatal care within 12 weeks of pregnancy ***85.5%*** *(Q1-Q3 2010-11)*
- Infant mortality ***6.0 per 1,000 live births***

Childhood (1-15)

X children (% pop)

- Child Poverty **26.4%**
- Hospital admissions due to respiratory infections ***262.6 per 100,000 population***
- Hospital admissions due to accidental injury ***2036.1 per 100,000 population***
- Children in Need ***685 (31/3/10)***
- Looked After Children ***137***
- Obesity : ***Reception 12.0%***
- Obesity: ***Year 6 23.7%***
- Immunisation : MMR 1st & 2nd dose by 5years ***79.9%***
- Mental health: effectiveness of CAMHS – composite score as of Dec 2010 - ***14*** (England 15.2 and NW 14.9)

Young adulthood (16-24)

X people (% pop)

- NEETs 2010 ***350*** people aged 16-18 (9.3%)
- Teenage pregnancy: ***57.2 per 1,000 pop <18***
- Hospital admissions due to alcohol: ***153.9 per 100,000 population***
- Sexually Transmitted infections 2008-10: ***Chlamydia 1851 cases; genital warts 1483 cases***
- Chlamydia screening (2010-11) ***34.4%*** 15-24 year population tested
- Alcohol: ***50%*** of those under 18 are drinking at least once a week (local college survey 2009)
- Suicide ***35*** (2007-09) ***Rate 9.63*** (England 7.85, NW 9.24 per 100,000 population)

Healthy adulthood (25-64)

X people (% pop)

Lifestyle choices:

- Smoking prevalence ***25%***; prevalence for manual workers ***30.9%***
- Binge drinking ***23.9%***
- Obese ***25.9%***

Number of people with long term conditions (All ages):

- Hypertension ***18,411***
- CHD ***5,665***
- Diabetes ***6,911***
- COPD ***3,048***
- Stroke ***2,362***
- Depression ***11,924*** (11.94% GP pop aged 18+)

Access to screening by GP practice:

- Breast uptake ***57% to 79%***
- Cervical uptake ***72.3% to 85.9%***
- Bowel uptake ***33.3% to 66.7%***

Hospital admissions (all ages, per 100,000 population):

- Emergency admissions ***12,212***
- Alcohol specific ***965.8***
- Alcohol related ***2,790.4***
- Cancers ***1,264.5***
- Heart Disease ***588.1***
- Stroke ***183.8***

Older people (65+)

X people (% pop)

Life expectancy (2008-10)

- Males ***75.5***
- Females ***7 9.6***

Life expectancy at 65 (2008-10)

- Males ***16.0*** (England 18.22)
- Females ***18.6*** (England 20.82)

Inequalities in life expectancy (by ward 2006-10)

- Males ***11.1years*** (70.6 in Riverside, Daresbury 81.7)
- Females ***9.4 years*** (Riverside 74.9, Daresbury 84.3)

- All age all cause mortality:
- Males ***874.99 per 100,000*** population (2007-09)
- Females ***632.15 per 100,000*** population (2007-09)

- Hospital admissions due to ***falls 16.3 per 100,000 pop***
- Dementia: estimated ***1082 people aged 65+: QOF register 634*** people diagnosed

- Flu vaccination uptake ***74.8%*** (2010-11 PCT value)

HALTON JSNA: HEALTH & WELLBEING COMMISSIONING PRIORITIES

Pregnancy & 1st year of life

X live births in

Screening: improve provision and evaluation of screening programmes throughout the maternity pathway.

Health Inequalities

- Improve intelligence on prevalence of domestic abuse
- postnatal depression and other mental health illness
- breastfeeding support
- specialist needs and complex care during the maternity pathway

Preconception: review of preconception care

Access and Choice

- improve early access and use of community settings for antenatal & postnatal care
- Ensure real choice in place of birth
- Develop a service user engagement strategy to inform service improvements

Childhood (1-15)

X children (% pop)

Child Poverty

- Cultural challenge and raising aspirations
- Early intervention
- Whole family approach
- Single point of access to support services
- Improved information sharing

Obesity

- Improve prevalence data tackle the obesenogenic environment
- Maintain targeted weight management interventions
- communication strategy
- workforce capability
- Evaluate current interventions

Child Immunisations

- Improve access
- Named person in every GP practice
- Check immunisation status at every opportunity

Accidental Injury

- Co-ordinated approach, with appropriate targeting at different age groups
- Assess current provision against NICE guidance

Dental: prevention and access

Young adulthood (16-24)

X people (% pop)

Child Mental Health & Emotional wellbeing

- Implement Strategy across universal and Preventative Services, targeted services, specialist services, including discharge and transition arrangements

Teenage Pregnancy

- Provision and access to a full range and choice of sexual health information, advice and services
- holistic health services in a range of settings
- Provision in identified
- training and development for SRE & PHSE
- social marketing campaigns

Sexually Transmitted Infections

- STI surveillance to identify and work on any clusters, trends and impacts
- health promotion messages
- Continue to develop a wide range of venues for delivery

Substance Misuse

- data on smoking prevalence
- Tackle illicit sales of alcohol and tobacco
- Targeted prevention on smoking, alcohol and drugs
- Staff training to screen, recognise and refer on.
- Early intervention
- A range of support to meet individual needs

Healthy adulthood (25-64)

X people (% pop)

Lifestyles

Smoking: 52-week quit follow up; hospital staff training and referral pathways; normalisation of smoke-free lifestyles

Substance misuse: Improve life opportunities; reduce drug related crime ; staff training; access to health improvement and protection programmes; whole family approach; service user involvement

Alcohol: communications and social marketing; HIA of planning applications process; staff training; GP engagement

Obesity: brief interventions and access to weight management; CVD targeted prevention alignment

Long term conditions

Cancer: early detection; screening and vaccination; continue pathways and treatment improvements

CVD: reduce GP practice variation in QOF performance;

Stroke: prevention; access to specialist stroke rehabilitation ; coordinated community stroke services

COPD: early detection; diagnosis; pathways; specialist community services

Mental Health: Early detection; seamless referral pathways; refresh suicide prevention strategy; physical health needs; employment and accommodation

Older people (65+)

X people (% pop)

- A wider range of community based services are developed and commissioned to meet the range of health related illnesses that affect older people
- Address the continuing issue of falls in older people - prevention of falls and care if someone does have a fall.
- Continuing to deliver high quality Intermediate Care services to support improved rehabilitation rather than reliance on Residential Care.
- Investigate the full potential of technology, such as Telecare and Telehealth, to support care closer to home for older people.

Dementia

- Development of Dementia Peer Support
- Commissioning of Assessment, Care and Treatment Service
- Commissioning of Dementia Care Advisors
- Training for professionals in basic awareness
- Advanced training for professionals
- Improved quality in existing services i.e. memory clinic, Community Mental Health Team etc.

HALTON JSNA: DATA ON WIDER DETERMINANTS OF HEALTH

Economic

- Unemployment (Job Seekers Allowance) rate ***5.5% = 4242*** adults (Dec 2011)
- ***10.1%*** working age adults in Windmill Hill claiming Job Seekers Allowance
- Working age adults claiming out of work benefits ***14, 480*** (May 2011) or ***18.6%***
- Windmill Hill ***36.2%*** working age adults claiming out of work benefits (May 2011)
- Youth unemployment rate (18-24years) ***13.2% = 1440 people*** (Dec 2011)
- Long-term (2008-25) economic (Gross Value Added or GVA) ***growth is forecast to average 2.9% a year.*** This rate of growth is higher than those expected for the North West (2.0%) and the UK (2.1%).
- Post-2012 outlook : ***0.5% annual growth*** (on average) in Halton's ***employment level***. This cancels out the 2008-12 decline (1.8% a year), with employment in 2025 (59,500) being virtually the same as in 2008 (59,600).
- Gap between Halton adult qualifications & GCSEs compared to England remains but is closing.

Community Safety

- Safeguarding adults: ***359*** abuse allegations were reported to Halton Borough Council in the year 2009-10.
- Hate crime: 25 reported race incidents, 6 homophobic reported ***19*** fulfilled hate crime criteria
- Domestic abuse 2009-10): ***189 cases*** referred to Multi-Agency Risk Assessment Conference (***232 children*** involved)
- ***40%*** domestic abuse cases are alcohol related

Housing

- As of March 2011 there were ***54,566*** dwellings in Halton. ***47.51%*** were in Council Tax Band A, nearly double that of the England average and higher than North West
- ***25%*** housing in Halton is social rented accommodation (higher than NW and England)
- Windmill Hill has the highest percentage of households being social rented at ***92%***; the lowest is ***0%*** in Birchfield
- There were ***158*** Statutory Homeless Households and ***23*** households in temporary accommodation (April 2009 to March 2010)
- In 2009 ***19.3%*** of households were in fuel poverty. A rise of ***45%*** since 2006.
- There were ***255*** mortgage possession claims in 2010, leading to ***200*** orders being made.

Transport

- The number of cars licensed in Halton between 2002 and 2009 increased by ***22%***
- Since 2001, Halton has experienced an ***increase in traffic growth***. This increase is greater than the increase experienced by Great Britain as a whole.
- ***45%*** of Halton residents are either 'very' or 'fairly satisfied' with the local transport information provided by the Council.
- ***49%*** are either 'very' or 'fairly satisfied' with the local bus services provided/supported by Halton Borough Council.
- The rate of all persons and children ***killed or seriously injured*** on the roads is higher than comparators although there have been reductions. Rates are below trajectories.

Social care & vulnerable people

- Proportion older people discharged from hospital to intermediate care/ rehabilitation/ re-ablement who are still living 'at home' 3 months after discharge: ***68.8%,*** lower than NW and England. Higher for females (72.5%) than males (61.5%) and for those aged 65-74 (82.4%) than total 65+ population
- Clients and carers receiving self directed support as percentage of all receiving community based support ***27.5% = 1555*** out of total of 5655
- Carers receiving services ***1120***
- Adults with learning disabilities in settled accommodation ***79.5%,*** higher than NW & England
- Adults with learning disabilities in paid employment ***7%***, higher than NW & England
- The number of people on CPA 3211.
- Proportion of adults on CPA receiving secondary mental health services in settled accommodation ***78.1%*** and in employment ***10.7%*** (PCT values)

HALTON JSNA: WIDER DETERMINANTS COMMISSIONING PRIORITIES

Economic

- To develop a strong, diverse, competitive and sustainable local economy.
- To foster a culture of enterprise and entrepreneurship and make Halton an ideal place to start and grow a business.
- To develop a culture where learning is valued and raise skill levels throughout the adult population and across the local workforce
- To promote and increase the employability of local people and remove barriers to employment to get more people into work
- To maximise an individual's potential to increase and manage their income, including access to appropriate, supportive advice services.
- That people are supported and given the opportunities to work for as long as they want to.

Community Safety

- Reducing the potential for abuse of vulnerable adults by delivering safer recruitment policies and procedures, underpinned by competence-based training and development systems.
- Contribute to robust Safeguarding adults prevention agenda on an interagency and intra-agency basis
- Focus on borough wide enforcement activity, both proactive and reactive which is intelligence led and demand driven
- Strengthen mainstream Advocacy Services to ensure the needs of people with limited or no capacity for representation are particularly addressed.

Housing

- Improve conditions in the private rented sector
- Increase the number of people on income based benefits who live in energy efficient homes
- Improve the provision of supported housing for an ageing population
- Improve equality of access to housing adaptations
- Increase the supply of affordable housing in the Borough
- Reduce the level of overcrowding within social rented housing
- Deliver increased employment outreach activity with Registered Social Landlords through Job Centre Plus and Halton People into Jobs

Transport

- Reduce the need to travel, in particular the need to travel longer distances though integrated planning
- Social marketing campaigns that encourage the use of walking for short trips and cycling
- Enhancement of current facilities for walking and cycling to improve usage
- Continue to provide bus services as these enable people access to services and social networks which are essential to wellbeing;
- Continue to provide door to door specialised community transport services for those with higher level disability or mobility problems
- Encourage the development/use of alternative fuel vehicles
- The longer term consideration of the implementation of road user charging in addition to that brought in as part of the Mersey Gateway Project

Social care & vulnerable people

Social care

- personal budget for care – develop flexible arrangements with providers .
- Sustainable, flexible supply of local authority commissioned provision.
- Measure outcomes.
- Remodelling services as required
- If necessary, review eligible support tasks within the Supporting People Eligibility Criteria.
- Analysis of the uptake of services and supports for carers.

Vulnerable Children

Halton Safeguarding Children Board priority outcomes:

- Children and young people are protected from abuse
- Appropriate support for abused children

Disabilities

- Delivery of National Service Framework for Long Term (Neurological) Conditions
- Improved local support services, including rehab and enablement;
- Improved access to health improvement, and screening services
- Increase training and employment opportunities

National Institute of Health & Clinical Evidence (NICE) guidance

NICE are global leaders in the production of gold-standard guidance, based on bespoke evidence reviews into the cost effective and efficient interventions across clinical and public health priorities. These are supplemented by commissioning guides and care pathways within and across individual pieces of guidance to support commissioners and providers in ensuring robust care management. NICE is also involved in the development of the Quality Outcomes Frameworks for GPs and will soon be tasked with producing guidance on key areas of social care.

Fair Society, Healthy Lives – the Marmot Review

The Marmot Review identified evidence and made recommendations in the key policy areas – the social determinants of health - where action is likely to be most effective in reducing health inequalities. These are:

- early child development and education
- employment arrangements and working conditions
- social protection
- the built environment
- sustainable development
- economic analysis
- delivery systems and mechanisms
- priority public health conditions
- social inclusion and social mobility.

National guidance on COPD, CVD, Diabetes, Healthy Weight, Tobacco Control, Alcohol, Dementia, Mental Health, Children

There is a wide range of national guidance based on best available evidence of cost effective and efficient interventions and approaches. There range from National Service Frameworks and Strategies to reports commissioned/produced by national expert organisations such as Kings Fund.

National Service Frameworks and Strategies can be found on the Department of Health website http://www.dh.gov.uk/en/index.htm

Local Insight work

Intelligence reports and data tell us what is happening but stop short of telling us why. For example we know that cancer deaths in Halton are amongst the highest in the country. We know some of the risk factors that lead to this such as smoking rates, screening uptake and to some extent deprivation. Once we know what is happening we need to understand why in order to put in place appropriate services and advice that connect people people's attitudes, motivations, barriers, aspirations and so on. Locally, Halton PCT and Borough Council use a range of qualitative research techniques to discover these insights, such as.

- Halton Residents Survey
- Social marketing on alcohol, tobacco, smoking during pregnancy, obesity

NHS Evidence

It is not possible to find ready-made systematic reviews of evidence on every subject. It is sometimes necessary to supplement evidence from NICE guidance and/or national policy with bespoke reviews of evidence. NHS Evidence provides a portal through which to search multiple databases of primary research papers, policy documents, NICE guidance, Social Care Institute of Excellence (SCIE) guidance and so on.

Needs assessments, equity audits, health impact assessments

The Public Health Evidence & Intelligence team carry out are range of topic based health needs assessments and health equity audits. These use a wide range of local and national data, policy, evidence reviews and details about local services and local consultations (where available) to describe the current and future health needs of our local communities. They also assess where gaps in service provision and/or improvements in service delivery mechanisms or performance are needed to reduce inequities. Halton Borough Council also carry out needs assessments of major policy areas such as Housing, Child Poverty and Substance Misuse. Recently, some of the larger scale polices and developments in the area have been subject to health impact assessments to determine likely impacts of the developments at various stages and remedial action to ensure potential negative impacts are not realised.
http://www.haltonandsthelenspct.nhs.uk/pages/YourHealth.aspx?iPageId=6271

HALTON JSNA: NATIONAL AND LOCAL POLICY CONTEXT

- Add policy context here

HALTON JSNA: AREA FORUM (AF) HEALTH & WELLBEING PRIORITIES

AF1 Broadheath Ditton Hale Hough Green	AF2 Appleton Kingsway Riverside	AF3 Birchfield Farnworth Halton View	AF4 Grange Halton Brook Heath Mersey	AF5 Halton Castle Norton North Norton South Windmill Hill	AF6 Beechwood Halton Lea	AF7 Daresbury
Health is generally similar to the borough average. Cancer incidence: Broadheath and Hale: high, Ditton and Hough Green: low . Life expectancy slightly lower than the borough average (except Hale). Death rates from cancers high. Deaths from circulatory diseases are low Infant mortality high in Broadheath and Hale Overweight/obese children at reception age low but higher Year 6 age. NEETs: lower children claiming free school meals: high A&E attendance for 0-15 year olds: high. Crime high levels of burglary, criminal damage to dwellings and deliberate fires.	Health is generally worse than the borough average. Cancer incidence is higher than the borough average in Kingsway and Riverside but lower in Appleton. Life expectancy: lower Death rates under 75 years from cancers and circulatory diseases: higher Infant mortality: lower than average in Appleton and Kingsway but higher in Riverside. Overall, slightly higher levels of obese children but lower for overweight. NEETs: higher children claiming free school meals: lower. Crime and anti-social behaviour an issue. Economy: poor, with higher rates of unemployment, people on out-of-work benefits and youth unemployment than the Halton average.	Health is generally better to the borough average. Cancer incidence and deaths under 75 years from cancer: lower. Life expectancy for both males and females is above the borough average apart from male life expectancy in Halton View which is slightly lower. Premature (under 75 years) death rates from cancers and circulatory diseases: lower Infant mortality : lower The picture for child obesity and overweight is mixed NEETs: lower children claiming free school meals: higher Crime: low Economy: good, with relatively low levels of unemployment, worklessness, youth unemployment. High levels of GCSE attainment (5+ A*-C inc. English and Maths).	Health is slightly worse than the borough average apart from Mersey. Cancer incidence is higher than the borough average in Halton Brook and Mersey but lower in Grange and Heath. Life expectancy slightly better than the borough average. Deaths under 75 years from circulatory disease: higher Deaths from cancers: lower. Infant mortality: lower Overweight/obese children: higher Economy: overall poor, and quite poor GCSE attainment (5+ GCSE's A*-C inc. English and Maths). However, Heath ward is an exception, as this area generally performs better than the Halton average across most indicators.	Health is worse than the borough average. There is a geographical split with Norton North and South having better health experience than Halton Castle and Windmill Hill. (one of worst in borough) Cancer incidence is higher than the borough average in Norton South and Windmill Hill but lower in Norton North and Halton Castle (lowest in the borough). Life expectancy : lower Death rates from cancers and circulatory diseases: higher (not in Norton North). Infant mortality: high. Overweight/obese children: low in Norton North and South but higher in Halton Castle and Windmill Hill. NEETs: good children claiming free school meals and A&E attendance for 0-15 year olds: high. Crime: high	Deprivation: Beechwood: low Halton Lea: high Beechwood has better than average health statistics and Halton Lea worse than average. Cancer incidence is lower than average . Life expectancy : Halton Lea: lower Beechwood: higher Infant mortality lower. Overweight/obese children: lower. NEETs: good. However, higher than average levels of children claiming free school meals and A&E attendance for 0-15 year olds. Crime: high levels of burglary, criminal damage to dwellings and deliberate fires.	Health is better than the borough average. Cancer incidence is slightly higher than the borough average but deaths from cancers are much lower than average. Life expectancy for males is the best in the borough and is also higher than the borough average for females. Deaths from circulatory diseases: low Infant mortality: higher (small population size) Obesity and overweight levels for children are low. Emergency admission rate for children aged 0-15: high NEETs: good Crime: low Area is one of the most affluent with low levels of unemployment, and higher than average household income.

HALTON JSNA: ASSETS BASED APPROACH

Definition

***"A health asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses."* Antony Morgan, associate director, National Institute for Health and Clinical Excellence (NICE), 2009**

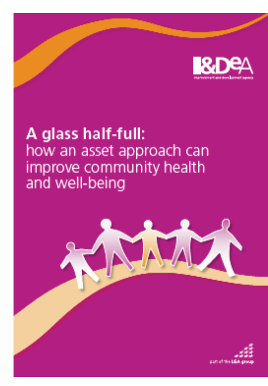
IDEA (2011) 'A Glass Half Full. How an asset approach can help community health and wellbeing.'

Whilst the JSNA is a useful tool to identify where there are health inequalities or deficits in the health and wellbeing of our communities, Halton has a number of health assets that help support wellbeing and promote health.

Assets can help us more able to cope in times of stress, make a place a good place to live and give people options on how to help.

Organisations
Public sector
Contracted public sector
Voluntary sector
Private sector shops, jobs, finance, housing
Service users
Children...
...and their families
Social capital
Communities
Peer groups
Outcomes

Diagram OPM (2007)

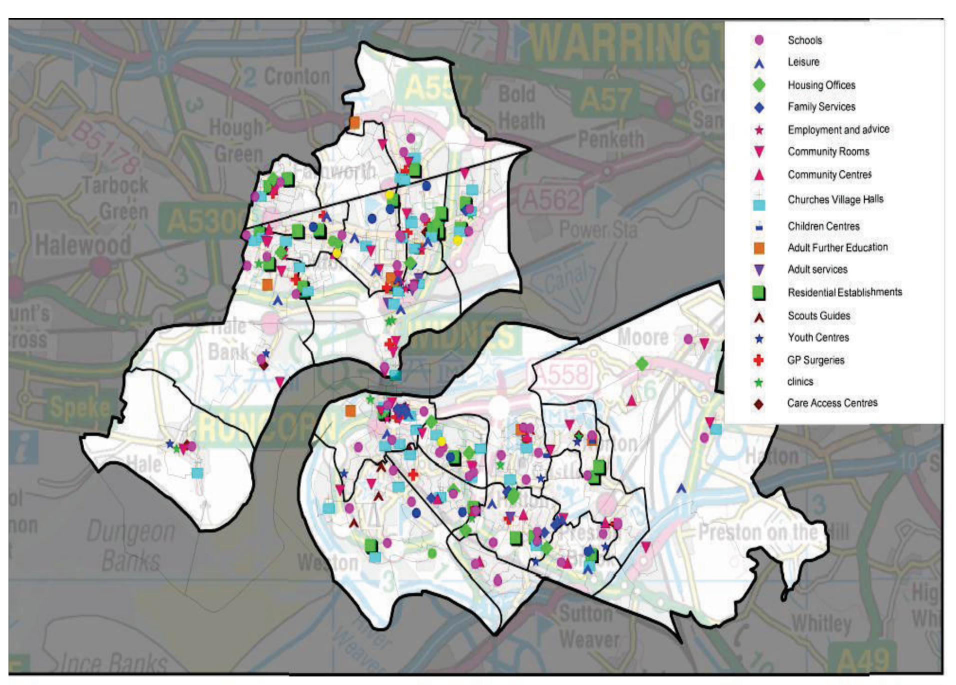


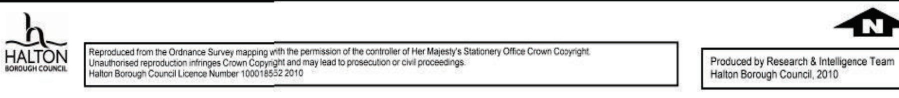
As well as Public and Private Sector assets, such as services delivered by Halton Borough Council and the NHS locally, private health and social care providers etc, the communities of Halton provide essential health assets.

An asset is any of the following:

- The practical skills, capacity and knowledge of local residents
- The passions and interests of local residents that give them energy for change
- The networks and connections – known as 'social capital' – in a community, including friendships and neighbourliness
- The effectiveness of local community and voluntary associations
- The resources of public, private and third sector organisations that are available to support a community such as Community Development officers, Police Community Support Officers, Voluntary leaders.
- The physical and economic resources of a place that enhance well-being, such as buildings and funding.

Physical assets – *buildings where health, social care or wellbeing services are delivered from or where community groups may meet.*





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Community Assets

Children

Halton Children's Trust Website www.haltonpartnership.net/childrenstrust
An information point which lists various information resources and details of services that are available across Halton to support children and young people.

Public Sector Health Assets

NHS Choices Web Site www.nhs.uk
Details of local health services, including those delivered in the community

Change for Life Web Site www.nhs.uk/Change4Life
For healthy living tips and details of where you can join in with fun health activities

Halton Borough Council Social Care Services
For information on a range of social care services
http://www3.halton.gov.uk/healthandsocialcare/

Healthy Living

Halton's Health & Physical Activity Development www.halton.gov.uk
http://www3.halton.gov.uk/leisureandculture/sportsclubsandcentres/sportsdevelopment/
A timetable of Physical Activity Supported by Halton Borough Council

Halton Sports Directory
http://www3.halton.gov.uk/leisureandculture/sportsclubsandcentres/sportsclubsdirectory/
For a directory of sports clubs and voluntary sports organisations in Halton

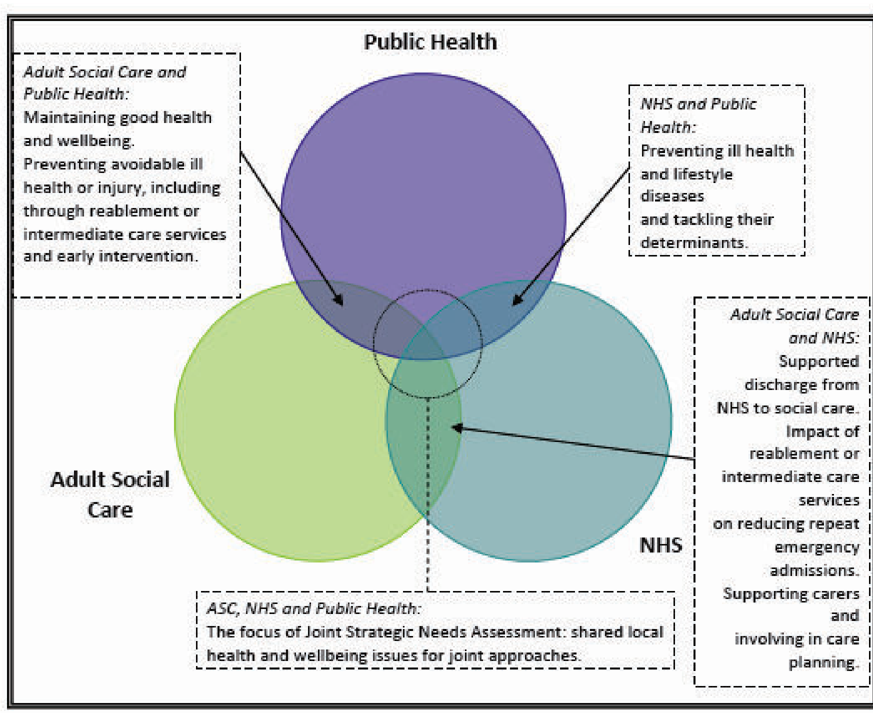
Health Improvement Team http://www.healthimprovementteam.co.uk/
Range of activities such as weight management, health trainers, men's health, mental health improvement, children's health activities, Stop Smoking service and others.

Voluntary and Community Sector

Halton & St Helens Community and Voluntary Action
http://www.haltonsthelensvca.org.uk/
Provides advice, information and development support services to voluntary, community, not-for-profit and faith organisations and volunteers in the Boroughs of St Helens and Halton.

Halton Borough Council Community Development team
http://www3.halton.gov.uk/communityandliving/communityadvice/
The team offers a range of support to new and existing community groups and voluntary organisations.

Shared priorities



There are three outcomes frameworks that have come out of the Government's plans for reform across the NHS, public health and adult social care.

- The NHS Outcomes Framework 2011/12 (December 2010)
- The 2011/12 Adult Social Care Outcomes Framework (March 2011)
- A public health outcomes framework for England, 2013-2016 (January 2012)

There is considerable overlap between the public health outcomes framework and the NHS Outcomes Framework. In particular Domain 4 of the public health outcomes framework and Domain 1 of the NHS Outcomes Framework both centre on preventing people from dying prematurely, with indicators around life expectancy, reducing premature mortality from circulatory disease and cancers and infant mortality amongst others.

There is less overlap between indicators within the Public health outcomes framework and the Adult Social Care outcomes framework. Although the aims of domains do share similar themes of maintaining good health & wellbeing and quality of care and the care experience, there is less overlap with indicators. These centre of the independence of people with mental illness and learning disabilities around employment and housing (Domain 1 of both frameworks). Domain 2 of the Adult Social Care outcomes framework includes an indicator on the effectiveness of prevention/ preventive services. The methodology for measuring this indicator has not yet been developed and although it does not appear in the public health outcomes framework, it is easy to see how this links to the range of health improvement activity detailed in the public health domain 2 (as well as the other three domains)

There is greater overlap between the NHS outcomes framework and the Adult Social care outcomes framework. This is around Domain 3 Adult Social Care and Domain 4 NHS outcomes framework's Ensuring People have a positive experience of care (and support). There is also overlap between the two for supported discharge to reduce emergency admissions and improve independence on public sector 'formal' care.

All three framework's are underpinned by the concept of protection/ safeguarding of the public and providing effective, cost effective high quality treatment and care.

2011/12 Adult Social Care Outcomes Framework at a glance

*Placeholder in 2011/12 **Deferred to 2012/13

1 Enhancing quality of life for people with care and support needs

Overarching measure

1A. Social care-related quality of life

Outcome measures

People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.

1B. The proportion of people who use services who have control over their daily life
1C. Proportion of people using social care who receive self-directed support, and those receiving direct payments

Carers can balance their caring roles and maintain their desired quality of life.

1D. Carer-reported quality of life**

People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.

1E. Proportion of adults with learning disabilities in paid employment
1F. Proportion of adults in contact with secondary mental health services in paid employment
XX. Proportion of working age adults in contact with social services in paid employment (to replace 1E/1F)*
1G. Proportion of adults with learning disabilities who live in their own home or with their family
1H. Proportion of adults in contact with secondary mental health services living independently, with or without support

2 Delaying and reducing the need for care and support

Overarching measures

2A. Permanent admissions to residential and nursing care homes, per 1,000 population
*XX. Effectiveness of prevention/preventative services**

Outcome measures

Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.

*XX. Effectiveness of prevention/preventative services**

Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.

2B. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
*XX. Effectiveness of early diagnosis, intervention and reablement: avoiding hospital admissions**

When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.

2C. Delayed transfers of care from hospital, and those which are attributable to adult social care
*XX. Effectiveness of reablement: regaining independence**

3 Ensuring that people have a positive experience of care and support

Overarching measure

People who use social care and their carers are satisfied with their experience of care and support services.

3A. Overall satisfaction of people who use services with their care and support
3B. Overall satisfaction of carers with social services**

Outcome measures

Carers feel that they are respected as equal partners throughout the care process.

3C. The proportion of carers who report that they have been included or consulted in discussions about the person they care for**

People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.

3D. The proportion of people who use services and carers who find it easy to find information about support

People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.

This information can be taken from the Adult Social Care Survey and used for analysis at the local level.

4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

Overarching measure

4A. The proportion of people who use services who feel safe

Outcome measures

Everyone enjoys physical safety and feels secure.
People are free from physical and emotional abuse, harassment, neglect and self-harm.
People are protected as far as possible from avoidable harm, disease and injuries.
People are supported to plan ahead and have the freedom to manage risks the way that they wish.

4B. The proportion of people who use services who say that those services have made them feel safe and secure
*XX. Effectiveness of safeguarding services**

Vision

To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest.

Outcome measures

Outcome 1: Increased healthy life expectancy, ie taking account of the health quality as well as the length of life.

Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

1 Improving the wider determinants of health

Objective

Improvements against wider factors that affect health and wellbeing and health inequalities

Indicators

- Children in poverty
- *School readiness (Placeholder)*
- Pupil absence
- First time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- People with mental illness or disability in settled accommodation
- *People in prison who have a mental illness or significant mental illness (Placeholder)*
- Employment for those with a long-term health condition including those with a learning difficulty/ disability or mental illness
- Sickness absence rate
- Killed or seriously injured casualties on England's roads
- *Domestic abuse (Placeholder)*
- *Violent crime (including sexual violence) (Placeholder)*
- Re-offending
- *The percentage of the population affected by noise (Placeholder)*
- Statutory homelessness
- Utilisation of green space for exercise/health reasons
- Fuel poverty
- *Social connectedness (Placeholder)*
- *Older people's perception of community safety (Placeholder)*

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions
- *Child development at 2-2.5 years (Placeholder)*
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- *Emotional wellbeing of looked-after children (Placeholder)*
- *Smoking prevalence – 15 year olds (Placeholder)*
- Hospital admissions as a result of self-harm
- *Diet (Placeholder)*
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- *Cancer diagnosed at stage 1 and 2 (Placeholder)*
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible
- Self-reported wellbeing
- Falls and injuries in the over 65s

3 Health protection

Objective

The population's health is protected from major incidents and other threats, while reducing health inequalities

Indicators

- Air pollution
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for tuberculosis
- Public sector organisations with board-approved sustainable development management plans
- *Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)*

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

Indicators

- Infant mortality
- Tooth decay in children aged five
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- *Mortality from communicable diseases (Placeholder)*
- *Excess under 75 mortality in adults with serious mental illness (Placeholder)*
- Suicide
- *Emergency readmissions within 30 days of discharge from hospital (Placeholder)*
- Preventable sight loss
- *Health-related quality of life for older people (Placeholder)*
- Hip fractures in over 65s
- Excess winter deaths
- *Dementia and its impacts (Placeholder)*

HALTON JSNA:NHS OUTCOMES FRAMEWORK

1 Preventing people from dying prematurely

Overarching indicators

1a Mortality from causes considered amenable to healthcare
(The NHS Commissioning Board would be expected to focus on improving mortality in all the components of amenable mortality as well as the overall rate)
1b Life expectancy at 75

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease*
1.2 Under 75 mortality rate from respiratory disease*
1.3 Under 75 mortality rate from liver disease*
1.4 Cancer survival
i One- and ii five-year survival from colorectal cancer
iii One- and iv five-year survival from breast cancer
v One- and vi five-year survival from lung cancer

Reducing premature death in people with serious mental illness
*1.5 Under 75 mortality rate in people with serious mental illness**

Reducing deaths in babies and young children
1.6.i Infant mortality*
1.6.ii Perinatal mortality (including stillbirths)

2 Enhancing quality of life for people with long term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions (EQ-5D)**

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition***

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions

Reducing time spent in hospital by people with long-term conditions
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers (EQ-5D)**

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 28 days of discharge from hospital***

Improvement areas

Improving outcomes from planned procedures
3.1 Patient-reported outcomes measures (PROMs) for elective procedures

Preventing lower respiratory tract infections (LRTIs) in children from becoming serious
3.2 Emergency admissions for children with LRTIs

Improving recovery from injuries and trauma
3.3 An indicator needs to be developed.

Improving recovery from stroke
3.4 An indicator needs to be developed.

Improving recovery from fragility fractures
3.5 The proportion of patients recovering to their previous levels of mobility/walking ability at i 30 days and ii 120 days***

Helping older people to recover their independence after illness or injury
3.6 The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services***

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
4b Patient experience of hospital care

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to inpatients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 An indicator needs to be developed based on the survey of bereaved carers

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 An indicator needs to be developed.

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

5a Patient safety incident reporting
5b Severity of harm
5c Number of similar incidents

Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare-associated infection (HCAI)
i MRSA
ii *C difficile*
5.3 Incidence of newly acquired category 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

One framework
defining how the NHS will be accountable for outcomes
Five domains
articulating the responsibilities of the NHS
Ten overarching indicators
covering the broad aims of each domain
Thirty-one improvement areas
looking in more detail at key areas within each domain
Fifty-one indicators in total
measuring overarching and improvement area outcomes

The NHS Outcomes Framework 2011/12 at a glance

**Shared responsibility with Public Health England*

***EQ 5D™ is a trademark of the EuroQol Group. Further details can be found at: www.euroqol.org*

****Indicator also included in the Adult Social Care Outcomes Framework*

Indicators in italics are placeholders, pending development or identification of a suitable indicator

REPORT TO:	Health Policy & Performance Board (HPPB)
DATE:	6.3.12
REPORTING OFFICER:	Strategic Director - Communities
PORTFOLIO:	Health and Adults
SUBJECT:	Bridgewater Community Healthcare NHS Trust
WARD(S):	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To receive a presentation from Kate Fallon, Chief Executive and Harry Holden, Chairman of Bridgewater Community Healthcare NHS Trust regarding their application to become a Foundation Trust. The consultation document is appended to the report.

2.0 **RECOMMENDATION: That HPPB:**

i) Note content of the presentation
ii) Comment on the proposals for Bridgewater to become a Foundation Trust.

3.0 **SUPPORTING INFORMATION**

3.1 Bridgewater provides healthcare services in Ashton, Leigh and Wigan, Halton and St Helens, Trafford, Warrington and Community Dental Services in all of the above areas plus Bolton, Stockport, Tameside and Glossop and West Cheshire.

3.2 Bridgewater is currently seeking views from patients and the public on its plans for becoming a Foundation Trust. The Foundation Trust will have unique governance arrangements which include **members** (public, patients and staff) and **governors** (elected by members or nominated by partner organisations).

3.3 Patients, local people and partner organisations have been invited to express their views on the proposed governance arrangements for becoming a Foundation Trust during a 12 week consultation period, ending on April 30

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**
Not applicable

6.2 **Employment, Learning & Skills in Halton**
Not applicable

6.3 **A Healthy Halton**
All issues outlined in the presentation will focus directly on this priority.

6.4 **A Safer Halton**
Not applicable.

6.5 **Halton's Urban Renewal**
Not applicable.

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.

Your community healthcare services. Your chance to get involved.

Consultation about our plans to become a Foundation Trust

Bridgewater
Healthcare at the heart
of your community

Contents

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Bridgewater Community Healthcare NHS Trust would like to acknowledge the support of patients and public in compiling this document.

Bridgewater Community Healthcare NHS Trust is one of the largest providers of NHS community healthcare services in the North West.

Chairman and Chief Executive's introduction

We want our patients, their families and carers, our staff, our communities and partner organisations to have a greater say in the future development of the services we provide.

We believe the best way of achieving this is by becoming a Foundation Trust as this will give us greater freedom to respond to the needs of our patients and give them more say in how our services are run.

It is government policy for all NHS Trusts to become Foundation Trusts in the next few years. We plan to become a Foundation Trust by April 2013.

We have already done a great deal to help us on our way to achieving Foundation Trust status and now we need to get feedback on the arrangements which we are proposing to put in place.

We are carrying out a 12 week consultation on the proposals for the governance arrangements outlined in this consultation document.

These arrangements include building a membership base from among our patients, their families and carers, our staff and our local communities and establishing a Council of Governors to represent them. Find out more about what becoming a member means on page 11.

Please take the opportunity to read this document and learn about our plans. Please tell us what you think. Details of how to do this are included at the end of this booklet.

We would also like you to sign up as a member of our Trust to ensure that you can have your say on the future of local community healthcare services. A membership application form is included at the back of this booklet.

Harry Holden
Chairman

Kate Fallon
Chief Executive

Harry Holden
Chairman

Kate Fallon
Chief Executive

We provide NHS services to a population of 1,015,370 people living in Ashton, Leigh & Wigan, Halton & St Helens, Trafford and Warrington.

About us

We also provide specialist community dental services in these areas plus Bolton, Stockport, Tameside & Glossop and Western Cheshire. We are called Bridgewater Community Healthcare NHS Trust because of the Bridgewater Canal and its network of links to the communities we serve.

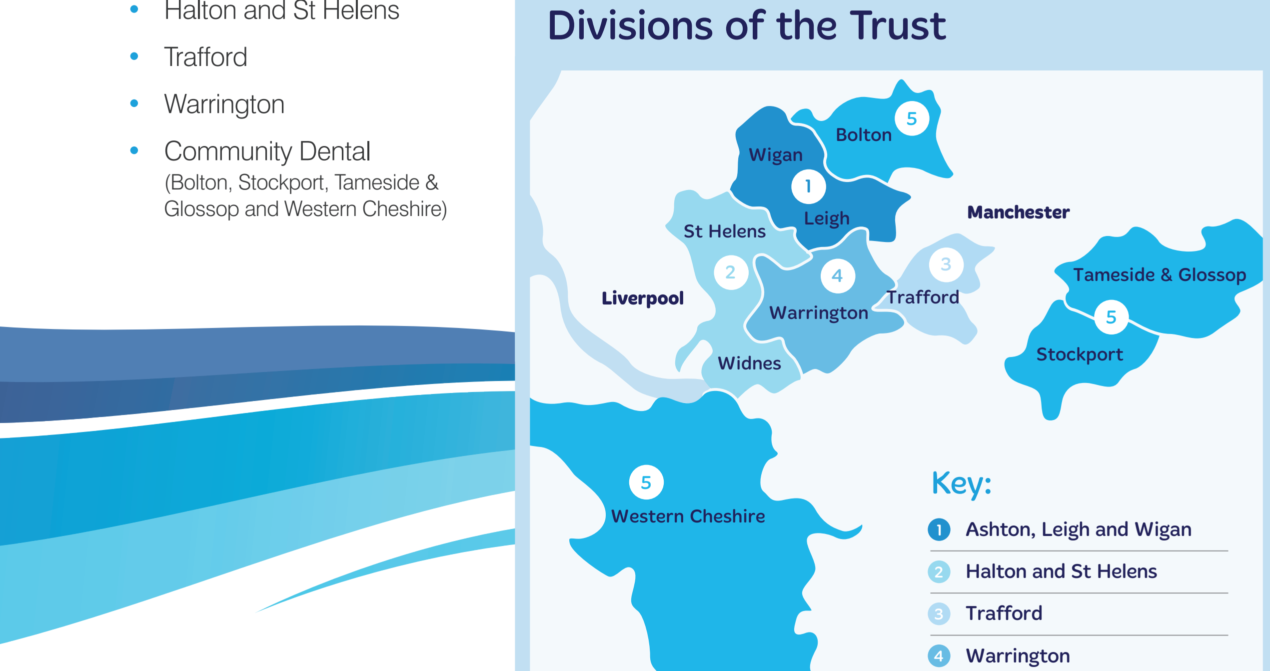
We employ 4,211 staff who support our mission to improve local health and wellbeing through providing care close to home, for example in clinics, health centres and patients' own homes. We also deliver healthcare services within locations at the heart of our local communities, such as schools, community centres and GP surgeries.

The delivery of services is organised into five divisions:

- Ashton Leigh and Wigan
- Halton and St Helens
- Trafford
- Warrington
- Community Dental
  (Bolton, Stockport, Tameside & Glossop and Western Cheshire)

Community health services provide care, treatment and support for the youngest to the oldest members of our communities and everyone else in between. In many cases we have to support people's healthcare throughout their lives.

We are passionate about delivering care close to home and we believe that becoming a Foundation Trust (see page 8) will enable us to continue providing NHS services which are tailored to the current and future needs of the people and communities we serve.



Our Services*

A summary of services is provided below:

Child Health	Health Visiting, School Nursing, Child Development Centres, Audiology, Complex Needs, Safeguarding, Child and Adolescent Mental Health Services, Children's Community Therapy, Nursing and Continuing Care.
Health and Wellbeing	Health Improvement Services, including: Stop Smoking Services, Weight Management, Health Trainers, Sexual Health.
Urgent Care	Walk-in-Centres, District Nurses (including Out of Hours), GP Out of Hours, Intermediate Care, Home Based Intravenous Therapy.
Long Term Conditions	Specialist services including: Community Neuro Services, Continence Services, Community Matrons, Services for people with heart problems, diabetes, respiratory, and stroke.
Specialist Services	Dermatology, Orthopaedic and Musculo-Skeletal Services, Podiatry, Cancer and Palliative care, Wheelchair Services and Equipment, Mental Health, Community Physiotherapy, Occupational Therapy, Community Midwifery, Dietetics, Learning Disability Services, Homelessness Services, Falls Prevention.
Offender Health	Services provided to prisons and young offender institutions in Ashton, Leigh & Wigan and Warrington divisions.
Dental	Specialist Dental Services for vulnerable people including: people with physical and learning disabilities, looked after children and those with anxiety issues, Prison Dental Services and Oral Health Promotion.

* Please note that not all services are provided in every division of the Trust.

Our vision for the future

Mission

As an organisation working with and for local people we aim to address health inequalities and improve quality of life. This is reflected in our Mission statement:

To improve local health and promote wellbeing in the communities we serve.

Vision

To achieve our Mission we will talk to, listen to and work with people to improve the delivery of healthcare and we will work with partners to deliver integrated services to improve health and wellbeing. This is reflected in our vision:

By working with local people and partners, we will promote good health and be a leading provider of excellent community healthcare services in the North West.

Values

We have adopted a set of values which underpin the developing culture of our organisation and outline the attitudes, behaviours and culture of our workforce.

Patient Centred
Patient care is our priority.

Encourage Innovation
We encourage and embrace new ideas to deliver improvements in patient care.

Open and Honest
We communicate clearly to develop relationships based on mutual trust and respect.

Professional
We provide a quality service for patients by investing in our staff and recognise and value their contribution.

Locally led
We will continually develop our knowledge of the communities we serve, so that we can be responsive to local needs.

Efficient
We will use our resources wisely to ensure quality patient care and value for money.

Strategic objectives

Our plans and ambitions for the future are under-pinned by our mission, vision and values. As a provider of community healthcare services, we are committed to excellence at every level.

We have listed below some of our key priorities which will help us deliver on our objectives over the coming years.

Strategic Intention	Strategic Objective
Patients	**We will** demonstrate improvement in the delivery of high quality, safe, excellent and effective personal community healthcare for our patients. **We will** make it easier for patients/carers to access our services where and when they need them. Our Priorities are: • Increase support for our vulnerable patients including children, people with disabilities, the homeless and elderly. • Improve services for those with long term health conditions including diabetes, cancer, respiratory and cardiac conditions and dementia. • Improve access and availability for community services and use new technologies that support care closer to home.
Community	**We will** work with local communities to improve services that support their health and wellbeing, establishing targets that will demonstrate that we are achieving this. Our Priorities are: • Develop services which help people to prevent ill health and those which help to avoid unnecessary admission to hospital. • Develop more integrated (joined up) services and packages of care together with key partner organisations.
Organisation	**We will** be financially secure and accountable across our entire organisation. **We will** deliver value for money by ensuring efficiency in all our activity and processes to enable and drive innovation. **We will** achieve NHS Foundation Trust status by 2013 and be assessed as a leading provider of community healthcare in the North West by 2015. Our Priorities are: • We will use the freedoms Foundation Trust status offers to improve and invest in services and patient care.
People	**We will** develop world class skills, competencies and experience to deliver high quality care through our workforce planning and education and be seen as the employer of choice. **We will** engage with our staff, fostering talent and developing leaders, to deliver change, innovation and improvement. Our Priorities are: • We will invest in our staff to deliver excellent care and support to the communities we serve.

Foundation Trusts are firmly part of the NHS and subject to its standards, performance ratings and systems of inspection. Their primary purpose is to provide NHS care to patients according to NHS quality standards and principles.

What is a Foundation Trust?

NHS Foundation Trusts are different from existing NHS Trusts in the following ways:

- They are independent legal entities.
- They have unique governance arrangements and are accountable to local people, who can become members and governors. Each NHS Foundation Trust has a duty to consult and involve a board of governors (comprising patients, staff, members of the public and partner organisations) in the strategic planning of the organisation.
- They have greater freedom from central government control. As self-standing, self-governing organisations, NHS Foundation Trusts are free to determine their own future.
- They have new financial freedoms and can raise capital from both the public and private sectors within borrowing limits determined by projected cash flows and therefore based on affordability. They can retain financial surpluses to invest in the delivery of new NHS services.
- They are overseen by Monitor (Independent Regulator of Foundation Trusts).

Bridgewater is currently an NHS Trust and is seeking to become a Foundation Trust.

We will continue to deliver on the principles of providing care that is free at the point of delivery. Becoming a Foundation Trust will not directly result in any changes to the services that we provide.

Our commitment to working with local people will be achieved through developing a formal membership scheme and giving members the opportunity to vote for representatives on our Council of Governors. More details are provided over the next few pages.

As a Foundation Trust, we will also be required to change our name to Bridgewater Community Healthcare NHS Foundation Trust.

Becoming a Foundation Trust will ensure the continued delivery of locally led NHS healthcare in the heart of the communities we serve. This is of critical importance as we address the health needs of local people who are living longer.

What are the benefits?

We must also provide accessible and cost effective care for people throughout their lives, including care for increasing numbers of people with complex conditions.

Some of the key benefits of becoming a Foundation Trust are:

- Our decision making will be local, as opposed to being dictated by central government, which will enable us to respond more quickly to the needs of both our patients and local communities.
- Local people and organisations will have a much greater role in the planning and design of our services and in setting our priorities by establishing a membership base and a Council of Governors.
- Both public and staff members will be able to elect the majority of representatives on our Council of Governors.
- The Council of Governors will represent members, local communities and other organisations and be able to influence key decisions about the Trust and our services and have a say on key appointments.
- We will be able to plan and manage our finances over a longer period of time and generate a surplus of money which will allow us to invest in new and improved services for patients.
- We will be required to meet all the standards set by the Independent Regulator of Foundation Trusts 'Monitor' as well as standards set by other authorities including the Care Quality Commission.

Our decision making will be local, as opposed to being dictated by central government

It is government policy for all NHS Trusts to become Foundation Trusts during the next few years. All NHS Trusts will become NHS Foundation Trusts or become part of an existing Foundation Trust. The following pages outline our proposals for the governance arrangements for the Foundation Trust.

What are we consulting on?

We want people and organisations to provide feedback on our proposals to give local people and patients a greater influence over the development and delivery of their local community health services. We also want people to comment on our suggestions for membership and the Council of Governors.

Having your say

Please read the following pages and complete the Tell us what you think form and return to the FREEPOST address in the envelope provided. No stamp is required. We have also included a membership form. You can also attend one of our public consultation events (please see page 21).

Becoming a Foundation Trust means, that we need to have a membership base that reflects the communities that we serve. Our membership will be made up of our patients, their carers and families, residents, members of our local communities and our staff.

What is membership?

Some facts about being a member:

- Membership is free and will be open to anyone aged 14 or above. We are proposing this age as we provide a large number of services to both children and young people. We want all our members to be able to vote in our governor elections because we feel this is an age at which young people can make their own informed decision.
- All members can exercise a vote in elections for the Council of Governors.
- It is up to each individual member how much time they wish to devote to membership and members will be able to select from three levels of membership but can change this at any time.
- Members will have equal access to services as non-members.
- Members aged 16 years, or above can stand for election as a governor.
- Individuals can be members of more than one Foundation Trust.

Becoming a member of the Trust provides new ways for local people, patients, carers and staff to contribute effectively to the development of the Trust. Members will be able to positively influence the way in which the Trust is managed.

Join us as a member and you will be able to:

- Receive regular information, such as members' newsletters.
- Receive invitations to join in focus groups, surveys and give feedback on aspects of the Trust's services.
- Be kept informed of plans for future development and be asked for views on strategic service improvements, to give a public and staff perspective on future proposals.
- Have a say, through the Council of Governors, on decisions about proposed changes to services and future plans for the development of the Trust.
- Elect fellow members as representatives to serve on the Council of Governors.
- Stand for election to the Council of Governors, (if aged 16 or above).
- Register for the online NHS Discounts Scheme, which is exclusively for NHS Staff and Foundation Trust members.

Consultation questions:

Do you agree that the minimum age to become a member should be 14 years?

Do you agree that all members should be able to vote in governor elections from the age of 14?

(please see form at rear of document to give your view on these questions)

Levels of membership

When you become a member, you will be asked to select one of the following levels of membership.

This is to ensure that members are able to choose the level of involvement with the Trust. If you change your mind, you will be able to change this preference at any time.

Level 1

Receive information about the Trust and issues affecting local health services at regular intervals, including invitations to events including the Annual Members' Meeting and Annual General Meeting, receive voting papers for the elections to the Council of Governors.

Level 2

Members will receive the same information as Level 1 members and receive invitations to participate in surveys and discussion groups, which will allow members to comment on service developments and the Trust's future strategic plans.

Level 3

Members will receive the same information as Level 1 and 2 members and will also receive more detailed information about governor vacancies, how to stand for election as a governor and receive invites to events for potential governors.

Consultation questions:

Do you agree with our proposed three levels of membership?

(please see form at rear of document to give your view on these questions)

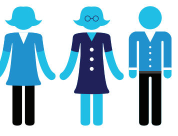
Becoming a member

Becoming a member is free of charge and easy to do. To become a public member, please complete the membership form at the back of this document.

You can also complete the online membership application form at **www.bridgewater.nhs.uk/ft**

Staff will automatically become members and do not need to complete the membership form.

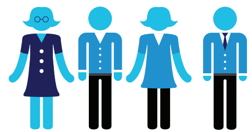
You can also contact **communications@bridgewater.nhs.uk** or telephone **01942 482672** to learn more about membership.



How will membership be structured?

We are proposing two membership constituency categories:

&



Public

Staff

Public Constituencies

The Trust has taken a decision to have a single public constituency for patients, carers and members of the public, to reflect the fact that the majority of our patients will be resident in the boroughs we serve and therefore eligible for the public constituency. This also reflects the reality that a significant proportion of the population of the boroughs we serve will be service users, or will have accessed our services at some time.

The public constituency will be divided into the following six sub-constituencies which are based on local authority boundaries, Primary Care Trust (PCT) boundaries and the operational divisions within the Trust:

Ashton, Leigh and Wigan
(comprising the Borough of Wigan and mirroring the area covered by Ashton, Leigh and Wigan Division of the Trust).

Halton
(comprising the Borough of Halton and is part of the area covered by the Halton & St Helens Division of the Trust).

St Helens
(comprising the Borough of St Helens and is part of the area covered by the Halton & St Helens Division of the Trust).

Warrington
(comprising the Borough of Warrington and mirroring the Warrington Division of the Trust).

Trafford
(comprising the Borough of Trafford and mirroring the Trafford Division of the Trust).

Community Dental
(for people receiving specialist dental treatment in the boroughs of Bolton, Stockport and the PCT areas of Tameside & Glossop and Western Cheshire).

Rest of England
(comprises all other parts of England and will ensure that carers, or relatives of our patients can also have a say on our services).

Eligibility for public membership:

- Anyone aged 14 or over living in one of the areas defined as the public constituency.
- Staff members will not be eligible to join the public constituencies but will be eligible to join the staff constituency.

All public members will be entitled to vote to elect governors from their respective sub-constituencies to provide representation on the Council of Governors.

Consultation questions:

Do you agree with our plans for public membership constituencies?

(please see form at rear of document to give your view on these questions)

Staff Constituency

Our staff are our most valuable resource and will remain part of the NHS when we are authorised as a Foundation Trust. The Trust is keen to ensure that as many staff as possible are involved in and have a say in our organisation's future and development.

Eligibility for staff membership will be open to any individual who is employed by the Trust under a contract of employment with the Trust provided they are:

- employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
- been continuously employed by the Trust under a contract of employment for at least 12 months.

The Trust intends to operate a system of automatic membership for staff, the impact of which is that all staff eligible for membership will become members unless they advise that they do not wish to be included.

Staff members will be allocated to one of the sub-constituencies of the Staff Constituency. Any member of staff who leaves the Trust's employment can be transferred to the appropriate public constituency.

All staff members will be entitled to vote to elect governors from their respective sub-constituencies to represent them on the Council of Governors.

Staff sub-constituencies:

- Registered Nurses/Midwives
- Allied Health Professionals/other registered healthcare professionals
- Clinical support staff, including Assistant Practitioners/Healthcare Assistants
- Medical
- Dental
- Non-clinical support staff, including managerial and administrative staff.

Consultation questions:

Do you agree with our proposals for staff membership?

(please see form at rear of document to give your view on these questions)

The views of members will be represented at the highest level within the Trust through establishing a Council of Governors. Our Council of Governors will play an important role in influencing the direction and decisions taken by the Trust.

Council of Governors

The Council will be made up of members of the public and staff constituencies as part of a democratic voting process. In addition to this, a number of governors will be appointed to represent the Trust's partner organisations.

The Council of Governors will not have responsibility for the day-to-day running of the Trust but will have the following important statutory responsibilities:

- To appoint and, if appropriate, remove the Chair and Non-Executive Directors.
- To decide the remuneration, allowances and other terms and conditions of office of the Chair and Non-Executive Directors.
- To approve the appointment, (by the Non-Executive Directors) of the Chief Executive.
- To appoint and, if appropriate, remove the Trust's financial auditors.
- To provide their views to the Board of Directors during the Trust's forward planning process.
- To receive the Annual Report and Accounts.
- To hold the Board of Directors to account for the performance of the Trust.

In addition to this governors will also:

- Represent the interests of the local community and be consulted on proposed changes to how services are delivered.
- Provide an active link between the NHS Foundation Trust and communities.
- Review the Trust's Membership Strategy and support the recruitment of members.
- Be actively involved in forums and advisory groups.

Governors will be elected for a term of three years and will be eligible for re-election at the end of this period.

Structure of Council of Governors

The Trust is proposing a Council of Governors made up of 34 governors. This includes 18 governors elected by members of our Public Constituency and nine governors elected by our Staff Constituency. The number of public governors must exceed the staff and partner governors combined. This allows us to invite nominations for seven governors from partner organisations.

Public – 18

Staff – 9

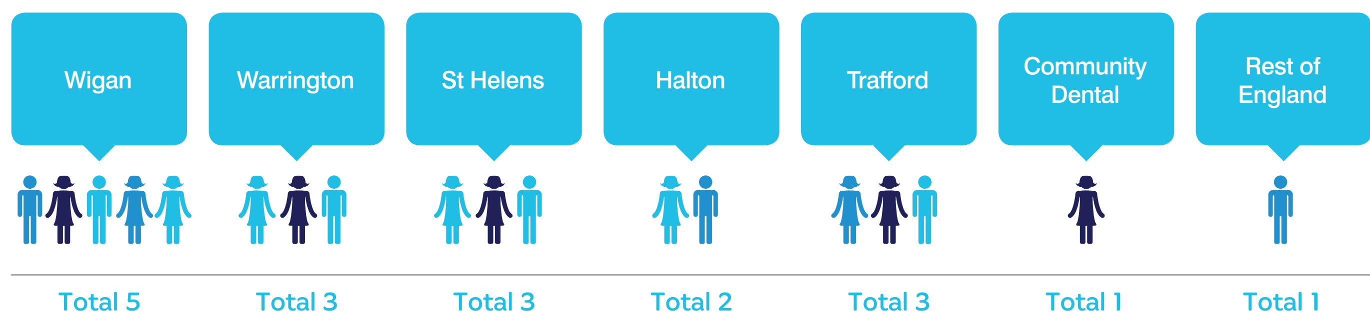
Appointed-Partner – 7

Total 34

Table of Council of Governors for membership constituencies:

Public Governors (elected)

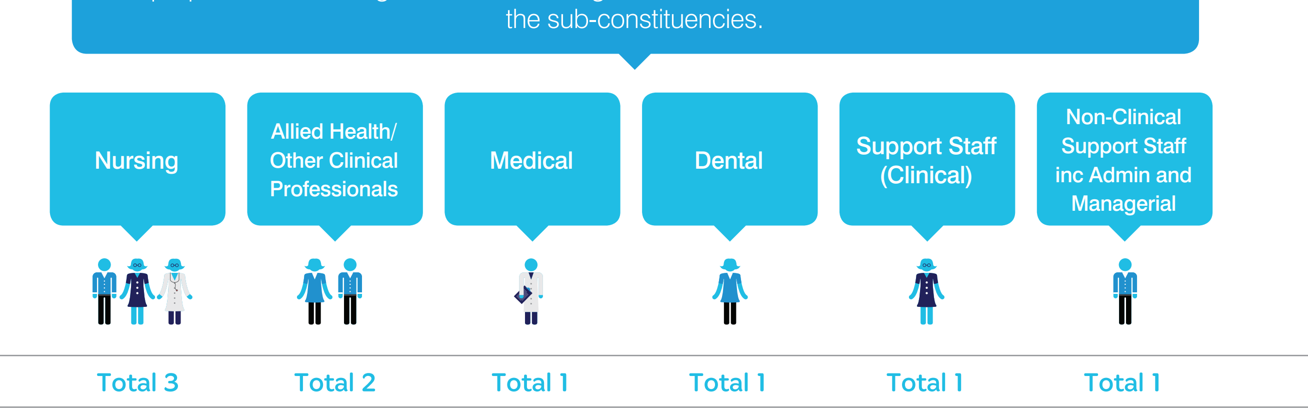
We propose the following allocation of public governors based on the population size and the level of service we provide in each of the sub-constituencies.



Wigan	Warrington	St Helens	Halton	Trafford	Community Dental	Rest of England
Total 5	Total 3	Total 3	Total 2	Total 3	Total 1	Total 1

Staff Governors (elected)

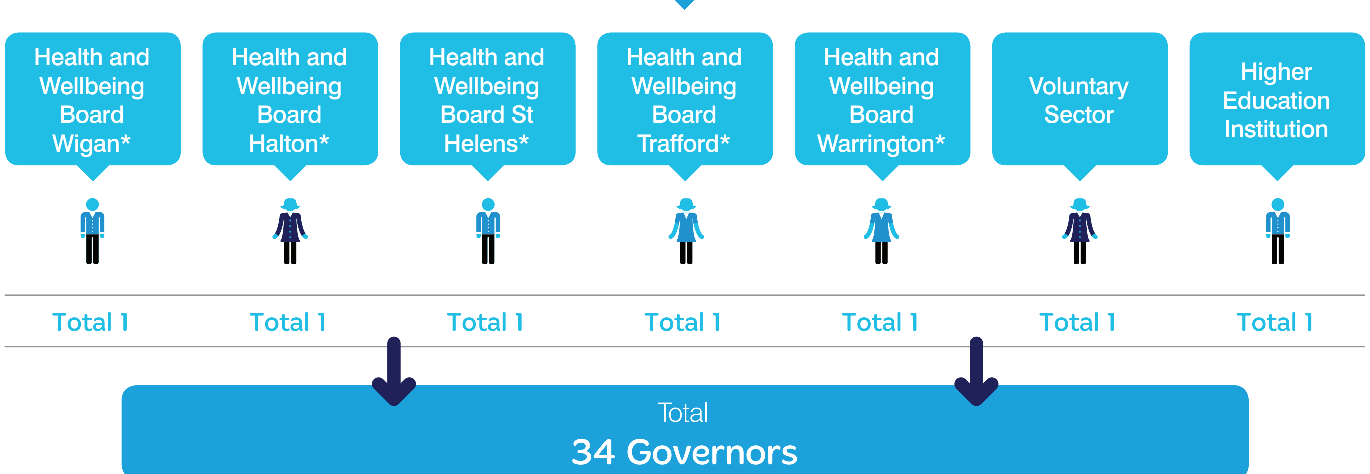
We propose the following allocation of staff governors based on the numbers of staff in each of the sub-constituencies.



Nursing	Allied Health/ Other Clinical Professionals	Medical	Dental	Support Staff (Clinical)	Non-Clinical Support Staff inc Admin and Managerial
Total 3	Total 2	Total 1	Total 1	Total 1	Total 1

Partner-appointed Governors (appointed)

We have decided to seek nominations for appointments to the council of governors from a number of organisations and forums.



Health and Wellbeing Board Wigan*	Health and Wellbeing Board Halton*	Health and Wellbeing Board St Helens*	Health and Wellbeing Board Trafford*	Health and Wellbeing Board Warrington*	Voluntary Sector	Higher Education Institution
Total 1	Total 1	Total 1	Total 1	Total 1	Total 1	Total 1

Total
34 Governors

Explanation of Health and Wellbeing Boards

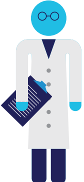
Health and Wellbeing Boards will bring together locally elected councillors with the key commissioners, including representatives of clinical commissioning groups, directors of public health, children's services and adult social services, and a representative of local HealthWatch (the new patients' representative body) in each borough.

When agreeing nominations from the Health and Wellbeing Boards we must take into account the legal requirement to have at least one governor from a Local Authority and at least one Governor from an NHS Commissioning organisation on the Council.

The Council of Governors will be involved in key decisions about the future of the Trust

Consultation questions:

- Do you agree with the proposed number of public governors?
- Do you agree with the number of staff governors proposed?
- Do you agree with the proposals for appointed partner governors?



(please see form at rear of document to give your view on these questions)

The Trust Board will be legally accountable for the safe and effective operation of the Trust's services and ensuring that we meet our statutory obligations.

Board of Directors

The Board provides leadership and strategic direction to the organisation and is also responsible for ensuring that the Trust performs well and meets all targets.

The Board comprises 13 Directors of whom eight are Non-Executive Directors, including the Chairman, and five Executive Directors, including the Chief Executive.

As a Foundation Trust the Board will continue to undertake this role but will work closely with the Council of Governors, which will be chaired by the Chairman of the Trust.

Working in this way will ensure that the Council of Governors will be involved in key decisions about shaping the future of the Trust.

The Board provides leadership and strategic direction to the organisation

Relationship between Members, Council of Governors and the Trust's Board of Directors

Members

Staff, Service Users & the Public. i.e The "stakeholders" of the organisation

Elect representatives to form the Council of Governors

Consult with and inform members

Council of Governors

Chaired by the Trust Chairman. The Council of Governors is made up of the representatives elected by members and nominated representatives of the Trust's Partnership organisations. The Council holds the Board of Directors to account for the Trust's performance and represents the interests of the members and other stakeholders.

Holds the Board of Directors to account for the performance of the Trust

Submit forward plans for approval

Board of Directors

Includes the Trust Chairman, Chief Executive, Executive Directors and Non-Executive Directors of the Trust. It has responsibility for management of the Trust and its services and sets the strategic direction for the Trust and holds the executive directors to account for the day-to-day running of the Trust.

What happens next?

Have your say

Tell us what you think about our plans and sign up to become a member using the forms at the back of this booklet, or attend one of our public consultation events.

Feedback on the consultation

When the consultation period has ended, we will review all feedback and take this into account when making our application to become a Foundation Trust, to the Secretary of State for Health.

We will publish a summary of feedback to the consultation on our website and details of how it has influenced our plans. If the Secretary of State supports our application it will then be assessed by Monitor (the Independent Regulator of Foundation Trusts), who will then decide if we can become an NHS Foundation Trust.

If you have any questions or comments about this consultation please email **communications@bridgewater.nhs.uk** or telephone **01942 482672.**

Foundation Trust timetable key dates:

Consultation ends:
April 30 2012

Publish summary responses to consultation:
May 2012

Application to Secretary of State:
December 2012

Monitor Assessment commences:
January 2013

Public consultation events:

Halton & St Helens
8th Feb, 16:00 – 18:00

Crownway Community Centre
Crown Street, Newton le Willows,
WA12 9DA

Ashton, Leigh & Wigan
22nd Feb, 10:30 – 12:30

Kingsleigh Methodist Church
73 King Street, Leigh, WN7 4LJ
01942 606630

Ashton, Leigh & Wigan
22nd Feb, 18:00 – 20:00

Leigh Miners Welfare 4 Kirby Road,
Twist Lane, Leigh, WN7 4EF
01942 671782

Halton & St Helens
23rd Feb, 11:00 – 13:00

St Helens World of Glass,
Chalon Way East, St Helens WA10 1BX

Warrington
2nd March, 12:00 – 14:00

Village Hotel Centre Park,
Warrington WA1 1QA

Trafford
5th March, 10:00 – 12:00

The Horrocks Meetings Room
St Matthews Hall Chester Road,
Stretford Manchester, M32 8HF

Trafford
6th March, 18:00 – 20:00

Sale Masonic Hall, Tatton Road,
Sale M33 7EE

Warrington
6th March, 19:00 – 21:00

Firgrove Hotel Knutsford Old Road,
Warrington, WA4 2LD

Ashton, Leigh & Wigan
12th March, 11:00 – 13:00

Queens Hall Methodist Church
46 Market Street,Wigan, WN1 1HX
01942 244358

Ashton, Leigh & Wigan
12th March, 18:00 – 20:00

Wigan and Leigh College
Parsons Walk, Wigan
01942 763206

Halton & St Helens
13th March, 11:00 – 13:00

The Foundry Lugsdale Road
Widnes, WA8 6DA

Warrington
21st March, 13:00 – 15:00

Peace Centre Great Sankey
Peace Drive Great Sankey
Warrington, WA5 1HQ

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Contact address:
Bridgewater Community Healthcare NHS Trust
Bevan House
17 Beecham Court
Smithy Brook Road
Wigan
WN6 7JA

Email: communications@bridgewater.nhs.uk
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Agenda Item 5c

REPORT TO:	Health Policy & Performance Board
DATE:	6th March 2012
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health & Adults
SUBJECT:	Comprehensive cancer Centre for Cheshire & Merseyside
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This briefing paper seeks to provide information on the work that has been taking place in Cheshire and Merseyside to consider and bring forward proposals for the development of World Class Cancer Services in Cheshire and Merseyside through the establishment of a new Cancer Centre in Liverpool and the further development of services across the area.

1.2 To ask for support for the delivery of a wide-ranging communication and involvement exercise designed to share the proposals with a wide range of stakeholders across Cheshire and Merseyside and further afield where appropriate.

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

3.0 **BACKGROUND**

3.1 In autumn 2010, Pricewaterhouse Coopers (PwC) were engaged by Liverpool PCT to undertake a high level affordability study to review the cost and affordability of building a new comprehensive Cancer Centre co-located with a redeveloped Royal Liverpool Hospital. The final report was published in March 2011. The study reviewed 2 options – **a Standalone Cancer Centre and a Cancer Centre with an element of shared services with the RLBUH.** The capital cost of both options (based on 80 inpatient beds) was **£116.5m** and **£105.2m** respectively **(both excluding VAT)**.

4.0 **KEY ISSUES FOR HALTON**

4.1 Both Trust Boards have worked together to consider and bring forward an affordable proposal which incorporates:

- A new build Clatterbridge Cancer Centre adjacent to the

proposed new build Royal Liverpool Hospital (RLH)
- A separate dedicated entrance for the Cancer Centre
- The majority of cancer inpatient services provided by Clatterbridge Cancer Centre, to be accommodated within the RLH scheme with flexibility within the cancer centre to provide additional, flexible inpatient/day care services
- Radiotherapy, chemotherapy, dedicated imaging and outpatient services to be provided within the Cancer Centre
- Appropriate, dedicated patient and staff access links between the Cancer Centre and RLH buildings with required clinical adjacencies conducive to effective and efficient delivery of patient care and clinical trials
- A dedicated adjacent free car parking facility for cancer patients.
- Clinical Trials unit to be provided in collaboration with RLH and the University assuming essential laboratory support of the Cancer Centre
- Cytotoxic pharmacy to remain on the CCO Wirral site
- A satellite facility to remain on the CCO Wirral site comprising ambulatory, radiotherapy and chemotherapy, outpatients services and proton therapy

4.2 In making the above recommendations it is recognised that certain patients will have to travel further for certain elements of their care. However, it is important to emphasise that radiotherapy and chemotherapy services would continue to be provided on the original Clatterbridge site. Outpatient chemotherapy services and radiotherapy services for patients with more common cancers such as breast, prostate and lung would continue to be provided on the site for local patients. Only those patients who require more complex treatment, or require inpatient facilities, would be required to travel to the new centre in Liverpool.

4.3 Senior clinicians believe very strongly that cancer research will be strengthened by closer integration between the University of Liverpool, Cancer Research UK, Clatterbridge Cancer Research, the Royal Liverpool Hospital and Clatterbridge Centre for Oncology NHS Trust. The Clatterbridge Cancer Research laboratories have recently relocated to share the “bio-campus” with other partners in central Liverpool. Only CCO remains physically isolated from this important and growing research community. By relocating CCO, all patients including those from Wirral and Western Cheshire would benefit from greater participation in international-standard research and clinical trials.

4.4 The Royal Liverpool University Hospital employs the greatest number of specialist cancer doctors and other clinical professionals. Most specialist cancer surgical teams for residents of Merseyside and Cheshire are based at the Royal

Liverpool and the hospital also hosts the majority of specialist cancer pathology and radiology services for the region. Patients from Wirral and Cheshire already travel to the Royal Liverpool University Hospital site for treatment and care. Closer physical integration between the Royal Liverpool University Hospital and Clatterbridge Centre for Oncology would enable greater collaboration between expert cancer teams and improve the experience of cancer patients through the delivery of seamless care.

4.5 Lastly, it is important to note that the relocation would reduce the inequalities in access to health care for the population of Merseyside and Cheshire as a whole. The majority of CCO's patients (67%) live north of the River Mersey. The general characteristics of this population are that they suffer from the highest death rates from cancer in England, and that they are amongst the poorest citizens and consequently are less able to travel to access health services. Logically, the main cancer centre should be located where the majority of its patients can access it with relative ease; this is in central Liverpool. The impact on travel times of these proposals has been considered.

5.0 TIMESCALES

5.1 It is estimated that the Cancer Centre scheme could open with, or shortly after, the new Royal Liverpool Hospital in 2017. This would involve the completion and approval of outline and full business cases by the Board of CCO – and monitor assessment of each – and the completion of formal public consultation. It is considered that the clinical and service case for change has been made effectively.

6.0 STAKEHOLDER INVOLVEMENT

6.1 It is now vital to involve a wider range of stakeholders in the debate. It is proposed that the plans identified in this paper, and the real and continuing benefits for patients that these plans are designed to bring, are shared with a wider range of stakeholders immediately. This will ensure that people are informed about the reasons for the proposed changes and that they have an opportunity to comment on and influence these plans. Staff in the Cheshire and Merseyside PCT Clusters, supported by the MCCN have developed a stakeholder involvement plan and are in a position to launch these plans after PCT Cluster agreement. It is proposed that this will be led by the Cheshire PCT Cluster, with Merseyside leads involved closely.

7.0 POLICY IMPLICATIONS

7.1 These are contained within the report.

8.0 **OTHER/FINANCIAL IMPLICATIONS**

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

9.1 **Children & Young People in Halton**
Please see 9.3

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

9.3 **A Healthy Halton**
The development of a Comprehensive Cancer Centre will impact on the health of cancer patients in Halton. All patients would benefit from greater participation in international-standard research and clinical trials. The closer physical integration between the Royal Liverpool University Hospital and Clatterbridge Centre for Oncology, would enable greater collaboration between cancer teams and improve the experience of cancer patients through the delivery of seamless care. The relocation of the Cancer Centre, would reduce the inequalities in access to health care for the population of Merseyside and Cheshire as a whole.

9.4 **A Safer Halton**
N/A

9.5 **Halton's Urban Renewal**
N/A

10.0 **RISK ANALYSIS**

10.1 Patients would access the new Cancer Centre for more complex care or require inpatient facilities, which would require traveling to Liverpool as opposed to Clatterbridge. If stakeholders do not support the options for the development of a new Cancer Centre, the level of care and access to cancer support services will remain at its current level. As cancer rates in the local population are higher than the national average in some cases, this may cause increased demand and pressures on current local health services.

11.0 **EQUALITY AND DIVERSITY ISSUES**

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

12.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**
None under the meaning of the Act.

APPENDIX 1

Scrutiny Briefing Report

Overview and Scrutiny Board

Briefing Report Title: Comprehensive cancer Centre for Cheshire & Merseyside

Date: 10th February 2012

Contact: Leonie Beavers, Managing Director
Liverpool PCT and Jackie Robinson, Head of Engagement & Involvement, NHS Merseyside, Nutgrove Villa, Huyton, Tel: 0151 244 3459

Directorate: NHS Merseyside Cluster

Scrutiny Theme: Health Policy and Performance Board

1. Overview

This briefing paper seeks to provide information on the work that has been taking place in Cheshire and Merseyside to consider and bring forward proposals for the development of World Class Cancer Services in Cheshire and Merseyside through the establishment of a new Cancer Centre in Liverpool and the further development of services across the area.

To ask for support for the delivery of a wide-ranging communication and involvement exercise designed to share the proposals with a wide range of stakeholders across Cheshire and Merseyside and further afield where appropriate.

2. Background

Cancer incidence and mortality in Cheshire and Merseyside

2.1 Incidence (new cases) and mortality (death rates) represent a major challenge within Merseyside and Cheshire. For all cancers combined, the incidence of new cancers (Fig.1) and cancer mortality rates across the network are higher than the national average. Breast, lung, colorectal, prostate and upper gastro-intestinal (GI) cancers account for over 90% of all new cases of cancer and over 75% of cancer deaths, both nationally and across the cluster.

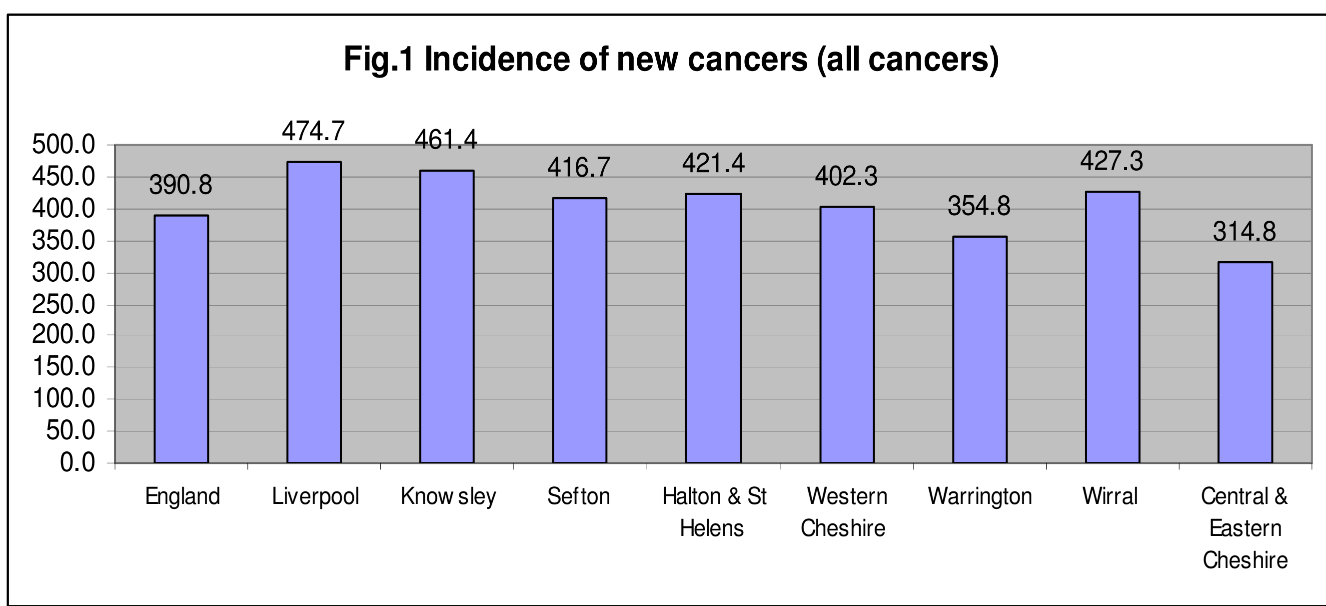
2.2 The incidence of new cases of breast cancer across the cluster is lower than the national average. Mortality rates for breast cancer across the cluster are lower than the national average except for in Liverpool. The incidence of new cases of **lung cancer** across the cluster is higher than the national

average and almost twice the national rate in Liverpool and Knowsley. Similarly, lung cancer mortality rates across the cluster are higher than the national average and almost twice the national rate in Liverpool and Knowsley.

2.3 The incidence of new cases of colorectal cancer and colorectal cancer mortality rates are higher across the cluster than the national average. The incidence of new cases of prostate cancer across the cluster is lower than the national average except for Sefton. Prostate cancer mortality rates across the cluster are higher than the national average. The incidence of new cases of upper GI cancer across the cluster is higher than the national average (Fig.13). Similarly, upper GI cancer mortality rates across the cluster are higher than the national average.

NB

- All incidence and mortality rates are per 100,000 population
- Incidence data is for 2006-8
- Mortality data is for 2007-9



Current configuration of cancer services

Hospital Cancer Services

Thirteen hospital trusts provide cancer services within the Merseyside and Cheshire Cancer Network. Ten of these 13 are designated to provide specific specialist (tertiary) cancer services. Table 1 **Error! Reference source not found.**shows which hospitals host specialist teams, most of which have been officially designated by commissioners through the cancer network in response to NICE improving outcomes guidance. The table also shows which

hospitals provide non-specialist (secondary care level) diagnostic and treatment services for their local populations

Table 1: The distribution of specialist cancer services in the network

	Aintree University	Alder Hey Children's	Betsi Cadwaladr	Clatterbridge Centre for	Countess of Chester	Liverpool Heart and	Liverpool Women's	Royal Liverpool and	Southport and Ormskirk	St Helens and Knowsley	The Walton Centre	Wirral University	Warrington and Halton
Local cancer services[1]	✓		✓		✓	Lung only	Gynae only	✓	✓	✓		✓	✓
Anal								✓					
Brain & CNS											✓		
Chemotherapy[2]	Clinic			✓	clinic			clinic	clinic	clinic			clinic
Children's		✓											
Head & neck	✓												
Liver	✓												
Lung surgery						✓							
Neuro-endocrine[3]	✓							✓					
Ocular								✓					
Oesophago-gastrc	✓		✓			✓							
Pancreas								✓					
Radiotherapy	✓			✓									
Sarcoma								✓					
Specialist gynae							✓						
Specialist haematology								✓					
Specialist skin[4]								✓		✓			
Teenage & young adult[5]		✓		✓				✓					
Testicular								✓					
Specialist urology								✓				✓	

[1] 'Local cancer services' defined as diagnosing and treating most common cancers.
[2] Clatterbridge provides out-reach clinics for daycase chemotherapy on several hospital sites.
[3] A single neuro-endocrine specialist multidisciplinary team (MDT) is managed jointly by Aintree and the Royal.
[4] Specialist skin MDT is hosted by St Helens & Knowsley. Associated unit is the Royal for T-cell lymphoma.

Radiotherapy

Clatterbridge Centre for Oncology NHS Foundation Trust (CCO) is the sole provider of radiotherapy within the Merseyside and Cheshire Cancer Network (MCCN). The centre is based in Bebington on Wirral and treats around 5,500 patients with radiotherapy each year. A course of treatment for most patients will be made up of a series of appointments during which they will receive fractions of their overall dose of radiotherapy. CCO delivers approximately 83,000 fractions of radiotherapy each year. Ninety per cent of these treatments are for patients living within the Merseyside and Cheshire Cancer Network area.

Although 67% of the patients served by CCO live north of the River Mersey, CCO is located south of the river. Relative to the number of new cancers diagnosed, the PCTs on the south side of the river (Wirral and Western Cheshire) account for a larger number of the radiotherapy fractions delivered within the network, compared with patients elsewhere in the network, although it must be noted that the Sefton population appear to benefit from higher radiotherapy rates than other PCTs north of the Mersey, which might be explained by the higher numbers of older residents.

It would appear that the patients who live closest to the radiotherapy centre benefit from greatest access to treatment. The effect of distance upon access may be most apparent in the frailest of patients.

To improve access for patients, CCO opened a satellite radiotherapy unit adjacent to the Walton Centre in early 2011. This provides services for patients requiring radical (curative) radiotherapy for breast, prostate and lung cancer as well as stereotactic radio-surgery. This benefits around 900 patients a year (a little over a third of the total number of patients living north of the River Mersey who need radiotherapy). Patients needing more complex radiotherapy or who have other medical needs, cannot be treated at a satellite unit as they require the full medical support only available in a cancer centre. Thus many Cheshire and Merseyside residents continue to need access to the service at Clatterbridge

Chemotherapy

Chemotherapy for haematological malignancies is delivered under the care of consultant haematologists in local hospitals operating within local multidisciplinary teams. Patients requiring specialist diagnosis and treatment are managed through the multidisciplinary team based at the Royal Liverpool University Hospital. Chemotherapy for solid tumours (i.e. non-haematological) is delivered under the care of oncologists employed by Clatterbridge Centre for Oncology. All inpatient chemotherapy is given at CCO’s base in Bebington on Wirral, but patients can access outpatient or day-case chemotherapy more locally

through 11 weekly clinics operated by CCO oncologists on six hospital sites. Approximately 70% of chemotherapy patients are treated in these clinics and this is set to rise as nearly all new chemotherapy treatments expected to come into clinical practice will not require an inpatient stay.

Surgical oncology

Most patients requiring surgery for cancer are able to have their operation at their local hospital, under the care of a local multidisciplinary team. This is the case for many common cancers, such as breast and bowel, where there are sufficient numbers of patients to maintain the surgical skills of local teams.

Patients with less common cancers, or those requiring more complex operations, will have their care managed by specialist multidisciplinary teams hosted in fewer, designated hospitals. Largely in response to national guidance from the National Institute for Health and Clinical Excellence (NICE), the centralisation of specialist surgery has quickened pace over the last decade.

Pathology

With the exception of Clatterbridge Centre for Oncology and Liverpool Heart and Chest Hospital, each trust in the network hosts a pathology department. These departments are not homogenous, and they operate as a network to ensure that all patients have access to clinically appropriate pathology tests and expertise irrespective of where they live and what their local hospital can provide. The pathology departments in each of the general acute trusts provide a broad range services which reflect the hospital services they provide. Where a trust hosts a specialist multidisciplinary team, the trust's pathology department likewise develops specialist expertise.

Radiology and nuclear medicine

All trusts in the network have a radiology department that supports day to day clinical services. As with pathology departments, the radiology teams work as a network so that patients requiring more specialist imaging or interventional radiology procedures can be referred on to other trusts if their local trust does not provide the service.

Proposals to improve and develop Cancer Services in Cheshire and Merseyside

In 2008 the **Merseyside and Cheshire Cancer Network (MCCN)** commissioned an expert review of the configuration of Cancer Services in Cheshire and Merseyside with the aim of developing recommendations to ensure that services were delivered in the most optimal way to improve outcomes for patients. The resulting report 'The organisation and delivery

of non-surgical oncology services in the Merseyside and Cheshire Cancer Network'[6] was presented to the Cancer Taskforce in October 2008. In brief, the report summed up certain reasons for considering a change in the service model location and delivery of non-surgical oncology in the MCCN area including:

- Encouraging the major expansion of radiotherapy through the development of satellite radiotherapy units closer to the populations served and limiting the size of major centres to a maximum of eight LINACs.
- The decentralisation of chemotherapy requiring a larger clinical workforce with a greater local presence than is currently available.
- More flexible service delivery models required which were less dependent on a single centre and more served through networks of care.
- The increasing use of multi-modality treatment regimes suggesting that, in the longer term, isolated oncology centres were no longer appropriate.
- The organisation of hospital services in MCCN meant that integrated cancer care was dependent on oncologists to secure the integrity of patient pathways. It was more difficult to achieve this from a remote centre.
- The needs of the network population were high in terms of cancer care but the results were likely to be inhibited by poor accessibility to oncology services as well as by late presentation. Closer alignment of oncologist to local providers would shift the balance of leadership in cancer care and would support improving the overall organisation and delivery of care.
- Developing cancer research in Liverpool, an essential component of all cancer care and of medical research, was compromised by the absence of academic oncology leadership. The isolation of the current cancer centre and its distance from surgical oncology and MDTs were factors in the difficulty in addressing this deficiency.

Since that time the PCTs in Cheshire and Merseyside have supported the establishment of additional Consultant Oncology posts across the region, (and associated additional clinical nurse specialists), a satellite radiotherapy unit has been opened by CCO on the Aintree Hospital site and a Chair in Medical Oncology has been appointed by the University of Liverpool. In addition CR:UK have opened research centre in Liverpool adjacent to the RLBUHT site.

However, despite these developments, certain ongoing issues still need to be addressed if local people are to receive the highest quality care available and to benefit from the best possible clinical outcomes. First and foremost is the issue of the geographical location of the specialist Cancer Centre on the Clatterbridge hospital site. In their report Baker and Cannon confirmed that

"When it was first established, the Clatterbridge campus provided a wide range of medical and surgical services; this is no longer the case and the oncology facilities are now isolated from modern medical and surgical practice. During this time, the complexity of cancer treatments has increased dramatically, patients are older and sicker and the treatments have more side effects. In most cancer centres, most of the beds are used for patients who are seriously ill because of their underlying cancer or because of the side effects of treatment. The management of these conditions requires ready access to both critical care facilities and the on-site access to the full range of general medical and surgical expertise. This is no longer possible at Clatterbridge".

In their work to look at options for the future location of the specialist centre to address the issues above, Baker and Cannon looked at a long list of nine options which were assessed against ten criteria. The preferred option, following this appraisal process, proved to be **the move of the main oncology centre to the Royal Liverpool Hospital site with a link oncology centre at Aintree Hospitals and a local unit retained on the Clatterbridge site. This preferred option was considered and supported by the Cancer Taskforce, which included representatives from Trusts and PCTs across the network.**

In considering this option and the support for the establishment of a comprehensive cancer centre on the site of the Royal Liverpool Hospital it was noted that such a centre would:

- Ensure better co-ordination of pathways of care for cancer patients by bringing together key specialist services on a single campus, which currently hosts the majority of Cancer Multi-Disciplinary Teams (MDTs).
- Ensure that patients benefit from closer integration between the NHS and research teams within the University of Liverpool and other key research partners e.g. CR:UK
- Ensure that specialist services are located in a place most easily accessible to the majority of patients so that more patients could benefit from improved access particularly those who need repeated and regular radiotherapy for certain types of cancer and for palliation
- Make best use of NHS resources by enabling clinical teams to work more effectively and efficiently together
- Be a focus for innovation and knowledge, complementing and amplifying the efforts of all partners including local employers and councils to promote the region as a premier choice for investment
- Maintain those NHS services which are best delivered in more local settings including local district general hospitals and the community.

Importantly, the development of a comprehensive cancer centre would bring the inpatients facilities for radiotherapy and chemotherapy onto a single large acute teaching hospital campus that already offers a wide range of specialist cancer services that would benefit patients from across the network.

Benefits for patients living in Wirral and Cheshire

In making the above recommendations it is recognised that certain patients will have to travel further for certain elements of their care. However, it is important to emphasise that radiotherapy and chemotherapy services would continue to be provided on the original Clatterbridge site. Outpatient chemotherapy services, and radiotherapy services for patients with more common cancers such as breast, prostate and lung would continue to be provided on the site for local patients. Only those patients who require more complex treatment, or require inpatient facilities, would be required to travel to the new centre in Liverpool.

It is also important to emphasise that the current location of the cancer centre has no critical care facilities (i.e. high dependency or intensive care unit) or acute medical cover. Increasingly complex chemotherapy and radiotherapy treatments require these services and these can only be provided on a full acute hospital site. Keeping the cancer centre isolated on a non-acute site is regarded as unsustainable by senior clinical advisors.

Thirdly, senior clinicians believe very strongly that cancer research will be strengthened by closer integration between the University of Liverpool, Cancer Research UK, Clatterbridge Cancer Research, the Royal Liverpool University Hospital and Clatterbridge Centre for Oncology NHS Trust. The Clatterbridge Cancer Research laboratories have recently relocated to share the ‘bio-campus’ with other partners in central Liverpool. Only CCO remains physically isolated from this important and growing research community. By relocating CCO, all patients, including those from Wirral and Western Cheshire, would benefit from greater participation in international-standard research and clinical trials.

Fourthly, the Royal Liverpool University Hospital employs the greatest number of specialist cancer doctors and other clinical professionals. Most specialist cancer surgical teams for residents of Merseyside and Cheshire and based at the Royal Liverpool, and the hospital also hosts the majority of specialist cancer pathology and radiology services for the region. **Patients from Wirral and Cheshire already travel to the Royal Liverpool University Hospital site for treatment and care.** Closer physical integration between the Royal Liverpool University

Hospital and Clatterbridge Centre for Oncology would enable greater collaboration between expert cancer teams and improve the experience of cancer patients through the delivery of seamless care.

Lastly, it is important to note that the relocation would reduce the inequalities in access to health care for the population of Merseyside and Cheshire as a whole. The majority of CCO's patients (67%) live north of the River Mersey. The general characteristics of this population are that they suffer from the highest death rates from cancer in England, and that they are amongst the poorest citizens and consequently are less able to travel to access health services. Logically, the main cancer centre should be located where the majority of its patients can access it with relative ease; this is in central Liverpool. The impact on travel times of these proposals has been considered

Primary Care Trust Board Consideration

All Primary Care Trusts (PCTs) in the Merseyside and Cheshire Cancer Network have received and approved two previous papers relating to non-surgical oncology services and Clatterbridge Centre for Oncology NHS Foundation Trust. The first paper (March/April 2008) sought PCT boards' support for an expansion of radiotherapy services through the development of two satellite services: one adjacent to the Walton Centre and one adjacent to the Royal Liverpool University Hospital.

The second paper (June/July 2009) presented the recommendations from the Baker and Cannon report. That paper noted that relocation of CCO into Liverpool, whilst desirable, would take several years to plan and deliver, and so a series of interim measures were proposed. These measures involved:

- the enhancement of clinical services at Clatterbridge Centre for Oncology to improve care for acutely ill patients;
- the establishment of an academic oncology unit at the Royal Liverpool University Hospital in partnership with the University of Liverpool and Clatterbridge Centre for Oncology;
- the development of acute oncology services to enhance the care for cancer patients in all acute hospitals in Merseyside and Cheshire;
- the establishment of radiotherapy facilities at the Royal Liverpool University Hospital site including a potential underwriting of any access premium from Liverpool and Knowsley PCTs.

PCT boards approved these measures in principle and endorsed Liverpool PCT to lead on the procurement of radiotherapy facilities on the Royal Liverpool site through an open competitive tender.

Co-ordinated through the cancer network, significant progress on all of these initiatives has been made since then as identified in section 5

above. Work to take forward the procurement of satellite radiotherapy facilities at the Royal Liverpool Hospital site was initiated and has involved detailed analyses of clinical models of care, informed by a number of clinical experts from both within the network across England. Following detailed consideration the cancer network and the radiotherapy procurement team led by Liverpool PCT agreed that the benefits to patients that could be derived from a satellite facility at the Royal would be outweighed by the cost of delivery and confirmed that **a larger-scale relocation of CCO, as per the central recommendation of the Baker and Cannon report and within an earlier timescale, would offer far greater benefits to all patients Cheshire and Merseyside and would represent far greater value for money**. Thus Liverpool PCT and the Cancer Network agreed the need to support the development of proposals for the establishment of a Comprehensive Cancer Centre on the Royal Liverpool Hospital site in tandem with plans to rebuild the new Royal Liverpool Hospital.

Detailed proposals

As a result of this situation, in autumn 2010 Pricewaterhouse Coopers (PwC) were engaged by Liverpool PCT to undertake a high level affordability study to review the cost and affordability of building a new comprehensive Cancer Centre co-located with a redeveloped Royal Liverpool hospital. The final report was published in March 2011. The study reviewed 2 options - **a Standalone Cancer Centre and a Cancer Centre with an element of shared services with the RLBUH.** The capital cost of both options (based on 80 inpatient beds) was **£116.5m** and **£105.2m respectively (both excluding VAT)**.

Following the production of the PwC report, the PCT requested that CCO and the RLBUH work in partnership to bring forward a proposal which would maximise the potential for using shared clinical and non clinical support services and infrastructure, where appropriate, to drive down both capital and revenue costs, whilst ensuring the Value for Money was maximised for taxpayers.
The key elements of the PCT vision were:-

- Relocation of the Specialist Cancer Centre to the redeveloped Royal Hospital site.
- Enhanced research capacity (symbolised by more research beds).
- Reconfiguration of the existing Clatterbridge site infrastructure to provide satellite radiotherapy, proton therapy, chemotherapy and out-patient service.
- Retention of the satellite radiotherapy service adjacent to the Walton centre and
- Maintenance of CCO’s current range of existing network clinic arrangements.

To progress this request, a Joint Clinical Workshop was held in May 2011 with senior colleagues from CCO, RLBUHT, the University of Liverpool and the Cancer Network. This was a very productive workshop and a strong, collective agreement was reached across both Trusts on a joint vision for the future provision of Cancer Services. This vision enunciated:

"The creation of a World Class Comprehensive Cancer Centre, co-located on the new RLBUH site for the Merseyside and Cheshire Network, which brings together in partnership for the first time specialist NHS cancer services with the University of Liverpool and other research partners on a single acute campus enabling :

- ***Seamless pathways of patient centred care for our patients.***
- ***Best Use of NHS resources.***
- ***A centre of excellence for Cancer treatment and research.***
- ***Best possible cancer care and health outcomes**."*

This vision was supported by both Trust Boards subject to affordability.

Subsequent to the workshop both Trusts have worked together to consider and bring forward a more affordable proposal which incorporates

- A new build Clatterbridge Cancer Centre adjacent to the proposed new build Royal Liverpool Hospital (RLH).
- A separate, dedicated entrance for the Cancer Centre.
- The majority of cancer inpatient services provided by Clatterbridge Cancer Centre, to be accommodated within the RLH scheme with flexibility within the cancer centre to provide additional, flexible inpatient / day care services.
- Radiotherapy, chemotherapy, dedicated imaging and outpatient services to be provided within the Cancer Centre.
- Appropriate, dedicated patient and staff access links between the Cancer Centre and RLH buildings with required clinical adjacencies conducive to effective and efficient delivery of patient care and clinical trials.
- A dedicated adjacent free car parking facility for cancer patients.
- Clinical Trials Unit to be provided in collaboration with RLH and the University assuming essential laboratory support of the Cancer Centre.
- Cytotoxic pharmacy to remain on the CCO Wirral site.
- A satellite facility to remain on the CCO Wirral site comprising ambulatory, radiotherapy and chemotherapy, outpatients services and proton therapy.

Timescales

It is estimated that the Cancer Centre scheme could open with, or shortly after, the new Royal Liverpool Hospital in 2017. This would

involve the completion and approval of outline and full business cases by the Board of CCO - and Monitor assessment of each - and the completion of formal public consultation. It is considered that the clinical and service case for change has been made effectively.

Stakeholder involvement

It is now vital to involve a wider range of stakeholders in the debate. It is proposed that the plans identified in this paper, and the real and continuing benefits for patients that these plans are designed to bring, are shared with a wider range of stakeholders immediately. This will ensure that people are informed about the reasons for the proposed changes and that they have an opportunity to comment on and influence these plans. Staff in the Cheshire and Merseyside PCT Clusters, supported by the MCCN, have developed a stakeholder involvement plan and are in a position to launch these plans after PCT Cluster agreement. It is proposed that this will be led by the Cheshire PCT Cluster, with Merseyside leads involved closely.

Scrutiny Action

- Note the background to and the progress achieved with regard to the plans for cancer services in Merseyside and Cheshire since 2008.

- Take account of the progress and intentions outlined above, in the Cheshire and Merseyside

- Support the delivery of inclusive stakeholder involvement and engagement plans, led by Cheshire PCT Cluster with strong support from Merseyside.

Conclusion

Overview and Scrutiny Committee are asked to discuss and note the proposals and to identify any further information they would wish to receive as part of the cancer development proposals.

Agenda Item 5d

REPORT TO: Health Policy and Performance Board

DATE: 6th March 2012

REPORTING OFFICER: Strategic Director – Policy & Resources

PORTFOLIO: Resources

SUBJECT: Sustainable Community Strategy Performance Framework 2011 – 16 and Mid- Year Progress Report 2011/12.

WARDS: Borough-wide

1.0 PURPOSE OF REPORT

1.1 To provide information on the progress in achieving targets contained within the 2011- 2016 Sustainable Community Strategy for Halton.

2.0 RECOMMENDED THAT:

i. The report is noted

ii. The Board considers whether it requires any further information concerning the actions taken to achieve the performance targets contained within Halton's 2011–16 Sustainable Community Strategy (SCS) arising from the mid year review.

3.0 SUPPORTING INFORMATION

3.1 The Sustainable Community Strategy, a central document for the Council and its partners, provides an evidenced-based framework through which actions and shared performance targets can be developed and communicated.

3.2 The previous Sustainable Community Strategy included targets which were also part of the Local Area Agreement (LAA). In October 2010 the coalition government announced the ending of government performance management of local authorities through LAAs. Nevertheless, the Council and its partners need to maintain some form of effective performance management framework to:-

- Measure progress towards our own objectives for the improvement of the quality of life in Halton.
- Meet the government's expectation that we will publish performance information.

3.3 Thus, following extensive research and analysis and consultation with all stakeholder groups including Elected Members, partners and the

local community and representative groups, a new SCS (2011 – 26) was approved by the Council on 20th April 2011.

3.4 The new Sustainable Community Strategy and its associated “living” 5 year delivery plan (2011-16), identifies five community priorities that will form the basis of collective partnership intervention and action over the coming five years. The strategy is informed by and brings together national and local priorities and is aligned to other local delivery plans such as that of the Halton Children’s Trust. By being a “living” document it will provide sufficient flexibility to evolve as continuing changes within the public sector continue to emerge.

3.5 As such, articulating the partnership’s ambition in terms of community outcomes and meaningful measures and targets to set the anticipated rate of change and track performance over time, will further support effective decision making and resource allocation.

3.6 The views of Lead and Senior Officers and Elected Members have been captured in a number of forums within Halton BC and Partner organisations, via the Health SSP and Health Performance Sub Groups, who were consulted on the selection of appropriate measures and targets in the period April to October 2011.

3.7 Selected measures and targets for Health in Halton’s strategic community priorities are summarised in Appendix 1, using the Halton Corporate template, designed for the purpose of bringing together all relevant items of performance information. For instance, this considers the levels of performance that have been achieved to date and provides a contextual backdrop in relation to national, regional and statistical neighbours. The template also provides a clear evidence based rational for measure selection, which will further evidence and support value for money judgements by the Audit Commission and ensure outward accountability.

3.8 Placeholder measures have also been included where new services are to be developed or new performance information is to be captured, in response to legislative changes; for which baselines for will be established in 2011/12 or 2012/13, against which future services will be monitored.

3.9 An annual ‘light touch review‘ of targets contained within the SCS, will also ensure that targets remain realistic over the 5 year plan to ‘close the gaps’ in performance against regional and statistical neighbours.

3.10 Attached as Appendix 2 is a report on progress to the 2011-12 mid – year position which includes a summary of all indicators within the new Sustainable Community Strategy and additional information for those specific indicators and targets that fall within the remit of this Policy & Performance Board.

4.0 CONCLUSION

4.1 The Sustainable Community Strategy for Halton, and the performance measures and targets contained within it will remain central to the delivery of community outcomes. It is therefore important that we monitor progress and that Members are satisfied that adequate plans are in place to ensure that the Council and its partners achieve the improvement targets that have been agreed.

5.0 POLICY IMPLICATIONS

5.1 The Sustainable Community Strategy for Halton is central to our policy framework. It provides the primary vehicle through which the Council and its partners develop and communicate collaborative actions that will positively impact upon the communities of Halton.

6.0 OTHER IMPLICATIONS

6.1 The publication by Local Authorities of performance information is central to the coalition government’s transparency agenda.

7.0 IMPLICATIONS FOR THE COUNCIL’S PRIORITIES

7.1 This report deals directly with the delivery of the relevant strategic priorities of the Council.

8.0 RISK ANALYSIS

8.1 The key risk is a failure to improve the quality of life for Halton’s residents in accordance with the objectives of the Sustainable Community Strategy. This risk can be mitigated thorough the regular reporting and review of progress and the development of appropriate actions where under-performance may occur.

9.0 EQUALITY AND DIVERSITY ISSUES

9.1 One of the guiding principles of the Sustainable Community Strategy is to reduce inequalities in Halton.

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

Document	Sustainable Community Strategy 2011 – 26
Place of Inspection	2nd Floor, Municipal Building, Kingsway, Widnes
Contact Officer	Hazel Coen DM (Performance & Improvement)

APPENDICES

Appendix 1 - Health SCS Performance Framework 2011-16.
Appendix 2 - Mid Year SCS Progress Report for 2011/12

APPENDIX 1 - HEALTHY HALTON

Background Information to the Sustainable Community Strategy Partnership Indicators 2011/12 to 2015/16

Index:

Definition	Lead Partner	Responsible Officer	Page
Alcohol related hospital admissions (NI 39)	PCT	Collette Walsh	2
Prevalence of breastfeeding at 6-8 weeks (NI 53)	PCT	Julia Rosser/Caroline Lees	5
Obesity in Primary school age children in Reception (NI 55)	PCT	Eileen O'Meara	7
Obesity in Primary school age children in Year 6 (NI 56)	PCT	Eileen O'Meara	8
Reduction in under 18 Conception (new local measure definition for NI 112)	HBC	Lorraine Crane/ John Bucknall	9
All age, all cause mortality rate per 100,000 Males (NI 120a)	PCT	Sue Forster	11
All age, all cause mortality rate per 100,000 Females (NI 120b)	PCT	Sue Forster	13
Supporting PI: Mortality rate from all circulatory diseases at ages under 75 (NI 121)	PCT	Sue Forster/ Sarah Johnson	15
Supporting PI: Mortality from all cancers at ages under 75 (NI 122)	PCT	Sue Forster/ Daniel Seddon	16
16+ Smoking quit rate per 100,000 (NI 123)	PCT	Eileen O'Meara	17
Mental Health - No. of people in counselling/ day services or on waiting lists. **(NEW)**	PCT	Dave Sweeney/ Lyn Marsden	18
Social Care **(NEW)**: Proportion of older people supported to live at home through provision of a social care package	HBC	Sue Wallace-Bonner	19
Increase the % of successful completions (drugs) as a proportion of all in treatment (over 18)	HBC / PCT	Steve Eastwood	20
Increase the % of successful completions (Alcohol) as a proportion of all in treatment (over 18)	HBC / PCT	Collette Walsh	21

Background information

Statistical Neighbours for Halton performance information

- Hartlepool
- St Helens
- Tameside
- Redcar and Cleveland
- Sunderland
- Stockton-on Tees
- Darlington
- North East Lincolnshire
- Salford
- South Tyneside

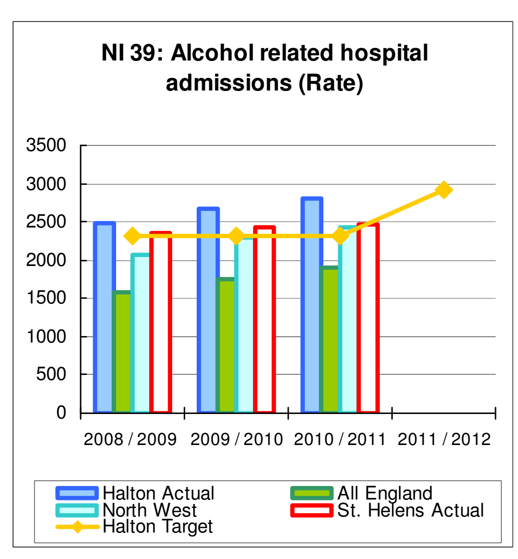
APPENDIX 1 - HEALTHY HALTON

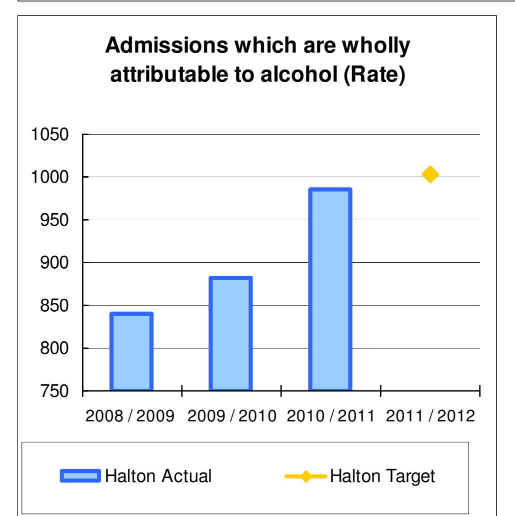
Merseyside Cluster local authorities:

Knowsley Metropolitan Borough Council
Liverpool City Council
Sefton Council
St Helens Metropolitan Borough Council
Halton Borough Council

APPENDIX 1 - HEALTHY HALTON

Alcohol related hospital admissions (NI 39)	
Lead Partner Agency:	PCT
Responsible Officer:	Collette Walsh
Good is:	A lower rate of admission than the projected trend.





Brief Description / Indicator Purpose:

This indicator measures the rate of alcohol related admissions per 100,000 population using Hospital Episode Statistics.

The rate is calculated using data on those finished admissions that are classified as ordinary or day cases or maternities and that have an alcohol-related primary or subsidiary diagnosis code within the admission episode. Each admission is assigned an attributable fraction based on the diagnosis codes and age and sex of the patient. Where an admission has more than one relevant diagnosis code, the highest attributable fraction is used. Negative attributable fractions are not used. In the case of children aged under 16, only alcohol-specific diagnoses are used (those with an attributable fraction of 1.)

These values are then aggregated to obtain totals by sex and five-year age band. The resultant totals are then divided by the corresponding population estimate to get an age/sex-specific rate. Each rate is then multiplied by the corresponding figure in the standard European age profile and aggregated. The rate is obtained by dividing the aggregated figure by the total European standard population.

	2008/09	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
Target 1 :Halton alcohol related hospital admission Target (NI39) (Rate)	2313	2323	2309	2916	3027	3142	3261	3385
Halton alcohol related hospital admission Actual (Rate) Previously NI 39	Synthetic estimate 2486	Synthetic estimate 2680	Predicted Value 2809					
Relevant Statistical Neighbour Target (St. Helens)[2]				2442.8	2521.2	2571.6		
Target 2: Halton AAF 1 Target (Rate)				1002.6	1020.7	1039.0	1057.8	1076.8
Halton AAF 1 actual (Rate)	841	882.3	984.9					

APPENDIX 1 - HEALTHY HALTON

Number of target AAF 1 admissions				1225	1247	1269	1292	1315
Actual number of AAF admissions	1027	1067	1203					
Benchmarking:								
All England	1582	1743	See note					
Northwest	2068	2295	See note					
St Helens [1]	2348	2433	See note					

Supporting Commentary & Target Rationale (2011 / 2012 Onwards):

Alcohol is a key priority for health and the wider partnership and should continue to be monitored by the Health SSP.

This is not a target for the IPM (Improved Performance Measures). Thus, the PCT will continue to monitor for no significant increase / deterioration in health performance.

Halton LA Alcohol Target

1) **Target 1 : AAF>0 (Previously NI 39).** The target is **2916 annual rate for 2011/12.** This is based on a projection of 4.8% increase in the rate from 2010/11 (synthetic estimate of 2809 10/11 rate). This is in line with the trend since 2002/3 – A decrease of 1% has then been calculated.
   This target is set utilizing verified data only.

2) **Target 2 : AAF= 1 Admissions which are wholly attributable to alcohol**
   In 20010/11 there were 1203 AAF 1 admissions that were wholly attributable to alcohol **(Rate 984.9)**. Given that we expect a 4.8% increase, we will then aim for a 3% reduction in the actual number of admissions for alcohol related AAF= 1 harm in 2011/12. This rationale has been projected through to 2015/16

Therefore: A 1.8% increase in the AAF1 admissions in 2011/12 would make the number of admissions 1225 and the rate **1002.6**

This target is set utilizing unverified local data only. There is a discrepancy between the verified and the local data due largely to the robust data cleansing that happens at a local level.

Target 2: 2011/12
To achieve an annual rate of 1002.6. This would equate to 1225 admissions, and a 3% reduction in the anticipated growth.

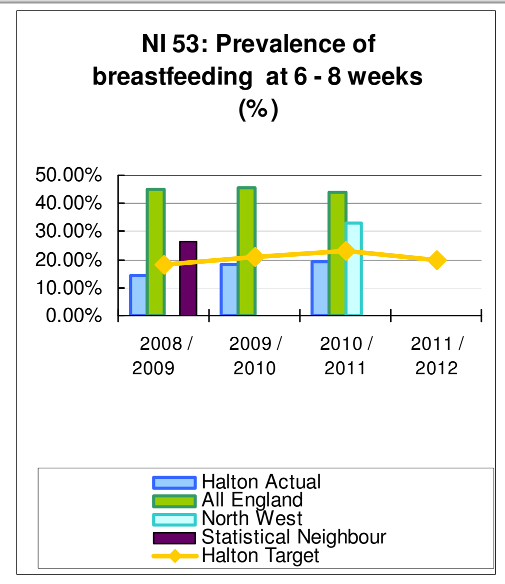
Target 2: 2012/13
To achieve an annual rate of 1020.7 This would equate to 1247 admissions, and a 3% reduction in the anticipated growth.

In both cases, the aim of the targets is to slow the trend and reduce the rate of increase.

[1] This could be from regional or family benchmarking data.

APPENDIX 1 - HEALTHY HALTON

Prevalence of breastfeeding at 6 - 8 weeks (%) (NI 53)



Lead Partner Agency:	PCT
Responsible Officer:	Julia Rosser/Caroline Lees
Good is:	An increase in the percentage coverage and prevalence year on year.

Brief Description / Indicator Purpose:

To provide an impetus to enhance health and children's support services to mothers to sustain breastfeeding and thus give children a good start early in life.

Coverage: 100 % known feeding stats of all babies agreed.

Worked Example:
If 500 children were due for 6 – 8 week checks in the quarter. 350 are recorded as being totally breastfed. 50 are recorded as being partially breastfed and 75 not breastfed at all, then:

Breastfeeding prevalence equals ((350 + 50)/500)) *100 = 80.0%.

Breastfeeding coverage equals ((350 + 50 + 75) /500)) * 100 = 95.0%.

	2008/09	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
Halton Target	18.00%	21.00%	23.00%	20%[1]	22%	24%	26%	28%
Halton Actual	14.06%	18.19%	19.18%					
Target (St. Helens)				25% per 90% known feeding stats	26% Per 95% known feeding stats	27% For 97.5% known feeding stats		
Benchmarking:								
All England	45.20%	45.40%	44.0%					
Northwest			32.7%					
Relevant Statistical Neighbour[2]				Consider to monitor versus St Helens or the Merseyside Cluster				

Supporting Commentary & Target Rationale (2011 / 2012 Onwards):

Breastfeeding prevalence rates are still challenging therefore it is recommended that this target is retained.

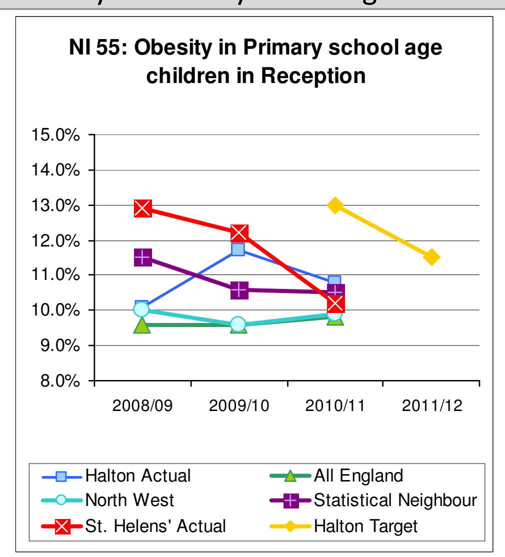
Target part of the IPM based on 3680 babies totally or partially breastfed at 6-8 weeks.

This target has been set and revised three times during the target setting process. The final 11/12 target of 20% is confirmed by the Public Health Breastfeeding Lead, Julia Rosser with the following rationale, the following years will need to reviewed every 12 months.

It is recommended that the 11/12 the target should be set at 20% (as an average over the year). This represents a 3.1% increase, and is a challenging target that is set above the Strategic Health Authority recommended target of 2%.
This target will be monitored in conjunction with breastfeeding initiation rates 74.6% England Average (Source - Child Health Profile Feb 2011). Breastfeeding initiation rates are not reported at a LA level, instead they are reported at PCT level and full year 10/11 result was 48.56% and Q3 YTD was 48.6%.

[2] This could be from regional or family benchmarking data.

Obesity in Primary school age children in Reception (NI 55)



Lead Partner Agency:	PCT
Responsible Officer:	Eileen O'Meara
Good is:	Good performance is: • A reduction in the proportion of obese children over time, • A minimum of 85% of eligible pupils being measured.

Brief Description / Indicator Purpose:

The percentage of children in reception who are obese, as shown by the National Child Measurement Programme (NCMP).

Data is reported one year in arrears.

For the purposes of this indicator, children are defined as obese if their body-mass index (BMI) is above the 95th centile of the reference curve for their age and sex according to the UK BMI centile classification (Cole TJ, Freeman JV, Preece MA. Body mass index reference curves for the UK, 1990. 1995; 73: 25–29). A child's height (in metres), weight (in kilograms), date of birth and sex are needed to calculate their BMI.

	2008/09	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
Halton Target			13.00%	11.5%	11%	10.5%	10%	9.5%
Halton Actual[1]	10.1%	11.7%	10.8% [1]	12%				
St Helens (Target and Actuals)	14.3% (Actual 12.9%	14.1% (Actual 12.2%)	13.9% (Actual 10.2%)	11%	10%	9.5%		
Benchmarking:								
All England[1]	9.60%	9.60%	9.80%					
Northwest[1]	10.0%	9.60%	9.90%					
Relevant Statistical Neighbour [3]	11.50%	10.60%	10.50%	TBC				

Supporting Commentary & Target Rationale (2011 / 2012 Onwards):

Halton's performance for 2010 has shown fluctuation with a continued variable trend over the last few years. Halton remains above the national and north west average. Halton shows an increasing obesity rate in line with increasing obesity rates for the England and North West averages.

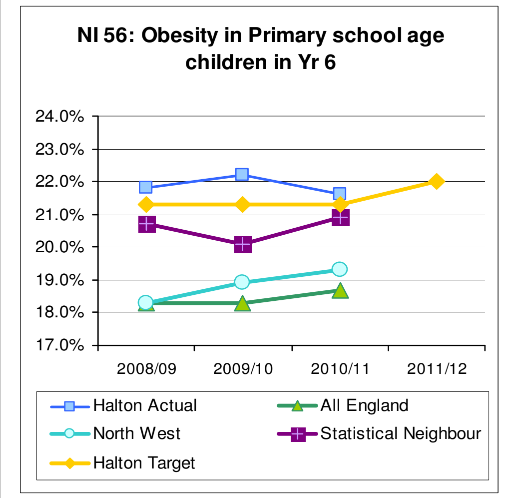
Targets for 2014/15 and 2015/16 set at the SSP Performance Group on 1.9.2011 by Eileen O' Meara and subsequently updated on receipt of the latest published 2010/11 Obesity rate for September 2010/11 12% .

Note 1 – Based on September 2009/10 NCMP NHS IC

[3] This could be from regional or family benchmarking data.

APPENDIX 1 - HEALTHY HALTON

Obesity in Primary school age children in Yr 6 (NI 56)



Lead Partner Agency:	PCT
Responsible Officer:	Eileen O'Meara
Good is:	Good performance is: • A reduction in the proportion of obese children over time, • A minimum of 85% of eligible pupils being measured.

Brief Description / Indicator Purpose:

The percentage of children in year 6 who are obese, as shown by the National Child Measurement Programme (NCMP).

For the purposes of this indicator, children are defined as obese if their body-mass index (BMI) is above the 95th centile of the reference curve for their age and sex according to the UK BMI centile classification (Cole TJ, Freeman JV, Preece MA. Body mass index reference curves for the UK, 1990. 1995; 73: 25–29). A child's height (in metres), weight (in kilograms), date of birth and sex are needed to calculate their BMI.

	2008/09	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
Halton Target			21.30%	22%	21.5%	21%	20.5%	20%
Halton Actual	21.8%	22.2%	21.60% [1]	23.7%				
Benchmarking:								
All England[1]	18.3%	18.30%	18.70%	TBC				
Northwest[1]	18.3%	18.90%	19.30%	TBC				
Relevant Statistical Neighbour [4]	20.7%	20.10%	20.90%	TBC				

Supporting Commentary & Target Rationale (2011 / 2012 Onwards):

Halton's performance for 2010 has show fluctuation with a continued variable trend over the last few years.

Halton remains above the national and north west average. Halton shows an increasing obesity rate in line with increasing obesity rates for the England and North West averages.

Agreed target should be retained as obesity rates in Halton are still high, now including obesity at reception

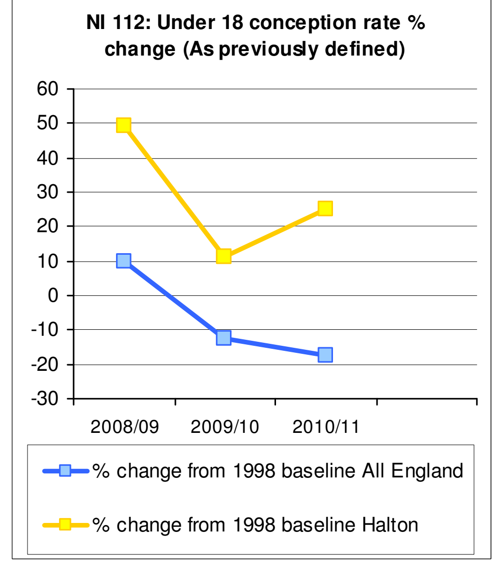
Targets discussed and reviewed at the Health SSP Performance Group on 1.9.2011 by Eileen O' Meara on 1.9.2011 to 2011/12 to 2015/16 and subsequently updated on receipt of the latest published 2010/11 Obesity rate for September 2010/11 23.7% .

Note 1 – Based on September 2009/10 NCMP NHS IC

[4] This could be from regional or family benchmarking data.

APPENDIX 1 - HEALTHY HALTON

Reduction in the Under 18 conception rate (NI 112)



Lead Partner Agency:	HBC
Responsible Officer:	Lorraine Crane/John Bucknall
Good is:	A reducing rate from the baseline year.

Brief Description / Indicator Purpose:

Previous guidance defines the national target to reduce the under 18 conception % rate by 50% by 2010 (compared to the 1998 baseline rate) as part of a broader strategy to improve sexual health. (Target shared between the Department of Health and the Department for Children, Schools and Families.) The old definition is graphed opposite.

To make this measure more meaningful this target will be monitored as a reduction in the rate per thousand rolling quarterly average annual rate from the 2009 baseline, and actual numbers of conceptions

	2008/09	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
Halton Target	Previously used a % reduction against the 1998 baseline in line with NI definition			58.1 Rolling Quarterly Av Rate Reduction of 1.43% (2 conceptions)	Reduction of 3%	Reduction of 3%	Reduction of 3%	Reduction of 3%
Halton Actual	70.5 Rolling Quarterly Av. Rate (Dec 07)	52.6 Rolling Quarterly Av. Rate (Dec 08)	58.9 Rolling Quarterly Av. Rate (Dec09)= 140 conceptions					
Benchmarking:								
Rate per 100 All England	41.8	40.5	38.2					
Rate per 1000 Northwest	47.2	45.9	47.3					

Supporting Commentary & Target Rationale (2011 / 2012 Onwards):

This is still a significant area of concern in Halton and it is therefore recommended that this target be retained.

The above table has been obtained from the Ofsted Performance Profile, showing the % change from the 1998 baseline of 47.3 conceptions per 1000 in 1998.

Halton's performance for 2010 has shown a significant drop in performance, with increases noted in the number of conceptions. Good performance is typified by a higher percentage reduction from the baseline year.

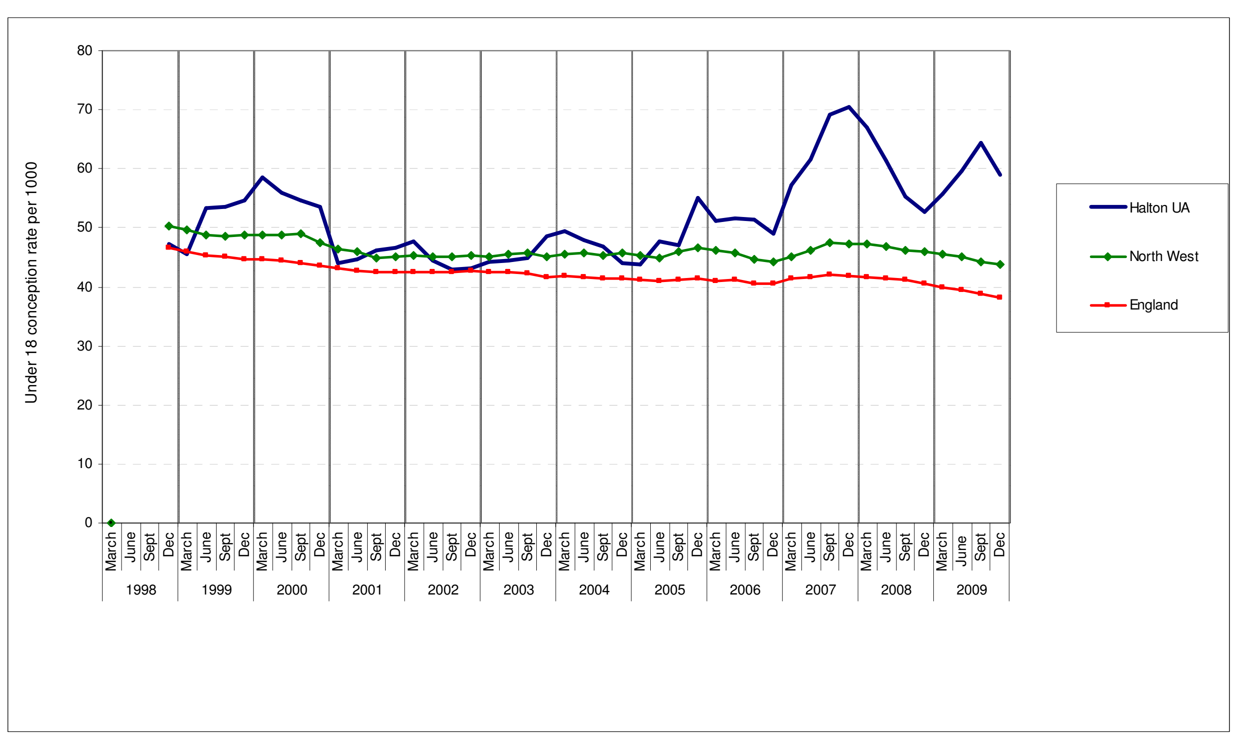
Halton remains considerably above the national average. At December 2009 (last published data) the England average was 38.2 per 1000 and the Regional average was 47.3 per 1000. Thus, a target of 21.3 conceptions per 1000 in 2010/11 (-55% from the 1998 baseline of 47.3 per 1000) was highly stretched.

The target was discussed and agreed by Children's & Enterprise SMT on 20.7.2011

APPENDIX 1 - HEALTHY HALTON

Halton has made a decision to use 2009 figures as a baseline in setting future targets for this area. Given that data is available in arrears, quarter 1 of 2011/12 relating to the latest information for the quarter ended March 2010, the target is to see a reduction of a reduction of 2 conceptions by Dec 2010. This equates to 1.43% reduction in the total conceptions for 2010 (140 conceptions) of the 2374 girls aged 15-17 in Halton) and then 3% year on year with a caveat to review.

The decision has also been made to monitor under 16's and 2nd conceptions but the under 18 conceptions will remain the overarching priority.

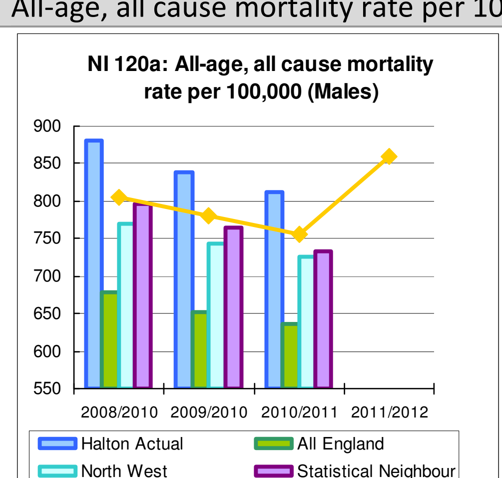


	2005	2006	2007	2008	2009	2010
Halton UA Total Population	2,537	2,553	2,539	2,492	2,374	2,281 Mar 2010
Average no. of conceptions per quarter (Rounded)	35	31	45	33	35	Not available

The latest ONS for Halton in Quarter 1 of 2010 is 60.7 rolling quarterly average per 1000 girls aged between 15 and 17. This equates to 40 actual births. The impact of seasonal variations will continue to be closely monitored and action targeted.

APPENDIX 1 - HEALTHY HALTON

All-age, all cause mortality rate per 100,000 (Males) (NI 120a)



Lead Partner Agency:	PCT
Responsible Officer:	Sue Forster
Good is:	'Good' performance is typified by a reduction in rates. For Spearhead areas 'good' performance is typified by a reduction in rates that results in a reduction in the inequality gap with England.

Brief Description / Indicator Purpose:

All Age All Cause Mortality (AAACM) supports the following national PSA targets:

- By 2010, increase the average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women.
- Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth, i.e.
  - Starting with local authorities, by 2010 to reduce by at least 10% the gap in life expectancy between the fifth of areas with the 'worst health and deprivation indicators' ('the Spearhead Group') and the population as a whole
  - Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the 'routine and manual' socioeconomic group and the population as a whole

The indicator is reported and monitored as two separate mortality rates - one for males and one for females. Each of these rates is a single figure for all causes and all ages combined. Single year rates are used to enable timely reporting. (The associated national target is assessed using 3-year average figures).

The target is based on a calendar year and not financial year.

	2008/09	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
Halton Target	805	780	755	858.8	850.2	841.7	833.3	824.9
Halton Actual	880	838	811.35					
Benchmarking:								
All England	679	652	636.07					
Northwest	769	743	725.02					
Relevant Statistical Neighbour [5]	796	765	733.09					

Supporting Commentary & Target Rationale (2011 / 2012 Onwards):

Whilst the latest data shows some significant improvement in life expectancy this is still a key

[5] This could be from regional or family benchmarking data.

priority in Halton and it is therefore recommended that the target be retained
Cancer and circulatory diseases are the biggest contributor to all age all cause mortality.

Benchmarking data from Health Profile supplied by Sue Forster.

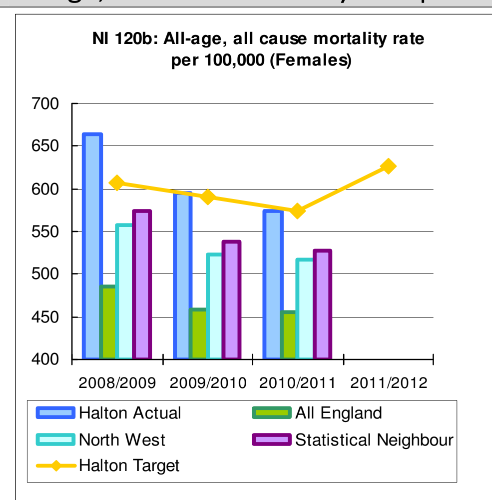
New targets for the calendar years 2011 through to 2015 have been produced using trend data from 3 year rolling rates to estimate the forward trend. A small change to the number of deaths or the population can greatly affect the annual rate both up and down and this is why 3 year rates have been used for target setting to account for annual variations. It is suggested that data is reviewed annually once annual verified data is released and amendments to targets are made based on this

The latest verified information for all cause mortality for males is 2009 which shows that Halton was above target and higher than England the North West and it's ONS statistical neighbour industrial hinterlands. Whilst male mortality in Halton has improved over time it is still very challenging and current unverified data for 2010 shows that the male Halton rate rose slightly from 2009.

Programmes such as Health Checks Plus are in place to indentify people 'at-risk' of major issues such as obesity, smoking, alcohol consumption, hypertension, CVD risk, cancer and cancer screening all of which are indentifying people and ensuring appropriate health interventions are put into place. Quality, Improvement, Innovation and Prevention Programmes across Mid Mersey which cover Halton and St Helens, Warrington and Knowsley plans are in place for CVD, stroke and urgent care pathways to ensure that essential health programmes are delivered in the most cost effective way to improve patient outcomes.

APPENDIX 1 - HEALTHY HALTON

All-age, all cause mortality rate per 100,000 (Females) (NI 120b)



Lead Partner Agency:	PCT
Responsible Officer:	Sue Forster
Good is:	'Good' performance is typified by a reduction in rates. For Spearhead areas 'good' performance is typified by a reduction in rates that results in a reduction in the inequality gap with England.

Brief Description / Indicator Purpose:

All Age All Cause Mortality (AAACM) supports the following national PSA targets:

- By 2010, increase the average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women.

- Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth, i.e.
    - Starting with local authorities, by 2010 to reduce by at least 10% the gap in life expectancy between the fifth of areas with the 'worst health and deprivation indicators' ('the Spearhead Group') and the population as a whole

    - Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the 'routine and manual' socioeconomic group and the population as a whole

The indicator is reported and monitored as two separate mortality rates - one for males and one for females. Each of these rates is a single figure for all causes and all ages combined. Single year rates are used to enable timely reporting. (The associated national target is assessed using 3-year average figures).

The target is based on a calendar year and not financial year.

	2008/09	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
Halton Target	607	590	574	627.1	620.8	614.6	608.5	602.4
Halton Actual	663.82	595.12	573..63					
Benchmarking:								
All England	486	459	454.83					
Northwest	557	523	516.64					
Relevant Statistical Neighbour [6]	574	538	527.39					

Supporting Commentary & Target Rationale (2011 / 2012 Onwards):

Whilst the latest data shows some significant improvement in life expectancy this is still a key priority in Halton and it is therefore recommended that the target be retained
Cancer and circulatory diseases are the biggest contributor to all age all cause mortality.

Benchmarking data from Health Profile, supplied by Sue Forster.

[6] This could be from regional or family benchmarking data.

APPENDIX 1 - HEALTHY HALTON

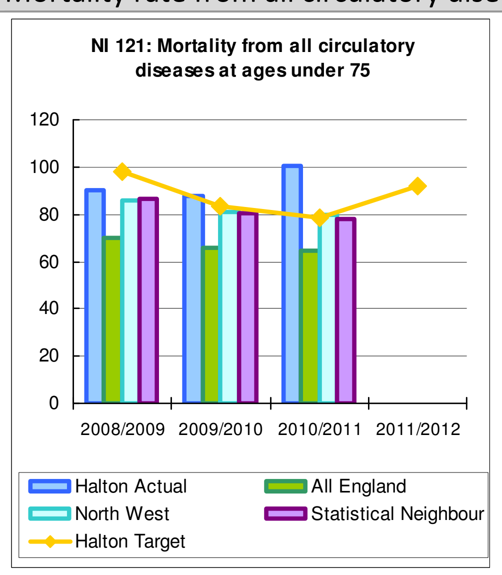
New targets for the calendar years 2011 through to 2015 have been produced using trend data from 3 year rolling rates to estimate the forward trend. A small change to the number of deaths or the population can greatly affect the annual rate both up and down and this is why 3 year rates have been used for target setting to account for annual variations. It is suggested that data is reviewed annually once annual verified data is released and amendments to targets are made based on this

The latest verified information for all cause mortality for females is 2009 which shows that Halton was above target and higher than England the North West and it's ONS statistical neighbour industrial hinterlands, however female mortality has made significant improvements in recent years. Unverified data for 2010 shows that female mortality has decreased further but still just above target.

Programmes such as Health Checks Plus are in place to indentify people 'at-risk' of major issues such as obesity, smoking, alcohol consumption, hypertension, CVD risk, cancer and cancer screening all of which are indentifying people and ensuring appropriate health interventions are put into place. Quality, Improvement, Innovation and Prevention Programmes across Mid Mersey which cover Halton and St Helens, Warrington and Knowsley plans are in place for CVD, stroke and urgent care pathways to ensure that essential health programmes are delivered in the most cost effective way to improve patient outcomes

APPENDIX 1 - HEALTHY HALTON

Mortality rate from all circulatory diseases at ages under 75 (NI 121)



Lead Partner Agency:	PCT
Responsible Officer:	Sue Forster/Eileen O'Meara/ Sarah Johnson
Good is:	"Good" performance is typified by a reduction in rate. For Spearhead areas "good" performance is typified by a reduction in rate that results in a reduction in the inequality gap with England.

Brief Description / Indicator Purpose:

Circulatory disease is one of the main causes of premature death (under 75 years of age) in England, accounting for just over a quarter of all such deaths in this age group. Reducing mortality rates will therefore make a significant contribution to increasing life expectancy.

This is a Department of Health PSA Target.
Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

	2008/09	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
Halton Target	98.2	83.21	78.31	91.8	89	87.2	85.5	83.8
Halton Actual	89.9	88.0	100.23					
Benchmarking:								
All England	70	66	64.67					
Northwest	86	81	79.8					
Relevant Statistical Neighbour [7]	86.3	80.6	77.83					

Supporting Commentary & Target Rationale (2011 / 2012 Onwards):

Whilst the latest data shows some significant improvement in life expectancy this is still a key priority in Halton and it is therefore recommended that the target be retained

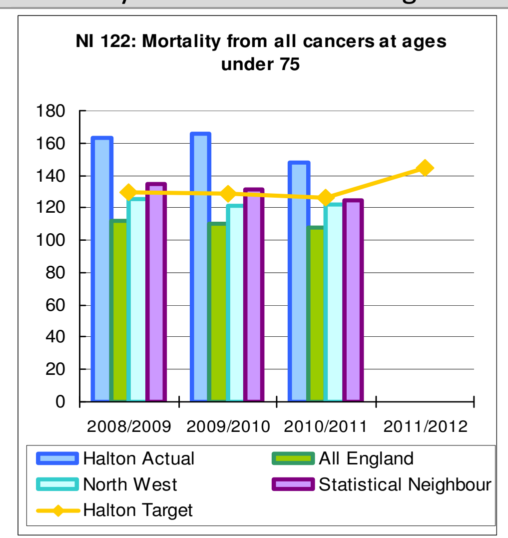
It has been decided to make the target more realistic based on actual achievement over the last three year trends. With this in mind the target proposed is 91.8. (based on a 5% reduction on 2010 achievement)

Benchmarking data from Health Profile , supplied by Sue Forster.

[7] This could be from regional or family benchmarking data.

APPENDIX 1 - HEALTHY HALTON

Mortality from all cancers at ages under 75 (NI 122)



Lead Partner Agency:	PCT
Responsible Officer:	Sue Forster/Eileen O'Meara/ Daniel Seddon
Good is:	"Good" performance is typified by a reduction in rate. For Spearhead areas "good" performance is typified by a reduction in rate that results in a reduction in the inequality gap with England.

Brief Description / Indicator Purpose:

Cancer is one of the main causes of premature death (under 75 years of age) in England, accounting for nearly 4 in 10 of all such deaths in this age group. Reducing mortality rates will therefore make a significant contribution to increasing life expectancy.

This is a Department of Health PSA Target.

Substantially reduce mortality rates by 2010 from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

	2008/09	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
Halton Target	129.15	128.9	126.41	145	140	135	130	125
Halton Actual	154.24	166.0	147.96					
Benchmarking:								
All England	112.2	109.9	108.05					
Northwest	125.2	121.5	122.19					
Relevant Statistical Neighbour [8]	135.0	131.5	124.88					

Supporting Commentary & Target Rationale (2011 / 2012 Onwards):

* Actual data for 2008 calendar year shown against 2008/09 and local provisional data for other years, which will be updated as actual data becomes available.

The two charts below described the rolling annual cancer mortality for the two boroughs of Halton and St Helens, over the past two years. The data is provisional, being sourced from the public health mortality files ahead of national validation. In contrast to national data, which is just under two years old, this data is available within just a few months of events. However, it must be viewed with a certain level of caution.

The charts show that for people of all ages, and for those under 75, cancer mortality is falling steadily in both boroughs. This is very encouraging, as until now Halton's mortality rates seemed to be stubbornly high, and not falling convincingly in recent years.

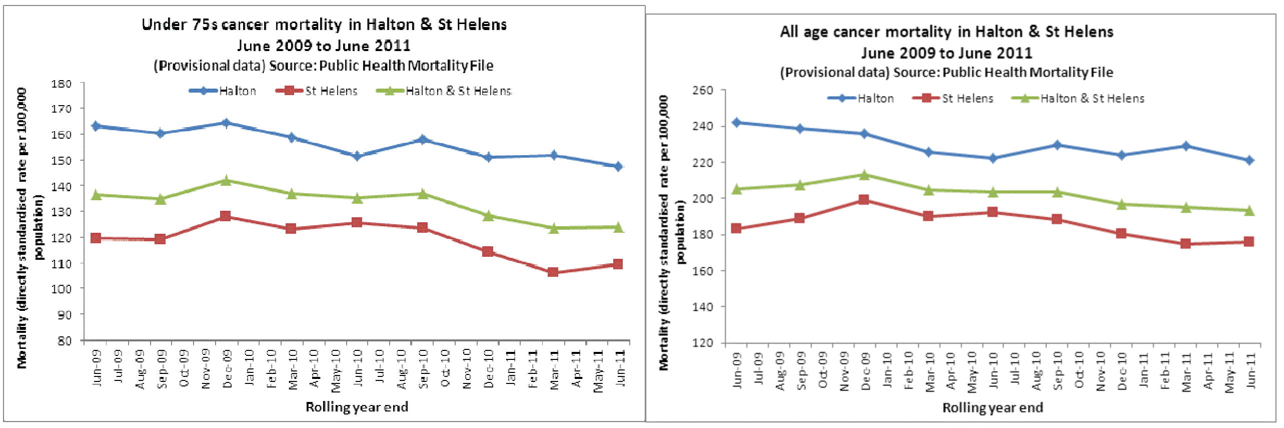
Rates remain higher in Halton than in St Helens. But they are dropping by about 5/100,000 each year. This represents more than 5 lives saved each year just in Halton.

[8] This could be from regional or family benchmarking data.

APPENDIX 1 - HEALTHY HALTON

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.

Dan Seddon, Public Health Consultant
September 2011



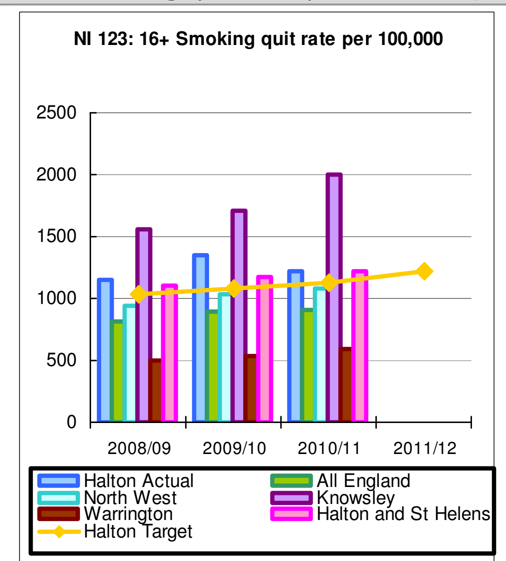
Target rationale:

> Take the 2007/9 (as the latest confirmed actual) figures as a baseline, and adopt a target for the next three years of 145 per 100,000 for 2011/12, 140 for 2012/13, and 135 for 2013/14, 130 for 2014/15 and 125 for 2015/16. This target for a steeper fall is reasonable, given the success of smoke free legislation over the past five years, the effectiveness of our stop smoking services, and the advent of the bowel screening programme, which we estimate saves a handful of lives each year.

Benchmarking data from Health Profile supplied by Sue Forster.

APPENDIX 1 - HEALTHY HALTON

16+ Smoking quit rate per 100,000 (NI 123)



Lead Partner Agency:	PCT
Responsible Officer:	Eileen O'Meara
Good is:	Good performance is typified by maintenance of the number of four-week smoking quitters who have attended NHS Stop Smoking Services per 100,000 population at least the average level achieved in the period 2004/05 - 2006/07.

Brief Description / Indicator Purpose:

This indicator relates to clients receiving support through the NHS Stop Smoking Services. A client is counted as a self-reported 4-week quitter if they have been assessed 4 weeks after the designated quit date and declares that he/she has not smoked even a single puff on a cigarette in the past two weeks. The indicator is a count of treatment episodes rather than people. So, if an individual undergoes two treatment episodes and has quit at four weeks in both cases, they are counted twice.

Stop Smoking Services are a key NHS intervention to reduce smoking and are part of a programme of action needed to meet the national target to tackle the underlying determinants of ill health and health inequalities by reducing smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less. They are currently monitored through assessment of 4-week smoking quitters.

	2008/09	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
Halton Target	1038	1082	1128	1223.55	1228.5	1263.62	1268.2	1273.3
Halton Actual	1155	1351	1223					
Benchmarking:								
All England	813	895	911					
Northwest	939	1038	1086					
Relevant Statistical Neighbour [9]	K: 1556 W: 497 HSTH: 1105	K: 1715 W: 538 HSTH: 1177	K: 1998 W: 589 HSTH: 1219					

Supporting Commentary & Target Rationale (2011 / 2012 Onwards):

Whilst overall smoking rates in Halton have decreased considerably in recent years, tobacco is a major risk factor for cancer and heart disease and a major contributor to the health inequalities gap between Halton and England. It is therefore recommended that this target be retained.

Halton exceeded the 2010/11 quit target and now have the 3rd highest quit rate in the North West.

Rate per 100,000 quoted equivalent to 1159 quitters for 2010/11.
Rates per 100,000 selected to avoid showing figures as population fluctuates.

[9] This could be from regional or family benchmarking data.

APPENDIX 1 - HEALTHY HALTON

Mental Health - No. of people in counselling/ day services or on waiting lists. NEW		
New measure	Lead Partner Agency:	PCT
	Responsible Officer:	Dave Sweeney/Lyn Marsden
	Good is:	Reduced number on waiting list
	Brief Description / Indicator Purpose:	
	It is suggested that we take the numbers of people accepted and still awaiting therapy appointment for SHS IAPT and Bridgewater Primary Care Psychological therapy services and apply that total as a percentage to the total numbers referred by GPs. Example: In one quarter there are 110 GP referrals. 40 are referred to SHS IAPT, of which 23 are still awaiting appt 60 are referred to Bridgewater Primary Care Psychological therapy services of which 31 are still awaiting appt. The calculation would be 54/110*100 = 49% of referrals still waiting for appointment.	

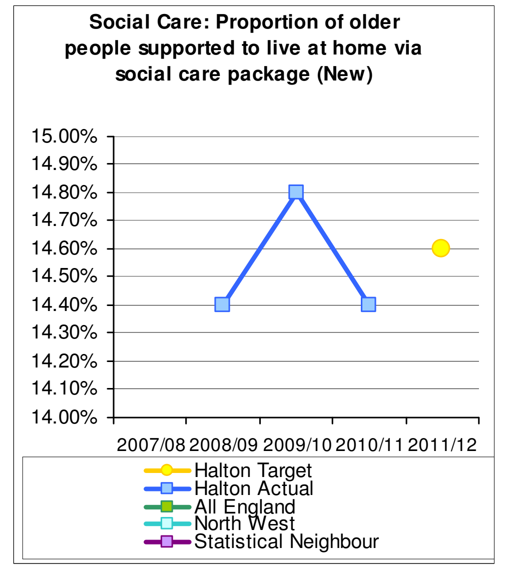
	2008/09	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
Halton Target	New indicator			Baseline to be established	Targets to be confirmed once baseline established			
Halton Actual	New indicator							
Benchmarking:								
All England	Local measure , benchmarking information not available from the PCT							
Northwest								
Relevant Statistical Neighbour [10]								

Supporting Commentary & Target Rationale (2011 / 2012 Onwards):
This is in line with the SCS objective to improve access to health services, and improve mental health.

[10] This could be from regional or family benchmarking data.

APPENDIX 1 - HEALTHY HALTON

Social Care **(New)**: Proportion of older people supported to live at home through provision of a social care package **NEW**



Lead Partner Agency:	HBC
Responsible Officer:	Sue Wallace-Bonner
Good is:	**Higher - Increasing proportion of older people supported at home**

Brief Description / Indicator Purpose:

This indicator measures the proportion of older people (65+) who are supported by Adult Social Care Services to live independently in their own home.

The indicator measures The number of people 65+ who are supported with an Adult Social Care Service Package as a percentage of the Older people population for Halton.

The higher the percentage, the greater the number of older people are supported to live independently. The focus is on managing long term conditions and early prevention and intervention, thus which in turn aims to reduce the number of people admitted/re-admitted to hospital and those admitted to long term care.

	2008/09	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
Halton Target	N/A	N/A	N/A	14.6%	14.8%	15%	15.2%	15.4%
Halton Actual	14.4%	14.8%	14.4%					
Benchmarking:								
All England								
Northwest								
Relevant Statistical Neighbour [11]								

Supporting Commentary & Target Rationale (2011 / 2012 Onwards):

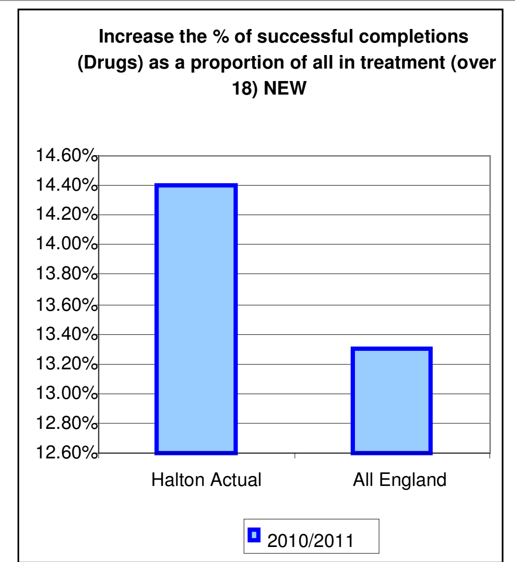
The target rationale is for an incremental increase on the baseline (2010/11). The increase will take into account the pressures from an ageing population and associated increased demand.

The increase reflects the shift to early intervention and preventative models of care, which prevent hospital admissions/readmissions and admissions to long term care (residential and nursing placements).

NI comparative date to be obtained from RAP or NW Performance leads as a new measure.

[11] This could be from regional or family benchmarking data.

APPENDIX 1 - HEALTHY HALTON

Increase the % of successful completions (Drugs) as a proportion of all in treatment (over 18) **NEW**	
	Lead Partner Agency: HBC / PCT Responsible Officer: Steve Eastwood Good is: Increasing % of successful completions Brief Description / Indicator Purpose: The proportion of clients who successfully completed Drug treatment out of all the clients who were treated in the same period. There are more people drug free as a % of total people.

	2008/09	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
Halton Target	New indicator			Above NW Average	Above NW Average	Above NW Average	Above NW Average	Above NW Average
Halton Actual	New indicator		14.4%					
Benchmarking:								
All England	Data not previously available . This is a new indicator		13.3%					
Northwest			13.8%					
Relevant Statistical Neighbour [12]			9.8%					

Supporting Commentary & Target Rationale (2011 / 2012 Onwards):

The target has been set to achieve performance above the North West Average. It is intended to review this after 12 months, once the new provider is firmly in place and performance is established.

[12] This could be from regional or family benchmarking data.

APPENDIX 1 - HEALTHY HALTON

Increase the % of successful completions (Alcohol) as a proportion of all in treatment (over 18) **NEW**		
Placeholder 2012/13	Lead Partner Agency:	HBC / PCT
	Responsible Officer:	Collette Walsh
	Good is:	Increasing % of successful completions
	Brief Description / Indicator Purpose:	
	The proportion of clients who successfully completed Alcohol treatment out of all the clients who were treated in the same period.	

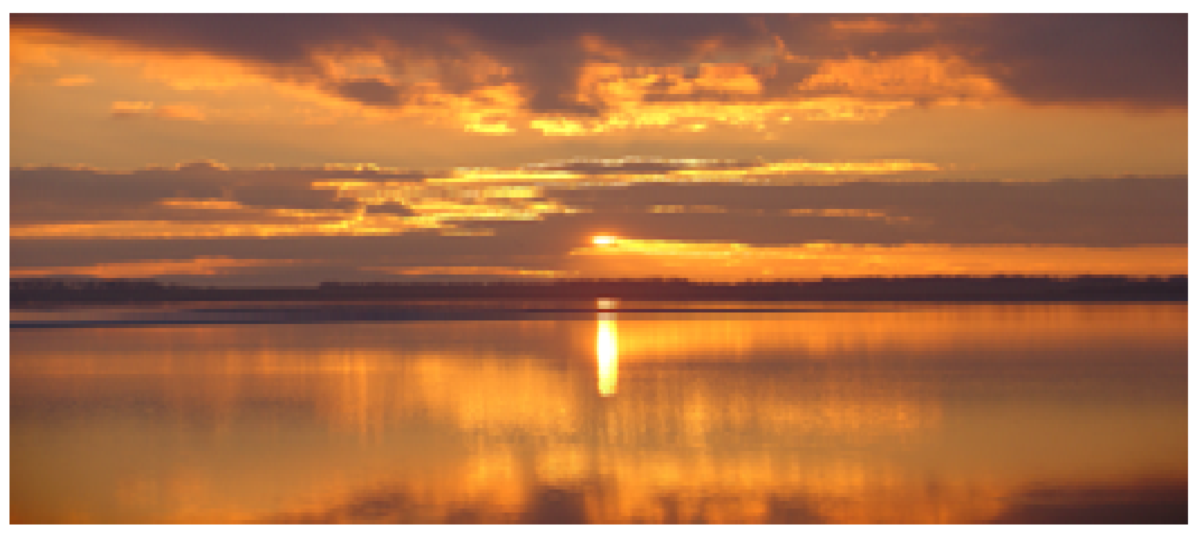
	2008/09	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
Halton Target	New indicator				Baseline to be established	Increasing % of successful completions		
Halton Actual								
Benchmarking:								
All England	Data not currently collected on a national basis. This is a local measure							
Northwest								
Relevant Statistical Neighbour [13]								

Supporting Commentary & Target Rationale (2011 / 2012 Onwards):

This new service will be established in 2012/13. Targets will then be set following the collection of data in year 2012/13 and a baseline established.

The aim of this service is to increase the % of successful completions as a proportion of all people in treatment for an alcohol addiction.

[13] This could be from regional or family benchmarking data.



The Sustainable Community Strategy for Halton

2011 - 2016

Mid-year Progress Report

01st April – 30th Sept 2011

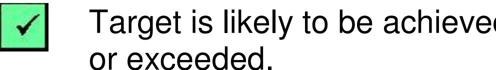
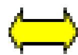
Halton Strategic PARTNERSHIP

Document Contact (Halton Borough Council)	Hazel Coen (Divisional Manager Performance & Improvement) Municipal Buildings, Kingsway Widnes, Cheshire WA8 7QF hazel.coen@halton.gov.uk

This report provides a summary of progress in relation to the achievement of targets within Halton's Sustainable Community Strategy 2011 - 2016.

It provides both a snapshot of performance for the period 01st April 2011 to 30th September 2011 and a projection of expected levels of performance to the year-end.

The following symbols have been used to illustrate current performance as against the 2011 target and as against performance for the same period last year.

	Target is likely to be achieved or exceeded.		Current performance is better than this time last year
	The achievement of the target is uncertain at this stage		Current performance is the same as this time last year
	Target is highly unlikely to be / will not be achieved.		Current performance is worse than this time last year

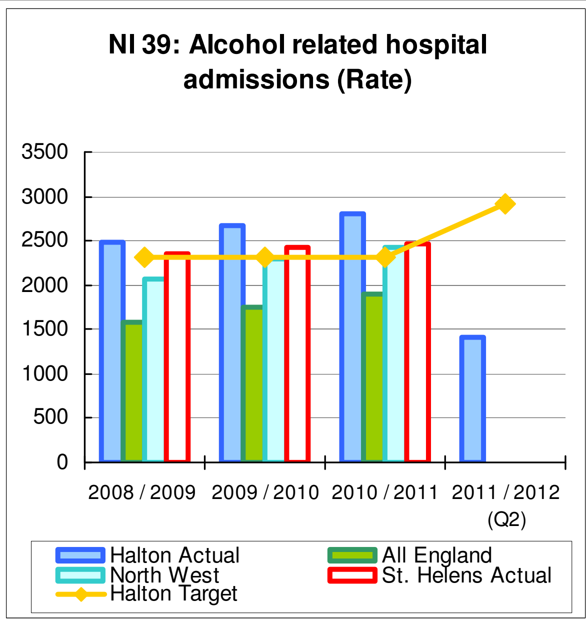
Healthy Halton

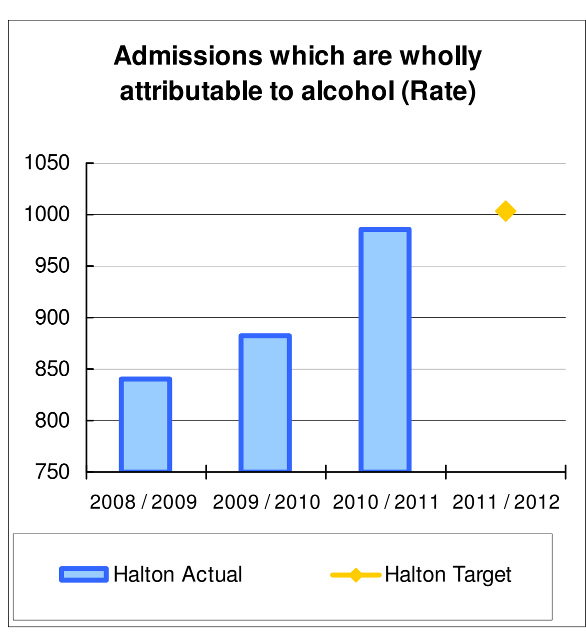
Page	Ref	Descriptor	2011 / 12 Target	Direction of travel
4	HH 1*	a) Alcohol related hospital admissions (NI 39) (Rate 100,000 pop.)	?	
4	HH 1*	b) Alcohol related hospital admissions – AAF =1 (Rate)	N/A	New Measure
6	HH 2	Prevalence of breastfeeding at 6-8 weeks (NI 53)		
7	HH 3	a) Obesity in Primary school age children in Reception (NI 55)		
8	HH 3	b) Obesity in Primary school age children in Year 6 (NI 56)		
10	HH 4	Reduction in under 18 Conception (new local measure definition for NI 112)		
11	HH 5	a) All age, all cause mortality rate per 100,000Males (NI 120a)		
12	HH 5	b) All age, all cause mortality rate per 100,000 Females (NI 120b)		
13	HH 6	Mortality rate from all circulatory diseases at ages under 75 (NI 121)		
15	HH 7	Mortality from all cancers at ages under 75 (NI 122)		
17	HH 8	16+ Smoking quit rate per 100,000 (NI 123)		
19	HH 9	Mental Health - No. of people in counselling/ day services or on waiting lists. (NEW 2011)	Placeholder 2012 / 13	New Measure
20	HH 10	Proportion of older people supported to live at home through provision of a social care package (NEW 2011):		
21	HH 11	a) Increase the % of successful completions (drugs) as a proportion of all in treatment (over 18)		
22	HH 11	b) Increase the % of successful completions (Alcohol) as a proportion of all in treatment (over 18)	Placeholder 2012 / 13	New Measure

NB - Measures HHI and HH11 are also reported within the Safer Halton priority area as SH 10 and SH7 respectively.
Measure HH4 is also reported under CYP 15

SCS / HH 1[1]	Reduce alcohol related hospital admissions (NI 39) Rate per 100,000 population

	2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Qtr 4	Current Progress	Direction of Travel
a)Alcohol related hospital admissions AAF > 0 (Previously NI 39)	2839	2916	1419.1		?	
b)Admissions which are wholly attributable to alcohol AAF = 1 (Rate)	984	1002.6	Not yet available		N/A	New Measure





Data Commentary:

This indicator measures the rate of alcohol related admissions per 100,000 population using Hospital Episode Statistics.

Each admission is assigned an attributable fraction (AF) based on the diagnosis codes and age and sex of the patient. Where an admission has more than one relevant diagnosis code, the highest attributable fraction is used. This is shown as the first measure, where the alcohol attributable fraction AAF> 0, previously NI 39.

The second measure provides further detail and relates to admissions which are wholly attributable to alcohol in other words AAF =1.

Performance Commentary:

As key services start up in 2012/13, it is envisaged that there will be an impact on admissions that are both wholly and partially related to alcohol. It is anticipated that these developments will slow the rate of increase in alcohol related admissions.

[1] SCS / HH1 is also replicated under Safer Halton as SCS / SH10

Summary of Key activities taken or planned to improve performance:

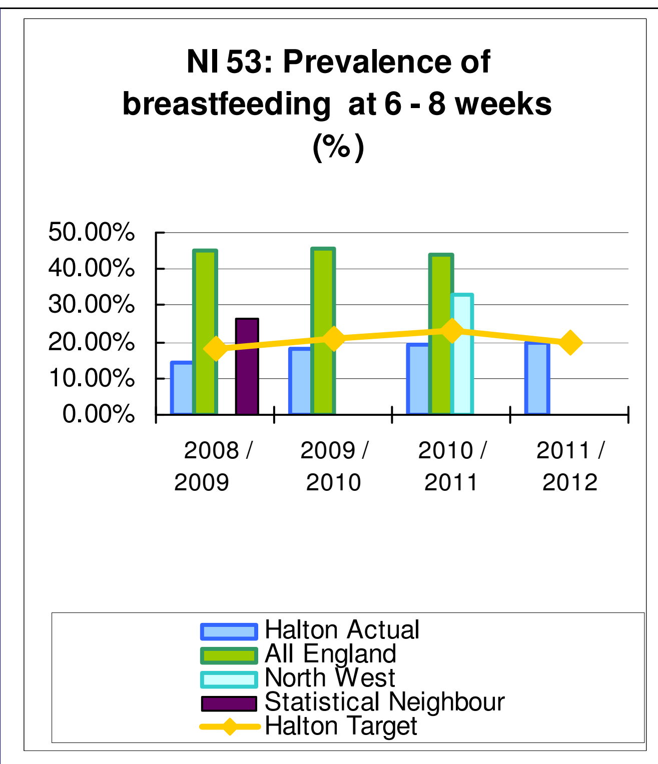
- A programme of Identification and Brief Advice (IBA) Training for key frontline professionals is being rolled out across the borough. The aim is to ensure that advice is on offer for people who would benefit from reducing their drinking, alcohol problems are identified earlier and that there is a referral to treatment services for those requiring more intense support.

- An innovative, new, integrated, recovery orientated substance misuse treatment service commenced service delivery on 01 February 2012. Considerable investment has been made to increase capacity and modernize treatment services, allowing us to change the way in which we tackle alcohol and drug related problems. The service will not only address drinking or drug taking behaviours but will aim to identify and tackle underlying causes and ensure that factors which help increase a person's chances of getting and staying well are enhanced. For example, does the service user have a job, a safe place to live, robust family relationships and feel included within the community? Support and advice will be on offer for service users and their families and the wider partnership will be engaged to explore and tackle cross cutting themes, including safeguarding and social inclusion.

- Alcohol Liaison Nursing (ALN) Services are being developed in Whiston and Warrington Hospitals. The Alcohol Liaison Nursing Service will be established to provide high quality, evidence based alcohol treatment at the Emergency Departments and on hospital wards. The service will bridge the gap between inpatient admission and community treatment by providing the opportunity for acute hospital patients to be given an alcohol intervention and education on their alcohol use and, for those who need it, the opportunity to be fast-tracked to appropriate community services. The services will avoid unnecessary admissions and enhance the care given to people who regularly attend hospital for alcohol related harm.

- A Review of the Tier 4 Alcohol Treatment Service is underway at the Windsor Clinic Mersey care on behalf of Halton & St Helens and NHS Mersey. There is a requirement to ensure that service provision for very complex and vulnerable cases are aligned with the new, recently commissioned, community based Tier 2/3 Recovery Services.

SCS / HH2	% Prevalence of breastfeeding at 6-8 weeks (NI 53)



2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Qtr 4	Current Progress	Direction of Travel
19.18	20.00	**19.85%**		✓	↑

Data Commentary:

Quarter 1 and Quarter 2 have both been updated. Good performance is an increase in the percentage coverage and prevalence year on year.

Performance Commentary:

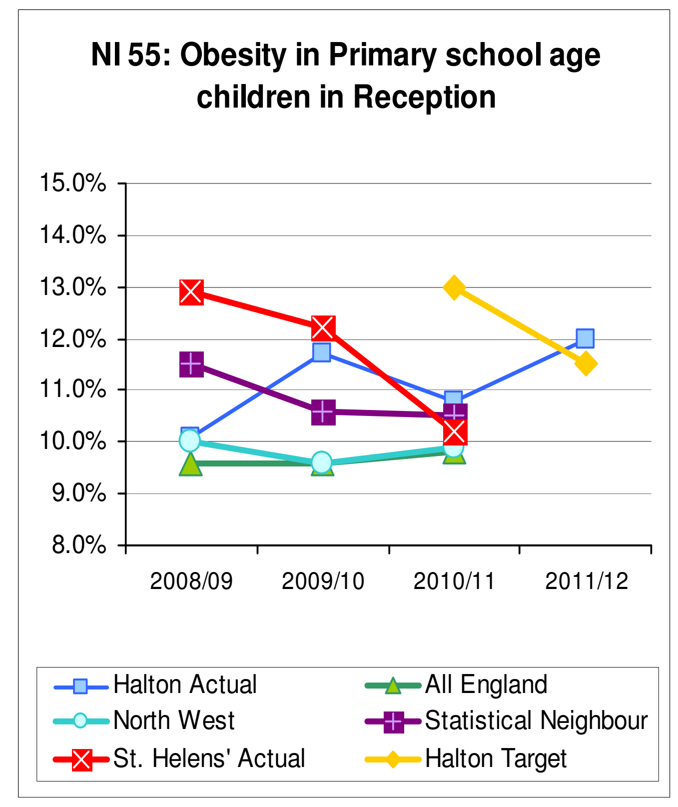
The prevalence of breastfeeding at 6-8 weeks is very close to being on target.

Summary of Key activities taken or planned to improve performance:

Progress has been made towards improving breastfeeding rates in Halton

- Bridgewater Halton and St Helens division achieved UNICEF Baby Friendly stage 1. Work is underway towards Stage 2, UNICEF deadline for assessment November 2013
- The Infant Feeding Coordinator post, and Breastfeeding support worker job descriptions have been through Agenda for Change and recruitment is imminent. .
- Breastfeeding is a Joint Commissioning Unit priority
- The Whiston CQUIN in place. Indications of increased attendance at infant feeding sessions.
- The Peer support incentive scheme being evaluated and plans to continue for another 6 months.
- Feedback from incentive scheme suggests it encourages engagement with peer support services.
- Progress made with Bridgewater Community Healthcare NHS Trust to ensure adequate coverage of 6-8 week breastfeeding data, available at postcode level. Continue to maintain baby friendly premises.

SCS / HH3a	Obesity in Primary school age children in Reception (NI 55)



2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Qtr 4	Current Progress	Direction of Travel
10.8	11.5	12.0%		✗	↓

Data Commentary:

The percentage of children in who are obese, as shown by the National Child Measurement Programme (NCMP). Data is reported one year in arrears.

Q3 data is newly released official data.

Performance Commentary:

New data is recently released official data for 2010/11. Halton has once again exceeded the 85% target for Reception and Year 6 children with height and weight recorded.

Childhood obesity in Halton is fluctuating.

Summary of Key activities taken or planned to improve performance:

Halton's performance for 2010 has shown fluctuation with a continued variable trend over the last few years.

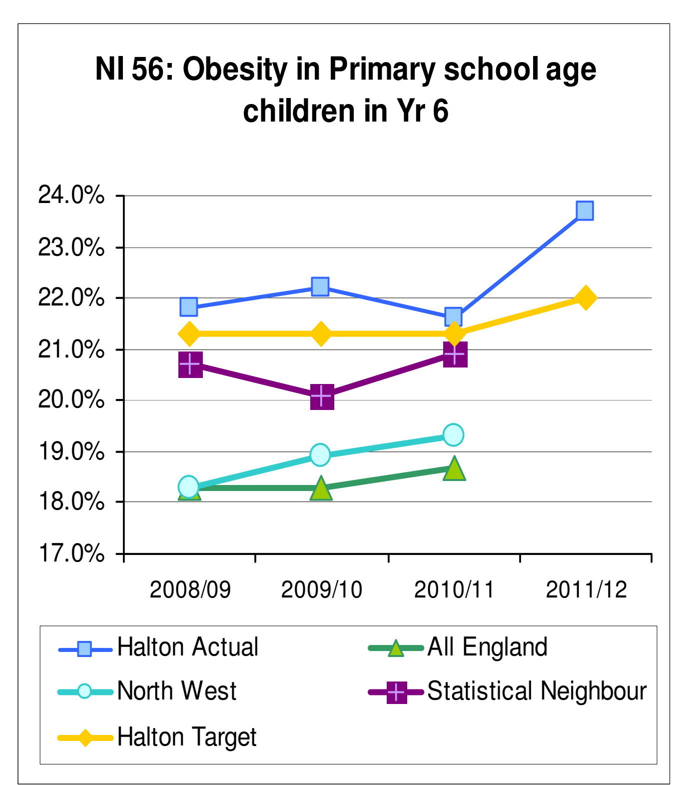
Halton remains above the national and north west average. Halton shows an increasing obesity rate in line with increasing obesity rates for the England and North West averages.

Recent funding for a Breast feeding coordinator and weaning services should have an impact in future years.

A number of healthy weight programmes are now in place for early years and should start to have an impact in the coming year. These include recent funding for a Breast Feeding Coordinator and weaning services, cookery lessons for parents, active tots groups, sow and grow, and education and training for parents and service providers.

New Service Specifications for Children's Centres have been agreed and these include work on meeting the Healthy Early Years Standards which include food standards and healthy eating.

SCS / HH3b	% Obesity in Primary school age children in Year 6 (NI 56)



2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Qtr 4	Current Progress	Direction of Travel
21.6	22.0	23.7%			

Data Commentary:

The percentage of children in year 6 who are obese, as shown by the National Child Measurement Programme (NCMP). Data is reported one year in arrears.

Q3 data is newly released official data.

Performance Commentary:

New data is recently released official data for 2010/11. Halton has once again exceeded the 85% target for Reception and Year 6 children with height and weight recorded with 95.3% of children being measured in year 6.

Childhood obesity in Halton is fluctuating

Summary of Key activities taken or planned to improve performance:

Halton's performance for 2010 has show fluctuation with a continued variable trend over the last few years.

Halton remains above the national and north west average. Halton shows an increasing obesity rate in line with increasing obesity rates for the England and North West averages.

The school Fit4Life Programme which tackles overweight and obesity for children aged 6 to 13 years was rolled out in June 2011 and the results are not therefore reflected in this latest National Child Measurement Programme result. The Fit4Life programme targets schools with the highest obesity rates. It offers education for teachers and children and their parents in cooking, healthy eating and the importance of exercise. It runs fun exercise classes for all children in the school. Data from the pilot programme shows a reduction in obesity amongst those schools that participated as the figures below demonstrate. We anticipate that with further roll out school age obesity figures will fall.

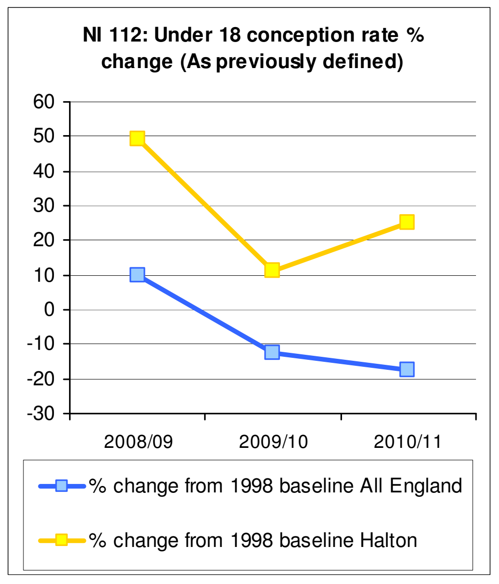
Fit4Life Pilot School Results

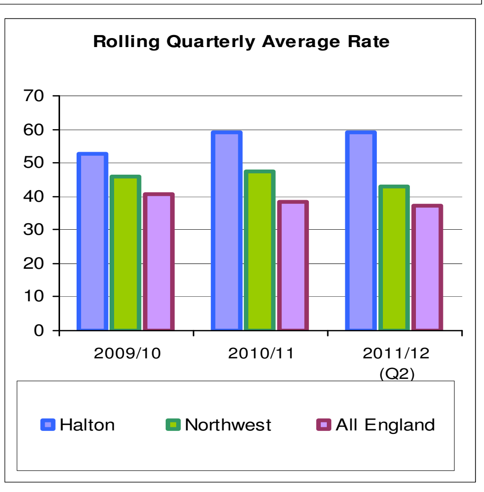
	School 1	School 2	School 3	School 4	School 5	School 6
Halton 2009	51 %	49 %	46 %	45 %	45 %	42 %
Halton 2010	***26 %***	***38 %***	***34 %***	***40 %***	***23 %***	***31 %***

Teenage weight management is being tackled via the Alive and Kicking Programme for all 14 to 19 year olds.

This programme offers a personal trainer style programme for all teenagers across Halton. It is now embedded in the colleges and some of the secondary schools. It also runs classes teenagers can access at Halton Stadium and is proving popular. The 2010/11results show 75% of teenagers participating have lost weight and 70% are now fitter. Unfortunately these figures do not contribute to the target as it is based on the weight of 11 year olds.

SCS / HH4	Reduction in under 18 Conception (new local measure definition for NI 112)





2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Qtr 4	Current Progress	Direction of Travel
58.9 Rolling quarterly average rate	-1.43% reduction 58.1 Rolling quarterly average rate	+0.1% increase 59.0 rolling quarterly average rate			

Data Commentary:

Performance is based on ONS data releases and Qtr 2 performance is based on the ONS release covering the rolling 12 months Q3 2009 to Q2 2010.

To make this measure more meaningful this target will be monitored as a reduction in the rate per thousand rolling quarterly average annual rate from the 2009 baseline, and actual numbers of conceptions.

Performance Commentary:

During the rolling 12 months (Q3 2009 – Q2 2010) there have been 136 conceptions, representing a 4 less conceptions on the previous rolling 12 months.

Whilst these numbers indicate that progress is positive this measure also takes into account the reduction in the population base of 15-17 year old females in the Borough (from 2392 to 2295) and therefore reflects a slight increase in the rolling quarterly rate. This is however an improvement upon the same period last year, and represents good progress.

Summary of Key activities taken or planned to improve performance:

We are continuing to work with school governors to extend sexual health services and projects such as Teens and Tots delivered in schools. Workforce training on prevention and support has been increased to frontline staff and parents.

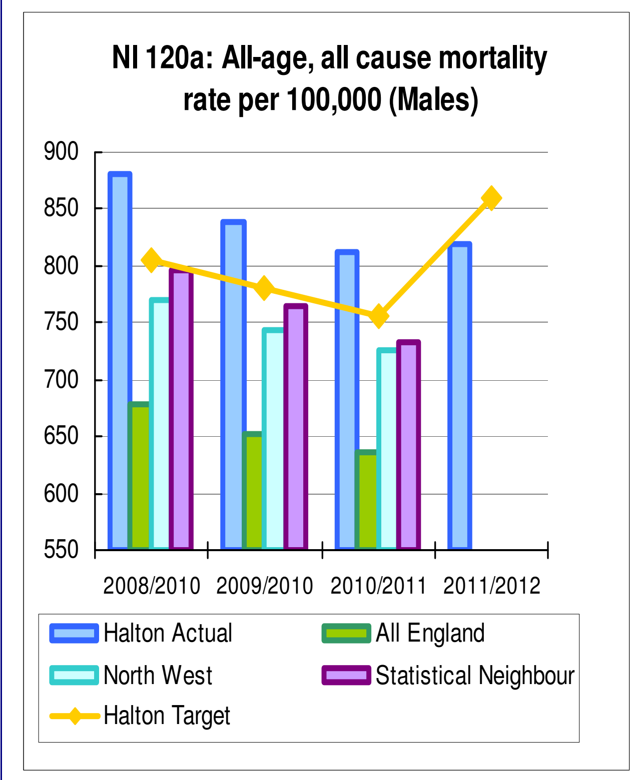
We are increasing the support to young people at risk of teenage pregnancy by offering the DfE funded Teens and Toddlers programme to more high schools in Halton.

We continue to improve access to contraceptive services and provision for young people, including Long Acting Reversible Contraception (LARC) and condoms.

Robust care pathways are in place for prevention and support in all high schools and we continue to support pregnant young women of school age to remain in education, employment and training.

A comprehensive co-ordinated packages of support is available for teenage parents through Children's Centres which include; antenatal and postnatal care, access to education and training, advice on childcare, benefits, housing.

SCS / HH5a	All age, all cause mortality rate per 100,000 Males (NI 120a)



2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Qtr 4	Current Progress	Direction of Travel
811.35	858.8	818.4		✓	↑

Data Commentary:

The indicator is reported and monitored as two separate mortality rates - one for males and one for females. Each of these rates is a single figure for all causes and all ages combined. Single year rates are used to enable timely reporting.

Q2 data was updated to the end of September by Public Health Intelligence Team (PHIT).

Performance Commentary:

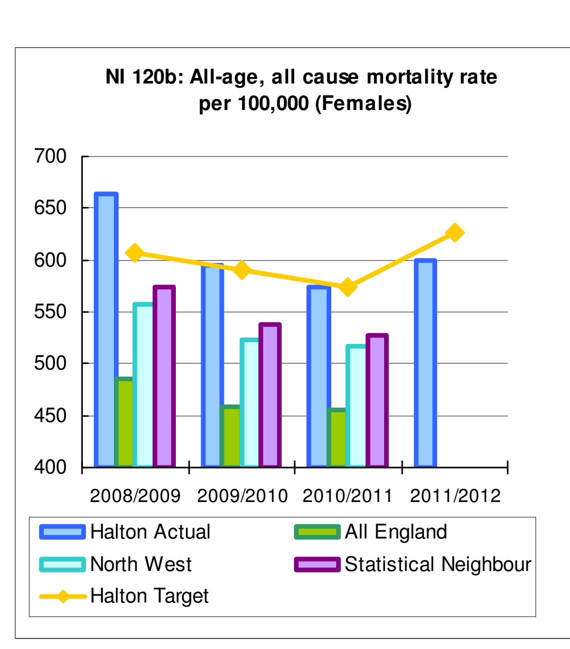
Male deaths have reduced since December 2010 where 2010 official data shows the rates were 811.35 whereas in year 2011 the rates have varied from 818.4 to 780.3 showing a consistent downward trend.

Summary of Key activities taken or planned to improve performance:

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.

Programmes such as Health Checks Plus are in place to indentify people 'at-risk' of major issues such as obesity, smoking, alcohol consumption, hypertension, CVD risk, cancer and cancer screening all of which are indentifying people and ensuring appropriate health interventions are put into place. Quality, Improvement, Innovation and Prevention Programmes across Mid Mersey which cover Halton and St Helens, Warrington and Knowsley plans are in place for CVD, stroke and urgent care pathways to ensure that essential health programmes are delivered in the most cost effective way to improve patient outcomes.

SCS / HH5b	All age, all cause mortality rate per 100,000 Females (NI 120b)



2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Qtr 4	Current Progress	Direction of Travel
573.63	627.1	600		✓	↓

Data Commentary:

The indicator is reported and monitored as two separate mortality rates - one for males and one for females. Each of these rates is a single figure for all causes and all ages combined. Single year rates are used to enable timely reporting.

Q2 data was updated to the end of September by Public Health Intelligence Team (PHIT).

Performance Commentary:

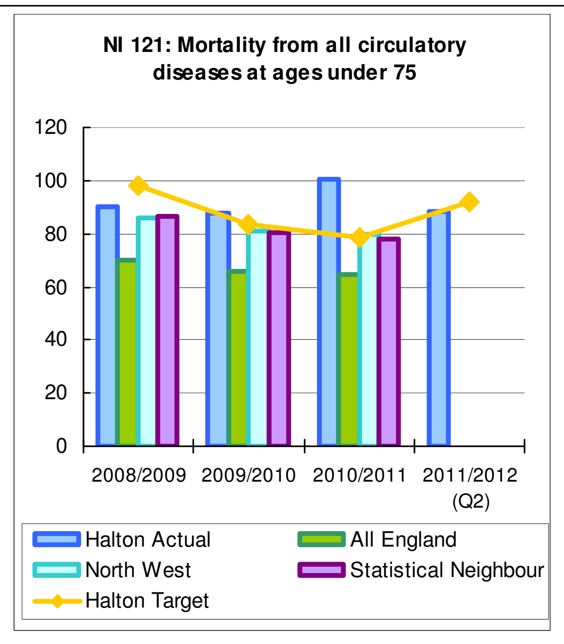
The latest verified information for all cause mortality for females is 2010 which shows that Halton was higher than England, the North West and its ONS statistical neighbour industrial hinterlands. However female mortality has made significant improvements in recent years.

Summary of Key activities taken or planned to improve performance:

Whilst the latest data shows some significant improvement in life expectancy this is still a key priority in Halton .Cancer and circulatory diseases are the biggest contributor to all age all cause mortality.

Programmes such as Health Checks Plus are in place to indentify people ‘at-risk’ of major issues such as obesity, smoking, alcohol consumption, hypertension, CVD risk, cancer and cancer screening all of which are indentifying people and ensuring appropriate health interventions are put into place. Quality, Improvement, Innovation and Prevention Programmes across Mid Mersey which cover Halton and St Helens, Warrington and Knowsley plans are in place for CVD, stroke and urgent care pathways to ensure that essential health programmes are delivered in the most cost effective way to improve patient outcomes

SCS / HH6	Mortality rate from all circulatory diseases at ages under 75 (NI 121)



2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Qtr 4	Current Progress	Direction of Travel
100.23	91.8	88.5		✓	↑

Data Commentary:

Q1 data was updated on 09.09.2011, by Public Health Intelligence Team (PHIT).

Performance Commentary:

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 current programmes in place.

Circulatory disease is one of the main causes of premature death (under 75 years of age) in England, accounting for just over a quarter of all such deaths in this age group. Reducing mortality rates will therefore make a significant contribution to increasing life expectancy.

Summary of Key activities taken or planned to improve performance:

Whilst the latest data shows some significant improvement in life expectancy this is still a key priority in Halton.

Identifying people without established Cardiovascular Disease (CVD)
We continue to progress with our early detection agenda as evidence suggests that our Health Checks PLUS scheme significantly contributes to detecting CVD and other major illnesses earlier. Almost 14 000 Health Checks PLUS assessments have been undertaken within the last 12 months – 45% of these on Halton residents. We have secured new and alternative providers of HC+ assessments. We have also commissioned a community pharmacy pilot in Halton where by individuals can have a HC+ assessment at the pharmacy.

Optimisation of evidenced based therapy – clinical pathways and treatment options.
We continue to work with local GP in developing robust clinical pathways that improves the diagnosis and management of Cardiovascular Disease. These include Palpitations, Atrial Fibrillation and Stroke Prevention

We are also in the process of repatriating key treatment interventions to our local hospitals. Angioplasty for the treatment of Coronary Artery Disease – this new service will be based within Warrington and Halton Hospitals Foundation Trust improving the patient's journey and anticipated 'Length of Stay' for acute patients.

Smoking

Smoking has a major impact on levels of heart disease. Smoking cessation rates are on target and progressing well. It is expected that we will make the target. Smoking cessation is seasonal with most smokers quitting in the last quarter of January to March. Halton has one of the highest quit rates in the northwest. Halton is now concentrating on improving smoking in pregnancy figures and will be commencing a new evidence based initiative to encourage quitters to remain quit for the duration of the pregnancy.

Patients with COPD are now identified and referred on via the Stop Smoking Service. These patients often have heart as well as respiratory disease. All patients receive information and education. Working with smokers and offering brief advice is now a key part of the critical learning pathway for all clinical staff.

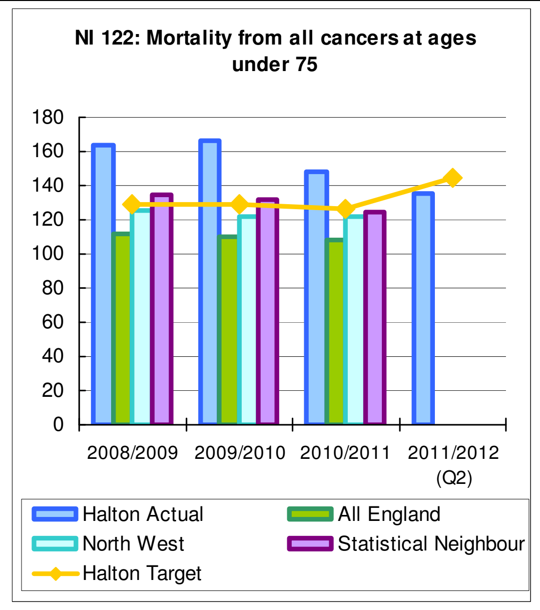
Obesity

Obesity is another major contributor to high levels of heart disease.

The weight management services commissioned support the high numbers of patients identified as obese through the Health Checks Plus Programme. A recent audit of outcomes and outputs indicates that overall services are meeting their targets and levels of customer satisfaction are high.

Adult weight management services are now embedded. There has been a considerable reduction in the waiting time for level 3 & 4 specialist services. Numbers for exercise on prescription have increased and will continue to expand. Men's Health will be further expanded.

SCS / HH7	Mortality from all cancers at ages under 75 (NI 122)



2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Qtr 4	Current Progress	Direction of Travel
147.96	145.0	135.3		✓	↑

Data Commentary:

Q2 data has been updated based on actual data.
Cancer, along with circulatory disease, is the leading causes of early death. Provisional data to November 2011 shows a continuing fall in cancer deaths.

Performance Commentary:

Cancer is one of the main causes of premature death (under 75 years of age) in England, accounting for nearly 4 in 10 of all such deaths in this age group. Reducing mortality rates will therefore make a significant contribution to increasing life expectancy

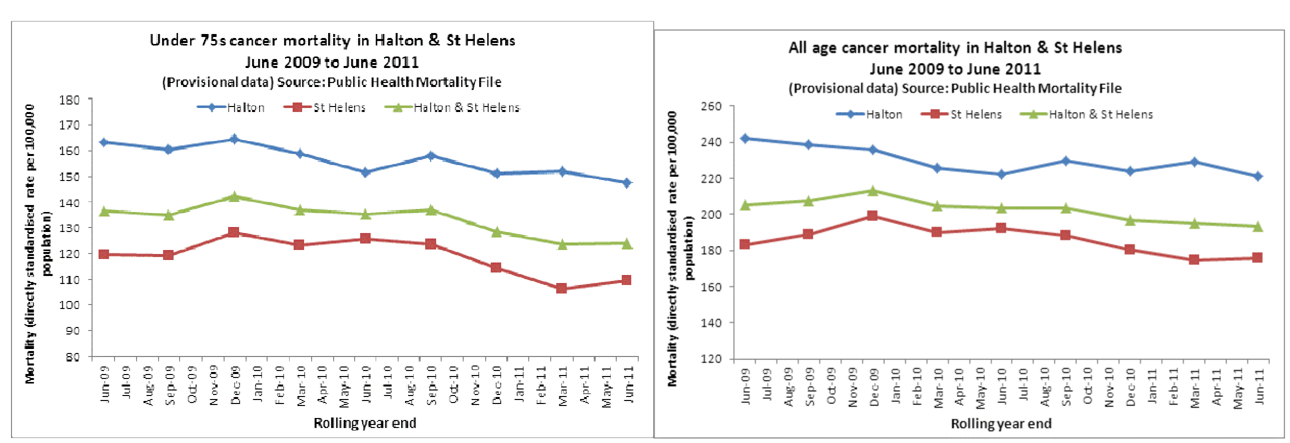
The charts show that for people of all ages, and for those under 75, cancer mortality is falling steadily in both boroughs. This is very encouraging, as until now Halton's mortality rates seemed to be stubbornly high, and not falling convincingly in recent years.

Summary of Key activities taken or planned to improve performance:

Rates remain higher in Halton than in St Helens. But they are dropping by about 5/100,000 each year. This represents more than 5 lives saved each year just in Halton.

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.

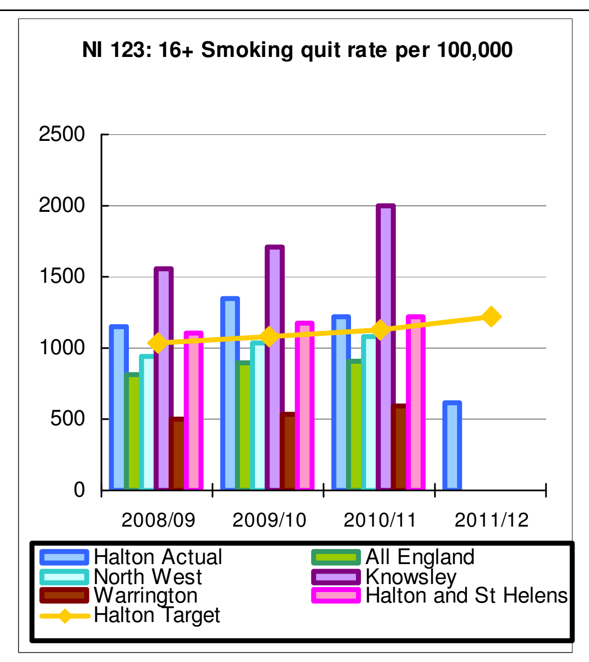
The two charts below described the rolling annual cancer mortality for the two boroughs of Halton and St Helens, over the past two years. The data is provisional, being sourced from the public health mortality files ahead of national validation. In contrast to national data, which is just under two years old, this data is available within just a few months of events. However, it must be viewed with a certain level of caution.



There are local, regional and national activities to reduce the burden of cancer deaths in Halton. They are all about raising awareness of cancer, and encouraging earlier presentation with symptoms. Local activities include the well known "Get Checked" campaign run by volunteers; screening for cancer of breast, bowel or cervix; and GP based educational programmes. Regional activities across Merseyside are the iVan cancer awareness vehicle; a project to save 424 lives across Merseyside and Cheshire by getting patients to their GP earlier; and campaigns such as the cough campaign (a cough for more than three weeks should be taken to the doctor). National cancer awareness campaigns have started with the bowel cancer campaign in January 2012, and will continue with a lung campaign later in the year.

Some of the other health improvement programmes also reduce the burden of cancer over a longer term. For example, reduced smoking rates, especially in men, are now paying off through falling lung cancer rates.

SCS / HH8	16+ Smoking quit rate per 100,000 (NI 123)



2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Qtr 4	Current Progress	Direction of Travel
1223	1223.55	614.69		✓	↑

Data Commentary:

This indicator relates to clients receiving support through the NHS Stop Smoking Services. A client is counted as a self-reported 4-week quitter if they have been assessed 4 weeks after the designated quit date and declares that he/she has not smoked even a single puff on a cigarette in the past two weeks. The indicator is a count of treatment episodes rather than people. So, if an individual undergoes two treatment episodes and has quit at four weeks in both cases, they are counted twice

Performance Commentary:

Whilst overall smoking rates in Halton have decreased considerably in recent years, tobacco is a major risk factor for cancer and heart disease and a major contributor to the health inequalities gap between Halton and England.

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. It is expected we will meet the Quarter 4target. For Quarter 2 a rate of 614.69 per 100,000 equates to 635 smokers quitting smoking.

Summary of Key activities taken or planned to improve performance:

Key tobacco control initiatives to run throughout the year are:

- Delivery of smoking prevention programmes for schools and young people via joint working between the Canal Boat project and the PCT.
- Training for teachers on illicit tobacco and its dangers.
- Tobacco Control training provided for 60 PSHE primary teachers across Halton & St Helens per annum, including support and evaluation of cascade of training to pupils.
- Social marketing driven, comprehensive, and highly visible coverage of targeted interventions delivered across Halton and St Helens.
- Deliver 12 Brief Intervention training sessions-1each month.
- Implement new intervention to encourage pregnant smokers to stay quit for the term of the pregnancy.
- Raise profile of SUPPORT stop smoking services by targeted brief Intervention training to Halton General and HCRC staff Pre-Op, Cardio respiratory, minor Injury 100% outpatient services in Halton General and 5 Borough Mental Health settings in Halton, trained in referral pathway to stop smoking services.

- Increase the number of Pharmacies offering support to smokers from 15 to 25.
- Increase in cessation data collected from GP practices
- 10% Increase in annual numbers of under 18 attending support to stop smoking
- Increase awareness of the Support service to areas of High deprivation and deliver targeted campaigns to pregnant and manual smokers.
- Incentive scheme developed for pregnant smokers.
- Social marketing programme delivered for pregnant smokers.

SCS / HH9	Mental Health - No. of people in counselling/ day services or on waiting lists. (NEW)

	2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Qtr 4	Current Progress	Direction of Travel
New Measure	New Indicator	Baseline to be established	N/A		Placeholder 2012/13	New measure

Data Commentary:

This measure has been agreed as a placeholder indicator and targets are to be set once 2011/12 data is confirmed.

Performance Commentary:

Summary of Key activities taken or planned to improve performance:

The 5 Boroughs Foundation Trust are currently proposing a new and robust model of care, 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. 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.

SCS / HH10	Proportion of older people supported to live at home through provision of a social care package (NEW)

2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Qtr 4	Current Progress	Direction of Travel
14.4%	14.6%	15.4%		✓	↑

Social Care: Proportion of older people supported to live at home via social care package (New)

	2008/09	2009/10	2010/11	2011/12
Halton Target				14.60%
Halton Actual	14.40%	14.80%	14.40%	15.40%

Legend: Halton Target, Halton Actual, All England, North West, Statistical Neighbour

Data Commentary:

This indicator measures the proportion of older people (65+) who are supported by Adult Social Care Services to live independently in their own home.

The indicator measures The number of people 65+ who are supported with an Adult Social Care Service Package as a percentage of the Older people population for Halton.

Performance Commentary:

The figure reported for Q2 has been taken as at end December 2011. The figure as at September 2011 (Q2) is not available due to data quality issues which affect reporting for the Q2 period.

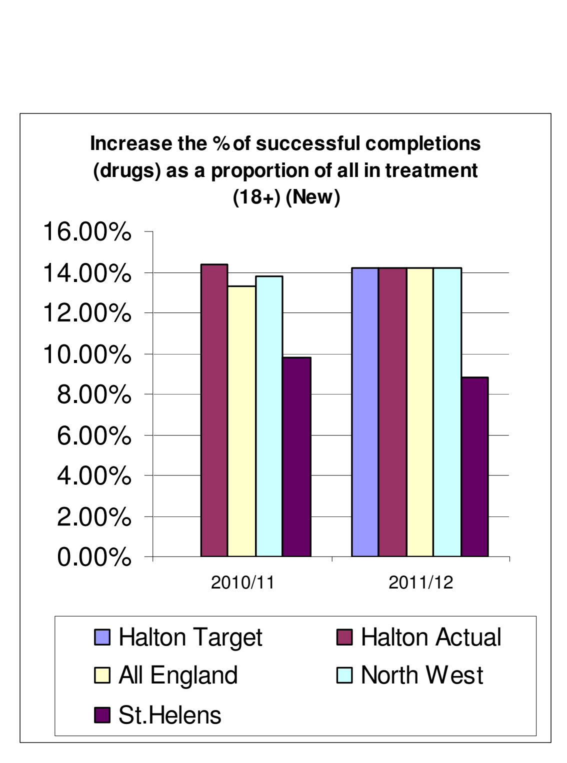
Despite the reporting issues, at the end of December the target for 2011/12 has been significantly exceeded. The number of older people being supported through the provision of a social care package has increased from 2,468 in March 2011 to 2,691 at the end of December 2011, an increase of 223 older people.

Likely explanations for the increase are increases in demand associated with an increasingly ageing population. The Council continues to advocate supporting residents in their own home for as long as possible and this is reflected in the performance of this indicator.

Summary of Key activities taken or planned to improve performance:

The Care Management service will continue to offer a personalised approach through a self directed support process developing individualised support plans and care packages tailored to individual need.

SCS/ HH11a[2]	Increase the % of successful completions (drugs) as a proportion of all in treatment (18+)



2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Qtr 4	Current Progress	Direction of Travel
14.4%	Above NW average 14.23%	**14.18%**		✓	⬇

Data Commentary:

Data is provided by the National Treatment Agency (NTA) monthly successful completions reports for partnership and regional/ national levels for quarter 2 (Apr – Sep 2011)

Performance Commentary:

The target has been set to achieve performance above the North West Average. It is intended to review this after 12 months, once the new provider is firmly in place and performance is established.

The figure of 14.18% for Halton represents 82 successful completions out of a total in treatment of 578 in the previous 12 month rolling period

Summary of Key activities taken or planned to improve performance:

The new Substance Misuse Service, provided by CRI, commenced on the 1st February. It is anticipated that following implementation of their 'foundations for recovery' model of delivery, performance will continue to exceed that of the national average.

[2] [2] [2] SCS / HH 11a is also replicated under Safer Halton as SCS /SH 7a

SCS/ HH11[3]b	Increase the % of successful completions (Alcohol) as a proportion of all in treatment (18+)

	2010/11 Actual	2011/12 Target	2011/12 Qtr 2	2011/12 Qtr 4	Current Progress	Direction of Travel
Placeholder 2012/13	New indicator	N/A	Baseline to be established		Placeholder 2012/13	New Measure

Data Commentary:

Performance Commentary:

This new service will be established in 2012/13. Targets will then be set following the collection of data in year 2012/13 and a baseline established.

The aim of this service is to increase the % of successful completions as a proportion of all people in treatment for an alcohol addiction. It is a measure of how successful the Tier 3 Community Service is, in treating alcohol dependency and ensuring that the in-treatment population does not remain static.

Summary of Key activities taken or planned to improve performance:

Following a robust and comprehensive competitive tender process, the new Substance Misuse Provider in Halton 'CRI' commenced service delivery on 1st February 2012. Work is underway to embed the service and to support CRI to deliver quality, recovery orientated interventions which put the service user at the centre of their recovery journey rather than being a passive recipient of care.

Key Stakeholders will be invited to a 'meet and greet' event in February 2012 to enable the wider partnership to learn more about the new Substance Misuse Service.

[3] [3] SCS / HH 11b is also replicated under Safer Halton as SCS / SH 7b.

Agenda Item 5e

REPORT TO: Health Policy and Performance Board

DATE: 6th March 2012

REPORTING OFFICER: Strategic Director Resources

PORTFOLIO: Health and Adults

SUBJECT: Performance Management Reports for Quarter 3 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 third quarter of 2011/12 to December 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 third 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: Communities Directorate

Department: Prevention and Assessment Services

Period: Quarter 3 - 1st October 2011 – 31st December 2011

1.0 Introduction

This monitoring report covers the Prevention and Assessment Services third quarter period up to 31st December 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 5.

2.0 Key Developments

Customer Care
Following Feedback received during the Care Quality Commission inspection of Adult Social Care in Halton (in 2010), and from other research, it was highlighted that people wanted a less formal way of raising concerns. 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.

Safeguarding
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.

Domestic Abuse and Sexual Violence
The Halton Survivors of Domestic Abuse and Sexual Violence held a Conference in support of 'The White Ribbon Campaign', which was opened by Derek Twigg MP and closed by Councillor Shaun Osborne. 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.

Six Lives
Work is ongoing to ensure progress is maintained in responding to the Ombudsman's Report Six Lives. Work primarily relates to healthcare services access/reasonable adjustments and Mental Capacity Act and has begun to be progressed through the multi-agency Healthcare for All sub group of the Learning Disability Partnership Board. Health passports are now in use, individuals and their families are being encouraged to take control of these and take them to Doctor's/health appointments. There are three training sessions with Whiston Hospital staff, are being carried out in January, February and March, on Learning Disability awareness. Meetings have taken place to look at supporting/training staff within the sexual health clinics in Halton around Learning Disability awareness.

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. A 12 week health promotion workshop for men is due to start at the beginning of February. Discussion took place with carers from Halton Adult Learning Disability Support, (HALDS), a local family and carers support group regarding the team and how people can access specialist Learning Disability health support. The Anticipatory Care Calendar via Merseyside and Cheshire Cancer network is being progressed through the Supported Housing Network, Alternative Futures, Community Integrated Care and European Wellcare. Senior staff are being trained during February and March and care staff are going to use an E-Learning programme to be accredited to use the calendar. Halton are a pilot site for the new E-Learning package. Three training sessions with Whiston Hospital staff are being carried out in January, February and March, on Learning Disability awareness. Meetings have taken place to look at supporting/training staff within the sexual health clinics in Halton around Learning Disability awareness.

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. The Board continues to meet on a bi-monthly basis with dedicated themes. The health steering group continues ongoing work ongoing action planning on the Health assessment.

3.0 Emerging Issues

Safe Around Town
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. A steering group has been established and Halton Speak Out have agreed to lead on the project to be established at Halton Lea.

Energy Act 2011
The Energy Act 2011 (introduced on 18th October 2011) creates a step change in the provision of energy efficiency measures to homes and businesses. The Act includes provisions on the Green Deal which is a new finance framework that will provide householders and businesses with the upfront capital to carry out energy efficiency improvements to their premises and repay through their energy bill. This will be achieved by attaching a Green Deal charge to the electricity meter at the property concerned with the protection of the Green Deal ' Golden Rule ' that is, any charge attached must be less than the expected savings from the retrofit. As to what role we will play in delivering the Green Deal is unclear at this point but Government guidance is expected early 2012.

Reconfiguration of Care Management
In order to transform Adult Social Care in line with Putting People First and fully implement Self Directed Support and respond to an agenda that incorporates prevention, inclusion and personalisation, the current way in which services are delivered in adult social care needs to be reviewed.
There is an increasing requirement for joint working between health and social care to be facilitated to ensure the population's health inequalities and needs are being addressed. Growing evidence supports the establishment of multi-professional health and social care teams to address the needs of high risk people within the community.
Currently, the adult social care delivery system in Halton is working as a hybrid with the new Self Directed Support processes effectively being superimposed on the previous social care delivery system. In this review, the proposed new model of delivery will have the effect of providing an efficient, productive and responsive service for the local population. The new model would also have the potential to facilitate integrated care partnerships with health partners locally.

A Reconfiguration Board has been established and supporting work streams are developing a proposed model.

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	9	✓	9	?	0	✗	0

All 'other' objectives / milestones are presently on track to achieve annual targets; and are therefore not being reported by exception at this time.

5.0 Performance indicators

5.1 Progress Against 'key' performance indicators

Total	4	✓	4	?	0	✗	0

Four of the 'key' performance indicators remain on track to achieve annual targets. However, there is currently one new indicator relating to Air Pollution Control which cannot be reported at this stage and will be reported at the end of the financial year. Further information can be found within Appendix 2.

5.2 Progress Against 'other' performance indicators

Total	18	✓	14	?	3	✗	1

There are three ‘other’ performance indicators which are uncertain to achieve annual targets at this stage. One indicator relates to ethnicity of older people receiving an assessment; due to the small ethnic population in Halton, any fluctuation in this group can change the track of whether the target will be achieved. One indicator relates to adults with learning disabilities in settled accommodation this figure is a percentage of disabled people known to the Council. Another indicator relates to issues with the recording of carer services within the Carefirst system.

One indicator that will not achieve annual target this year relates to permanent admissions to residential and nursing care homes. This is a new indicator for 2011/12, which now includes admissions in the 18+ range rather than just the 65+ range previously reported.

Also there are five indicators that cannot be reported at this time which relate to data that will be reported at the end of the financial year. Further information can be found in Appendix 3.

The remaining fourteen Council and Area Partner indicators are on track to achieve annual targets and are therefore not being reported by exception at this time.

6.0 Risk Control Measures

During the development of the 2011 -12 Service activity, the service was required to undertake a risk assessment of all Key Service Objectives. No ‘high’ risk, treatment measures were identified.

7.0 Progress against high priority equality actions

Where a Key service objective has been assessed and found to have an associated ‘High’ priority, progress will be reported in quarters 2 and 4.

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 ‘key’ performance indicators
Appendix 3	Progress against ‘other’ performance indicators
Appendix 4	Financial Statement
Appendix 5	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 3	Supporting Commentary
Commence implementation of the Early Intervention/Prevention Strategy to improve outcomes for Older People in Halton. **Mar 2012.** (AOF6 & 7)	✓	The Intergenerational strategy has now been completed as part of the implementation of the Early Intervention and Prevention strategy. The associated action plan to the overall strategy has been further amended and agreed and a financial resource mapping has been initiated. All first year milestones for the strategy have been completed or are on course for completion by March 2012.
Commence implementation of Telecare strategy and action plan. **Mar 2012.** (AOF 6 & 7)	✓	Implementation of the Telecare strategy is ongoing. The service is currently exceeding the targets set for numbers of people receiving a service.
Continue to establish effective arrangements across the whole of adult social care to deliver self directed support and personal budgets. **Mar 2012** (AOF6)	✓	Currently reviewing the self directed support processes, policies and procedures to ensure that they are compatible with the reconfiguration of adult social care and reflect best practice and learning.
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. Further evaluation of performance is underway and will be monitored through the Intermediate Care Partnership Board
Commence implementation of Business Plan for Oak meadow. **Mar 2012.** (AOF 6&7)	✓	The refurbishment of Oak Meadow has been completed and the development of the venue for community based services is progressing and on target for full implementation.

Appendix 1: Progress Against 'key' 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 3	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 'key' performance indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 3	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	68.1	✓	⬇	This is a cumulative figure of 1183 and equates to 352 people in receipt of intermediate care in the 65+ age bracket. The cumulative figure is slightly lower compared to Q3 2010/11 at 1199.
PA 5	Percentage of people fully independent on discharge from intermediate care/reablement services	N/A	40% (New Indicator).	59%	✓	⬆	The figure for Q3 relates to people discharged from the service during this period. This has seen a significant increase in the last period.
Service Delivery							
PA 6	Number of people receiving Telecare Levels 2 and 3	166	164	138	✓	⬆	There is an increase in the number of people supported by Telecare and the final figure is expected to exceed the target.

Appendix 2: Progress Against 'key' performance indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 3	Current Progress	Direction of Travel	Supporting Commentary
Quality							
PA 14	% of items of equipment, and adaptations below £1,000, delivered within 7 working days (Previously CCS 5, PAF D54 and BVPI 56)	96.65	96	97.84	✓	⇧	There are some data quality issues with the recording of equipment for Deafness Resource Centre (DRC) which are currently being investigated. As a result of this, the Q3 figure does not include DRC equipment.
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	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 3: Progress against 'other' performance indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 3	Current Progress	Direction of Travel	Supporting Commentary
Service Delivery							
PA10	Percentage of adults with Learning Disabilities in Settled accommodation (Previously NI 145 – Complex Care)	92%	90%	88.3%	?		317 learning disabled people of working age (18-64) in settled accommodation. This is a percentage of 359 learning disabled people known to the council for the time period 01/04/2011 – 31/12/2011.
Fair Access							
PA 21	Ethnicity of Older People receiving assessment (Previously PCS 4b)	0.59	1.5	0.30	?		In Q3 there was one client whose ethnicity was other than white. This indicator is subject to great fluctuation given the small ethnic population in Halton.

Appendix 3: Progress against 'other' performance indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 3	Current Progress	Direction of Travel	Supporting Commentary
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%	27.87%E	?	⇧	Work around changes of recording carer services within the Carefirst database is almost complete. Figure provided for Q3 is an estimate based on the data currently available.
PA 31	Permanent Admissions to residential and nursing care homes (18+) per 100,000 population (2A)	105.05	108.74	155.14	✗	Refer to comment	Currently 107 clients aged 18+ have been admitted to permanent residential or nursing care, giving an indicator value of 155.14. Target based on 100 people. As this is a new indicator for 2011/12, that now includes admissions in the 18+ range rather than just the 65+ range. There is no comparative data.
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 current data was provided in quarter 1 as information is only available each year in May – following the collection, submission and assessment of the Adult Social Care Combined Activity Return (ASC-CAR).

Appendix 3: Progress against 'other' performance indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 3	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 in January/February 2012, with results becoming available in Q1 2012/13.
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 in January/February 2012, with results becoming available in Q1 2012/13.
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 is an annual survey which will be undertaken in January/February 2012, with results becoming available in Q1 2012/13.
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 Adult Social Care Combined Activity Return (ASC-CAR) at the end of the financial year. Results will be available in Q1 2012/13.

Appendix 4: Financial Statement

COMMUNITIES – PREVENTION & ASSESSMENT DEPARTMENT

Revenue Budget as at 31st December 2011

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	**Variance To Date** (overspend) £'000
Expenditure				
Employees	7,682	5,290	5,197	93
Other Premises	67	35	27	8
Supplies & Services	549	259	291	(32)
Consumer Protection	443	222	218	4
Transport	144	108	91	17
Food Provision	16	12	7	5
Aids & Adaptations	113	41	61	(20)
Contribution to JES	403	0	0	0
Community Care:				
Residential & Nursing Care	9,647	5,712	6,437	(725)
Domiciliary & Supported Living	6,716	4,513	5,218	(705)
Direct Payments	2,463	1,847	1,820	27
Day Care	231	157	236	(79)
Other Agency	178	116	114	2
Contribution to Intermediate Care Pool	2,563	1,940	1,875	65
Total Expenditure	**31,215**	**20,252**	**21,592**	**(1,340)**
Income				
Other Fees and Charges	-119	-89	-52	(37)
Sales Income	-76	-76	-75	(1)
Reimbursements and Other Grant Income	-448	-164	-152	(12)
Residential & Nursing Income	-3,521	-2,438	-2,756	318
Community Care Income	-709	-500	-660	160
Direct Payments Income	-82	-62	-109	47
Transfer from Reserves	-343	0	0	0
LD & Health Reform Allocation	-4,272	-4,272	-4,272	0
PCT Contribution to Care	-621	-424	-454	30
PCT Contribution to Service	-1,716	-1,674	-1,696	22
Total Income	**-11,907**	**-9,699**	**-10,226**	**527**
Net Operational Expenditure	**19,308**	**10,553**	**11,366**	**(813)**
Recharges				
Premises Support	413	296	296	0
Asset Charges	160	9	9	0
Central Support Services	3,663	2,680	2,681	(1)
Internal Recharge Income	-566	-322	-322	0
Total Recharges	**3,670**	**2,663**	**2,664**	**(1)**
Net Departmental Total	**22,978**	**13,216**	**14,030**	**(814)**

Appendix 4: Financial Statement

Comments on the above figures:
In overall terms the net operational expenditure for Quarter 3 is £879,000 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 £93,000 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 will be met by year end.

The main pressure area is the Community Care budget which is currently £927,000 over budget profile net of income. However this is an increase in overspend of only £15,000 from Quarter 2. There has been an increase in spend due to the resolution of some outstanding disputes for Continuing Health Care of £689,000, mainly Adults with Learning Disability clients. The full year effect of this is £827,000. Although the first half of the year experienced increasing numbers of service users accessing the community care service quarter 3 has seen numbers stabilise and this has been accompanied with an increase in income due to the changes in the Fairer Charging Policy being realised. Staff across the Directorate have also worked extremely hard to ensure the budget is monitored very closely and ensure all possible action is taken to bring this very volatile budget back in line. The year end position for the Community Care budget is expected to be a £1.2m overspend.

Contribution to Intermediate Care Pooled Budget

Revenue Budget as at 31st December 2011

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	1,569	1,184	1,176	8
Supplies & Services	446	258	201	57
Transport	10	10	10	0
Other Agency Costs	157	118	118	0
Total Expenditure	**2,182**	**1,570**	**1,505**	**65**
Income				
Total Income	**-113**	**0**	**0**	**0**
Net Operational Expenditure	**2,069**	**1,570**	**1,505**	**65**
Recharges				
Central Support Charges	453	340	340	0
Premises Support	41	30	30	0
Total Recharges	**494**	**370**	**370**	**0**
Net Departmental Total	**2,563**	**1,940**	**1,875**	**65**

The above figures relate to the HBC contribution to the pool only.

Appendix 4: Financial Statement

Comments on the above figures:

In overall terms revenue spending at the end of quarter 3 is £65,000 below budget profile, which in the main relates to expenditure on supplies & services that is £57,000 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 31st December 2011

	2011/12 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
Social Care & Health				
Oakmeadow Phase 2	50	50	49	1
Total Spending	**50**	**50**	**49**	**1**

Appendix 5: 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 3 - 1st October 2011 – 31st December 2011

1.0 Introduction

This quarterly monitoring report covers Commissioning and Complex Care Services for the third quarter period up to 31st December 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

Commissioning

Tenders have progressed for the floating support services and a report is to be taken to Executive Board Sub Committee on 12th January 2012 advising of the outcome and recommendation to award. The Tender processes for the domestic abuse services and the CIC accommodation services were terminated due to lack of competition. Requests will be made for waivers for extensions to existing services while proposals for future service delivery are considered.

Over recent months details of the Homes and Communities Agency's Affordable Housing Programme for the 2011/12 – 2014/15 period have emerged. For Halton funding has been secured by Halton Housing Trust, Arena, Liverpool Housing Trust and Cosmopolitan Housing Association to develop 320 dwellings – 119 of these in Runcorn and 201 in Widnes. This is welcome news at a time of growing waiting lists and a depressed housing market.

Extra Care Housing Tenders

The Tender process for the commissioning of the care element of the new Extra Care housing schemes will commence in January 2012. This will include the two new schemes on Liverpool Road (in partnership with Halton Housing Trust) and the Boardwalks (in partnership with Cosmopolitan).

Dementia Care Advisors:
The new contract will be completed and issued in January and the service will be delivered through a partnership between Alzheimer's Society and Age UK. The service will be joint across Halton and St Helens; however, Halton Borough Council will be the lead organisation for the contract.

3.0 Emerging Issues

Model of Care to develop a Comprehensive Community services infrastructure for Adults with Learning Disabilities
Consultation on the de-commissioning of the assessment and treatment in-patient beds provided by the 5 Boroughs Foundation Trust has now concluded. Generally the response is in favour with some reservations. To ensure transparency a multi-stakeholder group including Commissioners across Health and Social Care in Halton, St Helens, Knowsley and Warrington will be established to develop a full response. Equality Impact Assessments and Health Impact Assessments will be completed.

Substance Misuse
There is a requirement by both the National Treatment Agency, and under the Crime and Disorder Act, for Partnerships to undertake regular needs assessments. The last needs assessment undertaken by the Drug Action Team was in 2009/10 to inform the 2010/11 adult treatment plan. With the publication of the Coalition Drug Strategy in December 2010 and a new Substance Misuse Provider in the Borough from January 2012, it would seem an appropriate time to undertake a needs assessment.

The aims of the needs assessment would be to;

a) Identify the substance misuse related needs of people in Halton.
b) Identify the patterns of substance misuse with the Borough.
c) Provide the strategic direction to ensure that the Safer Halton partnership reduces the impact of substance misuse on people and communities in Halton.

Electronic Monitoring – Domiciliary Care
Work has commenced to develop an agreed and effective system to deliver electronic monitoring to domiciliary care providers operating in Halton.

Sheltered Accommodation
A strategic review of all sheltered accommodation will commence in February 2012 and will consider a current position statement, a market analysis and a recommendations report.

4.0 Service Objectives/Milestones

4.1 Progress Against 'Key' Objectives/Milestones

Total	7	✓	6	?	1	✗	0

Six 'Key' Objectives / Milestones are presently on track to achieve annual targets. However, at this stage there is some uncertainty whether the indicator for the Joint Strategic Needs Assessment (JSNA) will achieve the annual target. Additional information can be found within Appendix 1.

4.2 Progress Against 'Other' Objectives/Milestones

Total	16	✓	11	?	5	✗	0

It is uncertain at this stage whether four of the 'Other' Objectives / Milestones will achieve annual targets. The implementation and review of the Single Point of Access is unlikely to be completed by the end of March due to the number of external workstreams involved. The number of Carers receiving a carers break and the maintenance of carer assessment leading to the provision of services is also uncertain at this stage. The evaluation of the JSNA is due to be undertaken during March 2012; again this holds some uncertainty as to whether the target will be achieved. Additional details are provided within Appendix 2.

However, eleven of the remaining indicators for the Department are on track to be achieved and are therefore not being reported by exception at this time.

5.0 Performance Indicators

5.1 Progress Against 'Key' Performance Indicators

Total	6	✓	3	?	2	✗	1

Three 'Key' Performance Indicators are presently on track to achieve annual targets. However, it is uncertain at this stage whether the two indicators relating to dementia will achieve annual targets due to data quality issues and partnership reporting. One indicator will not achieve annual target due to issues surrounding

the recording of data. Additional details are provided within Appendix 3.

5.2 Progress Against 'Other' Performance Indicators

Total	**9**	✓	7	?	2	✗	0

At this stage of the reporting year it is uncertain whether two 'other' performance indicators will achieve annual target based on estimated data due to issues with the recording of data and fluctuations in primary client type.

There are three indicators that cannot be reported at this time as they relate to the Adult Social Care Survey which is taking place between January and March. Baselines will also be re-established in 2011/12 for three other indicators CC1-CC3. Further information can be found in Appendix 4. However, the remaining indicators are on track to achieve annual targets and are therefore not being reported by exception at this time.

6.0 Risk Control Measures

During the Development of the 2011-12 Service activity, the service was required to undertake a risk assessment of all Key Service objectives.

Where a Key service objective has been assessed and found to have an associated 'High' risk, progress against the application of this risk treatment measure will be reported in quarters 2 and 4.

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 Q3	Supporting Commentary
Implement the Local Dementia Strategy, to ensure effective services are in place. **Mar 2012.** (AOF6 & 7)	✓	Draft contract for Dementia Care Advisors has now been completed, the service will be provided in partnership between Alzheimer's Society and Age UK and recruitment of staff will take place at the end of January 2012. 5 Borough Partnership are currently implementing changes to both the Adults and Later Life Mental Health pathways. This will aim to improve access to service and quality of the service delivered. The adult pathway redesign will be implemented in April 2012 and a pilot of the Later Life redesign will also start in April in Wigan with learning used in Halton.
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)	✓	The Carers Centre applied for a Big Lottery bid and were informed on 19.1.12, that they have successfully got through to the second stage. If approved lottery funding would be received May/June 2012. Carers Centre Manager has appointment to discuss future funding with PCT/NHS on 30.1.12 Children and Enterprise have funded £6,000 towards a post within the Carers Centre to deliver training/group work for Young Carers until the end of March 2012, Esmee Fairbairn have funded £33,500 for a Young Carer workers post, this is until December 2012. John Moores have funded £5,000 towards the cost of a Young carers worker.

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 Q3	Supporting Commentary
Introduce specialist support provision for victims of a serious sexual offence **Mar 2012** *(AOF6 & 7)*	✓	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 and provide forensic medical examination, care and aftercare. St Marys in Manchester was the first SARC in the country; they began offering a service for children 5 years ago. They now see 450+ children a year. The contract to provide SARC services across the four Cheshire LSCB areas began in April 2011. Activity and performance is reported to the Cheshire SARC Management Board. The service has received positive feedback from stakeholders and those accessing the service from across Cheshire.

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 Q3	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)	✓	Three surveys were distributed during Q3 in relation to care and support services. The three surveys were as follows; 1) Quality of Home Care. 2) Care Home - Service Users. 3) Care Home - Next of Kin. In addition a further survey was administered in relation to changes to the National Blue Badge scheme and an increase in charges to users of the Blue Badge scheme in Halton. The results of the consultations are in the process of evaluation.

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 Q3	Supporting Commentary
Ensure HealthWatch is established and consider working in partnership with other Councils to deliver this. **Mar 2012** (AOF 32)	✓	LINK Transition Sub Group continues to meet. LINk Board Members focus group took place in Sept 2011 and LINK Board Focus Group taking place in Dec 2011 to gather views on how they think Halton's Local HealthWatch could be structured, what services it could deliver to meet the remit etc. HBC HealthWatch Project group meeting in Dec 2011 with Legal to seek advice on possible models of Local HealthWatch. Due to meet with Mersey Cluster Local Authorities in New Year to discuss possible cross boundary working. Development of Local HealthWatch specification to be started in New Year. Dept of Health time scale for implementing Local HealthWatch remains October 2012.
Update the Joint Strategic Needs Assessment (JSNA) summary of findings, following community consultation, to ensure it continues to effectively highlight the health and wellbeing needs of people of Halton. **Mar 2012** (AOF 6)	?	Comments received through ratification process to be taken on board in the future refresh of the JSNA. Research and Intelligence and Public Health Analyst working on developing a data sheet with links to all current data. Draft refresh protocol developed. JSNA Evaluation due to be undertaken in March 2012 where refresh protocol to be agreed i.e. what changes constitute a redraft of chapter, what will trigger a new chapter etc.

Appendix 1: Progress Against 'Key' 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 Q3	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 agreed, the shadow board has been established and met for the first time during Q3. Detailed governance structures and reporting mechanisms into the Health and Wellbeing board have been drafted and currently being approved. Advanced discussions regarding the transfer of Public Health to the Council continue.

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 Q3	Supporting Commentary
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)*	?	There are a number of workstreams that are working concurrently to redesign mental health services in the borough. • 5 boroughs partnership adult acute pathway • 5 boroughs partnership later life and memory services • Review of the Social work role within the Older People's Community Mental Health Services • Review of the Social work role in the Functional Community Mental Health Team Each of these pieces of work will feed into an effective mechanism for access to services. It is unlikely that all of this work will be completed by the end of March 2012.
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 of the Gateway service.
Maintain the number of carers receiving a carers' break, to ensure Carers needs are met. Mar 2012 (AOF7)	?	Carers Assessors and Assessment meetings are in progress to ensure that carers' needs are met. Performance is also being monitored and reviewed through performance management meetings in each service area and supervisions.
Maintain the numbers of carers provided with	?	Carers Assessors and Assessments meetings are in progress to ensure that carers' needs are met. Performance is also being

assessment leading to the provision of services, to ensure Carers needs are met. Mar 2012. (AOF7)		monitored and reviewed through performance management meetings in each service area and supervisions.

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 Q3	Supporting Commentary
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)*	?	Comments received through ratification process to be taken on board in the future refresh of the JSNA. Research and Intelligence and Public Health Analyst are working on developing a data sheet with links to all current data. Draft refresh protocol developed. JSNA Evaluation due to be undertaken in March 2012 where refresh protocol to be agreed i.e. what changes constitute a redraft of a chapter, what will trigger a new chapter etc.

Appendix 3: Progress Against 'Key' Performance Indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 3	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	3.87E	✓	⬇	Work around changes of recording carer services within the Carefirst database is almost complete. Figure provided for Q3 is an estimate based on the data currently available.
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%	4.8%	?	⬆	Although this figure has seen an improvement on Q2 it is still difficult to accurately assess if the data that is collected through Carefirst is complete and up to date
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%	2.9%	?	⇔	Again this figure is increasing on Q2, but only marginally. However, this clearly demonstrates that there is work to do with primary care and 5 boroughs partnership to ensure timely and efficient diagnosis of Dementia.

Appendix 3: Progress Against 'Key' Performance Indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 3	Current Progress	Direction of Travel	Supporting Commentary
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. Halton Borough Council has also registered as part of the no second night out protocol to tackle rough sleeping
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	4.71	✓	↑	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	12.94E	✗	↓	Work around changes of recording carer services within the Carefirst database is almost complete. Figure provided for Q3 is an estimate based on the data currently available.

Appendix 4: Progress Against 'Other' Performance Indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 3	Current Progress	Direction of Travel	Supporting Commentary
Cost and Efficiency							
CCC 1	% of client group expenditure (MH) spent on domiciliary care services (Previously PCS15)	29%	Baseline to be re-established in 2011/12	33%	N/A	⇧	There has been a slight increase in expenditure for MH domiciliary care services this quarter compared to 31% at Q3 last year.
CCC 2	% of client group expenditure (ALD) spent on domiciliary care services (Previously PCS1)	38%	Baseline to be re-established in 2011/12	63%	N/A	⇧	There has been a significant increase in expenditure for ALD domiciliary care services this quarter compared to 40% at Q3 last year.
CCC 3	% of client group expenditure (PSD) spent on domiciliary care services (Previously PCS2)	23%	Baseline to be re-established in 2011/12	76%	N/A	⇧	There has been a dramatic increase in expenditure for PSD domiciliary care services this quarter compared to 24% at Q3 last year.
Service Delivery							
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	4.16E	?	⇩	Work around changes of recording carer services within the Carefirst database is almost complete. Figure provided for Q3 is an estimate based on the data currently available.

Appendix 4: Progress Against 'Other' Performance Indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 3	Current Progress	Direction of Travel	Supporting Commentary
Fair Access							
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 4).	25	21	7	?		The figure for Q3 has seen a decrease compared to the same quarter in 2010/11 (20) and it is uncertain at this stage whether the target can be achieved in 2011/12.

Appendix 4: Progress Against 'Other' Performance Indicators

Ref	Description	Actual 2010/11	Target 2011/12	Quarter 3	Current Progress	Direction of Travel	Supporting Commentary
CCC 38	Social Care-related Quality of life (Adult Social Care Survey) **1A.**	18.9%	Baseline to be confirmed	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%	Baseline to be confirmed	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 42	Overall satisfaction of people who use services with their care and support (Adult Social Care Survey) 3A.	61.7%	Baseline to be confirmed	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 CARE DEPARTMENT

Revenue Budget as at 31st December 2011

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	7,413	5,474	5,476	(2)
Other Premises	333	266	262	4
Supplies & Services	2,985	1,787	1,791	(4)
Contracts & SLA's	518	140	84	56
Transport	295	201	176	25
Emergency Duty Team	103	52	41	11
Community Care:				
Residential & Nursing Care	806	574	498	76
Domiciliary Care	359	184	187	(3)
Direct Payments	144	114	125	(11)
Block Contracts	174	126	117	9
In-House Day Care	23	5	10	(5)
Food Provision	33	17	13	4
Other Agency Costs	558	423	430	(7)
Payments To Providers	4,218	3,325	3,324	1
Grants To Voluntary Organisations	270	253	258	(5)
Total Expenditure	**18,232**	**12,941**	**12,792**	**149**
Income				
Residential & Nursing Fees	-68	-45	-49	4
Direct Payment Charges	-3	-3	-4	1
Community Care Income	-4	-4	-9	5
Sales & Rents Income	-176	-151	-149	(2)
Fees & Charges	-446	-253	-291	38
PCT Reimbursements : Care	-202	-125	-168	43
PCT Reimbursements :Service	-2020	-1,241	-1,287	46
Reimbursements	-457	-254	-236	(18)
Government Grant Income	-293	-185	-188	3
Total Income	**-3,669**	**-2,261**	**-2,381**	**120**
Net Operational Expenditure	**14,563**	**10,680**	**10,411**	**269**
Recharges				
Premises Support	464	327	327	0
Transport	449	326	326	0
Central Support Services	2,729	1,892	1,892	0
Asset Charges	406	0	0	0
Internal Recharge Income	-88	0	0	0
Net Total Recharges	**3,960**	**2,545**	**2,545**	**0**
Net Departmental Total	**18,523**	**13,225**	**12,956**	**269**

Appendix 5: Financial Statement

Comments on the above figures:

Net operational expenditure is £269,000 below budget profile at the end of the third quarter of the financial year.

The Community Care element of Mental Health Services is forecast to be £162,000 below budget based on data held for all known care packages. This figure is subject to fluctuation, dependent on the number and value of new packages approved, and the termination or variation of existing packages. At the end of Quarter 3 the net position is £121,000 below profile.

Expenditure on Contracts and Service Level Agreements is projected to be £120,000 below budget at the year-end. The savings are on the Bredon Respite Services contract (£35,000) Homelessness Service contract (£30,000), and payments to Bed and Breakfast providers for homelessness support (£55,000).

Transport costs in Adult Day Services are in the region of £30,000 below budget profile. This results from the replacement of taxi contracts with transport provided by fleet vehicles. It is anticipated that spend will be £40,000 below budget at the end of the financial year.

Income is currently above the target to-date. The previous quarter's report, referred to the possibility of Community Centres income not achieving the target, as a result of wider economic pressures. However, action has been taken to maximise income from room lettings, and it is now anticipated that this target will be achieved. The figures in the table above include a projected over-achievement of Community Care income of £74,000 for the full year, which is included within the £162,000 projected net underspend for Community Care referred to above.

At this stage, net expenditure for the Complex & Commissioning Care Division is anticipated to be £360,000 below budget at the end of the financial year.

Capital Projects as at 31st December 2011

	2010/11 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Allocation Remaining £'000
Renovation Grant	214	60	61	153
Disabled Facilities Grant	660	500	428	232
Energy Promotion	6	0	0	6
Stairlifts	200	175	197	3
RSL Adaptations	560	350	291	269
Modular Buildings	27	15	0	27
Choice Based Lettings	40	13	11	29
Extra Care Housing	463	0	0	463
User Led Adaptations	55	10	0	55
Total Spending	**2,225**	**1,123**	**988**	**1,237**

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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Agenda Item 6a

REPORT TO: Health Policy & Performance Board

DATE: 6 March 2012

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & 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' (i.e. adults at risk of abuse) in Halton.

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

3.0 **SUPPORTING INFORMATION**

3.1 The Safeguarding Adults Board's priorities, structure, reporting arrangements, membership and work plan have been reviewed, taking into account the establishment of the Health and Well-Being Board in shadow form, and the need to look creatively at mechanisms for engaging as partner agencies and individuals at a time of reducing resources and major change. The revised work plan will demonstrate a greater focus on prevention, aim to strengthen links with Dignity and Domestic Abuse agendas, and examine Safeguarding provision in self-directed support and Personalisation.

3.2 The protocol between Halton Borough Council Adult Social Care and the Police Public Protection Unit is being further revised to include guidance on:

- Cases where an alleged perpetrator lacks capacity for criminal intent and
- The offence (under the Mental Capacity Act 2005) of ill-treatment or willful neglect of a person lacking or thought to lack capacity.

3.3 A generic Recruitment and Selection training course, available to Halton Borough Council managers with responsibility to appoint to positions in contact with vulnerable adults, has been reviewed with the outcome that a new, modular course is being designed to incorporate a greater emphasis on Safer Recruitment in a context of Safeguarding Adults. Safer recruitment principles and practice are already embedded in the existing course, but the content will be developed to help raise awareness of the importance of Adult Safeguarding, especially for those who have infrequent contact with adults at risk of abuse. The revised course will provide a modular approach

including both E-Learning and classroom activity, to enable new and existing managers to undertake those elements pertinent to their particular needs. The E-learning element will be available to all agencies and employers with on-line access. Halton Safeguarding Children Board provides Safer Recruitment training modules, with particular reference to Safeguarding Children.

3.4 Safeguarding and Dignity elements have been incorporated into new guidance for staff in Residential and Nursing Homes and staff working in Domiciliary Care: ‘Nutrition And Hydration In Care And Support’.

3.5 In May last year the BBC showed an investigative Panorama programme that highlighted the abuse of people with learning disabilities and autism in Winterbourne View, an assessment and treatment residential service near Bristol for people with complex needs. Secretly filmed footage appeared to show residents being pinned down, slapped, doused in water and taunted, a senior member of staff "punishing" a patient by sitting and stamping on her, putting her in a headlock and dragging her around by the arms.

Twenty-four patients were transferred from Winterbourne View following the investigation and the the owners, Castlebeck, closed the facility last June.

Following a Police investigation, ten people were charged with ill-treatment and wilful neglect of four of the patients concerned. During their appearance at Bristol Crown Court on 9th February 2012, three staff pleaded guilty to the ill treatment of residents. All three have been released on bail to await sentencing at a later date.

Two others pleaded not guilty and no pleas were entered for six people. Their cases will be heard in March 2012.

Avon and Somerset Police said a further three people who were arrested during the investigation will not face charges.

3.6 The Ministry of Justice is carrying out a consultation ‘Getting it right for victims and witnesses’, about the Government’s proposed approach:

- To ensuring that victims and witnesses get the support they need, both to overcome the consequences of crime and to participate fully in the criminal justice process

- To ensuring that offenders take greater responsibility for repairing the harm they have caused, through a combination of financial reparation and restorative justice.

The consultation (closing date: 22 April 2012) is aimed at all criminal justice agencies, the victim support and advice sector, local authorities, the judiciary, and all representative bodies and charitable organisations with an interest in this area in England, Wales and Scotland, and can be accessed

via the link below:

http://www.justice.gov.uk/consultations/victims-witnesses-cp3-2012.htm

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.

Agenda Item 6b

REPORT: Health Policy and Performance Board

DATE: 6 March 2012

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Neighbourhood Leisure & Sport

SUBJECT: Draft Sports Strategy

WARDS: Borough wide

1.0 PURPOSE OF REPORT

1.1 To consider the draft sports strategy. This strategy has been considered by The Employment, Learning, Skills and Community PPB who have referred it to The Health PPB for comment.

2.0 RECOMMENDED That:

(1) the report is noted; and

(2) Board Members comment on the draft Sports Strategy 2012 -2015.

3.0 SUPPORTING INFORMATION

3.1 This year a key objective of the council is to produce a new sports strategy for Halton. Consultation, essential for the success of the strategy, has already begun with sports forums and others with an interest in sport.

3.2 An outline draft copy of the Halton Sports Strategy 2012 -15 is attached at Appendix 1.

3.3 The strategy takes into account government policy, Sport England Strategy, National policies from other relevant bodies; relevant regional policies, sports specific policies and local plans, strategies and priorities.

3.4 The strategy identifies 6 key themes

- Increase Participation and Widening Access
- Club Development
- Coach Education and Volunteering
- Sporting Excellence
- Finance and Funding for Sport
- Sports Facilities

It will be underpinned by the need for Partnership working with local and national key partners and active promotion and publicity to raise the profile of sport.

3.5 A key outcome is to increase participation in which Halton has made excellent progress. This is evidenced within the strategy. Many successes and initiatives of Halton Borough Council have contributed to the rise in performance since 2005;

- Improved leisure facilities, notably a new athletics facility, 2 AstroTurf Pitches, Indoor Tennis Centre, expansion of Gym facilities Kingsway Leisure Centre.
- Partnership with DC Leisure to manage the council's Leisure Centre's and to develop participation.
- Sports participation project, working with other sport providers especially within the voluntary sports club sector to improve and increase the opportunities available within community settings
- Free access to Park activities including Tennis, Basketball and Bowling
- Free junior sports pitch hire.
- 100% rate relief for sports club
- Extended programmes of activity across all providers e.g. partnership with Halton and St Helens Primary Care Trust including delivery of programmes, such as, Target wellbeing, Mens GO and specialist weight management programme
- Comprehensive health walks programme

3.6 The council maximizes external funding that is available for Sport. The ability to secure grants and work with partners, to assist with future delivery, will be essential.

3.7 Investment in School Sport has significantly reduced since the government's withdrawal of funding to School Sports Partnership. As a consequence provision and policy for School sport is solely within the children and enterprise directorate and will be reported independently by that Directorate.

4.0 POLICY IMPLICATIONS

4.1 The Sports Strategy 2012 -2015 provides a vehicle through which the Council and its partners develop and communicate actions that will contribute towards a coordinated approach to sports delivery in Halton.

4.2 The Sports Strategy is monitored by the Halton Sports Partnership, which comprises of key stakeholders from the voluntary sport sector.

5.0 BUDGET IMPLICATIONS

5.1 These are contained within the report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Sport is cross cutting and the benefits gained from participation and involvement in sport contributes towards achieving wider council priorities, such as, improving health in Halton.

7.0 RISK ANALYSIS

7.1 Failure to deliver actions. This can be mitigated by regular review and progress meetings.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Consultation with representative organizations and individual service users will be necessary for the successful adoption of the Sports Strategy.

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

9.1 There are none within the meaning of the Act.

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Sports Strategy 2012-2015

OUR MISSION

" to enrich the lives of all Halton people through Sport and Physical Activity"

Foreword

Cllr Phil Harris & Terry Parle

Contents

1 Introduction
2 The Definition of Sport
3 The National Context
3 Sport and Health
4 The Community Benefits of Sports Development
5 Sport and Health
6 Equality and Diversity in Sport
7 The Local Context
8 Health in Halton
9 Key Themes and Objectives
10 Key Actions for the Council
11 Implementation and Monitoring

1. Introduction

This strategy is not a whole new approach to sports development in Halton. It builds on the foundations laid by our two previous sports strategies. Our 2002-2007 strategy identified key action points to tackle some of the major weaknesses that needed to be addressed if there was to be a secure foundation on which to develop sport in Halton. The strategy set priorities for the council's delivery of sport and has acted as a foundation from which Sport and Physical Activity has been developed.

Our 2006-2009 strategy developed eight key themes and objectives to develop sport and participation in sport in Halton. This new strategy will continue to direct our work on sports development and participation across Halton.

2. The Definition of Sport

For the purpose of this Strategy it is necessary to define what we mean by the term 'sport'. Therefore the following definition from the council of Europe's European Sports Charter (which has also been adopted by Sport England) has been embraced:

"Sport means all forms of physical activity which through casual or organised participation, aim at expressing or improving fitness and mental well-being, forming social relationships or obtaining results in competition at all levels."

Whenever the term 'sport' is referred to within this strategy, it means 'sport and physical activity'.

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3. The National Context

Sport England

In 2011 Sport England, the government agency responsible for building the foundations of sporting success in England launched its Sport England Strategy 2011-2015. This new strategy proposes 5 themes:

- Maximise Value from current National Governing Body (NGB) investment
- Deliver Places, People, Play
- NGB investment and support
- Market development – creating an environment in which key providers continue to invest in sport
- Strategic Investment and market intelligence

Sport England funds NGBs to deliver their 3 outcomes:

- Growing the numbers of people taking part in sport
- Maintaining this growth;
- Improving talent to help more people excel

They are investing £480 million (2009 – 2013) through 46 Governing bodies. Each sport has developed a whole sport plan that explains how it will use money to achieve its targets. Other recognised sports may also receive funding for specific projects through other funding schemes, such as, small grants scheme.

Sport England and UK Sport merger is due to be completed by April 2013. It is proposed that the merged body will incorporate current responsibilities for community and elite sport.

4. Community Benefits of Sports Development

Social Inclusion

Sport brings people together and can contribute to a sense of community. Participating in sport and physical activity can help tackle isolation and allows people to develop social networks and raise self esteem and confidence. Sport can make a difference in the community by building pride, confidence and a sense of purpose to people's lives.

Community Cohesion

Sport can also play a major role in promoting greater knowledge, respect and contact between various cultures and establish a greater sense of citizenship. Sport can give people a sense of belonging; people from different backgrounds and cultures participating on equal levels.

Regeneration Programmes

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The role of sport within regeneration programmes is recognised nationally and should be reflected locally. Sports provision results in employment and inward investment, via spending on both sports equipment and spectating. Capital projects often provide significant employment opportunities both during construction and the subsequent operation of facilities.

Community Safety and Crime Reduction

Whilst it is not possible to claim that sport alone can reduce levels of youth crime, there are an increasing number of examples of projects where sport has been a key tool in reducing levels of crime e.g. through Positive Futures schemes. Using sport as a constructive use of time has been shown to divert young people away from crime and engaging young offenders at risk of re-offending.

Lifelong Learning

There is increasing evidence to show a link between involvement in sport and physical activity and improved educational attainment. Sport also provides people with the opportunity to learn new skills and acquire qualifications that can lead to employment. However, a vast amount of sports provision relies on volunteers and ensuring volunteers receive the right training and support to improve and keep skills up to date is crucial for the ongoing delivery of sport within the community and voluntary sector.

The Environment

Open space, including green belt and formal parks, can accommodate a wide-range of formal and informal sporting activities, and as such is a valuable sporting resource. Using such spaces for sports provision can contribute to land-use management and help create awareness of, and support for, its continual existence. Sport and the provision of sports facilities can make an important contribution to the regeneration of ‘run down’ areas and can improve the quality of the local environment. The design of sports facilities should be such that they contribute to sustainability issues, through such considerations as energy efficient buildings and ensuring access by public transport or linkages to cycle networks.

5. Sport and Health

The World Health Organisation recognises the benefits of physical activity and identifies physical activity as one of the “best buys in public health”, not only reducing the risk of certain diseases such as obesity, type 2 diabetes, osteoporosis, and coronary heart disease, but also the symptoms of health problems such as anxiety, hypertension, stroke and various forms of cancer. There is a direct link between low levels of physical activity and increasing levels of obesity. Nationally in 2008/09 there were 7,988 hospital admissions with a primary diagnosis of obesity. This was over eight times higher that the number in 1998/99 (954) and more than 50% higher than in 2007/08 (5,018). Over the period 1998/99 to 2008/09, in almost every year, more than twice as many females were admitted to hospital with a primary diagnosis of obesity than males. The North West Strategic Health Authority (SHA) has both the

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largest number of admissions with either a primary or secondary diagnosis of obesity (19,184) and the highest admission rate (279 per 100,000 population).

Many people's lives are becoming increasingly sedentary. Levels of everyday physical activity are as high as those required for people to remain fit and healthy. The cost of inactivity on our health is clear. Inactivity places a significant burden on the NHS for the treatment of long-term conditions and of acute events such as heart attacks, strokes, obesity, diabetes, hypertension, heart disease, and many forms of cancer.

The Department of Health recognises that an active lifestyle is a key to better health. It estimates the cost of physical inactivity at £8.2 million annually (cost to the NHS and related costs e.g. absence from work etc). This excludes the contribution of inactivity due to obesity, which is estimated to cost £2.5 billion annually with levels of obesity having trebled since the 1980s. It is estimated that 70% of men and 63% of women are overweight or obese and approximately 16% of two to 15 year olds are now obese.

The Department of Health's *Start Active, Stay Active* strategy, published in July 2011, sets out the national approach to increasing participation in sport. This includes setting new targets for adults to achieve 150 minutes of moderate intensity activity (or 75 minutes of vigorous intensity activity). However, across all age groups, the report recommends that people are active in some way every day. By being active daily, individuals will gain some health benefits which result from acute responses that occur for up to 24–48 hours following activity. Being active daily may also help to develop more sustainable, lifelong activity habits.

19-64 year olds

The Department of Health has recently issued new guidelines on the levels of activity people need to achieve to remain fit and healthy. It recommends that adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.

Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or combinations of moderate and vigorous intensity activity.

Adults should also undertake physical activity to improve muscle strength on at least two days a week.

All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

65 years +

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Older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits. Older adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week. For those who are already regularly active at moderate intensity, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity. Older adults should also undertake physical activity to improve muscle strength on at least two days a week. Older adults at risk of falls should incorporate physical activity to improve balance and co-ordination on at least two days a week. All older adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

NHS Halton and St. Helens

NHS Halton and St. Helens (also known as Primary Care Trust [PCT]) is the organisation responsible for providing healthcare services to the residents of Halton. As part of the modernization of NHS services PCTs as they currently operate will be disbanded as from April 2013 and the Commissioning of NHS services will transfer to local GP Commissioning Consortia.

As from 1st April 2011 community health services in Halton and St. Helens will be delivered through a new, expanded NHS Trust known as Bridgewater Community Healthcare NHS Trust. The transfer of services is taking place for an initial period of two years as part of the national Transforming Community Services (TCS) programme, which separates the commissioning and provision of community services.

The Health Improvement function is one of the areas that will be delivered by Bridgewater Trust. This includes work programmes such as Fresh Start, Cook and Taste, Health Trainers, Specialist Weight Management, GO Men's Health, Family Exercise, Family Eating, Accident Prevention Exercise (APEX), Recharge and Men's Recharge, Halton Healthy Schools, Recipe for Health (Exercise on prescription), Fit 4 Life and Passport 2 Health.

The Trust works closely with the Council and has developed a diverse range of physical activity sessions in Halton. This provides an ideal opportunity to integrate health care services and health promotion activities with sports and recreation activities within Halton.

6. Equality and Diversity in Sport

The Government has recently published its new *Equality Strategy – Building a Fairer Britain.* Through this strategy the government has pledged to:

- Inspire a generation of young people to get involved in competitive school sport through the new Olympic and Paralympic-style competition. This will give all schools (mainstream and special) and all

pupils (including those with disabilities or special educational needs) the opportunity to get involved;
- Ensure a wider sporting, social and economic legacy from London 2012 across the UK and inspire a new era in public attitudes towards inclusion and equality. In particular, we are committed to using the opportunity of the Paralympic Games to help change attitudes and perceptions towards disabled people;
- Work with governing bodies of different sports to tackle homophobia and transphobia in sport.

7. The Local Context

Halton Borough Council and Halton Strategic Partnership have recognised the importance of developing a sustainable approach to sports development and have stated the importance of sport and physical activity through the Sustainable Communities Strategy and the Council's Corporate Plan.

The Sustainable Communities Strategy

Halton's Sustainable Communities Plan has five priorities for action:
- A Healthy Halton
- Employment, Learning and Skills in Halton
- A Safer Halton
- Children and Young People in Halton
- Environment and Regeneration in Halton.

Sport and physical activity clearly has a role to play within all these priorities and especially in relation to supporting children and young people and improving health and well being. The council has also highlighted Sport as a key priority for improvement and the priorities and actions set within this strategy for sport and physical activity will help achieve this drive for a better service. The Healthy Halton Strategic Priority highlights the need to *increase physical activity, improve diet and early detection and treatment of disease.*

The Corporate Plan

Halton Borough Council's corporate plan has highlighted *Healthy and Active Lifestyles* as a specific area of focus. It pledges that the Council will strive to improve the future health and prospects of Halton residents, particularly children, through encouraging and providing opportunities to lead healthier and physically active lifestyles. Future planned activity could include:

- Improving the health of Halton school children by increasing the percentage of children participating in sport for fun and fitness;
- Reviewing and updating the Sports Strategy and Facilities Strategy and begin their implementation during 2011/2.

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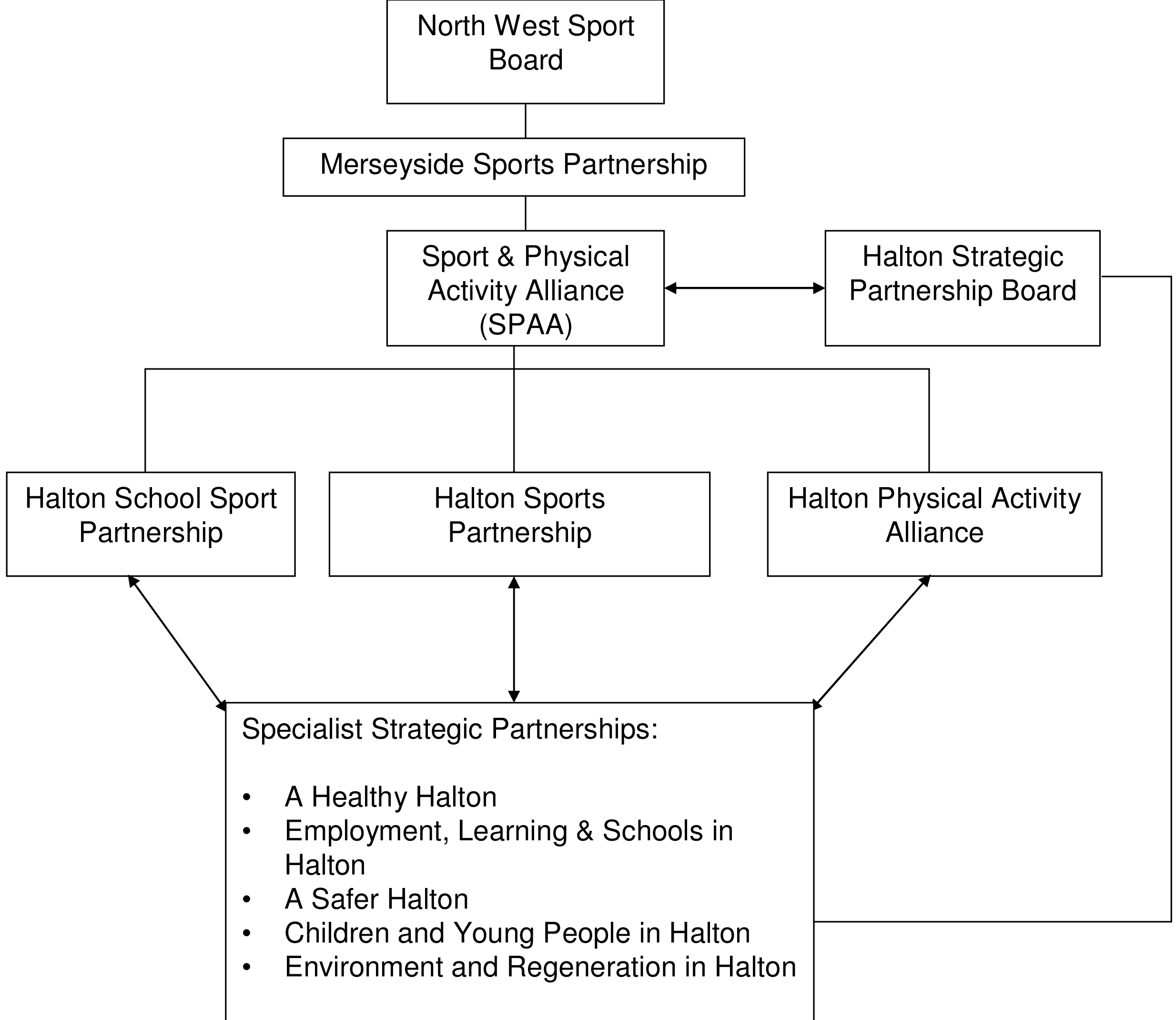
The Partnership Framework



Halton has an independent sports council, The Halton Sports Partnership (HSP), which aims to promote sport throughout the borough, encouraging participation in sport and offering advice and assistance to clubs, organisations and individuals in their quest for sporting success and participation.

There is a good relationship between the council and HSP meetings take place regularly to discuss key issues. The HSP will continue to act as the voice of voluntary sports clubs in Halton, and co-ordinate and raise issues through its partners to increase participation and become accountable for local investment.

This strategy will direct all partners to produce implementation plans including sports specific action plans and partnership service plans for young people, parents, coaches, officials and volunteers; to help to improve local coaching and competitive opportunities; develop and support high quality clubs and to create Merseyside wide development squads. Halton needs to ensure that it

remains involved with the work of the County Sports Partnership (Merseyside Sports Partnership is the local CSPs) and supports the delivery of all programmes. Sport England invests in CSPs to deliver services for national governing bodies and programmes for young people.

Halton's Young People and Sport

Since May 2010, the Coalition Government has introduced a number of reforms that have and will have a significant impact on the way services are delivered. Some of these reforms have directly affected the Children's Trust and these changes in policy and legislation will have a bearing on how the Children's Trust will prioritise its services.

Under the previous Government, Children's Trusts became statutory following the Apprenticeships, Skills, Children and Learning (ASCL) Act 2009. This statutory footing was revoked however by the Coalition Government reforms. Children's Trusts across the country were directly affected as:

- the duty on schools to co-operate through Children's Trusts was removed
- the requirement on local authorities to set up Children's Trust Boards and the requirement on those Boards to prepare and publish a joint Children and Young People's Plan (CYPP) was ended
- the regulations underpinning the CYPP and the statutory guidance on Children's Trusts were withdrawn

The Coalition Government has however reconfirmed its commitment to working in partnership to improve outcomes for children and young people through locally agreed partnerships, such as Children's Trusts.

Through discussions between partner agencies within Halton Children's Trust, it became clear that there was a collective will to continue to work in partnership to improve outcomes for children and young people in Halton, and that should be within the existing partnership for children and young people arrangements – Halton Children's Trust.

With this commitment to continue to work in partnership through the Children's Trust, there was universal agreement that a new Children & Young People's Plan should be produced, taking into consideration the Coalition Government's reforms and the progress made in Halton, while also providing strategic direction for the next three years.

All work between all services and agencies within Halton that sit within the Halton Children's Trust structures falls within the framework outlined within the Children & Young People's Plan 2011-14.

In October 2002 Central Government launched the PE, School Sport and Club Links (PESSCL) Strategy to ensure that "all children, whatever their circumstances or abilities should be able to participate in and enjoy physical

education and sport". The PESSCL strategy was driven through eight programmes:

- Specialist Sports Colleges
- School Sports Co-ordinator Partnerships
- Gifted and Talented Programmes
- QCA PE and School Sport Investigation
- Step Into Sport
- Professional Development
- School /Club links
- Swimming

The aim was to deliver high quality PE and Sport to all young people regardless of ability and Halton benefited from additional investment to support he infrastructure and delivery.

The Government removed funding for this programme during 2010. However, some of the elements of the programme are being retained. The new School Games Competition will encourage young people to get involved in sport. Halton has received support, until August 2013, to appoint a School Games Organiser (SGO) in its Children and Enterprise department. In addition to an annual calendar of competition the following programmes will continue to be offered to young people:

- Change4Life Sports Clubs
- Young Ambassadors
- Playground to Podium
- yoUR Sport
- National School Sport week

In recent years a large amount of external funding has gone into school sport provision as part of National Programmes aimed at increasing the amount and quality of PE in schools and improving school facilities for sport. Approximately £2.3 million of funding was awarded to Halton through the New Opportunities Fund (NOF) now known as BLF PE and Sport programme to improve primary and secondary schools sports facilities.

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8. Health in Halton

One of the key priorities for Halton identified in both the Sustainable Communities Strategy and the Corporate Plan is to develop A Healthy Halton.

> *To create a healthier community and work to promote well being and a positive experience of life with good health, not simply an absence of disease, and offer opportunities for people to take responsibility for their health with the necessary support available.*

This strategy forms part of the wider strategic priority to create a Healthy Halton. An increase in participation in sport and physical activity is a key part of creating A Healthy Halton and is proven to contribute to a healthy lifestyle, and tackling issues such as child and adult obesity, heart disease and early death. Halton currently has a number of serious health issues which an increase in sports participation and active lifestyle could play a significant role in improving:

- Halton has higher than average levels of adult obesity in England and higher than the average in the North-West;
- Halton has higher than average levels of child obesity in England and higher than the average in the North-West;
- Halton has higher than average levels of smoking in England and higher than the average in the North-West;
- Halton has lower than average levels of health eating in adults – the joint 26th worst in England;
- Halton has the 34th highest level of smoking in adults in local authority areas in England;
- Halton has the joint 2nd worst life expectancy for females and the 9th worst for males in England.

Halton Borough Council and Halton Strategic Partnership recognise that raising levels of sporting activity is a key part in tackling these health issues.

9. Key Themes and Objectives

The Sports Partnership has identified 6 key themes that guide the direction of this strategy and the development of sport in Halton. They are:

Key themes

1. **Increase Participation and Widening Access:** To ensure sport and physical activity opportunities exist for all members of the community.

2. **Club Development:** Supporting clubs to be safe, effective and child friendly and actively increasing club membership.

3. **Coach Education and Volunteering:** Improving the quality of coaches and support for volunteers.

4. **Sporting Excellence:** Improving the opportunities for individuals to reach their full potential from grassroots to excellence.

5. **Finance and Funding for Sport:** We will maximise the funding available for sports projects and individuals within the borough.

6. **Sports Facilities:** Diversify the range and improve the quality of sports facilities.

Key Theme 1: Increase Participation and Widen Access

To develop and support the provision of opportunities for sport and physical activity that promote integrity, fair play and respect that are accessible regardless of age, gender, race, ability or personal circumstances. We will encourage individuals to develop their ability and remain active through their lives.

We aim to sustain current participation levels and where possible encourage people to start participating in sport and exercise. Within this access, transport, pricing, marketing and programming will need to be addressed.

Actions:

- Focus on increasing 14 – 25 year old participation through Sportivate programme; develop additional opportunities for students studying at Further and Higher Education establishments to participate in sport and physical activity.
- Help NGB's achieve their grow and sustain targets
- Support existing sports clubs and community groups
- Encourage and support new community activity. Increasing adult participation, specifically women and older adults, through Sports Participation Project
- Continue to offer the Halton Leisure Card Scheme. A discount available for target groups to help reduce 'cost' as a barrier to participation.
- Support school activity programmes, such as, Fit 4 Life to contribute towards a halt in childhood obesity amongst children under 11.
- Facilitate Sports Fair Week to showcase sports and physical activities, which are taking place locally throughout voluntary sports clubs and venues in Halton. Promote come and try it sessions, demonstrations and competitions. (Majority free).
- Use sporting events such as the Olympics to inspire people to take part in sport.
- Encourage and support local events such as Run the Bridge (Halton's 5 mile Road Race), Widnes Football Cup and Vikings in the Community.

Halton currently has the 15th highest rate of adult participation in sport and active recreation of local authority areas in England. Figures for NI8 indicate that 27.4% of adults in Halton *participated in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 12 days out of the last 4 weeks.* We have seen a 7.3% increase in adult participation in the past 5 years – the second highest improvement in England and the highest in the Liverpool City Region. This is a significant achievement and above the rate expected for a borough such as Halton. This can be attributed to the multi agency approach to tackling inactivity and coordinated investment in local programme delivery.

GRAPH insert?

Sports Development Officers

Halton Council employs three Sports Development Officers. Their role is to support, manage and organise a wide range of sports activities designed to increase participation in sport, both through direct provision and partnership working. Officers currently focus on creating opportunities that enables individuals to start, stay and succeed in sport, working to increase activity levels to help improve the health of Halton's less active residents and working to support and develop local sports clubs. Halton's Priority Fund and Sport England fund supports full and part-time officers to increase participation in sport in areas of social deprivation and amongst identified target groups. Examples of these include the Sports Participation Project, Community Sports Coach Scheme and Halton Sport Partnership Project.

The council needs to take a role in ensuring all sports development officers are aware of the different services they are providing to avoid duplication and share good practice and local knowledge.

The Sports Development Continuum is now a well-known model helping to outline the sporting stages of an individual. These stages are:

- Foundation – early development of basic skills; catching, throwing, movement of the body
- Participation – playing sport mainly for 'fun'; enjoyment, health and fitness
- Performance – playing sport at a competitive club or county level;
- Excellence – playing and competing at the highest level.

The sports development continuum is a dynamic process, with people moving in both directions at all ages of life. Consequently, it is important that sporting structures are in place to meet people's needs wherever they are within the continuum.

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Sport England

Sport England is the government agency responsible for building the foundations of sporting success, by creating a world leading community sport environment of clubs, coaches, facilities and volunteers. Sport England's framework for community sport in England sets out how it will play the lead for the strategic development of sport.

Merseyside Sports Partnership (MSP)

Merseyside Sport Partnership, is our local County Sports Partnership, and is a network of agencies committed to establishing a fully inclusive structure that will enable people of all ages within Merseyside to benefit from Sport & Physical Activity. Its vision is to improve the quality of life for the people of Merseyside through Sport and Physical Activity. There are 49 County Sports Partnership in England and their aim is to create a multi agency partnership to deliver activities and services relating to Sport England's single system for sport. Sport England invests in CSPs to deliver services for national governing bodies, to support work with local government and with children and young people, and deliver Sport England's key legacy programmes Sportivate and Sport Makers.

National Governing Bodies

Some national governing bodies of sport such as the Lawn Tennis Association, the Rugby Football League and the English Cricket Board fund regional or county sports development officers with geographical responsibility to oversee the development of their sport. These officers are involved with all aspects of the promotion and development of their sport including the writing of county sports specific development plans. These plans show how the governing body wants their sport to develop. If sports specific development plans are produced in Halton they will need to accord with these governing body plans.

National Research / Trends

The General Household Survey (GHS) and research undertaken for Sport England has produced reports and research information into national levels of participation and general trends in sports participation. Over the last ten years, participation in sport in general has been rising steadily, although overall levels of participation are now starting to stabilise. As well as participating in sport, millions of people also watch or follow sport at a local or national level. As well as taking part in and watching sport, 2% of the national workforce is employed in sports related activity.

Local Research

A considerable amount of research and consultation into sports participation in Halton has been undertaken.

The Sports Participation Project works towards creating a more vibrant community in Halton by increasing opportunities for adults to be more physically active and participate in sport. Community based activities are developed following consultation with the local community and working partners. New activities are promoted and supported to become self sustainable in the long term. The project engages with hard to reach populations that need assistance to overcome barriers that have prevented regular participation.

The Active People Survey measures how many people participate, who they are, what sports they do and how this varies across England.

Active People Survey data is used to publish local sports profiles, which provide a detailed profile of each local authority, including data on sports participation, health, market segmentations and facilities.

Research has also been conducted to find out what barriers to participation there are in Halton. Pricing and poor transportation were the two most common reasons given as affecting people's ability to participate, especially amongst young people, disabled people and older people. Addressing equalities issues was considered as a significant barrier that needs to be addressed if participation levels are to be increased. The Active People Survey data, market segmentation profiles, local consultation through HSP and local studies all need to be considered when compiling local action plans.

SPORTS PARTICIPATION CASE STUDIES

Working with Cancer Support

Nicola Bashford Outreach Worker for Widnes & Runcorn Cancer Support Group remarked; "As part of our ongoing Cancer Prevention Strategy, I am always on the look out for activities that are suitable and fun for our members. "It can be a challenge to get the right instructors, venues and activities so the support and guidance from the Sports Participation Project has been invaluable.

Working in partnership with the Sports Participation Project ensures we have benefitted from existing knowledge and practical advice which has strengthened the quality of the work I do.

Being part of the 'Get Active' forum keeps me informed and up to date and further promotes the activities we operate. Our organisation has also had fantastic support and funding for taster activities for our Men's group (Grumpy Old Gents!) who have had hours of fun attending activities such as archery, golf and badminton, helping their group to bond and get active."

Table Tennis

Through targeted work membership has increased significantly during 2008 – 2011 with over 500 new members attracted to local clubs. Local sports clubs

have embraced a new way of working, for example, Family Table Tennis sessions allowed families to access activity for only £1 per person and those with a Halton Leisure Card free of charge. With other grants session such as Bounce into Action were planned and delivered for older adults.

Key Theme 2: Club Development

We will offer a network of support to clubs to be safe, effective and child friendly to enable them to deliver their aims and encourage improved standards within the borough. We will work in partnership with sports clubs to facilitate and develop high quality sports opportunities for the local community

Actions:

- Support clubs with NGB club mark and Club Halton submissions to increase the number of club mark accredited clubs in Halton.
- Provide appropriate support and assistance, such as funding clinics, to enable sports clubs to maximise the use of their activities and facilities in order to increase opportunities available for residents.
- Continue to offer Sports Resource Centres to local sports clubs.
- Encouraging the formation of new sports clubs where demand exists.
- Each Leisure Centre to have a club call notice board to promote local opportunities
- Improve the links between sports clubs and schools, colleges, universities and other organisations.
- Promote local clubs on the Councils website.

It is estimated that there are over 150 voluntary sports clubs in the borough, catering for all ages and levels within the sports development continuum, covering a variety of sports ranging from athletics and swimming to boccia, kurling and wheelchair Rugby. In addition to providing opportunities for participation, many sports clubs offer coaching and competition at all standards for their members. Runcorn Rowing Club has national and international representatives as club members. Rugby League and football are also strong in the borough. However there are some sports that currently have no clubs based in Halton such as archery and volleyball.

Some clubs in the borough have reported difficulties in maintaining membership levels in the light of competing leisure activities and the difficulty of retaining competent members and volunteers who are willing and able to support the club. All clubs need to consider their long-term future and how the club can be sustained. Clubs need to review the skills of their members, be it in terms of coaching, officiating or administration. In addition to a skilled volunteer base, clubs need to ensure that they have appropriate structures, policies and procedures in place e.g. a club constitution and child protection policies. As well as being ‘good practice’ such information is becoming essential if clubs intend to apply for funding or consider developing partnerships with schools. Many National Governing Bodies (NGBs) of sport now operate their own accreditation scheme that recognises good practice and clubs can gain ’clubmark’ status. Halton has its own accreditation scheme, Club Halton, to support those clubs working toward their NGB accreditation and for those without a governing body scheme e.g. Sports 4 All Club (a multi sports club for young people with a disability).

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There are two sport resource centres accessible to the voluntary sporting community of Halton. The sporting community is able to use the centres as a resource to assist with the development and running of their sports clubs, organisations or forums. Resources available include:

- Loan of sports specific and generic equipment, books, journals, magazines, DVDs and CDs
- Use of computer, printer and scanner equipment
- Internet access
- Photocopier
- Fully equipped meeting rooms

Key Theme 3: Coach Education and Volunteering

We aim to support coaches and volunteers in sport and increase the number and quality of sports coaches, officials and administrators working and volunteering in the Borough.

Actions:

- Coordinate an annual coach education programme, organize workshops to support high delivery, providing a subsidy for those supporting a Halton club accredited club.
- Increase the number of people gaining sports related qualifications. Focus on supporting individuals through NGB level 1 and 2 qualifications.
- Continue to support new and existing volunteers through the Halton Volunteer Incentive Scheme.
- Provide a young leader award programme, and mentor to sustain regular volunteering.
- Offer a recognition and reward programme for sport volunteers in Halton.
- Promote and facilitate the Sport Makers programme to Halton residents.
- Support Games Makers and sign post to local volunteering opportunities.

Halton's Sports Development Team, the NGBs, Merseyside Sports Partnership and voluntary sports clubs organise courses to develop individuals' skills in coaching, administration and officiating. Each NGB of sport has its own qualifications for coaching, and courses are organised to enable potential and existing coaches to gain qualifications and improve their coaching knowledge.

Courses in umpiring, refereeing and judging are also held to ensure the quality of officiating is maintained and improved. Many secondary schools now offer pupils the chance to study physical education as a GCSE or A Level subject as well as the opportunity to study for and obtain Sports Leader UK Awards.

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Sports Coach UK Courses, Running Sport Workshops and Volunteer Investment Programme both aim to support the volunteers that sustain sports clubs. The Running Sport programme offers short workshops and literature in general administrative subjects such as ‘funding and promoting your club’, ‘the role of the volunteer’ and ‘running a club’. Sportscoach UK provides generic coach education courses in topics such as safeguarding and protecting children, equity in your coaching and coaching children. Running Sport offers support to sports volunteers and the people who manage them, offering free information packs, a volunteer network and awards for recognition of good practice.

There is a need to develop a co-ordinated approach to sports education opportunities. All these programmes should be used as tools to help support the voluntary sports sector of Halton. The Sports Development Team currently produces an annual calendar of workshops.

Encouraging young people to join a club, particularly within a specific section for juniors will help to improve membership levels and hopefully provide the adult members of the future. Sports Development delivers a diverse activity programme in partnership with local clubs and schools, including Sports Leaders UK leadership courses that focus upon increasing junior membership of sports clubs and generally increasing physical activity amongst young people. This is only possible with clubs that can ensure safe, quality-sporting opportunities for all.

The Halton Volunteer Scheme has been devised in partnership with Halton Sports Partnership and Halton Borough Council, the scheme aims to recruit, reward and recognise and support volunteers aged 9+ years and mentors those who are dedicating their time voluntary to the sporting sector of Halton. The Incentive Scheme is divided into four sections 50, 100, 150 and 200 hours. On completion of each milestone a certificate and gift are awarded, all who complete the milestone are invited to the Annual Volunteer Recognition evening.

Many providers require the services of National Governing Body of sport qualified and experienced coaches who have been Criminal Record Bureau cleared. Consequently, there is an increasing opportunity for sports coaches who are engaged with sports clubs to obtain further employment opportunities as coaches, often at times which do not clash with club sessions e.g. during the day or during school holidays.

Key Theme 4: Sporting Excellence

We will provide support from grass routes to excellence for athletes, coaches and officials to help them reach their full potential.

Actions:

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- Through sports specific development forums provide support to talented athletes, coaches and officials to help them reach their full potential.
- Work in partnerships with schools and sports clubs to discover, develop and support talented athletes to perform to the best of their ability at the highest standard.
- Support School Games Organiser and promote and facilitate schools participation in annual sporting calendar.
- Hold an Annual Sports Awards to celebrate success of local sporting individuals and clubs and highlight local achievements.
- Support and facilitate investment in local performers through access to grants, such as, Sports Development Grant Scheme; Merseyside Bursary Scheme; Town Twinning Grant and other sponsorship and scholarship schemes.
- Continue to offer a Platinum card to support National and international performer with free or subsidised access to Leisure Facilities.
- Holiday programmes to be delivered throughout the borough with a wide range of sports.
- Attract and support the hosting of Regional, National and International sporting events in Halton.

UK Sport is the nations high performance sports agency responsible for investing £100 million per year in Britain's best Olympic and Paralympic athletes. It has no direct involvement in community or school sport.

Sport England funds 46 National Governing Bodies of Sport. Each sport has developed a whole sport plan that provides a framework at all levels to increase participation and raise levels of achievement.

These sports are:

Angling, archery, athletics, badminton, basketball, boccia, bowls, boxing, cricket, canoeing and kayaking, cycling, equestrian, football, fencing, goalball, golf, gymnastics and trampolining, handball, hockey, judo, lacrosse, modern pentathlon, mountaineering, movement and dance, netball, orienteering, rounders, rowing, rugby union, rugby league, sailing, shooting, skiing/snowboarding, softball / baseball, squash and racketball, swimming, table tennis, taekwondo, tennis, triathlon, volleyball, waterskiing, weightlifting, wheelchair basketball, wheelchair rugby and wrestling.

Governing Body Services

National Governing Bodies of sport provide a major role in getting people to start, stay and succeed in sport. Sport England remains committed to providing support and guidance to governing bodies to ensure the development of individual sports. It is important on a local level that developments accord with the plans and strategies of the different governing bodies of sport.

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Some of these strategies focus simply on facility development, whilst some include plans for the development of the sport at all levels of the sports development continuum, including plans for coach development, officials and administrators. Plans with excel outcomes have targets, such as, increase number of academy athletes and improve world ranking.

A number of National Governing Bodies have produced facility development strategies. These strategies vary greatly in the level of detail and the stages of production. Whilst it is not possible to discuss each of these strategies in detail, it is clear that any proposed new facilities within Halton will need to accord with the priorities laid out in these documents.

Where organisations are intending to develop facilities via external funding they will need to produce sports development plans to show how the new facilities will contribute to the development of that particular sport. Such plans will need to accord with the priorities of governing body strategies, and clubs will need to link into specific sports development initiatives.

Merseyside School Games

The Sports Development Team works closely with the Local Education Authorities School Games Organiser to ensure Halton enters as many teams as possible in the Merseyside School Games. The Merseyside School Games is held in July for primary aged children. The role of School Games Organiser is intended to help schools increase participation, competition and progression for young people in sport through the successful delivery of the new School Games. The council's School Games Organiser works closely with the sports development team, local schools, voluntary sports clubs, Halton Sports Partnership and coaches to organise borough squads to represent Halton at the Merseyside School Games and other inter borough events. Compared to most other Merseyside boroughs, Halton has a relatively small club base and therefore finds it difficult to enter all events, particularly in some of the more minority sports. However, Halton does do well in the sports with which it has a strong club base.

Representing your borough at a regional event can be a rewarding and inspiring occasion for young people, but overall position within the School Games should not be seen as the marker for the overall standard of sports participation and provision within the borough. As well as the main Merseyside School Games, there are stand-alone events, such as, cricket and rugby competitions.

The School Games Organiser, for Halton, coordinates and produces an annual competition calendar. The new School Games is a year round, inclusive sports competition that's designed to get young people of all ages and abilities enjoying the benefits of competitive sport. The UK School Games is an annual event for the most talented school-age athletes.

Sports Development Grant Scheme

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There is a wealth of talent in the borough with many athletes achieving County and regional representation with some going on to gain international honours. The council's Sports Development Grant Schemes directly targets sports clubs and talented individuals, since the schemes introduction in 2000 over £350,000 has been given to organisations and individuals to fund sports activities.

Junior clubs have benefited from free pitch fees and 100% rate relief has been given to local clubs.

The Councils Platinum Card/Liverpool City Region Elite Card are designed to support the borough's top sportsmen and women who are participating in a sport recognised by Sport England and are in the top 10 in their national rankings or recognised squad. In addition referees and officials who are required to undergo a fitness test are also eligible. Card holders must be Halton residents and not receive salaried or professional earnings from sport. Card holders and bursary grant recipients have supported local and county activity such as coaching and personal appearances.

The council also supports professional and semi professional clubs, such as, Widnes Vikings and Runcorn Linnets. These clubs have the ability to involve and inspire local people in all areas of sport and are able to attract investment.

Key Theme 5: Finance and Funding for Sport

Actions:

- To train and develop an effective staff with the necessary skills, knowledge and values required to deliver this Strategy.
- Secure adequate and sustainable financial resources for sport and physical activity in Halton.
- Provide a Sports Development Grant Fund for distribution to individuals and sports groups.
- Provide good quality advice and support to all those seeking to access funding to improve the sports and physical activity facilities and programmes within Halton.
- Provide support to clubs wishing to gain Community Amateur Sports Club (CASC) status

Halton Council has committed increased revenue funding for sport in the borough over the past years in recognition of its commitment to improve Sports delivery. The council committed capital funding for a new athletics facility for which £1.5 million was invested. In addition, the council invested £1 million to improve sports pitch drainage to address issues.

To assist sports clubs and community groups to access funding that will enable them to implement some of the recommendations arising out of the Strategy for Sport, the Sports Development Team need to work closer

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together to maximise use of limited resources. Funding clinics take place regularly to assist clubs.

Sport will need to establish an increasingly creative approach to financing sports provision. Measures will need to include maximizing the opportunities which exist for grant aid, lottery funding and revenue support, considering alternative methods of provision, improved partnership working and ensuring internal arrangements are efficiently and effectively organised, so that the objectives of this strategy can be achieved.

A number of previous funding routes are no longer available for sports development. Funding that has previously been available through the Neighbourhood Renewal Fund and its successor, Working Neighbourhood Fund. These funding streams are no longer available.

Kingsway Leisure Centre, Brookvale Leisure Centre and Runcorn Pool are managed on behalf of Halton Council by DC Leisure, a private leisure management company. The existing 10 year (2015) contract required DC Leisure to inject approximately £1.53 million of capital investment into the facilities. DC have continued to make capital investments into the ageing facilities and during 2010 they invested over £325,000 across the 3 sites including a Gym expansion and new sauna at Kingsway Leisure Centre, replacement IT and Access control system across the sites and new pool filters and flooring at Runcorn Swimming pool. In addition they continue to invest in an annual maintenance programme in order to keep the facilities up to the standards expected of modern sports facilities.

Sport England Funding Routes

Sport England is currently running a number of opportunities to apply for funding for sports development.

Small Grants

The Sport England Small Grants Programme uses lottery funding to make awards of between £300 and £10,000 to not-for-profit organisations to deliver new community projects to either grow or sustain participation in sport or to support talent development.

Sportsmatch

Sportsmatch makes awards to not-for-profit organisations that have secured sponsorship to deliver new community projects to grow or sustain participation in sport.

Sportsmatch uses money from the government to encourage new sponsorship of grassroots community sport. Priority is given to applications seeking to match sponsorship from the commercial sector but donations from private individuals or charitable trusts are also acceptable provided they meet the sponsorship eligibility criteria.

Awards of between £1,000 and £100,000 can be made to match funding from no more than five sponsors, with each sponsor contributing a minimum of £1,000. Sport England funding for the project must be spent by 31 March 2012.

Iconic Facilities Fund

Sport England's Iconic Facilities fund draws on the inspirational pull of London 2012 to create local beacons for grassroots sport. They are investing £30m over the next three years in innovative, large-scale, multi-sport facilities' projects that are regionally significant for at least two sports and can demonstrate long-term financial viability.

The Iconic Facilities fund is part of the £135m Places People Play initiative which will deliver an Olympic and Paralympic legacy of increased sports participation by bringing the magic of a home Games into the heart of local communities. It is being delivered by Sport England in partnership with the British Olympic Association, the British Paralympic Association, with the backing of The London Organising Committee of the Olympic Games and Paralympic Games.

Iconic Facilities is one of the three Places programmes which will transform the places where people play sport, in cities, towns and villages across the country.

The facilities supported through these programmes will be the only ones to carry the London 2012 Inspire mark, a permanent celebration of their role in the legacy of the Games.

In this way, Iconic Facilities will use the inspirational pull of London 2012 to enhance a successful existing funding programme, previously known as the Sustainable Facilities fund.

Inspired Facilities

The Inspired Facilities fund aims to help organizations refurbish, upgrade or covert sports facilities into a venue suitable for sport and accessible to the whole community. This programme forms part of Places People Play, Sport England's programme to deliver a London 2012 legacy of increased mass participation in sport. The programme is investing £50million of National Lottery funding in up to 1000 community sports projects between 2011 and 2014.

Key Theme 6: Sports Facilities

We will continue to modernise and develop a network of accessible, high quality, value for money facilities, to improve the quality and range of

provision for customers. We will protect, improve and promote parks and open spaces for sport and recreation.

Actions:

- Ensure existing facilities are well managed, well maintained, fully utilised, accessible and sustainable in the long term.
- Complete a full review of Haltons Playing Pitch Strategy.
- Complete an indoor and outdoor sport facility asset review.
- Work with partners to improve access for local people to existing community facilities and develop new facilities where deficiencies are identified.
- To protect playing fields, parks and open spaces from developments that would not enhance and improve the sports provision available.
- Continue to encourage the use of parks, playing fields and open spaces managed by the Council and other agencies, for organised and informal sport and physical activity.

Planning Influences

Halton's Unitary Development Plan (UDP) provides the statutory planning framework to transform the quality of Halton's environment and improve economic prosperity and social progress through sustainable development.

The UDP 's strategy to enable the provision of new and the protection of existing sports facilities in Halton is detailed in the 'The Green Environment Chapter' under the Sport, Recreation and Children's Play policies and proposals and 'Leisure, Tourism and Community Facilities Chapter' (this chapter deals with indoor facilities only). This strategy generally aims to: focus on the protection, enhancement and creation of outdoor playing spaces for sport and recreation and outdoor playing spaces for children, both equipped playgrounds and casual informal playing spaces in order to promote equity and participation. Several proposed schemes are shown on the UDP

The implementation of these strategic objectives will be enabled through the following specific policies:
GE12 – Protection of outdoor playing spaces for formal sport and recreation.
GE13 – Intensify use of existing outdoor sports and recreation provision.
GE14 – Noise generating sports
GE15 – Protection of outdoor playing spaces for children
LTC1, LTC2 & LTC3 – Development of Major Leisure and Community Facilities
LTC4 – Development of local leisure and community facilities
LTC5 – Protection of community facilities
LTC10 – Water based recreation

Several other policies are also relevant to the provision of indoor sports facilities. In addition to its UDP policies, the council must consider other organisations' strategies when determining planning applications involving the provision or loss of sports facilities, these include:

Government Planning Guidance – the most relevant for sports purposes are; Planning Policy Guidance Note 17, which requires the council to demonstrate that it has sufficient open space, including sports facilities, by undertaking an Open Space Audit. The council's needs to refresh its Playing Pitch Strategy to provide the guidance to inform future developments.

Sport England – in addition to providing the council with advice on all sporting issues, Sport England must be statutorily consulted on any development proposals that involve the loss of any council or other educational owner playing fields and the Government must be informed of their objections.

Surrounding Local Authorities Plans

There are five local authority areas, which are adjoined to Halton in the Merseyside/Liverpool City Region grouping. It is important that facility provision is developed in a coordinated manner to avoid duplication and poor use of resources.

Quest

The QUEST quality award scheme provides agreed quality standards for the management and operation of sports facilities and to sports development services. It allows service providers to assess their own service and make judgments on the quality of service delivered. This has a particular relevance with the need to ensure continual improvement within the council's Leisure services. Kingsway Leisure Centre, Brookvale Leisure Centre and Runcorn Pool where all awarded highly commended or excellent status in 2011 Quest assessments.

Active Places

Sport England has an active places website which provides a database of what sports facilities currently exist. The project provides a new media for increasing awareness and promotion of facilities with existing and potential new participants.

This section provides an overview of the current provision of indoor and outdoor sports facilities throughout the borough, further details can be found at www.activeplaces.co.uk.

Indoor Sports Provision - Council Owned Facilities

Indoor sports facilities in the borough are provided by the public, voluntary and commercial sector. Halton currently provides wet and dry indoor sports facilities at Kingsway Leisure Centre and Brookvale Recreation Centre.

Kingsway Leisure Centre in Widnes comprises a 25 metre pool and teaching pool, an eight badminton court sports hall, squash courts, aerobic/dance studio x 3, fully equipped gym, health suite sauna and steam room, and a crèche/activity room. Brookvale Recreation Centre in Runcorn comprises a 25 metre pool, six badminton court sports hall, 1 court hall, fully equipped gym, aerobics/dance studio, and Floodlit All weather Pitch. Runcorn Pool comprises a 25 yard pool and fully equipped gym.

The facilities are owned by Halton Council and operated under a 10 year contract by DC Leisure. These centres not only provide facilities for sport and physical activity, but they also organise activities to enable people of all abilities to take part in sport and physical activity. These classes can be as varied as tai chi to circuit training. The centres run specialist sessions and are partners in the Councils Leisure Card Scheme a discount scheme for target groups to help reduce 'cost' as a barrier to participation.

The three facilities represent a variety of different building types and ages. The age and internal layout within the buildings obviously affects the type and quality of services that can be provided. DC Leisure have implemented a programme of maintenance and facility improvements to their centres as part of their contract to ensure the buildings remain at an acceptable standard and have undertaken internal alterations to accommodate changes in 'leisure trends', including new and upgraded disabled changing facilities.

Halton Stadium
The Halton Stadium is a unique facility and Halton Borough Council's flagship leisure, conference and sports facility, it has 13,500 seating capacity on match days. The stadium is owned and run by Halton Borough Council. Designed and built to provide far more that a world class arena for sporting events, the Stadium also provides function and banqueting facilities for the residential area and outstanding hi-tech conference facilities for business communities of Halton and beyond. The stadium pitch has been converted to a state of the art 3 Generation pitch opening up the stadium as a world class training and competition venue. The Widnes Vikings will make their return to Super League in 2012 and introduce this playing surface to the countries top flight professional rugby league clubs.

The West Stand of the stadium contains the Halton Stadium Health & Fitness Suite consisting of the Halton Regional Table Tennis Centre, Café Bar, Health & Fitness suite, crèche, sports injury clinic and much needed leisure and lifestyle services for the local residential sports and business communities.

Other Indoor Facilities

In addition to Council owned sports centers, there are a number of small pools at commercial facilities plus pools at Chesnut Lodge and West Bank Primary Schools. These pools allow some limited community use.

Schools in Halton offer a range of indoor sports facilities. Four badminton court sports halls exist at some Secondary schools, whilst several schools have smaller sports halls or gymnasiums. Most Secondary schools now offer extensive use of the school sports facilities for community use in the evening and at weekends, this provision will be increased further on completion of Building Schools for the Future projects on current Grange and Wade Deacon School sites. Generally access is good at St Chads, The Heath, Bankfield and Sts Peter and Paul.

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Around the borough there are also numerous small halls, which whilst not necessarily designed specifically for sport, are used for activities such as recreational badminton, keep fit, martial arts and yoga.

Commercial Indoor Facilities

There are several commercial facilities that are provided by different private leisure operators, located within Halton or just outside in neighbouring boroughs. The newest and largest commercial leisure facility in Halton is the Hive; this will consist of Widnes Superbowl an indoor bowling alley, ice rink operated by Planet Ice, Reel cinema, hotel and food outlets.

DW Fitness Club, which is located in Widnes. Facilities include a 20m indoor pool, large gymnasium, two exercise studios, spa and steam facilities.

Fitness First has one commercial site in Runcorn. Facilities include gymnasiums, fitness studios, sauna and steam rooms. There is a small commercial site operating from the Heath Technology Park. Both have been partners in Halton GP referral scheme.

The De Vere Daresbury Park has an indoor pool and fitness gym, spa, sauna and squash courts.

For further details on sports facilities please visit the Active Places website www.activeplaces.co.uk

Outdoor Sports

Outdoor Grass Pitches and Wickets

The local authority is the major provider of outdoor pitches for both summer and winter sports. Halton's Open Spaces Service provides 74 outdoor pitches for football, rugby, bowls, baseball, tennis and basketball. These facilities are located at 11 different sites across the borough; the distribution of pitches varies greatly. A Halton Playing Pitch Strategy, was produced in 2004, the key recommendations of this playing pitch strategy helped to allocate resources to improve pitch drainage. There is a need to refresh this strategy in order to inform future provision and attract investment.

Football is one of the most popular outdoor sports in the Borough and there are 36 full size football pitches and 25 junior/mini soccer pitches managed by The Open Spaces Service.

Over £200,000 has recently been invested in Halton Sports to provide a new home for Runcorn Linnets FC.

Within Halton there are currently no public cricket wickets. There are privately owned cricket facilities; at Runcorn CC, Widnes Cricket Club, Moorfield CC and Hale CC.

The majority of secondary schools have football and cricket pitches and a few of the primary schools have grass areas large enough to accommodate junior or mini soccer. A number of these pitches are available for community use.

The changing facilities at many of the Council sites was of poor quality and needed upgrading and refurbishing. The Heath now has new changing accommodation with £500,000 invested during 2006/07 season.

Many of the council's pavilions although having more than one changing room only offer communal showering facilities. This makes it impossible to accommodate males and females at the same time. One of the fastest growing sports in the country is women's' and girls' football. Whilst at present there are only two junior girls' football team, two rugby league clubs and one girls' cricket team in Halton, most schools now play girls football and an increasing number are beginning to play cricket and rugby. Adequate changing facilities adjacent to quality pitches are of significant importance in providing for and developing the women's game. As these sports develop in Halton there is likely to be an increasing demand for good quality pitches with suitable changing and showering facilities that can accommodate women's' and girls' teams.

The 2004 Playing Pitch Strategy identified that Halton had 1 pitch for every 1,236 adults above the national average of 1,840, the level of satisfaction with provision is relatively high. Statistically there are just enough pitches in the borough to accommodate existing and predicted demand although the strategy recommends that some of the adult pitches should be converted to junior pitches to accommodate the increasing demand for junior and mini soccer pitches. In addition, the growth in junior football and women's' and girls' football could mean that without improvements to the ancillary facilities a site with several pitches could only be used by one team as they are unable to share the changing accommodation with teams of different genders or age groups.

As well as the need for improvements to changing accommodation, the leveling and drainage at many of the sites was poor and needed improving to improve the quality of the pitch and also help to achieve optimum usage of the facilities. The Councils Open Space Service invested over £1 million in the drainage and playing service to address necessary improvements to the quality of grass pitches and Halton schools have identified poor drainage as being a main concern with regards to their outdoor facilities. An increase in unauthorised use and vandalism of all pitches, and ancillary accommodation is also affecting the quality of provision.

Within Halton there are a few sports clubs which either have their own facilities or lease pitches and ancillary accommodation from the council. Leasing facilities enables the clubs to manage and maintain the facilities themselves and can enable them to apply for funding to improve these facilities. However, leased facilities are often only used by one club during the weekends and evenings and more flexible use of the facilities and / or agreed sports development programmes should be considered when agreeing new leases.

Baseball and softball facilities are provided at Halton Sport. However, the vision of Halton Sports as a centre for baseball and softball is subject to the governing body securing external funding.

Synthetic Sports Pitches
There are currently three sites with outdoor synthetic sand based sports pitches in Halton. These facilities are located at Brookvale Recreation Centre, The Heath School and The Bankfield High School. These facilities provide opportunities for football and hockey all facilities provide good quality pitches and changing accommodation. At present community use at all these sites has the potential to increase. A new 3rd Generation pitch has been installed at Halton Stadium. This provides not only a training and competition venue for Widnes Vikings but a new all year round competition and training venue for local community sports clubs, in particular a much needed floodlit rugby training facility.

Outdoor Courts
There are a total of 9 tennis courts located at three different sites. Some of these sites have large numbers of courts and others just a few. The condition of the courts varies.

Lane Tennis Club relocated to Widnes Tennis Academy on the Sts Peter and Paul Catholic College and now provides 3 indoor and 2 mini indoor tennis courts and 6 outdoor courts. The club are seeking funding for the outdoor courts to be floodlit.

There is one site providing outdoor netball courts in the borough with indoor courts being provided to the community at St Chads and Sts Peter and Paul Schools. There are 24 outdoor basketball courts funded through the English Basketball Association's Outdoor Basketball Initiative (OBI). These OBI sites are located across the Borough. Various organised basketball activity sessions have been held on these facilities although no comprehensive programme of use exists. The Councils Open Space Service has developed new 'Multi Use Games Areas' within identified residential/community areas and these facilities include provision for outdoor basketball/football. These areas assist in the provision of activities for young people during school holidays and can be used as a tool in combating youth nuisance.

Athletics Facilities
Halton now has a state of the art athletics track consisting of a six lane floodlit synthetic track with field event facilities, new changing facilities, a club house/meeting room and fenced show pitch for football and rugby. The facility provides Halton with excellent training and competition facilities for athletics. The resident athletics club won promotion in 2011 for the first time in 20 years and has seen its membership grow with associate members coming from a recreational jog club.

Golf Courses
Phase 1 of the remediation of the northern section of St Michael's Golf Course was recently completed. The remediation refers solely to the clean-up of the

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contaminated land and not the restoration of the site. We hope that some form of golf provision can be reinstated, once all the site works are complete, but we still appear to be some way off.

Bowls
There are 11 public bowling greens in the borough at 6 sites. Most have clubs based at the greens, which welcome both male and female members. However, there are clubs, which have no female changing or toilet facilities and would need alterations to their ancillary facilities if it were to develop a women's section.

Parks and Informal Recreation
Walking – There are a number of mapped routes and trails of differing lengths around Halton. The Urban walks programme highlights 6 circular walks around council key buildings. A programme of volunteer led walks has been developed across the borough, often in partnership with other local community groups as a means to encourage 'inactive' people to take part in physical activity. Moving on from walking people are now encouraged to start jogging at the 3 new Run in Halton sites. Phoenix Park, Runcorn Town Hall Ground and Pickering Pastures have measured course for residents to access all year round. Markers guide participants round the course and participants can challenge themselves to run/walk 100m to 1 mile or 3km courses.

Cycling – There are a number of cycle routes and networks around the borough and more routes have been proposed as part of Halton's Transport Development Plan.

10. Key actions for the Council
Having established the key themes the Sport and Recreation Service has identified key areas to ensure progress is made in delivering a Strategy.

Key areas identified include:

1. **Partnership working with local and national key partners at strategic and operational level.**
   We will offer a network of support to the sporting sector to enable them to deliver their aims and encourage improved standards within the borough. We will assist in the structured development of sports by working with key partners including voluntary sports clubs, schools and national governing bodies and health bodies to offer programmes of activities that help improve health in the borough.

2. **Raise the profile of Sport**
   We will effectively market and publicise the Sport Development Service to ensure we effectively promote and raise awareness of Sport Development Initiatives.

We will ensure that all members of the local community have access to information regarding sporting opportunities and physical activity and the

benefits of participation. We will promote sporting events and celebrate successes in order to raise awareness of sport and physical activity.

To encourage more people to join sports clubs, clubs need to ensure that as many people as possible are aware of their existence. Many clubs already have their own websites with detailed information about their clubs training, events, match reports etc and often the younger members can be encouraged to take a role in developing these sites for their club. In addition to the council's Sports Development website, the Halton Sports Partnership has developed a website which provides useful information and support for the voluntary sports sector. Further avenues for promoting clubs need to be considered and encouraged to ensure the public know about all the opportunities that are available for participation in sport.

11. Implementation and Monitoring

The responsibility for the implementation and monitoring of this strategy lies with the Halton Sports Partnership which comprises of key stakeholders from the voluntary sports sector. The council's Community and Environmental Department has given direction to the production of this strategy and have helped direct the key themes.

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Agenda Item 6c

REPORT TO:	Health Policy & Performance Board
DATE:	6 March 2012
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Neighbourhood, Leisure and Sport Health and Adults
SUBJECT:	Draft Tenancy Strategy
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of this report is to present Halton's Tenancy Strategy as a draft document for further consultation and to seek Members' views on the content of the Strategy.

2.0 **RECOMMENDATION: That Members of the Policy and Performance Board note and comment on the attached draft Tenancy Strategy.**

3.0 **SUPPORTING INFORMATION**

3.1 **Background**

3.1.1 The Coalition Government's White Paper of November *2010 "Local decisions: a fairer future for social housing"* introduced the concept of fixed term tenancies for social housing providers rather than the "Lifetime Tenancies" currently offered. Registered Providers (RPs - previously known as Registered Social Landlords) are able to offer fixed term tenancies from April 2012.

3.1.2 Under the terms of the Localism Act local authorities must develop a Tenancy Strategy setting out recommendations for the type of tenancies that should be offered in the local area, the length of those tenancies (if fixed term tenancies are proposed) and the circumstances in which they should be offered and renewed. In developing their own tenancy policies RPs are to have due regard to the local authority's Tenancy Strategy, however, they do not have to adhere to the recommendations of the local authority Strategy.

3.1.3 The timescale for local authorities to develop their tenancy strategies is proposed to be within 12 months following enactment of the Localism Act (November 2011). Consequently, RPs are able to start offering the new tenancies some seven months before the local authority must develop an approach recommending whether and, if so, how they are used. For this reason, officers have started to develop a Tenancy Strategy, on the understanding that it may need to be revised as a result of any guidance published following enactment of the Act.

3.2 **Progress to date**

3.2.1 Officers met with RPs in September 2011 to discuss their respective positions with regard to the use of fixed term tenancies. It was clear that RPs are at different stages in terms of developing their own approaches, some more advanced than others, and in some respects were looking to the Council for a steer. Equally the Council was looking to RPs to give an indication of the circumstances in which they considered they may want to use fixed term tenancies so that it could evaluate whether or not there were sound reasons for doing so and incorporating these in a strategy.

3.2.2 The Council's starting position was that it was willing to be flexible but would need to evidence why there should be a departure from the status quo if a tenancy strategy advocating limited use of fixed term tenancies is to gain support. However, as RPs are not obliged to adhere to the local authority's strategy there is a risk that should an RP decide to use fixed term tenancies, the Council would have no influence over how and when they are used or renewed if they are not included as an option in the Tenancy Strategy. The development of a Strategy which gives a limited level of support for fixed term tenancies would allow the local authority to set parameters guiding their use in order to protect vulnerable people and maintain sustainability in Halton's communities.

3.2.3 After much discussion, including the role of Affordable Rents and the proposed Welfare Reforms in the equation, it was agreed that RPs would provide examples, together with copies of early drafts of any Board reports on affordable rent and tenancy policies. The Council would then endeavour to pull together common themes with a view to developing a permissive rather than a prescribing strategy e.g. describing circumstances where it may be appropriate to use flexible tenancies.

3.2.4 Officers received responses from two RPs which outlined the principles on which they wish to develop their approach. A consistent theme was the need to maintain stable, cohesive and balanced communities but also highlighted was the need for a flexible approach that can be tailored to the diverse needs of customers and protect vulnerable groups, ensuring that the use of fixed term tenancies does not act as a disincentive for people to improve their lives and maintaining continuity in children's education.

3.3 **Halton draft Tenancy Strategy**

3.3.1 A Strategy has been drafted which permits RPs to make use of the new fixed term tenancies should they wish to do so whilst at the same time making it clear that the Council's preference is to maintain the status quo. The Strategy, which is attached as Appendix A to this report, sets the parameters for their use.

3.3.2 The minimum term for fixed term tenancies is proposed to be five years (in line with current Government thinking) but RPs can extend this period if they wish.

3.3.3 The draft Strategy recommends that fixed term tenancies are not suitable for:

- Existing social housing tenants who became assured tenants prior to 1st April 2012 and who are transferring to another property;
- Where the property is part of a supported housing development that provides specialist accommodation for particular client groups, including sheltered housing.
- Where the tenant is someone over the prevailing state retirement age.
- Where the property is located in an area of very low demand and/or high multiple deprivation where the local authority has serious concerns about the long term sustainability of the area. In these circumstances, the local authority will initiate discussions with the relevant Provider(s) to request that they temporarily suspend the use of fixed term tenancies in that area.
- Where a tenant with a secure or assured tenancy is required by a Provider to move due to redevelopment e.g. they are being required to move, not seeking to do so.

3.3.4 The Council expects that in most cases fixed term tenancies will be renewed upon review, particularly where:

1) the tenancy was originally offered in response to a particular set of circumstances or vulnerabilities (e.g. the household was fleeing harassment or domestic violence or is under a witness protection programme or was a person leaving local authority care, or has mental health problems) and the household is assessed as still being vulnerable.

2) the household contains dependants of pre school age or in full time education, unless 2) below applies.

3) the property has been adapted to meet the needs of a disabled person and that person still resides in the property and needs the adaptations.

3.3.5 Circumstances where the tenancy may not be renewed include where:

1) There has been a change in the composition of the household which has resulted in the household under occupying the accommodation.

2) There has been a substantial improvement in the household's financial circumstances to the extent that continued occupation of the property by the household would present a conflict with the charitable objectives or primary purpose of Providers to provide housing for those in necessitous circumstances.

3) An adapted property is no longer suitable for the tenant's needs e.g. where adaptations have been provided for a disabled person who is no longer resident in the property, the adaptations are no longer required, and there are other families needing this type of adapted accommodation.

3.3.6 Tenancy strategies are not intended to be a means of enforcing tenancy agreements and, therefore, the Strategy states that it does not expect RPs to use fixed terms tenancies as an enforcement tool, for example, refusing to renew a tenancy on the grounds of rent arrears or anti social behaviour. Existing legal remedies and possession proceedings, as appropriate, should be pursued to tackle these issues. However, the Strategy recognises that there may be circumstances where possession proceedings are so far advanced that it may not be appropriate for RPs to renew a tenancy. It will be for RPs to judge these cases on merit mindful that they will have to justify such action should the tenant seek to exercise their right to appeal.

3.3.6 In all circumstances (except due to significant improvement in financial circumstances) it is recommended that the RP arrange for more suitable accommodation to be offered to the household within its own or another RP's stock.

3.3.7 The draft Strategy will need to be the subject of further consultation with existing social housing tenants and prospective tenants who are on the Council's and other RPs' waiting lists. It is expected that the consultation period will be from 26th March to 23rd April 2012 and that the Strategy will be signed off at Executive Board in June.

4.0 POLICY IMPLICATIONS

4.1 The Tenancy Strategy is intended to provide guidance for RPs in the development of their tenancy policies. It has been developed to comply with Government proposals contained in the Localism Act, however, may need to be revised at a future point should further guidance be issued following enactment of the Act.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 There may be financial implications arising from the need to consult with existing and potential future tenants of social housing.

5.2 The implications of the use of fixed term tenancies are clearly outlined in the draft Strategy. However, the Strategy has been framed so that it minimises the impact on HBC services and on Halton's communities.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The Strategy recommends that fixed term tenancies are renewed where the household contains pre school age children or children in full time education, unless there has been a substantial increase in the financial circumstances of the household to the extent that continued occupation of the property would present a conflict with the RPs charitable objectives to provide housing for those in necessitous circumstances.

6.2 **Employment, Learning & Skills in Halton**
The Strategy has been framed so that there are no barriers to those seeking employment or career development as a result of the use of fixed term tenancies.

6.3 **A Healthy Halton**
The Strategy recommends that fixed term tenancies are renewed for vulnerable people, whose health and well being could be adversely affected by having to move as a result of the termination of a fixed term tenancy.

6.4 **A Safer Halton**
The Strategy aims to minimise the risks to sustainable communities and thus community safety which could potentially result from the use of fixed term tenancies.

6.5 **Halton's Urban Renewal**
The Strategy aims to protect the sustainability of Halton's communities from the use of fixed term tenancies by reserving the right of the Council to request that the RP suspend their use should an area be identified as potentially being at risk.

7.0 RISK ANALYSIS

7.1 The risks of using fixed term tenancies are clearly outlined in the draft Strategy. However, the Strategy has been framed so that it minimises the risks to HBC services and to the sustainability of Halton's communities.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 An Equality Impact Assessment has been undertaken on the Strategy. No negative impacts were found on any of the protected characteristics.

9.0 REASON(S) FOR DECISION

9.1 Local authorities have a statutory duty to develop a Tenancy Strategy within 12 months of enactment of the Localism Act 2011.

9.2 The decision to develop a Strategy which permits the use of fixed term tenancies should RPs wish to use them was taken as it allows the Council to exercise some influence over their use.

10.0 ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

10.1 The development of a Strategy which does not include fixed term tenancies was considered. However, Registered Providers are only required to have due regard to the local authority's Strategy when setting their own tenancy policies and are not compelled to follow the Council's recommendations. Consequently, a Strategy which did not include fixed term tenancies would mean that the authority would have no influence over their use should providers decide to introduce them for their stock. This option was, therefore, rejected.

11.0 IMPLEMENTATION DATE

11.1 The Strategy would take effect from the date it is approved by the Council's Executive Board.

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

Document	Place of Inspection	Contact Officer
Draft Tenancy Strategy	Runcorn Town Hall, second floor	Joanne Sutton
Localism Act 2011	Municipal Building, second floor	Eleanor Carter

Communities Directorate

Tenancy Strategy 2012

Consultation Draft

Version 8 Jan 12

Halton Borough Council
Tenancy Strategy 2011

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Introduction

This is Halton Borough Council's first Tenancy Strategy. It has been developed in response to the Localism Act 2011 which places a statutory duty on local authorities to develop a strategy which sets out what type of tenancies should be offered by Registered Providers of social housing (henceforth referred to as Providers) in the local area.

Context

The White Paper *"Local decisions: a fairer future for social housing"*, published in November 2010, set out the Government's intentions to radically reform social housing in England. It is based on the premise that social housing should only be for those who need it and should act as a springboard to higher aspirations as individuals' circumstances improve. It points to long waiting lists, overcrowding and under occupation within the sector as evidence that the system is not currently working.

Central to the housing reforms is the introduction of a new time limited tenancy which is subject to review at the end of a fixed term to ensure that the tenant is still in need of the accommodation. In framing their tenancy policies, Providers should have regard to the local authority's approach to the new flexibilities as set out in its Tenancy Strategy.

There are some concerns that the new approach will reinforce residualisation of the sector, further stigmatise and disadvantage those in social housing and detract from efforts to promote community cohesion and tackle worklessness. These concerns are explored more fully later in this document.

In preparing this Strategy Halton Borough Council has had regard to its prevailing allocations policy and the sub regional allocations policy which will come into force when Halton introduces the Property Pool Plus Choice Based Lettings in 2012. The Council has also had regard to the Halton Homelessness Strategy 2009-13.

What the Tenancy Strategy covers

In accordance with the proposals set out in the Localism Bill, this Strategy sets out:

1. What kind of tenancies Providers should offer.
2. The circumstances in which Providers should grant a tenancy of a particular kind.
3. Where the tenancy is for a fixed term, the recommended length of the term.
4. Circumstances in which the Provider should grant a further tenancy on the ending of the existing tenancy.

The Strategy takes into account the local economic circumstances and housing needs prevailing at the time the Strategy was written.

Considerations

This section of the Strategy outlines the factors that have been taken into account in developing the Council's approach.

Relationship with Affordable Rent regime

In order to reduce the amount of public subsidy needed for new social housing development the Government introduced the affordable rent regime (where rents are pitched at up to 80% of market rents in the area) at the same time as fixed term tenancies. The Tenant Services' Authority (TSA) has introduced a new Tenancy Standard to take account of the new affordable rents.

Much of the language that surrounds fixed term tenancies and affordable rents seems to have become interchangeable and this appears to have caused some confusion around whether properties let at affordable rents must also be fixed term tenancies. However, the Homes and Communities Agency's National Affordable Housing Programme prospectus clarifies this issue:

> *"The TSA does not intend to prescribe the type of tenancy that Registered Providers should use when homes are let on Affordable Rent terms. Providers will have flexibility on the type of tenancy to be offered for Affordable Rent, and they will retain the option to offer lifetime tenancies should they wish to do so."*

Social rented housing in Halton

Social rented housing makes up over a quarter of the total housing stock in the Borough, equating to 13,500 properties. In 2010 the Council commissioned consultants to undertake a Strategic Housing Market Area Assessment (SHMAA) for Halton and the surrounding areas of St Helens and Warrington. Analysis of the findings of the Halton study reveals that:

- Flats and maisonettes make up just over a quarter of the social rented stock, however, CORE data (which records new social housing lettings) reveals that turnover of this accommodation type is relatively high (making up 44% of general needs stock let in 2010/11).
- Almost two thirds of social housing tenants had lived in their home for more than five years.
- Average household sizes in the sector are lower than for other tenures.
- An estimated 2,251 (16%) social tenants under occupy their accommodation by at least two bedrooms (using the bedroom standard)[1], with 60% of those being non pensioner households without children (1,344).

[1] A separate bedroom is allocated to each married or cohabiting couple, any other person aged 21 or over, each pair of adolescents aged 10 - 20 of the same sex, and each pair of children under 10. Any unpaired person aged 10 - 20 is paired, if possible with a child under 10 of the same sex, or, if that is not possible, he or she is given a separate bedroom, as is any unpaired child under 10.

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- An estimated 1,329 households (10%) are classed as overcrowded using the bedroom standard.
- A fifth of social housing tenants are unemployed and three quarters claim full or partial Housing Benefit (*source: HBC Housing Benefit records*).
- The median annual gross household income for social housing tenants in Halton was £9,821 with the median savings/debt level being £211 in debt. This gives a median figure of potential access to funds of £29,250, which is insufficient to access market housing.
- 1,528 social housing tenants indicated that they either need or are likely to move in the next two years with 80% of these preferring to stay in social housing and 17% wanting to buy a home.
- There is significant demand for social housing from private tenants and a quarter of owner occupiers with a mortgage who are looking to move would like to move to the sector.

It is clear from the findings of the survey that social housing in Halton plays a key role in meeting housing need and is valued both by existing social housing tenants and those currently housed in other sectors but current levels of under occupation indicate some scope to make better use of the housing stock. The survey also revealed that despite the relatively high proportion of existing social housing, there is a need for an additional 891 affordable housing units per annum.

Outcome of consultation with tenants, applicants for social housing and Registered Providers

To be inserted

Impact on vulnerable households

The use of fixed term tenancies, **if applied universally**, could have an adverse impact on vulnerable households. For example, approximately 1,000 elderly people under occupy their social rented home (SHMAA 2010). If those homes had been let on fixed term tenancies it is possible that the tenants would be forced to move which would uproot the elderly person from their existing community where they may be receiving vital support and the move could have an adverse impact on their health and emotional well being.

Families with children of school age could also suffer as a result of having to move, for example if the parents' financial situation improved. The children may need to move schools as a result of the move which could have an adverse impact on their educational attainment.

There are also potential issues of uprooting disabled people from suitably built or adapted accommodation or forcing someone to move from an area where they currently receive care (in which case they may need an extra bedroom) or give care to a vulnerable relative or other person.

Additionally, there are some social housing applicants who have complex and sometimes multiple needs, for whom the provision of a settled home is often a key determinant in them maintaining a more stable lifestyle. Examples include

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recovering drug addicts and alcoholics or people with mental health issues. Other groups who may benefit from more stability include care leavers, people fleeing from harassment or domestic violence and people who have previously been sleeping rough.

This Strategy seeks to protect vulnerable people from being uprooted from settled, suitable accommodation, as set out in the second part of the Strategy.

Impact of planned welfare reforms

The Welfare Reform Bill proposes a number of changes to Housing Benefit (HB) which have implications for the Tenancy Strategy, as described below:

Increased deductions from HB for non dependents living in the property are being phased in until 2013. This could cause a dichotomy for families with non dependent children as, if they are on a fixed term tenancy, and they encourage their children to seek other accommodation as a result of the increased financial pressure they could risk losing their home due to resulting under occupation and receive an under occupation penalty on their HB as described below.

The Government proposes to impose a cap on Universal Credit when it is introduced which will be set at the average earnings of a working family. If this amount is exceeded then HB payments will be reduced accordingly which could increase the number of households in rent arrears. If a build up of rent arrears is one of the criteria for ending a fixed term tenancy they could also lose their home as a result.

Universal Credit, which it is proposed will include Housing Benefit, will be paid directly to the claimant. Consequently there is an increased risk of households falling into arrears with their rent which could result in them losing their home.

The Government proposes reducing HB payments for working age tenants who are occupying accommodation that is too large for their needs. While again there is a risk of rent arrears being accrued initially, in this respect, fixed term tenancies may actually help to make best use of the housing stock and minimise the risk of increased arrears. However, the ability of Providers to rehouse under occupying tenants in smaller accommodation is dependent on the availability of suitably sized properties.

Potential burden on Registered Providers

If Providers decide to use fixed term tenancies they are likely to experience additional administrative burdens resulting from tenancy reviews, providing advice and securing alternative accommodation for households whose tenancy is not being renewed, and dealing with appeals.

Finally, if tenancies are not renewed, Providers will need to meet the costs associated with bringing properties up to an acceptable standard in order to attract a new tenant and with rent loss for the period the property is empty.

Mortgage availability

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The current housing market downturn was primarily triggered by the realisation of the scale of bad debts held by the financial institutions. As a consequence banks and building societies are now much more cautious in their lending practices meaning that potential borrowers are required to pay much greater deposits and lending multipliers have reduced. For example, "in 2007 the average deposit paid by a first time buyer in the UK was 10% of the property value, by the end of 2009 this figure had increased to 25%" (Hometrack Feb 2010).

Consequently even if the financial circumstances of social housing tenants improves, this is not a guarantee of them being able to access market housing since they would need substantial savings, which could take several years to build up, to be able to secure a mortgage.

Capacity and suitability of the private rented sector

Since the recent housing market downturn the private rented sector has played an increasingly significant role in meeting housing needs for two distinct groups. On the one hand there are those households who traditionally would have sought market housing but are unable to do so due to steep house price increases and/or the lack of a sufficient deposit to satisfy mortgage requirements. On the other, there are those who traditionally would have sought social rented housing but are unable to access the sector due to an increase in housing waiting lists and a declining number of vacancies caused by reduced mobility from the sector into owner occupation.

The private rented sector in Halton has grown by around 46% since the 2001 Census and now makes up around 10% of the housing stock. It is likely that this growth is attributable to a combination of factors. Firstly, from the widespread availability of buy to let mortgages in the years leading up to the downturn which was augmented by the concept of housing as a prudent investment. And in more recent years there has been a growth in the number of "reluctant" landlords who are unable to sell their properties in current market conditions and consequently let them out on a short term basis to realise a regular income until the housing market improves.

Despite the growth in the sector locally, Halton's private rented stock is still proportionately smaller than national and regional levels and anecdotal evidence from Halton's Strategic Housing Market Assessment reveals that demand for private rented housing currently outstrips supply by a ratio of around 5:1. Furthermore the SHMA, and the Halton Private Sector Stock Condition Survey conducted in 2009, found that housing conditions in the sector are significantly worse than in other tenures with higher levels of non decency, category 1 hazards and lower levels of energy efficiency.

There is, therefore, concern that fixed term tenants whose tenancies are not renewed and are not offered alternative social housing could be forced to seek accommodation in an already overburdened sector and to accept poorer housing conditions than those they previously enjoyed.

Potential impact on homelessness

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Households whose tenancies are not renewed for whatever reason and are unable to purchase a property or secure private rented housing for the reasons stated above may find themselves homeless. This could result in additional pressure on the Council's Housing Solutions service and, depending on the circumstances of the household, could potentially result in them receiving an offer of another fixed term tenancy in the social rented sector. This would seem to defeat the object of using fixed term tenancies as a means of creating mobility within the sector and would undoubtedly lead to unnecessary stress to the household and cost to the Council and Providers.

Impact on sustainable communities

Halton shares many of the social and economic problems more associated with its urban neighbours on Merseyside. Halton is ranked the 27th most deprived borough nationally according to the 2010 Indices of Multiple Deprivation (IMD) and 21 Lower Super Output Areas (LSOAs) in Halton fall within the top 10% most deprived LSOAs in the country, with 10 LSOAs in the top 3%.

Due to the development of the Runcorn New Town, much of Halton's social housing stock is heavily concentrated in well defined and sometimes fairly isolated neighbourhoods and it is these areas that are ranked highest in terms of multiple deprivation. For example, the most deprived area in the Borough, Windmill Hill, has the highest concentration of social housing, exceeding 95% of the total housing stock and similar levels of deprivation are shown for areas like Castlefields, Halton Lea and Hough Green, all of which contain large social housing estates.

There is a need, therefore, to diversify not only the housing offer but also the socio economic mix of households living in these areas to prevent further decline and provide sustainable communities. Evicting fixed term tenants due to an improvement in their financial circumstances could act against the aspiration to create mixed and balanced communities and could further stigmatise social housing. There is also a risk that tenants will be less willing to look after their properties and invest in their communities if they have less security of tenure.

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The Tenancy Strategy

Halton Borough Council does not intend to prescribe the type of tenancy that Providers must offer their tenants and we recognise that many Providers with accommodation in Halton also operate across other local authority areas, where local circumstances and the recommended approach may differ.

This Strategy represents the Council's views and is intended to provide guidance to Providers with stock in Halton to assist them in framing their own tenancy policies. It has taken a great many years for tenants of social housing to secure the rights they now enjoy, and these should not be surrendered without strong justification.

However the Strategy does not preclude the use of fixed term tenancies, should Providers wish to adopt them to make best use of the housing stock, but recommends the parameters as to their use bearing in mind the considerations outlined earlier in the Strategy and the overriding need to build and maintain sustainable, cohesive communities.

The type of tenancies Providers may provide.

Introductory tenancies – Also known as "probationary tenancies", these can be offered to new tenants and would not apply to tenants transferring from one Provider (or local authority) property to another, irrespective of whether the property is let at a social, affordable or intermediate rent. The introductory period normally lasts for a period of 12 months and, provided there has been no breach of tenancy that would warrant eviction within that time, can be converted to an Assured Tenancy once the 12 months has elapsed. However, if the Provider has reason to believe that the tenant has breached the tenancy agreement it can from April 2012 extend the introductory period beyond 12 months.

Assured tenancies – Providers may continue to offer assured tenancies to transferring tenants, tenants converting from an introductory tenancy (or new tenants where there is no introductory scheme in place) regardless of whether the property is let at a social, intermediate or affordable rent.

Secure tenancies – Providers will not offer secure tenancies to new tenants as they are reserved for local authority use. However some Providers will have tenants with secure tenancies where the tenancies have been assigned to a Provider following a housing stock transfer.

Assured Shorthold tenancies – Providers have always been able to use Assured Shorthold Tenancies in certain circumstances e.g. provision of temporary accommodation. This Strategy does not seek to encroach on this. Within the context of this Strategy it is anticipated that this form of tenure will be used for "fixed term tenancies". Providers may use the new fixed term tenancies for new tenants, regardless of whether the property is let at a social, intermediate or affordable rent. It is recommended that the term of the tenancy will be for a minimum of five years. In framing tenancy policies and determining the circumstances in which fixed term tenancies should be granted or ended, Providers are requested to adhere to the Council's recommendations as set out below.

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The circumstances in which Providers should grant a tenancy of a particular kind.

Halton Borough Council would prefer that future social housing tenants maintain the security of tenure currently enjoyed by existing tenants. However, it recognises that Providers may wish to take advantage of the new tenure flexibilities in order to make the best use of their housing stock. If this is the case, the Council considers that fixed term tenancies are **not suitable** in the following circumstances.

1) Where the household is transferring from an existing Provider assured or local authority secure tenancy which was granted prior to 1st April 2012. This is to ensure that there are no disincentives for existing tenants to move to a more suitable or desirable property and there are no barriers to normal “churn” within the sector.

2) Where the property is part of a supported housing development that provides specialist accommodation for particular client groups, including sheltered housing.

3) Where the tenant is someone over the prevailing state retirement age.

4) Where the property is located in an area of very low demand and/or high multiple deprivation where the local authority has serious concerns about the long term sustainability of the area. In these circumstances, the local authority will initiate discussions with the relevant Provider(s) to request that they temporarily suspend the use of fixed term tenancies in that area.

5) Where a tenant with a secure or assured tenancy is required by a Provider to move due to redevelopment e.g. they are being required to move, not seeking to do so.

Where the tenancy is for a fixed term, the recommended length of the term.

Where a fixed term tenancy is offered, it is recommended that the term be for a minimum of five years. Providers may wish to offer longer periods as a matter of organisational policy but the Council sees no circumstances in which it would be appropriate to offer a fixed term tenancy for less than 5 years.

Circumstances in which the Provider should grant a further tenancy on the ending of the existing tenancy

The Council expects that in most cases fixed term tenancies will be renewed upon review, particularly where:

1) the tenancy was originally offered in response to a particular set of circumstances or vulnerabilities (e.g. the household was fleeing harassment or domestic violence or is under a witness protection programme or was a

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person leaving local authority care, or has mental health problems) and the household is assessed as still being vulnerable.

2) the household contains dependants of pre school age or in full time education, unless 2) below applies.

3) the property has been adapted to meet the needs of a disabled person and that person still resides in the property and needs the adaptations.

Circumstances where the tenancy may not be renewed include:

1) There has been a change in the composition of the household which has resulted in the household under occupying the accommodation by more than one bedroom. In these cases the Provider would be expected to arrange a move to a more suitably sized property within their own stock or with another Provider either through a transfer or mutual exchange.

   In determining whether or not a property is classed as under occupied Providers should have regard to the 'bedroom standard'. However, when making their decision Providers should also consider that while a household could technically be under occupying their accommodation using this criterion at the time of review, due to the age and sex of dependents they may not be in years to come and that a move to a smaller property could lead to overcrowding in the future. In these circumstances the Council recommends that the existing tenancy is renewed unless the household expresses a wish to move due to being unable to afford the rental contribution following changes to HB based on under occupation.

   This exception should also apply where the property is under occupied but this is not as a result of a change in household circumstances (e.g. due to low demand for the property it was under occupied on allocation);

2) There has been a substantial improvement in the household's financial circumstances to the extent that continued occupation of the property by the household would present a conflict with the charitable objectives or primary purpose of Providers to provide housing for those in necessitous circumstances. The Council does not want the use of fixed term tenancies to be a barrier to households seeking employment or attempting to improve their income and lifestyle through career progression and, therefore, would expect that this criterion would only apply infrequently.

3) An adapted property is no longer suitable for the tenant's needs e.g. where adaptations have been provided for a disabled person who is no longer resident in the property, the adaptations are no longer required, and there are other families needing this type of adapted accommodation. In these cases, the Council expects that the Provider will arrange for alternative suitable accommodation to be secured either through a transfer or mutual exchange within its own stock or another Providers.

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The Council expects that Providers will have robust and fair appeals processes in place to resolve any disputes that may arise.

The Council does not expect Providers to use fixed term tenancies as a short cut to enforcement procedures for breaches of tenancy conditions but accepts there may be circumstances where enforcement proceedings are so far advanced that it would not be appropriate to renew a tenancy. It will be for Providers to judge these cases on merit mindful that they will have to justify such action should the tenant seek to exercise their right to appeal.

When securing alternative accommodation for the household, Providers should take into account so far as is possible the household's area(s) of choice and whether they need to live in a particular area to give or receive care or support.

Providers are expected to contact tenants whose tenancies are due for renewal within a reasonable time period to assess the household circumstances and discuss options available to the household. Government guidance recommends a review period of six months, however Providers may want to consider making an initial contact with the household before this to ensure that there is sufficient time for the Provider to arrange alternative accommodation or for the household to purchase a home where this is likely to be deemed necessary.

Period of Strategy

It is intended that this Strategy provides guidance for Providers in setting their tenancy policies until such time as a new Strategy can be developed following the publication of further guidance from the Government.

Monitoring and review

The impact of this Strategy will be monitored as part of the monitoring framework for Choice Based Lettings. Should a need to review or amend the Strategy be identified as part of this process, the Council will consult Providers and any such other persons as may be prescribed by the Secretary of State.

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Agenda Item 6d

REPORT TO:	Health Policy and Performance Board
DATE:	6th March 2012
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health & Adults
SUBJECT:	Scrutiny Review of Autism
WARDS:	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To present the Board with the draft Scrutiny Review of Autism report for approval to be presented to the Executive Board.

2.0 RECOMMENDATION: That Members of the Board

(1) Note the contents of the report attached at Appendix 1; and

(2) Approve the report to be presented to the Executive Board.

3.0 SUPPORTING INFORMATION

3.1 The scrutiny review and resulting report (attached as Appendix 1) was commissioned by the Health Policy and Performance Board. A scrutiny review working group was established consisting of:-

- Six Members from the Board;
- Principal Policy Officer from the People and Communities Policy team;
- Practice Manager for Autism;
- Principal and Practice Managers from the Positive Behaviour Support Service (PBSS); and
- Operational Director (Complex and Commissioning).

3.2 In December 2010, the Department of Health issued statutory guidance and a delivery plan for local authorities and NHS organisations to support the implementation of the national autistic strategy "Fulfilling and Rewarding Lives". There is an expectation that local authorities will implement the requirements set out in the statutory guidance. A regional network group has been established and that will provide an opportunity to monitor progress towards implementing the statutory guidance locally. The scrutiny review provided a good opportunity to review our services in supporting people with autism spectrum conditions living in Halton.

3.3 This scrutiny review was conducted through a number of means:

- Monthly meetings of the scrutiny review topic group;
- Presentations by various key members of staff;

- Provision of information;
- Carer consultation;
- Site visit to Day Services; and
- National Autistic Society speaker.

4.0 POLICY IMPLICATIONS

4.1 Existing policies are endorsed by the report.

5.0 OTHER IMPLICATIONS

5.1 The report makes a series of recommendations under each separate area of evidence that was scrutinised and have been collated into an Action Plan for ease of reference and monitoring by the Practice Manager for Autism.

5.2 From 13th to 16th February 2012, the National Autistic Society will be undertaking a separate review of Autism in Adult services at Halton Borough Council and this may identify further recommendations.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

Although the scrutiny review focused upon services provided to adults, the PBSS does provide a service to children and young people as well as adults.

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

The scrutiny review recommendations link in to developing a culture where learning is valued and raise skill levels throughout the adult population and in the local workforce; and promoting and increasing the employability of local people and tackle barriers to employment to get more people into work.

6.3 **A Healthy Halton**

The scrutiny review recommendations link in to understanding how Autism effects the health of individuals in Halton and how the services currently provided lay firm foundations for a healthy start in life and support those most in need in the community by maximising and promoting autonomy, promoting a healthy living environment and lifestyles to protect and sustain individual good health and well-being.

6.4 **A Safer Halton**

None Identified

6.5 **Halton's Urban Renewal**

None Identified

7.0 RISK ANALYSIS

7.1 The report and recommendations support the Council's strategic priority of Improving Health. Taking on board the recommendations from the report will be positive steps to improving Autism services for people in Halton.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The implementation of the recommendations will help to improve services in Halton for people on the Autistic Spectrum Condition.

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

9.1 None under the meaning of the Act.

Draft Scrutiny Review of Autism

Report

February 2012

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1.0 PURPOSE OF THE REPORT

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

- Gain an understanding of Autism and an appreciation for the broad range of conditions that fall under the spectrum from low level to high functioning levels of autism;
- Examine the effectiveness of the current pathways for diagnosis and assessment for adults with an autism spectrum condition (ASC) in Halton;
- Gain an understanding of the Positive Behaviour Support Service and the benefits their interventions can bring to local service providers;
- Consider National best practice in relation to pathways for diagnosis and assessment for adults with autism spectrum conditions; and
- Consider ways to continue to make improvements and enable Halton to fully implement the statutory guidance and delivery plan.

2.0 STRUCTURE OF THE REPORT

This report is structured with an introduction, a brief summary of the methodology followed by evidence, analysis with findings/conclusions and recommendations. The annexes include the topic brief, methodology detail and an action plan to capture the recommendations from the scrutiny review.

3.0 INTRODUCTION

3.1 Reason the scrutiny review was commissioned

In December 2010, the Department of Health issued statutory guidance and a delivery plan for local authorities and NHS organisations to support the implementation of the national autistic strategy "Fulfilling and Rewarding Lives". There is an expectation that local authorities will implement the requirements set out in the statutory guidance. A regional network group has been established and that will provide an opportunity to monitor progress towards implementing the statutory guidance locally. The scrutiny review would provide a good opportunity to look at our services in supporting people with autism spectrum conditions living in Halton.

3.2 Policy and Performance Boards

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

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3.3 Membership of the Scrutiny Working Group

Membership of the Scrutiny Working Group included:

Members	Officers
Cllr Ellen Cargill Cllr Joan Lowe Cllr Dave Austin Cllr Margaret Horabin Cllr Martha Lloyd-Jones Cllr Carol Plumpton-Walsh Cllr Geoff Zygadllo	Paul McWade – Operational Director for Commissioning and Complex Needs Maria Saville – Principal Manager for Positive Behaviour Support Service (PBSS) Kath Devonshire – Practice Manager for PBSS John Williams – Practice Manager for Autism Emma Sutton-Thompson – Principal Policy Officer

4.0 Methodology Summary

This scrutiny review was conducted through a number of means:

- Monthly meetings of the scrutiny review topic group;
- Presentations by various key members of staff (detail of the presentations can be found in *Annex 2*);
- Provision of information;
- Carer consultation;
- Site visit to Day Services; and
- National Autistic Society speaker.

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

5.1 Autistic Spectrum Condition Awareness

Maria Saville, Principal Manager for the Positive Behaviour Support Service (PBSS) and Kath Devonshire, Practice Manager gave a presentation on the awareness of Autistic Spectrum Condition at the first meeting of the topic group. This covered:

- The Facts about Autism
- Triad of Impairments
- Communication
- Behavioural Excesses and Deficits
- Common misconceptions
- Common interventions
- Uncommon interventions

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Part of the remit of the PBSS is direct work with service users to assist with technical support and placement development. The team are currently working with the following services users:

Area	Service	Numbers
Halton	Adults	5
	Children	12
Knowsley	Adults	4
	Children	8
St Helens	Adults	3

There is currently a waiting list approaching 30 people.

As well as dealing directly with people who have behaviour that challenges services the team are also involved in crisis prevention and management. Since the team's establishment in November 2010 they have delivered training to approximately 150 staff across adult and children's services, including:

- support workers;
- managers;
- learning disability nurses;
- social workers; and
- school staff.
- Pilot parent Workshops delivered- including an evening workshop for parents of children with a new diagnosis of ASC and also a full behaviour that challenges workshop for parents on the waiting list.
- Training planned with Halton Autistic Family Support Group (HAFS) and Cheshire Asperger's Parent's Support Group (CHaPs). Key staff have been invited to attend a training workshop to help evaluate PBSS training workshop material (especially with regards to accessibility for parents)
- Training with Cavendish School with staff working in the ASC pathways class
- Training with Brookfield School staff
- Active member of ASC strategy group and training sub group

The majority of these have been Halton staff although some adults staff from Knowsley council have accessed the training.

5.1.1 Early Intervention

- Training delivered to Education Staff in the use of a specific assessment tool for children with ASC or other developmental disabilities (Assessment of Basic Language and Learning Skills, Revised- ABLLS-R)
- Proposed Pilot Project using Assessment Tool in new ASC resource settings within Halton- ongoing work happening on this
- Links to ASC diagnostic pathway

5.1.2 Invest to Save

The PBSS will serve those who have a Learning Disability/Autistic Spectrum Condition and present with the most complex needs.

It is the first in the UK to be staffed and led by Board Certified Behaviour Analysts (BCBA)

Core Aims for the individual service users are:
- Improved quality of life
- Increased opportunity for meaningful engagement
- More opportunity for education/cognitive development
- Increased opportunity for community participation
- Greater access to a less restrictive environment
- Improved relationships

The service is expected to achieve financial benefits by:
- Reducing demand for expensive, specialist out of area placements through prevention of placement, and by support for repatriation programmes;
- Correspondingly reducing pressure on Continuing Healthcare funding, which contributes significantly to these placements, and also social care & education funding; and
- Helping to create robust community services that will reduce pressure on local NHS inpatient beds, thereby facilitating programmes to reduce their number.

5.1.3 Conclusion

The group concluded that the awareness-raising session clearly demonstrated the "ground-breaking" work that the PBSS is involved in and the high level of expertise and knowledge that the team has. The group found the interventions that the team use to support positive behaviour very interesting.

Recommendations:

i) ***Members to support the continued work of the Positive Behaviour Support Service.***

5.2 Autism Strategy in Halton

Paul McWade, Operational Director for Commissioning and Complex Care gave a presentation on the Autism Strategy at the July meeting of the topic group. This presentation included the following main points:
- Statutory background
- Autism Spectrum Condition Strategic Group
- Progress on Halton's Autism Strategy

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It was highlighted that as the guidance is required by law, it is known as "statutory" guidance and this means that local authorities and NHS bodies must follow the relevant sections or provide good reason why they are not. If this is not followed, they could be liable to judicial review.

The topic group were briefed about the ASC strategic group being a multi-agency group including representatives from the PCT, 5Boroughs Partnership, Children's Services and Adult Services who meet on a quarterly basis and cover both children and adults.

Halton's Autism Strategy has been drafted to meet the requirements of the Fulfilling and Rewarding Lives Delivery Plan and covers a three-year period. The Strategy has an Action Plan that will be monitored by the strategic group on a quarterly basis. In order to ensure the strategy is fully implemented, a Practice Manager specifically for Autism has been recruited for a two year period.

5.2.1 Conclusion

The topic group supported the Autism Strategy and the recruitment of the Practice Manager for Autism.

Recommendations:

i) ***Halton's Autism Strategy to be approved and implemented by the ASC Strategic Group, Senior Management and Health Policy and Performance Board, Children's Trust, and Halton and St Helen's Clinical Commissioning Committee; and***

ii) ***Implementation of Autism Strategy Action Plan to be monitored and progress updates provided by the ASC Strategic Group.***

5.3 A Parent/Carer's Perspective

At the July meeting of the topic group, two parents/carers of young adults with Autism/Down's Syndrome in Halton attended the meeting to share their experience of services they had encountered, professionals and attitudes towards Autism. Both carers recounted their experiences from when their son/daughter were first diagnosed and some of the positive and negative experiences throughout their children growing up, especially with regard to information and attitudes of professionals.

5.3.1 Conclusion

The group felt that the contribution from parents/carers in this process was critical and this discussion with the two carers was very important in understanding the issues. Following the meeting and in preparation for the final scrutiny review report, Councillor Zygadlo requested that the carers were asked their views in terms of recommendations.

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Recommendations:

i) ***Continue to improve engagement with parents/carers, building on the work that has already taken place.***

5.4 Site Visit to Day Services

On 9th September the topic group had a site visit to Day Services, arranged by Eileen Clarke, Performance Manager, Halton Day Services. The group visited the following services:

- Independent Living Centre
- Altered Images Hair and Beauty Salon
- Shopmobility
- Refectory Café, Norton Priory
- Tea room/Brewery, Norton Priory

At each venue, members of the topic group were able to talk to people who worked/attended the services. This was invaluable to the work of the topic group. Members could clearly see how meaningful daytime activities had a positive impact on people's lives, increased their independence and confidence. Amongst the many comments that were given to the group, two in particular were highlighted as powerful messages to support the daytime activities:

Councillor Lowe asked one of the service users working at Shopmobility, if she also worked at The Coach House. The service-user replied "I used to work at the Coach House, but I don't have time anymore because I'm too busy working at other places".

On the visit to the Cottage Tea Rooms at the Brewery, a service-user wanted to tell the topic group that she was moving into supported living accommodation, and to know that she is now thoroughly enjoying her new found independence.

A detailed site visit diary is included in Annex 3.

5.4.1 Conclusion

Members of the topic group found the site visit to be a very positive and uplifting experience. There are some excellent examples of services available for people with autism spectrum conditions to engage in across Halton. Service users are being equipped with life skills and experience, which will enable them to live more fulfilling and rewarding lives within their local community and wider.

Recommendations:

i) ***Continue and extend the work opportunities, both paid and voluntary, for individuals with ASC in Halton enhancing skills to achieve this;***

ii) ***Increase publicity about the good work that is being progressed in day services; and***

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iii) Source funding for new batteries for the shopmobility scooters.

5.5 Day Activities for People with Autism

At the October meeting of the topic group, John Williams, Practice Manager for Autism gave a presentation around Day Activities for People with Autism. The main points of the presentation included:

- Detail of the services that are available in Halton
- The customer journey
- Employment and Volunteering venues
- Core aims of the Positive Behaviour Support Service
- Challenges facing the Council
- Recommendations to improve this area

5.5.1 Conclusion

The group concluded that there is still a long way to go with meaningful day activities for people with Autism although good progress has been made. There are challenges ahead, including attitudes and concerns, limited places within day services and voluntary service and lack of opportunities. Having the Practice Manager for Autism in post is a good opportunity for Halton to move forward in this area and overcome some of these challenges.

Recommendations:

i) Increase employment opportunities, both paid and voluntary, for individuals with ASC;

ii) Maintain the Pan-Disability model within employment services;

iii) Increase day service venues to replicate good practice within the service across the borough as social enterprises, to complete a feasibility study in 2012; and

iv) Increase the awareness of the benefits of employing individuals with ASC to local employers.

5.6 Employment and Autism

At the November meeting, Wesley Rourke, Operational Director for Economy, Enterprise and Property attended to give a presentation to the topic group. The presentation covered the following areas:

- Halton in context – employment, worklessness, not in Employment, Education or Training (NEET) and skills
- Business and Enterprise in Halton
- Background information to the service area and key priorities
- Six drivers of economic prosperity
- Employment, Learning and Skills division
- The Halton Employment Partnership (HEP)

- Apprenticeships
- What support is offered to people with ASC

5.6.1. Conclusion
Members of the topic group commented that the Council's input is acknowledged and recognised, especially in terms of enhancing the local community.

Recommendations:
i) Further promote joint working between relevant teams and inform team work priorities and projects.

5.7 National Autistic Society

During the January meeting, Clare Hughes, Regional Officer from the National Autistic Society attending the topic group and gave a presentation on the national and regional perspective of Autism.

Clare's role covers Cheshire and Merseyside and is funded by 10 Local Authorities to focus on developing local services and family support.

Clare explained how her role linked into the statutory guidance and gave examples of the local authority areas she had been working with.

5.7.1 Conclusion
From the presentation that Clare gave, Halton are in a good position regionally with some good examples of progress. The group also identified areas that require more work, in line with national and regional guidance, and these are detailed in the recommendations.

Recommendations:
i) Increase low level support for people with ASC;
ii) Increase the local provision for individuals with Aspergers;
iii) Increase awareness of ASC within workforce, for example, teachers, social workers, health colleagues, etc.; and
iv) Collect data on the number of adults and children with ASC borough wide.

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6.0 Overall Conclusion

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

It is recognised that there has been some good progress made in terms of services for adults with Autism in Halton over the past year, although much more is also required. Two major milestones have been the establishment of the Positive Behaviour Support Service and the recruitment to the Practice Manager for Autism post, both of which have already had a positive impact on services.

There are recommendations for further improvement that have been identified from this scrutiny review and these have been arranged into an Action Plan at Annex 5 for ease of reference and monitoring.

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Annex 1

TOPIC BRIEF

Topic Title: Autism

Officer Lead: Operational Director (Commissioning and Complex Care)

Planned start date: June 2011

Target PPB Meeting: March 2012

Topic Description and scope:
A review of current pathways to diagnosis and assessment for adults with autism spectrum conditions in Halton, focusing on understanding how localised services support these people and the implementation of the statutory guidance published for local authorities.

Why this topic was chosen:
In December 2010, the Department of Health issued statutory guidance and delivery plan for local authorities and NHS organisations to support the implementation of the nation autism strategy "Fulfilling and Rewarding Lives". There is an expectation that local authorities will implement the requirements set out in the statutory guidance. A regional network group has been developed and this will provide an opportunity to monitor progress towards implementing the statutory guidance locally. The scrutiny review will provide a good opportunity to look at our baseline information in supporting people with autism spectrum conditions living in Halton.

Key outputs and outcomes sought:

- An understanding of Autism and an appreciation for the broad range of conditions that fall under the spectrum from low level to high functioning levels of autism
- Examine the effectiveness of the current pathways for diagnosis and assessment for adults with an autism spectrum condition in Halton
- An understanding of the Positive Behaviour Support Service and the benefits their interventions can bring to local service providers
- Consider national best practice in relation to pathways for diagnosis and assessment for adults with autism spectrum conditions
- Consider ways to continue to make improvements and enable Halton to fully implement the statutory guidance and delivery plan

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

<u>Improving Health:</u>

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

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

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

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

Employment, Learning and Skills:

Key Objective C: To develop a culture where learning is valued and raise skill levels throughout the adult population and in the local workforce.

Key Objective D: To promote and increase the employability of local people and tackle barriers to employment to get more people into work.

Nature of expected/desired PPB input:

Member led scrutiny review of Autism.

Preferred mode of operation:

- Invite member from National Autistic Society to provide an overview of autism spectrum conditions and examples of areas of best practice nationally
- Meetings with/presentations from relevant officers within the Council to examine current practice regarding diagnosis and assessment pathways
- Talk from Positive Behaviour Support Service regarding the aims of their service, the type of training they can provide and support they offer to service providers who work with adults with autism spectrum conditions
- Site visit to Bredon respite provision, following receipt of training from the Positive Behaviour Support service

Agreed and signed by:

PPB chair ……………………… **Officer ……………………………**

Date …………………………….. **Date ……………………………….**

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Annex 2

METHODOLOGY DETAIL

a) Presentations

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

Name of officer	Title of Presentation
Maria Saville, Principal Manager and Kath Devonshire, Practice Manager of the Positive Behaviour Support Service (PBSS)	An Introduction to Autistic Spectrum Condition
Paul McWade, Operational Director for Commissioning and Complex Care	Halton's Autism Strategy
John Williams, Practice Manager for Autism	Day Activities for People with Autism
Wesley Rourke, Operational Director for Employment, Enterprise and Property	Employment Opportunities in Halton
Clare Hughes, National Autistic Society	The National Perspective

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Annex 3

Communities Directorate

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AUTISM SCRUTINY REVIEW SITE VISIT

Friday 9th September 2011

Independent Living Centre

Altered Images Salon

Shopmobility

Refectory Café, Norton Priory

Tea Room/Brewery, Norton Priory

AUTISM SCRUTINY REVIEW SITE VISIT

INDEPENDENT LIVING CENTRE

The Independent Living Centre is based at Collier Street, Runcorn and provides a service for people with Profound and Multiple Learning Disabilities (PMLD). Prior to the Independent Living Centre opening, these service users were based at Astmoor Day Centre, which was a unit based within an industrial estate which is isolated from the local community.

Each of the service users has a Support Plan. Each Support Plan is unique to the service user and provides a photographic process for various catering tasks, such as making a cup of tea or making a cup cake. The Support Plan includes a task monitoring sheet for staff to complete, in order to monitor the progress of the service user in completing their designated tasks.

Halton Day Services has established a catering training course which is called Pebbles. Pebbles is a step by step catering programme, through which people learn the skills and knowledge required in catering. The programme begins with equipping service users with the basic skills for catering and then allows service users with the basic skills for catering and then allows service users to progress and acquire more skills and knowledge. The Pebbles programme is ran at several Day Services venues across Halton. Once the Pebbles course has been completed, service users are fully skilled and trained and are able to then work in the cafés ran by Halton Day Services, or in a café based in the community if they are able to successfully seek employment. By progressing through the Pebbles programme, it has allowed service users to take on a mentoring role to other service users and support them to progress through the training programme successfully.

On the day of our visit, the service users were making cupcakes which were subsequently being delivered and sold at the Norton Priory Open Day. One of the ladies suffers from sleep apnoea and needed to rest in between tasks. Another two service users will only stir the cake mixture 10 times before they need to rest. To accommodate this, staff separate out the tasks into 10 minute slots between those service users, to ensure they are able to be fully involved and engaged in the task, but are also able to rest as required.

The catering programme is managed by a professional chef and her previous employment history includes being a personal chef to Joan Collins.

The Independent Living Centre has also utilised the outside space available to grow flowers, fruit and vegetables, which are then used in other Halton Borough Council catering facilities including the various community cafes which are ran by Halton Day Services. The flowers and vegetables have been planted in raised beds, to allow full accessibility for all service users to get involved in planting and nurturing and extracting the produce. In addition to this, there is also the “Chucky Chicken” project. This project has re-homed

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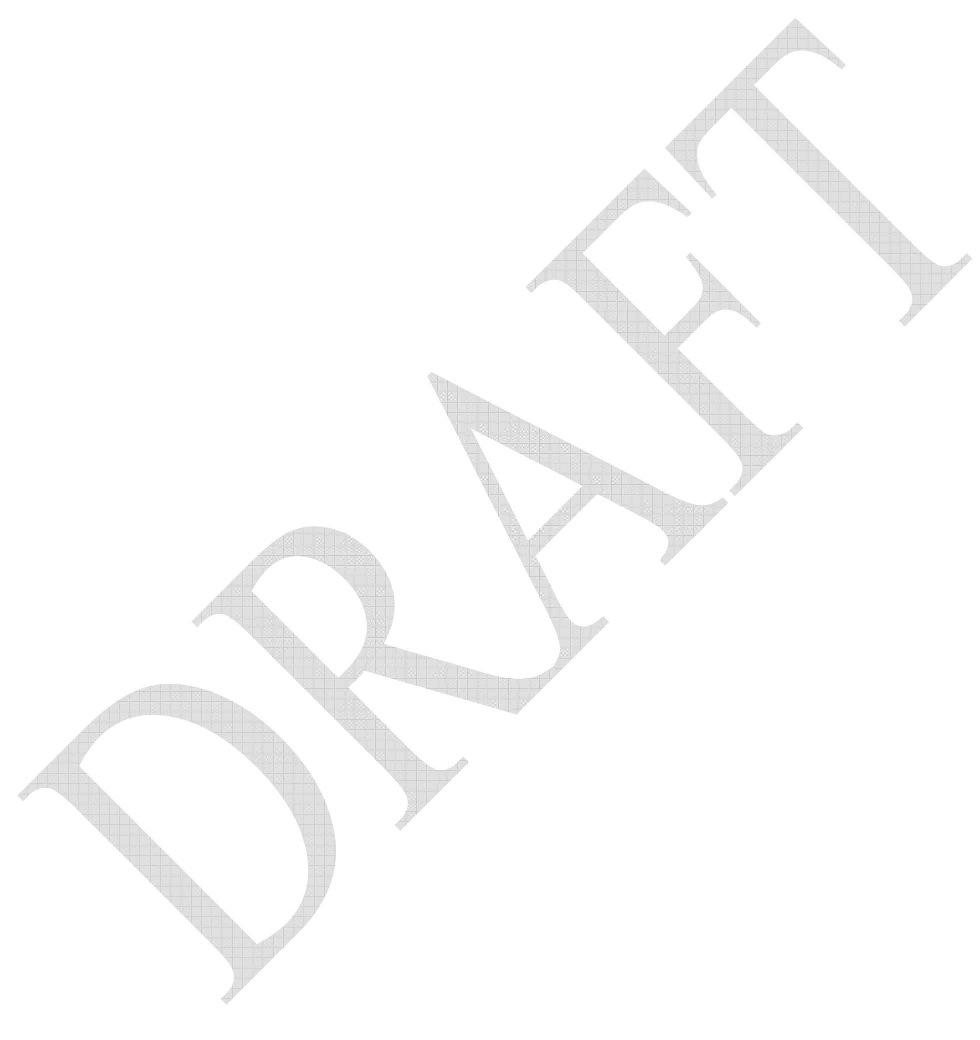
20 ex-battery hens. The eggs produced from the chickens are used by the various Day Services catering projects including Cup Cake Catering.

During the visit, one of the service users James showed us around the flower and vegetable beds. James was obviously very proud of what they were involved with at the Independent Living Centre.



AUTISM SCRUTINY REVIEW SITE VISIT

ALTERED IMAGES SALON

The Altered Image Salon is based on Granville Street in Runcorn. The salon is centrally located between the High Street and Church Street, which provides access to a good footfall for the salon. The salon was quiet at the time of our visit. When no customers are booked in, the service users will practice the skills they have learnt on each other as practical experience.

All service users working in the salon have a portfolio, in which to record all of the training they have undertaken. All service users working in the salon are undertaking an adapted NVQ Level 1 Certificate and Health and Safety training.

There is a full rotation of staff in the salon, so there are different workers in the salon each day and they rotate the tasks they are responsible for in the salon. The service users are fully supported by trained stylists and beauty therapists.

The Altered Image salon offers a full range of hairdressing services at very reasonable prices. They also offer manicures and gel nails.

The salon is open Tuesday – Saturday, with late night opening on a Friday night and this has led to a lot of trade from people who would like to have a hair or beauty treatment for the weekend. Research was undertaken regarding the opening times of other salons in the area in order to be competitive and the prices for hair and beauty treatments are also competitive with other salons in the area.

The salon has had a lot of custom since its opening in August. Customers who have received a hair or beauty treatment have given good reviews of the service they received.

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AUTISM SCRUTINY REVIEW SITE VISIT

SHOPMOBILITY

The Shopmobility store is based in a retail unit in Halton Lea, Runcorn. Shopmobility is run by Eddie, who is an extremely committed and enthusiastic individual.

On the day of our visit, there were four service users working in the shop. The people working on the shop have also been customers of Shopmobility, who are gaining valuable work experience as well as people skills.

A team meeting is held each morning and at the meeting it is decided what jobs people would like to do that day. The tasks to be completed in the store include cleaning the shop, cleaning the scooters, ensuring the scooters are in full working order and inputting information onto the computer system.

There are some issues with some of the scooters in that their batteries are not holding their charge any more. This means that the customers have to be informed that they can only do short trips (no more than 30 minutes) on the scooters. New batteries cost between £300 - £400 each.

There are plans to purchase another four scooters in the near future. Also if funding can be secured, there is potential for a Shopmobility store to be opened in Widnes.

It has become apparent that the customers view the shop as more than just Shopmobility. The staff have found that they are able to help customers with some of their other queries and signpost to other shops and services, if they are unable to provide the equipment required themselves.

Within the Shopmobility store, there is a display cabinet which contains items which have been made at The Coach House (another Halton Day Services project). The articles include Baby Cakes, which are a cake shaped item made up nappies, babygrows, bibs and other useful baby items; handmade cards and other craft items. Councillor Lowe asked Jenny, one of the service users working at Shopmobility, if she also worked at The Coach House. Jenny replied that she used to work at The Coach House, but she doesn't have time anymore as she is so busy working at other places.

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AUTISM SCRUTINY REVIEW SITE VISIT

REFECTORY CAFÉ, NORTON PRIORY

Norton Priory is based near Manor Park in Runcorn. Members of the Scrutiny Review Committee went to the café for lunch.

A number of service users work in the café, as they will have completed the Pebbles catering programme and have acquired the standard of catering skills required for working the café. For those service users who are undertaking the Pebbles programme, to secure employment at Norton Priory Café is held in great esteem.

The café offers a range of hot and cold food and a selection of beverages. Members of the committee ordered a selection of meals from the menu and all were found to be of a high standard and reasonably priced.

The vegetables used by the café are grown by the Country Garden scheme as seen at the Independent Living Centre.

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AUTISM SCRUTINY REVIEW SITE VISIT

TEA ROOM/BREWERY

The Cottage Tea Rooms are based on the grounds of Norton Priory in the walled gardens. The Cottage Tea Rooms also incorporates the micro-brewery and a gift shop. Attendees of the site visit were able to see how the micro-brewery operates and taste a sample of the beer being produced. The brewery project is supported by a Master Brewer, who is helping the service users to ensure all standards in the production of the beer are adhered to. The beer has its own branding of "Priory Ales". The beer is now available for sale at the Tunnel Top public house in Runcorn and will be offered to other local public houses to sell. In the near future, gift packs of the bottled beer will be available to purchase from the gift shop based within the Cottage Tea Rooms.

The Cottage Tea Rooms are open between 12pm – 3.50pm. On the day of the visit, there were four service users working in the tea rooms, with the assistance of two support workers. The service users were able to explain how much their job means to them and how much independence it has allowed them. One example of which was a young lady who now feels independent enough to move into her own tenancy in supported living accommodation.

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CONCLUSION

Members of the Scrutiny Committee found the site visit to be a very positive and uplifting experience. There are obviously some excellent examples of services available for people with autism spectrum conditions to engage in across Halton. Service users are being equipped with life skills and experience, which will enable them to live more fulfilling and rewarding lives within their local community and wider.

All of the venues visited during the day were found to be managed to very high standard and providing excellent opportunities for people with autism spectrum conditions to engage in real work experience, rather than a tokenistic approach. The support staff working at each venue demonstrated real enthusiasm and motivation for the service they provide and are working daily to empower the individuals they are working with.

For many of the service users we met during the visit who are on the spectrum, their behaviour has changed dramatically since engaging in Day Services and helped them to increase their confidence, independence, knowledge and skill base, which will help them in their everyday lives.

Following the site visit, the overall opinion of all members of the Scrutiny Review Committee was that this work needs to continue and expand in Halton. The services currently provided have already received international recognition and is an area of best practice that the borough should be proud of.

The members of the Scrutiny Review Topic Group would like to extend their thanks to all of the venues visited, the service users and staff for taking time to talk through their experiences. A special thank you is also given to Eileen Clarke who shared not only her knowledge but her passion for the work of Halton Day Services.

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Annex 4

Documents Considered including Best Practice within the review

National Guidelines:

- Fulfilling and Rewarding Lives: The Strategy for adults with Autism in England, Department of Health, 2010
- Draft Clinical guidelines for adults with Autism, NICE

Halton Borough Council documents:

- Draft Autism Strategy
- Corporate Plan – 2011 - 2016
- Sustainable Community Strategy – 2011 - 2026

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AUTISM SCRUTINY REVIEW
ACTION PLAN **ANNEX 5**

Action No.	Action	Responsible person	Timescale	Progress
1	Members to support the continued work of the Positive Behaviour Support Service (PBSS).	Members of the Health PPB	Bi-annually	Report due at the Health PPB on 6th March 2012.
2	Halton's Autism Strategy to be approved and implemented by the ASC Strategic Group, Senior Management and Health Policy and Performance Board, Children's Trust, and Halton and St Helen's Clinical Commissioning Committee.	John Williams	2012/13	Due for approval by approximately April 2012.
3	Implementation of Autism Strategy Action Plan to be monitored and progress updates provided by the ASC Strategic Group	John Williams	Regularly throughout 2012/13	Will begin once Strategy is implemented.
4	Continue to improve engagement with parents/carers, building on the work that has already taken place.	John Williams	Quarterly	Consolidating links with HAFS/CHAPs, parents and carers to inform the development of services.
5	Continue and extend the work opportunities for individuals with ASC in Halton enhancing skills to achieve this.	Stiofan O'Suillibhan/ John Williams	Quarterly	Funding has been secured from the NHS to provide a dedicated resource to pull all voluntary and statuary bodies together and align their opportunities for employment. This would include the private, retail and social enterprise elements of Halton. This will be

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				implemented through Training In Systematic Instruction (TSI). The driving force behind TSI is a positive and empowering values base. It places a positive expectation of people's potential to achieve - when we have taken notice of the tasks and environments that people are interested in.
6	Increase publicity about the good work that is being progressed in day services.	Stiofan O'Suillibhan	Bi-annually	Recent publicity includes work with MP Graham Evens about the sale of beer (made at the day service brewery) in a local pub the Tunnel Top and how this will develop into us making a sale in the bar at the Houses of Parliament. All beer has been made with the support of autistic people (this article was in the local paper during December 2011). The intranet is also fully utilised for publicity.
7	Source funding for new batteries for the shopmobility scooters.	Councillor E Cargill	Asap	The Area Forum has agreed to pay two thirds and we are awaiting to hear from Halton Lea Area Forum regarding the remaining one third.
8	Increase employment opportunities for individuals with ASC.	Stiofan O'Suillibhan/ Wesley Rourke	Quarterly	Funding has been secured from the NHS to provide a dedicated resource to pull all voluntary and statuary bodies together and align their opportunities

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				for employment. This would include the private, retail and social enterprise elements of Halton. This will be implemented through Training In Systematic Instruction (TSI). The driving force behind TSI is a positive and empowering values base. It places a positive expectation of people's potential to achieve - when we have taken notice of the tasks and environments that people are interested in.
9	Maintain the Pan-Disability model within employment services.	Wesley Rourke	Annually	Review annually
10	Increase day service venues to replicate good practice within the service across the borough as social enterprises, to complete a feasibility study in 2012.	Stiofan O'Suillibhan	April 2012	Feasibility study to be completed by April 2012 which will then inform future developments.
11	Increase the awareness of the benefits of employing individuals with ASC to local employers.	Stiofan O'Suillibhan/ Wesley Rourke	Annually	Working with the voluntary sector, for example, Halton Speak Out. Could present report to ELS Policy and Performance Board.
12	Further promote joint working between relevant teams and inform team work priorities and projects.	Stiofan O'Suillibhan/Wesley Rourke	Annually	Review annually
13	Increase low level support for people with ASC	John Williams	Quarterly	Current pilot with Mental Health Outreach team and Community Bridge

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				Builders.
14	Increase local provision for individuals with Aspergers	John Williams	Quarterly	On-going developments to provide information to feed into the commissioning of services.
15	Increase awareness of ASC within workforce, for example, teachers, social workers, health colleagues, etc.	Brian Hilton/ John Williams	Quarterly	ASC sub group for training is leading on the training needs of the workforce.
16	Collect data on the number of adults and children with ASC borough wide	John Williams	Quarterly	Collection of data from adult and children services.

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Agenda Item 6e

REPORT TO:	Health Policy & Performance Board
DATE:	6 March 2012
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health & Adults
SUBJECT:	Falls Prevention Topic Brief
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Board with details of the Falls Prevention Scrutiny topic as outlined in the attached topic brief.

2.0 **RECOMMENDATION**

That Members of the Board:

(1) Note contents of the report;

(2) Approve the Topic Brief outlined at Appendix A; and

(3) Nominate Members of the Board to form part of the Scrutiny Topic Working Group

SUPPORTING INFORMATION

3.1 Falls are a leading cause of mortality due to injury amongst older people aged 65 and over. They also contribute to the life expectancy gap between Halton and England. People who have been admitted to hospital following a fall are at increased risk of falling again in the next 12 months, experiencing loss of confidence and fear of falling, and of losing their independence through entering a residential care home.

3.2 Nationally the number of people aged over 65 is due to rise by a third by 2025, which is associated with increased incidence of falls of 2% per year. In Halton the number of people aged 85 plus is projected to increase, and this is the most vulnerable group.

3.3 It is good practice to periodically assess the effectiveness of services provided and this report seeks approval to carry out a scrutiny review of the Falls Prevention Service and the services provided.

3.4 Subject to agreement by Board to accept the topic brief; this report

seeks nominations from members of the Board to form a member led scrutiny working group.

4.0 **POLICY IMPLICATIONS**

4.1 The recommendations from the resulting scrutiny review may result in a need to review policies and procedures used by the Falls Prevention Service.

5.0 **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**

The overall aim of the Falls Prevention Service is to prevent and reduce the number of falls along with associated injuries amongst older people in Halton.

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 None identified.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

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

None under the meaning of the Act.

TOPIC BRIEF

Topic Title: Falls Prevention

Officer Lead: Damian Nolan – Divisional Manager, Intermediate Care

Planned start date: June 2012

Target PPB Meeting: March 2013

Topic Description and scope:
A review of the Falls Prevention Service to ensure that there is an effective multi agency approach to addressing the causes of falling and that the treatment and rehabilitation service in place is effective, thus ensuring that those who have fallen can continue to live healthy, safe lives with increased independence.

Why this topic was chosen:
Falls are a leading cause of mortality due to injury amongst older people aged 65 and over. They also contribute to the life expectancy gap between Halton and England. People who have been admitted to hospital following a fall are at increased risk of falling again in the next 12 months, experiencing loss of confidence and fear of falling, and of losing their independence through entering a residential care home.

The risk of falling increases with age, particularly in those 65 and over. 35% of over 65s are at risk of falling each year, rising to 45% of people aged 80 and over. Between 10- 25% of these fallers will sustain a serious injury. Between 22% and 60% of older people suffer injuries from falls, 10-15% suffer serious injuries from falls, 2-6% suffer fractures and 0.2 – 1.5% suffer hip fractures.

Regardless of the outcome, falls are associated with a loss of confidence, and a subsequent restriction in physical activity which leads to a further loss of capacity and bone density. This increases the risk of another fall and also the likelihood of entering residential care

Nationally the number of people aged over 65 is due to rise by a third by 2025, which is associated with increased incidence of falls of 2% per year. In Halton the number of people aged 85 plus is projected to increase, and this is the most vulnerable group.
(Source : Halton Joint Strategic Needs Assessment)

Key outputs and outcomes sought:

- Examine the effectiveness of the current pathways for assessments and appropriate interventions for those at risk of falls in Halton
- An understanding of the work undertaken by the Falls Prevention Service and the benefits their interventions can bring to those at risk.
- An understanding of the role that partner agencies including the fire services and the third sector have in helping prevent falls.
- Consider national best and evidenced based practice in relation to pathways

for assessment and appropriate interventions for those at risk of falls.
- Consider ways to continue to make improvements to services, thus enabling Halton to reduce admission rates to Hospital as a result of a fall.
- Examine the quality of care someone receives if they do have a fall.

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

<u>A Healthy Halton</u>

- Healthy and Active Lifestyles - Improve the future health prospects of Halton residents, particularly children, through encouraging and providing opportunities to lead healthier and physically active lifestyles.

- Good Public Health - Providing services and facilities to maintain and promote good public health and well-being.

- Intervention and Prevention - Working with service users to provide services focussed around intervention and prevention and where this is not possible, helping people to manage the effects of long term conditions.

- Maintaining Individual Independence - Providing services and facilities to maintain the independence and well-being of vulnerable people and those with complex care needs within our community.

Nature of expected/desired PPB input:

Member led scrutiny review of Falls Prevention.

Preferred mode of operation:
- Review of the NICE (National Institute for Health and Clinical Excellence) guidance related to Falls Prevention and how this is applied within Halton.
- Meetings with/presentations from relevant officers within the Council/Health Services and partner agencies (including the work of the High Impact Falls Working Group) to examine current practices regarding falls prevention.
- Presentation from the Falls Prevention Service regarding the aims of their service, support/interventions they offer to those at risk.
- Site visit to the Falls Prevention Clinic in Halton and other clinics outside of the Borough e.g. St Helens, Warrington etc.

Agreed and signed by:

PPB chair ……………………… Officer ……………………………

Date …………………………….. Date ……………………………….