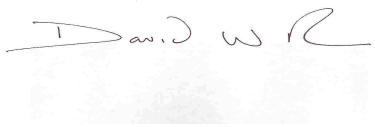
Public Document Pack

Health Policy and Performance Board

Tuesday, 29 May 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 Sandra Baker	**Labour**
Councillor Mark Dennett	**Labour**
Councillor Valerie Hill	**Labour**
Councillor Miriam Hodge	**Liberal Democrat**
Councillor Margaret Horabin	**Labour**
Councillor Chris Loftus	**Labour**
Councillor Pauline Sinnott	**Labour**
Councillor Pamela Wallace	**Labour**
Councillor Geoff Zygadllo	**Labour**
Mr J Chiocchi	**LINk**

Please contact Lynn Derbyshire on 0151 511 7975 or e-mail lynn.derbyshire@halton.gov.uk for further information.

The next meeting of the Board is on Tuesday, 11 September 2012

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

Part I

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

Agenda Item 3

REPORT TO: Health Policy & Performance Board

DATE: 29 May 2012

REPORTING OFFICER: Strategic Director, Corporate & Resources

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

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

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

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

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

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

REPORT TO: Health Policy and Performance Board

DATE: 29 May 2012

REPORTING OFFICER: Chief Executive

SUBJECT: Health & Wellbeing Shadow Board Minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

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

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

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

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

SHADOW HEALTH AND WELLBEING BOARD

At a meeting of the Shadow Health and Wellbeing Board on Wednesday, 22 February 2012 at Karalius Suite, Stobart Stadium, Widnes

Present: Councillors Polhill (Chairman) and Wright, W Rourke, A. McIntyre, S. Banks, P. Cooke, Dr K Fallon, D Johnson, J Lunt, D Lyon, E O'Meara, D Parr, M. Pickup, M. Roberts, N Rowe, N Sharpe, I Stewardson, D. Sweeney, G Ferguson and A. Williamson

Apologies for Absence: Councillors Hignett, Swain and C Hughes, Dr Richards, Dr Lyon, A Yeomans and J. Wilson.

Absence declared on Council business: None

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB13 MINUTES

The Minutes of the meeting held on 5 December 2011 were taken as read and signed as a correct record.

HWB14 PRESENTATIONS FROM PARTNER AGENCIES ON THEIR ORGANISATIONAL PRIORITIES

(1) Dwayne Johnson – Community Directorate

The presentation outlined the aims of the Community Directorate which included:-

- To address health inequalities and outcomes;
- Assess local need and sure availability and delivery of services;
- Protect/safeguarding;
- Professional Leadership;
- Managing culture change;
- To promote local access/partnership working;
- To provide an integrated approach to supporting local communities; and
- To promote social inclusion.

It was noted that the key priorities remained those contained within the National Health Service Act 2006, Section 75 Agreements between the NHS and the Council. The 2006 Act enabled the NHS and local authorities to work together, with pooled funds, lead commissioning, and integrated provision. The outcomes of the Act were to

design and deliver services around the needs of users and patients without worrying about organisational boundaries, eliminating gaps and duplications.

(2) Ann McIntyre/Jane Lunt – Children and Young People's Plan 2011 – 14

The presentation gave a broad outline of the Halton Children's Trust Joint Strategic Plan for 2011 – 14 which included all services for children and young people aged 0 – 19, young people leaving care aged 20 and over and young people with disabilities or learning difficulties up to the age of 25. The plan set out the Children's Trust vision for improving children's health and wellbeing. Further the plan focussed on vulnerable groups to ensure that they achieved the same outcomes as all children and young people in Halton and the role of the Halton Safeguarding Children Board. The Plan also set out the following overarching priorities for the Trust which aimed to improve outcomes for children and young people as follows:-

- through embedding integrated processes to deliver early health and support;
- through effective joint commissioning;
- by targeting services effectively.

The Board was advised that the Plan supported the Trusts Early Help and Support Programme which was driven by a National agenda – Munro Allen and Tickle. It was noted that the focus of Family Intervention Programme at level 3 had achieved total savings in three years of £4.2m.

(3) Dr. Kate Fallon – Bridgewater Community Healthcare NHS Trust

The presentation gave an outline of:-

- The services provided by the Trust and the footprint of areas receiving those services;
- The Trusts mission, vision and the challenge faced by the Trust;
- The Trust's aim of achieving foundation status and the consultation process.

The presentation also outlined the anticipated changes within the NHS in 2016/17, where GPs would be at the centre of commissioning services, and its potential impact on a new commissioning landscape. Dr. Fallon expressed her appreciation at the establishment of this Board and its partnership approach.

(4) Nick Rowe – 5 Borough's Partnership NHS Foundation Trust

The Board received a presentation on the role of the Specialist Mental Health and Learning Disability Trust, which provided secondary care services for adults, older people, CAMS, LD and Forensic. To date, approximately 3,360 Halton residents had access to this service. The Board noted that the priorities of the Trust for 2012 and beyond was to:

- to focus on providing accessible, high quality, community services to support service users in their own homes and communities for as long as possible to promote quality of life;

- ensure fit-for-purpose accommodation, delivering the full range of specialist assessment and treatment, was provided for in-patient assessment;

- to develop and maintain close partnership working within the local health economy with a number of agencies including the local authority, commissioning bodies, neighbouring acute hospitals and community trusts, independent sector, NHS Stakeholder bodies, patient, service user and carer bodies.

(5) Ian Stewardson – St. Helens and Knowsley Teaching Hospitals NHS Trust

The Board received a presentation on the future aspirations of the Trust to become a five star patient care organisation providing the following:-

- a welcoming, safe infection-free environment;
- best practice, high quality evidence based care;
- respectful, open inclusive communication;
- Efficient patient centred reliable systems;
- planned, personalised embedded pathway.

The long-term priorities of the Trust were for the Hospital to continue to play a major part in a high quality health and social care system that was financially and clinically sound. In order to proceed with these priorities a long term strategy needed to be agreed with the Merseyside cluster.

It was reported that the Trust would be receiving additional Government funding in the near future.

(6) Mel Pickup – Warrington and Halton Hospitals NHS Foundation Trust

The presentation provided an outline on the future aspiration of the Trust to be a vibrant, sustainable health care organisation and to be the provider of choice across Warrington and Halton for planned and emergency care and chronic disease management. It was noted that the Trust aimed to provide:

- Good core surgical services;
- Strong well reputed clinical teams;
- Orthopaedic/spinal growth – out of area referrals;
- Shared facilities/sites;
- Long-term condition management and working with community providers to deliver out of hospital care;
- Paediatric outreach; and
- Self-funding/private work.

Mel Pickup outlined to the Board the potential future pressures faced by the Trust which included future savings, whilst meeting public expectations with regard to quality standards and achieving Government performance targets.

(7) Simon Banks – Halton Clinical Commissioning Group

The presentation outlined the emerging vision for the group with the focus on the following key themes:

- Preventing People from Dying Prematurely;
- Enhancing quality of life for people with long-term conditions;
- Helping people to recover from episodes of ill-health or following injury;
- Ensuring people have a positive experience of care;
- Treating and caring for people in a safe environment and protecting them from avoidable harm;
- Improving health and wellbeing;
- Delivering care closer to home; and
- Promoting self-care, independent and community resilience.

In addition the presentation outlined the key priorities for the Trust and the Board noted that a public consultation event would begin on the 28th February until June 2012.

(8) Eileen O'Meara – Public Health NHS Merseyside

The presentation outlined the vision and priorities for public health for 2009-2013 which included:

- Improving the health of our local population;
- Supporting a healthy start in life;
- Reducing poor health resulting from preventable causes;
- Encouraging people to be tested for diseases quickly; and
- Ensuring that where people have existing chronic ill-health they receive effective and efficient care and support.

It was noted that there had been delays in the commissioning priorities for public health due to the recession, tender controls and vacancy management.

Arising from the discussion, the low number of people with disabilities accessing the health checks in Halton was highlighted, the figure was below those in St. Helens accessing this service. In response, it was noted that GPs were on board in ensuring those people with disabilities were accessing the health checks which were available to them.

(9) Paul Cooke – LINks

The Board received a presentation on the role of the Local Involvement Network (LINks) in the community and its priorities. It was noted that the LINks Service was an independent organisation and, to date, 950 people accessed this service.

RESOLVED: That the presentations be noted.

HWB15 PUBLIC HEALTH TRANSITION - VERBAL UPDATE

The Board received a verbal update on the Public Health transition progress to date. It was noted that by 16th March a transition plan had to be produced. The Transition Plan would be approved by the Council's Executive Board and by the relevant body within the NHS. In addition, a shadow structure needed to be in place and a commissioning plan agreed. A Director of Public Health for Halton post had been advertised and interviews would be held in March 2012. It was agreed that the Transition Plan would be e-mailed to all Board Members for comment with the request that any feedback be sent by e-mail before the deadline date of March 16th.

RESOLVED: That the report be noted.

HWB16 HEALTH AND WELLBEING STRATEGY

The Board considered a report of the Strategic Director, Communities which provided an update on the development of the Joint Health and Wellbeing Strategy. A Joint Health and Wellbeing Strategy Group led by the Director of Public Health had been set up and had held its first meeting in January 2012. It had agreed Terms of Reference, membership, a time line and project plan. It had also developed a draft outline framework and began to populate it with information. This had been presented to the Health Strategy Sub-Group.

It was reported that since the last meeting a narrative document, 'Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies' explained was published which set out the context of strategies and joint health and wellbeing strategies for Health and Wellbeing Board Members. In addition, the Department of Health had produced a draft guidance on Health and Wellbeing strategies which was currently open for consultation. The guidance would then be refined before publishing the final statutory guidance after Royal Assent, before Summer Recess 2012.

The Board was advised that at a local level, work was currently underway to ensure that Halton's existing Joint Strategic Needs assessment were fit for purpose (according to existing guidance). A key needs document had been developed which would be reviewed by commissioners. This document would assist the Health and Wellbeing Board in being able to identify the priorities that would underpin the Health and Wellbeing Strategy within the required life course approach. A copy of the Joint Strategic Needs Assessment had been previously circulated to Members of the Board.

Agreement on the Health and Wellbeing Strategy and alignment of a number of Clinical Commissioning Groups (CCG) priorities against these must be reached by early June 2012 to enable CCG to sign off commissioning intentions by the end of June. Consultation had started on determining the local priorities, with an event with Halton CCG planned for 28th February which would seek to gain the views of local stakeholders on the key priorities for the CCG and Health and Wellbeing Strategy.

It was also noted that a Public Health Transition event

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

It was recognised that as part of the consultation it was a priority to consult young people on the Health and Wellbeing Strategy.

RESOLVED: That the report be noted.

HWB17 HEALTH AND WELLBEING SERVICE PARTNERSHIP PROPOSAL

The Board considered a copy of the Health and Wellbeing Service Partnership Proposal between Halton Borough Council and Bridgewater Community Health Services.

The service areas covered by the proposal were those which were currently delivered by the Health Improvement Team (Bridgewater) and Surestart to Later Life/Community Bridgebuilders and Early Intervention and Prevention Services (HBC). The proposal would initially incorporate those services detailed, however, there were a number of options within this approach to further develop the partnership approach within the following services, sexual health, falls, oral/dental health promotion.

In order to ensure a successful transition and on-going positive working there were a range of key interfaces/ pathways of care within which the Health and Wellbeing Service had a key role.

It was proposed to develop a mix of professional teams of front line workers from the services detailed in the report with a focus on single line management and integrated service provision. Operational policies for the teams would be developed as part of the transition process and would be agreed as part of the implementation plan. New management arrangements would need to be put in place. Once the model and the partnership agreement arrangements had been agreed, further work would be required to develop an implementation plan and project group, this would include:-

- Budgets

- Re-design options
- Governance
- Accountability
- Staff establishment
- Policy and procedures
- Roles and responsibilities.

Decisions on the proposals and subsequent partnership arrangements would be taken at the joint meeting between Halton Borough Council and Bridgewater Executive Team on 31st January 2012. Formal agreement and an implementation plan would be signed off by the 31st March 2012. It was proposed that the new operational arrangements would be in place by 31st March 2013.

The Board was advised that high level outcomes were expected to be realised as a consequence of the integrated service which included:

- Improved access to community services, promotion, prevention, enablement, independence and well-being;
- Improved ability to deliver innovative services focused on the communities we serve;
- Ability to reflect and deliver local requirements to meet service users' needs with clarity in local accountability.
- Improved access to high quality training and development for staff;
- Improved efficiency and cost effectiveness;
- Increased functionality through integrated teams offering a wide range of flexible responses and skills.

In addition the proposed model would act as a catalyst for more integrated working, to develop a joint vision, build relationships and focus on the identified priorities.

RESOLVED: That

(1) the proposal to establish joint working arrangements be noted;

(2) the operational accountability framework be noted;

(3) the development of any required formal agreements be authorised;

(4) the development of an implementation plan be

authorised.

HWB18 LAUNCH OF HEALTH AREAS

The Board discussed the development of Health areas in Halton which would be based upon the current Area Forum footprint. The Health areas would be used to deliver the Health and Wellbeing Strategy for Halton, adopting a Community Development led approach and working closely with Public Health. Once the Health Areas approach had been agreed by Elected Members, a branding exercise would take place to ensure the most appropriate name was chosen for the Areas. A Health Areas Working Group would also be established.

It was proposed that consultation with Area Forums and the wider community would be carried out in the near future. A further update report would be brought back to the next meeting of the Board.

RESOLVED: That the report be noted.

HWB19 DEVELOPMENT OF A HEALTH & WELLBEING BOARD WEBSITE

The Board received an update on the development of a Health and Wellbeing Board website. Members of the Board had been invited to attend a web development workshop on the 7th February 2012. The workshop discussed the aims of the website, content, the intended audience and what functionality was required. Issues raised at the workshop included, governance, security and legal implications and branding of the website.

It was proposed that a further report would be presented to the next meeting.

RESOLVED: That the contents of the report be noted.

HWB20 FEEDBACK FROM HEALTH AND WELLBEING BOARD SUB GROUPS (CHAIRS)

The Board considered feedback from Health and Wellbeing Board Sub-Group – Commissioning. Terms of Reference for the Sub-Group had been agreed and work was on-going to establish a picture of the current position and an aspiration of commissioning in 12 months' time.

RESOLVED: That the report be noted.

HWB21 HEALTHWATCH UPDATE

The Board considered a report of the Strategic Director, Communities, which provided an update on the recent Government announcements regarding the establishment of local Healthwatch organisations and an outline of Halton's current position. Following feedback from local authorities and local involvement networks, the Department for Health had announced that the implementation date for local Healthwatch had been put back to April 2013, subject to Parliamentary approval. The implementation date for Healthwatch England, the body that would provide leadership, advice and support to local Healthwatch organisations, remained the same – October 2012.

It was recognised that the new start date would allow time for additional engagement with LINk members, members of the public and stakeholders as to how local Healthwatch could operate in Halton, which could then be considered in the development of the contract specification. In addition the extension to the transition period meant that the tender specification would not now need to be finalised until Summer 2012 allowing greater time to ensure that Halton could learn from the pathfinder areas and utilise further guidance from the Department of Health and Healthwatch England.

It was noted that new funding of £3.2m had been made available in 2012/13 for start-up costs in establishing local Healthwatch and included costs such as staff recruitment/training, office set up costs, and branding; a funding would be allocated as part of the Department of Health Learning Disabilities and Health Reform Grant in 2012/13.

It was noted that as a consequence of the new start date, the Halton LINk host contract had been extended up to an additional 12 months, March 2013. Further developments in Halton included:

- Halton LINk had been working with the Council and key stakeholders to prepare for the transition and had established a Transition Sub-Group of the LINk Board;

- the Council's Healthwatch Project Group had met with a representative from the Council's Legal Team to establish advice on developing a specification for an appropriate body corporate;

- Members of the Project Group would also meeting with colleagues from Merseyside local authorities to explore cross-boundary procurement of the Local Healthwatch support functions

RESOLVED: That the report be noted.

HWB22 DATE AND TIME OF NEXT MEETING

It was noted that the next meeting would be held on Wednesday 21st March 2012 at 2pm in the Karalius Suite, Stobart Stadium, Widnes.

Meeting ended at 4.00 p.m.

SHADOW HEALTH AND WELLBEING BOARD

At a meeting of the Shadow Health and Wellbeing Board on Wednesday, 21 March 2012 at Karalius Suite, Stobart Stadium, Widnes

Present: Councillors Hignett, Polhill (Chairman) and Wright and P Cooke, E Danton, K Fallon, M Forrest, D Lyon, D Johnson, E O'Meara, A McIntyre, D Parr, M Pickup, B Raistrick, M Roberts, N Sharpe, D Sweeney, G Ferguson and J Wilson.

Apologies for Absence: S. Banks, S. Barber, D. Edwards, N. Rowe, R. Strachan, A. Williamson, W Rourke and S. Yeoman.

Absence declared on Council business: None

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB23 MINUTES

The Minutes of the meeting held on 22nd February 2012 were taken as read and signed as a correct record.

HWB24 HEALTH AREAS UPDATE

The Board received an update report on the progress of locality health areas in Halton. A working group had been identified to progress this area of work and an inaugural meeting had taken place on 15th March 2012. A draft terms of reference detailing membership and an action plan had been produced and circulated to Members of the Board. It was reported that the initial priority for the Group was to develop an overarching brand for health and wellbeing in Halton to raise awareness and build ownership of the health and wellbeing agenda. It was anticipated that a favoured option for a brand and a communication and marketing plan would be developed in 12 weeks' time.

The Board was advised that the Area Forums which met three times each Municipal Year would provide a platform for Councillor and Community engagement and embed this agenda as core business. A presentation would be made at the June/July meetings to set the context, consult and outline future arrangements.

Members commented that representatives from the faith groups should be considered for membership of the locality health areas working group.

RESOLVED: That the report be noted.

HWB25 PUBLIC HEALTH TRANSITION UPDATE

The Board considered a joint report of the Strategic Director, Communities and the Interim Director, Public Health on the Public Health Transition plan.

The Board was advised that the current NHS reform programme set out proposals for the development of a new public health system. A key element of the proposals was the transfer of local public health leadership and commissioning from the Primary Care Trusts (PCTs) to local Councils. The key elements of the new public health system were summarised in the report.

Health and Wellbeing Boards, as a statutory Council committee, would provide the forum to bring together clinical commissioning groups, health and social care practitioners, public health and elected members with patient and public champions, to join up the public health agenda with the wider work of the NHS, social care and children's services.

The report provided details of the approach to be taken by Halton and the joint role the Borough Council had with Merseyside PCT cluster in co- developing the new local arrangements for public health. The public health transition assurance framework was attached at Appendix 1 and had been approved by Executive Board on 15th March 2012. It was noted that funding and responsibilities would formally transfer on the 1st April 2013, although would run in shadow from 2012/13.

The Board noted that from 2013/14 Councils would receive a ring fenced Public Health grant. In addition, the Government had announced £5.2b funding for the whole public health system of which £2.2b would be allocated to local authorities. Details were awaited of the distribution formula on which the allocations would be based. However initial indications were that Halton appeared to be underfunded.

As well as the transfer of public health responsibilities there would also be a transfer of public health staff for PCTs to local authorities. At present the Public Health Team work across Halton and St. Helens. It had been agreed that in order to support each area to discharge their public health duties two Public Health Teams would be created, one for Halton and one for St. Helens, each with a Director of Public

Health. It was anticipated that the Director of Public Health post would be in place by 30th March 2012.

It was noted that staff from the CCG would move into Runcorn Town Hall in May/June 2012. Arising from the discussion it was agreed that a report detailing an audit of NHS assets in Halton would be brought to the next meeting.

RESOLVED: That the plan to transfer public health functions to the Council be approved. D Johnson

HWB26 HEALTH AND WELLBEING BOARD WEBSITE

The Board received a presentation on the Health and Well Being Board website proposals. A workshop had been held to gather requirements for the website and the following had been requested.

- A website for the Health and Well Being Board and Officers Group that would assist with the management of the group;
- An area for sharing documents;
- A chat room; and
- A shared calendar.

Following a demonstration of the prototype site it was suggested that consideration be given to developing discreet areas, colour coding, an area to confirm attendance at future Health and Well Being Board meetings, an area to attach Health and Well Being Board agenda and minutes within the calendar and a facility to post details of other Health meetings within the calendar area.

RESOLVED: That the site be approved subject to consideration of the comments made.

HWB27 FEEDBACK FROM HEALTH AND WELLBEING BOARD SUB GROUP MEETINGS

The Board received an update report for each of the Health and Well Being Board Sub-Groups that sit under the main Board. With regard to the Health Strategy Group the Group had met on the 9th February and the following progress was reported:

- The JSNA and area health profiles were nearly complete;
- Consultation and engagement has started; and
- The group was developing a framework for prioritisation.

In respect of the Commissioning Group, the first meeting had been held on the 20th February. The Group discussed a number of key items including terms of reference, the Integrated Model for Commissioning, an update from the Clinical Commissioning Group and the One Plan.

The minutes from the meeting of the Health Strategy Group and the Commissioning Group had been previously circulated to the Board for information.

It was reported that the Public Health Commissioning Sub Group had met this week and considered draft Terms of Reference and transfer of contracts to the Local Authority.

RESOLVED: That the report be noted.

HWB28 HEALTH & SOCIAL CARE BILL UPDATE

The Board considered a report of the Strategic Director – Communities, which provided an update on the progress of the Health and Social Care Bill. The Health and Social Care Bill had passed through the House of Lords and was on track to progress through the Parliamentary system. As part of the Bill the Strategic Health Authorities and Primary Care Trusts would be abolished and the NHS Commissioning Board would take on its full responsibilities from the 1st April 2012. In addition, Clinical Commissioning Groups (CCGs) would be developed to cover England. The Government aimed to have the CCGs fully authorised by April 2013. The CCGs would be responsible for commissioning the majority of healthcare for their local population. It was expected that the CCGs would put arrangements in place to identify their substantive appointments from April 2012.

It was envisaged that the NHS Commissioning Board would temporarily host commissioning support services that grew from PCT clusters from April 2013 where those services demonstrated, through business review, that they would be viable. It was proposed that all these services would move to freestanding models by April 2016. Early indications suggested that there may be 25 to 30 NHS Commissioning Support services. It was anticipated that each Commissioning Support Service would have developed governance arrangements that would allow it to operate at arm's length from the PCT cluster by March 2012.

With regard to Public Health England (PHE), this was

to be established on 1st April 2013 as an Executive Agency of the Department of Health. Its overall mission would be to protect and improve the health and wellbeing of the population and to reduce inequalities in health and wellbeing outcomes. Further work to finalise the organisation design of PHE including the number and location of staff and offices would be conducted by the end of April 2012.

With regard to Local Government and Public Health Services, the expected date for any transfer of Public Health Staff from the NHS to Local Government was 1st April 2013. The provisions included a new duty on County Councils, London Borough Councils and Unitary Authorities, to take steps to improve the health of their local population. Local Authorities may fulfil their new health improvement duty through commissioning public health services and through working with clinical commissioning groups and representatives of the NHS Commissioning Board to integrate services.

In addition, Health Education England would be established as a Special Health Authority in June 2012 with a view to commencing operations from October 2012 and taking on full responsibilities by 1st April 2013.

As part of the Bill NHS Property Services Limited would be established and would be a property company wholly owned by the Department of Health. The principal function of the company would be to hold and manage part of the estate that was currently owned by PCTs. Due to the complexities of the Estate, it was envisaged that properties and staff may transfer from PCTs in a number of waves between September 2012 and March 2013.

It was reported that the Department of Health would reduce its staff from 2,400 to around 1,000. This would include staff leaving to join other new NHS organisations. It was also noted that the Government had tabled amendments to the Bill to enable local authorities to have flexibility and choice over the organisational form of local Healthwatch.

The Board requested that their appreciation to Louise Wilson for the thorough report be noted.

RESOLVED: That the report be noted.

HWB29 COMPREHENSIVE CANCER CENTRE FOR CHESHIRE AND MERSEYSIDE

The Board considered a report of the Strategic Director, Communities which sought to provide information on the work that had 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 development of services across this area.

The Board was advised that the report requested Members support for the delivery of a wide-range of communication and involvement exercise designed to share the proposals with a wide range of stakeholders across Cheshire and Merseyside and further afield where appropriate.

Mel Pickup, Chief Executive of Warrington and Halton NHS Foundation Trust, gave a verbal update at the meeting. It was report that in Autumn 2010, Price Waterhouse Coopers (PWC) had been 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 had been published in March 2011. The study reviewed two 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 80 in-patient beds, was £116.5m and £105.2m respectively (both excluding VAT).

The Board was further advised that both Trust Boards had worked together to consider and bring forward an affordable proposal which incorporated:

- 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 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 site; and
- A satellite facility to remain on the CCO Wirral site comprising ambulatory, radiotherapy and chemotherapy, outpatients services proton therapy.

In making the above recommendations it was recognised that certain patients would have to travel further for certain elements of their care. However, it was 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 also continue to be provided on the site for local patients. Only those patients who required more complex treatment, or required inpatient facilities, would be required to travel to the new centre in Liverpool.

It was estimated that the Cancer Centre 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.

RESOLVED: That the report be noted.

HWB30 DATE OF NEXT MEETING

It was noted that the next meeting would be held on Wednesday 23rd April 2012 at 2pm in the Karalius Suite, Stobart Stadium, Widnes.

Meeting ended at 3.25 p.m.

REPORT TO: Health Policy and Performance Board

DATE: 29 May 2012

REPORTING OFFICER: Strategic Director Resources

PORTFOLIO: Policy and Resources

SUBJECT: Performance Management Reports for Quarter 4 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 of the Prevention and Assessment and Commissioning & Complex Care Departments for the fourth quarter of 2011/12 to March 2012. The report details progress against service objectives/ milestones and performance targets, and describes factors affecting the service.

2.0 RECOMMENDED: That the Policy and Performance Board

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

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

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

3.0 SUPPORTING INFORMATION

3.1 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.

3.2 Following discussion with the Chair, the Board has been provided with an overview report which identifies the key issues arising from the performance in Quarter 4 for the Directorate.

3.3 The full departmental quarterly reports are available on the Members' Information Bulletin to allow Members access to the reports as soon as they have become available. This also provides Members with an opportunity to give advance notice of any questions, points or requests

for further information that will be raised to ensure the appropriate Officers are available at the PPB meeting. The two departmental quarterly monitoring reports are also available via the following link

http://intranet/documents/qmr/201112/communities/CQ4Reports

Members will also have received extract reports electronically from Committee Services (as previously presented to the Policy and Performance Board) for these two Departments, covering all areas falling within the remit of this Policy and Performance Board.

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

None under the Meaning of the Act.

Health PPB Thematic Performance Overview Report

Directorate: Communities Directorate

Reporting Period: Quarter 4– Period 1st January 2012 to 31st March 2012

1.0 Introduction

1.1 This report provides an overview of issues and progress within the Directorate that have occurred during the third quarter.

2.0 Key Developments

2.1 The revised Organisational Structure came into effect from 1st April 2011 and this Directorate Overview Report reflects the areas which now fall under the remit of the Communities Directorate.

Eileen O'Meara has now been jointly appointed as Director of Public Health until 2013 prior to the formal transfer of the Public health function into the Local Authority.

There have been a number of developments within the Directorate during the fourth quarter which include:-

I COMMISSIONING AND COMPLEX CARE SERVICES

Electronic Monitoring
Meetings have concluded and all Domiciliary Care Providers are signed up to the new Electronic Monitoring system from 1st April 2012. The first 12 months will act as a trial period for work to be carried out with internal systems linking via finance and IT to incorporate 'live billing'. This will conclude once the 12 month trial period is completed. This is on target to complete on time.

Provider Negotiations
All Providers across Residential and Domiciliary care have attended a meeting to discuss the 0% inflationary uplift and extension of contract on existing terms and conditions.
Letters confirming the above have been distributed to Providers for signing.

Commissioning
The existing Tender process has been completed for floating support services. The contract from April 2012 has been signed and work is underway with the new support Provider - Plus Dane, to ensure TUPE arrangements and transfer of service users will be completed by 1st April 2012. The accommodation services were awarded to the existing Provider, who are restructuring to ensure service delivery, in line with Tender proposals and a reduced contract value. A new Tender process is due to commence in May 2012 for the other accommodation services which have been extended to 31st October 2012.

Domestic Abuse services have been extended to 31st March 2013, and consideration is being given to alternative service models before a Tender process commences in September 2012.

The award of the Extra Care Housing and Support contract has taken place; this will mean changes for the existing provision within Dorset Gardens as well as the new provision at Naughton Fields (opening July 2012) and the Boardwalks (opening 2013).

The contract for the Dementia Care Advisors and the Dementia Cafés that will be delivered in partnership by the Alzheimer's Society and Age UK has been agreed and completed. Recruitment has taken place during February and March and the service will commence from 1st April 2012.

The independent sector Provider of the Community Enablement Service – Glenelg, supporting adults with learning disabilities, has given three months' notice to end the contract in June 2012. As a result of personalisation, the Provider has seen its contracted hours reduce to a level that is no longer viable. This service will not be re-commissioned and alternative support is being identified for the small number of people currently accessing the service.

II PREVENTION AND ASSESSMENT SERVICES

Integrated Multi Agency Safeguarding Hub
Work has begun on establishing an Integrated Safeguarding Unit which is jointly funded with the Clinical Commissioning Group (CCG) to lead on adults safeguarding and dignity work across the health and social care economy. The Unit will operate as a hub and spoke model which is a multi-agency efficient, flexible and responsive service to the local population. A steering group has been established and recruitment processes initiated.

Six Lives
Work is on-going to ensure progress is maintained in responding to the Ombudsman's Report Six Lives. Work primarily relates to healthcare services access/reasonable adjustments and the Mental Capacity Act and has begun to be progressed through the multi-agency Healthcare for All sub group of the Learning Disability Partnership Board.

Integrated Adult Learning Disability Team – Health Checks
The Integrated Adult Learning Disability Teams are working within GP's surgeries to ensure that the Learning Disability register held by each 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 started in February and has been well attended. 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 Learning Disability Nurses are encouraging GP practices to complete the LD health checks before the end of March and are attending clinics to offer support, advice and guidance to Practice Nurses etc. and to support those people with a Learning Disability.

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. In July the Learning Disability Partnership Board developed a Business Plan. The Business Plan includes three key actions for each of the six key themes from Valuing People Now e.g. health, employment etc. A lead Officer has

been identified to deliver each key action, and those lead Officers are contacted every quarter to provide progress updates on their key actions. The Business Plan updates are presented to the Learning Disability Partnership Board and will help to inform the next annual self- assessment report.

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 has been reviewed. A Reconfiguration Board has been established and supporting work streams are developing the model and action planning to support implementation around June 2012.

3.0 Emerging Issues

3.1 A number of emerging issues have been identified during the fourth quarter that will impact upon the work of the Directorate including:-

I COMMISSIONING AND COMPLEX CARE SERVICES

Nutrition Pilot
The Quality Assurance Team (QAT) is working with the PCT on improving the nutrition of vulnerable people within care services. Providers are piloting the new MUST toolkit which has been developed in conjunction with Dieticians, Speech and Language Therapists (SALT), the Health Improvement Team, HBC Operational Services, Training Department and the QAT. This will ensure that Care staff appropriately record the nutritional and dehydration/hydration records of each person. A training programme is being rolled out to all staff in each service incorporating Cooks, Seniors, Nurses, Care Assistants and Managers of Care Homes.

Early Detection of Depression in Older People Pathway and Guidelines
An Early Detection of Depression in Older People Pathway and Guidelines has been developed and is being used by Domiciliary Care Workers and Care Homes in Halton. The Halton BC Learning and Development Team received training in this area from an NHS approved specialist and they have cascaded it to Domiciliary workers and Care Home staff. It has been well received. The impact of the new pathway and guidelines will be evaluated in 6 months.

Residential Care
Work has started on setting up a steering group across the Residential Care market with Providers to look at quality and cost models. This will give the Authority sufficient understanding and evidence to inform the Tender process in 2014.

Domiciliary Care
Discussions have started with Providers on the forthcoming Tenders from 2013. This will roll out throughout 2012 prior to the Tender.

Learning Disability Self Assessment
The Halton and St Helens PCT validated learning disability self-assessment for 2011/12 was published in January 2012 and reported to the Clinical Commissioning Group in

March 2012. This measures progress made against the Ombudsman's report 'Six Lives and the provision of Public Services for People with learning disability.' In 17 areas the standard achieved was Effective or Excelling. 9 areas were flagged as Less Effective and actions are being considered to move these to Effective. A supplementary assessment was also submitted as part of the national response to the review of abuse uncovered at Winterbourne View. The validated results have yet to be published. The format of the 2012/13 self-assessment has been modified and the submission date brought forward to June 2012.

II PREVENTION AND ASSESSMENT SERVICES

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 has been reviewed. A reconfiguration Board has been established and supporting work streams are developing the model and action planning to support implementation around June 2012.

4.0 Performance Overview

The following information provides a synopsis of progress for both milestones and performance indicators across the key business areas that have been identified by the Communities Directorate. The way in which the Red, Amber and Green, (RAG), symbols have been used to reflect progress to date is explained at the end of this report.

I *Commissioning and Complex Care Services*

Key Objectives / milestones

Ref	Milestones	Q4 Progress
CCC1	Implement the Local Dementia Strategy, to ensure effective services are in place. **Mar 2012**. (AOF6 & 7)	✗
CCC1	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)	✗
CCC1	Introduce specialist support provision for victims of a serious sexual offence **Mar 2012** (AOF6 & 7)	✓
CCC2	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)	✓
CCC2	Update the 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)	✗
CCC3	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)	✓

Supporting Commentary

Local Dementia Strategy
The findings for the pilot of the Assessment, Care and Treatment Service (ACTS) is now complete and full implementation of the service will take place from April 2012. In addition the contract and recruitment of the Dementia Care Advisors is now complete. Discussions with the local GPs has begun to consider completion of the mapping of community Dementia services to meet the milestones and objectives of both the Mersey Cluster and the local Clinical Commissioning Group (CCG).

Halton Carers Centre
External funding applied for Carers Centre. The outcome of this will be known by June 2012.

Specialist Support Service for Victims of a Serious Sexual Offence
Referrals have raised slightly with police referrals now surpassing the amount of self-referrals. This is potentially due to the launch of the Dedicated Rape Unit. This period has also seen a significant increase in the amount of cases being taken up by the Crown Prosecution Service; four clients have been informed that their perpetrators have been charged and two court dates have been set for later in the year.

Service User Evaluation
A number of consultations took place during the final quarter of 2011/12. The statutory Adult Social Care Survey was undertaken. Questionnaires were sent to approx. 750 Adult social Care Service Users. The results of the survey are currently being analysed. The Adult Social Care Quality Assurance Team concluded analysis of the consultations which took place in Q3 with positive results. For example, a 93% satisfaction rate was achieved and Dignity and Choice were rated highly by Service Users. A survey of residents at Dorset Gardens took place in Q4 to find out what activities residents enjoy and what new activities residents would like to see introduced. The results of the Dorset Gardens activity survey are available on the Consultation Finder, via the Council Website.

Joint Strategic Needs Assessment (JSNA)
New JSNA Products have been developed including a JSNA Data Work Book to assist Commissioners in accessing the most current data available, to use alongside the Chapter narratives. A JSNA Commissioning Priorities Summary Document has also been developed which summarises the priorities identified in the JSNA across the life course, health and wider determinants and also by Area Forum area. These priorities are being cross referenced with Commissioners and Managers during Q4 2011/12 to ensure that they are still appropriate and will be made publically available during Q1 2012/2013.

Section 75 Agreements
Report on updates to Section 75 Agreements have now been agreed by partners.

Key Performance Indicators

Ref	Measure	10/11 Actual	11/12 Target	Q4	Current Progress	Direction of travel
CCC7	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, by age group.	4.6%	5%	4.5%		NA
CCC9	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		
CCC10	Number of households living in Temporary Accommodation (Previously NI 156).	4	12	6		
CCC14	Carers receiving Needs Assessment or Review and a specific Carer's Service, or advice and information (Previously NI 135).	24.13	24.13	21.36e		

Supporting Commentary

CCC7 – Target not met due to the complexities of recording data and a lack of consistency in the assessment process e.g. questions asked relating to dementia are not asked by every service area. Plans are in place to address this with two specific workstreams relating to Older Peoples Community Mental health teams and the development of the Later life and Memory Service in conjunction with 5 Boroughs Partnership. Work is underway to improve the coding process with the Clinical Care Commissioning Group.

CCC9,10 - Due to access problems with the Homeless team database, data has to be collated manually and is not yet available for Q4. The position at the end of December 2011 is reported above.

CCC14 - Figure provided is an estimate based on data currently available. Final year-end figures will not be known until completion of statutory returns at the end of May 2012. Performance is expected to be lower than target and may be explained by the higher volumes of Carers who are now accessing services via Halton Carers Centre.

II *Prevention and Assessment Services*

Key Objectives / milestones

Ref	Milestones	Q4 Progress
PA1	Commence implementation of the Early Intervention/Prevention Strategy to improve outcomes for Older People in Halton. **Mar 2012** (AOF6 & 7)	✓
PA1	Commence implementation of Telecare strategy and action plan. **Mar 2012** (AOF 6 & 7)	✓
PA1	Continue to establish effective arrangements across the whole of adult social care to deliver self directed support and personal budgets. **Mar 2012** (AOF6)	✓
PA1	Review and evaluate new arrangements for integrated hospital discharge Team. **Mar 2012** (AOF 6&7)	✓
PA1	Commence implementation of Business Plan for Oak meadow. **Mar 2012** (AOF 6&7)	✓
PA2	Develop Air Quality Action Plan. **Apr 2011 - Dec 2011**	✓

Supporting Commentary

Early Intervention/Prevention
All of the milestones for 2012 have been achieved. A progress report is currently being completed and an updated action plan will be developed.

Telecare Strategy and Action Plan
The Telecare Strategy has been fully implemented and the team is fully operational.

Self Directed Support
The review of the self-directed support process, policies and procedures is progressing within agreed timescales.

Integrated Hospital Discharge Team
Team fully operational, targets being met and exceeded.

Implementation of Business Plan for Oakmeadow
Business Plan fully implemented and operational. Further work on activity planning is underway.

Air Quality Action Plan
The draft Plan is ready and subject to internal consultation.

Key Performance Indicators

Ref	Measure	10/11 Actual	11/12 Target	Q4	Current Progress	Direction of travel
PA1	Numbers of people receiving Intermediate Care per 1,000 population (65+) (Previously EN 1)	98.07	99	91.67	✗	↓
PA 5	Percentage of people fully independent on discharge from intermediate care/reablement services	-	40%	58%	✓	N/A
PA 6	Number of people receiving Telecare Levels 2 and 3	149	164	240	✓	↑
PA 8	Percentage of VAA Assessments completed within 28 days (Previously PCS 15)	78.12	80	90.67e	✓	↑
PA 14	% of items of equipment and adaptations delivered within 7 working days (Previously CCS 5)	96.65	96	97.60e	✓	↑
PA18	a) % of scheduled Local Air Pollution Control audits carried out b) % of Local Air Pollution Control Audits being broadly compliant.	-	New Indicator	81% 85%	Refer to comment	Refer to comment
PA28	Repeat incidents of domestic violence (Previously NI 32)	Q4 = 29% End of year average = 25%	27%	27.6%	✓	↓

Supporting Commentary

PA1 – Target not met, however performance is still good when benchmarked against other areas. Numbers of people receiving service have increased on the previous year. This indicator is subject to increases in the estimated population of older people in Halton.

PA 5 - Excellent performance - indicates improvement in outcomes for people who use the service. National audit of intermediate care will provide further benchmark information.

PA 6 – The numbers of people receiving Telecare has increased and the target has been exceeded.

PA 8 – The figure provided is an estimate based on data currently available. Estimated performance is much higher than target and 2010/11 actual. Final year-end figures will not be known until completion of statutory returns at the end of May 2012.

PA14 – The figure provided is an estimate based on data currently available. Estimated performance is higher than target and 2010/11 actual. Final year-end figures will not be known until completion of statutory returns at the end of May 2012.

PA18 - This is a new indicator therefore no comparison can be made from previous years.

PA28 – Changes in reporting procedure to reflect guidance by CAADA has led to all high risk cases now being discussed at MARAC, and an increase in the number of repeats. 27.6% repeat incident rate represents 70 cases out of a total of 253 cases, one repeat incidence causing a 0.4% increase.

APPENDIX

Symbols are used in the following manner:

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

Direction of Travel Indicator

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

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

REPORT TO:	Health Policy & Performance Board
DATE:	29 May 2012
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health & Adults
SUBJECT:	Community Wellbeing Model in General Practice
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To outline the community wellbeing model in general practice.

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

3.0 **SUPPORTING INFORMATION**

3.1 **National Context**

3.1.1 The English Review 'Fair Society, Healthy Lives' brought together the best available global evidence on health inequalities. That evidence highlighted that health inequalities arise from social inequalities in the conditions in which people are born, grow, live, work and age. The review highlighted that action to address health inequalities will require action across all the social determinants of health by central and local government, the NHS, the third and private sectors and community groups.

3.1.2 There is a wealth of national policy, reports and good practice guidance that support the integration of health and social care provision with other services that have a role to play in reducing health inequalities. The Department of Health White Paper 'Equity and Excellence: Liberating the NHS' sets out the desire to promote integration and partnership working between the NHS, social care, public health and other local services.

3.1.3 The documents listed below provide further support for the role and function of community wellbeing approaches and cover scientific, policy and best practice perspectives.

<u>The Foresight Report: Mental Capital and Wellbeing</u>

The report used the best available scientific evidence to highlight the need to nurture the mental capital and wellbeing of the wider population, so that more people have the opportunity to 'flourish' throughout life. It demonstrated how achieving a small change in the average level of

wellbeing across the population would produce a large decrease in the percentage of people with mental disorder, and that this would also result a large drop in the percentage of people with sub-clinical disorder- also referred to as 'languishing'.

Healthy Lives, Healthy People

This White Paper outlines the government's commitment to helping people live longer, healthier and more fulfilling lives; and improving the health of the poorest, fastest. The document highlights that and there is a need to ensure that work on promoting and improving health and wellbeing is effectively integrated into the new systems for the NHS, public health and social care at both national and local levels.

Co-production for Health – A New Model for a Radically New World

This report highlights that the public health challenges we face as a nation require new approaches to address them. These new approaches include a co-production model that builds on local assets and empowers people to engage in health - as well as a broader, holistic approach to the delivery of health outcomes at a local level, one in which individuals and communities are aware of and can harness their assets and resources, and are empowered to shape their own futures.

A Vision for Adult Social Care: Capable Communities and Active Citizens

Sets out a new agenda for adult social care in which services a more personalised and more preventative. The review places an emphasis on delivering the best outcomes for citizens that help to build the Big Society.

A Glass Half Full: How a Community Asset Based Approach can Improve Community Health and Wellbeing,

This report was commissioned by the Improvement and Development Agency's Healthy Communities programme with the aim of helping local government to improve the health and wellbeing of communities. The report advocates an asset-based approach which builds on the strengths of communities and engages citizens in taking action to improve their health and wellbeing. An asset approach aims to strengthen the way in which practitioners work together with individuals and communities as co-producers to achieve better health and wellbeing outcomes on a local level.

What Makes People Healthy

This recent paper builds on an earlier publication 'A glass half-full: how an asset approach can improve community health and wellbeing'. It promotes different ways of engaging local communities in co-producing local solutions and reducing health inequalities. It challenges how public services are designed and delivered and requires a recasting of the relationship

between commissioners, providers, service users and communities. It puts a positive value on social relationships and networks, on self confidence and efficacy and the ability of people to take control of their circumstances. It highlights the impact of such assets on people's wellbeing and resilience and thus on their capacity to cope with adversity including poor health and illness.

3.2 **Local Context**

The Community Wellbeing model features in the Clinical Commissioning Group's Service Development & Improvement Plan in line with the Operating Framework for Improving Long Term Conditions.

3.3 Halton Joint Strategic Needs Assessment

Strong partnerships are required to take action on the social determinants that shape health inequalities. Joint strategies should be developed with relevant partners to promote recovery, improve health outcomes and address the broader determinants of health and wellbeing for the people of Halton.

3.4 **Ambition for Health**

The Ambitions and Outcomes of relevance are:

a) **Ambition - Reducing poor health resulting from preventable causes**

- Outcome 8 **-** by 2013 greater numbers of people will be eating a healthier diet.

b) **Ambition - Supporting people with long term conditions**

- Outcome 14 - by 2013 there will be greater awareness of the impact of mental health and wellbeing, and good services in place to support people in crisis and to prevent mental health problems escalating.

c) **Ambition - To provide services which meet the needs of vulnerable people**

- Outcome 17 - by 2013 any barriers our local populations experience in respect of their culture, ethnicity or sexuality, in gaining excellent access to opportunities to improve their health and to health services will have been removed
- Outcome 18 - by 2013 the needs of carers will be an integral part of our approach to providing support and care to our local population.
- Outcome 20 - we will work with local partners to ensure that, by 2013 all older people are treated with dignity and respect, and that we have services in place which are tailored to their needs.

d) **Ambition - Making sure people have excellent access to services**

and facilities

- Outcome 22 - by 2013 provide state of the art health & social care facilities, built to enhance user experience, which will assist in the improvement of the health & well-being of local communities.

e) **Ambition - Playing our part in strengthening local communities**

- Outcome 25 - by 2013 we aim to have contributed to creating vibrant, healthy and economically stable local communities.

4.0 POLICY IMPLICATIONS

4.1 The Rationale

A Community Wellbeing Practice (CWP) model has been underpinned by the ongoing research in the areas of salutogenesis, health assets, resilience and capability all of which focus on creating positive adaptation, protective factors and assets that moderate risk factors and promote wellbeing in individuals and communities.

4.2 A CWP model looks beyond traditional disease models in health care in order to include the factors that have been shown to generate health and wellbeing in individuals and communities.

4.3 Wellbeing can be broadly defined to consist of two dimensions*:

- Hedonic: positive feelings or positive affect (subjective wellbeing, life satisfaction, happiness)
- Eudemonic**:** positive functioning (engagement, fulfilment, sense of meaning, social wellbeing)

*Mental health, resilience and inequalities (2009) Friedli, L; World Health Organisation

4.4 There is abundant evidence to demonstrate that the skills and attributes associated with wellbeing are a core asset, protecting and enhancing the lives of individuals and communities.

4.5 Improved wellbeing not only leads to the prevention of disease but outcomes beyond this which include improved physical health; stronger social cohesion and engagement; better educational attainment; improved recovery from illness; stronger relationships and improved quality of life.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 It was first proposed that the CWP model be rolled out to 2 practices initially as a pilot phase. The investment required to finance the roll out of CWP model to 2 practices has been calculated at £125,000 of which £75,000 has already been allocated by Halton Council and NHS Halton and St Helens. The additional £50,000 was to be requested from the sub-committee.

6.0 **THE MODEL**

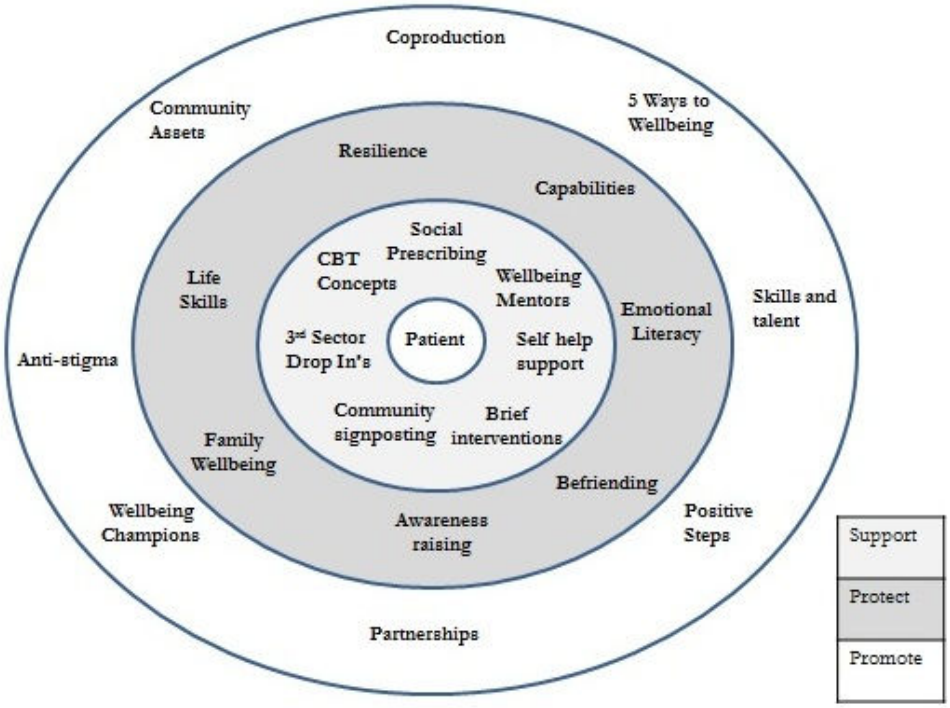
6.1 The CWP model has five overarching principles, which are :

- To look beyond traditional disease models in health care and to take action on the social determinants of health and wellbeing.
- To adopt salutogenic concepts - identifying the factors that create and support human health and wellbeing and that moderate against stress. (Salutogenesis is a well established concept in public health and health promotion).
- To ensure that individuals and communities have access to a range of integrated, holistic wellbeing interventions.

  To mobilise the assets of people and place, in order to generate social capital and create healthier and more resilient communities.

Forge partnerships with individuals, communities and other agencies and to work co-productively to reduce health inequalities.

6.2 Diagram 1 – A Community Wellbeing Practice Model



6.3 A central component of the CWP model will be the creation of an integrated network between general practice and local agencies that promote and protect individual and community wellbeing - especially those that provide psychosocial support to patients, and those that connect patients to wider assets in the community that are associated with positive health and wellbeing outcomes. Agencies that will form a part of this broader, holistic

network will include public health teams, the 3rd sector, housing trusts, the local authority and voluntary and community led groups.

6.4 In addition to the establishment of an integrated network, the CWP Implementation Plan v1.5 -which is currently out for consultation details five priority areas for action in the general practice setting, which if implemented fully will further enhance the capacity of general practice to support individuals and communities to achieve improved health and wellbeing outcomes.

6.5 The five priority areas for action detailed in the CWP Implementation Plan are:

1. The practice environment
2. Provision of wellbeing activities
3. Skills and competencies of staff
4. Stakeholder engagement
5. Marketing and communication

The CWP working group is currently engaged in a wider consultation with individuals, communities and other relevant agencies to gather their views and opinions as to what they believe a Community Wellbeing Practice ought to deliver.

7.0 IMPLEMENTATION

7.1 Halton Council and NHS Halton and St Helens have agreed a SLA with a 3rd sector provider - The Wellbeing Project CIC to work alongside clinicians and senior managers to research and develop the CWP model. The Wellbeing Project will also project manage the implementation of the CWP initiative as detailed in its SLA service specification.

7.2 An outline proposal for the CWP model was approved by the sub-committee and since then the Wellbeing Project has been collaborating with Halton CCG and Halton Council to develop detailed plans. A cross sector working group has been established to oversee this process and it is envisaged that this group will co-ordinate the roll out of the initiative to GP practices.

7.3 A letter was circulated to all 17 GP Practices which provided an outline of the CWP model. Practices that were interested in taking part in the first wave of the scheme were asked to forward an expression of interest - of which 7 practices registered an interest.

7.4 One of the main aims of the CWP model is to build a robust infrastructure so that the CWP initiative can be sustained over the medium to longer term without further investment. This will be achieved through the following mechanisms:

1. Forging partnerships between general practice and other stakeholders who have a part to play in promoting and protecting wellbeing. These partnerships will become the seedbed from which new projects and collaborations will spawn.

2. Creating a robust, integrated network with the voluntary and community sectors, through which wellbeing interventions can be coordinated and promoted within the general practice setting. These networks will also determine the mechanisms by which health practitioners can signpost patients into community based support.

3. Developing of the skills and competencies of practice staff so that they feel empowered to work together with patients, families and the community to find new and innovative ways of promoting health and wellbeing.

8.0 MONITORING

8.1 The CWP working group will monitor the attainment of KPIs detailed in the CWP Implementation Plan.

8.2 Quarterly reports will be prepared by the CWP working group and these will feed into the CCG sub- committee as well as the monitoring systems in Halton council and NHS Halton and St Helens.

9.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

9.1 Children & Young People in Halton

These are contained within the report.

9.2 Employment, Learning & Skills in Halton

These are contained within the report.

9.3 A Healthy Halton

These are contained within the report.

9.4 A Safer Halton

These are contained within the report.

9.5 **Halton's Urban Renewal**

This model will look to develop and make best use of current land and GP building.

10.0 **RISK ANALYSIS**

10.1 The broader the scope of this model will bring risk of burn out or unsustained services/reputational risk will incur if the scheme is not deemed to be successful.

11.0 **EQUALITY AND DIVERSITY ISSUES**

11.1 This is in line with all equality and diversity issues in Halton.

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

None under the meaning of the Act

REPORT TO: Health Policy & Performance Board

DATE: 29th May 2012

REPORTING OFFICER: Strategic Director - Communities

PORTFOLIO: Health & Adults

SUBJECT: Annual Report 2011/12 – Health Policy and Performance Board

WARD(S): Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Annual Report for the Health Policy and Performance Board for April 2011 - March 2012, attached at Appendix 1 to this report.

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

3.0 **SUPPORTING INFORMATION**

3.1 During 2011 – 12, the Health Policy and Performance Board has looked in detail at many of Halton's Health and Social care priorities during this period. Further details of these are outlined within the appended Annual Report.

3.2 The draft Annual Report was presented to Policy & Performance Board Chairs meeting on 4th April and no amendments were made.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications arising directly from the Annual Report. Any policy implications arising from issues included within the Annual Report will have been identified and addressed throughout the year via the relevant reporting process.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 As with the policy implications, there are no specific or other implications arising directly from the report. Any finance implications arising from issues included within it would have been identified and addressed throughout the year via the relevant reporting process.

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

6.1 **Children & Young People in Halton**

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

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

None identified.

6.3 **A Healthy Halton**

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

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 None identified.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 An Equality Impact Assessment is not required for this report.

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

None under the meaning of the Act.

Health Policy and Performance Board

Annual Report

April 2011- March 2012

As Chair of the Health Policy and Performance Board I would like to thank all the members of the Board for their valued contribution to the Board's work over the last 12 months. I would particularly like to thank Cllr Joan Lowe, for her support as Vice Chair to the Board. I would also like to extend my thanks to all Member's, Officers and Partners for their time and contributions to the work topics and for providing performance and update reports.

2011/2012 has been a busy year, seeing Halton set in motion actions to implement the Government's NHS reforms as outlined in the White Paper 'Equity and Excellence: Liberating the NHS'. This, against a backdrop of financial and resource pressures, has challenged our ways of thinking and will continue to mean some significant changes ahead.

During the last year the Board have been actively involved in a range of issues from policy developments and scrutiny reviews to being kept informed and offering views on the reforms taking place locally as a result of the NHS White Paper. The Board have had the opportunity to comment on a number of proposals and consultations such as the national Caring for Our Future Consultation, Windmill Hill Access Centre and the Cheshire and Merseyside Treatment Centre.

Health Policy and Performance Board Membership and Responsibility

The Board:
Councillor Ellen Cargill (Chairman)
Councillor Joan Lowe (Vice-Chairman)
Councillor Dave Austin
Councillor Sandra Baker
Councillor Mark Dennett
Councillor Margaret Horabin
Councillor Martha Lloyd Jones
Councillor Chris Loftus
Councillor Andrew MacManus
Councillor Carol Plumpton Walsh
Councillor Geoff Zygadllo
Local Involvement Network (LINk) representation is through a co-optee, Paul Cooke.

The primary responsibility of the board is to focus on the work of the Council, and its Partners, in seeking to improve health in the Borough. This is achieved through scrutinising progress against the aims and objectives outlined in the Council's Corporate Plan in relation to the Health Priority.

The Board have met seven times in 2011/2012. Minutes of the meetings can be found on the Halton Borough Council Website.

This report summarises some of the key pieces of work the Board have been involved in during 2011/12.

Government Policy - NHS and Social Care Reform

NHS Merseyside Cluster
The Board were kept informed of the development of the Merseyside cluster, its role and function and how it will operate within the context of the emerging NHS reforms. The Board are keen to ensure that Halton's interests are actively promoted within this structure.

Health & Wellbeing Board
The Council has a key role in the establishment and work of the Health and Wellbeing Board. The Health Policy and Performance Board have been kept up to date with development of the Shadow Health and Well-being Board and it has been agreed that the Health Policy and Performance Board would receive minutes of the Health and Wellbeing Board to enable the PPB Board to comment on the work undertaken and direction of the board

Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy
The Board considered a report on the 2011 Joint Strategic Needs Assessment (JSNA) and it was noted by the Board that the JSNA was very comprehensive. The JSNA identified that overall health in Halton has improved over the last 10 years, but there is still much to do. New priority areas identified include injury prevention, mental health, and sexual health. There was also a separate briefing for the Board on how to use the JSNA and its future role in supporting the development of the Joint Health and Wellbeing Strategy. The Board will continue to monitor health progress in the forthcoming year.

Services

Windmill Hill Access Centre
The Board received a report on Patient and Public consultation regarding the potential closure of the nurse led Windmill Hill Access Centre. As a result of the consultation it was proposed to close the nurse led access centre. The Board raised a number of issues and sought further clarity on how these changes would be communicated to the community.

Cheshire & Merseyside Treatment Centre
Views of the Board were sought by NHS Halton and St Helens as part of a formal consultation on future plans for the Cheshire and Merseyside Treatment Centre. The Board sought clarity on whether this would have an impact on the services provided at Halton Hospital and a number of other questions were raised by the Board as part of the consultation process.

Cheshire and Merseyside Vascular Review of the impact of non-arterial centre designation on Warrington Hospital and the people it serves.
The Board was advised by the Cheshire and Merseyside Vascular Review project board, subject to consultation, that they would not be recommending to commissioners the designation of Warrington Hospital as an arterial centre. The Board felt that the recommendation had failed to take account of the significant social and economic deprivation in Halton and the ageing population. Members of the Board highlighted that an impact assessment should be undertaken before any recommendation or decision was made.

Halton Health Policy and Performance Board have set up a Joint Strategic Scrutiny Board with Warrington and St Helens Borough Council's to look into the significant Changes to Arterial Vascular Services Provision affecting our three Borough's. There have been two meetings and

There will be consultation with all the providers, the voluntary sector, Patients Participation groups Halton Speak Out and Pensioners groups.

Redesign of Community Nursing Services
The Board were kept informed of the changes to community nursing services provided by Bridgewater Community NHS Trust resulting from the redesign and re-specification of those services.

Re-design of the Adult Acute Care Pathway and the Later Life and Memory Services
The Board was informed of the 5 Boroughs Partnership NHS Foundation Trust proposals to redesign the Adult Acute Care Pathway and the Later Life and Memory services for older people.

Positive Behaviour Support Service
The Board were kept informed of the work of the Positive Behaviour Support Service.

Model of Care to develop a comprehensive community learning disability services infrastructure for adults with learning disabilities
The board were advised of the progress of the implementation of the Model of Care and the next steps.

Policy

Caring for Our Future Consultation
Comments were sought from the Board on the national consultation, to be included in the local response. The board will be keen to follow the development on the funding of Adult Social Care in the year ahead.

Adult Social Care Customer Care Report 2010/2011
The Board were invited to comment on the key learning points identified from complaints received by the Authority.

Safeguarding
Members were given an update on key issues and progression of the agenda for Safeguarding Vulnerable Adults in Halton.

Adult Social Care Annual Report 2011 (Local Account)
The Board were presented with the first Adult Social Care Annual Report and invited to make comments to be considered in the development of the next annual Adult Social Care Report.

Smoke Free Play Areas
The Board where informed of the proposal to make public play areas in Halton Smoke Free invited to comment on the proposal. Whilst Member's sought clarity on a couple of issues around the practicalities of implementing such an initiative, Members of the Board supported the proposal and recognised that it formed part of a comprehensive approach in tackling the dangers of smoking around children, helping prevent Halton's children from becoming the next generation of smokers.

Business Planning 2012-15
The Board were offered the opportunity to contribute to the development of Directorate Business Plans for the coming financial year.

Scrutiny Reviews

Dignity in Care Scrutiny Review
The Board received a report on the scrutiny review of Dignity in Care. The report had been commissioned as Halton Borough Council was the only local authority in the country with a Dignity in Care Co-ordinator, as well as the only one that covered both the council and the wider remit of Health. The review highlighted many examples of the positive impact of The Dignity in Care Coordinator along with the findings of the Care Quality Commission's safeguarding inspection of Adult Social Care Halton. The inspection cited Halton as being innovative and challenging in its approach to ensuring local people received support promoted their dignity. The Board endorsed the recommendations from the findings of the scrutiny group and requested 6 monthly updates on the progress of the recommendations.

Homelessness Services Scrutiny Review
Members were nominated to the Working Group for the Scrutiny Review of Homelessness Services at the Health PPB held on 13th September 2011. The purpose of the review is to assess the Council's statutory duties and preventative role in relation to homelessness and to review service provision, with a particular focus on temporary accommodation schemes. Members visited the temporary accommodation schemes in January 2012.The first meeting of the working group took place in November 2011 and the last meeting is to take place in March 2012. The final report is to be presented to the Health PPB in June 2012.

Autism Scrutiny Topic report
A report was presented to the Health Board in March and the Board recommended that the report also be taken to the next Executive Board for them to accept and put an action plan in place.

Performance

The Board received information on quarterly monitoring reports and were provided with information on the progress in achieving targets contained within the Sustainable Community Strategy for Halton. Members were satisfied that adequate plans were in place to ensure that the Council and its partners achieved the health related improvement targets that had been agreed.

Work topics for 2012/2013

Work Topics to be examined in 2012/2013:

Falls Prevention - 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. There is to be a scrutiny 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

Report prepared by Emma Bragger, People and Communities Policy Officer. For further Health policy information please contact diane.lloyd@halton.gov.uk

REPORT TO: Health Policy and Performance Board

DATE: 29th May 2012

REPORTING OFFICER: Strategic Director – Policy & Resources

PORTFOLIO: Policy and Resources

SUBJECT: Sustainable Community Strategy Year End 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).

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, for example the restructuring of the NHS and pubic health delivery, implementation of Local Economic Partnerships and the delivery of the ‘localism’ agenda.

3.5 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 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.

3.7 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.

3.8 Attached as Appendix 1 is a report on progress to the 2011-12 year end 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.

3.9 Further detail is contained in the report , with corporate templates for each of the measures bringing together all relevant pieces of performance information in one place – considering the levels of performance that have been achieved over time to date. These templates also provide a contextual backdrop in relation to performance nationally, regionally and by our statistical neighbours where available. These show for a majority of measures, a continued trajectory of continuous improvement as shown by the upward direction of travel arrow, where performance is better than this time last year; or where performance has been maintained. A summary of key activities taken or planned to be taken to improve performance by the Council and its Partners is also stated for each measure by respective Lead Officers.

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

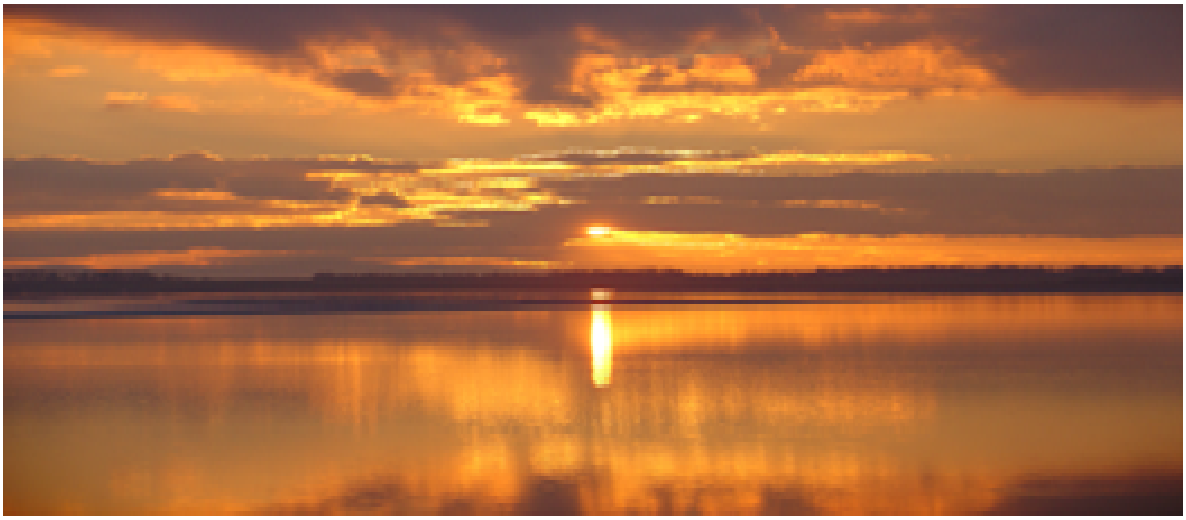
9.1 One of the guiding principles of the Sustainable Community Strategy is to reduce inequalities in Halton.

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 – Year End Progress Summary for 2011/12



The Sustainable Community Strategy for Halton 2011 - 2016

Year-end Progress Report

01st April 2011 – 31st March 2012

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

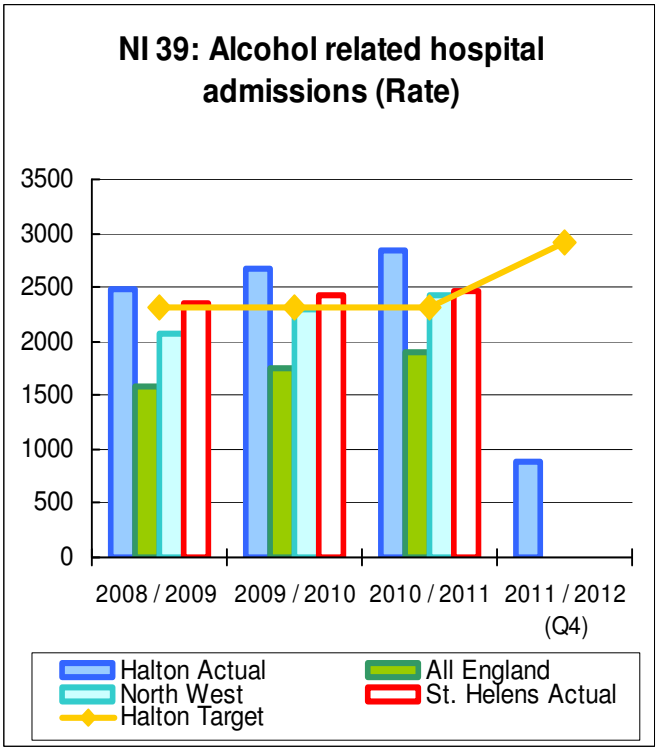
Page	Ref	Descriptor	2010 / 11 Target	Direction of travel
4	HH 1*	a) Alcohol related hospital admissions (NI 39) (Rate 100,000 pop.)	✓	↑
		b) Alcohol related hospital admissions – AAF =1 (Rate)	✓	New Measure
6	HH 2	Prevalence of breastfeeding at 6-8 weeks (NI 53)	✓	↑
7	HH 3	a) Obesity in Primary school age children in Reception (NI 55)	✗	↓
8		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)	✗	↓
12	HH 5	a) All age, all cause mortality rate per 100,000 Males (NI 120a)	✓	↑
13		b) All age, all cause mortality rate per 100,000 Females (NI 120b)	✓	↑
14	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)	✓	↑
16	HH 8	16+ Smoking quit rate per 100,000 (NI 123)	✓	↓
17	HH 9	Mental Health - No. of people in counselling/ day services or on waiting lists. (NEW 2011)	Placeholder 2012/13	New Measure
18	HH 10	Proportion of older people supported to live at home through provision of a social care package **(**NEW 2011**)**:	✓	↑
19	HH 11	a) Increase the % of successful completions (drugs) as a proportion of all in treatment (over 18)	✗	↓
20		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

Healthy Halton

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	**2651.7**	✓	↑
b)Admissions which are wholly attributable to alcohol AAF = 1 (Rate)	984	1002.6	-	**897.7 Jan 2012**	✓	↑



Data Commentary:

This indicator measures the rate of alcohol related hospital admissions per 100,000 population using Hospital Episode Statistics.
Verified LAPE performance data for 2011/12 is required.
Local Data can be utilised as an interim measure but verified data for final two quarters of 11/12 are outstanding in this report. Q4 is a proxy based on data to Feb 2012.

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

Performance Commentary:

Alcohol Related admissions (formerly NI39) have continued to rise, in line with the North West and England as predicted, however, there has been a reduction in the rate of increase between 2009/10 and 2010/11, from 7.8% (2008/9 to 2009/10) to 5.9% (2009/10 to 2010/11).

In relation to hospital admissions that are wholly related to alcohol, the rate of admissions for males has remained relatively static from 2007/08 to 2009/10 and the gap with the regional average has narrowed, however, in relation to females there has been a noticeable increase in the rate of wholly alcohol related admissions in 2009/10. (Source Local Data – PH Department March 2012)

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

Summary of Key activities taken or planned to improve performance:

Key achievements

Prevention

- More people are being screened for drinking at levels of increasing and higher risk and receive an intervention or onward referral to specialist services where necessary.
- Local awareness raising campaigns undertaken to raise awareness of alcohol related harm and recommended drinking limits.
- In-depth local research to inform social marketing initiatives
- Police, Trading Standards and Health developed an innovative, award winning Responsible Retailing Scheme.

Treatment

- Newly commissioned redesigned alcohol treatment services with a holistic, recovery focus.
- Newly commissioned Alcohol Liaison Nursing Service within Warrington Hospital – Whiston Service to be launched imminently.

Enforcement

- Introduction of Alcohol Treatment Requirements and liaison with Problem Solving Courts
- Conditional Cautioning Scheme established in Halton

Children and Young People

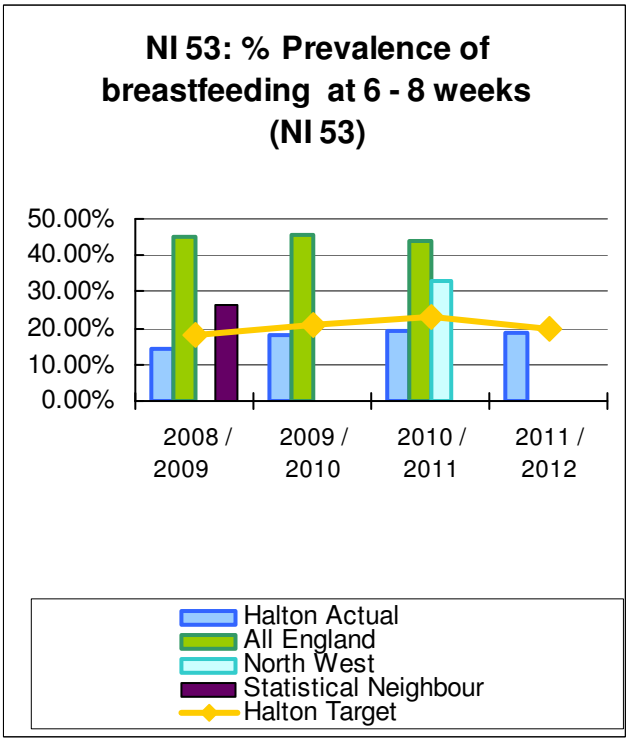
- Innovative Outreach Bus, taking support to young people in identified hotspots
- Newly Commissioned Specialist Treatment Service for young people
- Development of safe, creative space and diversionary activities for young people via the C Roomz
- Stay Safe – police and partners proactively targeting vulnerable children suffering the effects of alcohol

A New Alcohol Strategy for 2012-15 is under development and has been aligned with the new National Alcohol Strategy for England. Extensive consultation will begin shortly on the new local strategy which includes

- A Project to ensure that messages to all children, young people and families are relevant, appropriate and consistent and delivered within the most appropriate settings (including schools, colleges etc.).
- A single Alcohol Communication Strategy and local publicity campaign
- A collaboration with local businesses to make drinking environments in Halton safer, responsible and more attractive. Consideration will be given to gaining Purple Flag Status/ ArcAngel.

Healthy Halton

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%	**20.9% Qtr 3**	✓	↑

Data Commentary:

Quarters 1-3 have been updated. Qtr 3 is the latest available data from Public Health.
Good performance is an increase in the percentage coverage and prevalence year on year

Performance Commentary:

There has been some progress made against this target during 11/12 to increase the prevalence of breastfeeding at 6-8 weeks..

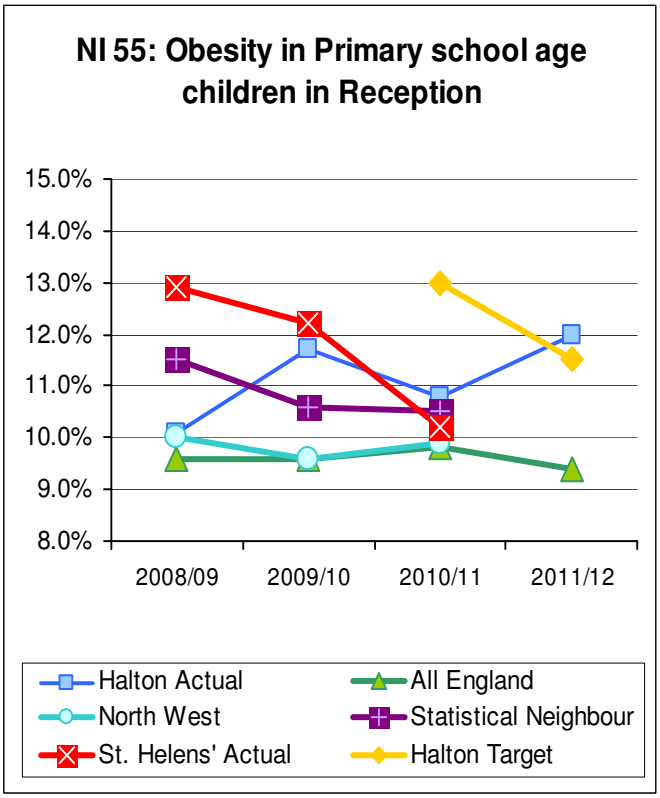
Summary of Key activities taken or planned to improve performance:

Progress has been made towards improving breastfeeding rates in Halton

- Bridgewater Halton and St Helens division is working towards UNICEF Baby Friendly stage 2, assessment November 2013.
- Audit planned of health and social care premises compliance to BFI standards
- The Infant Feeding Coordinator post, and Breastfeeding support worker jobs are being recruited.
- Breastfeeding is a Joint Commissioning Unit priority
- Kings Cross breastfeeding peer support service is currently out to tender, possibilities of service disruption.
- The Whiston CQUIN is on target. Plans to continue CQUIN, increasing target TBC.
- The Peer support incentive scheme will continue, end date estimated December 2012 (demand dependant)
- Continue to maintain baby friendly premises
- Finalising a guide to promoting breastfeeding through Healthy Schools, using a whole school approach

Healthy Halton

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%	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.

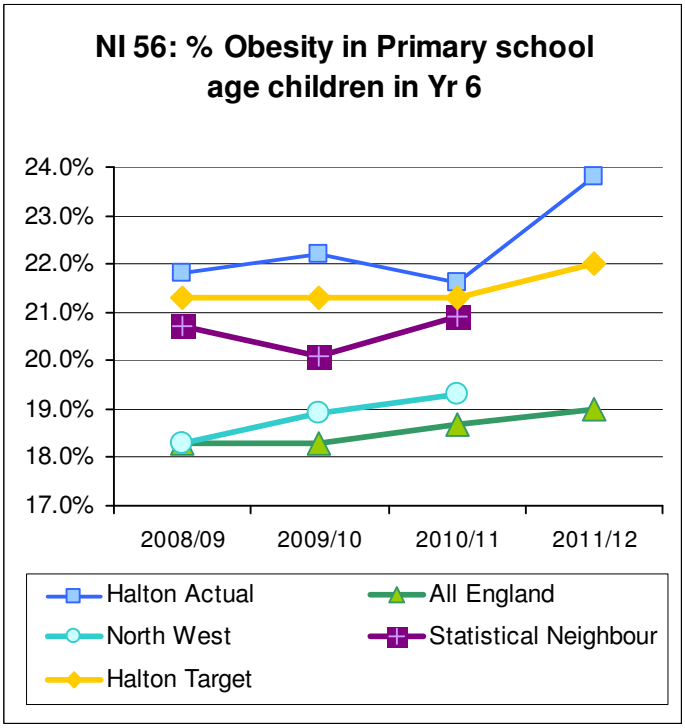
Recent funding for a Breast feeding coordinator and weaning services should have an impact in future years.

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, 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.

A shortage of Health Visitors on the Halton side has adversely affected Halton's Reception age obesity rate compared to St Helens. This situation has now been rectified and staff are in place.

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%	23.8%		

Data Commentary:

The percentage of children in year 6 (aged 11) 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:

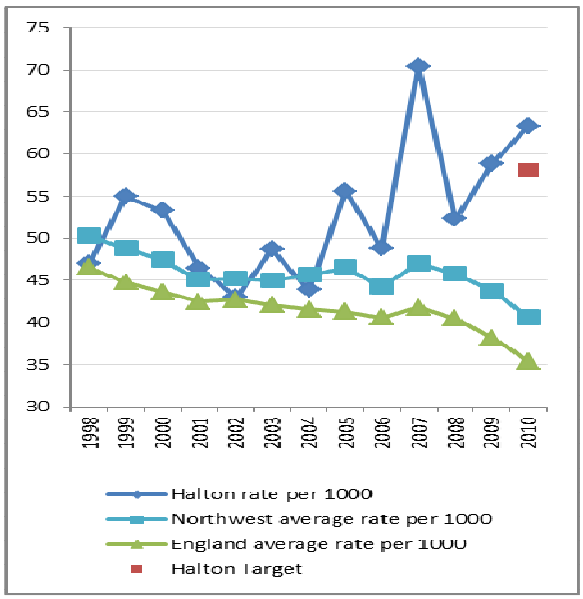
Halton's performance for 2010 has show fluctuation with a continued variable trend over the last few years. Halton remains above the national and north west average. Halton shows an increasing obesity rate in line with increasing obesity rates for the England and North West averages.

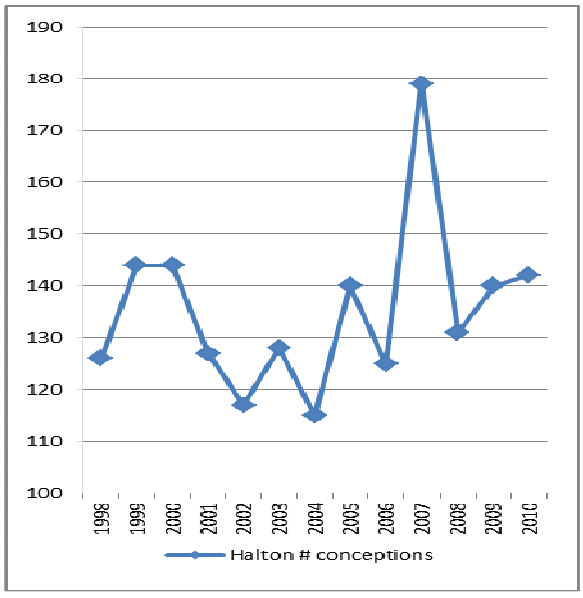
The school Fit4Life Programme which tackles overweight and obesity for children aged 6 to 13 years was rolled out in June 2011 and the results are not therefore reflected in this latest National Child Measurement Programme result. The Fit4Life programme targets schools with the highest obesity rates. 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	2009 Halton	2010 Halton
1	51%	26%
2	49%	38%
3	46%	34%
4	45%	40%
5	45%	23%
6	42%	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 3	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 59.5 rolling quarterly average rate	+3.6% 63.3 rolling quarterly average rate		

Data Commentary:

In February 2012 ONS released data which covered the calendar year for 2010. This is the latest full year data available. The number of conceptions in 2010 was 142, which is an increase of two conceptions compared to 2009.

Performance Commentary:

Halton's conception rate for under 18's continues to be an issue. Since the baseline was originally established in 1998 there has been a fluctuating picture in the numbers of conceptions reported with no sustainable reduction over time. Halton's position in relation to its statistical neighbours had the third worst increase in rate in comparison to 2009. Although the numbers are very low, Halton is seeing a small increase in the rate of conceptions for girls aged 13-15.

Summary of Key activities taken or planned to improve performance:

At a time when all areas are required to undertake measures to contribute to a reduction in the national deficit, it is essential that the most cost effective measures currently in place to tackling teenage pregnancy are identified and sustained. To support this, Halton will:

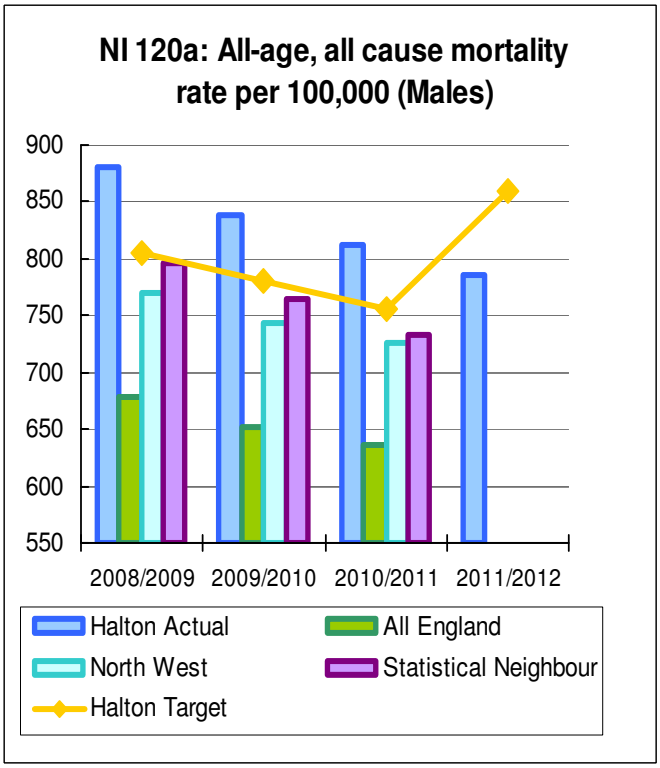
- Continue to work with schools to increase the number offering holistic health services delivered in schools, by youth workers.
- Prioritise initiatives that will have the widest and sustainable impact on reducing conceptions.
- Increase workforce training on Teens and Toddlers and reducing risk taking behaviour

Through the IYSS further develop universal, targeted and specialist support and advice on positive relationships.

- Increase the number the evidence based DfE funded Teens and Toddlers programmes in identified schools throughout 2012/13.
- Improve access to contraceptive services and provision for young people, including LARCs (Long Acting Reversible Contraception), although there is now medical debate about the impact of LARCs on bone density at a time when young women are still developing which may impact on the use of this type of contraception in young women
- Ensure robust care pathways are in place for prevention and support in all high schools.
- Continue to support pregnant young women of school age to remain in education.
- Identify appropriate courses for young parents with flexible start dates.
- Continue to deliver comprehensive co-ordinated packages of support for teenage parents within specialist and targeted youth provision
- Evaluate the contribution existing teenage pregnancy programmes and initiatives make to a reduction in child poverty.

Undertake cost benefit analysis of current initiatives. Incorporate teenage pregnancy population data into Child Poverty needs assessments (including district and ward level data.

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



2010 Actual	2011/12 Target	2011 Qtr 2	2011/ Qtr 4	Current Progress	Direction of Travel
811.35	858.8	812.4	785.1	✓	↑

Data Commentary:

Mortality targets are based on calendar year and not financial year. Data for 2011 is unverified and based on public health mortality files, final verification of 2011 data will be released December 2012. Data for Qtr 2 is to June 2011 and Qtr 4 to December 2011. Prior year comparators are to December 2010.
Each of these rates is a single figure for all causes and all ages combined. Single year rates are used to enable timely reporting.

Performance Commentary:

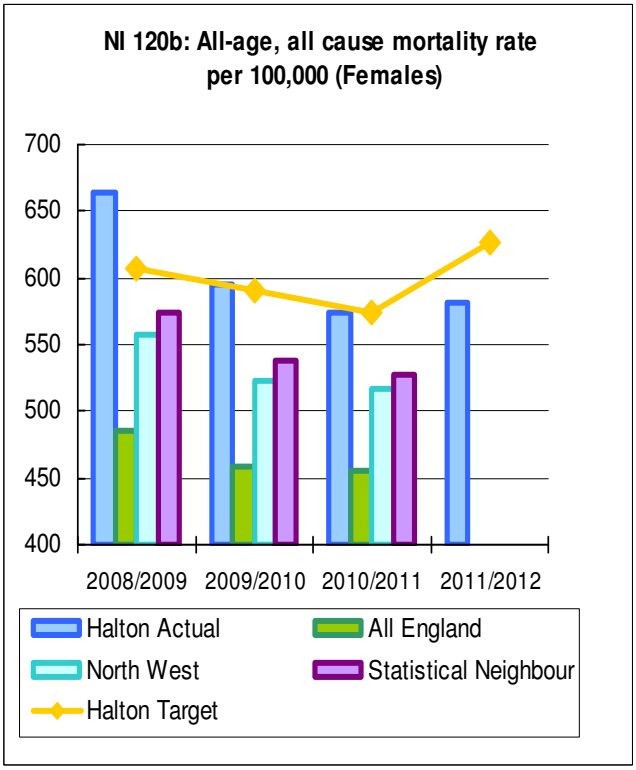
There has been a decrease in mortality throughout 2011 for males deaths from all causes. This equates to 20 less deaths from 2010

Summary of Key activities taken or planned to improve performance:

The key activities to improve deaths from all ages are linked with Circulatory diseases and the risk factors and cancer and risk factors. The main risk factors include smoking, alcohol, diet and exercise (weight management). In Halton work has been underway to identify people early with risk taking behaviour and therefore referral to appropriate intervention programmes. Between q1 and q3 2011/12 over 2400 Health Checks were undertaken by practices.

Within cancer further work is underway to invite practices to develop cancer plans. Cancers cause more deaths than any other specific area in Halton.

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



2010 Actual	2011/12 Target	2011 Qtr 2	2011 Qtr 4	Current Progress	Direction of Travel
573.63	627.1	574	**596**	✓	↑

Data Commentary:

Mortality targets are based on calendar year and not financial year. Data for 2011 is unverified and based on public health mortality files, final verification of 2011 data will be released December 2012.

Performance Commentary:

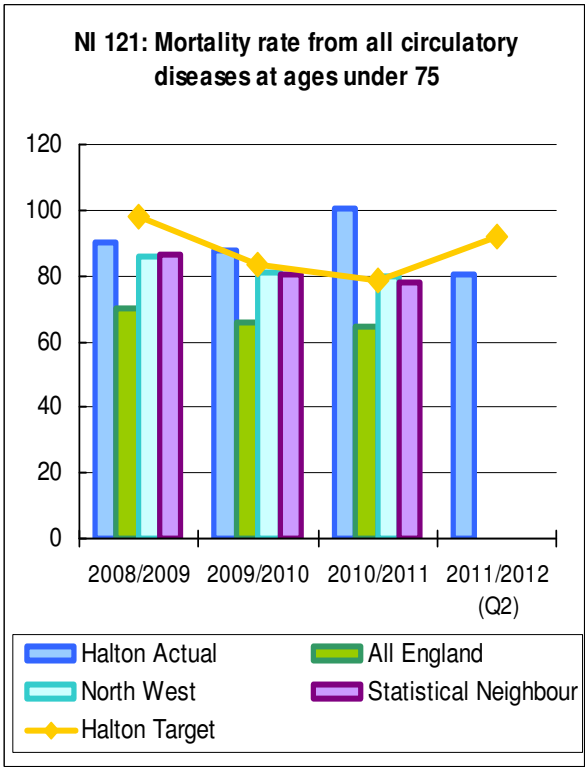
There has been a slight rise in all age all cause mortality for females throughout 2011, this is based on 12 more deaths than recorded in 2010.

Summary of Key activities taken or planned to improve performance:

The key activities to improve deaths from all ages are linked with Circulatory diseases and the risk factors and cancer and risk factors. The main risk factors include smoking, alcohol, diet and exercise (weight management). In Halton work has been underway to identify people early with risk taking behaviour and therefore referral to appropriate intervention programmes. Between q1 and q3 2011/12 over 2400 Health Checks were undertaken by practices.

Within cancer further work is underway to invite practices to develop cancer plans. Cancers cause more deaths than any other specific area in Halton.

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



2010 Actual	2011/12 Target	2011 Qtr 2	2011 Qtr 4	Current Progress	Direction of Travel
96.8	91.8	84.9	80.6	✓	↑

Data Commentary:

Mortality targets are based on calendar year and not financial year. Data for 2011 is unverified and based on public health mortality files, final verification of 2011 data will be released December 2012.

Performance Commentary:

Deaths from circulatory diseases under 75 have reduced throughout 2011. This accounts for 29 less deaths between 2010 and 2011.

Summary of Key activities taken or planned to improve performance:

Identifying people without established Cardiovascular Disease (CVD)
This initiative significantly contributes to detecting CVD and other major illnesses earlier so that we can empower patients to take control and also actively manage the disease onset. In 2011/12 (q1-q3) nearly 8000 Health Checks have been completed, 2400 for patients in Halton Practices.

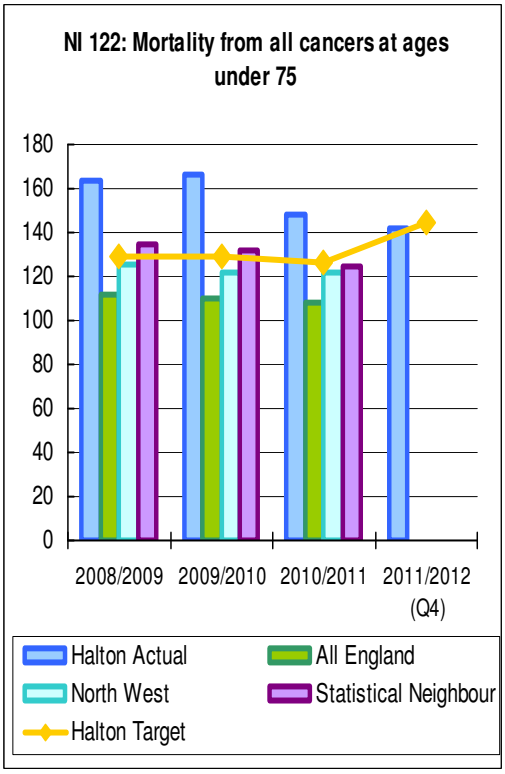
Diabetic Care
Work in underway to identify people who are pre diabetic to ensure appropriate lifestyle advice is give Structured Education programmes to ensure people manage their diabetes are seeing an increase in uptake and have good evidence to help manage outcomes.
Education booklets have just been developed for people with diabetes
Improvements in care pathways between hospital and primary care are in development.

Smoking
Smoking has a major impact on levels of heart disease. Smoking cessation rates are on target and progressing well. 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.
Newly commissioned weight management services are in place. There is a weight management services commissioned support the high numbers of patients identified as obese through the Health Checks Plus Programme.

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	141.9	✓	↑

Data Commentary:

It is important to note that this quarterly data are provisional, unvalidated, mortality rates per 100,000. In addition, Q4 is actually a proxy annual cumulative figure based on February 2012 data and will be updated in the next report.

Performance Commentary:

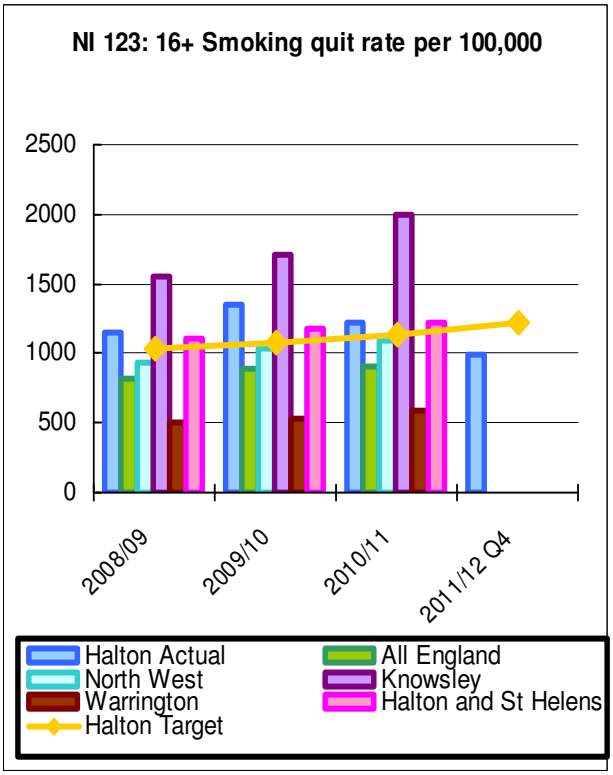
The commonest cancers under age 75 are breast, lung, bowel. Although some skin cancers are also common, they only rarely cause death.

After several years with very high cancer death rates, we are now seeing a consistent quarter by quarter substantial fall in cancer death rates in Halton. This is very welcome, and reflects behavioural and lifestyle choices by individuals, as well as the effectiveness of cancer awareness, early detection and screening programmes. The biggest single factor has been the decline in smoking prevalence amongst men. Though rates remain high compared to statistical neighbours and the north west, the outlook is now positive.

Summary of Key activities taken or planned to improve performance:

Bowel cancer screening is now offered to all 60-74 year olds registered with local GPs, every 2 years. It saves a small number of lives every year. Local GPs continue to work hard to encourage those people who don't attend for cancer screening, to reconsider. Despite funding challenges, the local " get checked" team of volunteers raises awareness of the common cancers. The Cancer Network has secured outside resource for the iVan cancer awareness vehicle, which spotted nearly 20 new cancers over a 12 month period; and the 424 lives project, which works with GPs to develop action plans on cancer diagnosis.

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	**958.33 Qtr 3**	✓	↓

Data Commentary:

Q1, Q2 and Q3 rates and actual numbers of quitters updated at 04.04.12 and will be updated in the next report. The full smoking figures for Q4 will not be available until mid June. Quitting smoking is seasonal with the majority of quitters stopping in January. It is expected we will make the target.

Performance Commentary:

Halton has a very successful stop smoking service with one of the highest quit rates in the North West. Smoking in pregnancy rates for the PCT show a downward trend over the past 3 years with a reduction of 4% from 2008/9 to 2010/11 that is from 25% to 21% at time of delivery.

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
- 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 Measure)

New Measure

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

Data Commentary:

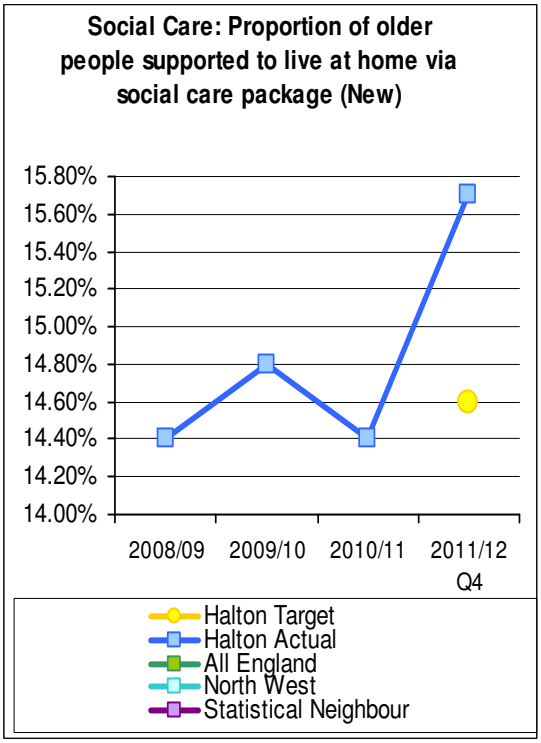
This measure has been agreed as a placeholder indicator and targets are to be set once 2011/12 data is confirmed.

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%	15.7%	✓	↑

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 at end March 2012 demonstrates that the target for 2011/12 has been 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 2,735 at the end of March 2012, an increase of 267 older people.

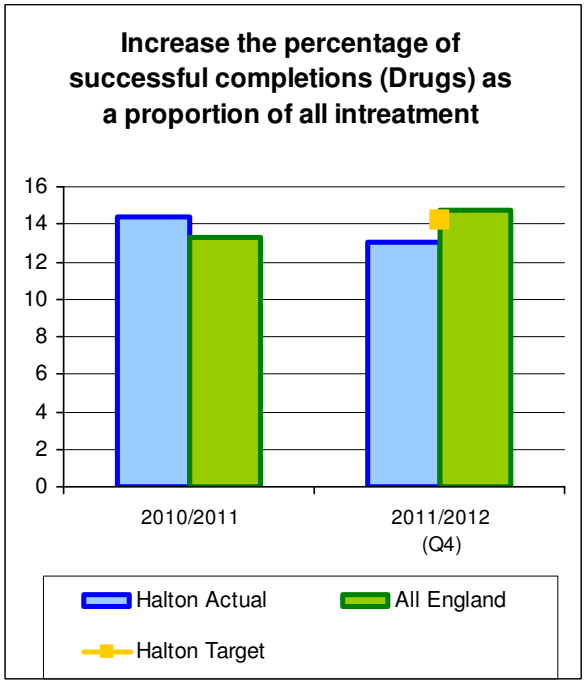
The likely explanation for the increase is increasing demand associated with an increasingly ageing population in the borough. The Council continues to advocate supporting residents in their own home for as long as possible and this is reflected in the performance of this indicator.

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.

Healthy Halton

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%**	13%	✗	↓

Data Commentary:

Data is for March 2011 to February 2012. Current performance for the NW is 14.5% and nationally 14.7%

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.

Data is provided by the NTA monthly successful completions reports for partnership, regional and national levels up to February 2012.

The figure of 13% for Halton represents 71 successful completions out of a total of 548 in treatment in the previous 12 month period. A further 6 successful completions would have seen Halton achieve the target.

Halton has done well to maintain this level of performance throughout this period as the service has been through re-structuring following the award of the substance misuse service contract.

Summary of Key activities taken or planned to improve performance:

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

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.

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

Placeholder 2012/13

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

Data Commentary:

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.

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.

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.

Healthy Halton

REPORT TO: Health Policy & Performance Board

DATE: 29 May 2012

REPORTING OFFICER: Strategic Director - Communities

PORTFOLIO: Health & Adults; Community Safety

SUBJECT: Safeguarding Unit

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To outline for the members of the Board details relating to the establishment of a 12 month pilot for an Integrated Adults Safeguarding Unit within Halton

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

3.0 **SUPPORTING INFORMATION**

Context

3.1 Keeping people safe and ensuring that they are treated with respect and dignity continues to be a high priority for the Council, NHS Merseyside, Clinical Commissioning Groups (CCG's) and Partner provider agencies who are committed to continue to build on the excellent results achieved in the Safeguarding Inspection to ensure Safeguarding and Dignity are central to the work that we do as a Health and Social Care Economy.

3.2 The Safeguarding/dignity model that previously operated in Halton was focussed in 3 key areas:

- *Strategic/Policy* - advice, guidance and policy development provided by the Adult Protection, Dignity and Domestic Violence Co-ordinator posts. (Local Authority)
- *Operationa*l - all Care Management cases, which have a safeguarding element to them, being dealt with directly by each respective Care Management Team; and
- *NHS Merseyside* - Safeguarding lead for Health- Operational, Commissioning and Strategic. (Local Authority).

3.3 There have been a number of recent National and Local drivers for change:

- An increase in the number of safeguarding referrals plus increasingly complex cases, including Care Homes requiring multiagency responses;
- The changes locally within the Health structure and the

establishment of CCG's;

- Winterbourne and other National Safeguarding incidents;
- The forthcoming government's response to the Law Commission's recommendations on strengthening safeguarding;
- The Equality and Human Rights Commission in its findings following their inquiry into older people and human rights in home care (Close to Home – November 2011) outlined a specific recommendation regarding SABs, as follows:
  Recommendation 7 : 'In fulfilling its commitment to implement the Law Commission's recommendation that adult safeguarding boards be placed on a statutory footing and led by local authorities, the government should ensure that there are clear lines of accountability when agencies other than local authorities conduct investigations. As part of this legislative change, consideration should also be given to strengthening and broadening the role of Directors of Adult Social Services in relation to adults not receiving publically funded community care services who may be at risk of harm';
- 'No secrets' (Department of Health 2000) gave local Social Services authorities lead responsibility for coordinating local multiagency systems, policies and procedures to protect vulnerable adults from abuse. In October 2008, the Department of Health carried out a large national consultation on safeguarding adults from abuse and harm called 'Safeguarding Adults', the review of the No secrets guidance. One of the key findings was the absence of adult safeguarding systems within the NHS to ensure that healthcare incidents that raise safeguarding concerns are considered in the wider safeguarding arena. The report also showed that there were opportunities to be gained from streamlining and integrating systems where investigations could be undertaken in parallel and the learning from both could be informative and help to develop communication between safeguarding teams and health agencies.

Integrated Safeguarding Unit – Model

3.4 The Unit will provide a hub and spoke model which is multi-agency efficient, flexible and responsive service to the local population.

The Unit will lead on adults safeguarding and dignity work across the health and social care economy. This will be achieved by:-

- Providing support to the Safeguarding Adults Board (SAB) and its sub groups;
- Providing support to the Halton Dignity Champion's Network;
- Ensuring key linkages continue with the Domestic Violence coordinator and services;
- Ensuring key linkages with children's safeguarding;
- Supporting the development of effective Interagency

Safeguarding Adults Policies and Procedures and Dignity Policies;

- Leading on prevention by responding to those cases that do not meet the Threshold for a safeguarding investigation;
- Supporting the development of CCG to enable the consortium has access to specific training etc.;
- Complementing the care home Quality, Innovation, Productivity and Prevention proposal and ensure the wider augmentation;
- Undertaking cases which have a **complex*** safeguarding element to them, including provision of chairs for safeguarding adults strategy meetings and case conference meetings. NB. Following completion of the safeguarding issues, cases would be returned to the respective Care Management Team;
- Supporting the local authority and its partner agencies to :-
    - Fully embed safeguarding adults policies and procedures and thus deliver consistent and robust outcomes for vulnerable adults
    - Monitoring the effectiveness of the delivery of their safeguarding adults activity
    - Providing advice and support regarding individual safeguarding adults cases.
- Halton Council now acts as the host to a major private Hospital (The Priory, Bennett's Lane Widnes). In order to meet the recommendations (made by the Winterbourne report) the Unit will provide the support and assurance for both Health and Social Care (alongside specialist commissioning, as legally required following Winterbourne guidance);
- Events at Winterbourne have highlighted the particular vulnerability of patients with learning disabilities/Autistic Spectrum Disorder who challenge services. There is considerable evidence of the use of restrictive practices with such patients, not least because many service providers are insufficiently skilled in managing complex challenging behaviour. There is now a strong and growing evidence base for the effectiveness of behaviour analytic approaches and these have been shown to significantly reduce the frequency, intensity and duration of challenging behaviour. The Unit will therefore have a Board Certified Behaviour Analyst (BCBA) to focus exclusively upon that cohort of patients who are funded (part or fully) by the NHS and who exhibit challenging behaviour.

***Complex** – those cases which incorporate the following aspects:

- Legal- involving police investigations
- Multiagency

- Nursing and residential homes- multiple abuse allegations
- Priory Hospital on-going allegations

Unit Structure

3.5 The Unit consists of the following posts:-

- Principal Manager (Safeguarding)
- Safeguarding/Dignity Officer
- Social Workers x 2
- Registered General Nurse x 2
- BCBA x 1

Benefits of the Unit

3.6 There are numerous ***advantages*** to the Unit, a number are outlined below:-

- Focal Point/'Hub' for staff, managers, outside agencies etc. to contact when they have safeguarding/dignity issues where advice, support and guidance is needed;
- Strengthen the support provided to the SAB, by strengthening the relationship between the local authority and partner agencies and other key stakeholders in Health, voluntary and independent sector;
- Reduced caseload, with respect to complex safeguarding issues, for the Care Management Teams, and further enhance the safeguarding expertise across care management teams;
- Ensure an effective response in relation to Health and reduce the workload/duplication with Continuing Health Care;
- Development and sharing of safeguarding and dignity expertise; and
- Improve communication between the operational teams, both within the council and external agencies and partners.

4.0 POLICY IMPLICATIONS

4.1 New policies and procedures are in development to ensure that the Safeguarding Unit will be able to effectively operate, particularly with regards to its interface with the Initial Assessment Team (IAT), Community Nursing, Acute Hospitals and Care Management Teams. The associated policies and procedures (inc. associated pathways) are being developed as part of the Multi-Disciplinary Teams, Care Homes and Care Management work streams.

4.2 The establishment of the Unit has impacted on the work of the People & Communities Policy Team - Policy & Resources Directorate, as certain work has transferred from the previous Safeguarding Service to the Policy Team. For example the 'Safeguarding Adults in Halton – Interagency Policy, Procedures and Guidance' document, is due to be revised during 2012.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The costs associated with the new Adults Safeguarding Unit are £284,596 per annum.

5.2 The Unit is going to be funded 50/50 across Health and Social Care. The 50% Health contribution (£142,298) has already been committed by NHS Merseyside/CCG. In terms of associated Council funding, appropriate funds are already in the budget and it has therefore not been necessary to invest any additional resources to establish the Unit.

5.3 There are a number of issues that are in the process of being resolved as part of the establishment of the Safeguarding Unit, including:-

- HR Processes;
- Referral pathways;
- Policies & Procedures;
- IT processes;
- Accommodation Issues;
- Marketing & Communications; and
- Home Office clarification (re: Priory)

5.4 The Unit's Principal Manager has been appointed and work continues on the development/delivery of the implementation plan for the Unit.

5.5 Following the 12 month pilot, an evaluation of the effectiveness of the Unit will take place to ensure that it provides an efficient and effective service to Health & Social Care Economy.

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

6.1 **Children & Young People in Halton**
SAB membership includes a Manager from the Children and Enterprise Directorate, as a link to the Local Safeguarding Children's Board and Halton Safeguarding Children Board membership includes adult social care representation.

Joint protocols exist between Council services for adults and children.

6.2 **Employment, Learning & Skills in Halton**
None Identified

6.3 **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.

6.4 **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.

6.5 **Halton's Urban Renewal**
None Identified

7.0 **RISK ANALYSIS**

7.1 There were capacity risks associated with the previous structure. This model has given us the opportunity to re-assess how we support the Safeguarding and Dignity agendas in the future, to ensure we are appropriately resourced to effectively protect those least able to protect themselves.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 An Equality Impact Assessment is not required for this report.

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

Document	**Place of Inspection**	**Contact Officer**
No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (March 2000)	People & Communities Policy Team	Louise Wilson

REPORT TO: Health Policy & Performance Board

DATE: 29 May 2012

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults

SUBJECT: Intimate Relationships and Sexual Health Needs for Adults Policy, Procedure and Practice

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Health Policy and Performance Board with the revised Intimate Relationships and Sexual Health Needs for Adults Policy, Procedure and Practice, for information.

2.0 **RECOMMENDATION: That the Board Note the contents of the report and associated document**

3.0 **SUPPORTING INFORMATION**

3.1 The original policy "Sexual Health Policy, Strategy and Guidelines" was developed in 2003, with subsequent reviews undertaken in 2009 and 2010.

3.2 The policy reviews are undertaken to ensure that all managers, staff and volunteers within the Communities Directorate have current and concise procedures, for addressing a range of sexual health issues that staff members may encounter with service users.

3.3 The policy has been reviewed and developed by a Policy Officer within the People and Communities Policy Team and in consultation with Divisional Managers, Principal Managers, Practice Managers, Safeguarding Adults Coordinator, Dignity in Care Coordinator and Legal Services.

3.4 Following this consultation, the amendments made to the policy include:

(i) More detail added to the Mental Capacity Act sections to provide clarity and include reference to Independent Mental Capacity Advocates
(ii) Legal references checked and updated where necessary following consultation with Legal Services

4.0 **POLICY IMPLICATIONS**

4.1 This policy should be used in conjunction with and is not intended to replace, the Safeguarding Adults in Halton Inter-Agency Policy, Procedure and Guidance 2010, where there are concerns about sexual abuse.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 No implications identified at this time.

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 purpose of this policy is to set the context/framework for a consistent approach by Halton Borough Council staff in addressing the personal, intimate relationships and sexual health needs of adults engaged in services commissioned or delivered directly by Halton Borough Council.

The policy endeavors to guide professionals who need to assess and manage matters of rights, responsibilities and risks in regard to intimate and sexual relationships.

6.4 **A Safer Halton**

None identified

6.5 **Halton's Urban Renewal**

None identified

7.0 **RISK ANALYSIS**

7.1 Through the implementation of this policy, by using a consistent approach to addressing the sexual health of service users, this will enhance the protection of adults who use care services.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 Vulnerable adults have the right to have the same opportunities in life as others. This policy aims to support this by taking a proactive

approach to deal with sexual health and relationships of service users.

8.2 An associated Equality Impact Assessment has been completed.

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

None under the meaning of the Act.

HALTON BOROUGH COUNCIL

Communities Directorate

Intimate Relationships and Sexual Health Needs for Adults

Policy, Procedure and Practice

February 2012

CONTENTS

INFORMATION SHEET

Service area	All teams
Date effective from	February 2012
Responsible officer(s)	Policy Officer, People and Communities Team
Date of review(s)	February 2014
Status: • **Mandatory (all named staff must adhere to guidance)** • **Optional (procedures and practice can vary between teams)**	Mandatory
Target audience	HBC Operational Staff
Date of committee/SMT decision	7th March 2012
Related document(s)	The National Strategy for Sexual Health and HIV, Department of Health, 2002 Progress and priorities – working together for high quality sexual health. Review of the National Strategy for Sexual Health and HIV, 2008 Choosing Health: Making health choices easier. White Paper Safeguarding Adults in Halton Inter-Agency Policy, Procedure and Guidance, 2010 Professional Boundaries Guidance, 2012 General Social Care Council Code of Practice for Social Workers Sexual Offences Act 2003 Mental Capacity Act 2005

Superseded document(s)	Intimate Relationships and Sexual Health Needs for Adults Policy, Procedure and Practice, 2010
Equality Impact Assessment completed	CIRA completed
File reference	

	POLICY	***Practice***
1	**Policy Statement**	
1.1	The purpose of this policy is to set the context/framework for a consistent approach by Halton Borough Council (HBC) staff, in addressing the personal, intimate relationships and sexual health needs of adults, engaged in services commissioned or delivered directly by Halton Borough Council.	*In implementing this policy, there is an expectation that employees of the Council will comply with the requirements of this policy and related documents and treat each individual accordingly*
1.2	The policy and associated guidance aims to draw together the legal framework, whilst also recognising: • Service users' individual uniqueness and diversity • Their right to privacy and independence and to make informed decisions which might include risks • That some individual's circumstances might make them vulnerable to abuse and may need support with minimizing or eliminating those risks • The importance of their physical and emotional wellbeing	
1.3	The policy endeavours to guide professionals who need to assess and manage matters of rights, responsibilities and risks in regard to intimate and sexual relationships.	
1.4	This policy is related to: • Safeguarding Adults in Halton Inter-Agency Policy, Procedures and Guidance, 2010 • Professional Boundaries Supplementary Guidance, 2012 Copies of the above documents should be available in teams but is also available on the Safeguarding Adults/Adult Protection page of the Halton Borough Council intranet and on the Halton Borough Council website at: www.halton.gov.uk/safeguardingadults	*Refer to "Safeguarding Adults in Halton Inter-Agency Policy, Procedure and Guidance, 2010" for specific procedures relating to alleged abuse, including sexual, physical and emotional abuse, domestic abuse, discrimination and exploitation* *"Professional Boundaries Guidance, 2012" for staff who have contact with vulnerable people in the course of their work*
2.	**Who was involved in the production of the policy?**	
2.1	This policy has been developed by a Policy Officer, People and Communities Policy Team. All relevant Divisional Managers, Principal and Practice Managers, Legal Services, Safeguarding Adults Coordinator and the Dignity in Care	

	Coordinator were consulted upon its contents. The policy has been presented to Senior Management Team for agreement.	
3.	**Definitions for the purpose of this policy**	
3.1	**Policy:** This policy is a statement about what the Directorate plans to do, to carry out its responsibilities in relation to the sexual health of service users and safeguarding vulnerable adults from abuse, including sexual, physical and emotional abuse, domestic abuse, discrimination and exploitation.	
3.2	**Procedure:** The steps that need to be taken to implement the policy	
3.3	**Practice:** Practice material identifies good professional practice in order to meet the service user's needs	
3.4	**Sexual Health** When we think of sexual health, the immediate association is Sexually Transmitted Infections (STI's), however, the reality is that sexual health goes well beyond the medical model of treatment. The World Health Organisation (WHO) defines sexual health as: *"A state of physical, emotional, mental and social well being, relating to sexuality: It is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.* *For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."*	*Refer to "Safeguarding Adults in Halton Inter-Agency Policy, Procedure and Guidance, 2010" for specific procedures relating to alleged abuse, including sexual, physical and emotional abuse, domestic abuse, discrimination and exploitation*
3.5	**Service User** As sexual health issues are common across all groups of people throughout this policy, reference is made to the term "service user". This term is used to represent an individual who may live with either a physical or sensory disability, mental illness, learning disability, substance dependence, or be someone who requires services as a result of an age related condition or serious illness.	
3.6	**Position of Trust** Guidance by the Home Office defines a relationship of trust as being "when one party is in a position of power or influence over the other by virtue of their work or the nature of their activity" (Home Office: caring for young people and the vulnerable). In the United Kingdom, a person holds a position of trust over another, may not engage in sexual relations with that person, as it is considered to be an abuse of trust", as defined by the Sexual Offences Act 2003.	*"Professional Boundaries Guidance 2012" for staff who have contact with vulnerable people in the course of their work*

3.7	Abuse of trust can result in loss of the alleged perpetrator's job or even their licence to practice their profession. Abuse of a position of trust for sexual relations can also lead to criminal charges being raised against the alleged perpetrator.	
3.8	**Consent** The Sexual Offences Act, 2003 defines consent as: "*A person consents if he agrees by choice and has freedom and capacity to make the choice."* The issue of age complicates matters as it is illegal to have sexual relations with someone under the age of 16 years, even if they were to "consent" it would not be valid consent, as they cannot legally do so.	
4.	**Mental Capacity Act 2005**	
4.1	Individuals who lack capacity to make decisions regarding their health and wellbeing may have rights under the Mental Capacity Act, 2005. This is a 'Framework' Act, in that it frequently does not state what is lawful and unlawful, but what framework needs to be followed for decision making. What is lawful or not lawful will always depend upon individual circumstances.	
4.2	This Act provides the definitions of both mental capacity and consent. The Act is unusual among Acts of Parliament in that it starts with five principles which underlie the whole of the rest of the Act. The first three of these address the independence agenda, protecting people from others making decisions on their behalf, if they have the capacity to make those decisions for themselves. Where a person demonstrably lacks capacity, the Act protects them from the consequences of their action or inaction. It does this by providing a structure so that others can make decisions on the person's behalf. The final two principles are designed to protect those who lack capacity by ensuring that any decisions made on their behalf are in their best interests and that the decision maker considers if there is a less restrictive alternative. This interplay between independence and safeguarding hinges on the assessment of capacity. These principles are as follows: • **Principle 1:** A person must be assumed to have capacity unless it is established that s/he lacks capacity • **Principle 2:** A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success	*"Mental Capacity Act 2005. Overall Policy, Procedure and Guidance July 2011" Staff should refer to the definitions regarding capacity and consent in Section 2 and the Principles of the Mental Capacity Act as cited in Section 4.0* *Staff must always assume that a person has the capacity to make a decision for themselves and do everything they can to support them to do so.* *Making what others (including staff) may consider an unwise decision does not in itself indicate a lack of capacity.* *We all make "wrong" decisions and learn from our mistakes.*

	• **Principle 3:** A person is not to be treated as unable to make a decision merely because he makes an unwise decision • **Principle 4:** An act done or decision made under this Act for or on behalf of a person who lacks capacity must be done or made in their best interests. • **Principle 5:** Before the act is done or the decision is made regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action.	*Vulnerable people must be allowed to do the same, provided they have the capacity to understand the risks and learn from them.*
4.3	The Mental Capacity Act applies to all individuals in England and Wales who are aged 16 and above and who lack (or may lack) capacity to make any specific decision. Hence everyone directly involved in the care and support of such individuals, including those employed in health and social care will be subject to the statutory responsibilities enshrined in the Act.	
4.4	An individual demonstrably lacking capacity will need someone to make any decisions on their behalf. The more important the decision, the greater the likelihood that more people will be involved. An assessment must be made as to capacity and, if appropriate, the best interests of the individual in respect of each decision. Generally a person's partner, family or friends will be able to provide advice on what is in the person's "best interests" and help when a decision needs to be made. However, in situations where this is not the case and the person is "un-befriended" then the local authority must refer the individual to an Independent Mental Capacity Advocate (IMCA). This is a service that has been established to provide independent safeguards for individuals lacking capacity. The IMCA does not make decisions, but acts in a consultative and advisory role (Halton Borough Council Mental Capacity Act, Overall Policy, Procedure and Guidance, July 2011, Section 12.0). There may be situations where informal decisions by family, friends or professionals cannot be followed. This may be because of a serious disagreement or where the legal situation is unclear and so formal decision making powers are required. In such cases, the Court of Protection (ibid, section 9) is used as a last resort. It has the powers to make a decision on behalf of a person, or can appoint a deputy to make such decisions. It can also declare whether a previous act that has already been or is about to be carried out is lawful or not.	*An IMCA may also be involved in other decisions concerning a care review or an adult protection case where the person lacks capacity – even where family members or others are available to be consulted. This is decided on a case by case basis according to circumstances.* *The IMCA is commissioned by the local authority. The IMCA must be approved by the local authority to undertake the role.* *Making an application to the Court of Protection. The matter should always be referred to the Divisional Manager for the service area concerned (or another in their absence). Divisional Manager will then contact legal services for advice.*
4.5	**Best Interests**	*If social care staff have*

	A key principle of the Act is that any decision made or procedure carried out on behalf of the person who is lacking capacity must be done or made in the person's "best interests" (ibid, Appendix 4). In order to ascertain what is in the person's best interests all attempts should be made to find out their own views (past and present wishes and feelings). It will be necessary to consult with others, identify all circumstances relevant to the decision and avoid discrimination. Is it possible that the person could regain capacity after medical treatment? If so, can the decision wait until then? All options need to be considered in order to decide what is best for the person. This is important because there may be an alternative approach which could prove less restrictive of the person's rights. Best Interests doesn't apply when the person has previously made an Advance Decision to refuse medical treatment while they still retained the capacity to do so. This advance decision must be respected at some future point when the person lacks capacity, even if you think that the decision to refuse treatment is not in their best interests. This is provided in the circumstances outlined in the Advanced Decision remain the same (ibid, Section 7.1-7.3).	*concerns about a capacity or best interests decision that affects the welfare of a person lacking capacity, the local authority should make the application to the Court of Protection.* *See also "Halton Borough Council Mental Capacity Act, Advance Statements and Decisions. Policy, Procedure and Practice, June 2010*
4.6	**Deprivation of Liberty Safeguards (DoLS)** These safeguards are an amendment to the Mental Capacity Act. They provide a legal framework to protect those who lack the capacity to consent to the arrangements for their care and treatment. In particular, they relate to situations where the levels of restriction or restraint used to deliver such care, are so extensive that the person is effectively deprived of their liberty. Prior to the introduction of DoLS, there were no legal processes to protect the interests of vulnerable people in these circumstances. DoLS apply to anyone who is 18 years of age and older. Generally DoLS apply to people who are in residential, nursing or hospital care, who lack the capacity to make decisions about their own circumstances. However, recent case law also indicates that individuals who have tenancies in a highly supported environment (including their own home in the case of support in the community) may also be subject to DoLS. In such situations you should seek legal advice and consider a referral to the Court of Protection. Those detained under the Mental Health Act already have legal safeguards to ensure that they are not detained illegally or inappropriately and do not come under these provisions.	*See Halton Borough Council, Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS), Policy, Procedure & Practice, July 2011.* *DoLS do not apply if the person is detained under the Mental Health Act 1983 (as amended by the 2007 Act). However, they do apply if a person is under Guardianship, part of Section 7 in the Mental Health Act.* *It is the responsibility of the Managing Authority to apply for a DoL authorisation (see Halton Borough Council Mental Capacity Act Deprivation of Liberty Safeguards (DoLS, Policy, Procedure and*

	Restraining a person is not necessarily a deprivation of liberty. It may be appropriate to prevent them causing harm to themselves or others. When used, restraint should be appropriate to the likelihood or potential seriousness of possible harm. However, the European Court of Human Rights in HL v United Kingdom (2004) has decided that where restriction is frequent, cumulative and ongoing, then consideration needs to be given as to whether it has exceeded what is permissible and become a Deprivation of Liberty. If in doubt refer to Legal Services for advice. Application for a DoL is made to the Council on a standard form. Following receipt of this, six separate assessments must be carried out by the Council within 21 days.	*Practice, July 2011 section 2.0)* *For a Standard Authorisation the Managing Authority must apply to the Supervisory Body (Halton Borough Council) using a standard form (ibid, section 2.1-2.6)*
5.	**Context**	
5.1	Sexual health affects our physical and psychological well-being. Sexual health is central to some of the most important relationships in our lives. Therefore, protecting, supporting and restoring sexual health is important (DH, 2002).	*Staff are expected to use their knowledge of relevant legislation, professional judgement and discretion in relation to whether or not a service user would wish to discuss such a matter, or to decide where it maybe legitimate to broach a particular issue with a service user.*
5.2	Although sexual health is about more than just the physical wellbeing of a person, sexually transmitted infections have been rising in the UK over the last decade. Some sexually transmitted infections will impact on a person's quality of life and future fertility. As many sexually transmitted infections can be present without any symptoms, seeking advice on reducing the risk of infections is an important factor in reducing the spread of these infections. This policy places emphasis on the sourcing of appropriate information to enable service users, their parents and carers to make informed decisions about sexual activity, behaviour and relationships.	*In dealing with suspicions of abuse, any necessary and appropriate response will be informed and guided by existing adult protection/safeguarding adults policies and procedures. Refer to "Safeguarding Adults on Halton – Inter-Agency Policy, Procedure and Guidance, 2010" for specific procedures relating to alleged abuse, including sexual, physical and emotional abuse, domestic abuse, discrimination and exploitation.*
5.3	From the outset, it is important to note that many service	

	users will not require any intervention or response from staff concerning their sexual health or intimate relationships. However, regardless of particular circumstances all service users and those responsible for their care, will benefit from guidelines, which outline roles and responsibilities in relation to sexual health.	
5.4	This document is intended to support staff working with all service users, regardless of age, disability, ethnicity, gender or sexuality. It promotes a shared philosophy and value base, which underpins the human rights, responsibilities and risks, in relation to the promotion of sexual health.	
5.5	It should be noted that this policy is not designed to respond to situations where concerns or suspicions of abuse of a service user arise.	
6.	**Rights and responsibilities of service users, staff and carers**	
6.1	People who use our services have the same human rights as all people to live a full life without abuse, be treated with dignity and respect, be supported, if required, to be able to experience the accepted and lawful range of personal relationships, which may include sexual relationships.	*Staff will not be expected to allow personal prejudices, judgements or sexual preferences to affect their work with service users. The employee must notify his/her manager if (s)he feels such a situation is likely to occur.*
6.2	In exercising these rights, service users have responsibilities to ensure other people's rights are not infringed.	
6.3	Any person to whom the Council provides care and support or for whom they commission care and support has the right to: • Be respected as an individual with rights to privacy, dignity, confidentiality and protection from abuse and exploitation • Be consulted about the type of care and support (s)he needs • Give consent and/or be consulted by others and to be involved in making decisions concerning their personal and sexual relationships • Participate in taking decisions and making choices that affect or may affect his/her lifestyle • Be accepted as a valuable member of the community and respected for their abilities and achievements • Receive services that promote independence and	*It is expected that managers will make sure that services are commissioned, designed and delivered to reflect the rights and principles in this document and identify areas where employees may need support or specialist training to enable them to implement this policy.*

	which inform choice and risk taking as part of personal development • Not be discriminated against because of age, gender, race, religion or belief, sexual orientation, transgender identity or disability • Have access to information held about themselves • Be treated respectfully, in relation to private and family life • Marry according to national laws • Make a complaint if they feel their human rights have been breached • Report abuse and exploitation without fear of reprisal • Protection from abusive and exploitative relationships • Be provided with support and advice • Expect people in positions of trust to exercise their duty of care and appropriately recognise professional boundaries. Service users have: • A responsibility to behave lawfully in public and private places when conducting personal and sexual relationships • A responsibility not to abuse other people	*It is expected that staff will work with service users and employees to enable service users to express their personal choices and preferences in respect of sexuality and personal relationships.* *Employees to understand the boundaries of their roles and take effective and appropriate action if these are breached.* *"Professional Boundaries Supplementary Guidance to General Social Care Council Code of Practice, 2012" for staff who have contact with vulnerable people in the course of their work.*
6.4	Where there are concerns about service users who may be engaged in abusive relationships, there are a number of issues which should be considered. These include: • Whether there is a power imbalance between the two people concerned • Whether tangible inducements have been used by one person, therefore indicating evidence of exploitation • Whether, in the case of heterosexual relationships, the people involved know about the risk of pregnancy • Whether both partners have knowledge and understanding of what constitutes safer sex and are	*The greatest possible care must be given to establishing <u>full and informed</u> consent to a sexual relationship by a service user, not only because this reflects what is in their best interests and may prevent abuse but also because it minimises any likely legal intervention. However, staff should be cautious of using the duty of care to deny people choice.*

	able to use this knowledge to reduce risks	
	PROCEDURE	***Practice***
7.	**Sexual Health**	
7.1	Dependent on individual circumstances, service users and staff may need additional/specialist information regarding the following issues: • At what stage of a man or woman's life they are fertile • Under what circumstances conception occurs • When the use of contraception might be appropriate • How sexual infections are transmitted • How the risk of sexual infection might be reduced and increased • The symptoms of sexual infections • Other genital conditions, not necessarily sexually transmitted (e.g. thrush and cystitis) • Where to get further information about genital conditions and sexual transmitted infections (including HIV and Aids) • A knowledge of Breast Awareness and accessing Breast Screening and Cytology Services for women and Testicular Examination for men.	*Staff will need to be aware of the appropriate services and agencies available to provide specialist advice and also have some understanding of sexual health.* *A list of useful numbers can be found in Appendix 1* *A list of useful resources can be found in Appendix 2* *Sexual health needs are an integral part of the overall health and wellbeing of service users and where appropriate should be addressed by service provision and reviews of care packages.*
8.	**Contraception**	
8.1	Service users may wish to make a decision about contraception themselves or they may wish to make a decision with their partner. It should be made clear that if there is the possibility of pregnancy through a sexual relationship then both parties have responsibility for contraception. • Decisions around the use of contraception should be based upon the informed choice of the service user and if they require assistance should be part of the multi-disciplinary approach • Service users should have choices as to where they go for information and who supports them in finding out the information. Gender may be an issue; e.g. who provides the finding out the information. Gender may be an issue e.g. who provides the information, who provides any support or advocacy • Service users to be supported to access more than one session of advice and information where appropriate	*Information about contraception is available from a range of health providers, including GP's, nurses and Family Planning Agencies. Where possible, service users should be enabled to access these services, with support if required and agreed by all parties concerned.* *Practical issues around the use of contraception may need to be discussed with the people it affects e.g. if the contraceptive pill is used, where it is kept and when it is taken. These issues should be*

	• Family members' views about contraception for their family member who uses a particular service will be taken into account if the service user requests or agrees with this. In some situations such information might be sought by a medical professional who is attempting to determine what is in a service users' best interest.	*noted in Care Plans where appropriate.* *Staff need to maintain confidentiality over matters concerning contraception.*
9.	**Fertility Treatment**	
9.1	Article 8 of the Human Rights Act (2000) does not guarantee to anyone a positive right to fertility treatment. However, the denial of fertility treatment to a person with a disability might involve Article 8 together with Article 12 and Article 14. In the UK, some health authorities provide for treatment on the NHS and others do not. Candidates for fertility treatment are selected according to criteria laid down in the Human Fertilisation and Embryology (HFE) Act and the Code of Practice.	
9.2	The HFE Act does not exclude any category of women from being considered for treatment, but two criteria listed in the Code of Practice have the potential to discriminate against disabled parents. They are: • The prospective parents' medical histories and the medical histories of their families and any risk of harm to the child • Children who may be born with the risk of inherited disorders	
10.	**Pregnancy, Adoption, Abortion**	
10.1	When a service user becomes pregnant, it is important that she is given careful counselling about the responsibilities of parenthood and the impact of parenthood on her own life. Advice also needs to be available about contraception to avoid further pregnancies (see Section 8. on Contraception).	*Medical advice for the service user should be sought at an early stage to ensure that appropriate medical care is implemented as soon as possible, viability of the pregnancy on medical ground is determined etc to enable the service user, family and carers to make informed decisions.*
10.2	Staff and carers need to be careful to offer balanced advice in this situation, helping the birthmother (and birthfather if it is appropriate to do so) to weigh up the advantages and disadvantages of continuing with the pregnancy, keeping the baby or considering adoption. Independent advice may be helpful in this situation.	
10.3	Children and Families Services in the locality area are	

	available to provide advice, support and counselling regarding the process of relinquishing a child for adoption or legal care proceedings. There is an additional service from After Adoption, a specialist voluntary adoption agency which provides independent advice, support and counselling with whom Children and Families have a service level agreement. They provide a service at any stage of the adoption process. Referral to the organisation can be made by the individual or by a professional on their behalf. Legal advice is essential to ensure that proper procedures are followed. Upon the child's birth, additional counselling should be offered to ensure adoption remains the plan.	
10.4	**Medical Intervention** Individuals have a common law right not to be subjected to medical intervention or treatment without their consent. No other person can legally provide consent on behalf of another person. This legal principle applies unless a person has been deemed mentally incapable of making a decision on the issue. In such a case an intervention may be carried out under the common law doctrine of necessity, if a doctor decides that a particular treatment is in the person's "best interests".	
10.5	For treatments such as abortion or sterilisation of adults deemed not to be capable of consenting to treatment, matters can only be decided upon by the High Court. Decisions as to whether or not to refer such matters to the High Court rest with the responsible medical practitioner.	
11.	**Masturbation**	
11.1	Masturbation or self-stimulation is a natural activity and a useful outlet for sexual expression, where other opportunities are limited. Knowledge and familiarity with one's own body also intrinsically linked to positive feelings.	*Staff are strictly forbidden to perform sexual relief or other sexual acts with/for a service user, as this could incur a charge of indecent assault.*
11.2	Service users should not be made to feel guilty about masturbation, because of personal values and attitudes held by individual members of staff. If masturbation seems to be taking place excessively or in inappropriate situations, this may indicate other issues which need to be addressed.	
11.3	Although service users are likely to have the same range of sexual needs as any other group of individuals, their options for both expressing and fulfilling such needs may be limited by a broad range of factors, including: • Psychological factors such as guilt or anxiety • Physiological factors such as poor circulation, skin infections or inflammations, poor vaginal lubrication and as a consequence of a number of physical disabilities	*Unless specifically contracted to do so, it is highly unlikely that direct care staff would be responsible for delivering such work e.g. direct situational teaching of masturbation, as this would be beyond their remit and could conceivably be*

	• Communication factors such as other language, speech impairment • Medical factors, including the side effects of some prescribed medications and the effects of some medications prescribed expressly to inhibit male erection • Socio-economic and environmental factors, including a lack of privacy within care settings and an absence of available information and understanding by care staff	*construed as criminal activity under the Sexual Offences Act, 1956.*
11.4	For service users who through their own choice (if this can be ascertained), have expressed an identified need of input and help in the area of masturbation, a Professionals Meeting should be convened. The meeting should involve Senior Managers and may also include medical or other appropriate professionals. Every effort should be made to involve the person in a meaningful way, preferably by his or her direct presence at meetings.	*The outcome of the Professionals Meeting, regarding decisions about the service user's wish to undertake masturbation will result in the formulation of a written Care Plan or protocol which will detail how, by whom, where and when any information and work is undertaken, how the process will be monitored and evaluated and by whom.*
11.5	Masturbation is a private and personal issue. However, it is important for both the protection of the service user and the workers involved that decisions regarding the area of masturbation should be reached only by consensus. This will help to ensure both a transparency of process and ownership of agreed decisions at senior management level within involved services.	
11.6	All efforts to work with a service user to attempt to change inappropriate behaviour should be established as an integral part of an overall sexual health education programme. Matters of sexual need will then be firmly based in a context of personal relationships, required privacy, health and hygiene and rights and responsibilities.	
12.	**Cross Dressing**	
12.1	This practice must be treated with respect and dignity and not seen as a subject for humour or ridicule. Nor should assumptions be made that it is an indication of a sexual identity problem or other problem.	*Individual staff may, because of strongly held religious or other views and experiences, feel unable to assist service users in relation to these specific issues, which may facilitate the*

		service user's sexual health and well being. In these circumstances, it may be appropriate to arrange for another worker to be involved.
12.2	It may be appropriate to discuss with the service how cross-dressing meets their needs, as part of establishing a therapeutic working relationship. This will also help to demonstrate to a service user an acceptance of their behaviour as being a valid part of their sexuality and also ensure that any service provided is as sensitive to their needs as possible.	*However, it is vital that <u>all</u> staff always support work, which help us to meet the individual's sexual health needs as part of their overall health and well being, thus following the values of the Intimate Relationships policy and values.*
12.3	For a person whose physical ability is diminishing there may be practical issues to resolve in a way that meets the individual's needs, without offending others. This should be dealt with without ridicule and sensitivity in order to minimise embarrassment.	
13.	**Lesbian, Gay, Bi-Sexual, Transgender**	
13.1	It is important to remember that everyone has a sexual orientation; it is not a term that refers solely to lesbian, gay or bi-sexual people. Halton Social Services supports work with its clients to discuss sexual orientation and to develop inclusive procedures. • Work with people regarding their personal and sexual relationships must be within the boundaries of confidentiality and privacy • Workers' behaviour should be consistent and non-exploitative • Workers will need to be aware of their own beliefs and values and how these may impact on their own behaviour • It is important to be aware of the assumptions, which surround sex and sexuality and for staff to understand the reasons why it is important not to make assumptions about individuals. • Service users should be encouraged to recognise their own rights and responsibilities • Staff should be aware of the sources of support and guidance in relation to working with people in respect of their personal and sexual relationships e.g.	*Individual staff may, because of strongly held religious or other views and experiences, feel unable to assist service users in relation to these specific issues, which may facilitate the service user's sexual health and well being. In these circumstances it may be appropriate to arrange for another worker to be involved.* *However, it is vital that <u>all</u> staff always support work, which help us to meet the individual's sexual health needs as part of overall health and well being, thus following the values of the Intimate Relationships policy.* *The law means that we have to ensure that LGBT people are treated equally.*

	availability of appropriate training, support from line manager • Staff should be made aware of the action to take should they encounter situations in which they feel unable to cope.	*Staff and carers should avoid, as a matter of good practice, all negative images and discriminatory language that could discourage service users from seeking advice they need.*
14.	**Pornography and Sexually Explicit Material**	
14.1	As service users have the same human rights as those of any other member of society. By definition, this will include the right of service users to own legal pornographic material.	*Illegal pornography must be removed at once and action taken if any staff or carers have been involved in allowing such material to be made available. For a detailed definition of what constitutes illegal pornography, please refer to Appendix 3.*
14.2	Although it is legal to access and own pornographic material involving adults, such material may be offensive and contrary to the value base of many individuals. Given such tensions, staff will need to balance the individual rights of service users to own such material, with their own principles and beliefs.	
14.3	In some cases staff could use the fact that a service user is accessing pornographic material, as an opportunity to explore underlying sexual health needs. For example, a service user may believe that pornography is their only option for sexual expression, whereas, access to education and the provision of opportunities to develop more meaningful social or personal relationships may bring about positive change for the service user.	*Halton Borough Council computers, or computers that Halton Borough Council are responsible for, must not under any circumstances be used to access pornographic material.*
14.4	It is important to distinguish the majority of such material from that, which would breach the Obscene Publications Act. Such material would, for example, feature illegal sexual activities e.g. those involving children, animals or torture. It is illegal to purchase or own these sorts of materials. It is also an offence to obtain such material for others.	*Staff must never promote or initiate the introduction of pornography and sexually explicit material to any service user.*
14.5	While staff may be involved with a service user who wishes to access such material, they also have a responsibility to explain issues of privacy in regard to its use, the offence it may cause to others and the legal context of such material (e.g. not showing to or risking access by minors).	*Many staff will wish to stress that they do not wish pornographic material to be displayed during visits to the homes of service users and should be supported in this by management.*
14.6	Services should ensure that people who wish to access or	*For service users who*

	purchase pornography or sexually explicit material, do so discreetly and confine its use to within the privacy of their own rooms. Pornographic material must not be displayed in areas where it is likely to cause offence to others e.g. communal areas, day centres etc. Pornography can be accessed via the internet, which workers should be mindful of. There is a fine line regarding the legality of pornographic material, as some such material may be classed as obscene and anything involving children is most definitely illegal and accessing/possessing such material is a criminal offence.	*through their own choice have expressed an identified need of input and help in the area of access to pornography, a Professionals Meeting should be convened. Every effort should be made to involve the person in a meaningful way, preferably by his or her direct attendance at subsequent meetings/discussions.*
14.7	If staff are unclear or concerned about the possible consequences of a service user accessing pornography and sexually explicit material, a properly informed risk assessment should be undertaken.	
15.	**Access to Sex Services**	
15.1	Situations may arise whereby a service user expresses a wish to seek the services of a sex worker (prostitute). In such circumstances staff must act within strict legal guidelines.	
15.2	Staff must not, under any circumstances, become directly involved in making arrangements on behalf of a service user. Acting in this way could potentially lead to a criminal conviction for procurement for prostitution.	
16.	**Staff Attitudes and Conduct**	
16.1	This policy aims to provide consistently applied good practice standards, in the approach of staff to dealing with the sexual health and intimate personal relationships of service users.	*Staff to adopt and follow the values and principles within this policy: privacy, dignity, confidentiality and protection from abuse.*
16.2	If staff deny or ignore a person's wish for sexual activity, or the development of a relationship, the person using the service is likely to be denied access to advice, knowledge and skills that are essential to making an informed choice or decision (for example, on issues of safer sex).	*Staff should develop an awareness of their own attitudes and how these influence decision-making processes and the way in which service users are supported in expressing their sexual and intimate relationship needs and sexuality.*
16.3	Staff will also need to be aware of the need for clear boundaries where personal contact may be misinterpreted and cause confusion. Staff will then be vulnerable and open to criticism.	
16.4	The Professional Boundaries Supplementary Guidance to General Social Care Council Code of Practice, 2012, provides the following definitions which staff should adhere	*"Professional Boundaries Supplementary*

	to: **Infatuations** You should be aware that sometimes service users can develop strong attractions to their care or support workers. If this happens to you, you should respond sensitively so that the service user is not embarrassed. When a service user has an infatuation with his/her care or support worker, it is more likely that your words or actions will be misinterpreted, for allegations to be made against you or for it to be interpreted as "grooming". If you discover that a service user is infatuated with you or a colleague, you should: • Report any signs (verbal, written or physical) that make you think the service user is infatuated, to your line manager • Talk with your line manager about how to deal with the situation as soon as you can and ensure that agreed actions are recorded • Whatever action you decide to take, try to avoid distressing the service user **Social Contact** Social contact includes mobile phones, email, text messages, social networking sites, letters, face to face communication or giving lifts to people). You should not: • Arrange any social contact with service users outside of work. If social contact outside of work happens by coincidence (seeing a service user at a social event, for example), you should take care in how you react and be aware that any social contact might be misunderstood. Tell your line manager if you have regular social contact with any service users, so that this can be noted. • Make contact with service users through social networking site such as Facebook, MySpace or Bebo • Give your personal details to service users. This includes your home address, personal mobile number or home telephone number and personal email addresses	*Guidance to General Social Care Council Code of Practice, 2012" for staff who have contact with vulnerable people in the course of their work* *Give appropriate and consistent cues to people who use our services and using language that is non-discriminatory and non-judgemental.*

	• Take service users to your own home • Give lifts to service users, unless this is part of your job role and has been agreed and recorded appropriately All work communications with service users should be carried out in line with the relevant Halton Borough Council policies. **Physical Contact** Physical contact includes physical intervention/restraint, moving and handling, intimate care, dealing with distress and sexual contact. Sometimes it is appropriate for you to have physical contact with a service user, but it is very important that you only do this in ways that are appropriate to your professional role. Physical contact should never be secretive, or for your own gratification. If you feel that any physical contact with service users could be misinterpreted, you should talk to your line manager so that the incident can be noted.	
16.5	If legal sexual activity is condemned, the person using the service is given a negative message about sexual expression. This will not promote a climate in which sexual health education programmes can be effective in improving sexual health. It also does nothing to prevent the behaviour recurring, even though this may be inappropriate. It may even give rise to further inappropriate behaviour or behaviour of a sexual nature, which challenges services.	
17.	**Partnership with Carers**	
17.1	It is important to recognise that parents and carers of service users have no legal say in what their adult relative does. The law does not recognise the ability of anyone to give consent on behalf of another person. However, it must be recognised that parents and carers often have an influence, a sense of responsibility and may have extreme difficulty coming to terms with their relative's approach to their personal relationships and their sexuality. It would be important to ensure that relatives and carers are part of all decision-making processes.	*All staff need to be aware of the potential tension between the various people involved in the care of service users. This awareness should be included in induction packs and training should be ongoing.*
17.2	People involved with service users need to be realistic and accept that family relationships are unique in every situation. It is preferable to initiate contact and work in partnership with carers, rather than respond to anxieties on a crisis basis. Parents/carers should only participate in discussions about personal and sexual relationships where the individual concerned has given permission to do so. This should only be undertaken in private with the individual's confidante, key worker or advocate.	*A service may wish to develop an explicit framework, which sets out clearly what the different relationships are between the service and the parents/carers and the service and the service user/ It is important to achieve a*

		balance between parental/carer involvement whist ensuring the needs of the service user are also met. For example, your service may decide that parents have the right to information but service users have the rights to confidentiality. This may need to be clearly stated in the service information.
17.3	Parents/carers should be offered opportunities to comment and be involved in the development of education/information about personal and social relationships for service users. By welcoming, listening and encouraging their involvement as partners in services for person in care, promotes dignity and respect for themselves and the service user. Information about such areas should be available to parents/carers before their relative starts to receive a service.	
17.4	The differing attitudes of parents and carers towards sexuality, needs to be recognised and handled sensitively. At the same time the rights, needs and views of service users must be the overriding consideration.	*Senior managers should be consulted where there is an unresolved conflict of opinion, which will have implications for the service to be delivered.*
18.	**Equal Opportunities**	
18.1	It is commonly recognised that there are individuals in society who are part of a number of socially excluded groups. These groups of people may be denied access to a wide range of facilities and services. Members from socially excluded groups may have uniquely individual needs in the area of personal and social relationships and care must be taken to ensure equity of service provision in addressing the needs of such individuals.	*Before undertaking work with any service user, staff should familiarise themselves with issues around discrimination and how such issues may impact on service users in relation to the promotion of sexual health.*
18.2	Unfounded assumptions about service users may exist on a number of levels. It can be easier for services to assume that older people, or disabled people have no sexuality. This serves to create barriers to those who may wish to seek help for sexual health concerns. Staff must be aware that any person regardless of age, disability or sexual orientation is entitled to pursue a sexual relationship if they wish to do so. This also encompasses people who live in their own home and are receiving services or for those service users who reside in a residential or nursing home. If service users	*Services should have in place policies regarding the following anti-oppressive practice and equal opportunities. Staff at all levels should be provided with training in respect of the above.*

	require support in order to pursue intimate relationships, then staff should be committed to providing the level of support required within ethical and professional boundaries.	
18.3	The outcome of prejudice and discrimination can lead to: • Service users deprived of potentially therapeutic interventions • Service users denied protection from sexually transmitted diseases • Service users being unable to voice their concerns or fears • Vulnerable service users left open to abuse or exploitation	*Where staff feel that equal opportunities are not an integral part of service delivery they should discuss these concerns with their line manager or another appropriate person (someone you feel comfortable with – this may be another manager within the department, or your professional body)*
19.	**Confidentiality and Information Sharing**	
19.1	The primary aims are to empower individuals and to ensure people are safeguarded, where necessary). Information must be shared only on a need to know basis, in accordance with legal obligations and good practice guidance. Service users who need help with issues of sex and sexuality, have a right to expect that the confidentiality and sensitivity of the matter be respected. At the same time they, as well as staff, need to understand that some information passes in confidence, relating to situations of abuse or other risk, will need to be shared with others (e.g. the line manager, policy, other partner agency).	*Refer to "Safeguarding Adults in Halton Inter-Agency Policy, Procedure and Guidance, 2010" for specific procedures relating to alleged abuse, including information sharing and confidentiality.*
19.2	The lawful criteria for the disclosure of information in the public interest, which would in other circumstances, be a breach of confidentiality are: • The safeguarding of the welfare of vulnerable children and adults • Maintaining public safety • Prevention of crime and disorder • The detection of crime • The apprehension of offenders • The administration of justice Before disclosing confidential information to a third party, consideration should always be given to seeking advice from legal services.	*A public authority that collects and retains and/or passes on personal information without the person's consent interferes with the right to private life and will need to justify its actions under the Data Protection Act and Article 8 (2) of the Human Rights Act. This requirement has implications for all public agencies holding personal information about individuals and the sharing of such information between all agencies.*
19.3	**Circumstances that justify Information Sharing** The following circumstances may be justification for sharing	

	information and where necessary, be considered in the decision making process. You should seek legal advice before any disclosure. These circumstances are where: a) There is an overriding public interest in disclosure, such as: • In the interests of national security or public safety • For the prevention or detection of crime, the apprehension of offenders, the administration of justice • In maintaining public safety, the protection of health or morals • For the protection of the rights or freedoms of others • For the safeguarding of the welfare of vulnerable children and adults b) Disclosure is required by court order or other legal obligation c) The person to whom the duty of confidentiality is owed has given informed consent. Consent should be explicit, informed and preferably be in writing. Any verbal agreement should be recorded with the date and time. Silence is not consent. d) Where the subject does not consent but: • Disclosure is necessary to protect the *vital interests* of a vulnerable person who is unable to give consent, or; • Where it is not viable to obtain consent from them e.g. in cases of/allegations of serious abuse or exploitation, or; • Consent by or on behalf of the subject has been unreasonably withheld • Information sharing without consent is necessary for the prevention or detection of crime, apprehension or prosecution of offenders and where these purposes would be likely to be prejudiced by non-disclosure • The Information Commissioner advised that this [in the case of vital interests is where the sharing is	

	necessary for matters of life or death, or for the prevention of serious harm to the individual]. This should only be used where there is substantial chance, rather than mere risk, that not disclosing or informing the data, subject of the intended disclosure, would be likely to prejudice the prevention or detection of crime.	
19.4	The above principles must direct decisions about whether information needs to be shared, when, with whom and for what justifiable purpose.	
19.5	Detailed confidential information should be revealed and discussed at a review as a matter of routine. If there are real concerns relating to matters of risk or protection, these should be discussed with the individual beforehand and if necessary referred to the line manager, to decide how the matter should be handled.	
19.6	**Risk to children** The use of the term "Schedule One Offender" has been replaced with the term "risk to children", which indicates that a person has been identified as presenting a risk or potential risk to children. The information that a person in Social Services' care or other community based setting is a risk to children, is sensitive and confidential. The information should be shared with the minimum number of key staff and carers necessary to: • Meet the needs of the person who is considered a risk to children • Protect vulnerable individuals (children or adults) with whom the person considered a risk to children, has contact in any setting. In normal circumstances other people should not be told of the individual's background. The only situation where information about the individual's offence or risk level should be revealed, is when the nature of a relationship has developed to such a point, where there is identifiable likelihood of harm or abuse. Such situations require sensitive handling both with the person considered a risk to children and the other party.	*Refer to "Safeguarding Adults in Halton Inter-Agency Policy, Procedure and Guidance, 2010" for specific definitions and procedures relating to significant harm and principles of information sharing and confidentiality.* *The Home Office has issued revised guidance in Home Office Circular 16/2005, which explains how to identify those who pose a risk, or potential risk, to children. It includes a consolidated list of offences, which all agencies can use to identify "a person identified as presenting a risk, or potential risk, to children". This guidance identifies the major offences, including sexual offences, against children currently on the statute.*
20.	**Service Standards and Provision**	
20.1	As with all policies, it is essential that the policy's requirements be incorporated into service specifications and contracts. All Service Specifications, Contracts and Service	*It is advised that all providers of services are able to access*

	Level Agreements should specify that compliance with this policy is good practice.	*training.* *Each service should have a nominated member of staff who takes the lead responsibility for ensuring the policy is implemented.* *All services should include guidance on relationships and expectations about behaviours in the Information Leaflet for Service Users and their carers so that these are clear.*
21.	**Assessment and Care Planning**	
21.1	Sexual health needs may form an integral part of a service users overall health and well-being. In attempting to address these, all assessment tools should incorporate issues regarding health and emotional well-being, which may be intrinsically linked to ways of improving or maintaining sexual health.	*In providing services, great care should be taken to be sensitive as to how services may impact on service users personal and social relationships. The manner in which services are provided may impinge on relationships and sexuality in ways which are not always obvious or visible to staff.* *Examples may include:* • *Physical alteration of sleeping arrangements between partners e.g. moving bed to ground floor* • *Lack of privacy within residential /nursing establishments* • *Care arrangements that may increase separation between partners e.g. extending day care*

		provision for one partner • *Prescription of medication which may reduce libido*
21.2	Dependent on the service being provided, sexual health may not be the sole focus of an assessment. In addition, anxieties may exist, perhaps more often than not on the side of the professional, who may sometimes be over cautious for fear of causing offence. However, good assessments will communicate that staff are open to understanding personal and social relationships, including issues of sexual health and sexuality.	
21.3	Key points to observe at all times are: • **DIGNITY** • **CHOICE** • **AUTONOMY** • **RESPECT** • **PRIVACY** • **INDEPENDENCE**	
21.4	As per National Minimum Standards for Care, fundamentally care and support workers should 'treat others as you would wish to be treated yourself'.	
22.	**Legislation**	
22.1	It should be noted that all people who use our services are subject to the same legislation in relation to matters of consent and capacity. The common law presumes that <u>all</u> adults possess the capacity to make their own decisions, unless proved otherwise.	*Summaries of relevant acts can be found in Appendix3* *Sexual Offences Act (1956)* *Sexual Offences Act (2003)* *Human Rights Act (2000)* *NHS & Community Care Act (1990)* *Equality Act (2010)* *Local Government Act (1988)* *Data Protection Act (1998)* *Mental Capacity Act (2005)*
22.2	Although services may seek to promote positive sexual	

	health, concerns will inevitably arise when service users deemed possibly unable to give consent, by way of capacity e.g. severe mental illness or learning disability, may be engaging in sexual activity. Legislation exists to protect certain categories of vulnerable persons from abuse or exploitation, yet in some cases will be a major obstacle in enabling, what for some service users, may be valuable sexual relationships.	
22.3	Legal advice must be sought by any agency attempting to intervene or provide support in the context of sexual relationships between service users, for whom issues of capacity and consent appear to exist.	

APPENDIX 1

Useful Contact Numbers

Organisation	Contact Details	Service/Support
After Adoption	Helpline: 0800 0568 578 Mersey Office: 0151 707 4322 **www.afteradoption.co.uk**	After Adoption is a specialist voluntary adoption agency, which provides independent advice, support and counselling.
Body Positive Cheshire & North Wales	PO Box 321, Crewe, CW2 7WZ Tel: 01270 653 150 Fax: 01270 653 158 Email: **contact@bpcnw.co.uk**	Provides information, advice, support and advocacy for people who are HIV positive, their partners, friends and families, carers and anyone who has concerns about someone who is HIV positive.
Broken Rainbow	Tel: 0300 999 5428 **www.brook-rainbow.org.uk**	Gay, lesbian and transgender advice line
Brook Advisory	Free & confidential helpline: 0808 802 1234 **www.brook.org.uk**	National voluntary sector provider of free and confidential sexual health advice and services specifically for young people under 25.
Cheshire Action for Sexual Health (CASH)	CASH, PO Box 321, Crewe, CW2 7WZ Helpine: 01270 653 156 Email: **info@gaymenshealth.co.uk**	Offers support, information and advice on all aspects of sexuality and sexual health.
Genito Urinary Medicine Clinic (GUM)	Hospital Way, Runcorn, WA7 2DA Tel: 01928 753 217	Provides testing and treatment for sexually transmitted infections.
Health Care Resource Centre	Widnes Health Care Resource Centre,	Contraception and sexual health clinic.

	Oak Place, Caldwell Road, Widnes, WA8 7GD Tel: 0151 495 5000	Provides contraception, emergency contraception, free condoms, pregnancy testing, sexual health advice and referrals for termination of pregnancy. Chlamydia screening available for under 25s.
The HIV Support Centre	Tel: 0800 137 437 **www.thehivsupportcentre.org.uk** 3rd Floor The Warehouse 7 St James Street South Belfast BT2 8DN	Provides confidential advice and information.
NHS Choices	**www.nhs.uk**	NHS Choices is a comprehensive online information service.
Samaritans	24 hour support Tel: 08457 90 90 90 Email: **jo@samaritans.org** Chris PO Box 9090 Stirling FK8 2SA **www.samaritans.org**	Confidential, non judgemental emotional support.
Terrence Higgins Trust	Tel: 0845 1221 200 **www.tht.org.uk** St Helens Branch Halton and St Helens PCT The Hollies Cowley Hill Lane St Helens Merseyside WA10 2AP	Terence Higgins Trust is the leading and largest HIV and sexual health charity in the UK.

	Tel: 01744 457 389 Fax: 01744 453 085 Email: **info.sthelens@tht.org.uk**	
Contraceptive Education Service Helpline	Tel: 0845 310 1334 Fax: 020 7837 3042 2-12 Pentonville Road London N1 9FP **www.fpa.org.uk**	Provides confidential advice and information on all aspects of contraception.
Rape and Sexual Abuse Support Centre	RASASC PO Box 35 Warrington WA1 1DW **www.rapecentre.org** Email: **support@rapecentre.org** Tel: 01925 221 546	A registered charity that aims to provide crucial specialist support, independent advocacy, counselling and information free of charge and in confidence in a safe and non-threatening environment for anyone accessing the service.
Halton Domestic Abuse Service	Tel: 0300 11 11 247	Provide domestic abuse support to local people in Halton
Halton Domestic Abuse Service Independent Domestic Violence Advisor	Tel: 0300 11 11 247 Mobile: 07944 081 530 Email: **idva@hadwaa.org.uk**	The role of the Independent Domestic Violence Advisor is to promote a service to victims at high risk. They work with a number of organisations to assist clients with the following: • Ensuring the safety of their children • Support to access safety measures • Assistance with choices of legal options and support through the court system • Liaison with agencies such as

		housing, CPS, police and solicitors on your behalf
Halton Domestic Abuse Service Floating Support	Tel: 0300 11 11 247 Mobile: 07944 081 508 Email: **lead@hadwaa.org.uk**	Floating support is a service that focuses on assisting individuals in the following areas: • Help to maintain, identify or access accommodation • Help with accessing appropriate support services e.g. benefits & financial management • Practical support to live independently and manage a home • Emotional support and safety planning • Support for children and access to children's outreach
Halton Women's Centre	Tel: 01925 246 910 Email: **info@therelationshipcentre.co.uk**	We are a specialist service offering a range of information and advice, emotional and outreach support services, family mediation and innovative training and resources to support everyone to develop healthier relationships.
Cheshire Police	Tel: 0845 458 0000 (24 hours)	This helpline will provide help and advice to residents for non urgent queries. If you required help for an urgent issue please ring 999
Cheshire Victim Support	Tel: 0151 424 2785 or	Provide help and advice for victims of

	Tel: 01270 750 068	crime
Force Marriage Unit	Tel: 020 7008 0151	Provides advice for those who have experienced forced marriage
Karma Nivarna	Tel: 0800 5999 247	Provide advice for males and females who are experienced forced marriage
Lesbian Gay Foundation Helpline	Tel: 0161 235 8035	Provide information and advice regarding issues with sexual orientation
St Mary's Centre Sexual Assault Referral Centre	Tel: 0161 276 6515 St Mary's Hospital Oxford Road Manchester M13 9WL Email: **stmarys.sarc@cmft.nhs.uk**	St Mary's Centre provides a range of services for people who have been raped or sexually assaulted. You can access one or all of their services depending on your needs. These services are available for men, women, children and young people. They include: • Immediate Crisis Support • Forensic Medical Examination • Access to Emergency Contraception • Sexual Health Screening for Sexually Transmitted Infections • Access to counselling support for as long as you need it • Access to an Independent Sexual Violence Advisor to provide support through any court action taken

APPENDIX 2

Useful Resources

NHS Choices Sexual Health Resources Videos	**Videos:** • Where to get contraception • Talking about using a condom • Contraception methods • Chlamydia Testing • Living with HIV • Coming Out • STI's • Herpes real story • Sex over 60 • Vasectomy • HIV real story • HIV & AIDS real story • Hepatitis C • Healthy and fulfilling sex life	http://www.nhs.uk/livewell/sexualhealth/
Resources for Sexual Health and Relationship Education	Various resources/reference materials available to purchase from website	http://www.sresources.co.uk/
Brook Advisory Service	Brook Publications sells an array of sex education resources, training manuals, leaflets and brochures for use by young people, teachers, health professionals, youth workers, sex advice workers and parents.	http://www.brook.org.uk/content/M1_publications.asp
F.P.A (Family Planning Association)	Information booklets relating to detailed information on individual methods of contraception, common	http://www.fpa.org.uk/information

	sexually transmitted infections, pregnancy choices, abortion and planning a pregnancy available to download.	
McCarthy, M Thompson D (revised 1998) Sex and the 3 R's (Second Edition) Right, Responsibility and Risks – A Sex Education Package for working with people with learning difficulties		Published by Pavillion

Appendix 3

Legislation

Sexual Offences Act 2003

The Sexual Offences Act 2003 overhauled the legal framework relating to sexual offences and includes provision to guard against the sexual abuse of children and vulnerable adults. It repealed most of the previous law in relation to sexual offences.

The main provisions of the Sexual Offences Act 2003, relating to vulnerable adults are:

- The Act gives additional protection to children and vulnerable adults
- The definitions of rape is amended to include intentional penetration of the vagina, anus or mouth with a penis and forced sexual penetration of objects
- Significant changes to the issue of consent
- A number of specific offences relating to children under the ages of 13, 16 and 18 years
- New offences to protect vulnerable persons suffering from a mental disorder
- New offences relating to forced sexual activity with anyone and forced self-masturbation
- Touching over clothing may constitute an offence
- The Act is gender neutral
- Discrimination against homosexuals has been removed

Sexual Offences Act (1956)

Section 7.0 of this act makes it unlawful for a man to have intercourse with a woman deemed to be “defective” outside marriage. The circumstances in which the term “defective” applies is purely a matter of clinical and/or legal judgement, but may apply to those with “a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning” e.g. a severe learning disability. This legislation does not apply to a male who is labelled as being “defective”.

This legislation also makes acts, which may amount to actual sexual intercourse, unlawful. Therefore, sections 9and 21 of the Sexual Offences Act make it unlawful for anyone to procure a woman labelled as being “defective” to have sex with a man and for anyone to remove such a woman away from the care of a parent, with the purpose that she shall have sexual intercourse with a man, respectively.

Although the above offences are unlawful by virtue of the act of, procuring of, sexual intercourse occurring outside of matrimony, intercourse with consent (either because consent was not given by the ‘defective’ woman, or she does not possess the capacity to give consent) may amount to an offence of rape both within and outside of matrimony.

Of particular relevance to staff is Section 27 of the Sexual Offences Act. This section makes it an offence for either the "owner, occupier or anyone who acts in the management or control of any premises" to "induce or knowingly suffer a woman who is a defective to resort to or be on those premises for the purposes of having unlawful sexual intercourse".

Human Rights Act (2000)

The Human Rights Act (2000) is intended to create a cultural shift, with rights enshrined in the European Convention of Human Rights permeating the decision making of the government and legal systems at all levels. The act has particular significance for disabled people.

Implications for disabled people:
Article 12 of the Human Rights Act (2000) has implications for some disabled people who are routinely discouraged by health authorities or social services from becoming parents. This may take the form of pressuring pregnant women with a disability to have an abortion. Either their disability is seen as an obstacle to effective parenting or it is feared that their disability is hereditary.

Historically some service users have been regarded by society as being inappropriate parents. For example, a disabled woman who is pregnant may encounter attitudinal discrimination at different levels and from a variety of professional associations. Physical barriers when using antenatal services also present a significant challenge in terms of access. Once a child is born, another series of barriers comes into play, as the need to demonstrate capacity as a parent is required by statutory services.

An individual with mental capacity to make decisions for him/herself has the right to marry and found a family. This may require public authorities, such as residential homes, to take positive steps to enable sexual relations to happen. See Article 8 of the HRA.

NHS & Community Care Act (1990)

In meeting requirements to make individual assessment of need, where appropriate the emotional and sexual health needs of service users should be sensitively considered and regularly reviewed.

Equality Act 2010

The Equality Act 2010 brings together into one Act all previous legislation around Equality and Diversity.

A major feature of the Act is to strengthen and promote two major responsibilities for public authorities, the General Duty and the Socio Economic Duty.

Local Government Act (1988)

Section 28 of the Local Government Act 1988 prohibits elected members of a local authority from intentionally promoting homosexuality or from publishing material with the intention of promoting the teaching in any maintained school of the acceptability of homosexuality as a “pretended family relationship”. Material relating to homosexuality within the context of a sex education programme will not be seen as a breach of the Act or in any way promoting homosexuality.

Definition of illegal pornography

Sections 63-67 of the Criminal Justice and Immigration Act 2008.

Possession of extreme pornographic images

(1) It is an offence for a person to be in possession of an extreme pornographic image

(2) An “extreme pornographic image” is an image which is both :
(a) pornographic, and
(b) an extreme image

(3) An image is “pornographic” if it is of such a nature that it must reasonably be assumed to have been produced solely or principally for the purpose of sexual arousal.

(4) An “extreme image” is an image which:
(a) falls within subsection 5 and
(b) is grossly offensive, disgusting or otherwise of an obscene character

(5) An image falls within this subsection if it portrays, in an explicit and realistic way, any of the following
(a) an act which threatens a person’s life
(b) an act which results, or is likely to result, in serious injury to a person’s anus, breasts or genitals
(c) an act which involves sexual interference with a human corpse, or
(d) a person performing an act of intercourse or oral sex with an animal (whether dead or alive)
(e) and a reasonable person looking at the image would think that any such person or animal was real

(6) In this section “image” means:
(a) a moving or still image (produced by any means); or
(b) data (stored by any means) which is capable of conversion into an image within paragraph (a).

REPORT TO: Health Policy & Performance Board

DATE: 29th May 2012

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults

SUBJECT: Positive Behaviour Support Service Policy, Procedure and Practice

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of the report is to present the Health Policy and Performance Board with the Positive Behaviour Policy, Procedure and Practice document for information.

2.0 **RECOMMENDATION: That the Board Note the contents of the report and associated document**

3.0 **SUPPORTING INFORMATION**

3.1 The Positive Behaviour Support Service (PBSS) is aimed at those service users who have a learning disability and who also present with behaviour that challenges services. The service is available to service users of all ages and there is a specialist children and adult's arm of the service.

3.2 The PBSS exists to :-

- Support mainstream services working with people with learning disabilities, whose behaviour is a significant challenge
- Work directly with people whose behaviour presents the greatest level
- Become a model of excellence at the forefront of evidence-based practice in this service area

3.3 Halton Borough Council is the service provider of the PBSS. A number of stakeholders have provided funding in order to access the service. The stakeholders are as follows:-

- Communities Directorate, Halton Borough Council
- Children and Enterprise Directorate, Halton Borough Council

- NHS Halton and St Helens
- NHS Knowsley
- Knowsley Metropolitan Council
- St Helens Council (adult services only)

3.4 The policy, procedure and practice document has been developed in order to provide information and guidance to stakeholders on how to access the service; who is eligible to receive support from the PBSS and how referrals and assessments will be dealt with by the team.

3.5 The representatives on the PBSS Steering Group from the other stakeholder areas, presented the policy for approval at their relevant boards.

4.0 POLICY IMPLICATIONS

4.1 The PBSS Policy, Procedure and Practice document, should be used in conjunction with the Assessment and Care Management Manual June 2010.

4.2 The PBSS will not hold care management responsibility for service users. This responsibility will still remain with the team/care manager who makes the referral into the PBSS. Therefore, the information and guidance provided in the Assessment and Care Management Manual is still relevant to the operational teams and to the service user.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The PBSS is funded by the Communities Directorate and Children & Enterprise Directorate, Halton Borough Council, NHS Halton and St Helens, NHS Knowsley, Knowsley Metropolitan Council and St Helens Council.

5.2 Representatives from each of the stakeholders are members of the PBSS Steering Group. At the Steering Group, members will receive regular information regarding funding sources and a breakdown of the support the PBSS are providing to each of their client groups.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The PBSS supports children and adults who present with behaviour that challenges services. This service will provide localised support which will eliminate the need to seek out of borough placements and reduce service package costs.

6.2 Employment, Learning & Skills in Halton

None identified

6.3 **A Healthy Halton**

The PBSS supports children and adults who present with behaviour that challenges services. This service will provide localised support which will eliminate the need to seek out of borough placements and reduce service package costs.

6.4 **A Safer Halton**

None identified

6.5 **Halton's Urban Renewal**

None identified

7.0 **RISK ANALYSIS**

7.1 The Positive Behaviour Support Service Policy, Procedure and Practice document should be used in conjunction with the Halton Borough Council Assessment and Care Management Manual June 2010 and any professional Code of Practice workers are registered to adhere to. The document provides information regarding how the service can be accessed and what can be expected. Workers within the Positive Behaviour Support Service will receive regular clinical supervision, to ensure professional practice standards are adhered to at all times.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 An associated Equality Impact Assessment has been completed.

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

None under the meaning of the Act.

HALTON BOROUGH COUNCIL

Communities Directorate and Children & Enterprise Directorate

POSITIVE BEHAVIOUR SUPPORT SERVICE

Policy, Procedure and Practice
February 2012

St.Helens Council

Knowsley Council

NHS Merseyside

CONTENTS

INFORMATION SHEET

Service area	Learning Disabilities
Date effective from	April 2012
Responsible officer(s)	Principal Manager, Positive Behaviour Support Service Policy Officer, People & Communities
Date of review(s)	April 2013
Status: • **Mandatory (all named staff must adhere to guidance)** • **Optional (procedures and practice can vary between teams)**	Mandatory
Target audience	All staff and managers within the Communities and Children & Enterprise Directorates; Halton & St Helens PCT; Knowsley PCT; Knowsley Metropolitan Council and St Helens Council
Date of committee/SMT decision	
Related document(s)	• Assessment and Care Management Manual June 2010
Superseded document(s)	N/A
Community Impact Review and Assessment completed	Completed
Adult Safeguarding Audit Tool Completed	Completed
File reference	

1.0	**POLICY**	***PRACTICE***
1.1	**Introduction** The Positive Behaviour Support Service exists to:- • Support mainstream services working with people with learning disabilities, whose behaviour is a significant challenge • Work directly with people whose behaviour presents the greatest level of challenge • Become a model of excellence, at the forefront of evidence-based practice in this area The Positive Behaviour Support Service is aimed at those service users who have a learning disability and who also present with behaviour that challenges services. The service is available to service users of all ages and there is a specialist children's arm and a specialist adult's arm of the service. Service users and their families residing in Halton, Knowsley or St Helens (please note for St Helens, the service is only available for adult service users) and people receiving services from NHS Halton and St Helens and NHS Knowsley, are able to access the service and Halton Borough Council is the service provider.	
1.1.1	**Background to the development of the service** It was identified that there was a local deficiency in services offering skilled specialist support to people of all ages living in community settings who have a learning disability, often including autism spectrum conditions and who present with behaviour that challenges services. This had sometimes led to a total breakdown in support for the service user, resulting in costly placements at a distance. Frontline services need the availability of expert advice and guidance to improve their service response. The development of a Positive Behaviour Support Service is therefore aimed at some of the most challenging individuals. They are also amongst the most costly to support. High placement costs, borne by NHS (through Continuing Healthcare budgets) and Local Authorities, are justified in terms of the complexity of the service user and the management of risk. However, the quality of provision is uneven and where placements are made out of area, this represents a loss of local resources. By developing a Positive Behaviour Support Service locally it provides a unique support service to those service users presenting with behaviour that challenges services in Halton, Knowsley or St Helens and reduces the financial constraints of seeking out of borough placements in the future.	
1.2	**Service Objectives and Delivery** The overall aim of the service is to reduce the frequency, intensity and duration of undesirable behaviour of people with a learning disability. The service works collaboratively with the service user and their families, front line staff and other professionals to achieve the service's overall aims.	

	In relation to service users who fit the eligibility criteria for the service and where direct intervention has been agreed, the service will: • Contribute to the multidisciplinary assessment of people. The particular focus of the service is to help with the understanding of underlying functions of behaviour that challenges services, parents or carers. • Acquire evidence to support assessment through a variety of techniques including direct observation of behaviour and gathering background information • On the basis of evidence gained through multidisciplinary assessment, contribute to drawing up plans designed to reduce behaviour that challenges services • Directly train frontline staff in the implementation of plans • Deploy staff from the service to work alongside families and frontline staff where deemed necessary • Monitor and review the success of planned interventions, refining them as necessary on the basis of evidence, in all cases working closely with the multidisciplinary team • Provide follow up support after interventions have been agreed and are up and running in order to monitor progress and provide top up training where necessary Direct support of individuals is time-limited, the aim is that frontline staff will be able to assume full responsibility for delivering care and support as specified in the exit criteria. For further details regarding the exit criteria, please see section 2.12 of the policy.	
1.3	**Training** In addition to providing direct support for service users, the Positive Behaviour Support Service also offers a variety of training packages to promote the overall aims of the service. This training can be accessed by request directly to the Positive Behaviour Support Service and such requests shall be reviewed by the team on a regular basis. The types of training offered by the team include the following: • Workshops to raise awareness and skills of professional staff • Generalised training on issues regarding behaviour that challenges services, for frontline staff • Training on specific issues e.g. active support • Problem-solving seminars for whole staff teams • Mentoring of individual staff • Support groups for family carers The Positive Behaviour Support Service will provide a rolling training programme on the Introduction to Applied Behaviour Analysis, this programme will be coordinated through the Corporate Training Centre. The team will also be able to design and deliver bespoke training to individuals or teams. The team may identify additional training needs through their work on individual cases and therefore training events to address these needs, will be held as required. The Positive Behaviour Support Service may signpost individuals to other relevant training.	

	Representatives from the Positive Behaviour Support Service are also involved in the Autism Spectrum Condition Training Sub Group for both children and adults and the Diagnosis Pathway Sub Group, to ensure that the principles of Applied Behaviour Analysis are included in the work of these groups.	
1.4	**Service Availability** The service maintains an administrative base, which can receive incoming telephone, fax and electronic communication between 09:00 – 17:30 Monday to Thursday 09:00 – 16:40 on Friday (excluding public holidays). During these office hours, the service ensures there is an appropriate staff member available to receive referrals and other queries relevant to the functions of the service. There is no expectation for new referrals to be responded to outside of these office hours. Referrals will only be dealt with by the team during office hours. Planned service delivery will be on a flexible basis, arranged around the assessed requirements of people receiving the service. These requirements are likely to result in deployment of staff outside office hours. Support Workers may be required to provide support to individuals or families outside of office hours, dependent upon the case they are involved in. The service must ensure that where staff are deployed outside office hours, back up professional level staff are available on call for the purposes of consultation and support. In addition, the Positive Behaviour Support Service may provide emergency out of hours telephone support to staff, parents and carers. The availability of this additional support will be assessed on an individual case basis and is dependent upon individual need.	
1.5	**Children's Act** The Children's Act 2004 provides the legal basis for how social services and other agencies deal with issues relating to children. These guidelines have been laid down so that all individuals looking after children, be it in the home, the work place, school or other locale, are aware of how children should be looked after in the eyes of the law. The Children's Act 2004 was designed with guiding principles in mind for the care and support of children. These are: • To allow children to be healthy • Allowing children to remain safe in their environments • Helping children to enjoy life • Assist children in their quest to succeed • Help make a positive contribution to the lives of children • Help achieve economic stability for our children's futures This act was brought into being in order for the government in conjunction with social and health services, to help towards common goals. The Act places a duty on local authorities to make arrangements through which key agencies cooperate to improve the wellbeing of children and young people and widen services' powers to pool budgets in support of this. To ensure that, within this partnership	

	working, safeguarding children continues to be given priority. The Act places a responsibility for key agencies to have regard to the need to safeguard children and promote their welfare in exercising normal functions. The Inter-Agency Cooperation element of the Children's Act, ensures that any agency that is aware of the maltreatment of a child – or this misconduct of a child's legal guardian – should make their findings known to other agencies that might have a hand in the protection of a child who would normally go unmonitored. In instances where the Positive Behaviour Support Service may be involved with a person who is aged between 16-18 years, both the Children's Act and the Mental Capacity Act (detailed below) could apply to that individual. It may be applicable in these situations that the appropriate worker within the Positive Behaviour Support Service, contacts Legal Services within Halton Borough Council to clarify which Act should be adhered to.	
1.6	**Mental Capacity Act** Individuals who are 16 and over and who can be shown to lack capacity are protected by the Mental Capacity Act (MCA, 2005). Its amendment, the Deprivation of Liberty Safeguards (DoLS 2008) provides further protection to those who are 18 and above and who also have a disorder or disability of the mind (i.e. who lack capacity). Together, these two pieces of legislation provide a legal framework for acting and making decisions on behalf of vulnerable people, who lack the mental capacity to make specific decisions for themselves. The MCA also aims to ensure that any decision made or action taken on behalf of such an individual will always be made in their best interests. In addition, DoLS ensure that any decision that is taken to deprive someone of their liberty is made according to well-defined processes. These are thoroughly documented and carried out in consultation with specific authorities. These processes also involve assessment, authorisation, care planning and monitoring, which together act in the best interests of vulnerable people who either are or may need to be deprived of their liberty, as a consequence of the care treatment they require.	*Mental Capacity Act Overall Policy, Procedure & Guidance HBC August 2010* *Mental Capacity act DoLS Policy, Procedure & Guidance HBC June 2010* *Careful adherence to these documents will protect both the individuals who lack capacity and those who are working with them. This is provided decision-making processes are fully recorded and decisions justified.* *See also: A Quick Guide to Key Policies and Procedures HBC 2010.*
1.7	**Safeguarding** The service will work in accordance with the Halton Safeguarding Adults Board and the Halton Safeguarding Children's Board policies and procedures relating to safeguarding vulnerable children and adults, for those service users who reside in Halton. For those service users who reside outside of Halton, the Positive Behaviour Support Service will ensure that they adhere to the appropriate Local Safeguarding Children Board or Local Safeguarding Adult Board's procedures, when they have concerns that a child or adult is at risk of harm. The Positive Behaviour Support Service will inform the relevant referral party of any safeguarding issues regarding service users the team are working with. It will be the responsibility of the care manager or social worker of the service user, to deal with any safeguarding issues in accordance with the policies and	*Halton Safeguarding Children's Board Procedures to Safeguard and Promote the welfare of Children October 2007 – Children and Young People's Directorate* *Safeguarding Adults Interagency Policy, Procedures & Guidance 2010 – Adults and Community Directorate* http://www.proceduresonline.com/knowsley/scb/ http://www.knowsley.gov.uk/families/social-care-

	procedures of their relevant Safeguarding Board. The service will report all significant incidents to Commissioners and will provide a quarterly safeguarding report. The Positive Behaviour Support Service Safeguarding Flowchart is included as Appendix 15.	and-health/adults-and-older-people/safeguarding-adults.aspx http://www.sthelens.gov.uk/openfile.htm?id=2027 http://www.haltonandsthelenspct.nhs.uk/pages/publications.aspx?iPageId=11908
1.8	**Information Sharing** In order to place the service at the forefront of best practice, it is expected that the service will establish formal links with a suitable research partner or partners in order to:- • Access expertise not otherwise available to the service • Keep abreast of latest research and practice • Become an active research partner • Offer professional development placements for mutual benefits	
1.9	**Consultation and Feedback** The service engages with relevant local forums such as the Patient Public Involvement Service and the Learning Disability Partnership Board and People's Cabinet, in order to inform and influence service development. The service monitors customer satisfaction through customer satisfaction surveys as specified in the exit criteria and other appropriate methods and also provides details of feedback in annual reports to the Commissioning Managers and Senior Management Team. The managers who will receive annual reports from the Positive Behaviour Support Service are:- • Operational Director Commissioning and Complex Needs Halton Borough Council • Operational Director Children and Families Services Halton Borough Council • Operational Director Partnership Commissioning NHS Halton and St Helens • Senior Commissioning Manager NHS Halton and St Helens • Operational Director Child and Family Health Commissioning NHS Halton and St Helens • Head of Children, Family and Maternity Services Commissioning • Head of Integrated Commissioning – Self Directed Support Knowsley Metropolitan Council • Assistant Director of Commissioning Children and Family Services Knowsley Metropolitan Council • Director of Commissioning Knowsley Metropolitan Council • Assistant Director, Commissioning and Business Support St Helens Council	
1.10	**Outcomes and Monitoring** Halton Borough Council, as the Service Provider, monitors and	

	records the following activity information:- • Details of staff employed, including contracted hours, qualifications, training undertaken, salary costs and expenses • Numbers and type of referrals received, how referrals are categorised and response times • Analysis of referrals by gender, age and ethnic background • Analysis of referrals by normal domicile, including type of accommodation and which Borough • Duration, intensity and level of involvement following referral • Team and individual workloads • People waiting for a service • Details of indirect services provided • Numbers and type of training events and numbers attending Halton Borough Council, as a Service Provider, also monitors and records the following outcomes:- • Quantitative comparisons pre-intervention and post-intervention of the frequency, intensity and duration of identified behaviours that challenge services, for each person receiving a direct intervention • Quantitative comparisons pre-intervention and post-intervention of the community participation of each person receiving a direct intervention • Qualitative feedback from referrers following intervention • Quantitative comparisons pre-intervention and post-intervention of the service cost of each person receiving a direct intervention.	
2.0	**PROCEDURE**	***PRACTICE***
2.1	**Referral Pathway for Children** To ensure that the referrals to the Positive Behaviour Support Service are the most appropriate, there will be a closed referral pathway. Please refer to Appendix 4 for the referral pathway flowcharts. The referral pathway is a working progress and its effectiveness will be monitored and reviewed accordingly. Referenced below are the referral pathways to be followed in Halton. Knowsley and St Helens will have their own referral pathways, which are currently under development and may be subject to change. The effectiveness of these referral pathways will be monitored by the Positive Behaviour Support Service on an ongoing basis. <u>Direct Referral Pathway</u> A direct referral for a child to the Positive Behaviour Support Service would be received from a Children's Social Care Team. Children who are receiving an active service from a children's social work team, can be referred directly via the following methods:- • Via their own social worker • By agreement at a Care Planning meeting/Child in Need	*<u>Referrals and Consultations 2008 – Children and Young People's Directorate</u>* *<u>Referrals & Assessment Standards 2008 – Children and Young People's Directorate</u>* *<u>Referral, Assessment & Planning 2008 – Children and Young People's Directorate</u>*

meeting or Child Protection meeting
- Via the Complex Care Panel

(Please note, if a decision is taken at a Care Planning, Child in Need or Children Protection Meeting or at a Complex Care Panel, the allocated social worker for the case is responsible for completing a referral form and submitting this to the Positive Behaviour Support Service).

Children receiving an active service from Child and Adolescent Mental Health Services or the Integrated Behaviour Support Team, can be referred to the Positive Behaviour Support Team, if it is felt that the Positive Behaviour Support Team can provide support that is better suited to that child's needs. It must be noted that the Positive Behaviour Support Service can refer back to Child and Adolescent Mental Health Services or the Integrated Behaviour Support Team if it is felt that either of these teams is more suited to that child's needs. There may be occasions which require joint working between either of these teams and the Positive Behaviour Support Service or where a child has met the Positive Behaviour Support Service exit criteria and the Integrated Behaviour Support Team, can pursue maintenance of effective intervention.

Children who are going through the Autism Spectrum Condition diagnosis pathway can also be referred to the Positive Behaviour Support Service, as part of the Early Intervention arm of the service.

<u>Indirect Referral Pathway</u>

The Integrated Working Support Team and the Disabled Children's Service will not be able to make a direct referral to the Positive Behaviour Support Team for Level A response (please see section 2.6 for further details on response levels). However, if staff from these teams identify that a referral to the Positive Behaviour Support Service may be beneficial, they can instigate a referral via either of these two routes:-

- By making a referral for the child to the social care team, who if applicable, can then make a referral for a Level A Response (please note, it is likely that the majority of children who would require a Level A response will be active within the social care team already)
- By making a direct referral for a Level B response. The Positive Behaviour Support Service will be able to make a professional judgement to upgrade a Level B response to a Level A if deemed appropriate. However, this should not be used as a "quick route" to the service. Referrals requiring a Level B response could also come via a Common Assessment Framework (CAF).

In relation to referrals from school professionals, these referrals should be processed by a Head Teacher. Head Teachers can only process referrals for children via their social worker, they will not be able to make a referral directly to the Positive Behaviour Support Service themselves. It is also recommended that the Educational Psychologist for the school is also consulted about

	the referral being made. An Educational Psychologist for the school can make an indirect referral to the Positive Behaviour Support Service via the social worker for the child. If a child does not have a social worker, the Head Teacher must first approach the Educational Psychologist for the school, in the first instance. The Educational Psychologist can then take the decision to make a referral for a Level B response, directly to the Positive Behaviour Support Service or via the Integrated Working Support Team or Common Assessment Framework (CAF).	
2.2	**Referral Pathway for Adults** Referrals to the Positive Behaviour Support Service for service users aged 18 years and above can be received from the following teams:- • Adults with Learning Disabilities Team – Halton Borough Council • Intensive Community Health Support Team – NHS Halton and St Helens • Community Learning Disabilities Services – Knowsley Metropolitan Council • Knowsley Integrated Provider Services • 5 Boroughs Partnership NHS Foundation Trust • Learning Disabilities Team – St Helens Council Any service user who requires input from the Positive Behaviour Support Service will be referred to the team by their current Care Manager. There may be cases where more than one team member will be involved with a service user, in order to ensure all of their needs are being met sufficiently. It must be noted that members of the Positive Behaviour Support Service, will not hold overall care management responsibility for a service user as the team does not have the capacity to care manage a case load. There may be a requirement for a member of the Positive Behaviour Support Service (Principal Manager or Practice Manager) to attend an Allocation Meeting or a Discharge Planning Meeting for a service user, to ensure that intervention from the Positive Behaviour Support Service is appropriate. Referrals made from Knowsley Metropolitan Council, will be identified at fortnightly allocation meetings. It is assumed that prior to all adult referrals to the Positive Behaviour Support Service, the care manager will have sought consent from the service user in the most appropriate way. The referral pathway is a working progress and its effectiveness will be monitored and reviewed accordingly. The referral pathway for St Helens is still currently being developed and is not completed as yet. Please refer to Appendix 5 for the Adult's Referral Pathway Flowchart.	*Assessment and Care Management Manual June 2010 – Adults and Community Directorate*
2.3	**Receipt and Allocation of Referrals** The Care Manager making the referral to the Positive Behaviour Support Service, for a child or adult, will be required to complete a referral form (see Appendix 6). This form can be submitted electronically via a secure email server, with the referral form being both password protected and encrypted, or submitted via post or secure fax facility. All referrals will be recorded on CareFirst 6, along with any subsequent assessment and service	

	package details for the client. In terms of the support the Positive Behaviour Support Service can provide, there are four key areas in which referrals will be prioritised under:- (1) Early Intervention (particularly in relation to Children's Services) (2) Crisis Prevention/Management (3) Technical Support (4) Placement Development The Positive Behaviour Support Service will acknowledge receipt of referrals within 24 hours (if a referral is received on a Friday, it will be acknowledged by the following Monday, except in the instances where a Bank Holiday occurs). When a referral is received by the team, the Principal or Practice Manager of the Positive Behaviour Support Service will consider it on the day of receipt. The review of the referral by the Principal or Practice Manager, will confirm eligibility for the service and will determine the response level required. Once the referral has been reviewed by the Principal or Practice Manager and deemed eligible and assigned the appropriate response level, the case will be dealt with by the Principal or Practice Manager or passed to a Behaviour Analyst within the team. The allocated worker must make contact with all relevant parties within the agreed response times. The allocated worker will complete a reviewing form (see Appendix 7).	
2.4	**Case Recording** Records will be stored in accordance with the Halton Borough Council Case Recording Policy.	*Case Recording Policy June 2010 – Adults and Community Directorate* *Access to Personal Records May 2006 – Children and Young People's Directorate* *Joint Working on Cases between Adults and Older People's Services and Children's Social Care Policy, Procedure & Practice January 2011*
2.5	**Eligibility Criteria** In assessing eligibility to access the Positive Behaviour Support Service, multiple factors are likely to be present and decisions as to whether the criteria are met remain a professional judgement that will be made by the Positive Behaviour Support Service. If subject to a dispute, there is a procedure in the case of disagreement (for further details, please see section 2.9 of the policy). The broad eligibility criteria for a child or adult to receive the service are that, the child or adult should present with behaviour that challenges services, associated with moderate or severe learning disability, including conditions such as autism spectrum conditions. There must also be continuing active involvement of a referring professional team.	

	The service will be expected to prioritise its limited resources on the most extreme manifestations of behaviour that challenges services. The behaviour should therefore be such that it jeopardises the physical safety of the child or adult service user or others, or seriously limits access to ordinary community facilities. Examples of behaviour are: aggression, self injury, inappropriate public sexualised behaviour, behaviour directed against property, repetitive behaviours and elective incontinence but this is not an exhaustive list. The frequency, intensity and duration of the behaviour that challenges services are factors that will influence a professional decision about eligibility. Non-direct services, such as mentoring support and support to family carers should be mainly targeted to indirectly support people meeting the broad eligibility criteria. However, where capacity allows and the expertise of the service can benefit a wider group, these services may be offered more widely. For example, some individuals with autism spectrum conditions will not have a learning disability but may come into consideration for provision of a non-direct service from the Positive Behaviour Support Service e.g. staff training centred on that individual. The assessment criteria is likely to consider multiple factors, the decisions as to whether the criteria are met remain a professional judgement that will be made by the service, however, this will be subject to a dispute procedure in the case of disagreement. The Principal Manager of the Positive Behaviour Support Service will be able to make a professional judgement, whether the service user would benefit from the service. If the eligibility criteria for the service is not met, access to the service will be at the discretion of the Principal Manager of the Positive Behaviour Support Service.	
2.6	**Response Levels for Referrals** **Level A Response** – *Level A response is described as a referral which requires a direct response for full assessment and intervention from the service. The criteria required to assign a Level A response are as follows:-* • Level A response will constitute a Functional Assessment (See Appendix 8) with reports, the development and dissemination of multi-element intervention plan, careful analysis of collected data and monitoring of progress, planning for service withdrawal, planning for transition and conduction of follow up procedures. • Level A response should be provided for the more complex and serious cases • A service user should be engaging in behaviours that challenge services. These behaviours should be considered with regards to frequency, intensity and duration. Also, consideration should be given to the impact of the service user's life and also the lives of others in the service user's daily environment. • A service user should not be disregarded for low frequency behaviours that have a high intensity or duration	

i.e. behaviours that do not happen very often but when they do, are extremely serious, such as occasional episodes of aggression. Nor should a service user be disregarded for low intensity but high frequency behaviours i.e. not overly serious behaviours but ones that happen so frequently they impact on the service user's life (and others) is of concern.

- Behaviour that challenges services can include: Self Injurious Behaviour (SIB), aggression, elective incontinence, behaviour directed against property, repetitive behaviours, inappropriate public sexualised behaviours.

- Any behaviour that poses a meaningful risk of harm (service user or other) or placement breakdown should be given a Level A response.

- It will be unlikely that a service user who has previously accessed the Positive Behaviour Support Service for a Level A response, will be given a Level A response again. A level B/C response would probably be more appropriate, however, there may be exceptions to this and professional judgement will always be used.

- On occasion, a service user may be assigned a Level A response, however, may need medical assessment to rule out biological conditions before a functional assessment can commence.

Level B Response – *Level B response is described as a referral which requires ongoing mentoring of staff from other agencies. The criteria required to assign a Level B response are as follows:-*

- Level B responses will consist of training and mentoring of staff from other agencies. For Children's Services, other staff and agencies could include: schools and education staff, care staff, social worker/community care workers and any other staff groups identified as the service develops. For Adult's Services, other staff and agencies could include: day services, care staff, supported housing staff, social worker/community care worker and any other staff groups identified as the service develops.

- Parents/carers would be able to access training and mentoring services through local schools or via parent support groups.

- Level B response will be given to a service user who does not require a Level A response, but would still benefit from access to the service. This may involve a service user whose behaviour that challenges services does not currently present a risk of harm or placement breakdown or a service user who has previously had a Level A response from the Positive Behaviour Support Service.

- Level B responses will consist of an identification of

	training needs and the design and implementation of such training. Also, ongoing mentoring of staff/parents/carers and the monitoring of transfer of training into practice. • Level B responses can be upgraded to a Level A response at anytime if deemed necessary • Level B referrals can be made by completing a Level B training referral request form **Level C Response** – *Level C response is described as a referral which requires one off consultation for advice and support. The criteria required to assign a Level C response are as follows:-* • Level C responses will consist of one off consultations for advice and support. The Positive Behaviour Support Service will be piloting a field based assessment process. The field based practice involves service providers gathering information on service users they work with, who present with behaviour that challenges services. The Positive Behaviour Support Service will provide a one off consultation with the service provider, regarding their findings from the information provided and suggestions for possible interventions to be used. **Level D Response –** *Level D response is described as a referral which requires a redirection to other services. The criteria required to assign a Level D response are as follows:-* • The service user will be excluded in some way from the eligibility criteria and a professional judgement is made that the Positive Behaviour Support Service would be of no benefit • Professional judgement will conclude the service user is not engaging in behaviour that challenges services that would warrant input from the Positive Behaviour Support Service. • The service user would benefit from an alternative service. • Appropriate consent has not been given. • Professional judgement concludes that any behavioural treatment would not be in the best interest of a service user.	
2.7	**Priority Levels for a Level A response** For all referrals received by the Positive Behaviour Support Service which are assigned a Level A response, will then be prioritised using the following levels:- **Priority Level 1** – Imminent threat of harm or placement breakdown, requiring urgent assistance. <u>Response Time:</u> Engagement with referrer and service user within 24 hours of receipt of referral, with urgent multi-disciplinary meeting arranged as soon as possible thereafter. Start of Functional Assessment within 5 working days of receipt of referral.	

	Priority Level 2 – Likely threat of harm of placement breakdown requiring assured response. Response Time: Engagement with referrer and service user within 48 hours of receipt of referral, with multi-disciplinary meeting arranged within 5 working days thereafter. Start of Functional Assessment within 5 working days of receipt of referral. **Priority Level 3** – Possible threat of harm or placement breakdown requiring considered analysis. Response Time: Engagement with referrer and service user within 48 hours of receipt of referral, with further action negotiated on merit. Start of Functional Assessment (if appropriate) within 5 working days of receipt of referral. In all cases following referral, it is the responsibility of the Positive Behaviour Support Service to communicate effectively and in a timely manner with referrers and other interested parties. Members of the team will strive to meet the timescales as specified above, however, during times when the team is working to full capacity these timescales will need to be reviewed. During times when the Positive Behaviour Support Service is operating a waiting list of referrals, the team will acknowledge receipt of referral and a formal response to the referral will be provided at the earliest opportunity. Please note that during such periods when the team is working to full capacity, a response may be not be received for a significant amount of time.	
2.8	**Care Planning** Functional Assessment – Stage 1: • A Functional Assessment will be completed on all service users referred to the Positive Behaviour Support Service, who have been assigned a Level A response • A Functional Assessment is used in order to measure and categorise the different types of behaviours • All presenting behaviours that occur frequently or are of a particular intensity or duration will be grouped together, there are a maximum of five classes in which behaviours can be grouped together. • For each class of behaviour, there are a series of questions to be answered in order to discover more detail about the behaviour that challenges services being presented. • A supplementary set of questions are also required to be answered during this assessment to gather further information around behaviour types and what constitutes their usual behaviour in certain situations. • A Preliminary Reinforcement Assessment is carried out in order to ascertain what the service user's likes and dislikes are in everyday life. Functional Assessment – Stage 2: • The second section of the Functional Assessment focuses	*Restrictive Physical Interventions Common Framework, Joint Policy, Procedure and Practice for Professionals working with Adults of All Ages Revised August 2010 Adults and Community* *Care Management Risk Assessment June 2010 - Assessment and Care Management Manual – Adults and Community* *Assessment and Care Management Manual June 2010 Adults and Community*

on environmental factors.

- The characteristics of the environmental settings the service user is exposed to are assessed, such as, questions regarding the types of building the service user spends time in, the security levels of the building and how it is furnished.

- The physical conditions of the environment, such as heat and light levels are assessed.

- How the service user communicates and how they control their environment in addition to questions regarding activities they are engaged in and lifestyle choices are also taken into account.

- In conjunction with the Functional Assessment, Questions About Behavioural Function (see Appendix 9) and the Motivation Assessment Scale (see Appendix 10) are completed in order to classify and categorise the behaviours which are presented by the service user.

- Once the Functional Assessment is completed, the responses provided then shape a Person Centred Behaviour Assessment and Intervention Plan.

<u>Intervention:</u>
The service helps the service user to acquire alternatives to behaviour that challenges services, to cope with events that evoke behaviour that challenges others. Common examples of person-focused intervention involve helping the service user to increase their general skills; to develop expressive communication; to use socially appropriate alternatives to behaviour that challenges services and to adopt specific coping strategies.

In relation to environmental factors, the service helps the service user to restructure their social environment to avoid situations that evoke behaviour that challenges services. This may include:-

- Enriching the environment to create more opportunities for social interaction
- To make learning easier and more efficient
- To increase opportunities for engagement in activity e.g. domestic, social, leisure or employment
- To manage task presentation and academic demand carefully
- Ensure reasonable access to tangibles such as food, drink and activity materials

<u>Maintenance:</u>
Following the implementation of the intervention plan, the Positive Behaviour Support Service will plan for the maintenance of behaviour change by ensuring:-

- Withdrawal of specialist staff is graduated as they hand over to the mainstream service staff

	• Interventions are embedded within the practice of the service and it's staff prior to withdrawal • Follow up for the purposes of monitoring and data reviewing Comprehensive hand over by Positive Behaviour Support Service when referrals are made to other relevant professionals.	
2.9	**Disputes** If a disagreement arises between the service and a referring team concerning the allocation of a referral or in the event of any other disagreement about the service arrangements, it should be referred to the Principal Manager of the Positive Behaviour Support Service and the referring team for resolution. If the disagreement remains unresolved, it should be referred to appropriate senior managers within the relevant organisations.	
2.10	**Consent** As the Positive Behaviour Support Service will have a specialist children's arm and an adult's service arm, there is a requirement of informed consent to be sought when a service is proposed for a service user who is aged under 18 years. Following a referral to the service for a child or young person aged under 16, who meets the eligibility criteria and are presenting with behaviour that challenges services, if the allocated worker proposes an intervention plan to work with this service user then informed consent must be sought. This consent enables the Positive Behaviour Support Service to share information with other agencies/services as appropriate in order to implement the Intervention Plan for the service user successfully. As the child or young person is aged under 16, consent must be sought from the person who has parental responsibility. A copy of the consent form to be signed can be found in Appendix 11. For referrals relating to service users aged 18 years or over, no consent form is required for the adult arm of the service as these service users are able to provide consent independently. The social worker who has made the referral to the Positive Behaviour Support Service, is responsible for assessing the mental capacity of the service user. The mental capacity of the service user, if aged 18 or over, is used to judge if the service user is able to provide consent independently. The social worker is responsible for seeking consent from the service user, prior to making a referral to the Positive Behaviour Support Service. Once the Positive Behaviour Support Service have completed a Functional Assessment with a service user, the team will ask the service user to consent to the planned intervention resulting from the assessment process, before implementation. Each service user (or the person who holds parental responsibility for the service user if aged under 16) must also sign an Information Sharing Checklist along with the allocated worker from the Positive Behaviour Support Service (see Appendix 12). The Information Sharing Checklist is signed by the allocated worker from the Positive Behaviour Support Service to state they have shared the relevant information with parents/carers so they are fully informed of the service being provided.	
2.11	**Service Provision** <u>Level A Response:</u> Following a Level A response referral, requiring a Functional	

	Assessment, a Person Centred Behavioural Assessment and Intervention Plan (see Appendix 13) will be developed by the Behaviour Analyst allocated to the service user. Behaviour Analysts look for relationships between behaviour and environment in order to help the service user change his or her behaviour by changing aspects of their environment. Rather than suppressing behaviour that challenges services, Behaviour Analysts will work with the service users to seek ways to teach alternative behaviours that have the same results or consequences. To do this, the Behaviour Analysts need to understand the relationship between behaviour and environmental events that are important and relevant to the individual. The service will be able to structure opportunities to make learning easier for people who otherwise find it difficult. Once the Person Centred Behavioural Assessment and Intervention Plan have been drafted by the Behaviour Analyst, this will be validated by the Consultant Behaviour Analyst or Principal Manager of the Positive Behaviour Support Service. The validated plan will then be checked for contextual fit with the service user. The self assessment for contextual fit (see Appendix 14) is used to ensure that the elements of the proposed Person Centred Behavioural Assessment and Intervention Plan fits the contextual features of the client's environment. The service user is asked to rate the plan in relation to their knowledge of what they are expected to do to implement the plan; how the plan fits with the personal values and skills and how well they feel they will be able to implement the plan successfully. The Behaviour Analysts will then discuss with the service user if any changes are required to be made to the Intervention Plan in light of the Contextual Fit Assessment. <u>Level B-D Response</u> For those referrals to the Positive Behaviour Support Service which are allocated a response level B, C or D, a Functional Assessment is not required. For these referrals, the type of service required for the service user/agency making the referral is to receive training, mentoring or signposting to other services. These referrals will be reviewed by the Principal or Practice Manager of the Positive Behaviour Support Service and will be responded to by an allocated worker.	
2.12	**Exit Criteria** In order for the Positive Behaviour Support Service to withdraw from providing technical support intervention to a service user or to staff members in receipt of training, the exit criteria will be dependent on:- • All staff/family members should be trained to competency and feel confident in implementing the intervention plan. The contextual fit meeting will address the issue of staff confidence. • Uncertainties among family and staff teams should have been addressed and resolved. • Staff/family members should be observed to be	*Prevention of Exclusion from Services Policy – under revision, Communities Directorate November 2011*

	consistently and appropriately implementing the intervention plan (proactive and reactive strategies) • Data on target behaviours should be showing a therapeutic trend – reduced and stable or continuing to reduce in frequency/duration/intensity. Functional Assessment Interview should be consulted for hypothesised rates of behaviour reduction. • Strategies should be in place for the training of new staff to agreed levels of consistency including theory training, staff overlaps, observations and feedback • Positive Behaviour Support Service staff to conduct two follow up visits approximately one month apart and be satisfied that: <u>School/Short Break/Supported Housing Settings/Other Settings:</u> • Staff adherence to interventions is being maintained at the agreed level • Manager is confident and accurate in the ongoing monitoring of the staff implementing intervention. <u>Home Settings:</u> • Parent/carer is confident in implementing the intervention • Concerns and anxiety of the parent(s)/carer(s) is reduced. <u>Termination of Service Criteria:</u> The Positive Behaviour Support Service can terminate access to the service for the following reasons: (1) Persistent unreasonable deviation from the agreed intervention plans by staff/parents/carers or the use of contradicting interventions, despite support provision. (2) Persistent cancellation of appointments (more than 3 cancellations) (3) Physical or verbal abuse directed towards any Positive Behaviour Support Service staff members	*Termination should not be the first action. For Termination of Service Criteria number 1 and 2, a review should be offered. The purpose of the review would be to highlight, discuss and hopefully resolve any practical issues there may be that are hindering whether the ability to conform to the intervention plan or to attend appointments e.g. illness. Termination of Service criterion number 2, would be considered on an individual basis in the context of risk towards staff.*
2.13	**Clinical Supervision** All members of staff within the Positive Behaviour Support Service will be supervised on an ongoing basis. The Principal Manager of the Positive Behaviour Support Service will supervise team members in accordance with the Halton Borough Council Supervision Policy, Procedure and Practice. The Principal and Practice Manager of the Positive Behaviour Support Service will	*Supervision Policy, Procedure and Practice April 2010 – Adults and Community*

	be supervised by the Consultant Behaviour Analyst in accordance with the Halton Borough Council Supervision Policy, Procedure and Practice. Some members of the Positive Behaviour Support Service will be working towards the following qualifications of Board Certified Assistant Behaviour Analysts or working towards Board Certified Assistant Behaviour Analyst accreditation and are therefore eligible to be supervised by the BCBA qualified Principal Manager. If Behaviour Analysts are working on a case of which they have no previous experience, they will be able to work with this service user but under the clinical supervisions of the Senior Behaviour Analyst.	
2.14	**Out of Borough Placements** There may be situations where the Positive Behaviour Support Service is working with service users who are placed out of borough. If the intention is to work with this service user to support them to move back to Halton, each case will be reviewed on an individual basis. The review of cases and the procedure to be followed to bring the service user back into borough, will involve the care managers and key workers involved with the individual, family members and carers. The overall management of an out of borough placements lies with the care manager of the service user.	
2.15	**Review Process** The effectiveness and success of the Person Centred Behavioural Assessment and Intervention Plan will be subject to review by the allocated worker. The timescale for reviewing the Intervention Plan will alter on an individual basis and will be dependent upon the behaviour that challenges services being presented, its intensity and duration and environmental factors affecting behaviours. All decisions regarding the interventions to be put into place and the timescales for review, will be data driven and stipulated in the Intervention Plan. This practice adheres to Behaviour Analyst Certification Board guidelines and Applied Behaviour Analysis (http://www.bacb.com/index.php?page=57) The Care Manager who has referred the service user to the Positive Behaviour Support Service will be able to track the progress of the service user via CareFirst 6. The assessment process has been developed in CareFirst 6, as a series of drop down lists to track progress through the Functional Assessment process and will enable the Care Manager to view what parts of the assessment have been completed. For Care Managers who do not have access to Carefirst 6, they will be able to request an update on their clients from the Positive Behaviour Support Service. This information will be delivered in adherence to data protection and client confidentiality guidelines.	
2.16	**Carers** If during the assessment process or service provision stage of accessing the Positive Behaviour Support Service, a worker within the team identifies that there is a requirement for a carers assessment to be carried out, a referral will be made in accordance with the Halton Borough Council Carers Assessment Policy. For carers who are identified outside of Halton, they will be referred to the relevant local authority to request a carers assessment.	*Assessment and Care Management Manual June 2010 Adults and Community Directorate*

2.17	**Compliments and Complaints** If the service user or family member is unhappy with any aspect of the service provided, or the way in which the referral/assessment process has been carried out, they will be able to make a complaint through the complaints process of Halton Borough Council. If the service user or a family member would like to compliment the service received, they can also do this through the compliments process of Halton Borough Council.	*Compliment and Complaint Factsheet for Adults and Community* *http://intranet/documents/handcdocs/complaints/kaingacomplaintorcompliment?a=5441* *Complaints, Comments and Compliments Children and Young People's Directorate* *Complaints, Comments and Compliments Joint Protocol July 2010 Children and Young People and Adult and Community Directorates.*

APPENDIX 1

GLOSSARY OF TERMS

Term	Definition
ABC recording	A method of recording what happened just before and just after instances of challenging behaviour
Abolishing operation	A decrease in the reinforcement effectiveness of an object or event caused by an establishing operation
Active Support	Active Support is a proven model that supports people with learning disabilities to plan the best use of their time, with the correct level of support, to engage or participate in all activities that make up day-to-day living. It is an evidence-based set of primary procedures that have been specifically designed for supporting people with severe disabilities and behaviour that challenges. It is a set of proactive strategies to improve the quality of person's environment so that the possibility of challenging behaviour occurring is in some cases avoided or reduced. Active support works well with people with learning disabilities and sensory impairment and for people who have no behaviour that challenges. It improves the quality of life of service users by showing support staff, managers and organisations how to support a more proactive way.
Applied Behaviour Analysis (ABA)	Applied Behaviour Analysis is a scientific approach to controlling and predicting behaviour. Behaviour Analysts focus on the observable relationships between behaviours and the environment. By identifying a relationship between a behaviour and the environment through functional assessment, Applied Behaviour Analysis principles can be applied to change that behaviour. ABA interventions are most universally used in the treatment of individuals who have a learning disability or developmental disorder.
Antecedent	An environmental condition or stimulus change existing or occurring prior to the behaviour of interest.
Automatic Reinforcement	Reinforcement that occurs without the involvement of other people
Aversive Stimulus	A stimulus change or condition that evokes behaviour that has terminated it in the past, that functions as a punishment when presented following behaviour, or as reinforcement when withdrawn following behaviour
Avoidance (contingency)	A contingency in which a response prevents or postpones the presentation of a stimulus
Backward Chaining	A teaching procedure in which a trainer completes all but the last behaviour in a chain, which is

	performed by the learner, who then receives reinforcement for completing the chain. When the learner shows competence in performing the final step in the chain, the learner emits the final two steps to complete the chain and reinforcement is delivered. This sequence is continued until the learner completes the entire chain independently.
Baseline	A measure of behaviour before intervention takes place against which interventions are judged
Behaviour	Everything that a person does that involves movement through space and time
Behaviour directed at property	Destruction or spoiling of objects, buildings or public space or own "private" space/property
Behaviour duration	The amount of time behaviour occupies as a proportion of observed time
Behaviour intensity	The magnitude or strength of behaviour e.g. from a tap to a slap
Behaviour rate	The number of occurrences of behaviour per unit of time
Challenging Behaviour	Culturally abnormal behaviour of such frequency intensity and duration that safety of person or others is placed in jeopardy or behaviour that limits or denies access to and use of ordinary community facilities. The most common forms of challenging behaviour are physical aggression, self-injury, damaging property, repetitive body movements and inappropriate vocalisation. It is estimated that 10-15% of people with a learning disability engage in challenging behaviour. The most common forms are aggression, self-injury, vocalisation and stereotypy (Emerson)
	Behaviour can be described ad challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead the responses that are restrictive, aversive or result in exclusion (Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, 2007)
Conditioned reinforcer	A stimulus change that functions as a reinforcer because of prior pairing with one or more other reinforcers: sometimes called secondary or learned reinforcers
Consequence	An object or event that follows behaviour and alters the likelihood that the behaviour will occur again in the future
Contingency	Refers to dependent or temporal relations between operant behaviour and it's controlling variables
Contingent	Describes reinforcement or punishment that is delivered only after the target behaviour has occurred

Continuous recording/measurement	Measurement conducted in a manner such that all instances of the response class(es)
Covert behaviour	Behaviour that is observed/experienced by the individual only and not other people – private events
Deprivation-satiation	Strengthening and weakening effects of reinforcing properties of an object or even with regard to the motivative establishing operation
Descriptive functional assessment	Direct observation of problem behaviour and the antecedents and consequences under naturally occurring conditions
Differential reinforcement of alternative behaviour (DRA)	A procedure for decreasing problem behaviour in which reinforcement is delivered for a behaviour that serves as a desirable alternative to the behaviour targeted for reduction and withheld following instances of the problem behaviour
Differential reinforcement of incompatible behaviour (DRI)	A procedure for decreasing problem behaviour in which reinforcement is delivered for a behaviour that is topographically incompatible with the behaviour targeted for reduction and withheld following instances of the problem behaviour
Differential reinforcement of other behaviour (DRO)	A procedure for decreasing problem behaviour in which reinforcement is contingent on the absence of the problem behaviour during or at specific times
Direct observation	When an experienced behaviour analyst observes events as they occur in the natural environment
Discriminative stimulus	A change in the presence of an object or event that signals a change in the availability of some other object or event that has reinforcing properties
Ecological assessment	An assessment protocol for obtaining data about complex interrelationships between behaviour and environment across multiple settings and persons
Engagement	Doing something constructive with materials (e.g. vacuum cleaning a floor), interacting with people (talking or listening to them), taking part in a group activity (watching the ball and running after it in football)
Environment	The circumstances in which the organism or part of the organism exists. Behaviour cannot occur in the absence of the environment
Escape behaviour	A contingency in which a response terminates (produces escape from) an ongoing stimulus
Establishing operation	A motivating operation that establishes reinforcement
Extinction	Discontinuing reinforcement of a previously behaviour until is reaches pre-reinforcement levels or ceases altogether
Extinction burst	An increase in the frequency of responding when an extinction procedure is initially implemented

Forward Chaining	A method for teaching behaviour that begins with the learner being prompted and taught to perform the first behaviour in the task analysis: the trainer completes the remaining steps in the chain. When the learner shows competence in performing the first step in the chain, he is then taught to perform the first two behaviours in the chain, with the trainer completing the chain. The process is completed until the learner completes the entire chain independently
Functional relations	The relationship between behaviour and environment: When an instance of behaviour results in a change in the environment which affects the future probability of the behaviour being repeated in future. Aspects of the social environment known to influence challenging behaviour are: the presence of aversive task demand or unwanted social attention, and the absence of social attention or a tangible item.
Functional assessment	A systematic investigation that identifies and describes functional relations. Aspects of the social environment that are most likely to influence the future occurrence of challenging behaviours may then be altered to make challenging behaviour a less likely occurrence
Functional assessment interview	An outline of questions that an experienced behaviour analysts uses to explain the occurrence and non-occurrence of challenging behaviour
Functional behaviour assessment	A way of collecting and analysing data about the function (purpose) of challenging behaviour before designing interventions to ameliorate its effects
Functional communication training	Replacing problem behaviour with another (specified) behaviour that services the same function
Generalisation	The transfer of learning from one situation to another and of maintaining learned behaviour over time
Indirect observation	When someone observes events as they occur in the natural environment on behalf of an experienced behaviour analyst
Intervention plan	A personalised document that specifies in what way specific aspects of the social environment should be changed and how the effects of change will be evaluated
Learning disability	A state of impaired intellectual functioning that normally becomes apparent in childhood and is associated with deficits in learning, maturation and social development
Learning history	A historical pattern of behaviour-consequence relations that is unique to every individual according to his or her interactions with the

	environment
Motivative operation	The presence or absence of an object or event that (a) momentarily establishes reinforcing properties in a particular object or event, and (b) evokes behaviour that contacts the object or event
Negative punishment	An object of or event that when removed following behaviour and has the effect of reducing the likelihood that the same behaviour will occur again in future
Operant behaviour	Behaviour that is selected, maintained and brought under stimulus control as a function of its consequences
Over correction	A behaviour change tactic based on positive punishment in which, contingent on the problem behaviour, the learner is required to engage in effortful behaviour directly or logically related to fixing the damage caused by the behaviour
Overt behaviour	Behaviour that can be observed (seen, heard, felt) by an observer
Partial interval record	A method for keeping track of when behaviour occurs in which the presence or absence of behaviour is recorded and within a pre-determined interval of time
Positive punishment	An object of or event that when presented following behaviour and has the effect of reducing the likelihood that the same behaviour will occur again in future
Positive reinforcement	An object of or event that when presented following behaviour and has the effect of increasing the likelihood that the same behaviour will occur again in future
Rating scales	A series of questions that yield a score indicating the most likely explanation for the occurrence of challenging behaviour
Repetitive Behaviours	Certain patterns of behaviour that are displayed on numerous occasions and on an ongoing basis
Response Cost	The contingent loss of reinforcers e.g. a fine producing a decrease of the frequency of behaviour: a form of negative punishment
Self Injurious Behaviour	Any behaviour initiated by the individual which directly results in physical harm to that individual. Physical harm includes bruising, lacerations, bleeding, bone fractures and breakages and other tissue damage
Stimulus Control	A situation in which the occurrence of behaviour is altered by the presence or absence of an antecedent stimulus
Target Behaviour	A (response) class selected for intervention
Task analysis	The process of breaking a complex skill or series of behaviours into smaller, teachable units; also refers to the result of this process

Three term contingency	The basic unit of analysis in the analysis of operant behaviour; encompasses the temporal and possibly dependent relations among an antecedent stimulus, behaviour and consequence
Time Out (from positive reinforcement)	The contingent withdrawal of the opportunity to earn positive reinforcement of the loss of access to positive reinforcers for a specified time: a form of negative punishment
Topography	The physical form or shape of behaviour
Unconditioned reinforcement	A stimulus change that increases the frequency of any behaviour that immediately precedes it irrespective of the organisms learning history with the stimulus. Also called – primary reinforcer or unlearned reinforcer

References

Definitions provided in the glossary were taken from the following sources:

Toogood, S. (2008). Functional Assessment Interview (Version IV)

Cooper, J.O., Heron, T.E and Heward, W.L. (2007). Applied Behaviour Analysis. New Jersey: Pearson Prentice Hall

Mansell, J, Beadle-Brown.J., Ashman, B and Ockenden (2005). Person Centred Active Support: A Multi-media training resource for staff to enable participation, inclusion and choice for people with learning disabilities. Brighton: Pavilion Publishing

Murphy, G & Wilson,B. (1985) *Self-Injurious Behaviour.* Kidderminster: British Institute of Mental Handicap Publications.

Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, 2007.

APPENDIX 2

POSITIVE BEHAVIOUR SUPPORT SERVICE STRUCTURE

PCT | **Halton** | **St Helens** | **Knowsley**

Clinical Supervisor
Dr Sandy Toogood
(BCBA – D)
(1 day per month)

Operational Director
Paul McWade

Principal Manager (BCBA) MS
Maria Saville

Practice Manager (BCBA)
Leah Vanono

Practice Manager (BCBA)
Kath Devonshire

Practice Manager (BCBA)
Kaneez Mustary

Practice Manager (BCBA)
Gillian Morgan

Care Manager (BCaBA)
Claire Welch

Care Manager (BCaBA)
Simone Doherty

Care Manager (BCaBA)
Sarah Northrop

Support Worker
Paul Cooper

Support Worker
Sharon Bretherton

Support Worker
Rachel Rowson

Support Worker
Yvonne Connolly

Support Worker
Katie Little

Business Support
Kate Cunningham
Diane Rowland

APPENDIX 3

TRAINING AGENDA

Training Currently Offered (being Developed) by the Positive Behaviour Support Team:

1) **'An introduction to Autistic Spectrum Conditions' :** an examination of the Triad of Impairments (language and communication impairments, social interaction difficulties, rigidity of thought), stereotypy/repetitive behaviours, imagination difficulties, abnormal sensory reaction, problem behaviour e.g. Self Injurious Behaviour.

2) **'What is behaviour':** an examination of behaviour definition and the three term contingency?

3) **'Considering consequences when dealing with behaviour that challenges services':** an examination of different consequences (reinforcement, extinction, punishment), how such consequences impact upon behaviour and future occurrence. Exploration of ethical considerations.

4) **'Motivating Operations':** the importance of motivation consideration when implementing procedures to reduce behaviour that challenges services.

5) **Functions of behaviour:** examination of core functions of behaviours, how interventions are planned with direct reference to function.

6) **Behaviour change procedures:** examination of prompting and chaining procedures that can be implemented to encourage new desirable behaviours.

7) **Data taking:** an introduction to data taking.

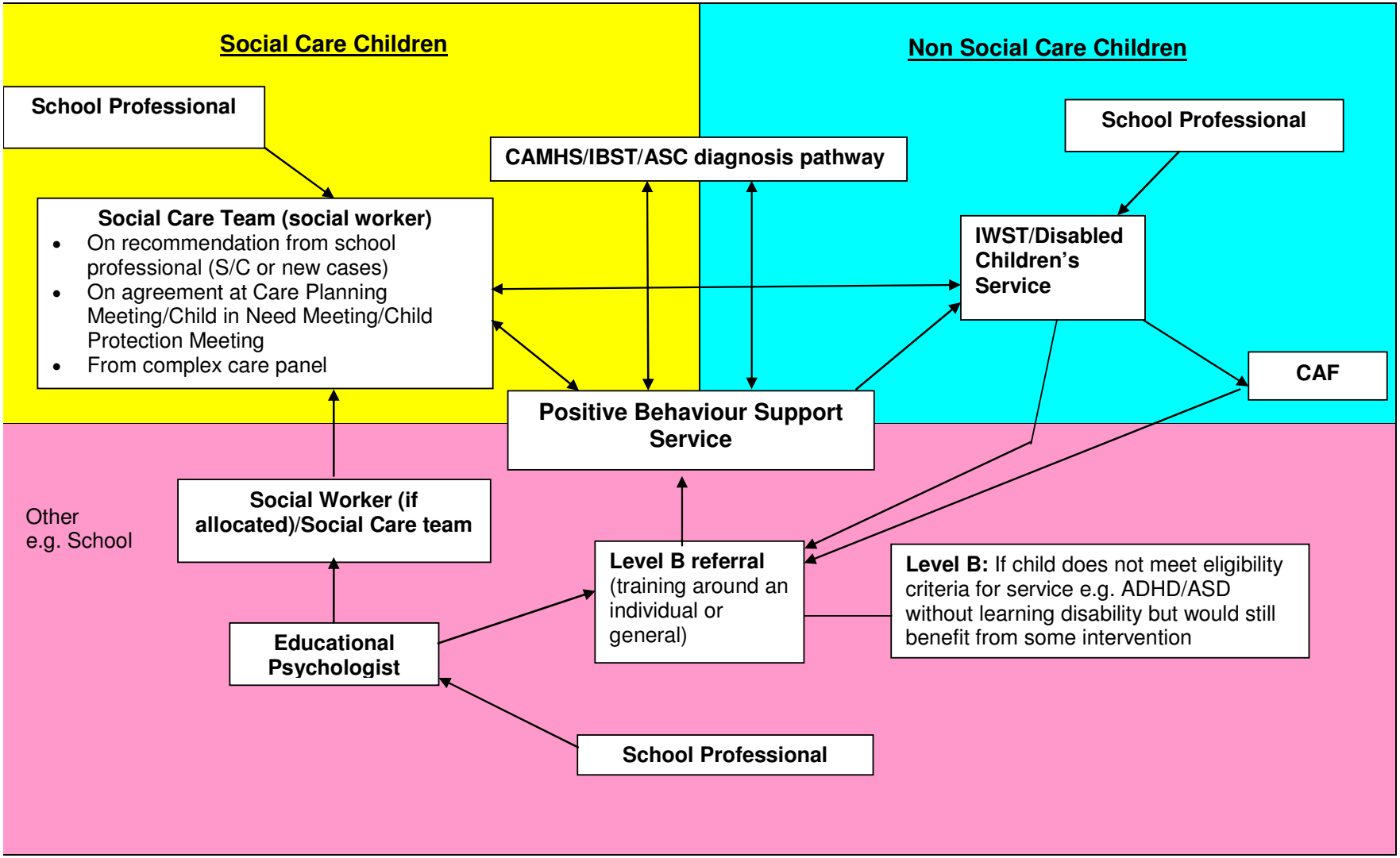
8) **Person Centred Active Support:** 1) an introduction to Active Support; 2) Full Active Support workshop

9) **Interactive Training:** On job training for staff supporting individuals. Strategies to increase engagement break down tasks to appropriate levels and incidentally reduce occurrence of behaviour that challenges.

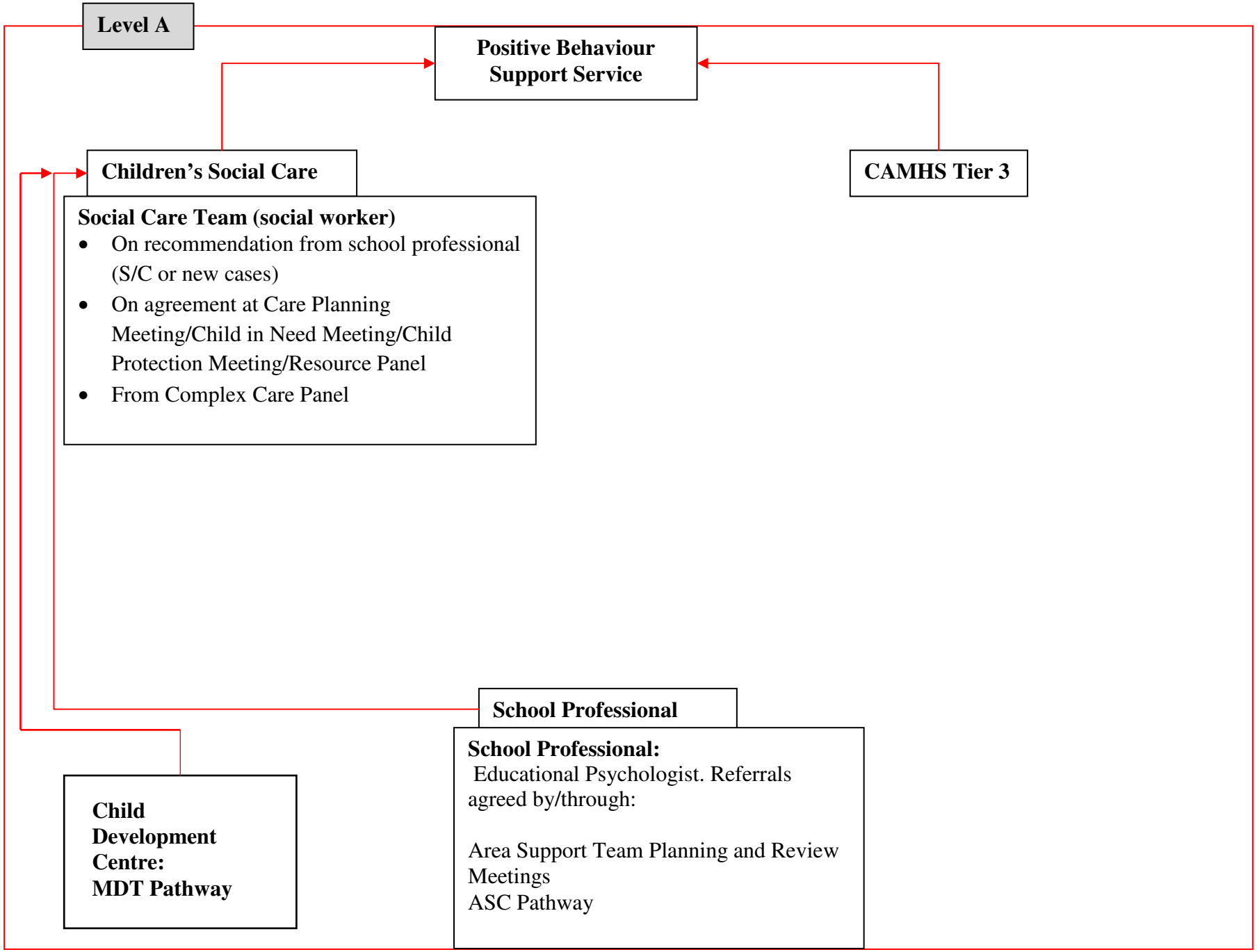
10) **Maintaining and generalising behaviour change:** Follow up sessions- ensuring that training is maintained and applied. Teaching skills to recognise when an individual's behaviour is changing in frequency, duration or intensity and act at that point, rather than allowing it to continue and a crisis point being reached.

APPENDIX 4

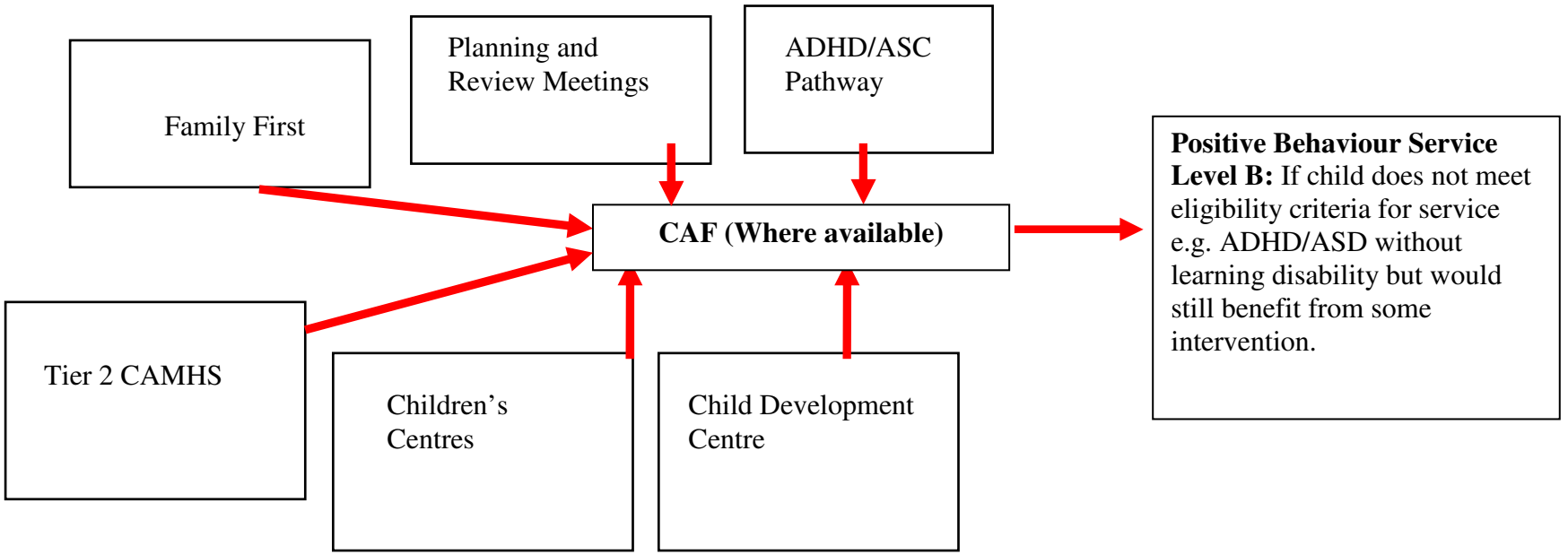
REFERRAL PATHWAY FLOWCHART FOR CHILDREN



Knowsley Metropolitan Council Children's Referral Pathway

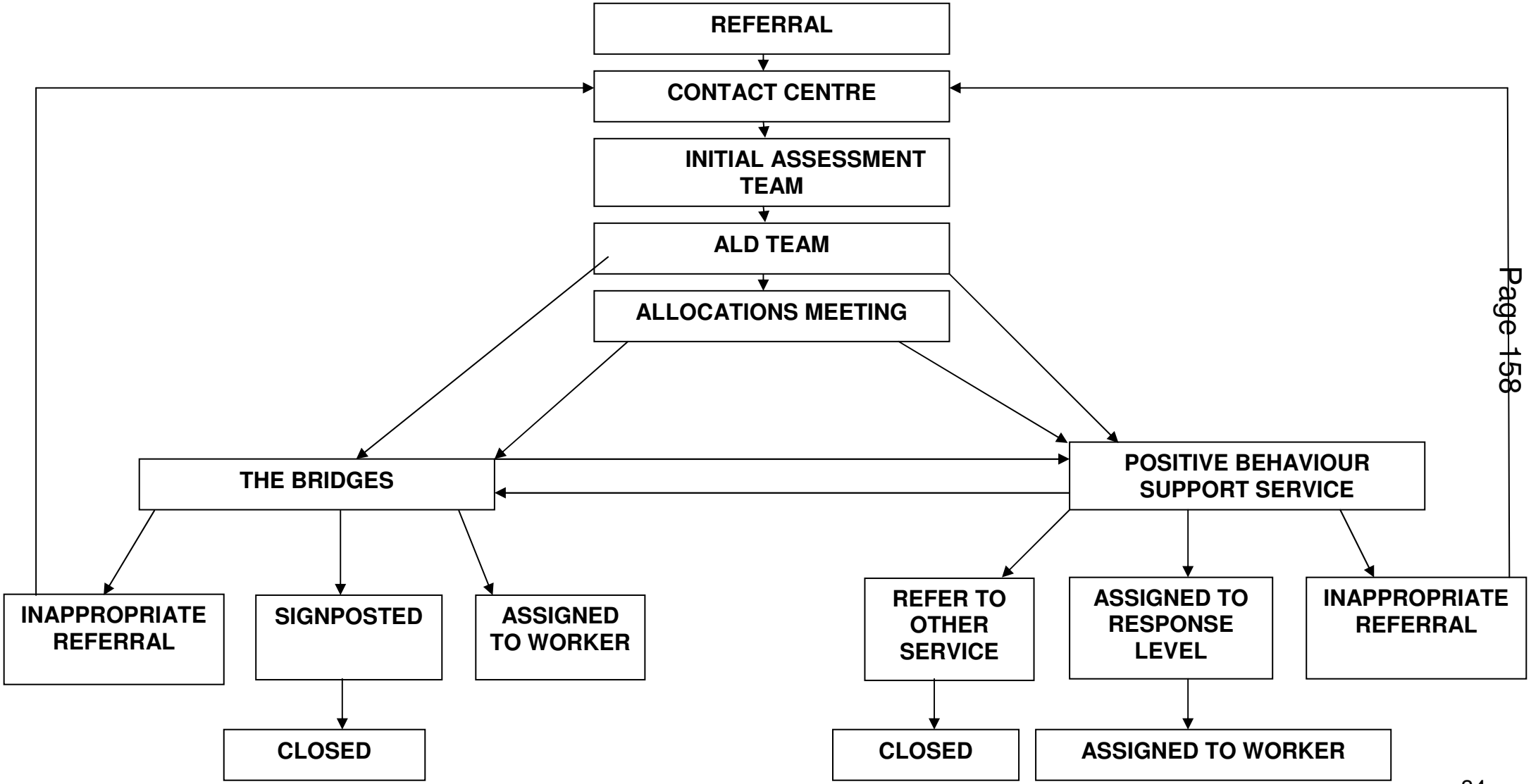


Level B


Family First
Planning and Review Meetings
ADHD/ASC Pathway
CAF (Where available)
Tier 2 CAMHS
Children's Centres
Child Development Centre
Positive Behaviour Service
Level B: If child does not meet eligibility criteria for service e.g. ADHD/ASD without learning disability but would still benefit from some intervention.

APPENDIX 5

REFERRAL PATHWAY FLOWCHART FOR ADULTS



APPENDIX 6

REFERRAL FORMS

PRIVATE AND CONFIDENTIAL

Positive Behaviour Service Referral Document (Children's Service)

Name of child:	**D.O.B:**	**Date of Referral:**
Address: **Telephone No:**		**Current placement:** **Support involved:** (Please name any current professionals/services already supporting child, **include contact number**)
Name of Parent/Carer:		
Parent/carer informed and in agreement with referral: YES / NO (please circle)		
Name of GP: **Address:** **Telephone No:**		
Diagnosis/Medical information:		
Has the child accessed the Positive Behaviour Service before:	**YES (specify when):**	**NO:**
Name of Referrer:		
Relationship to child:		
Address:		**Telephone No:**
REASON FOR REFERRAL:		
Description of challenging behaviour occurrence: (include information on types of behaviours, frequency and intensity)		
Describe the impact of challenging behaviour on the child's life: (include information on health well being, social interaction and family relations, school and home placements, inclusion in community)		
Describe the impact of challenging behaviour on the child's environment and family: (include information on potential placement break downs, damage to home/school environment, family relations)		

FOR OFFICE USE:			
Referral Date:	**Date Received:**	**Reviewed by:**	**Date Reviewed:**
Response Level: A B C D		**Date for first appointment:**	
Appointment attended by:		**Agreed category:** 1 2 3 (For Level A referrals)	
Case to be taken by:		**Carefirst Number:**	

PRIVATE AND CONFIDENTIAL
Positive Behaviour Service Referral Document (Adult's Service)

Name of person:	**D.O.B:**	**Date of Referral:**
Address: **Telephone No:**		**Current placement:** **Support involved:** (Please name any current professionals/services already supporting person, **include contact number**)
Name of significant others: e.g. parent/relatives/key worker		
Have relevant persons been informed of this referral? **Yes** (specify who) **No**		
Name of GP: **Address:** **Telephone No:**		
Diagnosis/Medical information:		
Has the person accessed the Positive Behaviour Service before:	**YES (specify when):**	**NO:**
Name of Referrer:		
Relationship to person:		
Address:		**Telephone No:**

REASON FOR REFERRAL:

Description of challenging behaviour occurrence:
(include information on types of behaviours, frequency and intensity)

Describe the impact of challenging behaviour on the person's life:
(include information on health well being, social interaction and family relations, day services and home placements, inclusion in community)

Describe the impact of challenging behaviour on the person's living environment and family:
(include information on potential placement break downs, damage to home/day services and environment, social interaction, family relations)

FOR OFFICE USE:

Referral Date:	**Date Received:**	**Reviewed by:**	**Date Reviewed:**
Response Level: A B C D		**Date for first appointment:**	
Appointment attended by:		**Agreed category:** 1 2 3 (For Level A referrals)	
Case to be taken by:		**Carefirst Number:**	

APPENDIX 7

REVIEWING FORM

Positive Behaviour Service: Reviewing Form
Client Name and Number:
Reviewer:
Date of review:

LEVEL OF RESPONSE TO REFERRAL		
Level	**Description**	**Reason**
A	Direct response for full assessment and intervention	
B	Ongoing mentoring of staff from other agencies	
C	One off consultation for advice and support	
D	Redirection to other services	

PRIORITISATION OF LEVEL A REFERRALS			
Priority	**Description**	**Response time**	**Reason**
1	Imminent threat of harm or placement breakdown, requiring urgent assistance	Engagement with referrer within 1 working day, with urgent multidisciplinary meeting arranged ASAP thereafter	
2	Likely threat of harm or placement breakdown requiring assured response	Engagement with referrer within 5 working days, with urgent multidisciplinary meeting arranged within 5 working days thereafter	
3	Possible threat of harm or placement breakdown requiring considered analysis	Engagement with referrer within 10 working days, with further action negotiated on merit	
Service to be implemented:			

ACTION			
Action to be taken:	**Target date of completion:**	**Date of completion:**	**Target date achieved?** (if no give reason)

APPENDIX 8

FUNCTIONAL ASSESSMENT

Please find attached the Functional Assessment Interview Document

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APPENDIX 9

QUESTIONS ABOUT BEHAVIOURAL FUNCTION

QUESTIONS ABOUT BEHAVIORAL FUNCTION (QABF)
Rate how often the child demonstrates the behaviours in situations where they might occur. Be sure to rate how often each behavior occurs, not what you think a good answer would be.

X = Doesn't apply 0 = Never 1 = Rarely 2 – Some 3 = Often

Score	Number	Behavior
	1.	Engages in the behaviour to get attention.
	2.	Engages in the behaviour to escape work or learning situations.
	3.	Engages in the behaviour as a form of "self-stimulation".
	4.	Engages in the behaviour because he/she is in pain.
	5.	Engages in the behaviour to get access to items such as preferred toys, food, or beverages.
	6.	Engages in the behaviour because he/she likes to be reprimanded.
	7.	Engages in the behaviour when asked to do something (get dressed, brush teeth, work, etc.
	8.	Engages in the behaviour even if he/she thinks no one is in the room.
	9.	Engages in the behaviour more frequently when he/she is ill.
	10.	Engages in the behaviour when you take something away from him/her.
	11.	Engages in the behaviour to draw attention to himself/herself.
	12.	Engages in the behaviour when he/she does not want to do something.
	13.	Engages in the behaviour because there is nothing else to do.
	14.	Engages in the behaviour when there is something bothering him/her physically.
	15.	Engages in the behaviour when you have something that he/she wants.
	16.	Engages in the behaviour to try to get a reaction from you.
	17.	Engages in the behaviour to try to get people to leave him/her alone.
	18.	Engages in the behaviour in a highly repetitive manner, ignoring his/her surroundings.
	19.	Engages in the behaviour because he/she is physically uncomfortable.
	20.	Engages in the behaviour when a peer has something that he/she wants.
	21.	Does he/she seem to be saying, "come see me" or "look at me" when engaging in the behaviour?
	22.	Does he/she seem to be saying, "leave me alone" or "stop asking me to do this" when engaging in the behaviour?
	23.	Does he/she seem to enjoy the behaviour, even if no one is around?
	24.	Does the behaviour seem to indicate to you that he/she is not feeling well?
	25.	Does he/she seem to be saying, "give me that (toy, food, item)" when engaging in the behaviour?

Attention	**Escape**	**Non-social**	**Physical**	**Tangible**
1. Attention	2. Escape	3. Self-stim	4. In pain	5. Access to items
6. Reprimand	7. Do something	8. Thinks alone	9. When ill	10. Takes away
11. Draws	12. Not do	13. Nothing to do	14. Physical problem	15. You have
16. Reaction	17. Alone	18. Repetitive	19. Uncomfortable	20. Peer has
21. "Come see"	22. "Leave alone"	23. Enjoy by self	24. Not feeling well	25. "Give me that"
Total	Total	Total	Total	Total

Matson, J.L & Vollmer, T. (1995). Questions About Behavioural Function (QABF). Baton Rouge, LA: Disability Consultants, LLC.

Appendix 10

MOTIVATION ASSESSMENT SCALE

NAME . **DATE** . **BEHAVIOUR** .

	Never						Always
1. Would this behaviour occur continuously if the person was left alone for long periods of time (for example, one hour)?	0	1	2	3	4	5	6
2. Does this behaviour occur following a command to perform a difficult task?	0	1	2	3	4	5	6
3. Does this behaviour occur when you are talking to other people in the room?	0	1	2	3	4	5	6
4. Does this behaviour ever occur to get an object, activity, food, or game that the person has been told he/she can't have?	0	1	2	3	4	5	6
5. Does this behaviour occur repeatedly, over and over, in the same way? (For example, rocking back and forth for five minutes)	0	1	2	3	4	5	6
6. Does this behaviour occur when any request is made of the person?	0	1	2	3	4	5	6
7. Does this behaviour occur whenever you stop attending to the person?	0	1	2	3	4	5	6
8. Does this behaviour occur when you take away a favourite object, activity, or food?	0	1	2	3	4	5	6
9. Does it appear to you that the person enjoys performing this behaviour, and would continue even if no one was around?	0	1	2	3	4	5	6
10. Does the person seem to do this behaviour to upset or annoy you when you are trying to get him or her to do what you ask?	0	1	2	3	4	5	6
11. Does the person seem to do this behaviour to upset or annoy you when you are not paying attention to him of her? (For example when you are sitting in a separate room, interacting with another person)	0	1	2	3	4	5	6
12. Does this behaviour stop occurring shortly after you give the person the object, activity, or food he/she has requested?	0	1	2	3	4	5	6
13. When this behaviour is occurring, does the person seem unaware of anything else going on around him or her?	0	1	2	3	4	5	6
14. Does this behaviour stop occurring shortly after (one to five minutes) you stop working or making demands of him or her?	0	1	2	3	4	5	6
15. Does the person seem to do this behaviour to get you to spend some time with him or her?	0	1	2	3	4	5	6
16. Does this behaviour seem to occur when the person has been told that he/she can't do something he or she wanted to do?	0	1	2	3	4	5	6

SCORING SHEET
Motivation Assessment Scale

A score is obtained for each of the four categories of maintaining variables by adding the scores for each of the category's four questions and computing a mean.

Scoring Summary

Self-Stimulatory	Escape/avoidance	Attention	Tangible
1_____	2_____	3_____	4_____
5_____	6_____	7_____	8_____
9_____	10_____	11_____	12_____
13_____	14_____	15_____	16_____
_____	_____	_____	_____

APPENDIX 11

CONSENT FORM

Positive Behaviour Support Service: CHILDRENS SERVICE
Work with individual clients:

Name has been referred to the Positive Behaviour Support Service. As part of this facility some or all of the following procedures are likely to be implemented:

1) A full Functional Assessment interview.
2) Indirect and direct observations of Name.
3) An experimental Functional Analysis
4) The formulation of a treatment intervention plan.
5) The collection of information from other services and individuals e.g. Name's school staff or social worker.
6) The sharing of information with other services e.g. Name's school staff or social worker.
7) The ongoing collection and evaluation of behavioural data.
8) The training of staff members with specific reference to name.

As good practice the Positive Behaviour Support Service seeks written consent to implement any such procedures.

STATEMENT OF CONSENT:

I give consent for name of service user to receive input from the Positive Behaviour Support Service. I understand that consent is voluntary and can be withdrawn at any time.

Signed: ..... Relationship to name: .....

Date:

STATEMENT OF CONSENT TO TREATMENT PLAN:

I am in approval of name's behaviour intervention plan.

Signed: ..... Relationship to name: .....

Date:

STATEMENT OF CONSENT TO TREATMENT PLAN MODIFICATION:

I am in approval of verbally stated modifications to name's behaviour intervention plan.

Signed: ..... Relationship to name: .....

Date:

If you are at all dissatisfied with any aspect of the Positive Behaviour Support Service, please contact Paul McWade (Operational Director of Complex Care): *email:* paul.mcwade@halton.gov *Tel:* 0151 471 7437 Ext 3503

APPENDIX 12

INFORMATION SHARING CHECKLIST

POSITIVE BEAHVIOUR SUPPORT SERVICE

Information sharing sheet

When meeting a new client the following information should be shared.

1) A brief description of what a Functional Assessment is ☐
2) Doing observations ☐
3) Possible data collection responsibilities ☐
4) The development of a treatment plan ☐
5) The need to information share ☐
6) Possible training aspects ☐
7) Consent ☐

(Tick to confirm discussion)

Name of service user:

Case Number:

Persons spoken with:

The above information has been shared in an appropriate and a suitably explanatory manner with the client,

Signed:
Date:

APPENDIX 13

PERSON CENTRED BEHAVIOURAL ASSESSMENT AND INTERVENTION PLAN

Please find attached the Person Centred Behavioural Assessment and Intervention Plan document.

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APPENDIX 14

Self-Assessment of Contextual Fit

The purpose of this questionnaire is to make sure that the elements of the proposed intervention plan fit the contextual features of your environment. We want to provide you the opportunity to rate (a) your knowledge of the elements of the plan, (b) your perception of the extent to which the elements of the plan are consistent with your personal values, and skills, and (c) your ability to implement the plan. We will discuss with you any changes to the plan that are necessary.

Please read the attached intervention plan, and answer the questions below.

Your name:_____. Your role / relationship:
.

Client name:_____. Behaviour Analyst:
.

Date reviewed:_____. Setting:
.

Knowledge of elements in the intervention plan

1. I am aware of the elements of this plan.

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

2. I know what I am expected to do to implement this plan.

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

Skills needed to implement the Behavior Support Plan

3. I have the skills needed to implement this plan.

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

4. I have received or will receive the training I need to be able to implement this plan.

   No training needed _____

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

Values are consistent with elements of the plan

5. I am comfortable implementing the elements of this plan.

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

6. The elements of this plan are consistent with the way I believe people with disabilities should be treated.

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

Resources available to implement the plan

7. I / we have the time needed to implement this plan.

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

8. I / we have sufficient funding, materials and space needed to implement this plan.

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

Effectiveness of the Plan

9. I believe the plan will be effective in achieving the specified outcomes.

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

10. I believe the plan will help prevent future occurrence of problem behaviors.

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

Best interests of the person

11. I believe this plan is in the best interest of the person.

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

12. This plan is likely to assist the person to be more successful in life.

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

13. This plan will make life better for me / us as a carer.

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

The plan is efficient to implement

14. Implementing this behavior support plan will not be stressful.

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

15. The amount of time, money and energy needed to implement this plan is reasonable.

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

Administrative Support – (service environments only)

16. My service agency provides the supervision and support needed to implement this plan.

1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Barely Disagree	Barely Agree	Moderately Agree	Strongly Agree

Thank you for completing this questionnaire. Your Behaviour Analyst will discuss your responses with you before proceeding to intervention.

Appendix 15

Safeguarding Flowchart

There are separate Safeguarding Policies and Procedures for the different funding partners of the PBSS. We need to be aware of them and at the very minimum, know where to find information and guidance on Safeguarding issues. Those staff working across all partners need to be familiar with each of the partner's policies.
The table below shows where you can find the relevant documents.

Partner/ Directorate	Policy, Procedure, Guidance Documents	Where to find them
Halton Adults Services	Safeguarding Adults in Halton	Hard copy in filing cabinet  U:\Policies\ HaltonChildren'sSocia
Halton Children's Services	Being revised – to be added in near future (as at Jan 2012)	
PCT	Safeguarding Adults in Halton	Hard copy in filing cabinet http://www.haltonandsthelenspct.nhs.uk/library/documents/ HTSHpctsafeguardingchildrenandvulnerableadultspolicyv2.pdf
Knowsley Adult's Services	Safeguarding Adults Policy Safeguarding Adults Procedures Safeguarding Adults Practice Guidelines	Hard copy in filing cabinet http://www.knowsley.gov.uk/families/social-care-and-health/adults-and-older-people/safeguarding-adults.aspx
Knowsley Children's Services	Knowsley Safeguarding Children Board Procedures Manual	http://knowsleyscb.proceduresonline.com/index.htm
St Helen's Adults Services	St Helen's Multi-Agency Safeguarding Adults Policy, Procedures and Good Practice Guidance March 2010	Hard copy in filing cabinet http://sthelenslscb.org.uk/SITEMANV2/publications/42/StHelensPolicyProceduresandGoodPracticeGuidance-March2010.pdf

In addition to being aware of the policies, PBSS staff must complete relevant training:

- All PBSS staff should have undertaken Halton's Safeguarding e-learning module
- All PBSS will complete Halton's Safeguarding Training Course over the coming months. Staff will be directed as to when to book onto this course and will do so through the Training reception.
- PBSS Practice Managers working with other partners should liaise with key people to identify training requirements and opportunities available through those partners eg Knowsley have already suggested that staff can attend their Safeguarding training.

If you suspect any instance of abuse or threat to the safety of somebody who you are working with, follow the procedure below:

1. Inform your line manager → line manager to inform Principal Manager (Maria Saville) or Paul McWade in Maria's absence.
2. Take direction from Maria/Paul on who will contact the professionals in safeguarding department of relevant partner organisation/directorate.

Contact details

Partner/Directorate	**For advice about safeguarding**	**To make a safeguarding referral**
Halton Children's	In review	In review
Halton Adult's and PCT		If possible criminal allegation: contact police immediately If not: 24 hour contact centre 0151 907 8306
Knowsley Children's		9am – 5pm: 0151 443 3792 or 0151 4433798 5pm – 9am (out of hours): 0151 443 2600 Emergency: Merseyside police 24hr number: 0151 709 6010
Knowsley Adults	0151 443 4261*	0151 443 4261
St Helen's Adult's		8.45am – 5.15pm: 01744 456600 5.51pm – 8.45am: 0845 0500148

*This team is very small so if personnel cannot be contacted and you are in any concern about potential safeguarding, do not delay in making a referral.

REPORT TO:	Health Policy & Performance Board
DATE:	29th May 2012
REPORTING OFFICER:	Strategic Director - Communities
PORTFOLIO:	Health & Adults; Community Safety
SUBJECT:	Close to Home – An inquiry into Older People and Human Rights in Home Care
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of the report is to present the Board with a summary of the findings and recommendations from the Equality and Human Rights Commission's inquiry into Older People and Human Rights in Home Care, along with details of a self – assessment conducted within Halton Borough Council (HBC), against the recommendations generated from the inquiry.

2.0 RECOMMENDATION

RECOMMENDED: That the Board:-

1) **Note contents of the report**
2) **Note completed HBC self-assessment document, resulting actions and progress to date attached at Appendix 1.**

3.0 SUPPORTING INFORMATION

3.1 As a result of wanting to find out whether the human rights of older people wanting or receiving care in their own homes were being fully promoted and protected; in November 2011, the Equality and Human Rights Commission undertook a systematic inquiry into the issue and the results of the inquiry were published in November 2011. Link to the full report below:-

http://www.equalityhumanrights.com/legal-and-policy/inquiries-and-assessments/inquiry-into-home-care-of-older-people/close-to-home-report/

3.2 In summary, the inquiry concluded that of the 500,000 older people who receive essential care in their own home paid for wholly or partly by their local authority, for too many, this care, delivered behind closed doors is not supporting the dignity, autonomy and family life which their human rights should guarantee.

3.3 Good quality home care is invaluable in providing older people with the support they need to keep their independence and control over their lives in familiar surroundings.

3.4 The inquiry found that although many older people receive care at home which respects and enhances their human rights, this was by no means a universal experience. It uncovered areas of real concern in the treatment of some older people and significant shortcomings in the way that care is commissioned by local authorities.

3.5 It also found that the legal safeguards provided by the Human Rights Act, which should be used to guarantee respect for the human rights of older people including preventing inhuman or degrading treatment, were not as widely used as they should be.

3.6 The inquiry concluded that bare compliance with the Act was not enough; public authorities also need to have 'positive obligations'; to promote and protect human rights. The inquiry also discovered a significant legal loophole which means that the majority of older people who receive care at home - that is, if they pay for all or part of it themselves or if it is delivered by a private or voluntary sector organisation - are not protected by the Act.

3.7 The inquiry was undertaken at an important point for social care, when the funding and delivery of care faces fundamental reform and therefore the results presents a good opportunity to make the changes recommended. There are a total of 25 recommendations within the report, which can be catergorised into three categories, as follows:

- **Proper protection -** The gaps in the current legal system need to be closed so that older people receive better protection. In particular, the loophole in the Human Rights Act needs to be closed so that home care is covered in the same way as residential care. The Commission will be working to secure support for these essential changes.
- **More effective monitoring -** Local authorities need to do more to incorporate human rights into the ways in which they commission care services and need to overcome the barriers which many older people face when raising concerns or making complaints. Problems in care delivery do not come to light quickly enough. The Commission will support local councils in understanding what they need to do and what best practice is.
- **Better guidance -** Older people and their families need to have access to better information when making choices about care provision and also need to know more about how their human rights should be protected when care is delivered. The Commission will work with private providers and the voluntary sector to provide accessible guidance on human rights for older people receiving care.

3.8 Halton Borough Council contributed to the inquiry and are highlighted a couple of times within the report by the Commission as having best practice within this area, for example via use of the ‘Dignity Challenge’ approach.

3.9 As a result of the inquiry it was decided to undertake an in house self-assessment exercise against the recommendations made by the Commission. Contributions were made to the assessment from Quality Assurance,

Commissioning, Safeguarding, Dignity, Direct Payments and Policy and the resulting self- assessment is attached at **Appendix 1.**

3.10 A number of recommendations made by the Commission can only be implemented at a national level and therefore it has been identified that no action is required in these areas. For the other recommendations when the assessment has been made (using R/A/G) then a supporting commentary has been added in support of the assessment. As a result of the assessment some action points have been highlighted in order to make improvements. These are highlighted within the self - assessment.

3.11 A report and the appended self-assessment were presented to the Safeguarding Adults Board on 5th April 2012. The Board acknowledged that most of the recommendations were already in place within Halton and it was confirmed that the associated action plan would be monitored through the Dignity Network.

4.0 POLICY IMPLICATIONS

4.1 As a result of some of the action points outlined within the self – assessment, this may result in the need to amend certain policies and procedures, for example the Safeguarding Adults in Halton – Interagency Policy, Procedures and Guidance, however this will be kept under review.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this stage.

6.0 IMPLICATIONS FOR OTHER COUNCIL 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 Commission's inquiry found that for far too many, the care provided to them is not supporting their dignity and human rights and it highlighted that the commissioning, monitoring and delivery of services have a crucial role to play in ensuring that this doesn't happen. The work undertaken as part of HBC's self-assessment exercise has provided assurances that the commissioning, monitoring and delivery of relevant services within Halton does support people's dignity, autonomy and family life.

6.4 **A Safer Halton**
The effectiveness of safeguarding adult arrangements is fundamental to making Halton a safe place of residence for adults whose circumstances make them vulnerable to abuse. The self-assessment exercise undertaken

does provide assurances that appropriate safeguarding processes are in place.

6.5 **Halton's Urban Renewal**
None identified

7.0 RISK ANALYSIS

7.1 If as a result of this inquiry and its associated recommendations we don't ensure that the services we commission and provide don't respect and enhance the human rights of older people then we open ourselves up to criticism and a position where we may fail in our duty to provide services which prevent inhuman or degrading treatment.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 An Equality Impact Assessment is not required for this report.

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

Document	Place of Inspection	Contact Officer
Close to home: An inquiry into older people and human rights in home care	People & Communities Policy Team	Louise Wilson

Communities Directorate

Close to Home - An Inquiry into Older People and Human Rights in Home Care (November 2011)

Equality and Human Rights Commission

Self - Assessment

(as at 24.4.12)

Overall Recommendation: To address gaps in the current legal and regulatory framework

Recommendation	Progress (R/A/G)	Supporting Commentary
1. The definition of 'public function' under Section 6(3) (b) HRA 1998 should be extended to include the provision of home care by private and voluntary sector organisations, at least when this is publicly arranged. This would bring home care into line with residential care services		Section 6 of the Human Rights Act (HRA) applies to all our services. Under our current contracts Clause 29.5 of the Domiciliary Care Contract 2009, it states that "***The Contract will act in respect of any person who receives of requests services under this Contract as if the Provider were a public authority for the purpose of the Human Rights Act 1998".*** (NB. Confirmed with Rob Barnett 17.1.12 – clause used is fine) Our contract also notes those current and future obligations under the Human Rights Act 1998 and any codes of practice and guidance issues by the Government and the appropriate enforcement agencies. In practical terms it is extended in the following: 1. Quality assurance / monitoring of the services including the new monitoring tool. 2. All Contracts / specifications across Adult Social Care (Domiciliary / Residential and Supported Living services, Sheltered) etc) have clauses that stipulate how each provider must comply with Human Rights Act. Providers are signed up to this. 3. Tenders – Include HRA 4. In addition our new monitoring tool that will be fully operational shortly will be used to measure provider compliance that includes Dignity and Human Rights Act in their own sub headings.
2. As there is no longer an independent regulatory body inspecting or monitoring adult social care commissioning, the oversight framework introduced in October 2010 to uphold standards should be evaluated by government no later than September 2012 to assess its effectiveness in promoting and protecting the human rights of older people receiving home care		No Action Required

3. The government should implement the provisions in the Equality Act 2010 outlawing age discrimination in services and public functions by no later than by April 2012, recognising the adverse impact of age differentiated treatment in social care and the link between negative ageist attitudes and human rights abuses of older people		• Reference is made to the Equality Act 2010 in all new contracts /specifications • As part of the review process undertaken by Social Workers, Workers monitor that the services provided to older people do not perpetuate age discrimination. • Quality Assurance (QA) will be writing to all Providers (200+) with a contract variation to ensure contract compliance with the changes in the Equality Act from April 2012. • As part of ensuring contract compliance, QA to request a copy from Providers of their updated Equality Policy which will incorporate the requirements of the Act. **Action Point 1:** QA Team – To issue a contract variation letter to all Providers and obtain copy of Provider's Equality Policies.
4. The CQC risk-based approach to the regulation of home care needs to place more reliance of care providers and obtaining the unconstrained voices of service users. We believe it is essential that the CQC inspects each care provider location at least once a year, as proposed by the Care Quality Commission (CQC) itself. These inspections should be complemented by a broad and fully inclusive range of methods of capturing information from users and their representatives – including by capitalising on the intelligence available from Local HealthWatch organisations		To complement CQC Inspections, Halton have planned visits to providers as detailed below and we also undertake monitoring based upon risk :- • Nursing Homes : 2 visits per year (however all have had more visits carried out) • Care Homes : 1- 2 visits per year • Domiciliary : 1 visit per year (however most have received 2 – 3 visits) • Supporting People services : 1 per year • Sheltered : 1 per year There is a methodology that describes how HBC monitor the services. If there are safeguarding issues, complaints etc then it may trigger a monitoring visit. We engage with Service Users via face to face consultation, questionnaires, Peer visits, family via annual questionnaires & face to face visits and other Stakeholders e.g. Health care professionals and we encourage advocacy. In terms of the HRA – there is a component that has been included in our recent consultation with service users & their family members. We have managed to collate data in this area for Human Rights. We have received approx 500 responses across domiciliary and residential at the moment. We are awaiting responses back from our other existing services across homeless, Mental Health, Floating Support and Domestic Abuse services. **Domiciliary Findings – Human Rights & Dignity** • 94% feel that the services they receive help them to feel in control of their daily life. • 98% of respondents feel the services they receive allow them to live as independently as

<table>
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<td></td>
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<td>possible.
• Dignity - 98% of respondents feel they are treated with dignity and respect by their care workers.

Residential Findings – Human Rights & Dignity
• 97% felt comfortable approaching care home workers with questions and requests and felt family members human rights were considered by care staff at all times.
• 93% stated they were very or fairly satisfied with the care they or their family member receive
• 92% Family member is offered good variety of food and drink
• 8 in 10 thought there were enough activities
• 93% care home staff always polite and respectful
• 92% strongly agree / family member is encouraged to maintain regular relationships and have regular contact with family and friends</td>
</tr>
<tr>
<td>5. Given that the CQC has no regulatory remit over personal assistants who are not supplied by a care provider, local authorities should develop ways of supporting those who employ their own personal assistants, to ensure older people's human rights are protected. This could include steps such as funding advocacy and advice services and facilitating voluntary registers for personal assistants</td>
<td>  </td>
<td>• Halton has developed 7 guidance booklets to help those who want to employ their own Personal Assistant. For those who need support to do this, then the Direct Payment Officers will work closely with the individual and their family to ensure they have all the relevant information and support available to make the decision to employ their own Personal Assistant. Training for Personal Assistants is available through the Social Care Alliance.

• Halton Borough Councils funds a range of advocacy services (see table below). These services are aimed at supporting people through either generic advocacy support or specialist provision. Future developments in relation to advocacy will include the implementation of an advocacy hub that will be formed in conjunction with the inception of the new Healthwatch programme from April 2013.

<table>
<tr><th></th><th>HBC funding</th><th>Other funding</th></tr>
<tr><td>Information giving</td><td>N/a</td><td>N/a</td></tr>
<tr><td>Advice</td><td>N/a</td><td>N/a</td></tr>
<tr><td>Befriending</td><td>£48,402</td><td>£55,341 (ACMM)</td></tr>
<tr><td>Short term issue based or crisis Advocacy</td><td>£57,366</td><td></td></tr>
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Citizen Advocacy	£4,680	
Advocacy visitors		
Self-advocacy	£42,398	£3,238 (HHT)
Peer Advocacy	£12,061	£15,198 (PCT)
	HBC funding	**Other funding**
Collective or group advocacy	£35,096	£3,040 (PCT) £3,238 (HHT)
Professional advocacy	£124,702	£3,040 (PCT) £20,000 (HHT)
Independent Mental Capacity advocates (IMCA)	£18,314	
Independent Mental Health Advocates (IMHA)		£29,352 (PCT)
Independent Domestic Violence Advisors (IDVA)	£27,000	
Independent Sexual Violence Advisors (ISVA)	£20,552	
TOTAL	**£390,571**	**£132,447**

Action Point 2 : Commissioning Team – Development and implementation of an Advocacy Hub as outlined above.

6. The Law Commission's proposal for a single statutory scheme for adult social care, an approach that we broadly support, should be implemented as soon as parliamentary time is available. The new statute should be expressly underpinned by human rights principles, putting social care on the same footing as NHS services		**No Action Required**
7. In fulfilling its commitment to implement the Law Commission's recommendation that adult		• Halton's present and historical arrangement for investigation of abuse allegations, concerns and disclosures is that if they are:

safeguarding boards be placed on a statutory footing and led by local authorities, the government should ensure that there are clear lines of accountability when agencies other than local authorities conduct investigations. As part of this legislative change, consideration should also be given to strengthening and broadening the role of Directors of Adult Social Services in relation to adults not receiving publically funded community care services who may be at risk of harm	?	(i) About matters occurring in any setting other than a hospital, the local authority takes the lead in coordinating the investigative process (although others e.g. Police might lead the investigation) (ii) About matters occurring in hospital, the NHS Trust investigates. Only if it were classed as a Serious Untoward Incident would the local authority (and other partners represented on the Safeguarding Adults Board and Quality & Performance sub-group) get to know anything about the individual case. There are some issues that have been highlighted with the current process and these need to be resolved. **Action Point 3 :** Divisional Manager (Independent Living) - Establish a short term 'Task and Finish' group (to include members from HBC and local NHS Trusts) to :- ○ Review the current arrangements; and ○ Consider the position regarding a local private hospital (The Priory) • The Council is in the process of establishing an Adult's Safeguarding Unit. The Unit will lead on adults safeguarding and dignity work across the Health and Social care Economy and will provide a model which efficient, flexible and responsive service to the local population. **Action Point 4:** Establishment of an Adults Safeguarding Unit for Halton
	✓	• Our local inter-agency Safeguarding Adults policy states the following: "People who fully fund their own care and support whether in a care home or other setting within the community, will be fully supported by these Safeguarding Adults Procedures." We also see evidence of people who self-fund receiving a safeguarding service as we record this data.

Overall Recommendation: To address the lack of awareness among local authorities about what human rights obligations mean in practice

Recommendation	Progress (R/A/G)	Supporting Commentary
8. Local authorities should mainstream human rights into their decision-making processes and business plans to ensure compliance with the HRA, including their positive obligations to promote and protect human rights. Human rights considerations should be at the centre of assessment, procurement and commissioning of home care, for example incorporating human rights requirements into care provider service specifications	✓	• Halton stipulates that the Equality Act 2010 and Human Rights Act are complied with in all new tenders /contracts & specifications, contract monitoring & consultation documents. • There are also regular discussions with existing providers on how this can be practically applied to existing or new services.
9. Before October 2012 local authorities should review their policies and practice in the light of this inquiry's findings as to the causes of potential breaches of human rights in home care. As a minimum this should include examination of the following: • the effectiveness of systems to overcome barriers that older people experience in raising concerns or making complaints • the design and operation of Resource Allocation Systems with a view to identifying and removing any age-related bias that may exist • the extent to which differential treatment linked to age is present in care planning and support for community participation • whether the diverse needs of older people are being met through commissioning practices • the extent to which their commissioning supports the delivery of care by a	✓	• Since Feb '10 we have held three Dignity Matters events to promote the work in progress to embed dignity and improve people's care experiences which is taking place across the multi-agencies. These events have allowed local residents including older and vulnerable people to feedback their concerns and work in partnership with both health and social care organisations to overcome barriers. Widespread publicity of a multi-agency Complaints Contact List has taken place to provide people with contact details to support systems in place.  Multi-Agency Concerns & Complaint The 'Help Us, Help You' campaign was launched November 2011 to facilitate a less formal approach in raising concerns or complaints. Also, Complaints and advocacy awareness sessions are being developed as another means of support. • Halton has introduced generic policies and procedures connected with Self Directed Support including the Resource Allocation system and as such this removes any sort of age related bias in terms of care planning etc. • The existing contracts for homecare, domiciliary care, residential care all cover in depth the extent of required training to ensure that the workforce is sufficiently qualified and equipped

sufficiently skilled, supported and trained workforce.		to deliver the required quality of service. The list of training is available through all relevant contracts and will be reviewed as part of the contract renegotiation for April2013. • Action Plans from the Dignity Matters events highlighted the range of dignity-related training being provided across the multi-agencies. A new Dignity e-learning programme has been developed with the first module launched December 2011 – Basic Awareness. The programme specifically incorporates Human Rights, modules 2 and 3 are to be launched Feb/Mar '12.  Dignity E-Learning Programme Sept '11.(
10. The Ministry of Justice, the Department for Communities and Local Government and the Department of Health should collaborate on producing guidance for local authorities on their duties under the HRA, including their positive obligations to promote and protect human rights, to provide a framework for operating more responsively to the needs of their communities when the Localism Bill is brought into force		No Action Required
11. To enhance the leadership of local authority elected members, training and guidance should be provided on using their scrutiny function and their roles on Health and Wellbeing Boards to maximise the promotion and protection of the human rights of older people	?	• Several Elected Members have undertaken Safeguarding Adults training, sessions have also being run with Elected Members regarding developing services for Older People and 'Aging Well'. • Members of the Health Policy & Performance Board have been involved in scrutiny reviews relating to Safeguarding and Dignity over the past 2/3 years. • Quality Assurance are about to start a training programme for Elected Members who are undertaking visits to services. As part of the visits the Elected Members will be carrying out consultation with service users. Some of these questions will focus on Human Rights and Dignity. Training will focus on the documentation they will be using and on the specific areas they should be focussing on but specifically on the guidance and protection of Human Rights

		of older people. **Action Point 5 :** QA Team - To commence training programme for elected Members as outlined above.
12. Through their guidance and training to HealthWatch Local organisations, HealthWatch England should adopt a proactive role in disseminating understanding of obligations under the HRA and the value of a human rights approach to home care		**No Action Required**
13. To ensure maximum human rights protection, consideration should be given to incorporating HRA obligations into local authorities' contracts with providers, to include clauses giving service users 'third party' rights to challenge the care provider for any breach of their human rights for which the care provider is directly responsible		The contract doesn't stipulate 3rd Party rights to challenge the care provider for any breach of their human rights for which the care home is directly responsible – BUT it does include: ***The Provider will act in respect of any person who receives or requests services under this Contract as if the Provider were a public authority for the purpose of the Human Rights Act 1998.*** NB. Rob Barnet has concluded that this clause is acceptable
14. Commissioning practice needs to balance allocation of resources against assessed home care needs that must be met, to ensure contracted providers can pay at least the National Minimum Wage to care workers, including payment for time spent travelling		• National Minimum wage is £6.08. • The Carers are paid £6.40 - £7.20. Travel time is included in our fee, we don't include payment for travel as an additional payment. • During the last Tender (Domiciliary), Halton implemented a scoring matrix and gave more points to Providers with good pay and conditions for their staff. This was an important factor before giving contracts to providers.
15. The Commission will work with the Association of Directors of Adult Social Services to produce voluntary national standards and guidance for elected local authority members and local authority officers with responsibility for commissioning home care or assessing home care needs (a) on their obligations under the		**No Action Required**

HRA, including positive human rights obligations, and (b) on the value of applying a human rights approach to home care services.		

Overall Recommendation: To address the lack of awareness about human rights and care entitlements amongst older people and their families

Recommendation	Progress (R/A/G)	Supporting Commentary
16. Much more consumer information should be compiled and made accessible about the quality of care providers and their specialist areas to enable home care users to make an informed choice, including by means of: • the development of in-depth provider profiles on the CQC website • support for a consumer feedback website • steps by local authorities to draw together and provide relevant information on care providers in their area • increased information sharing between the Local Government Ombudsman, local authorities and providers.	✓	• The **My Life** portal is a directory of services across HBC. http://halton.olminfoserve.co.uk/home/rascontentonly.aspx • The **'Help Us, Help You'** campaign was launched November 2011 to facilitate a less formal approach in raising concerns or complaints. Also, Complaints and advocacy awareness sessions are being developed as another means of support. • HBC regularly meet with CQC, other local authorities and Providers around information sharing. **Action Point 6 :** Information Team – To complement on line information, co-ordinate the production of a directory of services to support people in their choice of provider.
17. We welcome the steps being taken by the Social Care Institute for Excellence, Skills for Care, National Centre for Independent Living, Social Care Association and others to develop tools such as voluntary personal assistant (PA) registers in order to support those older people using direct payments looking for a better understanding of the workforce. However, in order that older people can, if they choose, benefit from the greater autonomy inherent in personalised home care, an increased focus is needed by government and local authorities on developing advocacy, guidance and brokerage	?	• Support and information is provided to those who wish to access the Northwest Personal Assistant Register and support is given to PA's who want to register their CV for potential employers to select. • Halton host support group meetings on a quarterly basis for those in receipt of a Direct Payment – providing speakers on Employment Law, HMRC, Training Requirements, Managing your Direct Payment. • See reference made in section 5 regarding advocacy services provided, along with the development of an advocacy 'hub'. In addition to the development of the 'Hub' work will be progressed to develop the local Age UK Information provision service into an advocacy service for Older People.

schemes.		**Action Point 7 :** Commissioning Team – Development of advocacy services for Older People, as outlined above.
18. The Commission will work with stakeholders including UKHCA to produce guidance for older people and their families about how their human rights should be protected in home care, however funded, and what to do if those rights are at risk – including the option of legal redress as a last resort.		No Action Required However some of our providers belong to the UK Home Care Association. This gives them guidance and templates that they can use.

Overall Recommendation: To ensure there are better arrangements in place to detect threats to human rights in home care

Recommendation	Progress (R/A/G)	Supporting Commentary
19. The CQC, local authorities and providers should develop more flexible ways of ensuring systems for exchanging information are designed to detect threats to human rights, including through the CQC and ADASS protocol		• North West Sharing Protocol is in place – All Authorities share concerns of contractual breaches/ suspensions etc. • The Divisional Manager and QA Manager meet quarterly with CQC to share information. This raises any queries or concerns. • We also share information with Halton & St Helens PCT.
20. The Local Government Ombudsman should take steps to increase public awareness of their role to investigate complaints about home care from self-funders		Halton don't do anything locally to promote that the Ombudsman can investigate complaints about providers from self-funders. **Action Point 8 :** Complaints Team - Put a link on HBC's website to http://www.lgo.org.uk/news/2010/oct/new-complaints-service-self-funded-adult-social-care/
21. The CQC should take steps to ensure maximum awareness by care workers of the protection available to whistleblowers under the Public Interest Disclosure Act, and the CQC's own role in responding to whistle blowing alerts		• CQC have just introduced a Whistleblowing Quick Guide, this alongside the NHS and Social Care Whistleblowing Helpline has been issued via email to all members of Halton Dignity Champions' Network and also all Halton providers – Domiciliary, Residential, Supporting People and Sheltered Accommodation to promote and raise their awareness. Whistleblowing is included in the Dignity E-learning and Safeguarding training. Whistleblowing policies are in place across multi-agencies. • Our 'Safeguarding Adults – Inter-agency Policy, Procedures & Guidance' in its section on the

		Legislative Framework contains information on the Public Interest Disclosure Act.
22. To ensure that threats to human rights are detected as early as possible, the CQC should take all available steps to facilitate feedback by any reasonable means from older people, their families and others. CQC should ensure that such intelligence is fed into their compliance monitoring and early warning risk assessments and acted upon where risks to human rights are indicated	✓	• CQC will also alert Quality Assurance if they have received complaints, concerns or have had a visit that highlighted issues in any of the areas detailed. Halton reciprocate this arrangement with CQC if there are any alerts, triggers or concerns. • Also we alert the Social Work team and the host authority if they are from out of borough. • The 'Help Us, Help You' campaign was launched November 2011 to facilitate a less formal approach in raising concerns or complaints. Also, Complaints and advocacy awareness sessions are being developed as another means of support.  Help us Help You.doc
23. With support from the Social Care Institute for Excellence and other organisations such as UKHCA, home care providers should share good practice that embraces a human rights approach to home care for older people	✓	Providers have many opportunities where good practice can be shared e.g. quarterly provider forums for both residential and home care providers, steering groups and they attend conferences/training. For example during 2010, Dignity Training sessions were held by the Dignity Co-ordinator with all providers.

Overall Recommendation: To address the status of home care workers

Recommendation	Progress (R/A/G)	Supporting Commentary
24. Skills for Care, the National Care Forum, the UKHCA, the Social Care Association, the English Community Care Association, the Health Professions Council, trade unions and other partners should work together to consider what steps will best enhance the status and skills of care workers, particularly those related to promoting and protecting human rights		**No Action Required**
25. The Commission strongly endorses the		• In the Domiciliary care tenders all providers stipulate their own costs.

recommendation of the Low Pay Commission that commissioning policies of local authorities should reflect the actual costs of care, including at the very least the National Minimum Wage	?	• Minimum wages – The Council evaluates wages / hourly rates as part of the tenders for social care. As part of the domiciliary care tender, the providers were measured and awarded points on pay, benefits and terms and conditions. All of Halton's providers do pay minimum wages and above. • Investigations currently taking place to explore the costs associated with care.

Action Points

Action Point	Description	Responsible Person	By When	Progress Commentary
1	Issue a contract variation letter to all Providers and obtain copy of Provider's Equality Policies.	Donna Ryan	April 2012	Completed - Letters were sent week commencing 3rd March 2012
2	Develop and implement Advocacy Hub	Mark Holt	April 2013	Consultation on the development of both the Advocacy Hub and Healthwatch is currently taking place with a range of local forums including the LINKs and Halton Older Peoples Empowerment Network. Once these events are completed the draft specification for the Advocacy Hub will be completed and the service agreed will then go out to tender towards the end of 2012. The new service that will be aligned with Healthwatch will be operational by April 2013.
3	Address current issues associated with current safeguarding processes via a short term multi-agency 'Task and Finish' group	Helen Moir	April 2012	Following meeting of the Group, a proposal is to be presented to the Board with a view to resolving the issues. This proposal to include the addition of the Priority and Northwest Specialist Commissioning to the draft Safeguarding Adults Protocol. Once agreed this can be embedded in the safeguarding procedures.
4	Establish an Adults Safeguarding Unit within the Communities Directorate of Halton Borough Council	Helen Moir	April 2012	Funding received from the NHS Mersey Cluster for 3 posts to develop an integrated safeguarding unit/hub. Principal Manager post has been appointed to and recruitment processes for other posts are being initiated.
5	Training programme to be held for elected Members who are undertaking visits to services.	Donna Ryan	April 2012	Training programme established which is being organised by the Council's Training Department – 15 Councillors are undertaking this training from March – June 2012. NB. Safeguarding, Equality & Diversity, Dignity & Dementia are the initial training that should be carried out. Councillors then have to the option to continue with further training at a later stage.
6	Co-ordinate the production of a directory of services to support people in their choice of provider to complement the information on the My Life Portal	Helen Moir	June 2012	Meeting to take place with Communitications and Marketing shortly to review current information and co-ordinate the production of additional information.
7	Ensure that the development of advocacy services for Older People is incorporated into	Mark Holt	April 2013	As well as developing an advocacy hub (see recommendation 5 above) there will be further development of generic advocacy services to

	the work of the Advocacy Hub as outlined in Action Point 3			extend into delivery of citizen and peer advocacy using trained volunteers. This will allow the existing paid services to focus on completion of specialist work that supports the whole system. This will be completed in line with the commissioning of the Advocacy Hub from April 2013.
8	Include a link on HBC's website to the Local Government Ombudsman relating to their role in investigating complaints about providers from self-funders	John Gibbon	March 2012	Information about the LGO role in investigating complaints from self-funders is included on the Adult social care complaints webpage. Information was also included in the Council's "Inside Halton" magazine March 2012 edition which goes to all households in the borough.

REPORT TO: Health Policy & Performance Board

DATE: 29th May 2012

REPORTING OFFICER: Strategic Director - Communities

PORTFOLIO: Health & Adults

SUBJECT: Any Qualified Provider Process

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To outline for the members of the Board details relating to the Any Qualified Provider (AQP) process within NHS Merseyside and details of three associated service specifications for :-

- Podiatry
- Muscular-skeletal services for neck and back plan
- Adult Hearing Aids

2.0 **RECOMMENDATION: That the Board:**

i) Notes the contents of the report
ii) Provide feedback on the three service spefications attached at Appendix 1

3.0 **SUPPORTING INFORMATION**

Background to AQPs

3.1 Since 2010, the Government has been committed to increased choice and personalisation in NHS-funded services. Choice for patients can be about the way care is provided, or the ability to control budgets and self-manage conditions. The government has specifically committed to extending patient choice of AQP for appropriate services.

3.2 By choice of AQP, the Government aims that when patients are referred (usually by their GP) for a particular service, they should be able to choose from a list of qualified providers who meet NHS service quality requirements, prices and normal contractual obligations.

3.3 The Government are undertaking a phased approach to implementation of patient choice of AQP, treating 2012/13 as a transitional year, starting with a limited number of community and mental health services. Based on discussions with national patient groups and an assessment of deliverability, the Department of Health identified a list of potential services for priority

implementation as follows:-

- Musculo-skeletal services for back and neck pain
- Adult hearing services in the community
- Continence services (adults and children)
- Diagnostic tests closer to home such as some types of imaging, cardiac and respiratory investigations to support primary assessment of presenting symptoms
- Wheelchair services (children)
- Podiatry services
- Venous leg ulcer and wound healing
- Primary Care Psychological Therapies (adults)

3.3 By October 2011, Primary Care Trust clusters were expected to identify three or more community or mental health services in which to implement patient choice of AQP in 2012/13, based on the priorities of pathfinder clinical commissioning groups, and having engaged with local patients and professionals.

As such NHS Merseyside have identified the following three services :-

- Podiatry
- Muscular-skeletal services for neck and back plan (MSK)
- Adult Hearing Aids

Following an engagement exercise with local patients and healthcare professional, the selection of these services was based on patients' priorities for improving quality of, and access to, NHS services.

3.4 It is expected that by the end of September 2012, PCT clusters should be able to implement patient choice of AQP in those services agreed locally.

3.5 **Qualification Process to become an AQP**

The qualification process will ensure that all providers offer safe, good quality care, taking account of the relevant professional standards in clinical services areas.

The governing principle of qualification is that a provider should be qualified if they:-

- Are registered with the Care Quality Commissioning and licensed by Monitor (from 2013) where required, or meet equivalent assurance requirements
- Will meet the Terms and Conditions of the NHS Standard Contract which includes a requirement to have regard to the NHS Constitution, relevant guidance and law
- accept NHS prices
- can provide assurances that they are capable of delivering the agreed service requirements and comply with referral

protocols; and
- reach agreement with local commissioners on supporting schedules to the standard contract including any local referral thresholds or patient protocols

3.6 Halton Borough Council will be an AQP and as such be able to tender for services through the AQP process.

Service Specifications

3.6 **AQP – Podiatry Services:** This AQP Service Specification is restricted to elements of Core Podiatry with the emphasis on community delivery of services and preventative treatment.

Core Podiatry is defined as 'the assessment, diagnosis and treatment of common foot pathologies associated with the toenails, soft tissues and the musculoskeletal system with the purpose of sustaining or improving foot health' (Farndon, 2006).

It is focused on the needs of those with low and medium levels of foot health need with referral on to specialised podiatry and extended scope podiatry and signposting to non-podiatric services where clinically appropriate, e.g. smoking cessation or weight management services.

Providers will be expected to provide appropriate staff training to ensure appropriate referrals to higher-tier podiatric services and non-podiatric services are made when needed.

3.7 **AQP – MSK:** This service is restricted to the community based provision of assessment, treatment and management of back and neck pain for patients with Whiplash associated disorders; Stiffness and restricted movement; Cervicogenic headaches; 'Mechanical' neck and back pain; Degenerative pain and Postural related neck and back pain. It is to be delivered by physiotherapists, osteopaths and chiropractors. The service is defined as an initial assessment, follow up appointments as appropriate to clinical need and support to patients for self-care.

The addition of AQP providers is expected to impact on Open Access physiotherapy services provided by The Royal Liverpool and Broadgreen Hospital and Aintree Hospital. These services are currently under review**.**

3.8 **AQP – Adult Hearing Aid Services**: The aim of the specification is to provide a comprehensive patient centred, direct access service for age related hearing loss in line with national guidance and local requirements.

This service will include a hearing needs assessment with provision and fitting and relevant follow- ups, rehabilitation and aftercare. The

Provider should have a suitable skill mix within their team and assessment and treatment provided by staff that are suitably registered/supervised, in appropriately sound treated settings.

It is important for the needs of local communities to be met and patients to receive high quality, efficient services delivered closer to home, with short waiting times and high responsiveness, free at the point of access.

3.9 The specifications have been presented to the Clinical Commissioning Group (CCG) and are now presented to the Board for review and comment.

4.0 POLICY IMPLICATIONS

4.1 None specifically identified, however work is on-going to develop Merseyside Service specifications in each clinical area and the CCG will have the opportunity to input into the development of these, following which they will be presented to the Health Policy & Performance Board as part of the consultation process.

4.2 It is feasible that the Council could consider providing some of the services and further consideration will be given to this opportunity.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None specifically identified, however tariffs have been established for each of the service areas.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
None identified

6.2 **Employment, Learning & Skills in Halton**
None identified

6.3 **A Healthy Halton**
All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**
None identified

6.5 **Halton's Urban Renewal**
None identified

7.0 RISK ANALYSIS

7.1 As the services are being commissioned across NHS Merseyside, we need to ensure that services available and delivered locally meet

the requirements of Halton residents and the performance of providers will therefore have to be closely monitored to ensure that this is the case.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 An Equality Impact Assessment is not required for this report.

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

Document	Place of Inspection	Contact Officer
Equity and excellence: Liberating the NHS	People & Communities Policy Team	Louise Wilson
Operational Guidance to the NHS : extending patient choice of provider	People & Communities Policy Team	Louise Wilson

SECTION B PART 1 - SERVICE SPECIFICATION

Service: Core Podiatry Service Specification

Service Specification No.	
Service	Core Podiatry
Commissioner Lead	
Provider Lead	
Period	Until September 2015
Date of Review	

B1_1.0 Population Needs

B1_1.1 National/local context and evidence base

The following are extracts from A Guide to the Benefits of Podiatry to Patient Care, The Society of Chiropodists and Podiatrists, 2010:

Foot and lower limb problems are common and are a significant cause of ill health, pain and disability and can lead to impaired balance increasing the risk of falling. It is estimated that eighty percent of older people have foot related problems *(Harvey et al., 1997)* and in an ageing society the prevalence of chronic foot problems will rise significantly *(Levy, 1992).*

General health and/or social problems are often detected by podiatrists who signpost patients to the appropriate agency, the self-referral process and community accessibility for these patients often proves to be the first point of contact for treatment and the podiatrist may be the first healthcare professional to assess their care needs.

Podiatry and foot health services are important to the public and this has been supported by the Government in the following publications:

- Health Care Commission Report ref C200601_0118, March 2007.
- Best Foot Forward, Help the Aged 2006 and Age Concern, Feet for Purpose 2007.
- Parliamentary Early Day Motion 777 to improve NHS access to foot health services.
- Alan Johnson Statement May 2008, *'development of good foot health services will be a priority objective of the national prevention plan'.*

B1_2.0 Scope

B1_2.1 Aims and objectives of service

The aims of the service are to achieve:

- High quality podiatric care efficiently and cost effectively to increase mobility and independence for adults and children
- In this context quality is defined through clinical effectiveness, patient experience and safety

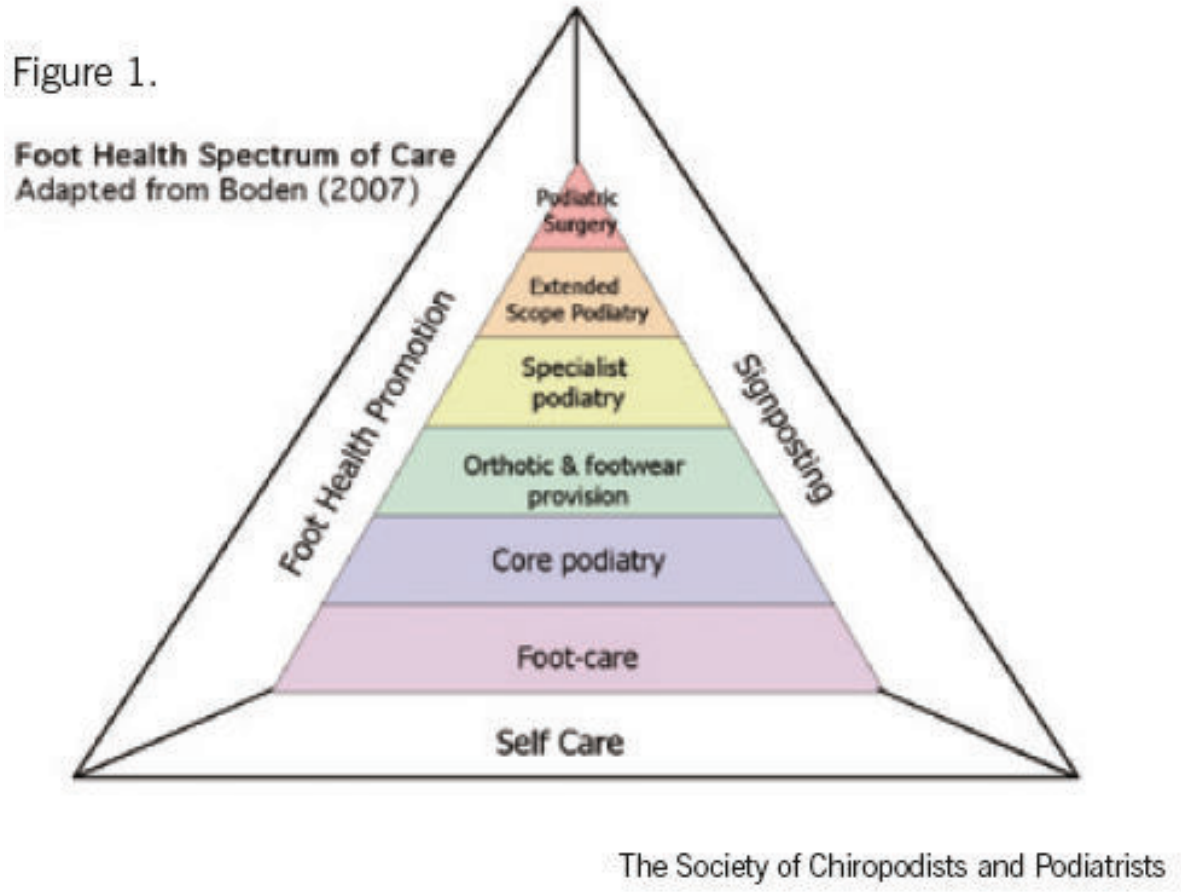
The objectives of the services are:

- To provide assessment and intervention for those patients with painful foot conditions where this has reduced mobility and independence
- To provide a surgical option for nail pathologies
- To provide management of foot pain associated with foot function and/or structural abnormalities for common foot and ankle conditions
- To provide footwear advice and orthotics as part of personalised care plans
- To provide foot health education information and public health information and to signpost to services
- To contribute towards falls prevention and maintain mobility and independence

B1_2.2 Service description

Figure 1 below illustrates the full spectrum of foot health care.

Figure 1: Foot Health spectrum of Care



This Any Qualified Provider Service Specification is restricted to elements of Core Podiatry within the spectrum with the emphasis on community delivery of services and preventative treatment.

Core Podiatry is defined as *'the assessment, diagnosis and treatment of common foot pathologies associated with the toenails, soft tissues and the musculoskeletal system with the purpose of sustaining or improving foot health'* (Farndon, 2006).

It is focused on the needs of those with low and medium levels of foot health need with referral on to specialised podiatry and extended scope podiatry and signposting to non-podiatric services where clinically appropriate, e.g. smoking cessation or weight management services. Providers will be expected to provide appropriate staff training to ensure appropriate referrals to higher-tier podiatric services and non-podiatric services are made when needed.

This Service Specification **covers**:

- Elements of core podiatry defined as the scope of practice obtained at graduation including the treatment of patients with biphasic peripheral pulses as a minimum determined by Doppler ultrasound; eighty percent (80%) peripheral sensation based on mononfilament assessment and **excluding** any co-morbidities requiring immuno suppressant medication including Anti-TNF and people with diabetes assessed under NICE Clinical Guideline 10 as at Increased Risk or above.
- Core podiatric conditions for people meeting the above criterion would include painful nail pathologies, dermatological conditions, corns, callus and fissures; heel pain and metatarsalgia; nail surgery procedures; vascular assessments and wound management associated with this case mix.
- Core Podiatry to only include patients who are clinically assessed as eligible through the medical and podiatric needs criteria assessment (see Section B1_2.4).
- Referral on to specialist podiatry service (as per local pathways) and signposting to non-podiatric services where clinically appropriate.
- Integral to the above is the provision of falls prevention advice (following local falls prevention pathway and guidance into specialist services where appropriate) and health education.
- Adults and children with a podiatric need including iatrogenic conditions without co-morbidity, i.e. foot conditions that are a result of health care treatment that do not have direct pathology but do have related lesions elsewhere in the foot.

This Service Specification **does not** cover:

- Personal foot care defined as toenail cutting and skin care including the tasks that healthy adults would normally carry out as part of their everyday personal hygiene.
- Specialist podiatry covering diabetes; peripheral arterial disease; systemic musculo-skeletal disorders; immune mediated connective tissue disorders; forensic podiatry, and; the use of advanced technology, e.g. surgical debridement.
- Extended scope podiatry practice including requesting blood tests; scans and interpreting results; injection therapy, and; the use of diagnostic ultrasound.
- Podiatric surgery, i.e. the surgical treatment of the foot and its associated structures by a podiatric surgeon.
- Complex biomechanics.
- Podiatry for children with concurrent medical conditions.
- Annual diabetic foot checks as these are commissioned from primary care. Local arrangements may be made for GPs to sub-contract this work to podiatrists but this is outside the scope of this specification.
- Domiciliary visits and care home service provision.

Services covered under Core Podiatry are detailed in Table 1 below:

Table 1: Services covered under Core Podiatry

Service	Description
Patients with foot problems, such as: Nail Pathologies • Dermatological conditions • Corns Callus/fissures • Long Term conditions where the risk of foot ulceration and infection is low, e.g. low risk diabetes, stable and low risk rheumatoid arthritis, multiple sclerosis, Parkinson's disease • Structural and functional abnormalities • Acute soft tissue pathologies requiring the use of local anaesthesia	To be responsible for the assessment, diagnosis, planning and implementation and evaluation of patients with subsequent production of individual care packages and provision of appropriate foot care education.
Non-specialised biomechanical clinics • Excluding complex biomechanical conditions	This may involve: • Anatomical and functional assessment of static and dynamic joint mobility • Assessment of soft tissue and muscle function • Strapping techniques • Neurological assessment • Footwear advice and referral to orthotist and specialised podiatry input
Diabetes Management consistent with NICE Clinical Guideline 10 • To be responsible for the podiatric assessment, diagnosis, planning and implementation, delivery and evaluation of people with diabetes assessed as Low Current Risk • Excludes annual foot health check which should be provided through primary care. (Note: GPs and commissioners may sub-contract this work to core podiatry but this will not be covered by the Any Qualified Provider Contract)	This will involve the examination of a patient's feet and lower legs to detect risk factors. Examination of patients' feet to include: • Testing of foot sensation using 10 g monofilament or vibration • Palpation of foot pulses • Inspection for any foot deformity • Inspection of footwear Classify foot risk as: • Low current risk (normal sensation, palpable pulses) • At increased risk (neuropathy or absent pulses or other risk factor) • At high risk (neuropathy or absent pulses plus

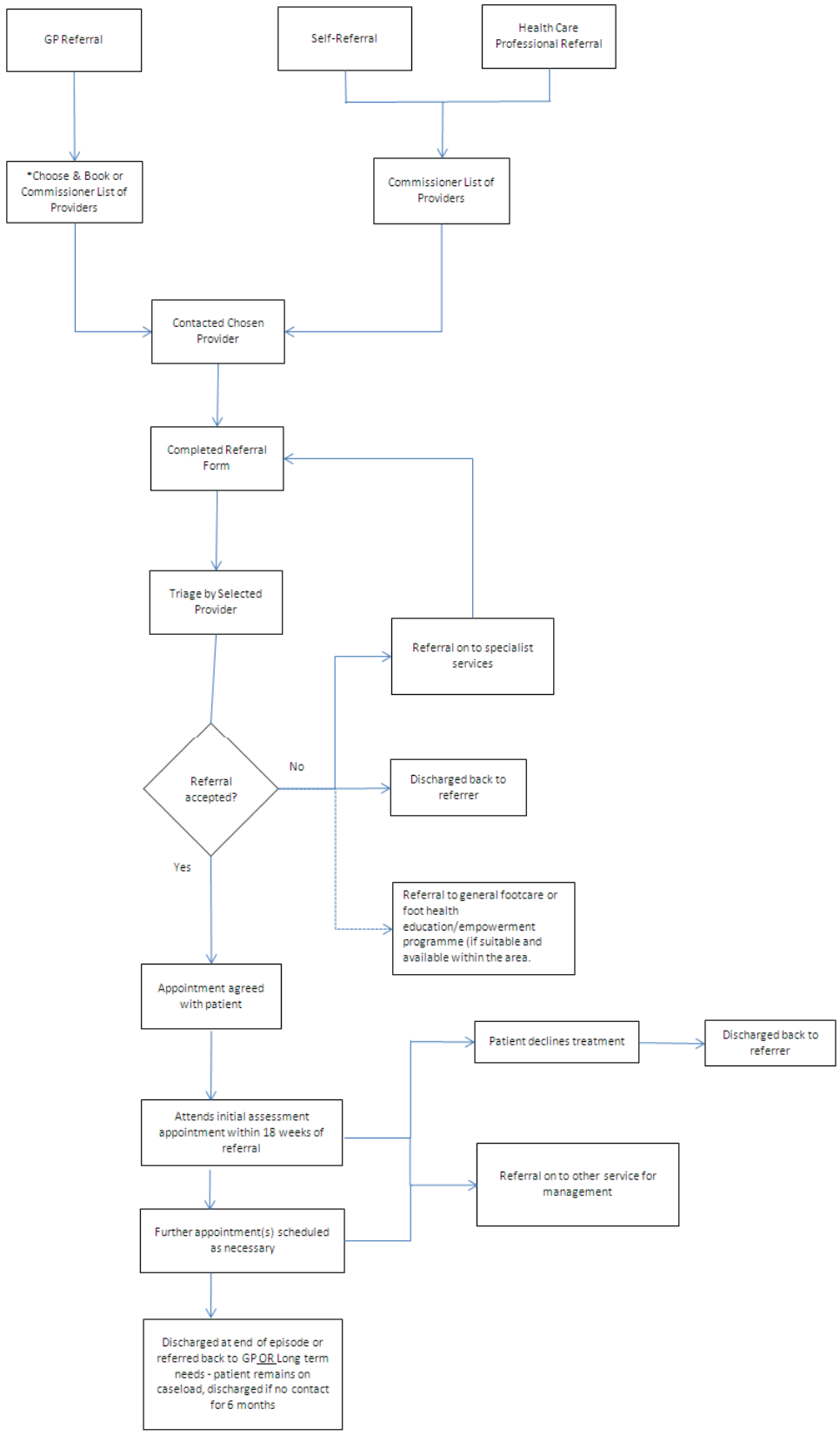
Service	Description
	deformity or skin changes or previous ulcer) • Ulcerated/infected foot Referral of at increased risk, high risk patients and patients with an ulcerated/infected foot to: • Specialist Podiatry or Extended Scope Podiatry as part of Multi-Disciplinary Team as per local pathway Treatment of patients assessed as low current risk may include: • Wound Care to include grades 0-1 on the Wagner Scale or equivalent and/or wound not healed after 4 weeks (see Appendix **Error! Reference source not found.**). (Note: Wagner Scale 2-5 patients to be referred to specialised wound care). • Assessment of vascular neurological and disease activity to help with treatment planning • Footwear advice and footwear referral • Provision of simple foot orthoses, basic insoles • Patient and carer foot and health education
Management of podiatric need of patients with rheumatoid arthritis. • To be responsible for the podiatric assessment, diagnosis, planning and implementation, delivery and evaluation of people with rheumatoid arthritis assessed as Low Current Risk • Excluding the at risk rheumatoid foot as defined by: ▪ Current use of TNF blockers, other biological disease modifying agents, or systemic immunosuppressants. ▪ A history of more than five years of medication with oral steroid. ▪ Current or recent vasculitis in the past 12 months. ▪ A history of ulceration and/or skin infection related to their inflammatory disease.	Assessment and Management of foot problems associated with many rheumatological conditions. • Biomechanical assessment • Provision of simple foot orthoses, basic insoles • Assessment of vascular neurological and disease activity to help with treatment planning • Footwear advice and referral to therapeutic footwear services • Referral to specialised team when tissue breakdown and/or acute episode or flare up • Patient and carer foot and health education

Service	Description
Nail Surgery Procedures • The treatment of nail pathologies such as ingrowing toe nails, involuting nails and mycotic or thickened toe nails	The correction of nail pathologies with the use of local anaesthesia (LA) and minor surgical techniques which involves: • Taking a medical history to ensure that the patient is medically fit to have local anaesthesia • Removal of part or the whole of the nail that is causing the problem • The use of a chemical to obliterate the nail matrix • Application of a post operative dressing • Arrange post operative follow up where patients undertake daily wound changes with review appointments with podiatrists until resolution and discharge
Vascular Assessments	• The use of Doppler to undertake vascular status • Visual observations of the lower limb • Onward referral where appropriate
Simple Wound Management • Wound Care to include grades 0-1 on the Wagner Scale or equivalent and/or wound healed within 4 weeks (see Appendix **Error! Reference source not found.**)	This may involve: • Debridement of the wound • Use of appropriate wound dressing • The use of deflective padding to ensure pressure relief • Provision of simple foot orthoses, basic insoles where appropriate • Review appointments until resolved or liaison with or referral to a specialised service • Referral of Wagner Scale 2-5 patients or patients whose wound has not healed within 4 weeks to specialised wound care
Integral to the above is:	
Contribution towards Falls Prevention	• Ability to refer to other services • Provision of simple foot orthoses, basic insoles where appropriate • Footwear evaluation and recommendation of appropriate footwear • Education and information on how to reduce the risk of falling • Home exercise programme

Service	Description
Patient Education Programmes	This may involve: • Patient advice and information as part of their care plan • Promoting self-care to patients in order to ensure good foot health and mobility • Health education promotion and education on smoking cessation, nutrition and exercise and signpost patients as appropriate

B1_2.3 Care pathway

Figure 2: Care Pathway



*Choose and Book - when available to all Providers

Stage 1 – Referral to Clinical Assessment

There are three referral routes:

- GP referral where the patient consults their GP with a foot problem and then is referred on to podiatry services.
- Referral by another health care professional where the patient is being treated by another health care professional, e.g. a physiotherapist, and then is referred on to podiatry services with a foot problem.
- Self-referral where the patient accesses podiatry services direct.

Patients entering the care pathway via GP referral will use 'Choose and Book' (when available to all Providers) or the Commissioner List of Providers to view the list of qualified providers and make an informed choice of provider. Patients may either access the 'Choose and Book' website in the GP's Practice (with the help of a 'Choose and Book' clerk) or at home on their home computer.

Self-referral patients and patients entering the care pathway via Health Professional referral will view the list of qualified providers via the Commissioning Organisation's website or via paper information available at GP Practices, Pharmacies, Dentists, Opticians, or Commissioning Organisation's offices.

GPs/Patients will contact the patient's chosen provider and complete a Referral Form (see Appendix **Error! Reference source not found.**). The Provider will assess the referral against the eligibility criteria. If the patient referral is not accepted, the patient's GP/patient will be informed that their referral has been rejected and give reasons for this rejection. Alternatively, the Patient may be referred to an alternative, more appropriate service.

If the Patient's referral is accepted then the Provider will contact the patient to arrange an initial assessment appointment. The initial assessment appointment should take place within 12 weeks of the referral.

Where a possible cancer or Red Flag condition is identified at triage or upon assessment, the Provider must take responsibility to fast track these patients in the most appropriate manner.

Stage 2 – Clinical Assessment to Discharge

The Patient attends his/her initial assessment appointment at which his/her condition is assessed and a Treatment Plan is formulated. Depending on the Patient's condition, advice or treatment may be given at this initial assessment appointment. If the Patient declines treatment they will be discharged back to the referrer.

Patients whose condition falls outside the scope of the services, e.g. increased risk diabetes patients, will be referred on to an appropriate other service for management.

For Patients whose condition falls within the scope of services, further appointments may be scheduled consistent with the scope of service.

Patients will be discharged at the end of an episode of treatment or referred back to their GP. Patients with long term needs will remain on the caseload but will be discharged if there has been no contact for a period of six months.

B1_2.4 Patient Assessment Tool

To ensure a consistent approach to patient assessment for access to podiatry provision use the following assessment tool based on two main criteria - Podiatric need and Medical need.

Table 2: Medical Need

Increased Risk Group	Low Risk Group	No Medical Risk
Neuropathic conditions Ischaemic Limb Conditions Scleroderma Rheumatoid or related inflammatory arthritis Diabetes Mellitus (according to risk classification) Poor Tissue Viability Neurological Disorders Steroids/Warfarin Chemotherapy/immunosuppressives	Osteo-arthritis Visual Problems Physical Disability Mental disability Learning Disabilities	No relevant medical history

Table 3: Podiatric Need

High Need Acute Conditions	**Medium Need** Painful Conditions	**Low Need** Non-painful conditions
Ulcerations Infections of skin and nails Acute biomechanical problems	Symptomatic corns Symptomatic moderate/heavy callus Chronic Biomechanics Severe Foot Deformities Painful nail and skin e.g. involution, painful foot warts (pain reduction)	Minimal diffuse callus Non-painful verrucae Skin care advice e.g. athletes foot, pressure points

Using the medical and podiatric needs criteria assess the patient as to their matrix position.

Table 4: Medical and podiatric needs matrix

Podiatric Need	Medical Need Increased Risk Group	Low Risk Group	No Medical Risk
High	Specialist Podiatry Manage to resolution	AQP Manage to resolution	AQP Manage to resolution
Medium	Specialist Podiatry Devise care plan to include self care and discharge where appropriate	AQP Devise care plan to include self care and discharge where appropriate	AQP Initial appropriate treatment, advice and discharge
Low	AQP Devise care plan to include self care and discharge where appropriate	AQP Initial appropriate treatment, advice and discharge	AQP Discharge back to referrer with appropriate advice

B1_2.5 Discharge Criteria and Planning

A person should be discharged if one of the following applies:

- Their specified course of treatment/episode of care has concluded or on re-assessment it is found that continuing treatment is unnecessary or inappropriate. Advice on self-help and training will be offered. Appropriate written information will be given.
- Patient moves to an area where the Provider has not been commissioned.
- Patient discharged themselves/service refused by person.
- Non-podiatry problem and referral to another agency, e.g. physiotherapist.
- New patients: On assessment it is found that treatment/therapy is unnecessary because of low medical/podiatric need. The Service will then offer advice on self help. Appropriate written information will be given. The patient is then discharged.
- Existing podiatry patients will be discharged if they have not received treatment within the last 6 months.
- Non-compliance with agreed treatment plan will lead to discharge after a reasonable period of time, i.e. 3 consecutive treatments.
- Patients who DNA the first appointment
- Patients who DNA three consecutive follow up appointments

NOTE:

- If NHS funded patients, either new or existing, strongly disagree with the decision to discontinue treatment they should contact the local commissioning group to complain. The podiatrist would provide the appropriate clinical decision making justification as part of the complaints process.
- Once discharged a patient will need a new referral.
- Where clinically appropriate, the Provider will send discharge information to the patient's GP.

B1_2.6 Population covered

This service specification covers the population of NHS Merseyside (currently Halton CCG, Knowsley CCG, Liverpool CCG, Sefton CCG and St Helens CCG). Merseyside has a patient population of around 1.2m. The communities served by the Clinical Commissioning Groups (CCG) include some of the most deprived areas of the country, and some of the most affluent. Its people are equally diverse in their ethnicity and social background. Overall, the area follows the national trend of an ageing population, with Southport in North Sefton have a higher than the national average proportion of older people.

In terms of number of GP practices across the Merseyside area, details are below

Sefton - 55

Liverpool – 94

Knowsley – 28

Halton- 17

St Helens – 47

PCT Population Estimates, selected age groups

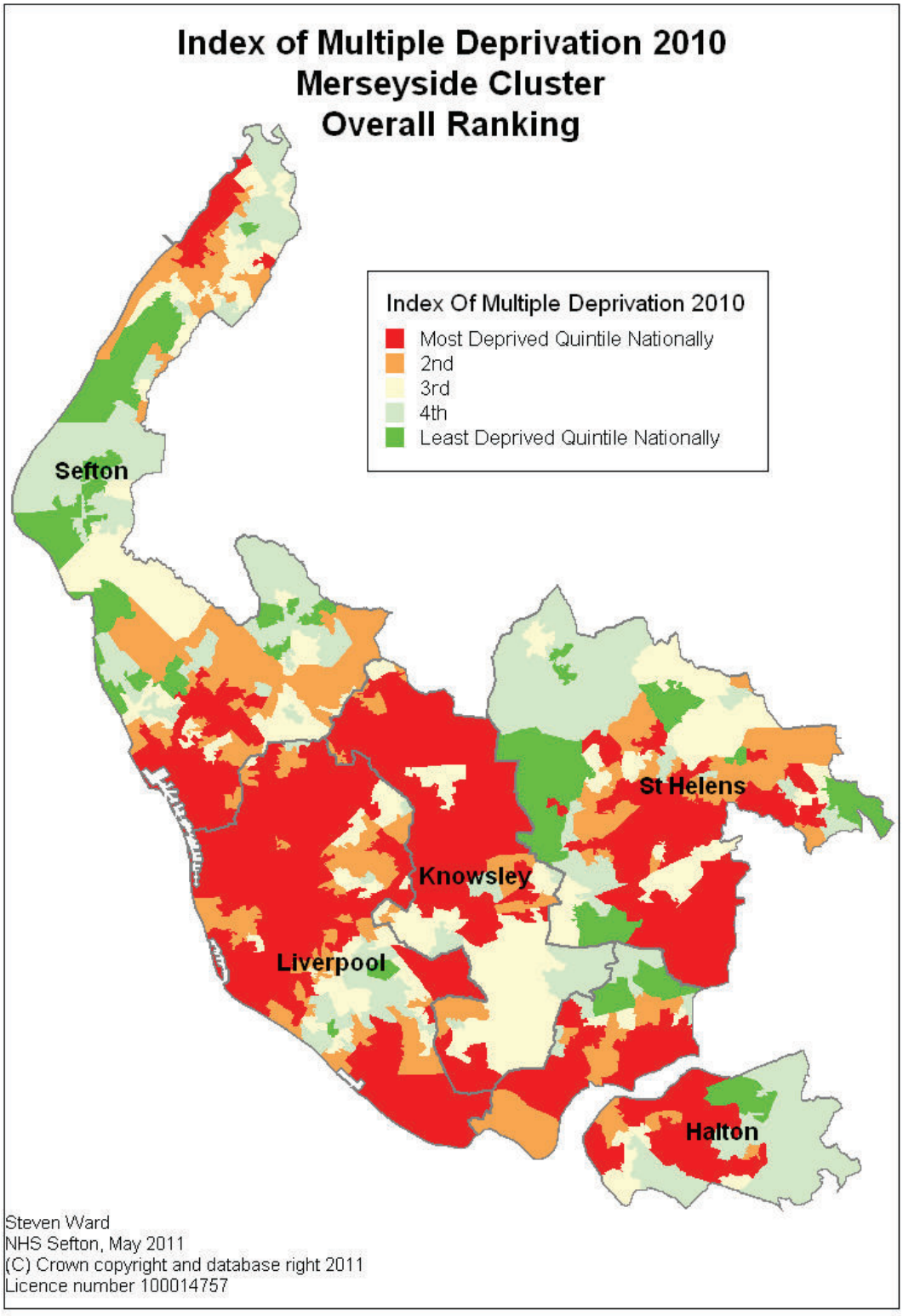
PCT	Persons All Ages	Persons 0-15 years	Persons 16-64 years	Persons 65 years and over
Knowsley	149,100	29,500	96,400	23,300
Liverpool	445,200	75,000	307,100	63,100
Sefton	272,900	47,300	169,200	56,400
Halton	119,300	24,200	77,700	17,400
St. Helens	177,400	32,700	11,3900	30,800

PCT	Persons All Ages	Persons 0-15 years	Persons 16-64 years	Persons 65 years and over
Knowsley	100%	19.8%	64.7%	15.6%
Liverpool	100%	16.8%	69.0%	14.2%
Sefton	100%	17.3%	62.0%	20.7%
Halton	100%	20.3%	65.1%	14.6%
St Helens	100%	18.4%	64.2%	17.4%

Source: 2010 Mid Year Population Estimates, ONS.

Deprivation

In terms of deprivation, according to the overall Indices of Deprivation 2010, Liverpool (ranked most deprived) and Knowsley (5th) are ranked in the five most deprived local authorities (out of 326 local authorities nationally). Halton (27th) is in the top 10% most deprived LAs, with St Helens (51st) in the top 16% and Sefton (92nd) in the top 30%


Index of Multiple Deprivation 2010
Merseyside Cluster
Overall Ranking
Index Of Multiple Deprivation 2010
Most Deprived Quintile Nationally
2nd
3rd
4th
Least Deprived Quintile Nationally
Sefton
St Helens
Knowsley
Liverpool
Halton
Steven Ward
NHS Sefton, May 2011
(C) Crown copyright and database right 2011
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Ethnicity

PCT	Persons	Persons	Persons	Persons	Persons	Persons
	All Groups	White	Mixed	Asian or Asian British	Black or Black British	Other
Knowsley	149,300	144,300	1,800	1,500	900	900
Liverpool	442,300	402,600	8,800	13,000	8,300	9,400
Sefton	273,300	263,700	2,500	3,000	1,500	2,700
Halton	118,700	115,700	1,000	900	400	600
St Helens	177,200	172,200	1,500	1,600	600	1,200

Source: ONS 2009 Ethnicity Estimates (Experimental)

Note: These totals will not match the overall population figures quoted in the 2010 population estimates above due to the different time periods.

Public/Private Sector workforce

In terms of workforce, estimates of the Public and Private Sector workforce shows that for LAs in Merseyside Sefton has the highest rate of public sector employment. At 23.5% the public sector employment rate is significantly higher than the UK average, while at 46.6% the private sector employment rate is significantly below the UK average.

Table 2: Public and private sector employment, by local authority, Jan-Dec 2010

Local Authority	Public Sector Employees as a Share of Total Employees[1]	Public Sector Employee Density[2]	Public Sector Employment Rate[3]	Private Sector Employee Density[4]	Private Sector Employment Rate[5]	Significance test of difference from UK average (95% confidence level)			
						Public Sector Employment Rate		Private Sector Employment Rate	
						Above UK Average	Below UK Average	Above UK Average	Below UK Average
	%	%	%	%	%				
Halton	18.1	12.0	15.9	54.1	50.0				
Knowsley	26.7	15.1	17.9	41.6	42.7				✓
Liverpool	29.9	21.5	18.1	50.4	41.4				✓
St. Helens	22.8	11.8	20.0	39.8	47.5				✓
Sefton	32.3	17.3	23.5	36.2	46.6	✓			✓
Wirral	29.5	14.4	19.5	34.3	45.7				✓
Liverpool City Region LEP	28.1	16.7	19.4	42.8	44.8	✓			✓

Source: ONS

1 Public Sector Employee jobs located in the area as a share of total employee jobs located in the area.
2 Public Sector Employee jobs located in the area divided by the area's population of 16 to 64 year olds.
3 Share of 16 to 64 year old residents of the area who report that they are employed in the public sector
4 Private Sector Employee jobs located in the area divided by the area's population 16 to 64 year olds.
5 Share of 16 to 64 year old residents of the area who report that they are employed in the private sector.

Source: Assessing the Impact of the Economic Downturn on Health and Wellbeing, Liverpool Public Health Observatory, February 2012.

B1_2.7 Any acceptance and exclusion criteria

The Provider will accept referrals meeting the following criteria:

- Patients registered with a GP practice within NHS Merseyside (currently Halton CCG, Knowsley CCG, Liverpool CCG, Sefton CCG and St Helens CCG) OR patients resident in the NHS Merseyside footprint
- Patients with a condition covered by the scope of the specification and who qualify for this service using the Patient Assessment Tool.
- It is the responsibility of the Provider to ensure that referrers to the service are eligible to refer to the service. NHS Somerset will not pay for any non eligible referrals.

B1_2.8 Interdependencies with other services

The Provider will accept self-referrals and referrals from GPs and health and social care professionals. The service will form interdependencies with the following services:

- GP practices

- Community health and social care services
- Independent providers
- Third sector organisations
- Patient support groups i.e. Expert Patient Programme
- Specialist NHS podiatry services
- Other NHS commissioned services
- Clinical Commissioning Groups

It is the responsibility of the providers to ensure that all appropriate details are communicated to the necessary recipients. Providers will be responsible for ensuring the accuracy of this information and any notifications.

The Provider needs to develop their relationships with other providers to become an integral member of the local health community. The role of service users will be an important component of this development and Providers should ensure effective mechanisms for their involvement and develop a positive relationship with the local involvement network (Healthwatch). The Provider will participate in service improvement in any relevant area where a need for service improvement has been identified.

The Provider will be required to comply with locally agreed pathways.

The Provider is expected to be involved in local care pathway discussions and work, ensuring the best and most efficient means of treating patients are adopted, including the movement of all relevant clinical information.

B1_2.9 Workforce

The Provider should have an appropriate skill mix within their team. Assessment should always be provided by a Health Professionals Council (HPC) member of staff. Treatment can be provided by staff who are either registered or supervised by a registered practitioner and who are appropriately trained, qualified and experienced.

In terms of training and development:

- All staff should be appropriately trained to undertake all procedures within the scope of their job role
- All staff should be able to demonstrate Continuing Professional Development activity
- Staff should participate in peer review networks, appraisal and Professional Development Plans

Providers are responsible for:

- Ensuring that all their staff who interact with service users are appropriately trained, qualified, Criminal Record Bureau (CRB) enhance checked and approved and professionally registered, where appropriate

B1_2.10 Facilities

Provider outlets and facilities should be accessible both in terms of public transport links and parking facilities and compliant with all relevant local and national laws, regulations and service requirements including:

- The Equality Act 2010
- The Disability Discrimination Act
- Building must meet all Statutory Compliance regulations

If relevant Acts or guidance is updated then Providers would be expected to comply with these updates.

Particular attention should be paid to the accessibility needs of people with sensory, physical and mental impairments, as well as those who may face, for instance, cultural or language barriers. The Provider should make adequate and reasonable provision for interpreters, carers and others from whom the patient may require assistance, providing information and signage in an appropriate range of formats, media and languages, and ensuring service and customer care is delivered in an inclusive manner which respects the diversity of users.

B1_2.11 Information Management & Technology (IM&T)

Providers should:

- Ensure that all NHS patient information and data gathered in the course of delivering the service is only used in pursuance of delivering the NHS services and is not held or used for any other purpose.
- Understand that all patient records (in any format) gathered in the course of delivering the service remain the property of the NHS and should be surrendered to the commissioner at any time on request, and in any case at the end of the contract.
- Have in place appropriate IM&T Systems and infrastructure to support the delivery of the specified services, management of patient care, contract management and business processes and comply with specific requirements and the underpinning information standards and technical specifications expected for NHS service provision.
- Ensure they have effective systems in place for handling information securely and confidentially and that they have appropriate sharing agreements in place with all partner organisations.

B1_2.12 Governance

The provider is required to have in place:

- An organisational structure that provides leadership for all professions and disciplines involved in delivery of the services

- Clear organisational and integrated governance (including clinical governance) systems and structures with clear lines of accountability and responsibilities for all functions
- A professional head of service/clinically accountable director with responsibility for operational and clinical governance within the service including clinical management and quality assurance

B1_2.13 Complaints

The provider must:

- Have formal complaints policies and procedures through which patients can raise issues with the service
- Respond to complaints in line with the NHS complaints procedure
- Provide to the NHS complaints service a summary of all complaints, responses and actions taken as a result on a monthly basis

B1_2.14 Marketing and Promotion of Services

Providers marketing and promoting their NHS services should adhere to the 'Code of Practice For The Promotion of NHS-Funded Services'.

The Provider will:

- Undertake communication activity and marketing campaigns in order to promote the NHS funded service. This will include producing marketing materials, information and literature relating to the service. Both the Commissioner and the Provider have the right to approve content of such materials. Materials may include posters, information sheets or electronic media on accessing the service.
- Comply with NHS branding guidelines when producing communication, marketing and patient promotion literature
- Any communication, marketing and promotional activity must be separate from other non-NHS funded services marketing and promotion activities
- Not pro-actively promote non NHS-funded services, activities or products which could be considered to be an alternative option to NHS provision to NHS patients using the service
- Not market NHS products and services as inferior to other products or services they or any organisation in which they have an interest provide
- Offer patients an opportunity to opt into receiving marketing information, and not make future contact without the patient's explicit opt-in consent

B1_2.15 Patient Engagement

The provider will record and monitor levels of patient experience with the service and identify themes, trends and areas for improvement.

The Provider will supply the results of surveys in full along with action plans for service improvement based on the outcome of patient surveys to the Commissioner.

Patient surveys will include questions around access, communication, quality and overall experience.

The Provider will comply with the NHS duty to involve users and stakeholders, and to undertake patient involvement under sections 242 and 244 of the NHS Act 2006, and subsequent involvement legislation.

The Provider will ensure that arrangements are made to secure the involvement of service users in the planning and development of services and in any proposals for changes in the way services are provided and/or in decisions that affect the operation of services.

B1_3.0 Applicable Service Standards

B1_3.1 Applicable National Standards

Good quality evidence for podiatry is identified within each of the following national documents:

- National Service Framework for Older People (2001)
- National Service Framework for Long Term Conditions (2005)
- Musculoskeletal Framework Services Framework (2006)
- Type 2 Diabetes Prevention and Management of Foot Problems (NICE, 2004)
- A Guide to the Benefits of Podiatry to Patient Care (The Society of Chiropodists and Podiatrists, 2010)
- National Service Framework for Diabetes: Standards (2001)
- Diabetes Commissioning Toolkit (2006)
- Rheumatoid Arthritis: National Clinical Guideline for Management and Treatment in Adults (Royal College of Physicians, 2009)

B1_3.2 Applicable Local Standards

This is intended as a non-exhaustive list. Clause [16] takes precedence.

B1_4.0 Key Service Outcomes

The key service outcomes are:

- Improved mobility and independence for patients
- Reduced foot pain
- Improved foot health
- A good patient experience

B1_5.0 Location of Provider Premises

The Provider's Premises are located at:
Not applicable

B1_6.0 Individual Service User Placement

Not applicable

SECTION B PART 1 - SERVICE SPECIFICATION

Mandatory headings 1 – 3. Mandatory but detail for local determination and agreement.

Optional headings 4 – 6. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement.

Service Specification No.	
Service	AQP Back and Neck Pain Musculoskeletal Treatment Service
Commissioner Lead	
Provider Lead	
Period	2012/13
Date of Review	

This service specification forms part of the NHS Standard Contract Terms and Conditions and must be read in conjunction with the same.

B1_1.0 Population Needs

B1_1.1 National/ local context and evidence base

In Europe nearly one-quarter of adults are affected by long-standing musculoskeletal (MSK) problems that limit everyday activity[1]. In the UK 16.5 million people have back pain[2]. In addition, 20% of the population present each year with a new onset or recurrences of an MSK problem[3].

Musculoskeletal disorders are the fifth highest area of spend in the NHS consuming £4.2 billion in 2008/9 [4] and increasing each year. MSK conditions also have a significant social and economic impact, with up to 60% of people who are on long-term sick leave citing MSK problems as the reason[2] and patients with MSK forming the second largest group (22%) receiving incapacity benefits[5].

1 Department of Health, 2006. Musculoskeletal Services Framework
2 Clinical Standards Advisory Group for Back Pain. London, HMSO, 1994
3 Clarke A & Symmons D. The burden of rheumatic disease. Medicine 2006; 34 (9): 333-335
4 ARMA 2010. Liberating the NHS: Transparency in outcomes – a framework for the NHS
5 CBI in associate with AXA, 2005. 'Who care wins: absence and labour turnover 2005'

Currently there are wide variations in the quality of service provision for the treatment of MSK back and neck problems, with:

- Limited patient choice in some areas;
- Long waiting times to access the service;
- Lack of community based services; and
- Poor patient experience and outcomes.

[Local commissioners to insert local population needs data and drivers for change]

B1_2.0 Scope

B1_2.1 Aims and objectives of service

The aim is to provide a comprehensive, patient-centred, easy to access back and neck pain service in the community, which delivers high quality, efficient services in line with national guidance and local requirements.

The service objectives are:

- To give patients a choice of provider.
- To provide improved access to services closer to home.
- To reduce waiting times to access the service and deliver treatment to enable patients to reach their individual treatment goals sooner. This could include an improved quality of life, return to work, more manageable pain.
- To deliver clinically effective treatments, that reduce the demand on secondary care services and reduce the need for more costly interventions.
- To provide community services that have a strong emphasis on patient education and self-management, thereby promoting active, healthy lifestyles and reducing recurrence of injury or illness.

B1_2.2 The Service

The service required is for the community based provision of assessment, treatment and management of back and neck pain in line with the acceptance and exclusion criteria and service requirements outlined in this specification.

The service requirements have been designed with consideration of NICE guidelines for Low back pain: early management of persistent non-specific low back pain[1]; Map of

[1] Clinical guidelines CG88 Low back pain: Early management of persistent non-specific low back pain, 2009. National Institute for Health and Clinical Excellence

Medicine pathways for Low Back Pain – initial management[1] and for neck pain[2]; Musculoskeletal Services Framework[3]; and built upon the learning from existing service model studies[4].

B1_2.3 Any acceptance and exclusion criteria

B1_2.3.1 Referral criteria:

A patient is eligible for referral to the service if they present with primarily back or neck pain with or without 'referred' symptoms to the limbs including:

- Whiplash associated disorders
- Stiffness and restricted movement
- Cervicogenic headaches
- 'Mechanical' neck and back pain
- Degenerative pain
- Postural related neck and back pain.

B1_2.3.2 Referral Mechanisms:

Routine: All patient referrals that are not categorised as urgent, for example:

- Patient with intermittent pain.
- Patient has a mild to moderate reduction in functional ability.
- Mild to moderate impairment of activities of daily living.
- Patient's condition has the potential for improvement with intervention.

Exclusions: Patients who meet any the following conditions are not appropriate for referral and therefore not covered in this service:

- Suspicions of serious pathology– urgent to secondary care or as per locally agreed pathways.
- Patients under 16 years of age
- Patients that do not meet referral criteria.
- Patients who are not registered with a GP in locality.
- Patients who it is recognised at point of referral / initial assessment have little or no potential for further or sustained improvement through undertaking a course treatment.
- Housebound patients

[1] **http://healthguides.mapofmedicine.com/choices/map/low_back_pain1.html**
2 **http://healthguides.mapofmedicine.com/choices/map/neck_pain1.html**
3 Department of Health, 2006. Musculoskeletal Services Framework
4 Back and neck pain services case study: Manual Therapies Back & Neck Service, NHS North East Essex – **http://healthandcare.dh.gov.uk/back-and-neck-pain-services**

- Patients with widespread or chronic (greater than 1 year) musculoskeletal pain.
- Patients who have a primary peripheral limb problem with secondary back and neck pain (e.g. hip or shoulder problems, foot or gait abnormalities).
- Women who are over 28 weeks pregnant.
- Patients requiring diagnostic tests

Urgent*:* Patient referral is considered urgent if one or more of the following apply:

- Patient dependent on strong analgesics
- Severe sleep disturbance due to condition.
- Clinical condition likely to significantly and quickly deteriorate without intervention.
- Severe impairment of activities of daily living.
- Deteriorating neurological states.

Patients who do not meet the referral criteria will be referred as per local pathways.

B1_2.4 Service description

The community based back and neck pain treatment service incorporates a package of care including:

- An initial assessment;
- Follow up appointments as appropriate to clinical need; and
- Support to patients for self-care.

B1_2.4.1 Requirements at each stage of the care package

B1_2.4.1.1 Self-care

The provider must encourage patients to be more involved in their own care and empower them to take further responsibility for wellness. The provider must provide information to patients (and as appropriate their carers) regarding self-care, in accordance with best practice. This should include weight management and exercise advice, and may include signposting to Health Trainers or other recognised community support services. Providers must ensure that this is undertaken at the outset and continued throughout the whole package of care and that a self-care management plan is provided to the patient upon discharge from the service.

B1_2.4.1.2 Initial clinical assessment

Providers are required to undertake an initial assessment appointment for all patients. During this appointment the provider must assess whether it is an appropriate referral and that the patient would benefit from their treatment package. For accepted referrals, it is expected that treatment should normally commence during this initial assessment appointment and a patient management plan should be agreed.

This initial assessment must include the identification of any red flags (indicators in the history or examination suggestive of serious underlying pathology) which should be managed as per local pathway.

The initial assessment must also include the identification and any yellow flags (indicators in the history or examination of psychosocial (surmountable) obstacles to recovery). All providers must be able to identify these obstacles and be able to work with patients towards overcoming them.

For all accepted referrals a Patient Reported Outcome Measure (PROM) pre-treatment questionnaire should be completed by the patient at the time of this initial assessment.

For all accepted referrals the provider should notify the GP and provide a copy of the patient's agreed intended care package. Any treatment agreed with the patient must be evidence based.

If a referral is not accepted by the provider, the provider will return the referral documentation to the referrer (GP or interface service) with detailed reasons for rejection sufficient to minimise inappropriate referrals in the future, and make recommendations (where appropriate) for on-going management of this patient.

B1_2.4.1.3 Follow-up appointments

For all referrals that are accepted, the provider will provide a package of care consisting of the necessary treatment required to meet the individual clinical needs of the patient.

Providers will need to set out in their response document which treatments they will provide. Any treatment offered as part of the package of care must have robust, evaluated clinical evidence. Treatments may include, but not be limited to, the following:

- Manual therapy: joint mobilisations and manipulation;
- Soft tissue mobilisation: muscles, ligaments, cartilage, neural;
- Exercise programmes;
- Acupuncture.

It is anticipated that the treatment will consist of, a maximum of 4 follow-up sessions,[1] however the duration of treatment should be appropriate to clinical need, and therefore where patients require more sessions this should be provided as part of the package. It is anticipated that a significant proportion of patients will be discharged with management plan at assessment stage. Note that as NICE Guidelines for Non-Specific

Deleted:

[1] Please refer to the accompanying currency paper that includes further details regarding the decision to suggest an average based on initial to follow up ratio of 1:4.

Low Back Pain[1] state up to 9 sessions, any patient who is deemed to require more than 4 sessions should be sent back to the GP following the 4th session for determination of appropriate course of action. The intervals between sessions should be consistent with good practice and appropriate for individual patient needs.

B1_2.4.1.4 Discharge from service

Patients should be discharged from the service when the expected clinical outcomes have been reached and/or it is deemed that a patient could derive no further benefit from continuing the course of treatment. Patients should be invited to complete the post-treatment PROM questionnaire and patient experience questionnaire at this stage.

Upon discharge patients are to be provided with a written maintenance programme and advice specific to their individual needs.

Within 5 working days of discharge from the service the provider will supply a discharge summary to the patient, and their GP. Where it is deemed possible, discharge information to GPs should be done via a secure electronic method. Discharge summary will include:

- A copy of the written maintenance programme
- Details of treatment given
- Details of clinical outcomes
- Any additional recommendations, including the conditions for re-referral to the same or another service

It is a requirement of all providers to ensure that at the end of their NHS-funded treatment patients are discharged promptly from the care of the provider and GPs are informed. If a patient re-presents within a 1 year, with either the same problem or with a different problem and requests a private consultation then the GP should be informed of this, provided that the patient consents to this.

B1_2.4.1.5 Out of scope

All diagnostic tests are out of scope for this service. If diagnostic tests are required, the provider must pass this request to the referring GP. It should be recognised that it is not anticipated that diagnostic tests will be a common request.

Patient transport arrangements do not form part of this service specification. Patients will be expected to make their own transport arrangements to the provider for treatment. Those patients who are entitled to assistance with transport under existing NHS

[1] Clinical guidelines CG88 Low back pain: Early management of persistent non-specific low back pain, 2009. National Institute for Health and Clinical Excellence

arrangements will be able to access this and it will be organised by their GP / as per local arrangements.

B1_2.4.1.6 Did Not Attend (DNA)

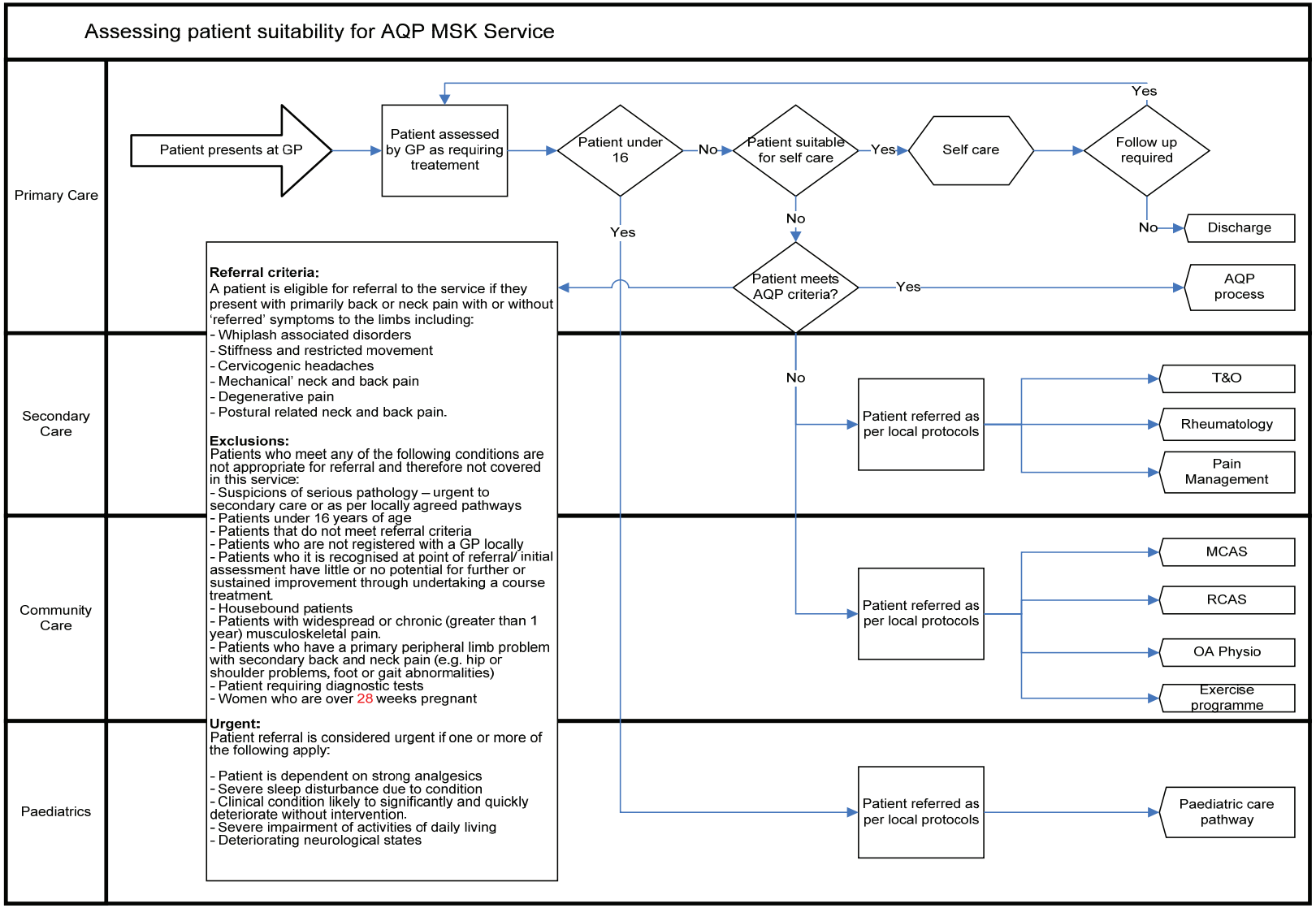
It is in the providers' interest to ensure they have mechanisms in place to minimise the number of patients who fail to attend pre-arranged appointments. If a patient DNAs an appointment they should be discharged from the service. The patient should be sent a copy of their self-care management plan upon discharge from service, and the GP sent a discharge letter.

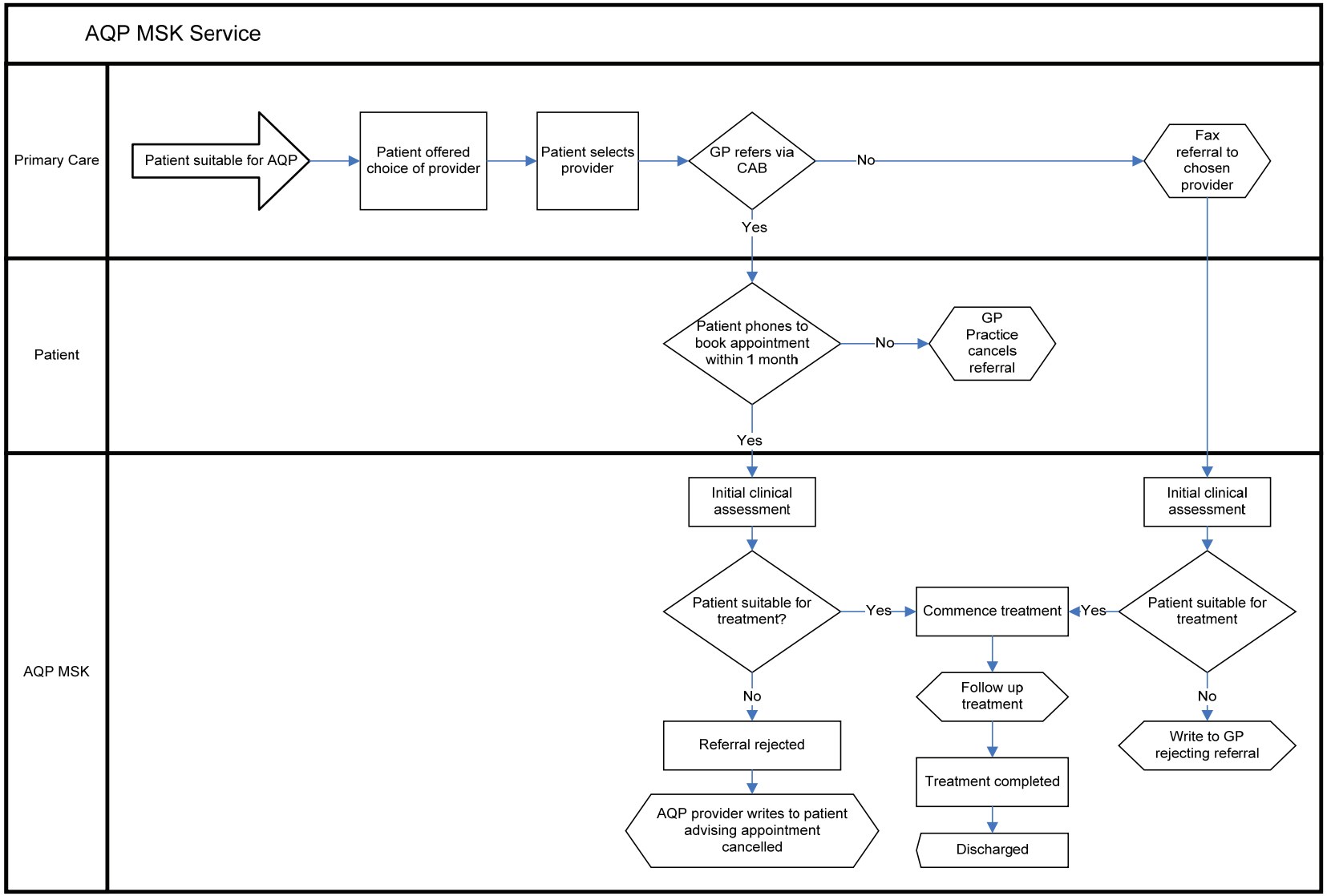
B1_2.5 Care pathway

This specification is designed to capture the activity following decision to refer to the back and neck pain service. ***[The care pathway will be as per local agreements, and factors for consideration, will necessarily be specific to your locality].***

The process flows below illustrate:

- Assessing patient suitability for AQP MSK Service
- Patient journey for AQP MSK Service


Assessing patient suitability for AQP MSK Service
Primary Care
Secondary Care
Community Care
Paediatrics
Patient presents at GP
Patient assessed by GP as requiring treatement
Patient under 16
No
Patient suitable for self care
Yes
Self care
Follow up required
Yes
No
Discharge
Yes
No
Patient meets AQP criteria?
Yes
AQP process
Referral criteria:
A patient is eligible for referral to the service if they present with primarily back or neck pain with or without 'referred' symptoms to the limbs including:
- Whiplash associated disorders
- Stiffness and restricted movement
- Cervicogenic headaches
- Mechanical' neck and back pain
- Degenerative pain
- Postural related neck and back pain.
Exclusions:
Patients who meet any of the following conditions are not appropriate for referral and therefore not covered in this service:
- Suspicions of serious pathology – urgent to secondary care or as per locally agreed pathways
- Patients under 16 years of age
- Patients that do not meet referral criteria
- Patients who are not registered with a GP locally
- Patients who it is recognised at point of referral/ initial assessment have little or no potential for further or sustained improvement through undertaking a course treatment.
- Housebound patients
- Patients with widespread or chronic (greater than 1 year) musculoskeletal pain.
- Patients who have a primary peripheral limb problem with secondary back and neck pain (e.g. hip or shoulder problems, foot or gait abnormalities)
- Patient requiring diagnostic tests
- Women who are over 28 weeks pregnant
Urgent:
Patient referral is considered urgent if one or more of the following apply:
- Patient is dependent on strong analgesics
- Severe sleep disturbance due to condition
- Clinical condition likely to significantly and quickly deteriorate without intervention.
- Severe impairment of activities of daily living
- Deteriorating neurological states
No
Patient referred as per local protocols
T&O
Rheumatology
Pain Management
Patient referred as per local protocols
MCAS
RCAS
OA Physio
Exercise programme
Patient referred as per local protocols
Paediatric care pathway


AQP MSK Service
Primary Care
Patient
AQP MSK
Patient suitable for AQP
Patient offered choice of provider
Patient selects provider
GP refers via CAB
No
Fax referral to chosen provider
Yes
Patient phones to book appointment within 1 month
No
GP Practice cancels referral
Yes
Initial clinical assessment
Patient suitable for treatment?
Yes
Commence treatment
Follow up treatment
Treatment completed
Discharged
No
Referral rejected
AQP provider writes to patient advising appointment cancelled
Initial clinical assessment
Patient suitable for treatment
Yes
No
Write to GP rejecting referral

B1_2.5.1 Referral source and route

It is recognised that self-care is important in ensuring healthy back and necks, and where appropriate (non-urgent referrals) the referrer may choose to provide conservative management (medication, advice, literature, re-assurance) for an appropriate period of 'watchful waiting'. Those patients whose conditions do not respond to conservative management will then be considered for the back and neck pain service.

If the GP or Interface Service believes that the patient meets the referral criteria for the service, they will complete a referral form (as agreed locally). The GP or Interface Service will also provide the patient with an information sheet (as agreed locally).

Patient chooses their preferred provider(s) and referral is sent from GP practice. For referrals from the interface service, these should also go via the GP – although this is subject to local protocols and procedures.

The referral will be valid for one month and patients should be made aware of this and to book their appointment within this timescale for the referral to be accepted. This information should be reinforced with inclusion on relevant patient literature. If patient is referred via CAB the referring practices will have to delete any UBRN not booked after a month. CAB referrals are not time limited.

B1_2.6 Continual service improvement / innovation plan

There are key expectations of providers around continuous improvement, with the focus that providers will engage their patients and review their services periodically to sustain efficient, effective and high quality services. In particular:

Service Improvement:

- Providers are expected to review service provision in the light of recent research to ensure that they are providing the most effective package of care.
- Providers should also demonstrate how they have already developed and improved their services through innovation.
- Providers are required to participate in and support research undertaken across all of the areas covered by this service.

Patient engagement:

- The Provider will record and monitor levels of patient experience with the service and identify themes, trends and areas for improvement.
- The Provider will supply the results of surveys in full along with action plans for service improvement based on the outcome of patient surveys to the Commissioner.
- Patient surveys will include questions around access, communication, quality and overall experience.

- The Provider will comply with the NHS duty to involve users and stakeholders, and to undertake patient involvement under sections 242 and 244 of the NHS Act 2006, and subsequent involvement legislation.
- The Provider will ensure that arrangements are made to secure the involvement of service users in the planning and development of services and in any proposals for changes in the way services are provided and/or in decisions that affect the operation of services.

B1_2.7 Population covered

This service specification covers the population of NHS Merseyside (currently Halton CCG, Knowsley CCG, Liverpool CCG, Sefton CCG and St Helens CCG). Merseyside has a patient population of around 1.2m. The communities served by the Clinical Commissioning Groups (CCG) include some of the most deprived areas of the country, and some of the most affluent. Its people are equally diverse in their ethnicity and social background. Overall, the area follows the national trend of an ageing population, with Southport in North Sefton have a higher than the national average proportion of older people.

In terms of number of GP practices across the Merseyside area, details are below

Sefton - 55

Liverpool – 94

Knowsley – 28

Halton- 17

St Helens – 47

PCT Population Estimates, selected age groups

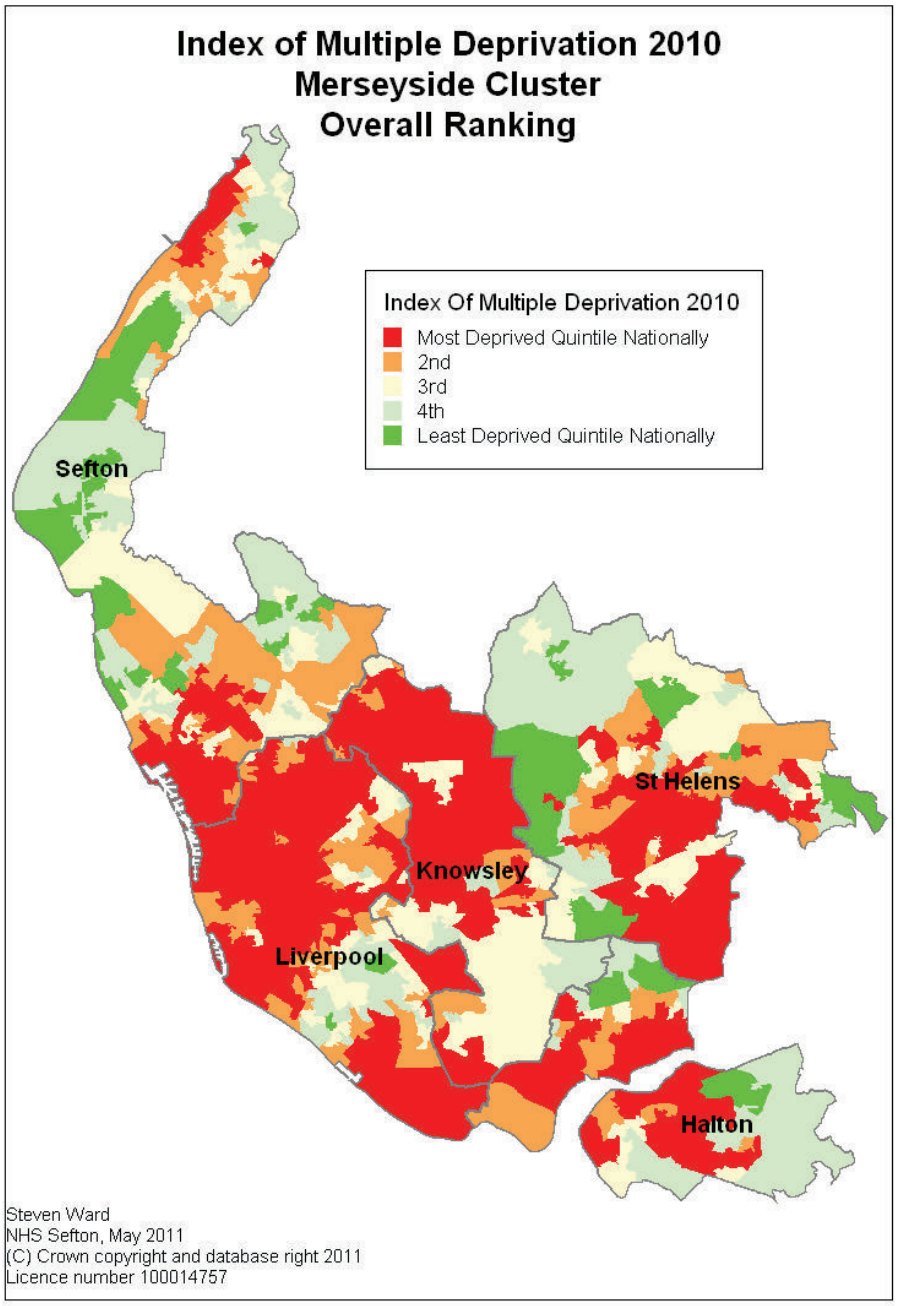
PCT	Persons All Ages	Persons 0-15 years	Persons 16-64 years	Persons 65 years and over
Knowsley	149,100	29,500	96,400	23,300
Liverpool	445,200	75,000	307,100	63,100
Sefton	272,900	47,300	169,200	56,400
Halton	119,300	24,200	77,700	17,400
St. Helens	177,400	32,700	11,3900	30,800

PCT	Persons All Ages	Persons 0-15 years	Persons 16-64 years	Persons 65 years and over
Knowsley	100%	19.8%	64.7%	15.6%
Liverpool	100%	16.8%	69.0%	14.2%
Sefton	100%	17.3%	62.0%	20.7%
Halton	100%	20.3%	65.1%	14.6%
St Helens	100%	18.4%	64.2%	17.4%

Source: 2010 Mid Year Population Estimates, ONS.

Deprivation

In terms of deprivation, according to the overall Indices of Deprivation 2010, Liverpool (ranked most deprived) and Knowsley (5th) are ranked in the five most deprived local authorities (out of 326 local authorities nationally). Halton (27th) is in the top 10% most deprived LAs, with St Helens (51st) in the top 16% and Sefton (92nd) in the top 30%


Index of Multiple Deprivation 2010
Merseyside Cluster
Overall Ranking
Index Of Multiple Deprivation 2010
Most Deprived Quintile Nationally
2nd
3rd
4th
Least Deprived Quintile Nationally
Sefton
St Helens
Knowsley
Liverpool
Halton
Steven Ward
NHS Sefton, May 2011
(C) Crown copyright and database right 2011
Licence number 100014757

Ethnicity

PCT	Persons	Persons	Persons	Persons	Persons	Persons
	All Groups	White	Mixed	Asian or Asian British	Black or Black British	Other
Knowsley	149,300	144,300	1,800	1,500	900	900
Liverpool	442,300	402,600	8,800	13,000	8,300	9,400
Sefton	273,300	263,700	2,500	3,000	1,500	2,700
Halton	118,700	115,700	1,000	900	400	600
St Helens	177,200	172,200	1,500	1,600	600	1,200

Source: ONS 2009 Ethnicity Estimates (Experimental)

Note: These totals will not match the overall population figures quoted in the 2010 population estimates above due to the different time periods.

Public/Private Sector workforce

In terms of workforce, estimates of the Public and Private Sector workforce shows that for LAs in Merseyside Sefton has the highest rate of public sector employment. At 23.5% the public sector employment rate is significantly higher than the UK average, while at 46.6% the private sector employment rate is significantly below the UK average.

Table 2: Public and private sector employment, by local authority, Jan-Dec 2010

Local Authority	Public Sector Employees as a Share of Total Employees[1]	Public Sector Employee Density[2]	Public Sector Employment Rate[3]	Private Sector Employee Density[4]	Private Sector Employment Rate[5]	Significance test of difference from UK average (95% confidence level)			
						Public Sector Employment Rate		Private Sector Employment Rate	
						Above UK Average	Below UK Average	Above UK Average	Below UK Average
	%	%	%	%	%				
Halton	18.1	12.0	15.9	54.1	50.0				
Knowsley	26.7	15.1	17.9	41.6	42.7				✓
Liverpool	29.9	21.5	18.1	50.4	41.4				✓
St. Helens	22.8	11.8	20.0	39.8	47.5				✓
Sefton	32.3	17.3	23.5	36.2	46.6	✓			✓
Wirral	29.5	14.4	19.5	34.3	45.7				✓
Liverpool City Region LEP	28.1	16.7	19.4	42.8	44.8	✓			✓

Source: ONS

1 Public Sector Employee jobs located in the area as a share of total employee jobs located in the area.
2 Public Sector Employee jobs located in the area divided by the area's population of 16 to 64 year olds.
3 Share of 16 to 64 year old residents of the area who report that they are employed in the public sector
4 Private Sector Employee jobs located in the area divided by the area's population 16 to 64 year olds.
5 Share of 16 to 64 year old residents of the area who report that they are employed in the private sector.

Source: Assessing the Impact of the Economic Downturn on Health and Wellbeing, Liverpool Public Health Observatory, February 2012.

B1_2.8 Access

B1_2.8.1 Provider requirements around access:

- The venue must be suitable and easily accessible to patients with good public transport links
- The service shall offer appointments at a suitable time and in easily accessible buildings (not restricted to medical buildings) for patients including provision for people with disabilities
- Special consideration may need to be paid to the provision of the service to accommodate race, language, physical and learning disability requirements and for those in employment as far as reasonable practicality allows
- A risk and suitability assessment of the venue must be undertaken and sent to the commissioner.

B1_2.8.2 Language:

- The service will be available to all patients who are registered with a local GP. If a translator is required the provider will be able to arrange and coordinate this via the commissioner
- The provider must ensure that printed materials can be made available in a suitable language and format so as to be accessible to all patients.

B1_2.9 Interdependencies with other services

B1_2.9.1 Whole system relationships:

To ensure a patient's experience is a streamlined journey and a good experience the provider must work collaboratively with the commissioner, primary care and secondary care providers and the interface service to deliver services in an organised and cohesive manner, and to reduce sequential waits between services. Where appropriate, the provider must demonstrate effective links with other statutory providers and voluntary sector organisations.

Providers are expected to cooperate and share information with others involved in a patients care, treatment and support while having regard to the patients' rights to confidentiality.

Upon initial receipt of referral (as well as throughout the course of treatment) the provider should contact the patient's GP for information that is appropriate and relevant to the referral and patient's care within the back and neck pain service. Upon discharge from the service the provider is required to supply a discharge summary to the patient's GP.

The patient information leaflet that all patients will be given at time of referral will state that patients should inform their provider at the time of initial contact if they do not wish for the provider to contact their GP; however it should be noted that there are circumstances where the patient's GP would be contacted without consent of the patient, particularly where there are issues of patient safety.

B1_3.0 Applicable Service Standards

B1_3.1 Applicable national standards e.g. NICE, Royal College

Any and all treatments undertaken by providers as part of the service must be robust, evidenced based, clinically effective treatments and the provider must be qualified and registered to provide these treatments.

B1_3.1.1 Professional standards and codes of conduct

Providers must be registered with the regulatory body appropriate to their profession and must adhere to the professional standards and codes of practice set out by that body.

B1_3.1.1.1 Chiropractic

Regulating body:
General Chiropractic Council

Standards:

- General Chiropractic Council Code of Practice and Standard of Proficiency (effective from 30 June 2010).
- Continuing Professional Development (CPD) Mandatory Requirements (September 2004).

B1_3.1.1.2 Osteopathy

Regulating body:
General Osteopathic Council

Standards:

- Code of Practice (May 2005)
- Standard 2000 – Standard of Proficiency (March 1999)
- Continuing Professional Development – Guidelines for Osteopaths

Note that this will be the new combined Osteopathic practice standards from September 2012.

B1_3.1.1.3 Physiotherapy

Regulating body:
Health Professions Council

Standards:

- Guidance of health and character (Jan 2010)
- Standards for the Good Character of Health Professionals
- Standards for the Health of Health Professionals
- Standards of Conduct, Performance and Ethics (July 2008)
- Standards of Proficiency (November 2007)
- Standards of Education and Training (September 2009)
- Your guide to our standards for continuing professional development (May 2008)

B1_3.1.2 Requirement relating to premises for activity

The providers must ensure that the premises used are safe and suitable for the delivery of this service. The service must be provided in a geographically convenient, easily accessible location which:

- Complies with health and safety legislation
- Has disability access
- Has appropriate waiting and treatment area
- Is appropriately furnished and equipped with necessary equipment
- Is of the highest level of cleanliness and hygiene
- Is easily accessible via public transport.

B1_3.1.3 Complaints

The provider must:

- Have a formal complaints policy and procedures through which patients can raise issues with the service
- Endeavour to resolve any complaints directly with the patient, and only escalate to the commissioner if the complaint cannot be resolved directly
- Adhere to local commissioner policies and procedures regarding complaints, including the need to inform the commissioner of all complaints
- Respond to complaints in line with the NHS complaints procedure and the relevant statutory regulatory body.

B1_3.1.4 Marketing of services

The provider will undertake communication activity and marketing campaigns in order to promote the NHS funded service. This will include producing marketing materials, information and literature relating to the service. Both the Commissioner and the Provider have the right to approve content of such materials. Materials may include posters, information sheets or electronic media on accessing the service.

In relation to the NHS branding, marketing and promotion of services, the Provider will comply with the terms and conditions of this contract (Clause 24).

B1_3.1.5 Safeguarding children and vulnerable adults

Providers must adhere to the terms and conditions of the contract (Clause 4A)

B1_3.2 Applicable local standards

This is intended as a non-exhaustive list. Clause [16] takes precedence

B1_3.2.1 Referral response times

The provider must demonstrate the ability to manage referrals in a timely fashion.

- Routine referrals should be offered an initial assessment appointment within 10 working days from the referral is received (subject to patient choice).

Note that for monitoring purposes the date of referral is the date that the provider receives the referral from the GP practice or when the patient books the appointment on Choose and Book.

B1_3.2.2 Integrated governance

The provider will demonstrate that there are clear organisation governance systems and structures, with clear lines of accountability and responsibility. The provider will ensure clinical and corporate governance processes are in place to include:

- Clinical governance lead
- Incident reporting
- Infection control
- SUI / PSI reporting and analysis
- Quality assurance
- Clear policies to manage risk and procedures to identify and remedy poor professional performance
- Evidence of peer and patient review and action taken

B1_3.2.3 Information technology and information governance

Providers must ensure that they are familiar with and comply with the NHS minimum information technology standards, and ensure (and be able to demonstrate) that they have the necessary systems and processes in place to comply with the NHS information governance requirements.

Providers must be Choose & Book compliant, or working towards compliance. Initial appointments must be directly or indirectly bookable through Choose & Book.

The Provider must ensure that the storage of medical records and information which is relevant to treatment and on-going care is passed between all parties in accordance with the Caldicott Principles and Data Protection Act (1998).

Providers should have an electronic patient administration and reporting system, meet IGSOC requirements and must be able to provide all necessary returns, including the Community Data Set, to the commissioner in the required format.

Providers must ensure that patient experience and PROM questionnaires are available in hard copy. Providers may also choose to offer patients the option of completing patient experience and PROM questionnaires electronically. The provider must ensure

that they have the necessary systems and processes in place to manage the administration of patient experience and PROM questionnaires.

B1_3.2.4 Audits

The provider must notify the commissioner of the result of any audit undertaken by a professional regulating body, or any other NHS commissioner.

The provider must allow the commissioner, or any individual or organisation acting on the behalf of the commissioner to inspect the quality of service through observation of service delivery, audit of patient records and data, audit of business processes and records relating to the service contract and audit of staff records, as required.

B1_3.3 Workforce

The service provider must describe and demonstrate that they are qualified to provide this service, and how they will assure commissioners of their competency to practice both at the time of contract letting, and throughout the contract life.

As per the NHS contract terms and conditions, providers must regularly and systematically review their professional practice in line with the professional standards as set out by their regulating body and be able to demonstrate how they assure this through regular review and/or appraisals. A report of any review or appraisal that takes place, including recommendations and any requirements for retraining, should be available to the commissioners upon request.

Each provider must encourage and allow for their staff to undertake Continued Professional Development consistent with the requirements of their professional regulator.

The provider must ensure that the following levels of supervision are provided to the clinical staff team:

- Management supervision
- Clinical supervision
- Safeguarding supervision

The provider must include the following roles (these do not need to be undertaken by different people):

- ***Service manager*** responsible for ensuring a high quality of clinical practice by all practitioners within the service, including necessary supervision of more inexperienced or junior staff and that all staff, including subcontractors, meet the requirements as set out in the service specification and the NHS Terms & Conditions
- ***Caldicott guardian*** responsible for ensuring compliance with all information governance requirements.

B1_4.0 Key Service Outcomes

The provider is to deliver a quality service to patients comprising safe clinical practice, clinical effectiveness and good patient experience. The service outcomes will be dependent on the local objectives for the service, but in all cases due consideration should be given to the mechanisms required to collect and analyse the data required to monitor and act on the delivery of these outcomes. The service outcomes are:

- 90% of patients for a non – urgent referral are offered an initial assessment appointment within 10 working days from receipt of referral
- 90% of patients sampled to have an individual care management plan (minimum sample size is 20% of all patients
- 100% of patients to be asked to complete a validated PROMS before treatment and afterwards
- 95% of patients sampled should report overall satisfaction with the service
- 95% of patients from protected characteristic groups (PCGs) should report overall satisfaction with the service
- 95% of all sampled GP referrers should report overall satisfaction with the service

B1_5.0 Location of Provider Premises

The Provider's Premises are located at:
[Name and address of Provider's Premises OR state "Not Applicable"]

Not applicable

B1_6.0 Individual Service User Placement

[Insert details including price where appropriate of Individual Service User Placement]

Not applicable for this service specification

SECTION B PART 2 -

SECTION B PART 1 - SERVICE SPECIFICATION

Mandatory headings 1 – 3. Mandatory but detail for local determination and agreement.

Optional headings 4 – 6. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement.

Service Specification No.	Version 1
Service	Direct Access Adult Hearing Service for Age Related Hearing Loss
Commissioner Lead	NHS Merseyside
Provider Lead	TBC
Period	2012 - 2015
Date of Review	

B1_1.0 Population Needs

B1_1.1 National/ local context and evidence base

The impact of hearing loss in adults can be great both at a personal and a societal level leading to social isolation, depression, loss of independence and employment challenges.

Assessing the hearing needs of patients with hearing loss, developing an individual management plan and providing appropriate interventions can reduce isolation, facilitate continued integration with society and promote independent living.

The ageing population means that demand for both hearing assessment and treatment services is set to rise substantially over the coming years. However, a significant proportion of this client group will have routine problems that do not require referral for an Ear, Nose and Throat (ENT) out-patient appointment prior to assessment. These patients would benefit from direct access to adult hearing care services with a referral being made directly from their GP enabling timely diagnosis and treatment.

One in six people in the UK have some form of hearing loss. Most are older people who are gradually losing their hearing as part of the ageing process, with more than 70% of over 70 year-olds and 40% of over 50 year-olds having some form of hearing loss.

Around 2 million people currently have a hearing aid, however, approx. 30% of these do not use them regularly, and there are a further 4 million people who do not have hearing aids and would benefit from them.

In addition we are faced with an ageing population, where there will be an estimated 14.5 million people with hearing loss by 2031. The World Health Organisation predicts that by 2030 adult onset hearing loss will be a long term condition ranking in the top ten disease burdens in the UK, on a par or perhaps exceeding those of diabetes and cataracts.

B1_2.0 Scope

B1_2.1 Aims and objectives of service

The aim is to provide a comprehensive patient-centred direct access adult hearing service for age related hearing loss in line with national guidance and local requirements.

The vision for people with age related hearing problems is for them to receive, high quality, efficient services delivered closer to home, with short waiting times and high responsiveness to the needs of local communities, free at the point of access.

Key principles of an integrated hearing service, within which the Direct Access Adult Hearing Service operates, is to:

- Improve public health and occupational health focus on hearing loss
- Reduce prevalence of avoidable permanent hearing loss
- Encourage early identification, diagnosis and management of hearing loss through improved patient and professional education
- Provide person-centred care, and respond to information and psychosocial needs
- Support communication needs by providing timely signposting to lip reading classes and assistive technologies and other rehabilitation services
- Promote inclusion and participation of people who are deaf or hard of hearing
- Compliance with clinical guidance and good practice

The Direct Access Adult Hearing Service is aimed at adults (over the age of 55) experiencing difficulties with their hearing and communication who feel they might benefit from hearing assessment and care, including the option of trying hearing aids to reduce these difficulties.

In line with British Academy of Audiology Guidelines for Referral to Audiology of Adults with Hearing Difficulty (2009) and British Society of Hearing Aid Audiologists Protocol and Criteria for Referral for Medical or other Specialist Opinion (2011), the Direct Access Adult Hearing Service may be provided to patients as long as they do not meet the contra-indications at SECTION 1 APPENDIX 1.

The purpose of the Direct Access Adult Hearing Service is to ensure:

- Equitable access to high and consistent quality care for all patients using the service
- A safe hearing service for patients that conforms to a recognised quality assurance tool e.g. the Improving Quality In Physiological Diagnostic Services - Self Assessment and Improvement Tool (IQIPS-SAIT) and is working towards IQIPS accreditation (as set out in Section 3 of the implementation pack). The service should also recognise published clinical guidelines/good practice (as set out in SECTION 1 APPENDIX 2).

Expected outcomes of the service:

- Increased patient choice and control as to where and when their treatment is delivered – providing on-going care closer to home
- Timely access to hearing assessment, fitting and follow-up
- Personalised care for all patients accessing the service
- High proportion of patients continuing to wear hearing aids
- High levels of satisfaction from patients accessing the service
- High levels of satisfaction from GPs referring into the service
- Reduced social isolation and consequent mental ill health (i.e. depression and onset of dementia)
- Improved quality of life for patients, their families/carers and communication partners

B1_2.2 Service description

B1_2.2.1 Service overview

The service required is for a direct access adult hearing assessment service, including hearing aid fitting (where required), follow-up and aftercare services for adults aged 55 or over, with suspected or diagnosed age related hearing loss for the registered population of NHS Merseyside.

Complex audiology services (for patients who meet the contra-indications detailed in SECTION 1 APPENDIX 1) and services for adults under 55 are not covered by this specification and should continue to be accessed by GP referral to the appropriate service. Providers need to ensure clear and formal accountability processes and structures are in place to ensure a safe, effective and integrated continuity of clinical care for all patients.

The Direct Access Adult Hearing Service will consist of:

- Hearing needs assessment
- Development of an Individual Management Plan (IMP)
- Provision and fitting of hearing aids

- Appropriate hearing rehabilitation e.g. patient education
- Information on and signposting to any relevant communication/social support services
- Follow-up appointment to assess whether needs have been met
- Discharge from hearing assessment and fitting pathway
- Aftercare service for up to 3 years, including advice, maintenance and review at 3rd year
- Battery, tips, domes, wax filters and tube replacement service
- Annual aftercare and review after 3 year pathway, where required

The overall service should be carried out in accordance with best practice and guidelines listed in SECTION 1 APPENDIX 2. Details of the service model can be found in section 2.3.

B1_2.2.2 Interdependencies with other services

The Direct Access Adult Hearing Service should be seen as part of wider integrated adult health and social care hearing services working in partnership with GPs, Primary Health Care teams, Ear Nose & Throat (ENT) departments, Audio-Vestibular Medicine (AVM) Audiology Departments, local authorities, the voluntary & community sector and independent providers.

The Provider must demonstrate how it will work with these other organisations to support patients to successfully manage their hearing loss and promote independent living. They should as a minimum have a well developed and audited pathway for communication with GPs and ensure a seamless integration of the Direct Access Adult Hearing Service within the wider health, voluntary and social services environment e.g. lip-reading classes, equipment services etc.

B1_2.3 Service model

B1_2.3.1 Assessment

Assessment should be undertaken within 16 working days of receipt of referral (unless the patient requests for this to be outside of this time e.g. holiday, sickness etc).

The Provider should ensure patients have an adequate understanding of the hearing assessment process before the appointment, by providing information (in a suitable language and format) in advance (either via the referrer or to be received by the patient at least 2 working days before the appointment) that explains the purpose of the assessment, what it involves and the possible outcomes. Providers should make patients aware of their right to communication support, and how to request this if required.

In addition, Providers should provide details of which professional (job title and name where possible) will perform the test as well as a choice of when and where it will take

place. Patients should be encouraged to bring a relative or significant other to the appointment for support if they wish.

AQPs should explicitly advise patients to ensure ears are wax-free prior to assessment (to avoid aborted/chargeable assessment appointments)

During the assessment appointment, the practitioner should ensure that communication with the patient is effective enough to be able to work in partnership with the patient to reach jointly agreed goals/outcomes, undertaking the following:

- A clinical interview to assess hearing and communication needs - this should establish relevant symptoms, co-morbidity, hearing needs, auditory ecology, dexterity, and cognitive ability, significant psycho-social issues, lifestyles (including driving, use of mobile phones, TV, etc) expectations and motivations
- Full otoscopy
- Measurements of pure-tone air and bone conduction thresholds - if there are contra-indications to performing Pure Tone Audiogram (PTA) - for example, occluding wax, discharging ear, exposure to sustained loud sound in the 24 hours preceding test - the patient must be informed of the reason for non-completion and rebooked or referred back to the GP for treatment as necessary. Such events should be recorded as 'Incomplete Assessments'
- Assessment of current activity restrictions and participatory limitations - using a formal validated self-report instrument - that will enable an outcome measure to be documented for both the individual patient and also the service. The Glasgow Hearing Aid Benefit Profile (GHABP) or Client-Orientated Scale of Improvement (COSI) or International Outcome Inventory for Hearing Aids (IOI-HA) are the preferred outcome measures for this service
- Assessment of loudness discomfort levels - where required
- Integration of assessment findings with patient expectations - to enable patients to decide on appropriate and suitable interventions (i.e. hearing aids, communication support, education etc)

Following the assessment, the practitioner should:

- Explain the assessment, including the extent, location, configuration and possible causes of any hearing loss and the impact hearing loss can have on communication e.g. poorer speech discrimination and sound localisation and the impact this can have on a personal and societal level.
- Discuss with the patient the management options available to address their hearing loss and whether a hearing aid would be beneficial, exploring the psycho-social aspects of the hearing loss, as well as the physical aspects (e.g. audibility of sounds and speech)
- Work collaboratively with the patient to establish realistic expectations for the management suggested providing all relevant literature (in a suitable language and format) to facilitate discussions

- Where hearing aids are expected to be beneficial and the patient wishes to accept provision of hearing aids, at the same appointment:
  - Undertake pre-fitting counselling, managing expectations as necessary
  - Develop a written Individual Management Plan (IMP) with the patient which defines the patients' goals and hearing needs and how they are going to be addressed
  - Discuss and document hearing aid options and agree types and models with the patient based on their suitability to the patients' hearing loss*
  - Discuss and document whether a unilateral or bilateral fitting is appropriate. Any decision in this respect must be based on clinical need and not financially driven. Bilateral fittings are not clinically appropriate where:
    - One ear is not sufficiently impaired to merit amplification
    - One ear is so impaired that amplification would not be beneficial (and should be referral back to the GP for onward referral to complex audiology or other support services)
    - The patient declines bilateral aiding where offered as appropriate (this should be confirmed in a signed statement by the patient)
    - Other reason (e.g. manipulative ability, otological)
  - Proceed to fitting (where appropriate – see sections B1_2.3.2 and B1_2.3.3) using open ear technology or take impressions and decide on choice of ear mould type and characteristics
  - Provide patient information (in a suitable language and format) and ensure that the patient has understood the major points arising from the assessment including details of the hearing aid(s) which have been, or will be, fitted and any follow-up arrangements
  - Electronically record details of the assessment appointment, including any comments by the patient.
  - AQPs to report back to GPs on the outcome of the assessment appointment
  - AQPs to refer patients with contra-indications back to the GP unless it is urgent

***Note:**

- Where an NHS-qualified provider also provides private hearing aids and a patient expresses a personal preference around hearing aids that cannot be met by the NHS funded service, or enquires about privately prescribed hearing aids, providers must advise the patient that the appointment is exclusively for NHS services and any further dialogue or information concerning private hearing aids must be dealt with at a separate patient booked appointment outside of the NHS-funded service.
- Providers should not promote their own private treatment service, or an organisation in which they have a commercial interest.
- Providers should not encourage patients to 'trade up' (i.e. to privately purchase more expensive hearing devices than is necessary)

- Where an enquiry is made because the patient is experiencing functional difficulty with an NHS provided device, every effort must be made to address this from within the NHS funded service. Where this is not possible, the Commissioner must be informed.
- Providers should issue patients with a maximum of 1 hearing aid for unilateral use or 2 hearing aids for bilateral use. Spare hearing aids are not part of standard NHS provision.
- For patients requiring assessment only (i.e. no fitting of hearing aids) tariff 1 applies (see Currency and Price details on pages 29-30)

B1_2.3.2 Fitting

Fitting (if not undertaken at assessment appointment – see section B1_2.3.1) should be undertaken within 20 working days from assessment (unless the patient requests for this to be outside of this time e.g. holiday, sickness etc). The patient should be made aware of their right to communication support for the fitting appointment; and if this is required the patient should still receive their fitting appointment with 20 working days.

At the fitting appointment (if separate from the assessment) the following should be provided and discussed with the patient:

- Otoscopy
- A review of the patient information and outcome measures (GHABP/COSI/IOI-HA)
- Selection and programming of hearing aids*
- Education of patient in order to reach a shared understanding of the benefits of hearing aid provision
- Objective measurements (e.g. Real Ear Measurements (REM)) to verify fitting by agreed protocol (e.g. BAA/BSA recommended procedure) and adjustment of hearing aid output to match target exceptions to be reported in the Individual Management Plan
- Modification of ear moulds/venting if necessary and repeat of objective measurements for verification
- Evaluation of subjective sound quality (including own voice) and fine tune if necessary
- With patients own aid(s) worn and switched on, teach the patient (using same model) how to:
  - Change battery – observe insertion and removal and correct processes for maintaining battery life
  - Operate controls
  - Switch between programmes
  - Insert and remove aids
  - Use loop
  - Take care of aids, including cleaning, re-tubing and what to do if the aid is damaged or appears not to be working

- Advise on acclimatising to the use of hearing aids and amplified sound
- Advise on battery warnings, battery supply, repair/maintenance service
- Supply cleaning wires if open ear fit
- Explain the purpose and function of hearing aid data-logging
- Advise on lost/damaged hearing aid charging policy
- Issue a copy of the audiogram, information (in a suitable format) on the aids, ear moulds, local services, and update the IMP and provide a battery issue book if appropriate
- Discuss patient's wider needs and provide signposting to any relevant support services (including lip-reading classes and assistive technologies), as agreed with the patient, in accordance with agreed local protocols
- Arrange a follow-up appointment - the patient should be offered a choice of face to face or non-face to face follow-up and given the option to bring a relative/carer

***Note:** Provision of NHS-funded hearing aid(s) will be of a minimum technical specification, as designated by the NHS, and obtained through the NHS Supply Chain. Supply Chain instruments/accessories must only be provided to patients seen in the NHS pathway.

If the fitting appointment is as a result of a re-assessment of the patient, the reasons for the new fitting and expected benefits of this to the patient should be documented. The provider should record:

- The change in threshold of the audiogram
- Details of both new hearing aid(s) issued and old aid(s) no longer in use. Old aids should be returned to the NHS Supply Chain

The Provider should maintain an adequate stock and range of hearing aids and accessories (such as tubes/domes) to support the ongoing care of patients using this service and keep an up to date stock that meets the minimum specifications, through using the NHS Supply Chain.

AQPs should include a facility for the patient to change from a monaural to binaural fitting within 10 weeks of the original fitting.

B1_2.3.3 One stage 'Assess & Fit'

The Direct Access Adult Hearing Service should ensure that two approaches are available to address the assessment and fitting requirements of the pathway:

- A single 'assess and fit' pathway where suitable, for patients to receive hearing aids at the initial assessment appointment - suitability depends on hearing loss, dexterity, cognitive ability, emotional readiness and patient choice
- A two stage pathway, where an impression of the ear is taken at the first assessment appointment for an ear mould to be made and the patient returns at a later date for the hearing aid fitting (or bilateral impressions for bilateral fittings)

Pre-appointment information should mention the two options, to prepare patients better in advance of having to make this decision.

B1_2.3.4 Follow-Up

A follow-up appointment should be undertaken within 10 weeks of fitting (unless there are clear documented, clinical reasons to do otherwise, or if patient chooses to wait beyond this period), in order to determine whether needs have been met.

Patients should be offered a choice of a face to face or non-face to face follow-up (e.g. telephone review or postal questionnaire) – the Provider should seek to meet the patient's preference where possible. However, AQPs need to make a clinical judgement as to the suitability of a non-face-to-face follow-up appointment.

If the patient opts for a non-face to face follow up and this proves unsuitable (for either patient or Provider), a face to face appointment should then be undertaken within 7 working days of the non-face to face contact.

A quicker follow-up appointment may be necessary in advance of the patient's pre-booked follow-up appointment (e.g. if the patient is experiencing difficulty with their aids) and this should be offered within 5 working days of the request from the patient.

Within the follow-up the provider should:

- Discuss with the patient whether the outcomes agreed within the IMP have been met and if not how to resolve residual needs and update the IMP as necessary
- Check on use of hearing aid(s) in terms of comfort, sound quality, adequacy of loudness, loudness discomfort, noise intrusiveness, telephone use, battery life, cleaning, use of loop and different programmes
- Confirm patient's ability to remove and insert aid and provide further help if needed
- Review hearing aid data-logging
- Fine tune hearing aid (if necessary) based on patient's comments
- Continue usage of the preferred validated outcome measure (GHABP/COSI/IOI-HA) plus any additional measures used to assess the effectiveness of the intervention and respond to result
- Conduct objective measurements e.g. REM (if necessary)
- Provide information (in a suitable language and format) and sign-posting to any relevant communication/social/rehabilitation support services

The Provider should:

- Update the IMP in conjunction with the patient to ensure that any residual need has a plan of action

- Maintain confidential electronic records of the follow-up appointment including completed copies of the outcome tool, any adjustments made to the aid(s) and comments made by the patient

B1_2.3.5 Aftercare

The Provider should provide on-going aftercare and equipment maintenance to patients for 3 years after fitting.

Aftercare services should include:

- Cleaning advice and cleaning aids for patients with limited dexterity
- Battery removal devices for those with limited dexterity
- Replacement of batteries, tips, domes, wax filters and tubing, where required
- Replacement or modification of ear moulds
- Repair or replacement of faulty hearing aids on a like for like basis
- Provision of information (in a suitable language and format) about wider support services for hearing loss

Patients should be able to access aftercare services (via face to face or non face to face methods) within 2 working days of the request. A postal repair service must also be available to patients for returns within 7 working days.

Aftercare may be provided by any member of staff or volunteer staff who is suitably trained and qualified for the task at hand e.g. BSHAA-approved Hearcare Assistant, but there must always be an experienced audiologist or hearing aid dispenser available in person or on request to provide further support if required.

Inclusion of: AQPs are required to replace lost or stolen hearing aids free-of-charge, though with the right to charge the patient if the provider believes the patient has been negligent.

B1_2.3.6 Review

Patients should be informed that whilst their current hearing aids are expected to remain appropriate for several years, it is best practice to review their needs 3 years after fitting. The Provider should carry out automatic recall to offer a review appointment as part of the aftercare element of the pathway. The Provider should inform the GP of the outcome of the review or if the patient declined a review.

Patients should be able to directly access a review appointment earlier than 3 years if they fail to continue to manage with their hearing aid(s) or if there is suspected significant changes in their hearing.

It is expected that most patients will be discharged (see section B1_2.1) back to their GP after the 3 year review. Tariffs will be dependent on whether the patient was a unilateral (tariff 2) or a bilateral (tariff 3) hearing aid user. Whilst these tariffs include the

3 year aftercare and 3 year review as described in sections 2.3.5 and this section, tariffs should be paid after the follow-up (2.3.4). A recovery schedule is recommended in the Currency and Price section on pages 29-30 to allow NHS Merseyside to then reclaim a percentage of the tariff should any part of the 3 year aftercare and review pathway be undelivered.

Where the review suggests that there are no significant changes, the patient should be discharged back to the GP with the Provider responsible for yearly aftercare and automatic recall to offer patients an annual review. In this instance, tariff 4 will apply.

Where review suggests that there are significant changes to a patient's hearing needs, the patient should be discharged back to the GP with the advice to undergo a full re-assessment and fitting pathway. The GP would be required to re-refer the patient to the service and the pathway described in section 2.3 will start again (and with the associated timescales and tariffs).

Within the annual aftercare and review period (i.e. after the 3rd year review and where a patient's hearing needs have not changed) if a hearing aid stops working due to mechanical failure and requires replacing outside of warranty, tariff 5 will apply. The patient would still remain within this annual aftercare pathway as per above.

B1_2.3.7 Battery Replacement Service

Batteries for hearing aids provided through an NHS qualified provider should be provided free of charge to NHS patients as part of the aftercare service, and should be of a designated specification according to the NHS Supply Chain.

Options for battery replacement include:

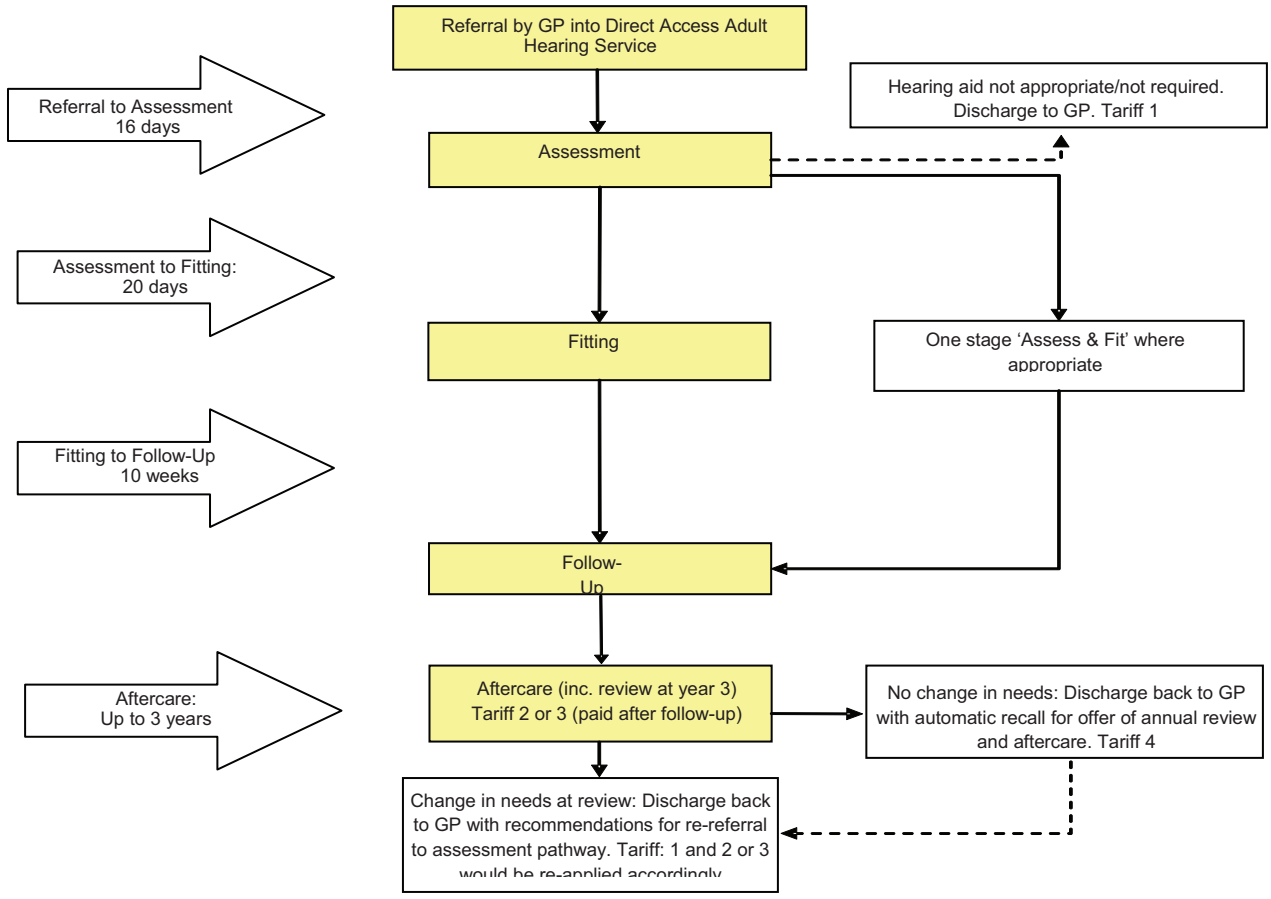
- By post (free of charge to the patient) from the Provider
- Collection from the Provider's service
- Via local supply points (e.g. a network of GP practices/health centres) supplied with stocks of good quality batteries in all commonly used sizes free of charge by the Provider.

The Provider is responsible for the purchase, provision and replacement of batteries to NHS patients and must supply the brand as designated by NHS Supply Chain.

B1_2.4 Care pathway

Figure 1 below shows the expected pathway and the expected response times. The response times should negate the need for a prioritisation system.

Figure 1: Expected pathway and response times



B1_2.5 Population covered

The Direct Access Adult Hearing Service is to be provided to eligible people registered to a GP practice within the NHS Merseyside area. This service specification covers the population of NHS Merseyside (currently Halton CCG, Knowsley CCG, Liverpool CCG, Sefton CCG and St Helens CCG). Merseyside has a patient population of around 1.2m. The communities served by the Clinical Commissioning Groups (CCG) include some of the most deprived areas of the country, and some of the most affluent. Its people are equally diverse in their ethnicity and social background. Overall, the area follows the national trend of an ageing population, with Southport in North Sefton have a higher than the national average proportion of older people.

In terms of number of GP practices across the Merseyside area, details are below

Sefton - 55

Liverpool – 94

Knowsley – 28

Halton- 17

St Helens – 47

PCT Population Estimates, selected age groups

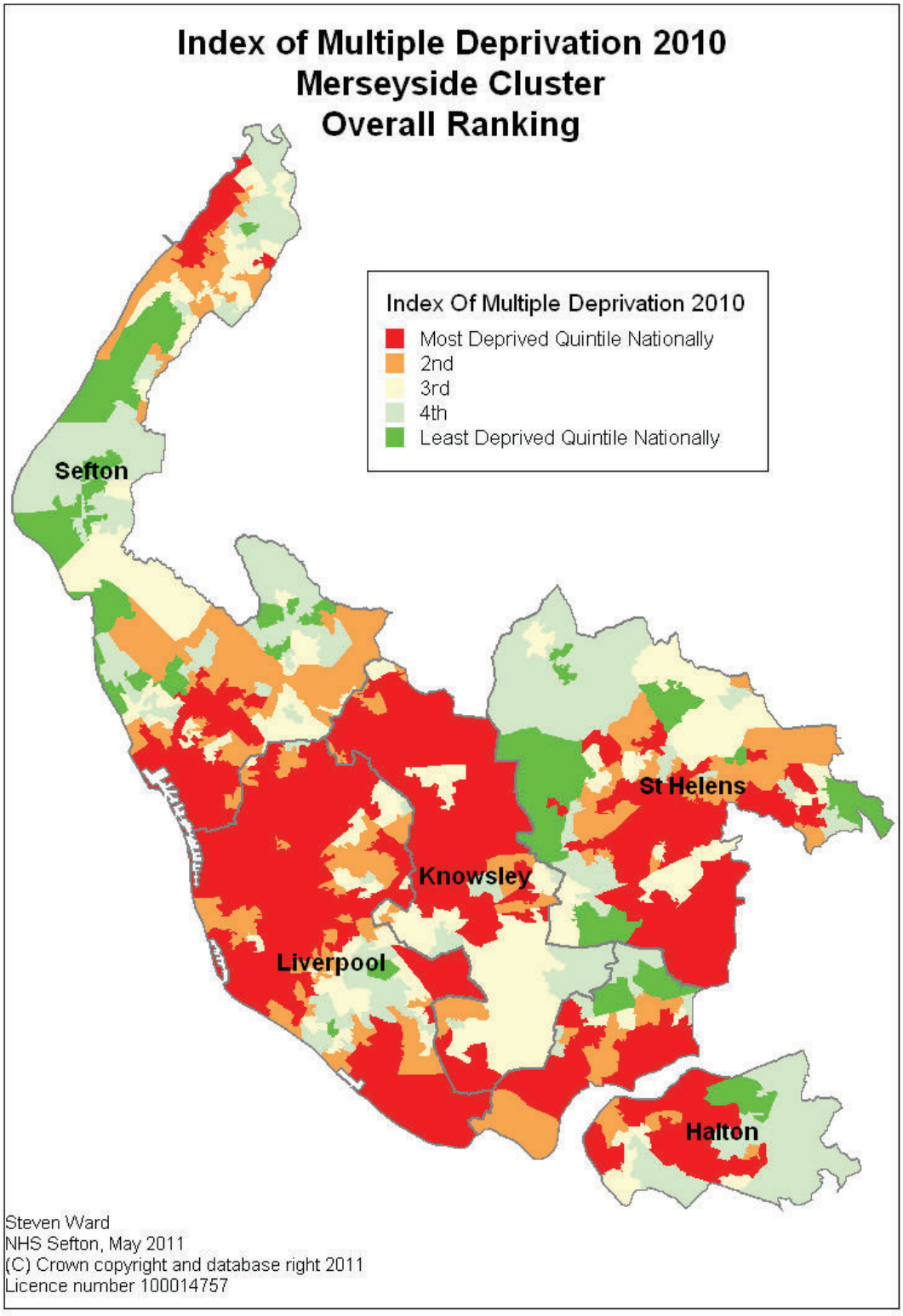
PCT	Persons All Ages	Persons 0-15 years	Persons 16-64 years	Persons 65 years and over
Knowsley	149,100	29,500	96,400	23,300
Liverpool	445,200	75,000	307,100	63,100
Sefton	272,900	47,300	169,200	56,400
Halton	119,300	24,200	77,700	17,400
St. Helens	177,400	32,700	11,3900	30,800

PCT	Persons All Ages	Persons 0-15 years	Persons 16-64 years	Persons 65 years and over
Knowsley	100%	19.8%	64.7%	15.6%
Liverpool	100%	16.8%	69.0%	14.2%
Sefton	100%	17.3%	62.0%	20.7%
Halton	100%	20.3%	65.1%	14.6%
St Helens	100%	18.4%	64.2%	17.4%

Source: 2010 Mid Year Population Estimates, ONS.

Deprivation

In terms of deprivation, according to the overall Indices of Deprivation 2010, Liverpool (ranked most deprived) and Knowsley (5th) are ranked in the five most deprived local authorities (out of 326 local authorities nationally). Halton (27th) is in the top 10% most deprived LAs, with St Helens (51st) in the top 16% and Sefton (92nd) in the top 30%


Index of Multiple Deprivation 2010
Merseyside Cluster
Overall Ranking
Index Of Multiple Deprivation 2010
Most Deprived Quintile Nationally
2nd
3rd
4th
Least Deprived Quintile Nationally
Sefton
St Helens
Knowsley
Liverpool
Halton
Steven Ward
NHS Sefton, May 2011
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Ethnicity

PCT	Persons	Persons	Persons	Persons	Persons	Persons
	All Groups	White	Mixed	Asian or Asian British	Black or Black British	Other
Knowsley	149,300	144,300	1,800	1,500	900	900
Liverpool	442,300	402,600	8,800	13,000	8,300	9,400
Sefton	273,300	263,700	2,500	3,000	1,500	2,700
Halton	118,700	115,700	1,000	900	400	600
St Helens	177,200	172,200	1,500	1,600	600	1,200

Source: ONS 2009 Ethnicity Estimates (Experimental)

Note: These totals will not match the overall population figures quoted in the 2010 population estimates above due to the different time periods.

Public/Private Sector workforce

In terms of workforce, estimates of the Public and Private Sector workforce shows that for LAs in Merseyside Sefton has the highest rate of public sector employment. At 23.5% the public sector employment rate is significantly higher than the UK average, while at 46.6% the private sector employment rate is significantly below the UK average.

Table 2: Public and private sector employment, by local authority, Jan-Dec 2010

Local Authority	Public Sector Employees as a Share of Total Employees[1]	Public Sector Employee Density[2]	Public Sector Employment Rate[3]	Private Sector Employee Density[4]	Private Sector Employment Rate[5]	Significance test of difference from UK average (95% confidence level)			
						Public Sector Employment Rate		Private Sector Employment Rate	
						Above UK Average	Below UK Average	Above UK Average	Below UK Average
	%	%	%	%	%				
Halton	18.1	12.0	15.9	54.1	50.0				
Knowsley	26.7	15.1	17.9	41.6	42.7				✓
Liverpool	29.9	21.5	18.1	50.4	41.4				✓
St. Helens	22.8	11.8	20.0	39.8	47.5				✓
Sefton	32.3	17.3	23.5	36.2	46.6	✓			✓
Wirral	29.5	14.4	19.5	34.3	45.7				✓
Liverpool City Region LEP	28.1	16.7	19.4	42.8	44.8	✓			✓

Source: ONS

1 Public Sector Employee jobs located in the area as a share of total employee jobs located in the area.
2 Public Sector Employee jobs located in the area divided by the area's population of 16 to 64 year olds.
3 Share of 16 to 64 year old residents of the area who report that they are employed in the public sector
4 Private Sector Employee jobs located in the area divided by the area's population 16 to 64 year olds.
5 Share of 16 to 64 year old residents of the area who report that they are employed in the private sector.

Source: Assessing the Impact of the Economic Downturn on Health and Wellbeing, Liverpool Public Health Observatory, February 2012.

B1_2.6 Location(s) of service delivery

The expectation is that the service will be provided from appropriate (see section B1_4.2) and accessible community based premises in the NHS Merseyside locality, with the service available and accessible to patients throughout the geographic area for the standard days/hours of operation.

B1_2.7 Days/hours of operation

Operating hours of the service across the geographic area covered by NHS Merseyside, should be 8.00am – 6.00pm, Monday to Friday, with an additional minimum of 5 hours regular extended opening hours on an evening/weekend, subject to local agreement.

Opening the service on statutory public holidays is for the discretion of the provider; however there will be a requirement for Providers to ensure patients are notified in advance of closures and have access to an emergency service for the provision of batteries and tubing.

B1_2.8 2.8 Any acceptance and exclusion criteria

B1_2.8.1 Acceptance criteria

The Direct Access Adult Hearing Service is for adults over the age of 55 with suspected or diagnosed age related hearing loss and who do not meet the exclusion criteria detailed in section 2.8.2

The Provider will need to have systems in place to accommodate patients who:

- Have sight loss/dual sensory loss
- Have learning disabilities – as special test facilities and techniques are needed
- Require domiciliary care – the Provider should provide all parts of the service at the patient's domicile (including residential or nursing homes) where this is requested in writing by a GP

Eligible patients must be referred into the Direct Access Adult Hearing Service by a GP.

B1_2.8.2 Exclusion criteria

The following patients should not be referred into the Direct Access Adult Hearing Service:

- Children and adults under 55 years of age (i.e. 54 and 364 days old)
- Complex adult patients who meet the contra-indications as set out in SECTION 1 APPENDIX 1

B1_2.9 Referral processes

B1_2.9.1 Accepting referrals

The Provider should have the ability to be able to receive referrals through the national NHS Choose & Book electronic referral system (entry level with ability to upgrade). Where a referrer is unable to use or access Choose & Book, an alternative (i.e. paper) referral process should be accepted.

B1_2.9.2 Rejecting referrals

The Provider must only accept referrals that meet the referral criteria covered by this specification.

Prior to referral, an initial assessment should be undertaken by the GP of the patient presenting with hearing difficulties to ensure that they do not fall within the exclusion criteria (see section B1_2.8.2).

Any inappropriate referrals received (i.e. for patients who meet the exclusion criteria) should be returned back to the GP within 5 working days for onward referral with sufficient feedback to minimise inappropriate referrals in future. If the Provider thinks

that there is an urgent need and the patient would require to be seen within 2 weeks, the referral should be made directly and the GP must be informed within 2 working days.

If a referral is received with insufficient information, the Provider should liaise with the GP to seek this information so as not to delay the patient's appointment. If it is not possible to get the necessary information then the Provider can return the referral to the GP for re-referral once all the missing information is known – providing patients are informed of any cancellations to pre-booked appointments following the return of the referral to the referrer.

Any referrals received that are not from a GP should be directed back to the referrer before any assessment is undertaken for this service with an explanation of the correct referral path and criteria. If an assessment as part of this service is undertaken in this scenario, the Provider will not be paid for this activity.

With regards to DNAs, AQPs are advised that after 2 DNAs, the patient should be referred back to their GP.

B1_2.10 Discharge processes

Any patient discharged (as per section 2.3.6) should be informed of how to get advice and support if they believe their hearing has deteriorated further or if their hearing aids are no longer fit for purpose.

The Provider should provide a discharge report to the GP and complete an Individual Management Plan for the patient.

B1_3.0 Applicable Service Standards

B1_3.1 Applicable national standards eg NICE, Royal College

Please see **Error! Reference source not found.** for applicable accreditation standards and guidelines.

B1_4.0 Other

B1_4.1 Workforce

The Provider should have an appropriate skill mix within their team in keeping with the recommendations set out in 'Transforming Adult Hearing Services for Patients with Hearing Difficulty – A Good Practice Guide', DH, June 2007. Assessment and treatment should always be provided by staff that are either suitably registered or are supervised by a suitably registered practitioner and who are appropriately trained, qualified and experienced (see SECTION 1 APPENDIX 3).

Audiologists, Registered Hearing Aid Dispensers and assistant/associate audiologists may provide a direct service to patients according to appropriate qualifications, skills and experience which are set out in SECTION 1 APPENDIX 3.

In terms of training and development:

- All staff should be trained to identify the contra-indications (SECTION 1 APPENDIX 1) and undertake appropriate action according to defined protocols
- In order to work unsupervised, staff need to be able to evidence that they have undertaken a minimum of 50 assessments and fittings in the preceding 12 months
- Newly qualified Audiologists need to spend a minimum of 2 weeks observing a qualified audiologist or dispenser, followed by 2 weeks working under the direct, full-time supervision of a senior audiologist Newly qualified staff undertaking this training period should have a portfolio/evidence to demonstrate competence
- Development of a skilled and modern audiology workforce should be supported by offering suitable clinical training placements to postgraduate, undergraduate and foundation degree students

B1_4.2 Facilities

Hearing assessments should be conducted in appropriately sound treated rooms where possible, such that ambient noise levels are compliant with the 'BS EN ISO 8253-1:1998 standard, Acoustics- Audiometric Test Methods – Part 1: basic pure tone air and bone conduction threshold audiometry'. If this is not possible (care home or domiciliary visits, community premises etc) the 35dBA standard should be achieved before undertaking testing. This should be done in situ with a portable sound level meter and the evidence of this undertaking documented.

B1_4.3 Equipment and Software

The provider should provide equipment and software for audiometric assessment and for the fitting & evaluation of hearing aid(s) and the recording and export of patient data including a minimum of:

- Otoscope
- Ear impression taking equipment
- Ear mould modification equipment
- Audiometer, objective measurement (e.g. REM) and 2cc test box systems that store data electronically in a form that can be readily exported and read into compatible NHS provider systems
- Appropriate and updated hearing aid fitting software
- A Patient Management System that stores data, including outcome questionnaire responses (e.g. GHABP/COSI/IOI-HA), electronically, in a form that can be readily exported and read into compatible NHS provider systems

- Computer hardware and software of a sufficiently robust standard to support the above systems, including secure back up facilities of all patient data

In addition:

- All audiometric equipment should be regularly calibrated to relevant national or international guidelines and undergo regular checks (Stage A, Stage B or Stage C checks) in accordance with national recommendations
- Equipment and electrical connections should meet the NHS requirments of safety of equipment used with patients and comply with the relevant NHSE recommendations

B1_4.4 Governance, Accreditation and Quality Assurance

The provider will be expected to undertake a quality audit such as the IQIPS-SAIT before delivering NHS services under the contract and continue using the quality audit on a regular basis. The provider will be expected to be working towards IQIPS accreditation standards and achieving accreditation when it becomes available.

B1_4.5 Marketing and Promotion of Services

Providers marketing and promoting their NHS services should adhere to the 'Code of Practice For The Promotion of NHS-Funded Services'.

The Provider will:

- Undertake communication activity and marketing campaigns in order to promote the NHS funded service. This will include producing marketing materials, information and literature relating to the service. Both the Commissioner and the Provider have the right to approve content of such materials. Materials may include posters, information sheets or electronic media on accessing the service.
- Comply with NHS branding guidelines when producing communication, marketing and patient promotion literature
- Any communication, marketing and promotional activity must be separate from other non-NHS funded services marketing and promotion activities
- Not pro-actively promote non NHS-funded services, activities or products which could be considered to be an alternative option to NHS provision to NHS patients using the Direct Access Adult Hearing Service
- Not market NHS products and services as inferior to other products or services they or any organisation in which they have an interest provide
- Offer patients an opportunity to opt into receiving marketing information, and not make future contact without the patient's explicit opt-in consent

B1_5.0 Key Service Outcomes

- 90% of patients referred to the service should be assessed within 16 working days of receipt of referral
- 90% of patients requiring hearing aid fitting should be seen within 20 working days of the assessment
- 90% of follow-up appointments should be within 10 weeks of fitting
- 90% of patients should be able to access aftercare within 2 working days of a request
- 95% of responses received from patients sampled via a service user survey should report overall satisfaction with the service

20% of the total value for annual delivered activity will be subject to the achievement of the above key service outcomes. Each outcome will be weighted equally. Penalty will be applied on the individual indicator failed in accordance with weighting i.e. 1 indicator failed is a penalty of 4% reduction; 5 indicators failed is a penalty of 20% reduction.

Please see** Error! Reference source not found. **for additional commissioner notes

SECTION 1 APPENDIX 1

Contra-indications which should not be referred into or treated by the Direct Access Adult Hearing Service

S1A1.1 History:

- Persistent pain affecting either ear (defined as earache lasting more than 7 days in the past 90 days before appointment);
- History of discharge other than wax from either ear within the last 90 days
- Sudden loss or sudden deterioration of hearing (sudden=within 1 week, in which case send to A&E or Urgent Care ENT clinic)
- Rapid loss or rapid deterioration of hearing (rapid=90 days or less)
- Fluctuating hearing loss, other than associated with colds
- Unilateral or asymmetrical, or pulsatile or distressing tinnitus lasting more than 5 minutes at a time
- Troublesome, tinnitus which may lead to sleep disturbance or be associated with symptoms of anxiety or depression
- Abnormal auditory perceptions (dysacuses)
- Vertigo (Vertigo is classically described hallucination of movement, but here includes dizziness, swaying or floating sensations that may indicate otological, neurological or medical conditions)
- Normal peripheral hearing but with abnormal difficulty hearing in noisy backgrounds; possibly having problems with sound localization, or difficulty following complex auditory directions.

S1A1.2 Ear examination:

- Complete or partial obstruction of the external auditory canal preventing proper examination of the eardrum and/or proper taking of an aural impression.
- Abnormal appearance of the outer ear and/or the eardrum (e.g., inflammation of the external auditory canal, perforated eardrum, active discharge).

S1A1.3 Audiometry:

- Conductive hearing loss, defined as 25 dB or greater air-bone gap present at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz.
- Unilateral or asymmetrical sensorineural hearing loss, defined as a difference between the left and right bone conduction thresholds of 20 dB or greater at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz.

- Evidence of deterioration of hearing by comparison with an audiogram taken in the last 24 months, defined as a deterioration of 15 dB or more in air conduction threshold readings at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz.

References:

British Academy of Audiology Guidelines for Referral to Audiology of Adults with Hearing Difficulty (2009)

BSHAA Protocol and Criteria for Referral for Medical or other Specialist Opinion (2011)

SECTION 1 APPENDIX 2

Accreditation Standards

S1A2.1 Improving Quality In Physiological diagnostic Services (IQIPS)

Accreditation Standards and Criteria

http://www.rcplondon.ac.uk/projects/iqips

S1A2.2 Published Clinical Guidelines and Best Practice

Hearing assessment, fitting, follow-up and aftercare services should follow best practice standards and recommendations as defined below:

- NHS Core principles
- National Institute for Health and Clinical Excellence Guidance/Quality Standards, when available
- Department of Health: Standards for Better Health
- Clinical protocols specified by British Society of Audiology and British Academy of Audiology
- British Society of Audiology guidelines on minimum training standards for otoscopy and impression taking 12
- British Society of Audiology and British Academy of Audiology guidance on the use of real ear measurement to verify the fitting of digital signal processing hearing aids12 and 13
- Guidelines on the acoustics of sound field audiometry in clinical audiological applications.
- Hearing Aid Handbook, Part 512
- British Society of Audiology Pure Tone air and bone conduction threshold audiometry with and without masking and determination of uncomfortable loudness levels
- British Society of Audiology recommended procedure for taking an aural impression
- British Society of Audiology recommended procedure for tympanometry (when undertaken)
- British Academy of Audiology Guidelines for Referral to Audiology of Adults with Hearing Difficulty (2009)
- Recommended standards for pre-hearing aid counselling (Best Practice Standards for Adult Audiology, RNID, 2002)
- Recommended standards for deaf awareness (Best Practice Standards for Adult Audiology, RNID, 2002)

- Guidance on Professional Practice for Hearing Aid Audiologists (British Society of Hearing Aid Audiologists, 2011)

SECTION 1 APPENDIX 3

Suggested Minimum Qualifications and Skills of Clinical Staff

S1A3.1 Professional Head of Service

They must have as a minimum the following qualifications and skills (or equivalent):

- BSc Audiology (or equivalent e.g. Hearing Aid Council examination or Foundation Degree in Audiology) level of expertise in audiology, with a Certificate of Audiological Competence (or equivalent)
- Registered with the Health Professions Council (HPC) as a Clinical Scientist in Audiology or registered with the Registration Council for Clinical Physiologists (RCCP) voluntary register as an Audiologist.
- Where the Government's Modernising Scientific Careers (MSC) programme brings about changes to registration requirements, senior audiologists must be registered accordingly.
- Appropriate training, skills and experience in testing, assessing, prescribing, fitting digital hearing aids and providing aftercare.

Relevant experience at a senior managerial level, including experience of team management in adult audiology and evidence of CPD including the provision of patient education related to hearing loss and hearing aids.

S1A3.2 Audiologists

They must have as a minimum the following qualifications and skills (or equivalent):

- BSc Audiology or Post Graduate Diploma in Audiology or pre 2004, Medical Physics and Physiological Measurement (MPPM) B-TEC and British Association of Audiological Technicians (BAAT) parts I & II, with training in Clinical Certificate of Competency.
- Registered with the HPC as a Clinical Scientist in Audiology or a Registered Hearing Aid Dispenser, or with the RCCP voluntary register. Where the Government's MSC programme brings about changes to registration requirements, audiologists must be registered accordingly.
- Evidence of appropriate and recognised training (including CPD) to conduct hearing assessments and rehabilitation, including the provision of patient education related to hearing loss and hearing aids.
- Appropriate training, skills and experience in objective measurements (e.g. REM) of digital signal processing (DSP) hearing aids.

S1A3.3 Registered Hearing Aid Dispensers

They must have as a minimum the following qualifications and skills (or equivalent):

- Hearing Aid Council qualification or Foundation Degree in Hearing Aid Audiology
- Registered with the HPC as a Hearing Aid Dispenser

S1A3.4 Assistant/Associate Audiologists

Assistant/associate audiologists must be trained to perform the functions for which they are employed

Such training maybe provided by BAA accredited training centres or national training courses for assistant audiologists, or specific topics such as the BSA course in otoscopy and impression taking or audiometry.

Associate audiologists would be expected to have completed the Foundation Degree in Hearing Aid Audiology (or equivalent).

REPORT TO: Health Policy & Performance Board

DATE: 29 May 2012

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Adults

SUBJECT: Reconfiguration of Care Management Services

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform the Board of changes to the delivery of Adult Social Care in Halton by the reconfiguring of assessment and care management services and a newly enhanced service for developing improved Safeguarding arrangements.

2.0 **RECOMMENDATION: That the Board: Note and comment on the contents of the report**

3.0 **SUPPORTING INFORMATION**

3.1 In order to transform social care in line with Putting People First and fully implement Self Directed Support (SDS) responding to an agenda that incorporates prevention, inclusion and personalisation, the current way in which services are delivered in adult social care has needed to be reviewed. The safeguarding of vulnerable adults continues to be a high priority for the Council and detail of developments relating to an integrated safeguarding unit, are outlined in the report to the Board on the 29th May.

3.2 A Strategic Reconfiguration Board chaired by the Operational Director (Assessment & Prevention) was established to oversee the reconfiguration of the care management and assessment service, with a project management approach and dedicated work-streams. The reconfiguration, involves the restructure of the current care management teams to create a dedicated multi-disciplinary duty function team. An Initial Assessment Team (IAT) will be responsible for all referrals, screening, signposting and initial assessments. There will be two Operational teams dealing with complex work, (one in Widnes and one in Runcorn) that are to become locality based care management teams with workers aligned to GP practices. The new model will be launched at the beginning of June 2012.

3.3 Currently the 'Assessment and Care Management' service in Halton is divided into differing service areas; learning disabilities, physical

and sensory disabilities, older people and OT services (via the Home Improvement and Independent Living Service (HHIILS) team). Please note that the reconfiguration has not included :-

- Mental health services as they are already integrated with 5Boroughs
- The Home Improvement side of the Home Improvement and Independent Living Service (HHIILS) team.

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. The new model of delivery will have the effect of providing an efficient, productive and responsive service for the local population. The model will also have the potential to facilitate integrated care partnerships with health partners locally.

3.4 **New Model of Delivery**

As 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 research, data and evidence supports the establishment of multi-professional health and social care teams to address the needs of high risk people within the community. The reconfiguration provided an opportunity to develop a new model of service delivery, as shown in Appendix 1 that built on the strengths of the existing system as follows by:

- Meeting the needs of as many people as possible at first contact by the creation of an Initial Assessment Team (IAT) to provide universal advice, guidance and act as a single point of access to all adults with adult social care needs;
- Facilitating people to undertake assessments and support plans with limited social services input;
- Providing a focus throughout all processes on prevention and re-enablement, to promote independence;
- Developing locality based care management teams, aligned with GP Practices and wherever possible and appropriate, co-located with other professionals; and
- Removing the division between adult, older people and the HHIILS teams by creating generic teams covering defined localities, therefore helping all adults in the local community according to demand.

4.0 **POLICY IMPLICATIONS**

4.1 New Assessment and Care Management Policies and Procedures are being developed to support the new model.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 Staffing levels associated with the new model has provided some efficiencies, whilst the functions of the new teams are not compromised. With the new model, the numbers of front line positions remain the same, the IAT Team has been developed from within the existing staff group. However there will be the opportunity to review this at a later stage. The budget for the new model has been reviewed (no additional resources have been required) and budgets will be aligned to the new operational teams on implementation.

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

6.1 **Children & Young People in Halton**

The new model continues to ensure the needs of younger vulnerable adults moving through transition from Children's services into adult services will be met; new pathways have been developed accordingly.

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

None identified

6.3 **A Healthy Halton**

All issues outlined in this report focus directly on this priority.

6.4 **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. This new model of delivery of Assessment and Care Management services (in addition to the development of the Safeguarding Unit) does provide assurances that appropriate safeguarding processes are in place.

6.5 **Halton's Urban Renewal**

None identified

7.0 **RISK ANALYSIS**

7.1 Staff will move to generic working practices and this has required detailed analysis of the workforce, including skill mix and training needs. The new model will need continued development to move towards improved and integrated service with Health.

7.2 As this is a significant reconfiguration of adult services, it will be subject to evaluation and review and a progress report providing details of an initial evaluation of implementation will be provided to

the Board in September 2012.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified

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

Document	Place of Inspection	Contact Officer
Bringing the NHS and Local Government Together- A Practical Guide to Integrated Working by Care Services Improvement Partnership (CSIP)	John Briggs House	Marie Lynch
The Kings Fund – Integrated Health and Social Care at Torbay – Improving Care for Mrs Smith	John Briggs House	Marie Lynch

NEW MODEL OF WORKING

APPENDIX 1

Initial Assessment Team (IAT)

- Based with the Contact Centre in Widnes
- Would receive all referrals for adult social care
- Check FACS appropriate
- Provide one-off response service (e.g. Meals on Wheels, Day Services, etc.)
- Undertake unscheduled reviews
- Assist people with completion of Supported Assessment Questionnaires (SAQ) for new referrals
- Signpost to other services
- Undertake more stringent screening providing good quality universal advice and guidance
- Collect contact assessment overview details for SAP which will upload directly into Carefirst thus reducing data entry input for operational teams
- For more complex support planning and care management refer to appropriate team where a worker will be aligned to a "zone" connected to the person's GP.

RUNCORN TEAM

- Castlefields and Windmill Hill
- Grove and Heath
- Weavervale Brookvale Murdishcar
- Tower

WIDNES TEAM

- Beaconsfield
- Appleton and Peelhouse
- The Beeches Upton and Upton Rocks
- Newtown Oakes Place Widnes and West Bank

REPORT TO: Health Policy & Performance Board

DATE: 29 May 2012

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Adults

SUBJECT: Intergenerational Strategy

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the draft copy of the Halton Intergenerational framework and action plan. This will include the main aims of the document and details of the associated action plan.

2.0 **RECOMMENDATION: That Members of the Health Policy & Performance Board note the report and Strategy.**

3.0 **SUPPORTING INFORMATION**

3.1 It is well documented that the UK has an ageing population. The reason for this relates to not only a decline in the birth rate, but also the number of older people longer is increasing. As society and local communities have evolved over the previous decades there has been a perception that there is a growing divide between older and younger generations. Local feedback has supported this perception with fear, caution, misunderstanding and anxiety being the overarching feelings expressed by both groups.

3.2 This framework aims to begin the process of developing and implementing a co-ordinated approach toward intergenerational activity in the borough. There is already a range of examples of intergenerational work in Halton within the framework; however, this has often been carried out in isolation and not as an overall strategic approach.

3.3 Interest in intergenerational practice and what it can achieve is growing amongst practitioners and policymakers. In 2009, the government allocated £5.5 million to promoting intergenerational practices and although Halton was unsuccessful in the bidding process it did open a number of opportunities that have successfully developed since then. The Halloween projects, Halton Community Radio event, Moorfields Bowling club, Hallwood Park Canal Boat project are just a selection of the many projects that have already been well supported and the aim of the document is to do more.

3.4 April 2010 saw Halton host the first Intergenerational conference that was attended by 200 members of the public of all ages. Activates on the day were wide-ranging, but, the lasting message that came from the day was that people in Halton no matter what age wanted to be involved.

3.5 The action plan initially looks at the setting up of an intergenerational group who will have responsibility for implementation of the action plan, including mapping of existing activity, financial planning and identification of gaps.

3.6 By working across directorates and organisations it is envisaged that the implementation group will be able to deliver a coherent and clear range of services, supported by Community Development. This will provide a strong foundation to help communication, breaking stereotypes and joint working across the age groups.

4.0 POLICY IMPLICATIONS

4.1 The Intergenerational framework and action plan has been formed as part of the Prevention and Early Intervention Strategy (2010-15), within this strategy intergenerational work is identified as a key strategic commissioning objective.

4.2 The aim of the intergenerational strand of the Prevention and Early Intervention strategy will be to bring younger and older people together in purposeful, mutually beneficial activities, which promote greater understanding and respect between generations and contribute to building more cohesive communities. The objective of this strand will be to embed intergenerational work as a key well-being and prevention activity of Halton Borough Council and to develop and promote intergenerational work and its benefits. Key activity will be the development of the council's intergenerational group into a robust strategic body that meets regularly to coordinate intergenerational activity across the borough.

4.3 Although intergenerational work is referenced in documents such as Our Care, Our Health, Our Say (Department of Health 2006) and Transforming Adult Social Care (Department of Health 2008), there are currently no direct Government policies to support intergenerational activities.

5.0 FINANCIAL IMPLICATIONS

5.1 The actions contained in the action plan will require no additional financial contribution from the Council and will be funded from within existing resources. Future funding opportunities to tackle some of the actions would be considered through the development of a business plan.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The intergenerational framework will deliver a range of opportunities for children and young people in the borough.

6.2 Employment, Learning & Skills in Halton

It is planned through the developments and activities that there will be a range of opportunities to help people of all ages learn new skills and participate in volunteering roles.

6.3 A Healthy Halton

By developing projects that support some of the most vulnerable parts of our community we can help to raise awareness and support people to become involved with services that are designed to keep people independent in their own communities.

6.4 A Safer Halton

The planned activities are designed to improve community cohesion and to bring together two different groups who are often marginalised. As well as the health benefits it is expected that this should also improve the safety and an improved perception of Halton and its communities.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 No specific risks identified for this particular framework, a risk register will be completed and managed through the Intergenerational steering group.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 No equality and diversity issues arise from this framework

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

None under the meaning of the Act.

HALTON BOROUGH COUNCIL

Communities Directorate

FRAMEWORK & ACTION PLAN FOR INTERGENERATIONAL ACTIVITY IN HALTON (2012 – 2015)

connexions GREATER MERSEYSIDE

Halton Children's Trust "Working together to make the difference"

NHS Halton and St Helens

CONTENTS

INFORMATION SHEET

Service area	All service areas
Date effective from	June 2012
Responsible officer(s)	Policy Officer
Date of review(s)	Annually
Status: • **Mandatory (all named staff must adhere to guidance)** • **Optional (procedures and practice can vary between teams)**	Mandatory
Target audience	All staff
Date of committee/SMT decision	
Related document(s)	N/A
Superseded document(s)	
File reference	

PREFACE

The purpose of this document is to provide Halton (HBC) with a framework that clearly defines intergenerational practice (IP) in terms of local and national priorities. The framework sets out the relationship between a particular project and relevant Indicator targets included within Halton's local area agreements (LAAs).

An intergenerational approach can help meet the needs of the future health, social care and wellbeing of Halton's residents. In particular, it can help us to respond positively to the increasing number of older people who are living longer - Halton's older population (Aged 65+) is projected to grow by 43% from 16,900 in 2008 to 24,200 in 2023). It can also help to address some of the problems of Halton's 16 – 18 year olds who are not in education, employment or training (NEET)

Outcomes are particularly important especially in wards such as Castlefields, where there is a poor record of youth engagement, large numbers of young people and high levels of anti-social behaviour. Bringing together the generations in such an environment can be can be of enormous benefit. Both age-groups can learn new skills and talents from each other, rather than perpetuating inaccurate stereotypes that are often presented by the media or a tiny minority.

To quote both a younger and an older delegate at a recent intergenerational conference in Halton

> *"We do have things in common even though it's a different era, so I do listen to older people."*
>
> *"I was unnerved walking toward a group of teenagers to get to a shop, but they parted and opened the door for me!"*

Bringing people from different generations together will not solve all of the problems in Halton, but finding more ways for people to engage in and develop their own lives and those of their communities, will be vital in creating a strong, sustainable and harmonious future for the borough. This document presents ideas that will help achieve this vision.

DWAYNE JOHNSON

STRATEGIC DIRECTOR
COMMUNITIES
HALTON BOROUGH COUNCIL

GERALD MEEHAN

STRATEGIC DIRECTOR
CHILDREN & ENTERPRISE
HALTON BOROUGH COUNCIL

Framework and Action Plan for an Intergenerational Strategy for Halton

1. Addressing the Growing Divide

The UK has an ageing population because its birth rate is in decline and its older people are living longer (Granville 2002). In addition, a growing divide between older and younger generations has arisen. Apart from our own families we spend much less time with people of different generations. This has been due to a number of factors such as: changing family patterns, an erosion of traditional community structures, age segregated activities, living arrangements and government social policy interventions or services that target specific groups (Hatton-Yeo, 2006). Taken as a whole, these factors reduce opportunities for different generations to meet and interact.

For this reason, it is important that shifting demographics and different patterns of community life are prevented from increasing the gap between the generations. To paraphrase Anne Weinstock (2009) Director of Youth Taskforce:

> **"It is vital for the long-term health of the nation that older members of our society age well, have the opportunity to pass down their wealth of insight and understanding to younger generations while recognising the skills and talents of our young people, so they can learn from them too. It is equally important that young people realise that many older people, because they have a longer and varied experience of life, are happy to support young people of all backgrounds."**

Interest in intergenerational practice and what it can achieve has grown amongst practitioners and policymakers in the UK and Europe since the 1990s (Abrahams, 2007; Hatton-Yeo, 2006). In 2009, the government allocated £5.5 million to promoting intergenerational practices (Appendix 1). Their 'Generations Together' programme aimed to increase the number of older people working on intergenerational activity; encourage a more strategic and sustainable approach; and provide robust evidence of the effectiveness of intergenerational initiatives (DCSF, 2009).There are also some readily accessible government policy documents suggesting intergenerational practice may be effective at achieving outcomes such as reducing ageism and stereotyping between generations. These include: *Building a Society for All Ages* (2009) *Every Child Matters* (2003, 2004), *The Learning Revolution* (2009) and *Strong and Prosperous Communities* (2009) and *Think Community* (2009). In addition, intergenerational projects have been suggested as a way of improving the health and well-being of older people while reducing loneliness and social exclusion (Abrahams et al., 2007; Robinson et al., 2006; Ellis, 2004).5

In 2008, the LGA commissioned the NFER to undertake a literature review to find out what is known about the effectiveness of intergenerational practice. The findings from this review highlighted the potential benefits that could be gained from intergenerational activity for the well-being of both young and older people (Springate et al., 2008). However, it also suggested the need for more research exploring the effectiveness of intergenerational practice in a UK context and demonstrating the outcomes and key factors of successful projects.

Intergenerational practice which refers specifically to activities involving older adults and younger people or children, can help to offset some of these factors and significantly increase understanding between the generations. By increasing this kind of activity and at the same time developing innovative ways for younger and older people to interact, it is possible to reverse the trend toward a breakdown in social cohesion. Leeds City Council have identified the following benefits arising from intergenerational approaches:

Empowers and engages individuals
Values skills and experiences
Brings people and communities together
Tackles crime and the fear of crime
Promotes good mental and physical health
Promotes a lifelong engagement with learning
Reduces isolation
Challenges negative stereotypes
Supports inclusive, adaptable neighbourhoods
Addresses inequality
Endorses citizenship
Encourages understanding and respect
Raises attainment and develops the aspirations of all generations

However, local areas differ and each community will harbour different strengths and challenges, hence a 'one fits all' approach will not work (Appendices 2 and 3 list challenges and key features of IP). However, by using an intergenerational strategy to address a range of local priorities linked to public service agreements and the National Indicator Set, Halton can decide upon a framework that represents best practice and offers positive outcomes.

Considering the challenges society faces, there is no simple solution that can close the generation gap. However, intergenerational activity will have a significant role to play in recreating that sense of community and neighbourliness that is missing and represents a better life for everyone.

2. Defining Intergenerational Practice

The term 'Intergenerational Practice' (IP) covers a wide range of activities and as a consequence is only loosely defined. There are however a number of core principles and characteristics and these are set out in the definition below:

> ***Intergenerational practice aims to bring people together in purposeful, mutually beneficial activities which promote greater understanding and respect between older and younger generations and contributes to building more cohesive communities. IP builds on the positive resources that the young and old have to offer each other and those around them.***
> (Beth Johnson Foundation, 2006)

Granville (2002) defines 'younger people' (aged up to 25) and 'older people' (aged 50 or over) and draws a distinction from multigenerational working which would include the generation between these two age groups. She also raises the issue of whether intergenerational activities should also include members of the same family. There is some evidence to suggest that doing so is less successful if the overall aim is to break down stereotypes between younger and older generations.

In bringing generations together, challenging negative stereotypes and breaking down barriers within communities, IP approaches are able to contribute significantly to the achievement of targets in various policy areas of national and local concern.

By defining intergenerational practice the strategy understands and incorporates the issue of safeguarding of vulnerable adults. The document 'No Secrets' (March 2000), published by the Department of Health and Home Office under section 7 of the Local Authority Social Services Act 1970, issued guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.

'No Secrets' suggests that local agencies should collaborate to achieve effective inter-agency working, through the formation of multi-agency management committees. In Halton, this forum is called the Safeguarding Adults Board. Prevention and intergenerational activity plays an important role in relation to safeguarding by supporting people to remain independent. Often the focus is on people who may be vulnerable or in vulnerable situations, these people can be at risk of harm or abuse because they are perceived as easy targets, owing to their age or disabilities; others live with few or no social contacts or in situations where they rely on others for daily support, or they lack the mental capacity to be aware of what may be happening to them. By supporting people to remain active, develop improved social networks and maintain their own health this strategy aims to support the ethos of safeguarding in the borough.

3. The National Policy Context

IP can contribute to Government targets in the following broad policy areas:

- **Community cohesion (Public Service Agreement (PSA) 21)**
- **Community Safety (PSA 23)**
- **Health and Wellbeing (PSA 18)**
- **Poverty and greater independence and wellbeing in later life (PSA 17)**
- **Children and Younger people (PSA 14)**
- **Families (Public Service Agreement PSA 14, 17,18, 21,)**

Community cohesion: Intergenerational approaches can support the achievement of cohesion by promoting meaningful interactions between people from different backgrounds and by encouraging more participation in culture and sport. Active communities can be supported by increasing levels of formal and informal volunteering by people from both ends of the age spectrum, where members of the community work to meet local needs. It fosters greater respect, trust and tolerance between young and old, helping both generations to feel more engaged, valued and empowered in their communities. This contributes to both young and old feeling more at ease with their local patch and sharing a much greater sense of belonging. At the heart of active participation are community based their sector organisations, often bringing different groups together and providing a platform to meet the needs of individuals and communities.

Community Safety: Intergenerational approaches have the potential to tackle crime, disorder and anti-social behaviour issues of most importance in each locality. This can help increase public confidence in the local agencies involved in dealing with these issues. By increasing mutual respect and trust between the generations IP contributes to making communities feel safer. This helps to reduce older people's fear of youth, frequently exacerbated by negative media coverage of alcohol abuse, drug abuse and youth crime.

This makes them more confident and tolerant in their dealings with young people in their community. This in turn has the knock-on effect of making young people feel less isolated, safe, more valued and more likely to want to engage with and make a positive contribution to their community.

Health and Wellbeing: Interacting with a younger generation helps to make older people feel less isolated and more involved in their communities. This in turn contributes to improving their general wellbeing and mental health. Active involvement in more physical intergenerational activities such as gardening and dancing also helps to improve older people's general health. Volunteering enables both young and old to get involved and make positive contributions in the community and also helps to improve the health and wellbeing of all involved. In general, when people of any age have the opportunity to experience success and mutual support, they develop a stronger sense of identity and self-esteem, which in turn positively impact on their wellbeing.

Poverty and greater independence and wellbeing in later life: The indicator refers to everyone over the age of 50 (around one third of the population and a very diverse group). A number of key aspects of independence and wellbeing have emerged from research and consultation with older people, which link to the role intergenerational approaches can play. For example, making a contribution to society and being satisfied with home and neighbourhood. This would include the impact of factors such as fear of social isolation and crime. IP enables older people to make a positive contribution by sharing their knowledge, skills, experiences and life stories with a younger generation. Older people can work in schools and colleges as volunteer mentors and functioning as positive role models for younger people. This can help the younger person improve their academic performance, social skills and general wellbeing. IP also offers a wealth of learning opportunities for older people (IT skills, second language learning and creative writing) and any new skills they develop can help them live a more independent and fulfilled life.

Children and Younger People: IP offers younger people a wide range of opportunities to become engaged in positive activities and be respected for the contributions they make. Increased participation supports their moral, emotional and social development. More specifically, engaging with older people improves their communication skills, self-confidence and self-esteem. This is especially true among younger people from communities with a poor history of engagement and the 25% of young individuals who do not engage in any positive activities outside learning. It can also help them to avoid becoming involved in pursuits that are anti-social and risky, such as crime, substance misuse and having unprotected sex. Positive participation can also increase motivation, improve attendance at school or college, which in turn helps academic performance and increases employment opportunities.

Families: Strong families are crucial components within communities and increasingly the importance of the extended family is seen as a way of achieving benefits for all generations. Grandparents and older kin often play a vital role in the success of their grandchildren and grandchildren reciprocate in their relationships and support. In situations where the extended family may have been weakened, opportunities exist to strengthen the family unit through older volunteers supporting parents, particularly those who are young, inexperienced and bringing up children on their own. There are increasing numbers of examples of intergenerational projects that provide support and skill sharing for young parents. All of the above policy areas are prioritised in the Government's Public

Service Agreements (PSAs) for 2008-2011, covering the following four main areas of social policy:

- **Fairness and opportunity for all (PSA 9-11 and 14-16)**
- **A better quality of life (PSA 12-13, 17-19 and 22)**
- **Stronger communities (PSA 21 and 23-26)**
- **A more secure, fair and environmentally sustainable world ((PSA27-30)**

(http://www.hm-treasury.gov.uk/d/psa 2008-2011-200409.pdf); See also Appendices 4 and 5 this document

National priorities are also set out in Departmental Strategic Objectives (DSOs) and highlighted in many policy documents that promote socially inclusive approaches to community development. In these documents the Government places a high priority on the involvement of all individuals and groups (including older and younger people). This type of engagement aims to empower individuals and communities, enhance personal development and wellbeing and strengthen community cohesion. Relevant policy documents include:

- **Every Child Matters (2003,2004)**
- **Reaching Out: Think Family (2007)**
- **Our Shared Future (2007)**
- **Youth Matters (2005, 2006)**
- **Aiming High for Young People (2007)**
- **Building a Society for All Ages (2009)**
- **The Learning Revolution (2009)**
- **Strong and Prosperous Communities (2009)**
- **Think Community (2009)**

4. The Local Policy Context:

In terms of our local priorities, IP is an adaptable approach that can be used to help meet National Indicator targets, whether working independently or through Local Strategic Partnerships. A major strength of IP is that it promotes cross-sector and cross-policy working. This approach is particularly relevant considering the current economic slowdown, with local authorities under increasing pressure to meet targets while reducing costs.

IP's considerable potential for supporting local authorities in their efforts to meet LAA targets has been recognised in various Central Government initiatives. However, the Government also acknowledges that successful IP programmes need to be locally delivered and supported and that local authorities have the pivotal role in achieving sustainable change.

This strong emphasis on local delivery is reflected in the *Generations Together Programme* (Appendix 1).

5. Intergenerational Activity in Halton

In April 2008, the Audit Commission undertook a Comprehensive Performance Assessment Inspection of Council Services and identified intergenerational activity as a key area of focus. Similarly, a baseline assessment of tension indicators in 2007 identified young people involved in anti-social behaviour and fear of crime amongst the key areas of focus for Halton.

From April 2009 the Older People's Service entered into a service level agreement with the Council's Community Development team to deliver targeted support to intergenerational activity across Halton.

The Community Development Service operates a locality-based service in tandem with the Area Forum boundaries. Within each of the seven areas a Community Development Officer has a neighbourhood base. This model of service delivery provides established relationships with community groups and partner agencies. It can be viewed as a spring board to delivering targeted activity and community engagement, but it also further develops participative communities, where people engage rather than passively receive.

The Service level agreement commissioned three hours of community development support per week, per area for an annual charge of £15k for two years. The support was to underpin intergenerational community activity and facilitate an Intergenerational Conference. Monitoring was quarterly and captured the following data:

- People aged 55+ benefiting from intergenerational activity
- Those aged 18-55 benefiting from intergenerational activity.
- Total under 18's benefiting from intergenerational activity.
- Total under 18's directly involved in providing activity.
- Total 18-55's directly involved in providing intergenerational activity.
- Total over 55's directly involved in providing activity.
- Total people of any age directly involved.
- Total events delivered.
- Total over 55's involved in broader activity

Service delivery should focus on positive activity that gels together young and old and contribute to improved health and emotional well being, improved quality of life, making a positive contribution and helping to identify gaps in provision and activity.

During 2008/09 thirty-two community led intergenerational events/activities were delivered. On the 25th April 2009 Halton's first intergenerational conference took place coinciding with the European day of solidarity between the generations. Over 200 people, young and old attended the event which focussed on positive activities i.e. games through the decades. Young people held workshops on e-communication demonstrating mobile phone and internet usage. Consultation for future intergenerational activity was collected any many attendees contributed to a video diary of their experiences and desires for relationships between the generations in our communities.

Following the conference, considerable emphasis was placed on introducing the theme of intergenerational activity with community groups and helping them develop further ideas for events and activities. This has led to the development of both an ethos which stresses the beneficial effects of IG activity throughout the Borough and an Action Plan for the development of specific projects for 2011 - 2012.

6. Ethos

Engagement and consultation mechanisms are well-developed in Halton. There is an established Older People's Empowerment Network with 600 members, a Youth Parliament and Citizens' Panel. The borough has had a strong thematic approach to IG activity since

April 2009. This focuses on the positive outcomes of joint activity between the generations. The general ethos is to effect a cultural change by creating opportunities for innovation through opportunities foe engagement in interactive activities. Many of these were initially piloted in the Heath School and the authority is now poised to extend what it has learnt in order to generate and build stronger community relations to further the network of IG activity across Halton.

To achieve this effectively a more collaborative approach is required. In particular, third sector organisations will have a pivotal role in consulting, developing and delivering, as well as supporting IG activity. The initiatives outlined in the action plan will strengthen short and medium term relations between the generations, while creating positive activity and better social cohesion for the longer term. This will in turn create a social change that will stimulate increasing community involvement and civic pride.

7. Outcomes

As Springate, Atkinson and Martin (2008) have pointed out in their Local Government Research report reviewing the UK literature on intergenerational practice, the activities involved are enormously varied and this can make it difficult to evaluate outcomes. Pain (2005) has pointed out that 'hard' and 'soft' outcomes are difficult to quantify as they are often diffuse and long-term. Consequently outcomes are best seen in the way that Granville (2002) described them as 'potential' rather than 'proven.' Outcomes are best categorised as relating to: all participants, older people, young people and communities (see Flowchart page 12).

All Participants: There are four principal outcomes typically reported by both young and old when they work together on a project. These are better mutual **understanding**, **friendship**, **enjoyment** and improvements in **confidence**. Changes in attitude are often seen from participant comments such as:

> "Previously I have always thought that old people moan a lot, but now because I have spoken to quite a few while on volunteering projects I have realised they are not."
>
> "My views of young people have really changed through being here and speaking to them; I've learnt a lot about how they think.
>
> (Halton International Conference, Diary Room, April 2009)

This greater understanding between the generations can greatly reduce former tension and Whitworth (2004) cites evidence of a reduction in complaints to the police, as residents became more tolerant of younger people, following the introduction the introduction of intergenerational sheltered housing project. Greater understanding helps to reduce negative stereotypes on both sides.

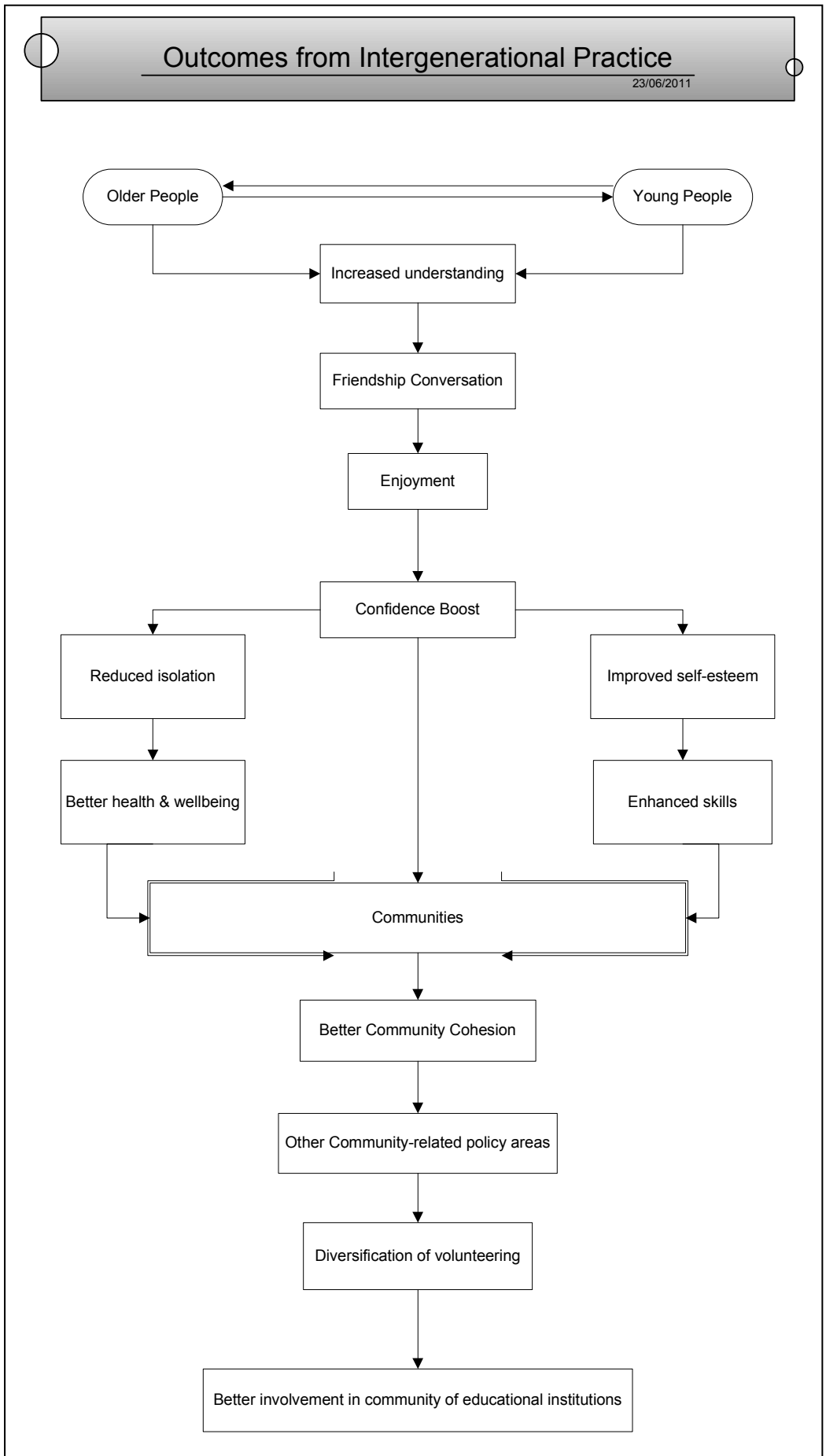
As the generations get to know each other through a joint activity, mutual trust tends to develop. This can often be perpetuated beyond the activity itself leading to further spin-off activities, improving relationships and genuine friendship. At the Halton Intergenerational Conference (2009) both generations showed genuine surprise at the fact they enjoyed each other's company, having initially expressed reservations, largely based on stereotypes. As the day progressed and they became more involved talking to each other and working together, both groups expressed increased enjoyment and confidence and a few from both generations, who hadn't had an opportunity to share a table, were sorry that they had missed a valuable opportunity to share ideas and conversation.

Older People: Three main outcomes are commonly referred to by older people as a result of participation in intergenerational activities. These relate to an improvement in **health and well-being**, **reduced isolation** and a renewed **sense of worth**. Older people reported that simply being more active and able to get out of the house on a regular basis could improve their fitness and mobility giving them a better quality of life. Opportunities to interact with others, make friends and take part in the activities, available can help to reduce feelings of social isolation. Older people frequently reported an enhanced sense of self-worth they had not felt for a long time, as a consequence of being able to contribute to the lives of younger people in various ways. Increased participation also tended to reduce their fear of crime and interacting with other age groups, through social networking, enabled them to feel less isolated while engendering a sense of belonging.

Young People: Young people typically experience two important outcomes through their involvement in projects and activities. These relate to gaining specific skills beneficial for their future and increasing their self-esteem. These skills are often based around improved communication and social interaction outside their own peer group and where the older people have acted as 'mentors' in some form of educational setting there can be clear improvements in the younger person's focus and personal achievement resulting in greater self-esteem and a lesser likelihood of their being seduced into more 'risky behaviour.'

Communities: Both Granville (2002) and Pain (2005) have pointed out that intergenerational relations affect the community as a whole through their use public space, social interactions and the degree to which individuals choose to participate in community life. As understanding and interaction between young and old get better, so too does community cohesion; this results in changes in attitudes and beliefs from both generations. This community factor can also spread to other policy areas and impact on social issues such as: fear of crime, social exclusion, racial tensions, community safety, regeneration and the citizenship curriculum. It can also match key government priorities including: social inclusion, citizenship and community development (Moore and Stratham, 2006). This is good strong evidence that intergenerational community developmental practice should be promoted as an effective means of addressing a range of policy agendas and providing a framework for whole community working.

One of the most beneficial outcomes of IP has been the surge of older people making positive contributions to their communities. Initially, this is via intergenerational activities and then later through volunteering for other community-based projects (Kaplan, 2002; Stanton and Tench, 2003). Where projects are education based, there is a tendency for education providers to become much more involved in their communities, making use of the skills of the wider community to achieve their own specific educational objectives (Cohen et al. 2006). The flowchart below provides a summary of the potential outcomes for both participants and communities. It is clear that good IP practice can generate positive outcomes for both individuals and communities. It can also contribute to other social policy agendas.


Outcomes from Intergenerational Practice
23/06/2011
Older People
Young People
Increased understanding
Friendship Conversation
Enjoyment
Confidence Boost
Reduced isolation
Improved self-esteem
Better health & wellbeing
Enhanced skills
Communities
Better Community Cohesion
Other Community-related policy areas
Diversification of volunteering
Better involvement in community of educational institutions

8. Action Plan and recommendations for the future 2012 – 2015

Halton has been successfully running intergenerational projects for over 2 years. Obvious questions to ask are why are we still doing this and can we provide significant evidence from outcomes that such projects really are beneficial to both generations involved?

The literature suggests that such projects are beneficial not only to both age groups concerned, but also for the community as a whole. However, it also indicates that being able to demonstrate clearly that significant positive outcomes actually do occur is difficult. Halton needs to achieve this in order to build upon its intergenerational projects of the past two years. All reported increases will be measured against baseline data for the particular ward within Halton and also nationwide.

Clearly, the development of an Intergenerational framework and accompanying action plan would be an important key component in Halton's social and health care strategy. This is committed to helping people live independently in their own home, with services targeted at individual need.

The following are examples of the type of local project (LP) that has already been identified as possible within Halton and would enable intergenerational work and would support the continued development of community cohesion in the borough. This is by no means an exhaustive list, but will form the initial basis of the practical work that will be carried out to help implement the strategy. It is planned that all of this activity can be developed and completed within existing resources and each model will be designed to ensure future sustainability.

Objective	Task	Stakeholders	Proposed outcomes	Timescale
Develop a multi-disciplinary team	Develop a team across Halton to implement the Intergenerational framework	• Public Health • Local Authority • Voluntary Sector • Libraries • Community Development • Halton Older People's Empowerment Network	• Implementation of the Intergenerational framework • Mapping of associated intergenerational activity in Halton • Manage the performance delivery of intergenerational work in Halton • Report performance to relevant Senior Management Teams	September 2012 – then ongoing

		• Children & Young People's Services		
Raising awareness of health	Develop training for schools on a range of health topics including: Alzheimer's, Stroke, Diabetes, Cancer	• Public Health • Local Authority • Voluntary Sector	• Increase in pupil's knowledge of key diseases • An increase in the number of young people volunteering in health related projects • An increase in the number of social interactions among voluntary sector partners	September 2012 – March 2013
Social Media	Develop a learning project that will introduce the use of technology such as mobile phones, Internet, Facebook, Twitter, photography across the different age ranges.	• Libraries • Community Centres • Kingsway Learning Centre • Acorn Centre • Adult Learning and Skills division.	• An increase in the number of older people using facebook • An increase in the number of social interactions among younger (teachers) and older (pupils) • An increase in the number of older people using technology such as mobile phones, digital cameras etc. • An increase in the number of young people volunteering to assist and mentor older people in the community	Jan- July 2013
Community Reminiscence	Extend the existing Voices Project which allows older people to reminisce about their experiences	• Libraries • Community Development • Halton Older People's Empowerment Network • Children & Young People's Services	• Increase in numbers of younger and older people volunteering to interview or be interviewed • Increase in the number of social interactions between the generations • Increase in specific interviewing skills acquired for both younger and older people	Jan – Dec 2013

Creative Writing	Develop a low-cost sustainable creative writing group for younger and older people.	• Culture and leisure • Voluntary sector organisations • Libraries	• Increase in the number of social interactions between the generations • Increase in the number of older people posting stories on facebook • Decrease in the measure of social isolation.	Sept 2013 – June 2014

9. Indicators and Local Targets

The following table presents a selection of 30 NIs which intergenerational approaches can effectively support. For each NI, the table provides the following information:

- **Related national policy area (Broad Policy Area)**
- **Appropriate Public Service Agreement (PSA)**
- **Number of local authorities that included the indicator in their LAAs (data taken from Beth Johnson – Intergenerational Practice, Policy and Performance – A Framework for Local Authorities (2009)).**
- **Examples of Halton IP projects that address that indicator**

In addition, HBC places emphasis on the following five local priorities:

- Children and Young People
- Employment, Learning and Skills
- Health
- Safety
- Urban Renewal

Halton's intergenerational projects have most relevance among the first four of these (see also columns '*Broad Policy Area'* and '*Examples of IP in Halton'* in the following Outcomes table). For example, intergenerational projects enable Halton's Older People's Services and Children's and Young People directorate to work together in a way that strongly supports community cohesion throughout the borough. This enables stereotypes to be challenged from both sides of the generation gap, through dialogue, joint activities and social interaction. Also, by learning new skills from each other, through volunteering opportunities, apprenticeships, employment, formal and informal learning, both can develop a range of skills that can be of immediate and future benefit to local employment, learning and skills. Further, many of the projects will have a positive impact on health and well-being among older people (see 'Outcomes from intergenerational practice,' flowchart).

Through mutual respect and understanding, older people will feel safer both at home and within the community, no longer perceiving all young people as a threat, but as younger neighbours. Younger people for their part will view the older generation as people with interesting lives they can engage with and learn from.

The impact of the intergenerational activities featured in the Action Plan above (page 13) will be to deliver a strategic approach that can deliver outcomes to local people that address the following targets from the Local Area Agreement and 'Ambition for Health:'

NI1	% of people who believe people from different backgrounds get on well in their local area.
NI2	% of people who feel they belong to their neighbourhood.
NI6	Participation in regular volunteering.
NI7	Environment for a thriving third sector.
NI11	Engagement in the arts
NI17	Perceptions of anti-social behaviour

NI23	Perceptions that people in the area treat one another with respect and consideration.
NI27	Understanding concerns about anti-social behaviour & crime issues by council and police.
NI110	Young people's participation in positive activities
NI138	Satisfaction of people over 65 with both home and neighbourhood
NI 139	Extent to which older people receive the support they need to live independently at home

Table of Relevant National Indicators, Policy Areas and IP Examples in Halton

NI	Descriptor	Broad Policy Area	PSA	No. of LAs Prioritising	Examples of IP in Halton
01	**% of people who believe those from different backgrounds get on well together in their local area**	• **Stronger and safer communities** • **A Safer Halton**	**21**	**85**	Halloween Events Intergenerational Conference Moorfield Bowls Club Halton Castle Community Art Hallwood Park Canal Boat Castlefields Story Norton Priory Farnworth P.S. Vegetable Garden Grange Co-op Women's Guild Halton Community Radio Event Surestart To Later Life Halton Community Bridge Builders Alice Court West Bank Flower Pots
02	**% of people who feel that they belong to their neighbourhood**	• **Stronger and safer communities** • **A Safer Halton**	**21**	**7**	Halloween Events Intergenerational Conference Hallwood Park Canal Boat Grangeway café Castlefields Story Norton Priory Farnworth P.S. Vegetable Garden Grange Co-op Women's Guild Hallwood Park Day of Action Surestart To Later Life Halton Community Bridge Builders Alice Court West Bank Flower Pots
03	**Civic participation in the local area**	• **Stronger and safer communities** • **A Safer Halton**	**15**	**7**	Intergenerational Conference Grange Co-op Women's Guild Surestart To Later Life

04	**% of people who feel they can influence decisions in their locality**	• **Stronger and safer communities** • **A Safer Halton**		**86**	Halloween Events Grange Co-op Women's Guild Halton Community Radio Event Surestart To Later Life Halton Community Bridge Builders Oakmeadow Community Resource
05	**Overall or general satisfaction with the local area**	• **Stronger and safer communities** • **A Safer Halton**		**43**	Intergenerational Conference Halton Community Radio Event Hallwood Park Canal Boat Halton Castle Community Art Grangeway Café Castlefields Story Norton Priory Hallwood Park Welcome Club Hallwood Park Day of Action Halton Community Radio Event Surestart To Later Life Halton Community Bridge Builders Oakmeadow Community Resource Alice Court West Bank Flower Pots
06	**Participation in regular volunteering**	• **Employment , Learning & Skills in Halton**		**42**	Halloween Events Intergenerational Conference Farnworth P.S. Vegetable Garden Grange Co-op Women's Guild Hallwood Park Day of Action Surestart To Later Life Halton Community Bridge Builders Oakmeadow Community Resource Alice Court West Bank Flower Pots
09	**Use of public libraries**	• **Stronger and safer communities** • **Employment , Learning & Skills in Halton**		**10**	Castlefields Story + Community Artist Surestart To Later Life Halton Community Bridge Builders

10	**Visits to museums or galleries**	• **Stronger and safer communities** • **Employment , Learning & Skills in Halton**		**2**	Surestart To Later Life Halton Community Bridge Builders Oakmeadow Community Resource
11	**Engagement in the arts**	• **Stronger and safer communities** • **Employment , Learning & Skills in Halton**		**24**	Halton Castle Community Art Castlefields Story + Community Artist Halton Community Radio Event Surestart To Later Life Halton Community Bridge Builders Oakmeadow Community Resource
13	**Migrants' English language skills and knowledge**	• **Stronger and safer communities** • **Employment , Learning & Skills in Halton**		**3**	Castlefields Story + Community Artist Hallwood Park Day of Action Surestart To Later Life
17	**Perceptions of anti-social behaviour**	• **Stronger and safer communities** • **A Safer Halton**	**23**	**57**	Intergenerational Conference Surestart To Later Life Halton Community Bridge Builders
21	**Dealing with local concerns about anti-social behaviour and crime by local council and police**	• **Stronger and safer communities** • **A Safer Halton**	**23**	**60**	Halloween Events Intergenerational Conference Mencap Support Grange Co-op Women's Guild Hallwood Park Day of Action Surestart To Later Life Halton Community Bridge Builders
23	**Perceptions that people in the area treat one another with respect and dignity**	• **Stronger and safer communities** • **A Safer Halton**		**6**	Halloween Events Intergenerational Conference Hallwood Park Canal Boat Mencap Support Grangeway Café

					Grange Co-op Women's Guild Castlefields Story + Community Artist Surestart To Later Life Halton Community Bridge Builders Oakmeadow Community Resource Alice Court West Bank Flower Pots
50	**Emotional health and children**	• **Children and young people** • **Healthy Halton**	**12**	**20**	Mencap Support Farnworth P.S. Vegetable Garden Surestart To Later Life Oakmeadow Community Resource Alice Court West Bank Flower Pots
56	**Obesity among primary school age children in year 6**	• **Children and young people** • **Healthy Halton**		**101**	Farnworth P.S. Vegetable Garden
58	**Emotional and behavioural health of children in care**	• **Children and young people** • **Healthy Halton**		**6**	Mencap Support Castlefields Story + Community Artist Surestart To Later Life
69	**Children who have experienced bullying**	• **Children and young people**		**23**	Moorfield Bowls Club Halton Castle Community Art Mencap Support Farnworth P.S. Vegetable Garden Grange Co-op Women's Guild Castlefields Story + Community Artist Alice Court West Bank Flower Pots
81	**Inequality gap in the achievement of a level 3 qualification by the age of 19**	• **Children and young people** • **Employment Learning & Skills**		**5**	Halton Community Bridge Builders Alice Court West Bank Flower Pots
82	**Inequality gap in the achievement of a level 2 qualification by the age of 19**	• **Children and young people** • **Employment Learning & Skills**		**3**	Halton Community Bridge Builders Alice Court West Bank Flower Pots

102	**Achievement gap between pupils eligible for free school meals and their peers achieving the expected level at Key Stages 2 and 4**	• **Children and young people** • **Employment Learning & Skills**	**11**	**3**	Halton Community Bridge Builders
106	**Young people from low income backgrounds progressing to higher education**	• **Children and young people** • **Employment Learning & Skills**	**11**	**9**	Halton Community Bridge Builders
110	**Young people's participation in positive activities**	• **Children and young people**	**14**	**75**	Halloween Events Intergenerational Conference Moorfield Bowls Club Grangeway Cafe Halton Castle Community Art Hallwood Park Canal Boat Mencap Support Castlefields Story Norton Priory Hallwood Park Welcome Club Farnworth P.S. Vegetable Garden Grange Co-op Women's Guild Castlefields Story + Community Artist Halton Community Radio Event Halton Community Bridge Builders Oakmeadow Community Resource Alice Court West Bank Flower Pots
111	**First time entrants to Youth Justice System aged 10-17**	• **Children and young people**	**14**	**76**	Halton Community Bridge Builders Alice Court West Bank Flower Pots
117	**16-18 year olds who are not in education, training or employment (NEET)**	• **Children and young people** • **Employment Learning & Skills**	**14**	**118**	Intergenerational Conference Halton Castle Community Art Grangeway Café Castlefields Story Norton Priory

					Halton Community Radio Event Surestart To Later Life Halton Community Bridge Builders Alice Court West Bank Flower Pots
119	**Self-reported measure of people's overall health and wellbeing**	• **Adult Health & Well-Being and Tackling Exclusion & Promoting Equality** • **A Healthy Halton**		**10**	Mencap Support Hallwood Park Welcome Club Farnworth P.S. Vegetable Garden Grange Co-op Women's Guild Surestart To Later Life Oakmeadow Community Resource
138	**Satisfaction of people over 65 with both home and neighbourhood**	• **Adult Health & Well-Being and Tackling Exclusion & Promoting Equality** • **A Safer Halton**	**17**	**6**	Intergenerational Conference Mencap Support Castlefields Story Norton Priory Hallwood Park Welcome Club Grange Co-op Women's Guild Hallwood Park Day of Action Halton Community Radio Event Surestart To Later Life Halton Community Bridge Builders Oakmeadow Community Resource Alice Court West Bank Flower Pots
139	**People over 65 who say they receive the information, assistance and support needed to exercise choice and control to live independently**	• **Adult Health & Well-Being and Tackling Exclusion & Promoting Equality** • **A Healthy Halton**	**17**	**20**	Hallwood Park Welcome Club Hallwood Park Day of Action Surestart To Later Life Oakmeadow Community Resource
148	**Care leavers in employment, education or training**	• **Adult Health & Well-Being and Tackling Exclusion & Promoting Equality** • **Employment Learning**	**16**	**6**	Mencap Support Halton Community Radio Event Halton Community Bridge Builders

		& Skills in Halton			
192	**Household waste recycled and composted**	• **Local Economy and Environmental Sustainability** • **Halton's Urban Renewal**		**68**	Hallwood park Day of Action
195	**Improved street and environmental cleanliness (levels of graffiti, litter, detritus and fly posting).**	• **Local Economy and Environmental Sustainability** • **Halton's Urban Renewal**		**72**	Intergenerational Conference Halton Castle Community Art Hallwood Park Day of Action Surestart To Later Life

10. Key Factors for Success

In order to achieve the positive outcomes discussed in the previous section and to avoid negative outcomes (Gibson, 2006), good practice around a number of key factors is necessary. Some of these relate to aspects of project management such as funding, monitoring, evaluation and planning. Others are more specific to intergenerational practice and these are shown in italics below. In their review of the literature on intergenerational practice Springate, Atkinson and Martin (2005) stressed the importance of:

- Projects adopt a **long-term approach**, with a series of activities that allow time for interaction and relationships to develop
- Staff should have appropriate **skills and training** to deal with both generations, rather than just the one
- There is some form of **preparation of participants** before they engage in intergenerational activities
- Activities are focused on **developing relationships** between generations
- Activities are **shaped by participants**, so that the address needs of both young and old
- The activities will result in **mutual benefits** that are appropriate for both generations

A summary of the Key Factors for Success:

Sustainability:	*Long-term approach* Funding Monitoring and evaluation
Staffing:	*Skills and training* Commitment and enthusiasm Time and availability Stability
Activities:	*Shaped by the participants* Participatory Varied and diverse *Focused on developing relationships*
Participants:	*Preparation* Characteristics of the elderly volunteers *Ensuring mutual benefits*
Organisation:	Planning Setting deadlines Transportation
Partnerships:	Strategic involvement *Operational relations*

11. Funding

There is at present no specific funding available for Intergenerational projects. Hence, the need for a 'business plan' to examine possible funding opportunities and ways of making available projects extend their remit to include IG where possible, at little or no extra cost. The IG sub-group would need to look at existing services to see how IG activity might be developed in this way. This approach represents a significant culture shift. By thinking outside of their own peer group and involving others who are much younger or older, each group should be able to look at itself afresh, identify and develop practice, where it could benefit from IG work.

For example, every quarter 'Active Pensioners' could meet jointly with the 'Youth Cabinet.' Initially this would involve fact finding and getting to know one another better. Involving minimal additional cost, this would lead to discussion and planning to see what joint activities could be developed and how these could be jointly funded. Alternatively, a typical community centre (such as Ditton), could become a focal point where young and old could regularly interact, by dint of being in the same building. Users could discuss the possibility of a joint project and this could be formalised by both groups meeting together every few months to plan jointly.

An alternative approach could involve IG living developments of the kind made use of by the National Association of Adult Placement Services - NAAPS (http://www.naaps.org.uk). These allow adult placements where an older person can offer a home to a younger individual and in return are given low level support and company. The younger person frequently lives rent free and has the opportunity to live in a home in an area that would typically be beyond their means. Beaurocracy is kept to a minimum and safeguards ensure neither 'Householder' nor 'Homesharer' can be exploited. Halton already has an excellent Adult Placement service and this could be adapted without extra cost to include IG placements.

12. Summary

Evidence of benefits -There is ample evidence from the literature of the past 10 years suggesting that intergenerational projects can be significantly beneficial to both younger and older age groups. Each group can gain knowledge of the other and this new awareness helps to counteract any negative stereotypes that have been picked up from their peers and the media. People previously avoided in the street due to fear or disinterest, can be engaged in conversation and may even become friends.

Older people once involved, discover that they can pass on some of their life experience to an interested younger audience and in doing so learn that they still have much to offer by connecting with the community outside of their home. As a consequence, this has knock-on effects that reduces their isolation, improves their confidence and enjoyment, which together promote wellbeing and better health (mental and physical). Through involvement in new learning and contributing their time as volunteers there are many skills they can acquire from younger people, particularly where technology is concerned.

Younger people for their part can benefit by gaining enhanced skills, better communication and stronger self-esteem. As a consequence, they can acquire a purpose and enthusiasm. They become more involved their community in a way that was previously lacking and in

the knowledge that older people value their opinions and are interested in engaging with them as friends, neighbours and fellow students operating from opposite sides of life.

Local communities benefit through the wealth of volunteering activity that stems from the engagement of both younger and older age groups. This can have a direct effect on 'hard-to-crack' social problems common to areas of Halton where there are higher than average levels of anti-social behaviour, vandalism and petty crime, large numbers of young people who are NEET and older people who feel socially isolated from their own community due to fear.

The current menu of intergenerational opportunities featured in the action plan draws strongly on the positive outcomes that can ensue. These outcomes can have an impact far beyond the confines of the project itself enabling mutual respect and genuine interest to replace suspicion, fear and ignorance. It is this kind of multiple-engagement, leading to lasting social change, that Halton values. For this reason, the intergenerational ideas featured here are seen as central to its overall prevention/ intervention strategy. As such, they are part of a grander approach within the authority to promote the individual and their social network. This can impact not only on health and social care, but also act as an important driver for cultural change.

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Appendix 1

Generations Together

The Government is currently funding the £5.5 million 'Generations Together' demonstrator programme to enable 12 local authorities to develop and evaluate intergenerational programmes that will become part of their mainstream provision. The local authorities chosen from over 140 bids for the funding are listed below and links are provided to their Generations Together websites or project information pages.

'Generations Together' funded local authority programmes:

- Ealing (London)
- Gateshead (North East)
- Hammersmith and Fulham (London)
- Luton (East of England)
- Manchester (North West)
- Northamptonshire (East Midlands)
- Plymouth (South West)
- Portsmouth (South East)
- Reading (South East)
- Somerset (South West)
- Wakefield (Yorkshire and Humber)
- Worcestershire (West Midlands)

The Beth Johnson Foundation are commissioned by the Department for Children Schools and Families (now DfE) to support local authorities in developing their intergenerational practice as an integral part of their service delivery model. With a focus primarily upon offering support to the local authorities who were short-listed but unsuccessful in obtaining Generations Together funding, the programme has an action learning style approach. This format creates opportunities for participants to address particular issues and challenges in small working groups, in a supportive environment of peers, each bringing their own issues/challenges to the group.

- Southampton 7 September
- Wakefield 24 September
- Wolverhampton 6 October

Clare Batty, National Intergenerational Development Officer, leads this work and can be contacted via clare@bjf.org.uk

Appendix 2

Challenges involved in intergenerational work

Recruitment and selection of older people

- Recruitment of older people can be time consuming.
- It can be difficult to engage sufficient numbers of volunteers.
- Older people can doubt they have anything to contribute to younger people.
- There can be peer pressure on older people not to attend.
- They can be busy and reluctant to give up the time to others.
- Older people may feel intimidated by younger people.
- Older men, in particular, can be difficult to engage.
- Some older people are better at working with young people than others.
- Safeguarding issues can be a barrier to the recruitment of older people.

Recruitment and selection of young people

- There is a danger that activities can reinforce the stereotypes they are trying to dispel.
- It may be more challenging with hard-to-reach groups and those with behaviour difficulties.
- Young people may think that older people are boring.
- There may be peer pressure not to attend.

Activities

- Young people and older people have different needs.
- It can be difficult to ensure activities are suitable for both.
- It can be difficult to find common points of interest.
- If young people are not kept occupied they are likely to disengage.
- Active older people are more likely to be selective about the activities they engage in.
- Young and older people alike expressed concern about not knowing what to expect.

Organisation and logistics

- Planning and organisation of intergenerational work can be challenging.
- This can be exacerbated by short-term funding as the bid can drive the project rather than the needs of participants.
- Finding a time that is suitable for young and older people to meet can be difficult.
- Finding a venue that is suitable for both can also be problematic.
- Active older people are busy and may find it difficult to commit to every session.
- Lack of transport can be a barrier to intergenerational work.
- Arranging transport can be time consuming and costly.

Working with partners

- It can be difficult to ensure the commitment of partners.
- Existing pressures of work can hinder the setting up and delivery of Intergenerational work.
- It can be difficult to sustain school staff's involvement.
- There can be a clash of older people with support staff in schools.
- Partners may not promote or prioritise intergenerational work.

Appendix 3

Do	Don't
Think about the wider picture from the start, including sustainability – what is likely to happen when the activity is finished?	Don't age segregate and think that IG needs to be a combination of the very young and the very old. The difference could be just a generation, or a mix of generations.
Identify someone who is the lead, but don't leave it all up to one person. Build in the capacity for collaboration.	Do not be overambitious.
Identify learning outcomes and shared priorities which will be of interest to all concerned.	Don't make the mistake of seeing older people as a single homogenous group. The needs of the younger old will be different from the older old and individuals can vary enormously!
Prepare thoroughly: involve all parties in discussions before the activity to ensure objectives are agreed. Discuss fears, queries and worries and take action to reduce these where possible.	Don't assume that everyone can attend all meetings – caring roles may restrict times when meetings are possible.
Identify key contacts within partner organisations, carers or families.	Don't exclude minority groups.
Plan thoroughly: participants should come from a wide range of backgrounds with a variety of differing needs.	
Allow enough time for activities when working with frailer older adults, getting to and from the venue, support while at the venue and if possible, offer the cost of transport.	
Consider the possibility of quiet time for adults (if desired) and space for the young people to be active (if desired).	

[The above are adopted from the 'Users' guide to intergenerational learning,'
'Generations Working Together – The Scottish Centre for Intergenerational Practice, 2011, p. 8.]

Appendix 4

Key features of effective intergenerational practice

Recruitment and selection of older people

- Be proactive in engaging older people, especially men, through community groups.
- Give older people accurate information so they can make an informed choice about participation.
- Meet the older people beforehand and select appropriate volunteers.
- Ensure a one-to-one ratio of older to young people.
- Where possible ensure young people work with a consistent group of older people.
- Consider gaining the commitment of older people to all sessions at the beginning.
- Match the older to the young people with the same interests.

Preparation of participants

- Understanding participants' needs is critical for success.
- Preparation sessions allow providers to get to know the participants and to assess their needs.
- Preparation sessions ensure participants know what is expected of them.
- Give advice and guidance to older people about how to work with younger people.
- Integrate older people gradually into intergenerational work.
- Use existing participants to support new ones.
- More preparation may be required for certain groups.
- Preparation work can involve young people in helping to shape the activities.

Activities

- Take account of the needs of the young and older people
- Tailor the activities to the needs of the curriculum in schools
- Ensure activities are based on a mutual or shared interest
- Young people need to have a genuine interest and knowledge they can contribute
- Involve the participants in the planning and design of activities
- Activities need to be interactive and allow young people to show themselves at their best
- Use 'ice breaker' sessions to allow young and older people to get to know each other
- Create a tangible product and celebrate achievements

Delivery

- Ensure deliverers have the skills to work with young and older people
- The passion of the providers can be a key factor for success
- Adopt a 'hands on' approach to incidents that allow a focus on common misconceptions
- Agree a code of conduct from the outset and have clear ground rules
- Ensure a high ratio of staff to participants

Organisation and logistics

- Allow time for planning and organisation.
- Make sure the length and duration of sessions is appropriate.
- Ensure that the venue is familiar to both young and old, or 'neutral'.
- Make the older people feel welcome and integrated into the setting.
- Ensure transport is provided, especially for the older people.
- Consider the health and safety aspects, especially CRB checking.

Appendix 5

Examples of unplanned and planned Learning and Outcomes

Intergenerational Learning	
Learning occurring as a result of other activities	**Learning from activities with planned outcomes**
Parent/ grandparent and toddler groups Volunteering in day centres Befriending Childcare Supporting young parents Participation in community consultation Working together to promote and achieve a change in a community Discussion and debate	Supporting young parents Involvement in community consultation Working together to achieve community change Discussion and debate Mentoring Sharing skills Family learning Activities in schools that are linked to the curriculum Learning a new skill together
Typical Learning Outcomes	**Typical Learning Outcomes**
Improved communication and interpersonal skills Changed relationships with community and / or family Increased confidence and understanding Interest in developing current or new skills	Improved communication and interpersonal skills Changed relationships with community and / or family Increased confidence and understanding New/ retained skills Opportunities for further progression

Appendix 7

This table shows the variety of activities available for a selection of different target groups in various settings alongside relevant programme aims and expected outcomes**.**

Children from Early Years	Young Adults	Working Age Adults	Active Older Adults	Frail Older Adults
Target Groups	**Activities**	**Settings**	**Programme Aims**	**Outcome for Learners**
Families **Looked after children** **Specific ethnic groups** **Living in disadvantaged neighbourhoods** **Young NEETS** **Young people with social, emotional or behavioural difficulties** **Older people**	**Reminiscence** **Horticulture** **Mentoring** **Using Technology** **Community Devt.** **History** **Cooking** **Creative Arts** **Volunteering** **New Skills Devt** **Literacy Devt.** **Storytelling** **Discussion & Debate** **Childcare**	**Schools** **Care homes** **Community centres** **Community settings** **Museums** **Libraries** **Archives** **Children's centres** **Nurseries** **Workplace** **Voluntary organizations.** **Community organizations.**	**Widening participation in learning** **Social cohesion** **Improving school attendance and performance** **Improving health and wellbeing** **Reducing anti-social behaviour or fear of it** **Providing role models** **Learning specific skills and gaining knowledge** **Making sure voices of different generations are heard** **Enhancing employability**	**New/ retained skills** **Gains in confidence and understanding** **Improved communication** **Changed behaviours** **Changed relationships with community and / or family** **Improved health and wellbeing**

REPORT TO: Health Policy & Performance Board

DATE: 29 May 2012

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Adults
Neighbourhood, Leisure and Sport

SUBJECT: Gypsy & Traveller Sites Pitch Allocations Policy, Procedure & Practice

WARD(S): Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To present Members of the Health PPB with the revised policy, procedure and practice for the allocation of pitches on the Council's Gypsy & Traveller sites, which includes the permanent site, known as Riverview, located in Widnes and the transit site located in Astmoor, Runcorn.

2.0 RECOMMENDATION: That:

i) The report be noted; and

ii) Members comment on the Policy, Procedure & Practice (PPP) attached as Appendix 1.

3.0 SUPPORTING INFORMATION

3.1 A revised PPP has been developed with regard to the Gypsy & Traveller Site Management Good Practice Guide published by Communities & Local Government (CLG) in July 2009. A number of officers have contributed to the development of the revised PPP, including, the Gypsy & Traveller Liaison Officer, the Principal Manager Housing Solutions and the Divisional Manager Policy & Development Services.

3.2 The PPP brings the procedures in relation to allocation of accommodation for Gypsies & Travellers in line with the homelessness legislation to ensure that those who are in the greatest need are offered pitches when they become available.

3.3 The CLG guide states that:
'It is essential that local authorities have a published scheme which sets out the policies and procedures for allocating pitches. The policy for allocating pitches should be clear, fair and transparent'.

The revised PPP includes the following:

- Eligibility criteria which individuals must meet in order to be considered for allocation of a pitch;
- Information regarding the way in which need is assessed and prioritised (which falls in line with the homelessness assessment criteria, as contained in the Housing Act 1996 Part VII and amended by the Homelessness Act 2002);
- Procedural details in terms of how individuals can register their interest for a pitch and the application process upon a pitch becoming available;
- The assessment/decision-making process, including the consideration that is given to applicant compatibility with existing site residents. This is in line with the CLG guidance, which states that *'in some circumstances, management may take account of factors which would adversely affect the suitability of the site as a social unit';*
- The procedure in relation to the transit site;
- A procedural flow chart and application/assessment forms are included as appendices.

3.4 The revised PPP complements the service provided to Halton's Gypsy & Traveller community by the Gypsy & Traveller Liaison Officers, the Site Wardens and the Gypsy & Traveller Education Consultant. These members of staff also work closely with the Gypsy & Traveller Police Liaison Officer and partners from the health sector.

3.5 The overall result of this co-ordinated service is that Halton's Gypsy & Traveller residents have the same opportunity as the settled community to access health, education and other services.

3.6 Gypsy & Traveller children are in attendance at two of the nursery schools within the borough, 14 of the primary schools and three of the high schools. There are also some pupils on the elective home education roll and their education is monitored by the local authority officer. Regular liaison and the provision of advice and support helps to ensure that children access education, demonstrate regular patterns of attendance and successfully move through the key stages.

3.7 All those residing on Halton's permanent Council-owned site access education as appropriate and are registered with local GP and dentist surgeries. Work also takes place to encourage inclusion for those who reside on the three privately owned sites in Halton.

3.8 The Council's permanent site was refurbished in recent years and now has a community building, which is available for use by the entire Gypsy & Traveller community within Halton and regular young peoples' groups and health events are held. Families are also

encouraged to access local Children's Centres and Sure Start facilities. The mobile library visits the sites regularly offering the opportunity to loan books and utilise computer/Internet access.

3.9 In 2009, Halton Borough Council opened a transit site, which offers Gypsies & Travellers coming into Halton a safe place to stay where they are able to access services. Families are able to stay for a three-month period, which must be followed by three months away from the site before they can return. The transit site has greatly reduced unauthorised encampments in Halton – only 14 have occurred in the last two years and these were successfully dealt with within hours and the only associated cost was staff time. This compares favourably against a neighbouring authority without a transit site where there were over 60 unauthorised encampments over the same time period, a number of which took weeks to resolve and involved court action and the associated costs.

4.0 POLICY IMPLICATIONS

4.1 The PPP will ensure that Halton complies with current good practice guidance and continues to offer an inclusive service to the Gypsy & Traveller community.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
The revised PPP places families with children in a priority need category for the allocation of an available pitch on the permanent site. Once resident on site, the services provided ensure access to education and health services.

6.2 **Employment, Learning & Skills in Halton**
Residents on the Gypsy & Traveller sites within Halton are encouraged and supported to access education and employment.

6.3 **A Healthy Halton**
The revised PPP places those who are vulnerable due to a physical or mental health issue in a priority need category for the allocation of an available pitch on the permanent site. Residents are supported to access health services.

6.4 **A Safer Halton**
The revised PPP outlines a fair approach to the allocation of pitches on the permanent and the transit site and therefore reduces the incidence of unauthorised encampments, which disrupt community safety.

6.5 **Halton's Urban Renewal**
The revised PPP contributes to the sustainability of Halton's communities.

7.0 **RISK ANALYSIS**

7.1 None identified.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 It is widely acknowledged that Gypsies and Travellers are amongst the most marginalised communities in the country and can suffer disproportionate levels of discrimination. The Equality Act 2010 places a general duty on public authorities to eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunity between different groups and foster good relations between different groups.

An associated Equality Impact Assessment (EIA) has been completed. No negative impacts were found on any of the protected characteristics.

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

Document	**Place of Inspection**	**Contact Officer**
Gypsy & Traveller Site Management Good Practice Guide (Communities & Local Government)	People & Communities Policy Team, 2nd Floor, Runcorn Town Hall	Natalie Johnson

HALTON BOROUGH COUNCIL

Communities Directorate

Appendix 1

Gypsy & Traveller Sites Pitch Allocations

DRAFT

Policy, Procedure and Practice

March 2012

CONTENTS

INFORMATION SHEET

Service area	Housing Solutions (Gypsies & Travellers)
Date effective from	March 2012
Responsible officer(s)	Principal Manager, Housing Solutions Gypsy & Traveller Liaison Officer
Date of review(s)	March 2014
Status: ▪ **Mandatory (all named staff must adhere to guidance)** ▪ **Optional (procedures and practice can vary between teams)**	Mandatory
Target audience	Operational staff involved in the allocation of pitches on Council owned Gypsy & Traveller sites
Date of committee/SMT decision	SMT: 11.04.2012
Related document(s)	Gypsy & Traveller Site Operational Procedures Site Licence Agreement
Superseded document(s)	Riverview Admissions Policy
Equality Impact Assessment (EIA) completed	03.04.2012
Adult Safeguarding Audit Tool completed	09.03.2012
File reference	TBC

1.0	POLICY	*PRACTICE*
1.1	**Introduction** Halton Borough Council owns and manages two residential caravan sites for Gypsies and Travellers, both of which have a residential site warden. The Riverview permanent site, located in Widnes, has 22 pitches for rent. The Warrington Road transit site, located in Astmoor, Runcorn, has 13 pitches for rent. Each pitch can accommodate a maximum of two caravans and two vehicles. The Council is committed to the provision of residential pitches for Gypsy & Traveller communities and the aim of this document is to ensure that pitches are allocated on a clear, fair and transparent basis.	Communities and Local Government (CLG) published a 'Gypsy & Traveller Site Management Good Practice Guide' in 2009, which states that *'it is essential that local authorities have a published scheme which sets out the policies and procedures for allocating pitches'.*
1.2	**Criteria** ***Eligibility*** In order to be considered for allocation of a pitch on the Riverview site, applicants must: ▪ Be aged 18 or over; ▪ Be from a Gypsy or Traveller background; ▪ Not have any serious criminal convictions (where 'serious' is considered to mean any crime for which a custodial sentence of two years or more was served and/or any violent offence); ▪ Not be intentionally homeless; ▪ Not have been excluded from any Local Authority site in the past. *In addition, those applicants who are adequately settled within permanent accommodation will not normally be considered for the allocation of a pitch on the Riverview site.* Consideration will only be given in exceptional circumstances, as determined by the Principal Manger, Housing Solutions. Such circumstances may include an element of risk for the applicant in their existing accommodation, the applicant having an overriding medical/health need or a need for the applicant to reside at Riverview in order	The CLG Guide states that *'qualification criteria may be set and evidence sought in relation to this.'*

	to care for an existing Riverview site resident. Those living in bricks and mortar housing who have a preference for living in a caravan are eligible to apply but will not normally be offered a pitch above those without any accommodation that they have a legal right to occupy. ***Assessment of Need*** Applications for a pitch will be prioritised in line with the homelessness assessment criteria (as contained in the Housing Act 1996 Part VII and amended by the Homelessness Act 2002). Therefore, applicants falling into the following categories will be given priority: *Homeless/threatened with homelessness in the next 28 days, meaning:* ▪ They have no accommodation that they have a legal right to occupy; ▪ They have accommodation but cannot gain entry to it; ▪ They live in a moveable structure but have nowhere to place it; ▪ They have accommodation but it is not reasonable for them to continue to occupy it; ▪ They face the risk of violence from someone who lives in their home or with whom they are associated; OR ▪ There is good reason to believe that continuing to occupy their home is likely to lead to violence from another person. *In a priority need category, meaning:* ▪ They or their partner are/is pregnant or have dependant children; ▪ They are homeless because of an emergency, for instance fire or flood; OR ▪ They are vulnerable as a result of: ▫ Old age, mental illness, physical disability or another special reason; ▫ Having served a custodial prison sentence; ▫ Having had to leave accommodation because of actual violence or threats of violence that are likely to be carried out; OR ▫ Other special reasons.	The CLG Guide includes the following relevant points: - *'waiting lists should include a system of prioritisation and pitches allocated in accordance with the scheme'* - *'the method of prioritisation should relate as closely as possible to the scheme for allocation of all other forms of social housing'* - *'priority should be given to those in greater need'.*

	Applicants who have a local connection will also be given priority. This would include having close family members residing on the Riverview site.	
2.0	**PROCEDURE**	***PRACTICE***
2.1	**Riverview permanent site** Anyone interested in being considered for allocation of a pitch on the Riverview site should contact the Gypsy & Traveller Liaison Officer on 0151 423 5849/0303 333 4300 to express their interest. They will be asked to complete an *Application for Allocation of Pitch Form* (see Appendix 1). Assistance will be available with completion of this form on request from the Site Warden/Gypsy & Traveller Liaison Officer. Details will be recorded on a *Pitch Interest List* and when a pitch becomes available on the Riverview site those on this list will be contacted and asked to complete a *Gypsy & Travellers Assessment Form* (see Appendix 2). Again, assistance is available with completion of the form on request. There will be a closing date for receipt of completed *Gypsy & Travellers Assessment Forms.* Applicants should be aware that there is a high level of demand for pitches on the Riverview site and there is limited movement with pitches rarely becoming available. Both the *Application for Allocation of Pitch Form* and the *Gypsy & Travellers Assessment Form* are available to collect from the Site Wardens and the Council's one-stop-shops (in Halton Lea, Church Street Runcorn and Brook Street Widnes). The forms can also be requested by calling the Gypsy & Traveller Liaison Officer on 0151 423 5849 or the Council's contact centre on 0303 333 4300. The *Pitch Interest List* will be reviewed annually and when a pitch becomes available to determine whether interested	*'Applications should be acknowledged and assessed as soon as possible after receipt and applicants should be placed on a waiting list if no suitable pitches are currently available' (CLG guidance).* *'Waiting lists should be regularly reviewed'* (CLG guidance).

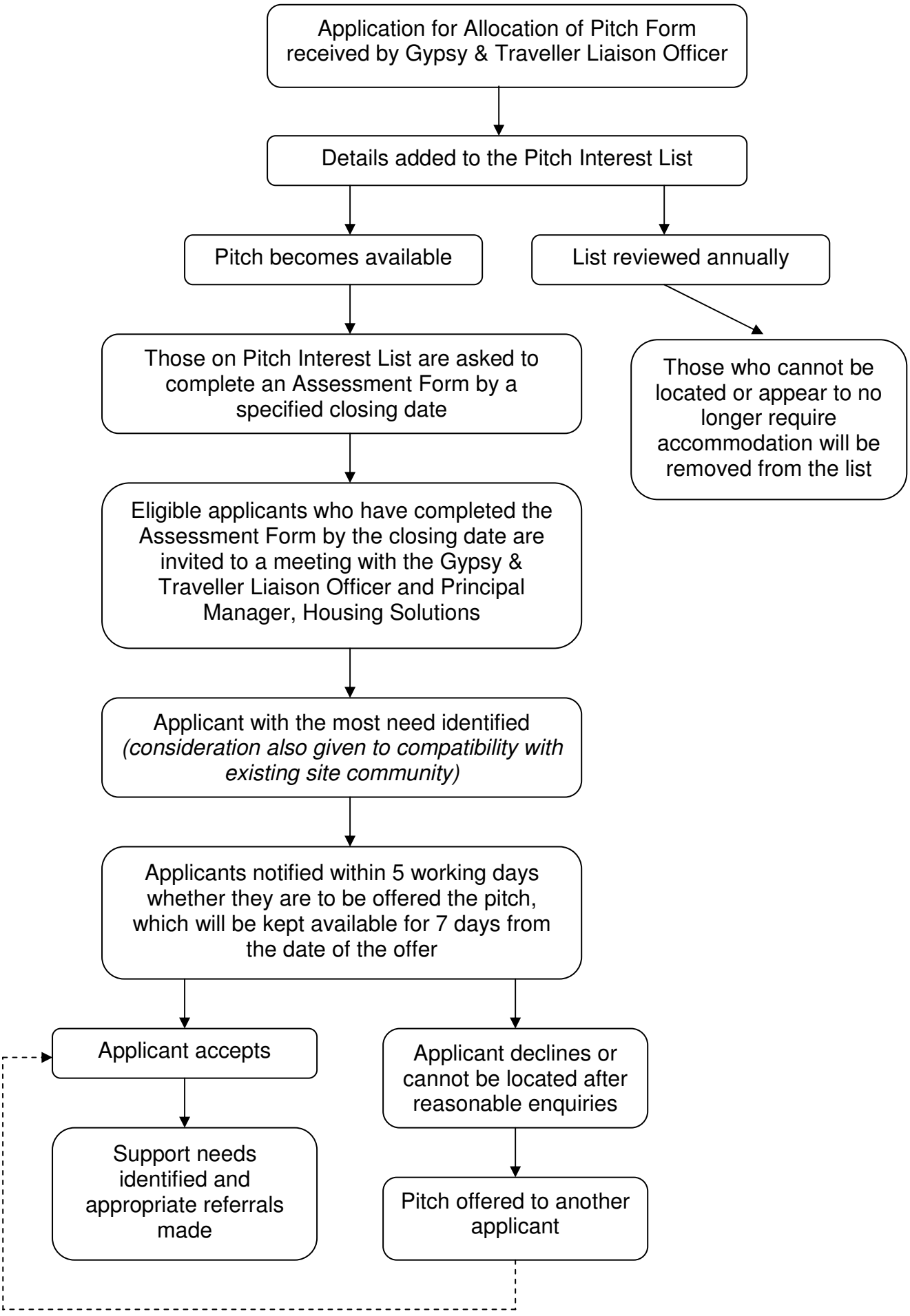
	persons still need/wish to be considered for a pitch. The council reserves the right to remove those who, upon reasonable enquiry, appear to no longer require accommodation or cannot be located. The information provided on the *Application for Allocation of Pitch Form* and the *Gypsy & Travellers Assessment Form* will be retained for a period of five years and used to inform Gypsy & Traveller Accommodation Assessments, which assess the amount of unmet need for pitches. Applicants must complete the *Gypsy & Travellers Assessment Form* in order to be considered for a vacant pitch. Information may be provided verbally but must be recorded on the form, which must be signed by the applicant to confirm that the information detailed on the form is correct. Anyone found to have given false information on the form will not be offered a pitch or in cases where they have already taken residency of a pitch they may be evicted. All eligible applicants who have completed a *Gypsy & Travellers Assessment Form* by the closing date specified will be invited to a meeting with a panel composed of the Site Warden, Gypsy & Traveller Liaison Officer and Principal Manager, Housing Solutions in order to discuss their application for a pitch further. The purpose of the panel meeting is to determine which applicant is most in need in accordance with the criteria outlined above. In the event that two or more applicants meet the same criteria, applications will be considered on a case-by-case basis in order to determine which applicant is most in need. Consideration will also be given to the compatibility of the applicant (and their family) with the existing Riverview site community and the potential for disruptive/anti-social behaviour and there will be an assessment of risk in this respect. However, the assessment of need will	The CLG Guide outlines that *'in some circumstances, management may take account of factors which would adversely affect the suitability of the site as a social unit'*, as it is acknowledged that *'sites are often occupied by extended family groups and this can help to ensure*

	always be the most important factor in deciding who will be allocated a pitch. As part of the assessment process, any support needs (i.e. aids/adaptations required) will be identified and the appropriate referrals made upon the acceptance of the offer of a pitch. All applicants will be notified within five working days as to whether or not they are to be offered a pitch. The pitch will be kept vacant for a period of seven days from the date of the offer. If the applicant does not take up occupancy of the pitch and cannot be located after reasonable enquiries, the offer will be withdrawn and the pitch allocated to another applicant. Any applicant who refuses the offer of a pitch will need to go through the application process again before any subsequent offers will be made. The decision of the panel is final. The council has a formal complaints procedure through which any issues can be raised and addressed (a complaint can be lodged by calling the Council's contact centre on 0303 333 4300 or filling in the online enquiry form on the Council's website). Upon acceptance of the pitch, the successful applicant will be issued with a Licence Agreement detailing fees and charges and the conditions that must be adhered to along with information regarding site management procedures.	*good community relations on site'.*
2.2	**Warrington Road transit site** There are no applied criteria for the allocation of pitches on the transit site – applicants will simply be offered a pitch if there is one available unless there are significant reasons for not doing so (e.g. serious criminal convictions, a record of arrears/anti-social behaviour or previous exclusion from a Local Authority site). In cases where there is more than one applicant being considered for a pitch on the	The CLG Guide advises that transit site pitches should be considered for short-term use in order to meet the immediate accommodation need of the applicant, especially in cases where there is no other authorised

	transit site, the criteria will be applied as for the permanent site to determine which applicant has the most need. Similarly, in the event that two or more applicants meet the same criteria, applications will be considered on a case-by-case basis in order to determine which applicant is most in need and most suited to taking residency of the pitch. The maximum length of stay on the transit site is three months, after which time a minimum of three months must be spent away from the site before another period of residency will be considered. As with the permanent site, once the pitch is accepted, a Licence Agreement will be issued, which details fees and charges and the conditions that must be adhered to. Information regarding site management procedures will also be provided.	accommodation.

Appendix 1

Process for allocation of pitches on the Riverview site



Appendix 2

GYPSY & TRAVELLERS APPLICATION FOR ALLOCATION OF PITCH FORM

Personal details – applicant					
Title	First name	Family name/surname	Date of birth	Age	National Insurance number

Current address (including postcode):			
Date moved in:			
Contact telephone numbers:	Home:	Work:	Mobile:
Email:			
Why do you need help with your housing situation?			
Is your contact address the same as your current address? If no, please write contact address below:			

Details of anybody else in your household wishing to live with you					
Title	First name	Family name/surname	Date of birth	Age	National Insurance number

If any member of your household is pregnant please state their name and the date the baby is expected to be born:	
Have you or anyone on this form previously resided at a site in Halton? If yes, please give details:	

Where:			
Date from:		Date to:	

Do you or anyone on this form have any health conditions Halton Borough Council should be made aware of? If yes, please give details:
Additional information
I have read/had read to me the declaration below.
As far as I/we are aware the information given on this application form is true. I/we understand that I/we may lose any pitch offered or let to me/us if false information is given.
I/we understand that the information recorded on this form will be retained by the Council for a period of five years and used to inform assessments of unmet need for pitches.

Applicant name – print:		
Signed:		Dated:
Spouse/partner name – print:		
Signed:		Dated:

Appendix 3

GYPSY & TRAVELLERS ASSESSMENT FORM

Personal details – applicant					
Title	First name	Family name/surname	Date of birth	Age	National Insurance number

Current address (including postcode):			
Date moved in:			
Contact telephone numbers:	Home:	Work:	Mobile:
Email:			
Why do you need help with your housing situation?			
Is your contact address the same as your current address? If no, please write contact address below:			

What type of accommodation do you live in? Please tick one of the boxes to indicate:			
House	☐	Caravan/mobile home	☐
Bungalow	☐	Care/rest home	☐
Ground floor flat	☐	Hospital	☐
Upper floor flat	☐	Armed Forces	☐
Multi-storey flat	☐	Prison	☐
Maisonette	☐	Hostel/night shelter/rough sleeper	☐
Bed-sit/studio	☐	Other – please state:	

What type of tenure do you have? Please tick one of the boxes to indicate:			
Owner-occupier/leaseholder	☐	Hostel	☐
Private tenant	☐	B&B	☐
Tied accommodation	☐	Rough sleeping	☐
Housing Association tenant	☐	Name of association:	
Council tenant	☐	Name of local authority:	
Living with relatives/friends/others	☐	Specify which and provide name and contact number:	

Appendix 3

If you are currently renting, please give details of the type of tenancy you hold. Please tick one of the boxes to indicate:			
Secure ☐	Assured ☐	Assured shorthold ☐	Verbal ☐
Tenancy start date:			
If this is a joint tenancy, please provide full name of joint tenant:			

Personal details – spouse/partner (if they are to live with you)					
Title	First name	Family name/surname	Date of birth	Age	National Insurance number

Current address (including postcode):			
Date moved in:			
Contact telephone numbers:	Home:	Work:	Mobile:
Email:			
Please describe your accommodation (e.g. three bedroom house/room in a house/two bedroom first floor flat):			

Is your contact address the same as your current address? If no, please write contact address below:

Details of anybody else in your household wishing to live with you and your spouse/partner					
Title	First name	Family name/surname	Date of birth	Age	National Insurance number

If any member of your household is pregnant please state their name and the date the baby is expected to be born:	

Have you or anyone on the application been in care? If yes, please give details:			
Name of person who was in care	Dates from and to	Where/name of local authority	Name of Aftercare Worker

Do you have any pets? Yes ☐ No ☐
If yes, please give details:

Have you been asked to leave your accommodation? Yes ☐ No ☐			
By what date?		Has the landlord applied for a court order?	Yes ☐ No ☐

Please list all addresses you have lived at over the last five years (most recent first):

Applicant addresses	Type of accommodation	Date from	Date to	Landlord's name, address and contact number	Reason for leaving
Spouse/partner addresses	Type of accommodation	Date from	Date to	Landlord's name, address and contact number	Reason for leaving

Income – you will need to provide proof of income/benefits				
	Applicant	Spouse/partner	If weekly, please tick	If monthly, please tick
Hours worked each week	hours	hours	☐	
Wages	£	£	☐	☐
Company pension	£	£	☐	☐
Income support	£	£	☐	☐
Jobseeker's Allowance	£	£	☐	☐
Employment Support Allowance	£	£	☐	☐
Child Benefit	£	£	☐	☐
Child Tax Credit	£	£	☐	☐
Disability Living Allowance – Mobility High / Medium / Low	£	£	☐	☐
Disability Living Allowance – Care High / Medium / Low	£	£	☐	☐
Incapacity benefit	£	£	☐	☐
Pension/Pension Credit	£	£	☐	☐
Bereavement	£	£	☐	☐
Carer's Allowance	£	£	☐	☐
Other state benefits – please specify:				
	£	£	☐	☐
	£	£	☐	☐
Maintenance	£	£	☐	☐
Money from anyone that lives with you	£	£	☐	☐
Housing Benefit	£	£	☐	☐
Council Tax Benefit	£	£	☐	☐
Student loan/grant	£	£	☐	☐
Insurance payment	£	£	☐	☐
Other – please state:				
	£	£	☐	☐
	£	£	☐	☐
For office use only – TOTAL INCOME:	£	£	☐	☐

Detail below any bank/building society accounts and other savings/valuable assets:		
Name of bank/building society	Account number	Amount held
		£
		£

Please detail below any further information that you think we may need to know:

TO BE COMPLETED BY HOUSING SOLUTIONS ADVISER:
Has the applicant ever approached this or any other Council for assistance with housing advice before?
Yes ☐ No ☐ If yes, please give details:

Is the applicant or anyone else on this form currently on a housing waiting list?					
Yes ☐ No ☐ If yes, please provide further details below:					
Where?		For how long?		Any offers?	

Does the applicant or any member of their household have any drug and/or alcohol issues?
Yes ☐ No ☐ If yes, please give details:

Does the applicant or any member of their household have or have they previously had any of the following conditions?		
Tuberculosis ☐	Mental health related illness ☐	Hepatitis A / B / C ☐
Any other health issues? Please state below:		

Has anyone ever taken action against the applicant or anyone on this form for anti-social behaviour?
Yes ☐ No ☐ If yes, please give details:

Has the applicant or anyone on this form had an Anti-Social Behaviour Order granted against them?			
Yes ☐ No ☐ If yes, please give details:			
Name of person with the order	Granted by (Local Authority, Housing Association etc.)	Court Action – please give details	Less formal action, i.e. a written warning – please give details

Has the applicant or anyone on this form ever been convicted of a criminal offence?				
Yes ☐ No ☐ If yes, please give details:				
Name of person convicted	Crime (please include arson, sexual offence, violent offence)	Date of sentence	Length of sentence	Length of time served

Has the applicant or anyone on this form served in the Armed Forces?			
Yes ☐ No ☐ If yes, please give details:			
Name of person who has served	Name of service	Dates served	Service number

Does the applicant or anyone on this form have a medical condition or disability that is made worse by their current housing situation and/or that may affect the suitability of any future accommodation they may be offered?
Yes ☐ No ☐ If yes, please give details:

Note details of any contacts, where appropriate:	Name	Support provided	Telephone number
Family Doctor			
Consultant			
Social Worker			
Community Psychiatric Nurse			
Solicitor			
Health Visitor			
Probation Officer			
Youth Offending Team			
Tenancy Support Officer			
Next of Kin			
Other(s) – please state			

Does the applicant have accommodation available to them in the UK or anywhere else in the world?		
Yes ☐	No ☐	If yes, please give details:

Additional information

Data Protection declaration/authority to disclose information
The information supplied in this form will be held on computer. I/we agree that Halton Borough Council may make enquiries on my/our behalf and authorise you to release any information requested by the Council that may be held under the Data Protection Act 1998. I/we authorise Halton Borough Council to make such enquiries as are thought necessary in connection with any of the information given by me/us. I/we understand that the relevant agencies may include, but is not limited to any police force, previous landlords, probation service, any service identified on this form and other council departments. I/we understand that enquiries will be made concerning my character and conduct of any previous tenancies or occupations of any property. I/we understand that the council reserves the right to suspend, remove or exclude from any scheme or service within the Housing Solutions service, if information received or held by Halton Borough Council indicates that I/we may not make a suitable tenant in accordance with current legislation. I/we confirm that the details given are true and correct. I/we understand that if any false information or statement has been provided, this may result in suspension, removal or exclusion. I/we understand that the information recorded on this form will be retained by the Council for a period of five years and used to inform assessments of unmet need for pitches.

Applicant name – print:	
Signed:	Dated:
Spouse/partner name – print:	
Signed:	Dated:

Appendix 3

FOR OFFICE USE ONLY:		
Date:	Time:	Name of Adviser:
Date:	Time:	Name of Adviser:
Date:	Time:	Name of Adviser:
Date:	Time:	Name of Adviser:
Date:	Time:	Name of Adviser: